

## 1 Submission to the Senate Standing Committee on Community Affairs

Senate Standing Committee on Community Affairs  
PO Box 6100  
Parliament House  
Canberra ACT 2600

### **Subject: Commonwealth Funding and Administration of Mental Health Services.**

#### Summary:

I offer information to support the case for Medicare to remove the two-tier system of payment for APS registered psychologists. I point out the possible risks of over-servicing with this type of system. I make a case for a more therapeutic/counseling/health orientation across the wide range of BOiMHC cases and not always employing the more physical medicine 'clinical' psychology model.

I make no comment on the current recommendation to reduce the number of Better Access appointments to redirect funds to other programs. The question of reducing Medicare appointments per year is a vexed one and many other Submissions cover the point (probably too many). The increase in funding for ATAPS team-based approaches to complex psycho-social problems in disadvantage groups is a *fate accompli* but necessary.

As a handful of other Submissions have intimated the use of psychologists in a team setting may have very important implications for the essential 'confidentiality contract' between the individual patient/client <and> the individual psychologist. The APS should produce a position paper on this central issue for Medicare as a matter of urgency.

I have a number of (Draft Only) appendices (Document-2) for the reader to utilize as they see fit. The whole submission should be considered a working draft.

As requested on your website I submit this document in MS-Word 2003 format. I note your advice that submissions may be converted to pdf format.

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## 1.1 Recommendations

**(a)** The Government's 2011-12 Budget changes relating to mental health;

Not addressed.

**(b) Changes to the Better Access Initiative, including:**

**(i)** *the rationalisation of general practitioner (GP) mental health services;*

I have read very well organized and insightful GP Care Plans. Some of the problems (besides the benefits) of GP referrals to psychologists are becoming more apparent. Case complexity dictates the complexity of a referral letter or a GP Care Plan. Issues of time and the use of planning *pro formas* are now well documented. Returning to brief referral letters has been recommended in other Submissions.

Some submissions question whether it is logical for a person with two days training in 'mental health' to write a detailed case plan for someone with a minimum of 6 years psychology education and supervised training (and various levels of practical experience) in professional psychology? On the other hand, many GP's have years of experience in patient presentation and illness behaviour.

However, currently GP mental health care plans could be seen as more an administrative procedure despite many plans being well written documents.

In (well defined) complex cases the psychologist should provide a solid report to the patient/client and the GP (subject to APS patient confidentiality considerations). How can this be justified, funded, and evaluated within the new Better Access arrangements? Medicare may want to give preferences on report content.

**(ii)** *the rationalisation of allied health treatment sessions;*

The question of limits on the number of sessions in a government funded program is inevitable. Other submissions also point out that many empirically-supported procedures and protocols for common conditions (such as severe anxiety and depression) often require a minimum of some 15 - 20 appointments for a successful intervention in the first instance.<sup>1</sup> This can vary widely for a range of reasons. An expert study group should convene to report on this unfortunate anomaly. Maybe it already has.

The new six sessions limit (plus extensions) will still allow relatively straightforward issues to be addressed effectively as well as allowing the patient/client themselves to assess whether they are suited to the therapeutic/health psychology approach in the longer term. It will still allow relatively affluent people to consider whether to invest their own money in further non-Medicare psychology appointments.

Group programs could be more strongly encouraged by Medicare to maximize the option of an additional 10 appointments for more carefully screened individuals. A modification of the university tutorial group with on-line CBT type exercises may be the best model for this. A number of excellent programs are already freely available (e.g., <http://www.anxietyonline.org.au/>).

The next Better Access Evaluation needs to address case difficulty and socio-economic status more closely. (See submission No 135 in particular). This relates more to the sociology of health but is important.<sup>2</sup>

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<sup>1</sup> Barlow, D. H. (2008). *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*. London: The Guilford Press 4th Edition.

<sup>2</sup> Wiley-Blackwell Sociology of Health and Illness. On-line Library.  
<http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291467-9566>

The question of the very high APS 'recommended only' fees is a related matter that needs to be addressed but in what way I am not sure. This in turn links to the even higher recommended hourly rate (and Medicare rates) for psychiatrists. Issues of powerful lobbies and self interest are obvious.

**(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs;**

I comment on the misuse of word 'clinical' in psychology in the main text. GP's invariably use a DSM-IV category as the basis for the referral. In concert with the use of ICD-10 by Medicare I imagine (and hope) ICD-11 will be replacing the DSM in Australia in the not to distant future.<sup>3</sup> There may be an opportunity with this better assessment and management framework to persuade GP's to remain within the fold in terms of brief referrals to registered psychologists (with or without Medicare). Retraining will be required (on-line?).

The re-direction of resources into ATAPS Divisional Team approaches still often needs accurate and reliable psychological assessments. Paradoxically this may encourage adherence to a medicalised or medico-legal psychology model which is sometimes inappropriate and/or ineffective.

Since 'psychology assessments' approaches may vary widely amongst registered psychologists Medicare will need to arrive at its own pro-forma/advisory for psychological assessment/report content. This will require a literature review/research project.

Medicare should explore overseas schemes for identifying/sampling so called 'case difficulty' independent of the psychologist contracted to provide the relevant psychology services for Medicare.

Patient confidentiality sometimes impinges (quite rightly) on the detail a psychologist can provide to a GP in writing. This important consumer protection issue needs clarification on the Medicare/DH&A websites and in policy terms.

**(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;**

'Mild to moderate mental illness' is an elastic and illusive term. See (b) (ii) above.

**(c) The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;**

The increased use of an ATAPS team approach for rural and remote and disadvantaged groups is logical. Workforce availability and the limitation on appointments will still ensure a gap between the best of intentions and reality on the ground. Also see (b) (i) – (iii) above.

**(d) Services available for people with severe mental illness and the coordination of those services**

The two volumes of the ICD-10 based 'Management of Mental Disorders' as now supplied by DH&A are an excellent resource for core case management skills. As far as I am aware no in-depth studies on defining 'case complexity' in different disadvantaged groups appear to have been undertaken by any of the parties in the Medicare Psychological Services system. This is an important scientific and practical step in coordination of new services. Again, an action research approach may be useful.

**(e) Mental health workforce issues, including:**

**(i) the two-tiered Medicare rebate system for psychologists;**

Science (and good program management) is concerned with objective outcomes and not rhetoric or unfounded assertions (Submission 140 gives the flavour of one person's day-to-day subjective challenges and viewpoint).

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<sup>3</sup> WHO & Collaborating Centre for Evidence in Mental Health Policy (1995/2000/2011). Management of Mental Disorders-Vol 1 & 2. Sydney. [www.crufad.org](http://www.crufad.org) & DH&A.

The two-tiered rebate system for psychologists should be terminated until such time as reliable data emerges - demonstrating that psychologist with the 'clinical' appellation produce significantly better symptom reduction and those broader patient outcomes - than other APS registered psychologists of diverse experience and training. This goes against the Specialist College philosophy but may suite Medicare better in terms of outcomes and reliable 'troops on the ground.'

Some submissions have recommended that 'clinical' endorsed psychologists have the same generous annual appointment settings and the same pay rates as psychiatrists. All these people need to do is re-train as psychiatrists.

Registered psychologists of the 'clinical' or 'counseling' or 'health' psychology orientation should not be given the 'up to 50 consultant services per annum' apparently now allowed for psychiatrists under the revised Medicare arrangements. I assume comments in some submissions about psychiatrists being eligible for up to 365 consultations per year are without foundation.

'Focused Psychological Strategies' with an experienced psychologist will include all those other elements in the therapeutic psychology process described by Meichenbaum (as one of the examples outlined in Document-2 Appendix) and the well known 'skilled helper' (non-pathologizing) approach of writers such as Egan,<sup>4</sup> Kanfer and Scheft<sup>5</sup> and more recently Gilbert and Leahy<sup>6</sup>.

In a further spirit of empiricism a regional based program is needed to cross check the over-diagnosis/wrong intervention *nexus* and identify the frequency of such *human errors* in a sample of so called 'generalist' and so called 'endorsed' psychologists. This would be a difficult undertaking but careful design and practitioner honesty would greatly aid such a risk management effort.

The over-servicing monitoring system needs more than the 'threat' of random auditing.

(ii) *workforce qualifications and training of psychologists;*

Not specifically addressed but see previous entries above.

I note the new Newcastle university courses of 'clinical-health' psychology which may start to take economic-social status factors more into account when developing interventions. Who knows, there might be an Australian 'health-counseling-clinical' Masters Psychology course at some stage.

As stated earlier this links to 'sociology of health' perspectives.

(iii) *workforce shortages;*

Not addressed.

**(f) The adequacy of mental health funding and services for disadvantaged groups, including:**

- (i) culturally and linguistically diverse communities,
- (ii) Indigenous communities, and
- (iii) people with disabilities;

Not addressed at this time.

**(g) The delivery of a national mental health commission;**

What would such a commission do that is not already covered by the PBA, APS, and DH&A/Medicare plus all the other related organisations at both Federal and State level?

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<sup>4</sup> Wosket, V (2006). Egan's Skilled Helper Model. London: Routledge.

<sup>5</sup> Kanfer, F. H. & Scheft, B. K. (1988). Guiding the Process of Therapeutic Change. Champaign, Ill: Research Press.

<sup>6</sup> Gilbert, P. & Leahy, R. L. (2007). The Therapeutic Relationship in the Cognitive Behavioral Therapies. NY: Routledge.

I wonder whether another Government umbrella organisation would serve to improve the situation on the ground. Probably better coordination is what is required.

In my view the developments in the United Kingdom under the central government NICE scheme are to be avoided at all costs but the Medicare super clinics and ATAPS programs may already be heading that way as far as psychological services are concerned.<sup>7 8 9 10</sup>

**(h) The impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups;**

*eHealth* is in the very early stages of development. In the case of Medicare one vital issue is to ensure this does not turn into an exercise in 'window dressing' for rural and remote locations. Literature reviews and university-based field research should be commenced now comparing face-to-face and teleconferencing approaches in psychological interventions (not psychotherapy) with Australia's unique conditions and cultures. This should be much more than 'Skype supportive counseling.'

As has recently been pointed out in the press in terms of the indigenous community the issue of stereotyping and over-use of the abnormality label in 'mental health' models is to be avoided. Psychiatric diagnoses for cases of very severe psychological disturbance are fully acknowledged.

**(j) Any other related matter.**

Not applicable.

## **1.2 The personal and professional context**

I reluctantly include career information simply to establish my credibility to comment on these issues as a practitioner. I commenced my working life as a craft apprentice in a steel works in S Wales, UK. Life as a 'blue collar' worker gave many lessons about survival in a high-risk psycho-social environment. Some patients/clients of the Better Access program and many in the ATAPS ones can find themselves in a 'survival' situation.

I began my studies in psychology in 1968. I was originally trained in the British empirical psychology tradition i.e., '*The most complex of arts evaluated by science.*'

I have had 40 years working as a professional psychologist in a wide range of roles and have been a full member of the APS for 36 years. I have taught in two Australian universities and been a researcher in CSIRO. I have a BSc (Hons) in Occupational Psychology (1971, UWIST), a Masters of Applied Psychology from Melbourne University (1978) and a PhD in Risk Psychology from La Trobe (1991). I have been a firm advocate of continuous professional development, self-directed study, and staunch protection of patient rights.

Following the above two post-graduate qualifications, I completed all 16 units and all 'clinical placements' (1992-1994) in the ANU Masters of Clinical Psychology as further professional development at 49 years of age. For me, this course confirmed that there were no differences in the

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<sup>7</sup> North, M. (1972). *The Secular Priests: Psychotherapists in Contemporary Society*. London: George Allen & Unwin.

<sup>8</sup> Cromby et al. (2007). *Our Big Fat Multi-Million Pound Psychology Experiment*. Nottingham: The Midlands Group.

<sup>9</sup> Cromby et al. (2007). Questioning the science and politics of happiness: Questioning whether Lord Lanyard's focus is wrong. Perhaps unhappiness is one of our precious assets. *The Midlands Group. The BPS Psychologist*, Vol 20, No 7, July 2007, p. 422-425.

<sup>10</sup> Smail, D. (2006). *Power, Interest and Psychology: Elements of a social materialistic understanding of distress*. Ross-on-Wye: PCCS Books.

*core skills* of a ‘clinical’ psychology approach to those I had already acquired in earlier training. To some extent I undertook the ANU study and placements to see if the *mystique* of ‘clinical psychology’ even then within the profession was justified. My conclusion was that it was not.

Ironically, I discovered this was still consistent with the scientific evidence much later on. Others obviously have a different viewpoint in terms of wanting to be highly paid ‘specialist.’

Following the studies at ANU I chose to remain in the category ‘General Psychologist’ within the APS because I did not agree with the APS splitting into different ‘fee structure interest groups’ seeking government sanction and approval. I believed this movement would lead to dissension within my professional organization. My concerns were subsequently borne out in full.

[See: Email Professor Lyn Littlefield Executive Director, APS Matters – 28 July 2011 – the latest news and information from the APS: ‘*A plea for unity.*’ Thursday 28 July 18:07.]

I have been registered as a general psychologist with Medicare since March 2008. I am now on a small bridging program for the College of Health Psychology which most closely approximates my preferred orientation in my work. I do not want or expect a higher Medicare fee than any of my APS colleagues. I chose not to advertise my services with a website.

Psychology is a fascinating and rewarding profession. My own orientation has always been that of service and research not personal gain. Friends in my ‘older APS psychologist’ group often suggest the concept of professional service is lost to corporate society. Maybe so called ‘evidence-based’ practice (and broad-brush government policy) has not yet quite managed to replace professional notions of ‘service and fair fees’ in terms of value to individuals and the community.

Being semi-retired means I have no axe-to-grind. I am simply interested in giving my own ‘*best approximation to the truth*’ of the current matter as I see it to the Senate Committee. I am very happy to be proven wrong in a rational debate.

### **1.3 Declaration**

Looking through many of the first 141 submissions in the Senate Committee’s website I think I could be forgiven for feeling a slightly lone voice in that many submissions seem to be *focused* on self interest (however subtle). I did not want to enter the discussion at this time and would have preferred to enter the debate next year when my arguments were fully assembled in book form. Confidential or ‘name withheld’ submissions are not the way to support open debate. A one-off opportunity and professional duty thus determines that I make a submission to the Committee at this time.

I ask the reader’s indulgence for any unintentional errors-of-fact.

Table 1 might be used to give a breakdown of the authorship of Submissions seeking to ensure ‘clinical’ psychologists maintain higher remuneration within Medicare.

**Table 1: Primary concerns of the person making submissions (on 141 Submissions)**

	Confidential	Name withheld	Name Supplied
Non Psychologists/Organisations	3	43	98
General and Other Psychologists	-	?	?
Clinical Psychologists	N/A	?	?
Continuation of higher fees for ‘clinical’ psychologist as the <i>main</i> focus.	(Figure will vary according to the readers own assessment).		

#### 1.4 The Key Issue: Patient outcomes

The dilemma of any profession charging ‘fair fees’ for effective service is one of the ethical backdrops to the Senate Committee’s deliberations. In the case of the ‘clinical psychology’ sub-group of the APS who are making a case for continued higher fees within Medicare possibly more detailed outcome research is required. What is the Australian evidence thus far?

*“Because general psychologists greatly out-number clinical psychologists, their inclusion in the scheme has been seen as one of the reasons for the cost blow-out [8]. Indeed, in 2009, general psychologists provided around double the number of Better Access services as clinical psychologists [5]. However, do they produce different patient outcomes?”*

*The evaluation by Pirkis and colleagues [1] provides data on symptom scores pre- and post-treatment for clinical psychologists, general psychologists and GPs. From these data it is possible to calculate uncontrolled (pre- vs post-therapy) effect sizes. The standardized mean change score was 1.31 for clinical psychologists, 1.46 for general psychologists and 0.97 for GPs. The effect sizes for the two groups of psychologists are similar and are comparable to the mean uncontrolled effect size of 1.29 reported in a meta-analysis of psychological therapies in routine clinical settings [18].*

*On the data available, it appears that **general psychologists produce equivalent outcomes to clinical psychologists and perhaps better average outcomes than GPs.**”*

From: Professor Anthony F Form. *Australia’s Better Access Initiative: Do the Evaluation Data Support the Critics.* (In press) editorial in Australian and New Zealand Journal of Psychiatry (as in Senate Committee Submission List - Additional Information received).

Submissions No 119 and 120 also make excellent practical points on the fact that there is no reliable evidence that the often more, quote, ‘narrowly focused’ clinically oriented psychologists produce better patient/client outcomes <> than their experienced psychotherapeutic generalist APS colleagues. I can do no better than quote Professor David Smail’s perspective on (overly) professionalised psychology in more recent times:

*That we are all ‘psychologists’ is a particularly unpalatable fact for a modern discipline that attempts to monopolize and, as it were, ‘patent’ psychology as a professional pursuit. In the end, that attempt must result in obvious absurdity.*

*For psychology [but not psychiatry?] to survive as an intellectual and practical undertaking, it needs in my view to cultivate a very strong sense of professional modesty and strive continually to make clear what the limits of its possibilities are.*

Professor David Smail (1996).

*How to Survive Without Psychotherapy.* (p. 249)

## 1.5 The slight ‘delusion of efficacy’

One will always come across people who say a short number of appointments with an experienced and ethical psychologist changed their lives. However, it seems to me that there too many of my colleagues who are often mistaken about the efficacy of their efforts as psychologists. This may include ‘clinical’ ‘counseling’ and ‘health’ orientated psychologists. For purposes of argument I (and others) have termed this the ‘delusion of efficacy.’ Professor David Smail and Dr Peter Lomas are the two writers on therapeutic psychology that I most value in their commentary on the ‘delusion of efficacy.’ The best text I have read on the notion of psychotherapy as a ‘house of cards’ is that by Robyn M. Dawes.<sup>11</sup> Professor David Smail’s final book is a close second.<sup>12</sup> I would then choose Scott Lilienfeld and his colleagues publications and Meichenbaum and Turk’s still relevant book on treatment adherence.<sup>13</sup>

Psychology is seen as a ‘helping profession.’ Nowadays, this very normal ‘efficacy delusion’ within the profession is not surprising when one thinks of the financial benefits involved. That is, in that following the habit of espousing *scientific rhetoric* and exhibiting this ‘efficacy delusion’ can now bring such large rewards rather than those of maintaining professional modesty.

This battle against professional self-delusion is one that can never be fully won (in any profession). Each individual psychologist must chose which side of the fence they sit on. Many remain ‘sitting on the fence’ as Professor George Singer once explained it to me.

There is a lack of rigorous micro patient/client outcome research (not just ‘symptom’ reduction) by the APS and DH&A/Medicare or studies sponsored by them. Considering the very large investment of government monies in these Better Access programs one could ask why a more targeted evaluation program for individual practitioners does not yet exist ‘*He who pays the piper calls the tune.*’ No doubt the PBA will be offering advice in this area soon.

## 1.6 NSW APS Branch Newsletter

The State Chair of NSW Branch of the APS is one Ms Cinzia Gagliardi. Her lead articles in the NSW Newsletter are always of interest. In the July 2011 Edition she has two paragraphs on her concerns about her profession as a person in the relatively ‘younger’ psychologist group.

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<sup>11</sup> Dawes, M. (1994). *House of Cards: Psychology and psychotherapy built on myth.* NY: The Free press.

<sup>12</sup> Smail, D. (2006). *Power, Interest and Psychology: Elements of a social materialistic understanding of distress.* Ross-on-Wye: PCCS Books.

<sup>13</sup> Meichenbaum, D. & Turk, D. C. (1987). *Facilitating Treatment Adherence: A Practitioner’s Guidebook.* NY: Plenum Press.



*'I struggle to understand how the requirements, set by the Psychology Registration Board of Australia (PBA) for training our 4+2 registered Psychologists has become so complex and difficult to undertake (a sentiment expressed by Mark England from our Sydney Branch) that this route will effectively become too difficult for any person or employer to consider: yet alternative ways of qualification (such as the 5+1 pathway, Masters programs, and Doctoral programs are being cut or failing to be rolled out in time).*

*Where does this leave us? Why would anyone want to join our profession? Why would anyone want to hire a Psychologist? We cost too much. It is too difficult to train us. And other groups can do our work for far less and without so much fuss!!!*

Cinzia Gagliardi 'Welcome from the NSW State Chair' PsychNews: The New South Wales Newsletter, July 2011, p.1).

Ms Gagliardi seems to have some of the same concerns about our profession that I do. We appear to be a small minority within the APS.

### 1.7 APS Colleges and Medicare

Submission (No 125) provides a Table of Membership of the various APS College 'endorsed' groups out of a total membership of some 20202 qualified psychologists in Australia (as at 31 May 2011, the latest available figures)

Approved area of practice endorsement	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Not supplied	Total
Clinical neuropsychology	2	91	-	57	16	10	183	19	6	384
Clinical psychology	86	1,439	16	544	343	107	1039	770	31	4,375
Community psychology	-	8	-	3	1	-	24	7	1	44
Counselling psychology	8	177	1	59	6	5	381	102	8	747
Educational and developmental psychology	3	121	-	61	21	16	147	54	4	427
Forensic psychology	6	116	8	46	22	6	92	34	1	331
Health Psychology	4	38	2	29	17	8	68	4	1	171
Organisational psychology	14	105	2	41	26	1	99	37	3	328
Sport and exercise psychology	3	18	-	20	6	1	12	7	1	68
<b>Total</b>	<b>126</b>	<b>2113</b>	<b>29</b>	<b>860</b>	<b>458</b>	<b>154</b>	<b>2045</b>	<b>1034</b>	<b>56</b>	<b>6875</b>

I was surprised to discover that the total figure for membership of all APS colleges is only 6875 (approximately 34% of the APS membership).

Of this figure on overall College membership 4375 members have 'clinical psychologist' classification with the Clinical College and endorsement with the PBA (22% of APS membership). Counselling psychology is the third largest group. Other submissions discuss the *fait accompli* of PBA 'specialist endorsements.'

From these data it appears that out of the full APS membership over 66% would be given the 'General Psychologist' classification. Who speaks for this major APS group to DH&A and Medicare (and the PBA)?

I have also been interested in the exact numbers of members of each of the APS colleges who have a Masters degree or above qualification in these various orientations within psychology. Of particular interest in relation to the Senate Committee's concerns is exactly how many members of the College of Clinical Psychology have Masters level training and above and how many have entered the College *via* so called grandfather clause/individual bridging plans, since September 2006, when Medicare payment of psychologists began,

I would appreciate anyone sending me this data for 2002-2011 if it is available.

I am a well qualified 'general psychologist' by stubborn choice. It is an understatement to say the 'splitting off' of the APS into separate vested-interest groups called Colleges has not been a complete success. The acrimonious establishment of the ACPA (Australian Clinical Psychology Association) is the case in point. Again, this is something that could be seen as a problem caused by some parts of the profession trying to mimic the specialist power-base and incomes of medicine.

Clearly, my own view is that the APS should have encouraged the continuation of professional interest groups with similar fees rather than support a 'specialist college' organizational structure with different fees.

## **1.8 'General' psychologists**

Major shifts in corporatizing the practice of therapeutic psychology are taking place. The PBA (APS) endorsement 'general psychologist' can cover a vast range of skills, training, experience and approach. The term has been used very loosely in the internal APS debate to date. As, for example, in the Email quotation in Section 1.4 below it seems to be almost used as a pejorative term ('\* 3 Better Access Evaluation – last three paragraphs).

Many empirically-supported procedures and protocols for common conditions such as severe anxiety and depression usually require a minimum of around 20 appointments for successful intervention. An expert study group should be convened to report on this unfortunate anomaly.

The 'Focused Psychological Strategies' nomenclature is a misleading one. Any experienced self-respecting registered psychologist will be trying to maximize approaches used in a 6, 10 or 12 appointments and beyond framework and be working at which ever level of the person's psychology that is necessary (Appendix 3).

'Focused Psychological Strategies' (FPS) with an experienced psychologist will include those other elements in the therapeutic psychology process as described by Meichenbaum in the well known 'skilled helper' (non-pathologizing) approach (see footnotes page 4).

Psychology as a science-based discipline and a practical human art is a legitimate view that stipulates a set of *core* skills. <sup>14</sup> Meichenbaum articulates these *core* skills for psychologists (with an equally useful riposte by J Hayley). <sup>15</sup> His conceptualisation includes:

**Table 1: Core Tasks of Psychotherapy: What Expert Therapists Do (Donald Meichenbaum)**

1. Develop a *therapeutic alliance*.
2. *Educate* the patient about his/her problems and possible solutions.
3. Help the patient *reconceptualize* his or her problems in a more hopeful fashion: *nurture hope*.
4. Ensure that the patient has or develops *coping skills*.
5. Encourage the patient to *perform “personal experiments”* in vivo: ensure that the patient takes “data” as evidence to *unfreeze their beliefs* about self and world.
6. Ensure that the patient *takes credit* for change: *nurture a sense of personal agency/sense of mastery*.
7. Conduct *relapse prevention*.

**Additional Psychotherapeutic Tasks for Treating Patients with a History of Ongoing Victimization**

8. Address the patient's *basic needs, safety* and help him/her develop *symptom regulation* including any *co-morbidity features*.
9. Address *memory work* and *help the patient retell* his/her story, but *help the patient* to alter *his or her belief system and implications*.
10. Help the patient *find meaning and transform pain*.
11. Help the patient *reconnect with others* who are not “victims”: address impact of trauma and disorder on *significant others*.
12. Address issues of *possible revictimization*.

*Core skills* are inevitably a matter of debate. This is only one view of the elements of the therapeutic process (Appendix 4). The term ‘therapeutic psychology’ may no longer be in vogue but it does serve to emphasise that a psychologist’s work is not simply about so called ‘clinical treatment.’ In my own opinion a major part of ‘therapeutic psychology’ is about giving people the skills (strategies, protocols, and procedures) to face life’s challenges and tragedies and giving people the hope and courage to do so. This also includes the group of persons accessing Medicare with psychological issues or specific acute illnesses and chronic medical conditions: or both.

‘Therapeutic and solidarity psychology’ as I define it incorporates or subsumes the supposed specialist sub-groups such as health psychology, counselling psychology, clinical psychology.

<sup>14</sup> Hofman, S. & Weinberger, J. (2007). *The Art and Science of Psychotherapy*. NY: Routledge.

<sup>15</sup> Meichenbaum, D. (2008). Core tasks of psychotherapy/counselling: What ‘expert’ therapists do. Presentation 12<sup>th</sup> Annual Melissa Institute Conference May, 2008.

Unlike self-help charlatans and people of similar ilk, a genuinely experienced and properly trained 'therapeutic psychologist' understands - [the difficulty](#) - of behaviour change for most people and the defences and rationalisations that may militate against positive outcomes (besides [external](#) factors).

Government funds are inevitably limited and I agree with the Medicare's attempt to focus resources on the more serious or complex psycho-social challenges in special needs groups with the limited sessions available.

There is one proviso to this. A handful of other Submissions have intimated that the use of psychologists in a team environment may have [important implications](#) for the essential 'confidentiality contract' between the individual patient/client <and> the individual psychologist. The APS should produce a position paper on this central issue for Medicare.

### **1.9 APS CClin assessment of the BOiMHC Evaluation Report of DH&A**

On the question of evidence of efficacy: this major APS group in the person of the [Chairman](#) of the 'National College of Clinical Psychologists,' had the following to say in July 2011: [I quote](#):

- **3. Better Access Evaluation -**

In response to members' requests for comments regarding the Medicare Better Access Evaluation, the NC (National Committee of the APS College of Clinical Psychologists) notes that there are many significant research methodological issues that diminish the credibility of the study.

1. The study did not meet fundamental standards of research design (it did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist).
2. It did not identify the nature or type of psychological intervention actually provided.
3. It did not factor in or out medication use by the client.
4. It did not factor in or out therapy adherence indicators.
5. It did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients.
6. It did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest.
7. It did not determine relapse rates by type of psychologist.
8. It was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session.
9. It was not subjected to peer review.

And what is needed is a [well-designed prospective study](#) aimed clearly at answering specific questions in accordance with principles of psychological research.

The 'generalists' claim that because the Medicare evaluation is convincing proof that 'general psychology' is the same as 'clinical psychology' and that there should be no recognition of the specialization. Clearly,

however, it is convincing proof that 'these generalists' have little critical clinical evaluation skill, the cornerstone of the specialised advanced evidence-based practice of a Clinical Psychologist.

Additionally, if it were true that equivalent outcomes should mean no recognition of clinical psychology as a specialty, then surely this means that the U,K's IAPT research - where untrained counselors demonstrated equivalent outcomes to psychologists - means that the government should treat psychologists the same as untrained counselors. It's a very slippery slope for psychology if we subscribe to these arguments.....

#### • 4. The APS position -

Many of you asked what the APS position is on the two-tier system and its inclusion within the TOR. The clinical college is fortunate in having a very good relationship with the APS Executive and we regularly have forthright, honest and mature discussions. Today I conveyed the feedback and questions which several hundred of you asked me to forward. In turn, APS Executive wishes to advise that it supports the two tier system and is articulating its response for release shortly."

Source: Email by Anthony M Cichello (Chairperson) 'Follow Up –Urgent – Submissions To Senate Community Affairs Reference Group .....' to APS Member Groups: College Clinical Psychology. Friday 7 July 2011 10:57pm.

### 1.10 'Clinical' psychologists

We all have our own methods for evaluating our effectiveness with individual clients/patients.<sup>16</sup> In recent years a dangerous anti-scientific precedent has been set within the APS in that the phrase 'clinical psychology' is seen by some people as some sort of *mystification mantra* indicating it is the only 'real psychology' that can solve all the client's problems all of the time.

This position reveals a surprising ignorance of research on psychotherapy demonstrating the importance of 'general factors' and the psychologist's personal characteristics as well as patient characteristics and education level for effective behaviour change.<sup>17</sup> This point, of course, being the *optimum* backdrop for empirically-supported protocols and procedures for particular human issues. The medical term 'treatment' actually refers to strategies, protocols and procedures 'transferred' to the patient/client in-session and out.

The same emphasis on *special skills* of 'clinical' psychologists in many of the almost *pro forma* Submissions from 'clinical' psychologists seems to ignore the best available evidence. That is, that that this group produces no scientifically proven differences in decreased symptoms or improved patient outcomes <> from their experienced 'general' psychology colleagues.

With this 'no difference' evidence the case for wanting a higher rate of remuneration based on the rhetorical argument of *special skills* alone goes against any notion of performance based pay. If you will forgive the irony, a 'clinical' psychologist might suggest this is some bizarre form of denial.

Considerable mention has also been made in many of the Submissions given on the Senate Committee website of 'clinical' psychologists being the only one's who can deal with complex

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<sup>16</sup> Duncan, B. L., Miller, S. A., & Sparks, J. I. (2004). *The Heroic Client: A Revolutionary Way to Improve Effectiveness Through Client Directed, Outcome-Informed Therapy*. San Francisco: Jossey-Bass Revised Edition. See also <http://www.centerforclinicalexcellence.com/>

<sup>17</sup> Lilienfeld, S. O. Lynn, S. J., & Lohr, J. M. (2004). *Science and Pseudoscience in Clinical Psychology*. NY: Guilford.

‘clinical’ cases in the BOiMHC system. As stated earlier, the word clinical is taken from medicine and is simply another *mystification mantra* in my view. Others may disagree.

All psychologists dealing with clients/patients of various types (not just ‘a diagnosis’) will be dealing with normal and sometimes ‘abnormal’ human complexity.

The APS College of Clinical Psychology has been a formidable driving force for the special status and remuneration of their particular APS members. Over the years I have spoken with many ‘clinical’ psychologists. There is no doubt in my mind that the APS ‘clinical’ psychology group undertakes their approach to the discipline with diverse philosophies-of-practice and that many of them do so in ways not strongly related to the medicalised ‘clinical psychology’ model taught in most Clinical Masters courses.

I am confident that a significant proportion of what is done by ‘clinical’ psychologists even in complex cases would be in the ‘supportive counselling-problem solving-and especially the focused psychological strategies’ domain. This is especially likely with a limit of 10 (+ a possible 6) appointments per annum under the proposed new Medicare arrangements.

### **1.11 Potential for inadvertent or conscious over-servicing**

I respectfully suggest that ‘clinical’ psychologists operating in the ‘supportive counselling/problem solving/focused psychological strategies’ mode should not charge the higher ‘clinical’ psychology Medicare fee.

This practice could be seen as a not very subtle form of over-servicing. More actuarial data on this issue should be developed by Medicare. That is, ‘clinical’ psychologists voluntarily invoicing for a lower FPS service. Careful research with APS members based on conditions of strict anonymity might provide some clear answers to the above assertion.

Irvin Yalom warns of the dangers of formal diagnosis causing the psychologist to focus on particular information in confirmation of the initial ‘abnormal’ or ‘clinical’ view of the person.<sup>18</sup> Formal ‘diagnosis’ thinking can also cause any psychologist to downplay social vectors impinging on the person in the rush to provide a specific ‘clinical treatment.’

These influences on the risk of over-servicing apply to all psychologists. The government agency paying for the service is particularly responsible for setting up a system of checks and balances against mis-‘diagnoses’ and over-‘diagnosis’ (issue identification and clarification?) when using the ‘clinical’ model in particular (See Submission No 62).

### **1.12 The APS Recommended Fee *vis-a-vis* the Redundant Medicare Two-Tier System**

I have followed the protracted debate on fees for APS psychologists of different orientations in the APS Magazine *InPsych*. Despite having a doctorate myself in my opinion the current APS fee of \$218 for a ‘standard psychological consultation of 45-60 minutes’ (even if ‘recommended only’) serves no good purpose to earn the respect of the ‘average person’ in the street. Discussions with patients who have been asked to pay close to this level by other psychologists and not necessarily

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<sup>18</sup> ‘Avoid Diagnosis (Except for Insurance Companies).’ Yalom I. (2001). *The Gift of Therapy*. London: Piatkus Chapter 2 p 4-5.

‘clinical’ ones often reveal disappointment and cynicism with the person they consulted. On the other hand we do also have the high-fee *placebo* effect as well. For myself, I have no issue with a ‘bulk bill rate’ as necessary.

Current Medicare arrangements conflict completely with the APS recommend fees framework. In the private sector all APS\_PBA ‘registered psychologists’ are at liberty to charge up to the full level of the APS recommended sessional rates for all types of psychological consultation. People in the APS College of Clinical Psychology may find it easier to charge close to the full APS rate when involved in medico-legal assessments (clinical format or otherwise). Medicare is a different matter.

I repeat: In the particular case of the College of Clinical Psychology their own Chairman officially sees no clear evidence of their outcomes for Medicare supported patients being any better <> than that of psychologists operating as comprehensively under the FPS (Focused Psychological Strategies) form of the Medicare programs.

I find it interesting that the current Clinical College Chairperson Anthony Chicello was also a key advocate for special treatment for ‘clinical’ psychologists since the flawed but successful Work Value case for ‘Clinical Psychologists’ before the Industrial Relations Commission in WA (WAIRC) in 2001.

This early WA ‘win’ set the precedent for a subsequent dogged campaign within the APS for ‘clinical psychologists’ to receive a higher sessional fee from Medicare than the similar ‘psychotherapy capable’ groups such as ‘counseling psychologists’ and ‘health psychologists.’

Much of the content of the 2001 ‘WA Clinical Psychology-Work Value Case’ re-appeared in a submission to the National Psychology Board of Australia on 23 November 2009 by Anthony. I congratulate my colleague in his perseverance in this matter even if I find myself disagreeing with his arguments. The history of this movement for special treatment of ‘clinical’ psychologists is a long one.

For example:

A C Page & Richie Poulton. *The Role of Clinical Psychologists in a Model Health Service*. Clinical Research Unit for Anxiety Disorders, St Vincent’s hospital, NSW in *The Bulletin of the Australian Psychology Society* – July 1991, p.6.).

Phil Renner & Professor Alex Blaszzynski. *Towards a More Efficient Mental Health Service in NSW Health: The Development of an Effective Clinical Psychology Workforce*. NSW Mental Health & APS, September 2004.

It has now become almost an urban myth that only someone with the government AHPRA/PBA sanctioned label ‘clinical psychologist’ can deal with the most complex cases of patients seeking assistance with serious problems. This is ludicrous.

The College of Counseling Psychology is at pains to point this out in their submission to the Committee (Submission No 125).

It is indeed ironic in my view that the Australian profession has had the same (normal) problems with ‘delusions of grandeur’ and ‘delusions of efficacy’ as Professor David Smail has suggested in the case of UK private practitioner psychology.<sup>19</sup>

Any correction of my and Professor Smail’s understanding the above picture would be welcomed.

### 1.13 Genuine Scientific Evidence

After all these years I find it *perplexing* that there is still no - rigorous scientific evidence - available from the largest APS CCLin group that Australian ‘clinical’ styled psychologists produce better therapeutic and health behaviour outcomes than other registered (and FPS) psychologists within the APS.

Randomised double-blind trials for intervention in psychological matters are notoriously difficult. Is it too harsh to suggest that ‘sales and science rhetoric’ is easier?

The burden of scientific proof is on any APS group who desire special treatment and payment. It is not on Medicare.

I thus politely suggest a change to the same fee structure for all APS psychologist who are approved for Medicare remuneration. What this one level of Medicare payment might be is not for me to say.

Medicare might also want to consider a more health/therapeutic Masters level degree being one of their preferences for registration as a provider from November 2011. On-line courses (still with supervision/practical placements) may help in this regard.

### 1.14 Alas, frail hope

A *trio* of bureaucratic juggernauts is now in play for professional as opposed to amateur psychologists. Hopefully logic and research evidence will eventually win the day in all legally registered psychologists receiving the same remuneration from Medicare. Private longer-term ‘psychotherapists,’ or medico-legal/forensic specialist who are registered psychologists, is another matter.

Finally, I firmly believe it is still the consumer or Consumer Associations who must evaluate the psychologist and their particular approach where they may wish to use the services of any particular APS member. I commenced this submission with a reminder of the principle of professional service and not just profit as in a pure business operation. Individual and corporate marketing and self aggrandizement is the albatross hanging around the psychology profession’s neck (as with so many others in today’s hyper-marketing world). Just sample some of the vast range of APS private practitioner websites to draw your own conclusions.

*Mel Henderson*

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MAPS/PBA Registered Psychologist

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<sup>19</sup> Smail, D. (1999). A Century of Psychotherapy: In L. King (Ed). Committed uncertainty on psychotherapy: Essays in honour of Peter Lomas. P 129-138. London: Whurr Pub. Also available <http://www.davidsmail.info/century.htm>