Parliament of Australia
Commonwealth Funding and Administration of Mental Health Services
Senate Inquiry

26 July 2011

Submission

To whom it may concern,

I am an endorsed Clinical Psychologist with the Psychology Board of Australia with 12 years experience in the field. I own a specialist private practice employing several clinical psychologists. I wish to voice my opinion regarding the proposed changes to the Medicare rebates, ATAPS program, and the review of the 2 Tier Medicare system.

1. Proposed Cuts to Medicare Rebates

I understand that there is an intention to cut annual sessions allowable under Medicare, from 12-18 sessions per year to 6-10 per year. My opinions are presented below:

- Most of our clients are being seen for 12-18 sessions and above per year. This is because they are complex clients with complex needs. Our practice specialises in eating disorders and this client population needs at least this number of sessions to achieve recovery. Evidence based treatment manuals for eating disorders all state that treatment sessions needed for recovery from an eating disorder are in the realm of at least 12 months of weekly sessions, followed by a period of follow up for maintenance of recovery.
- Many of the eating disordered clients present with co-morbid problems including depression, substance abuse, and personality disorders. Each co-morbidity means that further sessions are needed.
- We practice evidence based psychological interventions such as cognitive behaviour therapy. The evidence base for treatment of common conditions such as depression and anxiety disorders requires that clients complete 12-18 sessions on average. This is based on clinical trials of 'what works' in attaining lasting recovery. I thought that this was why the Medicare referrals allowed clinicians to service clients properly. Are we now expected to achieve good clinical outcomes in half the time? With what justification?

2. The 2-Tier Medicare Rebate System

At present, psychologists with an endorsement as clinical psychologists receive a higher rebate than generalist psychologists. This difference has been in place since the Medicare rebate system was started. The difference in rebate reflected the fact that clinically endorsed psychologists had to meet additional criteria in training, specifically, Masters or Doctorate level university training in clinical psychology. Generalist psychologists were those with 4 years training plus supervised experience, or psychologists with post graduate training in different psychological specialties (e.g., forensic, occupational).

My decision to undertake a Clinical Masters degree was made because I understood Clinical training to be the most evidence based, comprehensive and best training available to practice as a clinician. Throughout the world, Clinical Masters or Doctorate training in psychology is recognised as equipping clinicians to become highly skilled in clinical assessment, ICD-10 and DSM-IV disorders, case formulation and planning, and treatment of the full range of psychological disorders. Clinical psychologists are placed in positions such as management and coordination of services.

Clinical psychologists often supervise less trained psychologists. Clinical psychologists tackle the most complex and co-morbid psychological disorders, which less qualified psychologists are not trained to do.

The Clinical Masters degree was difficult to get into (I had first class Honours, which meant I was able to gain entry), highly competitive, and expensive (I paid over $10 000). I deferred making an income for 2 years and studied full time, supporting myself by working night shifts to get through. I did all of this because I knew that Clinical training would allow me to earn a higher income than if I chose to start working with only 4 years training. I was also aware that world wide, the minimum standard for registration as a psychologist was 6 years not 4, and that current Australian standards of psychological registration were lagging behind the rest of the world. I wanted to ensure that my level of skill and training was equivalent to overseas training, and I anticipated that in Australia the standard would soon be raised to come in line with the rest of the world.

After I finished university training I obtained work in the public sector. There, wages for psychologists were set according to training, with psychologists with a Clinical Masters degree or above being placed on higher salaries than psychologists without post graduate training. This difference was never questioned, and to my knowledge the public sector still pays clinically trained psychologists at a higher rate than four year trained psychologists.

If Medicare changes the 2 tier system to make clinical psychologists' pay the same as generalist psychologists, does this mean that the public sector will soon change as well? With what justification? I cannot understand why the Medicare system would not reflect pay scales in the public system for recognising training and experience.

On a personal level, I know the difference between my own skill level at 4 years training versus my skills after completing the Clinical Masters degree. At 4 years, I had a theoretical understanding of the history of psychology, and statistics. I knew nothing about clinical assessment, diagnosis, or the DSM-IV or ICD-10 disorders, let alone how to treat them. The Clinical Masters training equipped me to work clinically with clients. The 4 year degree did not prepare me at all to see clients – in fact I never even saw a client until I was in the Masters program.

Now, as the owner of a private practice, I only employ Clinically trained psychologists, as I know I can trust their skills base and training. I have supervised non-clinically trained psychologists and always find their skill level very much below that of a clinically trained psychologist.

I am aware that there is currently a very loud group of psychologists advocating against clinical psychologists, claiming that there is no evidence for the superiority of clinical training over generalist training. This group is loud because there are many of them and in comparison, relatively few clinically trained psychologists. I hope that simply because the generalist group are more numerous than clinically trained psychologists that the views of clinically trained people do not go unheard.

The generalist psychologists are stating that there is no evidence for better outcomes with clinical vs generalist psychologists. They are basing this claim on one small survey which asked for client feedback – hardly an unbiased trial looking at outcomes on mental health measures.

In my opinion, the generalist psychologists, as a result of never doing the Clinical Masters degree, are unaware of the gap in their skill level. To put it simply, they don't know what they don't know. This is potentially damaging to clients. Clinically trained psychologists have a depth and breadth of knowledge that is simply absent in psychologists without a post graduate degree. We do need more university places for Clinical Masters and Doctorate training in psychology, to bring up our skill

level and bring our minimum standards of training in line with the rest of the world.

Deciding to devalue clinical psychologists by cutting their Medicare rebates is a backwards step and not one that will ultimately benefit people suffering from psychological difficulties.

From the perspective of a small business owner, any cuts would make an enormous difference to my private practice. Currently we employ six clinically trained psychologists. These people are used to being paid at a certain rate and will not work for less than that. If there is no reward for working in the private sector, many of them will leave the job and work in the public sector where their skills are recognised. Others are considering leaving the psychology profession altogether, as they feel so devalued by the changes.

Our private practice specialises in the treatment of eating disorders, a highly complex and increasingly common problem with a high mortality rate. We are one of very few specialist psychology services available, and we play an important role in aftercare from the eating disorders units and hospitals. Obviously, we require staff who are highly trained. If we cannot pay them what they feel they deserve, they will leave. We will be forced to hire people with few skills and expertise, which will lower the standard of our service. I will need to consider closing the doors rather than offering an inferior service to such vulnerable clients.

3. Medicare Rebates Versus ATAPS Scheme

I have worked in private practice for the past 6 years, and have seen clients through the ATAPS system as well as through the Medicare rebate system. By far I have found the Medicare rebate system to be superior to ATAPS. This is because:

- it is much easier for clients to see their GP and get a 2710 plan done than it is for the ATAPS referral to be organised.
- there is much less stigma for clients to see their GP for a 2710 than to go under ATAPS, which does stigmatise people as the 'worst of the worst' – the ATAPS scheme is available for 'people with a mental illness'. In general people don't like to be called 'mentally ill' and will avoid this stigma if possible.
- I am able to be paid up front for appointments. With ATAPS I often waited for periods of several months to be paid in arrears. I cannot run a business this way – if all clients were referred just through ATAPS I would go broke in less than 3 months.
- The Medicare system allows me to charge a gap for services whereas ATAPS does not. The ATAPS fee is currently less than ½ the fee recommended by the Australian Psychological Society, and is too low for me to be able to run a business. My specialist clinic operates secretarial staff and 6 other psychologists, and my practice could not survive on ATAPS fees alone.
- The fee offered by ATAPS is unreasonably low and is an insult to my worth as a specialist clinical psychologist with 12 years experience.
- When I did see clients through ATAPS, I had major problems with people not coming to appointments. I believe that without the gap payment, clients did not value the service and did not make efforts to come to appointments. When people pay a gap for a service I think they value it more.