

NATIONAL COLLEGE OF CLINICAL PSYCHOLOGISTS

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Dear Committee:

***Re: ADDENDUM SUBMISSION TO THE SENATE INQUIRY
INTO THE COMMONWEALTH FUNDING AND
ADMINISTRATION OF MENTAL HEALTH SERVICES***

The Australian Psychological Society (APS) National College of Clinical Psychologists wishes to thank the Senate for the opportunity to add to our submission and evidence given at the Public Hearing held in Melbourne on 19th August 2011. The Addendum will provide information on issues which arose at the Public Hearing and which lead to further specific recommendations as follows:

Recommendations -

- 1. The Senate Committee is urged to ignore conflicts amongst Psychology groups as far as possible and focus on making the best recommendations for the delivery of mental health services to the Australian people. There is no term of reference to these disputes.**
- 2. It is anticipated that the recommendations below might save rather than increase costs, but should the recommendations call for more funding,**

reduce the funding to Headspace and EPPIC while still giving them as much as possible. (ToR (a))

3. Remove the need for a mental health plan where a single referral to a Generalist Psychologist or Clinical Psychologist is required, but retain it for flexible packages of care. Remove or reduce the reviews of the mental health plan for referrals to Clinical Psychologists, but retain arrangements for feedback to GPs. Ask GPs what their need is for feedback and review, and reduce this if appropriate. (ToR (b) (i) and (iii)).
4. Keep the two tiers of Generalist and Clinical Psychology services and establish 30 sessions for Clinical Psychology Services if possible, or at least 18 with no reference to exceptional circumstances, but let Generalist Psychology's Focused Psychological Strategies cap at 10 sessions. (ToR (b) (ii) and (iv) and (e) (i))
5. Retain the Government's proposal for well co-ordinated flexible packages of mental health services for those with severe and persistent mental disorders. (ToR (c))
6. Ask GPs whether they have been referring patients with severe and persistent mental disorders to Generalist Psychologist or Clinical Psychologist to better understand the nature of those requiring more than 10 or 12 sessions of psychological treatment. (ToR (d))
7. Reverse the roles of Medicare and ATAPS with regard to severity of disorder, except for retaining the provision of flexible packages of support services delivered through Medicare Locals and ATAPS for those with severe and persistent mental disorders. Those with mild disorders could be treated with Focused Psychological Strategies by Generalist Psychologists under ATAPS, while those with moderate to severe acute mental disorders and those with complex or co-morbid presentations should be referred to Clinical Psychologists under Medicare rebates. (ToR (a), (b) (ii) and (iv), (c) and (d))
8. There is no additional requirement for changes to workforce of Generalist or Clinical Psychologists. Both will increase at appropriate rates under current training conditions. (ToR (e) (ii) and (iii))
9. Use the APS "Find a Psychologist" website to find a Generalist or a Clinical Psychologist to provide services to a person with particular needs such as language needs, services to children or Indigenous culture (ToR) (f)
10. Establish a National Mental Health Commission (ToR (g))
11. Create on-line and telephone consultation item numbers in the Medicare Benefits Schedule and ATAPS services to allow Generalist Psychologists and Clinical Psychologists to provide services to rural and remote communities (ToR (h))

Misunderstanding of the aim of Better Access

The government and the Department of Health and Aging appear to have made an unwarranted interpretation of the aim of the Better Access initiative in November 2006. It was not aimed only at services for those with mild and moderate levels of severity of mental illness. There was no mention of severity levels. That is a concept which the current government has superimposed on the scheme. The “Background” introduction to the “Key findings from the program evaluation of the Better Access” states it correctly:

“The *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative was introduced in November 2006 in response to low treatment rates for high prevalence mental disorders like anxiety and depression.

The aim of Better Access is to improve outcomes for people with clinically-diagnosed problems by providing evidence-based treatment.”

The fact that these disorders are high prevalence does not confine them to a low severity level. These disorders can occur at severe and profound levels of severity and be extremely debilitating, but they are usually treatable. However, they may persist for years or a lifetime without treatment.

Implications for the Current Proposals

This misunderstanding has implications for the Commonwealth Funding and Administration of Mental Health. The government’s idea of using Better Access for mild and moderate levels of disorder and ATAPS, for the severely and persistently mentally ill, leaves out those with a moderately severe to severe mental illness which is a treatable condition, and those with complex or co-morbid presentations which require greater expertise and longer treatment times to achieve recovery.

Erroneous interpretation of the Better Access evaluation finding regarding the number of sessions used and the number needed

The Government appears to have made important but potentially inaccurate inferences from the number of sessions patients used, which averaged 5 to 6. However, note should be taken of the structure of the Medicare items being set at 6, with a further 6 upon review by the GP. This may have led both GPs and patients to assume that 6 sessions *should be* the norm. Patients might have felt reluctant to bother with the review, especially as they were feeling somewhat better, and they may have felt that the number was struck because it was right. Patients might have

felt that they “ought” to get better with this number of sessions and feel themselves a failure if they did not. The research findings might then be nothing more than a self-fulfilling prophecy of the arrangements, not a free test of how many sessions patients require to overcome their disorder. In addition, Generalist Psychologists delivering Focused Psychological Strategies quite probably had little more to offer after 5 or 6 sessions, and as they comprised 80% of those delivering services, this would contribute to the mean obtained. The government plans should be based upon meta-analytic research, more than on one limited study. This will show that more like an average of 20 sessions are needed if recovery from the mental illness is the aim.

In short, the study showed how many sessions were used, but not why.

The assumption made by the Department of Health and Aging and by the Government that those needing more than 10 sessions need to receive packaged care shows a very serious misunderstanding of the high prevalence mental disorders. It threatens to reinstate old-fashioned stigmatising beliefs that these disorders cannot be treated and that all that can be done is to provide support services. Members of the APS College of Clinical Psychologists anecdotally report that none of their patients who required more than 10 sessions had persistent mental disorder nor did they require a package of services. They needed more Clinical Psychological treatment in order to recover. Members are very familiar with the severe and long-term mentally ill, with many having worked in psychiatric residential hospitals in the past, and their observation that patients with severe and prolonged mental illness were not referred by GPs, although anecdotal, could support the government’s identified need to make arrangements for these patients to receive flexible packages of support services.

The quick survey conducted by the APS concerning the 13 % or 87,000 patients who required between 10 and 18 sessions has hidden an important group of patients: those who needed more than 12 sessions but who did not meet the criteria of exceptional circumstances. Their treatment was cut short prematurely. So long as too few sessions of Clinical Psychology treatment are available, patients will suffer unnecessary relapse, research will show the same patients coming back each year and the belief will be maintained that mental illness cannot be cured.

The Government has repeatedly said that those requiring more than 10 sessions can transfer to ATAPS, but this is not so. ATAPS has capped sessions too and does not allow such transfers within the one year. That pathway is simply unavailable.

Proposed Reversal of service roles: Medicare and ATAPS

It is the moderately severe and severe high prevalence conditions patients who need to be referred to Clinical Psychologists for treatment under the Medicare scheme, rather than those with mild conditions, although they could be referred to general psychologists for Focused Psychological Strategies or through ATAPS. The mildly mentally ill and the severe and persistently mentally ill could be provided with services under ATAPS. At ATAPS the mildly mentally ill will receive Focused

Psychological Strategies which is likely to be enough to facilitate their recovery. However, to do this, ATAPS would need a bigger allowance for ordinary people, not only their target groups. If it is preferred to leave ATAPS for the target groups then GPs would need to refer the mildly mentally ill to Generalist Psychologists under Medicare

It will help if GPs are encouraged to be more selective in their referrals to Generalist Psychologists and Clinical Psychologists. The severely and persistently mentally ill will receive a package of services to help them cope a little better, those with mild mental health problems will receive Focused Psychological Strategies from Generalist Psychologists, and those with moderate and severe high prevalence mental disorders or with complex or co-morbid presentations will be referred to a Clinical Psychologist for full assessment, diagnosis, case formulation and treatment of their conditions..

The GP Mental Health Plan

If only one service is required, there should not be a need for a mental health plan, just a simple referral. GPs should be consulted as to the frequency they want to review the patient, but it should be appreciated that review interrupts the treatment and may convey to the patient that they should be well by now. No other interventions require such reviews, and while it may have had a place when introducing the psychology profession to Medicare, that purpose has now been fulfilled. Clinical Psychologists are fully trained in mental illness to a level of specialisation and it seems unnecessary for all their work to be being regularly reviewed by GPs. If some GPs did not extend the referral for another six sessions based upon an improved DASS score (*a measure of distress, not psychopathology*), this could have artificially skewed the data concerning number of treatment sessions required for true recovery from the mental disorder. However, GPs should be kept informed by Generalist Psychologists and Clinical Psychologists and the frequency that GPs want this should be sought from them. Cost saving can be made if the review from Clinical Psychologists is not required or not required as frequently.

Are those requiring more than 10 sessions of treatment the same as the severely and persistently mentally ill?

Members of the APS College of Clinical Psychologists report that in their experience GPs do not refer the severely and persistently mentally ill to Generalist Psychologists. To clarify this important point the Senate Committee might ask the GPs about their basis for referral.

Patients who have presented with severe Major Depressive Disorder, and who had made significant progress with Clinical Psychology Services (and medication which was still being taken) have represented on a new Mental Health Plan. They have had to terminate treatment prematurely due to lack of Medicare assistance. Their

conditions had relapsed and as many have described it, they were “back to square one”. Their relapse was predictable as maintaining factors in their situations had not yet been resolved. .

Funding for Headspace and EPPIC

Whilst we appreciate the roles of Headspace and EPPIC, these areas should not be prioritised above fundamental treatment of acute mental disorders.

Where the recommendations made here call for more funding, it would seem that some should be taken back from the Headspace and EPPIC program allowances. Although very worthwhile programs and a laudable emphasis on children and youth, perhaps the amount of funding was greater than called for on balance.

Who represents Whom amongst Psychologists?

The College of Clinical Psychologists of the Australian Psychological Society represents over four thousand members (comprising of 3,206 Clinical Psychologists as well as Clinical Psychology Registrars, Clinical Psychology Trainees and Affiliates). Another party has claimed within their written submission that “No other professional body represents Clinical Psychologists . . .” and this is untrue. The Senate Committee is advised that many members of the APS College of Clinical Psychologists are likely to also be members of ACPA (recognising that many may be members of both organizations), and also that many Psychologists who are members of AAPi, may also be members of the APS which has over 20,000 members. A representative of AAPi claimed to represent all Psychologists and all female Psychologists, but does not have the mandate to do this. Of the matter of gender, it is true that – by far – Clinical Psychologists also tend to be female.

From the questions put to various witnesses, it may have been that the Senators did not understand the APS and College representatives accurately. The APS representatives were staff from head office, but the College representatives (both Counselling and Clinical) were all full-time independent practitioners holding elected office in the Society voluntarily. The jobs of the other organization representatives should also be explored to understand their presentations better. We have therefore provided our response to some questions put to others who appeared to be viewed as practitioners which were not put to us. We appreciate there were also time constraints and not all questions could be put to all witnesses.

Individual submission

As another group of witnesses mentioned that two of them had made individual bipartisan submissions and the Senate Committee expressed knowledge of this, it was thought that the Senate Committee may have liked to know that Erika Leonard

also made an independent bipartisan submission to the inquiry. Anthony Cichello has also written a ten page reply upon advice concerning another submission containing Possible Adverse Comments.

Qualifications of Clinical Psychologists

At the hearing in Melbourne on 19th August 2011, an accidentally inaccurate estimate by another witness was made of the number of psychologists who have been made Clinical Psychologists through the Medicare Assessment Team at the Australian Psychological Society. Owing to this faulty impression, detailed figures and explanation of the work of the Medicare Assessment Team at APS will be given.

This team was set up when Medicare rebates for 'Psychological' and 'Specialist Clinical Psychological' Services were introduced in November 2006. The team was commissioned by the Commonwealth Government to receive applications from Psychologists who, although not holding the standard qualification for Clinical Psychologists, considered that they had acquired the knowledge, skills and competencies of a Clinical Psychologist and should be able to deliver Specialist Clinical Psychology Services under Medicare.

On 30.09.2011 this pathway to gaining endorsement in any branch of Psychological practice was closed by the new national registration board, the Psychology Board of Australia (PsyBA), and no further applications could be received although those in process could have until 30.06.2013 to complete Individual Bridging Plans.

Individual Bridging Plans were only ever given to Generalist Psychologists who came close to demonstrating the knowledge, skills and competencies of a Clinical Psychologist. They comprised the relevant components for the individual of enrolling in up to three single units of an Australian Psychology Accreditation Council (APAC) accredited University program of Clinical Psychology, doing a workshop and assignment in psychopharmacology, writing up to three case studies, undertaking from 10 to 80 hours of supervision of their practice by a Clinical Psychologist supervisor and writing a Clinical Psychology research proposal. The University units were examined by the University while the case studies, psychopharmacology assignment and research proposal were examined by senior Clinical Psychologists of the Medicare Assessment Team with experience in University teaching of Clinical Psychology, maintaining the equivalence of standard.

Total figures for this activity are as follows:

- 1074 were already members of the College of Clinical Psychologists
- 2313 gained entry through standard qualifications and a further 102 were completing their period of supervised experience
- There were 903 applications from Psychologists who had higher qualifications in another branch of Psychology. 414 have been successful, 102 have been unsuccessful and 387 are still completing their Individual Bridging Plans and may eventually be successful or unsuccessful.

- There have been 526 applications from Generalist Psychologists with basic training only. (There are about 14,000 registered Psychologists with this basic level of training who could have applied, and the silent majority who have not applied should be noted.) 128 have been successful, 264 have been unsuccessful and 134 have still to complete their IBP.

Thus at 30.12.2010, of the 3,924 Clinical Psychologists registered with Medicare, 542 have gained that position through alternative equivalent training, a far cry from the “almost half” that the Senate Committee was given as an estimate by others. It should be noted that these Clinical Psychologists have not been “grandfathered” into the profession in the ordinary sense, they have each had to demonstrate equivalence of knowledge skills and competencies to that of a standard trained Clinical Psychologist by today’s standards, so they do not reflect any lowering of standards. The PsyBA’s independent acceptance of the results of the APS Medicare Team’s processing of applicants to become Clinical Psychologists confirms that there has been no lowering of standards.

Disputes amongst Psychologists

At the Public Hearing on 19.08.2011 at Melbourne, remarks were made about conflict amongst groups of Psychologists and questions were being asked about how these tensions could be resolved. The Senate Committee is urged not to allow its deliberations or recommendations to be distracted or high-jacked by these matters, but to maintain its focus on how best to deliver mental health services to the Australian people.

These intra-professional disagreements have been around a long time, although the very poor behaviour of a very few has not and is not to be tolerated. The disputes are not a function of the Medicare rebates or the recent budget proposals. The Senate Committee is advised that such conflict is best understood as representing some of the transitional difficulties that are to be expected within the new National Registration and Accreditation Scheme (NRAS) which will be managed well by the Psychologists Board of Australia (PsyBA), one of the registration boards managed in turn by AHPRA. Some disagreement can be a stimulus to constructive developments, as politicians would be well aware.

Please be aware that there appears to be something of a coalition of lobby groups who are attempting to confuse the concepts of specialisation and ‘superiority’. There is a long-standing internationally and Australian accepted specialisation within Psychology called Clinical Psychology which specialises within the field of psychiatric disorder. However, certain others are confusing this with notions of “superiority”, “better”, “elitism” and so forth. In no submission by Clinical Psychologists will the Senate Committee find these horrific value-laden terms be utilised and they may be a furphy to specialisations within Psychology. Two claims particularly require comment.

Firstly, the College of Counselling Psychologists, as written in Hansard, asserted that 70 percent of Counselling Psychology training is “the same” as Clinical Psychology training, and claimed that they sit in the same classes and undertake the same placements as Clinical Psychology programmes. This is not correct. At Swinburne University in Melbourne, recognised as the one Counselling Psychology training programme MOST similar to a Clinical Psychology training programme, the Counselling Psychology trainees sit in the introductory but not the advanced units of study in Psychopathology, Psychiatric Diagnosis and Case Formulation, Evidence-Based Psychological Therapy for Psychiatric Disorder and none of the Psychopharmacology. This equates to half of the coursework units in mental health that the Clinical Psychology trainees undertake. The Counselling Psychology trainee is not required to undertake placements in psychiatric units and mental health settings, whereas the Clinical Psychologist is required to do so. In all placements, trainees are continually assessed according to how they have demonstrated the integration and translation of their coursework theory knowledge into their practical application. This will be different between Clinical Psychology and Counselling Psychology since the theoretical base is not the same. There is no requirement of mental health research within the program for Counselling Psychology, whereas there is for Clinical Psychology. Trainees are assessed in their application of clinical knowledge and skills into clinical research, The PsyBA requires that a specialist psychologist who wishes to train as a specialist in a second field must complete 75 percent of the assessed post-degree supervision period required for the second specialisation, and the university will grant no more than 50 percent credit for the second degree. Additionally, APS advises that there is no greater than 50 percent in common between any two specialisations.

Thus, the Counselling Psychology training cannot be ANY MORE than fifty percent similar to that of Clinical Psychology.

The second comment to which a reply is required is that from AAPi who claimed that there were two equal pathways (professional masters/doctorate and “four year degree plus two years experience” available before 2010). Few of the silent majority of Generalist Psychologists (one in 28), who constitute 80 percent of the Psychology workforce, ever applied for Clinical Psychology status. These Psychologists are clearly not disenfranchised, as AAPi has claimed. The AAPi group have confused two separate concepts and possibly accidentally misled the Senate Committee. In fact, each training pathway did constitute a means of training to a level fulfilling the requirement for Generalist Registration ONLY. However, the integrated coursework, supervised and assessed practica, and clinical research training within the masters/doctorate was within the specialised field of Clinical Psychology and followed by a minimum of two years accredited supervision (for a masters graduate) or one year (for a doctorate graduate) to then qualify as having met the criteria for endorsement as a specialised Clinical Psychologist. The masters programmes in Clinical Psychology have been available within Australia since 1965, and doctoral programs internationally since the 1940s.

We would like to ask the Senate Committee members this question – if your mother required life saving brain surgery, would you send her to someone with 100 percent

competencies in that specialisation, or someone with no more than 50 percent or less competencies in that specialisation? To whom would you send your mother? Why is mental health to be regarded any differently?

The Senate Committee is asked to consider the silent majority of many thousands of registered psychologists who have been delighted to have a Medicare rebate and to be included in ATAPS/

Rural and Remote Clients

It is noted that Psychiatrists already have online consultations rebated under Medicare, in order to provide targeted services to patient populations with lower rates of access to Psychiatric Services. Since the Better Access Evaluation similarly demonstrated poorer rates of access to specialised Clinical Psychologist Services under Better Access, Clinical Psychologists need item numbers to be able to offer such services too

APS 'Find a Psychologist' Service

The Senate Committee is drawn to a website that is maintained on the APS Website listing both Generalist Psychologist and Clinical Psychologists, as follows - (<http://www.psychology.org.au/FindaPsychologist/Default.aspx?Mode=Advanced>).

This service enables GPs, Psychiatrists and the public to identify who provides services to a person with particular needs such as languages other than English, children, those from an Indigenous culture, telephone and internet therapy, and other specific requirements.

Once again, the Australian Psychological Society (APS) National College of Clinical Psychologists is most grateful to the Senate for the opportunity to add to our submission and evidence given at the Melbourne Public Hearing. We respectfully submit the comments and suggestions within this Addendum with the intention that it would provide relevant and practical information in relation to the issues which arose at the Public Hearing. Please do not hesitate to contact the APS Clinical College for any further queries.

Yours Faithfully,



Mr Anthony M Cichello
National Chair
APS College of Clinical Psychologists

Ms Erika Leonard
Chair of Board of Assessors
APS College of Clinical Psychologists