



**FOCUS PSYCHOLOGICAL SERVICES**  
**Gail Robertson Counselling**

04 August 2011

**To:**

**The Members Of The Senate Standing Committee On Finance And Public Administration  
References Committee  
Inquiry into Commonwealth Funding and Administration of Mental Health Services**

*The Government's funding and administration of mental health services in Australia, with particular reference to:*

(a) the Government's 2011-12 Budget changes relating to mental health;

(b) changes to the Better Access Initiative, including:

*(i) the rationalisation of general practitioner (GP) mental health services,*

I am concerned the referrals from GPs will drop off if they are not adequately remunerated. I also welcome the involvement of GPs in my patient's treatment, however, many clients with complex mental health issues do not have a stable relationship with a GP or medical practice and it can be challenging to work out who to provide feedback to.

*(ii) the rationalisation of allied health treatment sessions,*

This will adversely impact on the complicated patients typically referred to me – usually with a diagnosis of personality disorder, trauma, anxiety, panic, depression, substance abuse or any combination of the foregoing. They are often very financially disadvantaged so the Medicare rebate makes a difference to whether they can afford treatment or not.

*(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs,*

I am concerned the referrals from GPs will drop off if they are not adequately remunerated. I also welcome the involvement of GPs in my patient's treatment, however, many clients with complex mental health issues do not have a stable relationship with a GP or medical practice and it can be challenging to work out where to provide feedback and ask for a review and additional sessions.

*(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;*

Whatever the intention of the Government, the referrals I receive are not actually for mild or moderate mental illness but are often at the complex end of the spectrum however these Medicare items are the only items available for my use as a registered psychologist. The GPs seem to consider me a "clinical psychologist" and refer the type of patients they have always referred to me over the past 10+ years and these are often complicated and can be suicidal and parasuicidal. These patients often need intensive therapy if they are to recover sufficiently to operate healthily within our community and there were always some for whom 12-18 was woefully inadequate to treat their issues. There are few places to refer them to once Medicare was exhausted and there are few practitioners in our area with an interest in working with patients with Borderline Personality Disorder, the area I have trained and specialised in over the past eight years or so. Reducing the Medicare sessions to 10 means I can only see these very troubled individuals once every five weeks unless they are

Gail Robertson  
Psychologist MAPS  
PS0067845, APS 101464,  
Victims Services A00845, Veterans Affairs Provider No 1037101F/2646941A

“fortunate” enough to have been a victim of a crime in NSW where they can access funding through that source.

ATAPS in our area does not cover individual sessions.

The general psychologist Medicare item numbers cover “so-called” Focussed Psychological Strategies (FPS) comprising:

- Psycho-education (including motivational interviewing)
- Cognitive-Behavioural Therapy (including behavioural interventions and cognitive interventions)
- Relaxation strategies (including progressive muscle relaxation and controlled breathing)
- Skills training (including problem-solving skills and training, anger management, social skills training, communications training, stress management, and parent management)
- Interpersonal Therapy (especially for depression)

are less than adequate to treat clients with Borderline Personality Disorder. The evidence-based treatments for this population are Dialectical Behavior Therapy and or Schema Therapy. Although there are elements in treatment that fall under the rubric of “focussed psychological strategies” to successfully treat the patients I work with you need more advanced skills and training than suggested by the apparent simplicity of the FPS. Sometimes I feel to use the Medicare item numbers for FPS gives a false impression of the complexity and nature of my client’s problems and the treatment required, but to not do so financially impacts clients to such an extent that they can not afford treatment. This dialectic is very strong and the more evidence accumulates that Schema Therapy in which I have advanced training and am currently seeking international accreditation is extremely successful in treating patients with Borderline Personality Disorder, the more I worry about actually offering it to patients who need it and using the FPS Medicare items as I am needing to do a kind of simplification of the process (and therefore undermine the therapy effectiveness) to fit it under the FPS umbrella. Initially, despite thinking, studying and working in psychology since 1979, I was not sure FPS even meant. The classification of psychologist skill set feels a little like someone trained to do brain surgery being forced for financial reasons to offer head massage or phrenology instead.

*(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;*

Disappointingly, in Manly Warringah, NSW area where I practice, the local division of GPs only provide funding for group attendance and not for individual sessions under the Access to Allied Psychological Services program. When I queried this I was advised that the local division had insufficient administrative resources to organise individual sessions under the ATAPS program. This means that the Government initiative in increasing funding to this program as an offset to the reduction in the Better Access Initiative will not actually improve access to services provided to people with mental illness in the Manly Warringah area. Instead availability will diminish to the most disadvantaged in my community.

***(d) services available for people with severe mental illness and the coordination of those services;***

I work collaboratively with the local community mental health team in working with people with complex mental health issues including Borderline Personality Disorder. It is very challenging to find groups, public or private psychological treatment for these patients, and it becomes even more challenging to identify sources of funding for their treatment with suitably skilled and trained psychologists, of which I am one and recognised as such. The funding for many of these clients comes from the NSW Government Victims Services program, where a person who has been a victim of crime can access up to 22 hours of treatment for their psychological treatment. Many of my clients with severe and complex psychiatric issues are also frequently victims of crime so they access my services through this program. Many have been victimized many times in their life and therefore can apply for treatment for each crime and therefore can receive the intensive treatment they need to recover and improve their quality of life.

***(e) mental health workforce issues, including:***

***(i) the two-tiered Medicare rebate system for psychologists,***

This has been a very unhelpful development for psychologists, patients and the referring doctors, the latter two groups being extremely confused about what the difference is. I am also confused about why my Science degree, two full time years of supervised internship and four years working in psychiatric hospitals and continuing to work in private practice with psychiatric patients doesn't make me clinical.

**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.

Therefore to penalise the patients of "non-clinical" psychologists by only rebating 2/3 of the rebate available to patients of "clinical" psychologists is unconscionable and I deeply regret that members of my profession have pushed personal interest well above the interest of our patients. The imbalance in Medicare rebates also mean that "non-clinical" psychologists are generally unable to bulk-bill, even though many are willing, because the payment is inadequate to maintain the financial viability of their practice.

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 than a Clinical psychologist. Over time, I suspect that means that many similarly qualified and experienced psychologists may receive fewer referrals and be of less service to the community than their experience, training and record would warrant.

**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 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 to make up the skills deficit, similar to that applied in other countries when they increased training requirements for their psychologists. Why fully registered psychologists with say 5 years plus of experience could not have been deemed clinical at the time of the National Registration, as happened in some countries overseas so I understand, is not clear to me beyond the purely selfish interest of a minority of members of my profession.

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. Nor would it be cost-effective to study a Masters when nearing 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, 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 and 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 was 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 proscriptive 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 initially required we 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.

For our registration body to decree that we write half page per day of PD was patently nonsense, and has indeed now been reversed due to a general recognition of this. I am unsure who the PBA thought would read the critiques and how that would benefit our professional work with clients? This requirement 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. This 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. The best workshops I attend are usually from international experts rather than our own experts.

**Thirteen, 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?

**Fourteen, 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.

**Fifteen, it would seem reasonable to predict that the onerous PD requirements from 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 with its 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.

**Sixteen, while this is outside the gambit of your current inquiry, it is my understanding that the bulk of Medicare funding for psychological services is actually paid to the doctors who refer the patients** and see them for the 6th session review. It 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.

*(ii) workforce qualifications and training of psychologists,*

It is my opinion that the argument put forward for the division of psychologists into clinical and non-clinical has been neither fish nor fowl ie it is neither an acknowledgement of additional training eg Master or PhD versus 3 year degree (at the very minimum) nor by identifying individuals with exclusive or superior skills in psychological treatment and assessment. All psychologists had to demonstrate clinical diagnosis, assessment and treatment to be able to be registered to practise.

The division is an artifice that is becoming more entrenched by the week – DVA has now restricted use of item numbers I have used for the past six or so years to “clinical” psychologists. As a consequence I have not been paid for work I completed months ago. There are a new set of item numbers for “non-clinical” psychologists to use that I was told after some considerable discussion with DVA and Medicare.

The division into “clinical” and others is not assisting the plight of the distressed people needing the assistance of psychologists. Despite the very public maligning of general psychologists by certain “clinical” members of my profession, I still believe we have a useful skill set to assist the distressed and unhappy but our ability to do so is undermined by the actions of those who have deemed themselves an elite within the profession and thereby disadvantaged the provision of services provided by 80% of psychologists who were disinclined to join the clinical college of the APS, who completed their training pre mid 1990s when the idea of Masters in Clinical Psychology arose or who despite academic qualifications up to and included a PhD and considerable experience fell short of the narrow restricted grandfather provisions to becoming a member of the clinical college.

My own reasons for not applying were that my clinical supervisors were highly skilled and respected psychologists with over 50 years of experience between them and to join the clinical college I would have had to be supervised by a member of the clinical college. By my reckoning the experience of these individuals would have been less than that of my current clinical supervisors so I did not attempt it – this has now become one of those decisions I regret on a pragmatic level but I do not actually believe I would have been a better psychologist if I had applied and been accorded clinical status.

Increasingly, my patient profiles are adults, individual or group work, with personality disorders, trauma or comorbidities. My professional development is always to enhance my skill set with this population rather than to cover the range of possible presentations. If I am referred someone outside my preferred specialities, I simply refer them on.

*(iii) workforce shortages,*

The division of psychologists into “clinical” and “non-clinical” will lead to workforce shortages. As you can be very effective as a psychologist without a clinical masters but will be poorly remunerated and stigmatised as less than someone with a similar skill set but the magic “clinical” specialisation, and in addition there is no bridging training available to upskill yourself to be deemed “clinical”, and there are very few positions in any Masters of Clinical Psychology in Australia – why would anyone want to try to become a psychologist?

**(f) the adequacy of mental health funding and services for disadvantaged groups, including:**

- (i) culturally and linguistically diverse communities,
- (ii) Indigenous communities, and
- (iii) people with disabilities;

I would request that the Committee consider the needs for funding support for individuals with Borderline Personality Disorder with a view to the Dutch experience of offering 18 months of fully funded intensive treatment as a way of normalising behaviour and eliminating the financial impost this group represents in the

budgets of health, social services, housing, prisons, courts, police, etc etc.

**(g) the delivery of a national mental health commission; and**

**(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups;**

This would be welcome for some of my clients but hard to imagine using imagery rescripting as used in treating trauma and nightmares online. But I am excited at the prospect. Of course, government funding eg Medicare, Victims Services are lagging behind in being willing to subsidise sessions via the net. **and**

**(j) any other related matter.**

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 the needs of 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.

ms 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 say 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). Nor indeed that the APS is training Chaplains to provide counselling. Perhaps I should qualify myself as a Chaplain as they are not registered, I understand, and are apparently to practise without restrictions. How I envy them that freedom to use their training, education and experience to provide services to people in pain, as this is what I consider the non-endorsed, non-"clinical" poor old dogsbody psychologists like me have lost in all this and our profession and the services we provide patients are also weakened. This, I am sure, was not the intention of the Government in introducing the changes to fund and support Mental Health in Australia. I consider the Government has been poorly advised by my own professional body, of which I am no longer a member having resigned in disgust.

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