

e (i) The two tiered Medicare rebate system for psychologists

I find it quite extraordinary that , we, as clinical psychologists have to make a case as to why we should continue to receive a higher rebate as compared to general psychologists.

Clinical Psychology is a post-graduate qualification (6 or 7 + 2 years supervision) which provides specific, clinical and professional training for a proven, non-drug treatment of psychiatric disorders, as a minimum standard, as opposed to general psychologist (4 year + 2 years supervision) who receive no clinical or professional training, as a minimum standard to practice general psychology. Clinical psychologists are trained in the theory and practice of abnormal psychology, psychopathology, neuropsychology, behavioural medicine, health psychology, child, adolescent and family psychology, ethics, psychometric assessment, and professional practice to mention but a few areas.

Clinical psychology is a well-established discipline. There is an abundance of evidence that distinguishes the discipline of clinical psychology from (general) psychology, from an industrial, academic and professional point of view:

1. Work Value Case, Western Australia 2001 -

With regard to industrial recognition, the successful "Work Value" case for Clinical Psychology in Western Australia in 2001 heard by the Full Bench Hearing of the Industrial Relations Commission, handed down the decision that the discipline of clinical psychology was distinctly different and higher than that of general psychology. This was recognised and subsequently reflected in different Industrial Awards for clinical psychologists and psychologists, in Western Australia, and subsequently other states

2. National Health Service Review of psychological services.

In Australia and internationally, clinical psychology is recognised as a distinct and higher level of treatment. In 1989, the Management Advisory Service to the NHS differentiated the health care professions according to skill levels. Skills in this sense referred to knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills as follows:

Level 1- "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management).

Level 2 - undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol.

Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. **The group went on to argue that clinical psychologists are the only professionals who operated at all three levels and (I quote) "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists..."**

This is consistent with other reviews which suggest that what is unique about clinical psychologists is his or her ability to use theories and concepts from the discipline of psychology in a creative way to solve problems in clinical settings.

3. APA Division of Clinical Psychology and BPS Division of Clinical Psychology definitions of Clinical Psychology -

It is significant that both within the United States and Britain, clinical psychology is recognised as one of several specialisations within psychology. The link to APS is as follows -

<http://www.apa.org/ed/graduate/specialize/clinical.aspx> and Britain -

<http://www.clinicalpsychology.org.uk/> a website for the public.

Why argue for the same rebates for psychologists and clinical psychologists?

a. budget cuts

To suggest that clinical psychology is equivalent to (general) psychology flies in the face of well established academic, professional and industrial standards and demarcations. So, then, one has to consider why this debate has arisen at all.

It is understandable that the government wants or needs to rationalise mental health services but why make changes to the workforce that is specifically trained to effectively and efficiently provide a psychological service? This is like trying to suggest that a heart specialist and a general practitioner do the same work because they both treat heart problems, and decided that they should be paid the same.

Clinical psychologists by virtue of their comprehensive training are able to more rapidly assess and efficiently treat complex psychological and psychiatric problems.

b. campaign to disparage the profession of clinical psychology

Clinical psychologists have well been aware that since the introduction of rebates for psychological services through medicare that some psychologists have argued that the rebate should be equivalent. It would appear that there is a group of psychologists who have become louder and more aggressive in their attempts to have their view recognised and accepted, and have run email campaigns to disparage the profession of clinical psychology.

It would seem to me that this would be the only group that would argue that general psychologists are equivalent to clinical psychologists and therefore should be remunerated equivalently. Unfortunately, on a professional, academic, industrial and clinical level, as discussed above, they are on their own.

While it is true that some psychologists, who through years of self-initiated training and/or many years of experience, can over a long period of time, learn to deal with more complex issues, this cannot be said to be a minimum standard for all 4 year trained psychologists.

Without having done the clinical training, it is very easy (and naïve) to subscribe to the view that general psychology is the same as clinical psychology and that both can assess and treat to an equivalent standard. This lends itself to “I can do that” attitude. In this case, these psychologists, unfortunately, **don’t know what they don’t know**. All clinical psychologists have completed the general degree, and know from first hand experience the vast difference in level of competency that is acquired after a Masters/Doctoral post-graduate training program, as compared to a general degree, and how well that prepares them for clinical work.

c. unintended consequences

If the 4 year trained psychologists’ argument is to be accepted – that they don’t need clinical training to deal with a clinical/psychiatric population (i.e. they can do the work of a clinical psychologist, hence, wanting the same rebate)– then it would also

hold true that they would be equipped to work in other areas of psychology e.g. forensic psychology, neuropsychology, organisational psychology, etc without the postgraduate training that is required to work in these fields. This would again blur the distinction between general psychology and other very specialised areas of psychology, which professional, academic and industrial stakeholders would not support.

Quite simply a general psychologist's competence cannot be equivalent to a clinical psychologist. Clinical psychologists by virtue of their comprehensive training are able to more rapidly assess and efficiently treat complex psychological and psychiatric problems

b (ii). Rationalisation of allied health treatment sessions:

This is quite a concern that the number of sessions are to be reduced. The extra sessions for extraordinary circumstances allowed a safety net for people with moderate to severe presentation. These people cannot be treated within 10 sessions, and unless they can afford to continue without medicare, they will not, usually, be able to continue. The very significant problem of limiting the sessions to 10, is that one would have to know at the outset the severity of the presentation, and their ability to continue without medicare, before engaging in therapy. It would seem irresponsible to commence something that you know cannot be treated in that time, and yet one would not know until one commences therapy. In this case, the client may have to go to another service e.g. ATAPS, and start again. This would not be the most efficient use of funds.

Some clients who may need more than 10 sessions, may not want or need team based treatment as proposed by ATAPS.