

Senate Standing Committees on Community Affairs  
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## Commonwealth Funding and Administration of Mental Health Services Inquiry

I wish to contribute the following thoughts and opinions to the Inquiry. They are addressed mainly to the Terms of Reference:

- (b) changes to the Better Access Initiative,
- (d) services available for people with severe mental illness and the coordination of those services;
- (e) mental health workforce issues, including:
  - (i) the two-tiered Medicare rebate system for psychologists,
  - (ii) workforce qualifications and training of psychologists.

1. The introduction of the Medicare Better Access program in 2006 changed the face of the Australian Mental health system. For the first time, clients had the freedom to choose to consult a psychologist for psychotherapy at an affordable fee to address their mental health concerns. GPs could offer their psychologically troubled patients an alternative treatment option beyond that of private psychiatry or the overburdened and fragmented public mental health care system. The community response to the Better Access program has been overwhelming, and although there are residual concerns about appropriate targeting of services and increasing costs, the evaluation evidence to date suggests that the Better Access initiative has been an outstanding success in meeting a range of hitherto unmet needs for mental health care within the medical system. Nonetheless it is not without its issues, particularly with respect to the number of treatment sessions available to clinicians.

I conduct a private psychology practice in the inner north of Melbourne, and I accept referrals from a range of sources, predominantly GPs and consumer organisations. I am not registered as a "clinical" psychologist however I take referrals for complex clients in a number of areas in which I claim expertise, particularly ADHD, anxiety and panic disorder, OCD, depression and perinatal depression, including bipolar disorder. I have specialist interests in the areas of attachment-related trauma, family breakdown and adoption. Most of my clients could not afford to attend sessions were it not for the Medicare rebate. In many cases I bulk bill, or charge only a small copayment, because if I did not do this some clients could not afford to see me. Hence, under the existing Better Access arrangements I have had to tailor my treatment approaches to the maximum of 18 sessions available for clients. My experience over the last five years suggests that this has been a Procrustean bed, particularly with clients with severe presentations including complex co-morbidities and/or a long history of trauma, negative life events and social disadvantage.

My understanding of the psychotherapy research literature and my own practice experience is that 18 sessions of therapy per year are often insufficient to resolve the issues that accompany complex and severe presentations. For even moderate mental health disorders, the proposed reduction to ten sessions will be inadequate to complete treatment. Hence the ten session limit proposed under the reforms to Better Access for all clients presents me with a huge ethical dilemma. If I undertake to treat moderate to severe presentations within a time frame of ten sessions, three types of consequence can be anticipated, all undesirable.

First, I could embark on treatment, but discontinue after the ten sessions when the Medicare funding ceased and at that point refer the client elsewhere. To my mind this would be unconscionable, because a rupture in the therapeutic relationship would be traumatic for the client, and at least interrupt the process of change and recovery until he or she established a new relationship with another clinician. Additionally, I would have no option but to refer either to ATAPS or through the GP back to a psychiatrist, where appropriate services could not be

guaranteed to be timely or even available. Under such circumstances, many clients would not continue with therapy and their mental health problems again would go untreated. Due to such a disruption, their mental health issues may even be exacerbated.

Secondly, I could inform clients at the point of intake that they could only see me for ten sessions, once per month notionally, or perhaps intensively for ten weeks or less, and then wait until the next calendar year to resume therapy. Such an approach is ridiculous and unethical for those with significant disorders.

Thirdly, I could work pro bono to support my clients beyond ten sessions. I don't believe that this is seriously being suggested however?

Ironically, if a maximum of ten sessions is introduced for the Better Access programme, I will only be able ethically to offer treatment to those I assess at the point of intake to be suffering from mild disorders which can be resolved within ten sessions. These are likely to be drawn from among the ranks of the much maligned and disparaged "worried well"!

In summary, I believe that it would be shortsighted mental health policy and very poor psychological practice to cap the number of Medicare funded sessions at ten per calendar year. The unintended consequences of this proposal need to be carefully considered and addressed before such a step is taken. At the very least 18 sessions should be maintained, and indeed, I would recommend that the Better Access provisions should be increased to a basic allocation of 12 followed by a further 12 under exceptional circumstances. On average this would mean that clients with severe disorders would be able to be offered fortnightly therapy with confidence.

2. There has been significant misinformation propagated by psychologists who are members of the Australian Psychological Society (APS) college of clinical psychology regarding their superiority in both training and experience as practitioners of mental health services. Demonstrably false claims have been made that clinical psychologists are the only psychologists to have postgraduate education in the form of masters or doctoral degrees in psychology, with six or more years of training. In fact many psychologists who under the present system of Medicare funding are referred to as "generalists" also hold higher degrees and have had six or more years of training in psychology by way of masters or doctoral degrees, including PhDs. The only reliable difference between psychologists designated as clinical psychologists and other psychologists comes down to their membership of an APS professional college (or peer group).

Clinical psychologists belong to the APS college of clinical psychologists, and other psychologists not designated as clinical belong to other groupings. There are eight APS colleges: clinical neuropsychology, clinical psychology, community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology and sports psychology. The main cleavages of the profession, as they have developed over the last forty years in Australia, are these. Membership of any APS college, which now under the Psychology Board of Australia (PBA) provisions is known as "endorsement", generally requires a higher degree and therefore 6 or more years of academic training, or the capacity to demonstrate equivalent training and experience to the satisfaction of the college. Hence the "tiers" in the profession, in terms of the relative extent of formal training or its equivalent between practitioners, are reflected in the division between APS college members and non-college members. In general, non-college members are likely to have less formal academic training and/or experience than college members. However not all psychologists, regardless of their level of training, choose to become members of a college, nor even members of the APS. There is also considerable overlap between the colleges, with some APS members holding membership of two or even three.

The cleavage between clinical psychologist and generalist psychologist is an artefact of the politics by which the Medicare funding for psychology services was achieved, whereby the APS (which historically has been dominated by clinical psychologists) together with the clinical college

succeeded in persuading the politicians of the day of their professional superiority. Clinical psychologists continue to regard themselves as superior to other psychologists, regardless of others' college membership, even though the basis for this presumed superiority is not self-evident. The designation "clinical psychologist" does not reliably indicate years of training or experience, or expertise in the provision of mental health services, or effectiveness, or client outcomes or, most significantly for me, knowledge and skills, in short "competencies".

Anomalies abound. For example there are psychologists like myself with a PhD, ten years of academic training and 30 years of broad experience, and who are members of one or more (non-clinical) APS colleges, who are regarded as "lesser" generalist psychologists. Likewise, there are psychologists, newly graduated with a clinical masters degree and less than ten years in the profession, who take on the mantle of "superior" clinical psychologists. These anomalies are compounded by the fact that although clinical psychologists lay claim uniquely to being "scientist – practitioners" (although this should be true for all professional psychologists) they as a group cannot show scientific evidence for their elitist claims nor, curiously, does it appear to be a priority for them to conduct such research to demonstrate the validity of such claims. Research to date examining the head to head performance of clinical vs generalist psychologists working within the Better Access Scheme revealed no area of practice in which clinical psychologists showed superiority.

It follows that there is no apparent justification for clinical psychologists to be rebated by Medicare at a higher rate for their services than psychologists of other designations. However, higher levels of academic training (or demonstrated equivalent) may be a valid foundation on which to differentiate between psychologists, if there is a need to identify specialist practitioners. Hence, there may be a case to remunerate college members more generously than non-college members, by virtue of their greater education and experience, across the profession of psychology as a whole. Nonetheless, my very strong view is that unless and until there is a transparent, standardised assessment process through which all psychologists are asked to demonstrate their knowledge and skills in accordance with specific agreed criteria which define professional excellence for the provision of Medicare services, there is no defensible reason to pay some a fee premium over others.

It seems to me that the only way forward on this is a system of external examinations, such as are used in the medical profession to admit practitioners to particular specialities. To my mind, relevant criteria for remuneration by Medicare would focus on client outcomes, objectively measured, rather than practitioner training per se, although clearly training is likely to be one of the important determinants of client outcomes. Extensive, regular, continuing professional development post-registration is likely to be another determinant, as knowledge changes so quickly. Indeed, orthodoxy and hence training in psychology is now becoming outdated in less than ten years, fueled by rapid advances in the neurosciences. I note that the DSM-IV-TR is presently being extensively overhauled, and that the DSM-V to be released in 2013 will contain substantial changes to presently accepted diagnostic categories, necessitating updates in knowledge for all psychologists. Finally, given that the training and experience histories of psychologists currently providing Medicare funded services are so diverse, whether or not these practitioners are designated as "clinical", objective assessment and ongoing review of competencies should be seriously considered as part of the registration process for Medicare providers to ensure quality.

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