

4 August 2011

**Commonwealth Funding and Administration of Mental
Health Services
Senate Inquiry: Community Affairs References Committee**

This submission is a response to the changes to the Better Access Initiative in relation to the:

- ToR (e) mental health workforce issues, including - the two-tiered Medicare rebate system for psychologists,
- ToR (b) changes to the Better Access Initiative, including:(ii) the rationalisation of allied health treatment sessions,

The two-tiered Medicare rebate system for psychologists

1. Under the new national registration arrangements there is now endorsement for specialist areas of practice such that you are deemed either a ‘clinical’ (endorsed specialist) or a ‘generalist’ (not endorsed). Under Medicare clients of those deemed ‘clinical’ psychologists receive a higher Medicare rebate than clients of those deemed ‘generalist’ psychologists.
2. I am moved to contribute my voice to this Inquiry because of the possible harm to our profession and to public trust in our profession caused by some members of the APS clinical college, including the chair himself.
3. To justify the retention of the 2-teir system members of the APS Clinical Colledge argue that “Clinical Psychology is the only profession, apart from Psychiatry whose members have undertaken all the necessary training to deal with patients who present with complex problems. On 7/7/11, Mr Anthony Cichello (National Chair of the APS College of Clinical Psychology) wrote to all members of the clinical college exhorting them to post a submission to the Senate Inquiry asserted that:
 - *“Clinical Psychologists should be treated as Psychiatrists under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices”*;
 - *“Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based psychopathology, assessment, diagnosis, case formulation”*;
 - *“We are also arguing for a resumption, and even extension, of rebated sessions per annum based on our unique skills set with the most complex and severe of presentations.”*
4. Hence, he argues, the 2-teir arrangements should be retained so that clients of ‘clinical’ psychologists receive a higher rebate than clients of generalist psychologists.
5. There is limited evidence to show that only ‘clinical’ psychologists have received the necessary training and practical experience to provide services to patients who present with complex problems. This is an assertion which is not shared by the full range of professional psychologists who currently offer similar services under Better Access.

6. I am deemed a ‘generalist’ psychologist under the new registration system. Like my ‘generalist’ colleagues I have completed further qualifications to ensure that I can provide the best quality of care for my clients. In my case, in addition to CBT courses and other personal development activity I have undertaken more rigorous development activities, for example, the Australia and New Zealand Association of Psychotherapy (ANZAP) training program which is equivalent to **The Master of Medicine and Master of Science in Medicine (Psychotherapy)** offered by Sydney University at the Westmead/Cumberland Campus. It is administered by senior psychiatrists and psychologists and focuses on difficult and complex mental health issues.
7. The ANZAP Program is a 3 year part-time training program which covers psychopathology and mental health across the lifespan, evidence-based assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity of presentations, particularly in relation to Axis II disorders and psychosis requiring longer term interventions.
8. It is a clinical course with a didactic component (drawing on research in the fields of trauma and developmental theory, linguistics, memory and neurophysiology) and supervision of recorded patient sessions. It requires over the 3 years a minimum of:
 - 240 face to face teaching hours delivered by members of Sydney University faculty.
 - 300 clinical hours which are taped with the client’s consent and subsequently reviewed, evaluated and discussed in the form of ongoing case studies at weekend seminars, in individual supervision and in the weekly group meetings.
 - 120 one-to one individual clinical supervision of clients on a weekly basis, in my case by a psychiatrist.
 - 90 hours of seminars of one and half hours duration
9. Both clinical and theoretical development is assessed annually by means of a clinical viva and an essay based on the patient’s progress and discussion of theoretical concepts. A final year dissertation on a relevant topic is also assessed. The assessment is conducted by two faculty members who are not the candidate’s supervisors. General progress was assessed throughout the year – on clinical, theoretical and interactive ability. An ethical component kept matters relating to mental health issues in the foreground of our practice.
10. Many of my colleagues who are also deemed ‘generalist’ psychologists have PhDs in psychology, excellent reputations in various fields of psychological practice founded on a professional life-time of experience in both private and public clinical settings.
11. Under the distinction made by ‘clinical’ psychologists it is assumed that there is an equivalence between the amount of training required by a doctor (10 hours) and the training undertaken by professional psychologists many of whom have training and qualifications involving years of formal training up to and beyond a PhD. By contrast, the ‘clinical’ psychologists assume that their qualifications for the purposes of psychological services are equivalent to a psychiatrist with a medical degree and

superior to a doctor. However, under the two tier system those deemed to be 'general' psychologists are assumed to have qualifications equivalent to doctors who are not a psychiatrist who can offer focussed sessions after 10 hours training. As pointed out above, many psychologists who would be categorised as general psychologists have far more extensive and comprehensive qualifications, including through medical faculty courses, than the new category of generalist allows.

12. As a private clinician doctors refer people to me in order to deal with anxiety or depression. These disorders are often comorbid with other more serious conditions such as Borderline Personality Disorder, PTSD or, less frequently, psychotic conditions. I work side by side with 'clinical' colleagues in a successful and long established private practice. A quick analysis of our records reveals that there is no distinction between the complexity or range of disorders our clients present to us and no difference in outcome. The number of sessions provided to those with the more complex presentations is statistically the same for both categories of psychologist. We all have good reputations and are equally respected within the mental health community. However our clients might occasionally ask why one receives a bigger rebate than another. Our experience at the practice mirrors the results of the Better Access evaluation (based as it was on a random sample of representative clients and psychologists) which indicated no difference between the quality of services provided by registered and 'clinical' psychologists. So we must join our clients in asking why clients of one psychologist should receive higher rebates than another.
13. Having made these observations, I also recognise that the APS does raise a legitimate concern. It is important that we have a way of knowing that practicing psychologists have the necessary knowledge, skills and clinical experience to meet appropriate professional standards. . Herein lies the problem. When the new registration arrangements came into effect in mid 2010 there was a very brief opportunity for those who came through a nonstandard route (i.e. had not completed a clinical MA) to demonstrate that their knowledge, skills and clinical experience were 'equivalent' to an MA program. In cases where prior learning and experience were recognised but gaps were identified it was theoretically possible to undertake a bridging course – and some are currently doing this. This processes was conducted under the auspices of the APS but it was too brief and there was insufficient notice and time for interested psychologists to be informed about, prepare and submit their applications. The only recourse, we are advised, for those of us who were unable to take advantage of this brief opportunity is to complete a clinical MA.
14. Many of those who would be downgraded to the status of general psychologist under the current arrangements would find it onerous and redundant, after having obtained formal degrees from universities and undertaken extensive years of training and supervision to now be required to embark on a full clinical MA program followed by an additional two years of supervision in order to become a clinical psychologist.
15. There at least two options.
 - First, I propose, that a similar process to the one described in Para 11 above be initiated after consultation so that those that would be deemed general psychologists (many of whom are associate members of the APS) be assessed against appropriate professional standards and if necessary undertake bridging

courses, if required to provide a convergence between what would be defined as 'clinical' as opposed to 'general' psychologists.

- Second, if the first option is not practicable I would then recommend the abolition of the 2-teir system and embrace all psychologists who were registered in 1010 as clinicians and discontinue the 4 plus 2 route.

Proposed reduction of Medicare-funded sessions under the Better Access Initiative

16. As stated above in questioning the basis of the 2-teir system both 'clinical' and 'generalist' psychologists are equally well equipped to treat clients '*with the most complex and severe of presentations*'. As such I wish to add my weight in supporting the retention of up to 18 sessions for the small proportion of clients (about 15%) referred under Better Access who present with complex problems.
17. Cuts in the current Federal Budget to the Better Access Scheme. From a maximum of 18 sessions to 10 sessions (effective from November 2011) will contribute to significantly poorer outcomes for this group. In my experience, those who present with more severe mental problems, such as BPD, need at least 18 sessions and ideally more, in order to establish a good therapeutic relationship and to resolve the deep and very painful issues that afflict their lives. I am concerned that the changes proposed in the Budget will make it hard for them to complete a course of treatment so that there can be lasting benefits. If they are unable to complete therapy they may for example turn to their GP for solace or worse, present at hospital emergency wards.