13 April 2011

To The Members Of The Senate Standing Committee On Finance And Public Administration References Committee Inquiry into the Administration Of Health Practitioner Registration By The Australian Health Practitioners Regulation Agency (AHPRA)

I am writing today on behalf of myself and my patients to put before the Committee some issues affecting my practice.

The national registration of psychologists is, in principle, a good thing for assisting in treating and addressing Mental Health patients and their families Australia-wide. It facilitates ease of movement of psychologists across state borders and ensures that standards are uniform nationally.

However, I have grave concerns with other aspects of the national registration of psychologists.

Firstly I refer to the anomalous 2-tier system introduced into Medicare of Clinical vs all other psychologists.

There is no evidence that I have seen that means the graduates of a Masters in Clinical Psychology are superior to graduates from other specialities or from psychologists such as myself who have been registered and practised full time for 10+ years, completed a 4-year Science degree with majors in Psychology and Biology in 1984, followed up by a Graduate Diploma and then 2 years full-time, fully supervised unpaid internship before satisfying the requirements of the Australian Psychological Society (APS) to become a full member. I have spend thousands of dollars and considerable time in professional development activities since becoming registered to remain current with trends in my area of professional expertise and practice. My work includes 4 years, part-time, in psychiatric hospitals where I worked with psychiatrists and other psychologists. Why a recent graduate is deemed to be more qualified and granted a bigger Medicare rebate than I am is a mystery to me.

The new 2-tier system introduced by Medicare discriminated against my clients as their Medicare rebate is about considerably less than if they saw a "Clinical" Psychologist.

Referring doctors and psychiatrists think I am classed as Clinical because they have been satisfied with my results with their shared patients, however, should the 2-tier system continue, they would be remiss if they did not advise the patient it would cost more to see me that a Clinical psychologist. Over time, I suspect that means that many similarly qualified and experienced psychologists may receive fewer referrals and be unable to maintain a profitable practice. Hence others, as I am, may be thinking of leaving the profession altogether.

Secondly, there is a flow-on problem with the 2-tier Medicare system in that it has been even more harshly described on the national registration where most (I am advised by AaPI that it is about 80%) of registered psychologists are deemed "unendorsed". This seems to reflect very poorly on the qualifications/experience/effectiveness of the "unendorsed" psychologist. Almost implies we are not

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registered. That may make it hard for members of the public seeking treatment to feel confident in the treating psychologist with such a label.

Thirdly, while the 2-tier Medicare system has been increasingly consolidated in the national registration scheme, there is no real grandfather clause for professionals such as myself, and that was applied in other countries when they increased training requirements for their psychologists.

There are insufficient places to do a Clinical Masters which for someone like me is unlikely to teach me very much more than I have already learned from psychiatrists, professional development and my practice itself. It would not be cost-effective for me to study a Masters when I am only 7 years from retirement. The previous grandfather entry path was torturous for someone like me who qualified nearly 30 years ago before there was a concept of a clinical psychologist - everyone studied abnormal psychology, brain function, developmental psychology etc. My clinical supervisors were psychologists with 20 or 30 + years of experience. Under the APS, I had to be supervised by a clinical psychologist. This would have meant finding such a person who had more experience and training than I or that my then-supervisors already had. This proved to be impossible so this requirement became a barrier to me to applying to be rated clinical. Although I regret this course now there is no longer such an opportunity and my professional skills have been devalued (and those of my supervisors as well).

Fourthly, there is no recognition in the national registration system of my experience nor my population my training and experience have developed.

I am currently being accredited internationally as a Schema Therapist which aims to treat the cognitive, behavioural and emotional aspects of early maladaptive childhood schemas. I am also trained and experienced in Dialectical Behavior Therapy (DBT) developed for patients with Borderline Personality Disorder as is Schema Therapy. The patient population I work with are usually victims of trauma (crimes, abuse, childhood sexual assault, domestic violence, etc) and I treat them with therapies that are clearly evidence-based but are not easily fitted into the listed Focused Psychological Strategies. Parenthetically, may I point out that in Holland the government pays for 18 months of intensive Schema Therapy treatment for patients with Borderline Personality Disorder as it has been identified as more cost-effective than leaving them untreated and a drain on social services, health services, housing, the criminal justice system etc. Treatment in Holland involves at least twice weekly combination of group and individual therapy for the first year and then winding down over the next 6 months. This is a far cry from up to 12 government funded sessions under Medicare. I would like to see such a scheme implemented in Australia.

Fifthly, there is no recognition in the national registration scheme of any other advanced training for psychologists - forensic, health, neuropsychology to name a few. So electing to study a Masters in an area of professional relevance eg neuropsychology will not improve my position viz a vis the PBA.

Six, The Psychologists Board of Australia is populated from the APS therefore the same flawed thinking and political pressure has proceeded into the new board. The Chairman, PBA has written very dismissively to the Association of which I have recently become a member, the **Australian Association of Psychologists inc (AAPI)** about our concerns for our patients and our professional futures.

Seven, for those unendorsed, general psychologists such as myself, the notion of accepting the bulk bill rate of $81.60 when I need at least $120 per session to remain profitable is impractical and makes no

business sense. In addition, as the new system becomes entrenched my profitability and business viability is under threat as already some referrals go elsewhere for the higher Medicare rebate. So if it was the intention of Government to increase access to psychological treatment via the bulk bill system it is not working in my local area. I would be willing to bulk bill patients if the rebate was $120 per session instead of nearly $40 less.

Eight, because I have a large number of vulnerable patients in my practice eg Borderline Personality Disorder patients, who are often disorganised, unemployed, and sometimes living in unstable accommodation. It is disappointing to me that some of them are unable to get sufficient treatment as they can't afford to pay and I can't afford to bulk bill them. This is a sad reflection of our Mental Health system.

Nine, the APS claimed about half of psychologists were members but negotiated with Government as if it represented the views of all psychologists. In fact it mainly advocated the views of the Clinical college and its members. Although I am not sure of the makeup of the College I suspect it may be heavily weighted by academic psychologists teaching clinical courses. The APS has not advocated well for me and my similarly experienced peers with 4 years of academic studies and 2 years of internship.. At least doctors get paid for their internship unlike myself. The poor support for non-APS members by the APS means that they failed to advise non-APS members of their requirements for professional development and many other issues affecting the profession whilst professing to be representing all psychologists. It is rather short-sighted to appoint the APS as gatekeeper for psychological status and conditions when they did not equitably represent all psychologists but favoured the Clinical College members, possibly because more of them were in the decision-making roles on the APS managing committees.

Ten, I come back to how has the non-evidence based discrimination now embedded in the AHPRA via the PBA (Psychologists Board of Australia) improved the provision of psychological services to the Australian people? I would suggest not at all.

Eleven, the Professional Development requirements are very prosciptive and rather like we are naughty school children.

I have attended international conferences with psychologists, lawyers, judges and psychiatrists. At each conference, participants attended sessions that interested them and then recorded the hours of attendance in a general way eg International Conference for Psychiatry, Melbourne, 20 hours. Ludicrously, the PBA/APS requires that we sign attendance sheets (very school like!), and write half a page per day of attendance to explain how the material related to our "learning goals"! My learning goals are usually related to being a better therapist or to read about research into brain function that impacts on trauma or emotion regulation etc. I do not know them neatly 1 year in advance so I can write a "learning goals document". Indeed they evolve and are sometimes reactive to patients I am currently working with. I look at emerging material and identify research that is applicable to my patients or treatment protocols. I am sure this approach is common within my profession.

To be required to write half page requirement per day is nonsense - who will read my critiques and why would that benefit my professional work with clients? It seems to point squarely at the influence of academic psychologists on the AHPRA/PBA/APS. There is no evidence outside of academic courses that this is the optimum learning model. The PD requirements for lawyers is much less proscriptive and yet they are working in equally demanding, changing and responsible roles. Some of the workshops I have paid for, and closed my practice down to attend have been very poor and these have been from some of the Clinical psychologists

deemed to be better qualified than myself. I would be hard pressed to write a sentence about how such dismal workshops advanced my learning. A magistrate suggested I write a template for all training and then just regurgitate for every day of training. The magistrate was surprised at the requirement and could point to no similar demand asked of their profession.

Twelve, PD requirements to maintain Medicare provider status include that I need to attend workshops in anxiety, depression and areas I already have a body of knowledge about, practice in daily and really don't feel any great gaps is a waste of time, money and possible treatment time. I check up online or through journals on current research and trends as do other psychologists. This requirement from Medicare as advised by the APS seems more about keeping academic clinicians in the profitable workshop trail than any evidence-based strategy to improve the provision of psychological services in Australia.

Thirteen, I support the idea that a disgruntled patient only needs to complain to one body and that no longer can dodgy practitioners move to another state to avoid complaints.

Fourteen, not-with-standing the item above, where is the evidence of a disgruntled patient population poorly serviced by psychologists? In NSW, it appears that few psychologists were disciplined and from memory that seems to be mainly about sexual impropriety. So what problem is being solved by the onerous and discriminatory system set up by the AHPRA/PBA/APS triumvirate?

Fifteen, if it is to be that all psychologists need a Masters degree then perhaps the Government should pay us to attend, they should provide more places, that the universities should provide courses for 48 weeks of the year so it can be completed faster and finally that courses should be available after hours and on weekends. Perhaps even online. If this is to be the case then thought should be given to how to provide psychological support to the patients of established psychologists. I just looked at my client list quickly and while not all clients are current I have a list of about 680 individuals of whom I see perhaps 25-30 each week. Because many of my patients have been the victim of violence or sexual abuse, they are often at risk of self-harm or impulsive destructive, dangerous behaviours. If I have to leave to study to maintain my qualifications, I assume some of them will react to the perceived abandonment very poorly. I do not see how their needs will be accommodated while I study a higher degree, full-time, nor how I would manage financially to do so.

Sixteen, the onerous PD requirements that I imagine the PBA/APS/MEDICARE will increase over time without a solid evidence-base to justify it together with the funding dichotomy and the insulting discrimination into clinical vs non-clinical and unendorsed does not improve access to psychological support in Australia. Nor I imagine to better treatment. It is inherently flawed that the APS which has a strong bias to the members of the Clinical College is shaping the direction and demands placed on psychologists. It is analogous to putting the foxes in charge of the hen house.

Seventeen, while this is outside the gambit of your current inquiry, it is my understanding that the bulk of Medicare funding for psycholocal services is actually paid to the doctors who refer the patients and see them for the 6th session review. That in itself seems anomalous that referring GPs see the patient for 2 sessions probably no more than 1 hour in total and get more funding than the psychologists who see the patient for 1 to 12 hours. This probably warrants consideration in terms of the value for money.

In conclusion, may I say how sad I am for my patients who have to pay more to see me than others who are seeing someone deemed to be "clinical". Some of them have been in long term therapy with me and have progressed well and are unwilling to transfer to one of the 20% of psychologists deemed to be "clinical". I feel very angry that the self-focused psychologists driving the PBA/APS decisions seem to have lost sight of our patients and what these changes mean to their treatment, their relationship with their treating psychologists and ultimately to their future and their well being, to see nothing of the confusion the division has introduced into the Medical Profession who seem to have formed the view that if you are working with a psychiatric population you are Clinical. I haven't touched on the rather shocking news that there is a short course that GPs can undertake to be deemed equivalent to psychologist's 6-year training (in whatever combination).

I hope you as Members of this important Inquiry reverse the pattern of proscriptive professional development requirements, the 2-tier Medicare system and disenfranchising 80% of practising psychologists with the insulting "unendorsed" status.

Yours sincerely

Gail Robertson