November 2019

NSW Government
State Insurance Regulatory Authority (SIRA)

Dear Commissioner
I understand that the purpose of this consultation process is to seek views to inform revised regulatory requirements relating to the healthcare arrangements within the NSW workers compensation and compulsory third-party systems, to manage costs and improve outcomes for injured motorists and workers.

As stated in the Submissions outline:
SIRA have the following clearly identified goals in ensuring health care arrangements within the personal injury schemes in NSW promote safety and quality in services provided to injured motorists and workers and reflect the principles of value-based care.
In stewarding these schemes, your mission, you clarify is to ensure they are:
•equitable and fair
•efficiently delivered
•affordable for the community
•sustainable and viable for generations to come
•delivering scheme outcomes effectively
•providing positive experiences.

Professionally, I speak from the awareness which my experiences and community involvement has given me, across many business, organisational structures and health care settings in clinical private practice and working across three (3) different states of Australia, over the last 25 years.
I speak to the reality that if these issues remain unaddressed, the impact of the unintended consequences will be dire for the wider Australian population, and specifically to the poor and rural and remote community members in our midst, as the reality is; if this 2 tier division is maintained the professional futures of approximately 80% of the profession of Psychologist is at risk, as the .

Medicare: Anchoring of Disparity- False Narratives and Artificial Divisions

The introduction of the Medicare Better Access to Mental Health Care scheme in November of 2006 has proven to be a critically important initiative, providing over 30 million individual treatment services for Australians and their families with mental health disorders since its inception.

Australians need a wide range of psychologists, now and in the future. This two-tiered model has set the precedent for many government programs to follow Medicare's system and pay psychologists significantly less than their clinical endorsed colleagues (e.g. Department of Veterans Affairs). Over the last decade, significant misinformation has been provided to government and professional bodies such as Medicare, WorkCover, DVA, NDIS, falsely claiming the superiority of clinical endorsed pathway psychologists over other

clinically trained psychologists (for example, the multiple submissions made by the Australian Clinical Psychology Association and submissions by the Australian Psychological Society to varied organisations). The result of these non-evidence-based assertions and misinformation has led to the development of the two-tier Medicare rebate system, two-tier DVA and most recently a proposed two-tier NDIS system, ensuring that clinical psychology services receive significantly higher rebates than all other psychology services, for no "better" treatment outcomes.

What is a 'generalist' or 'registered' psychologist?

All registered psychologists are trained in and can diagnose, assess and treat clients, regardless of whether they are clinically endorsed or not.

Some psychologists choose to apply for endorsement in a particular area. In Australia, we have nine areas of endorsement, but only clinical endorsement attracts the higher rebate. Registered psychologists represent by far the majority of the Australian psychology workforce. In September 2016 there were 27,791 (79%) registered psychologists (incl. 3,725 other endorsed) compared to 7,620 (21%) clinical psychologists (AHPRA: 2016).

Relevantly, the Psychology Board of Australia (PsyBA) via its parent body the Australian Health Practitioner Regulation Agency (AHPRA) presently offers endorsements in areas of practice and other equally valid and effective pathways to registration. All psychologists experience advanced training with supervised practice. Further, all registered psychologists are required to undertake Continuous Professional Development (CPD) that is relevant to the scope of their practice.

Beyond the notion of Area of Practice Endorsement obtained via a more pedagogical educational process involving university master's courses, there is currently a supervised practice pathway to registration in Australia. These supervised pathways, essentially capture and effectively utilise more of the diversity available among students and thereby increases the overall validity of the training process. One reason for this is that some students are more aware of and more specifically targeted in their learning needs than others. Such students are more appreciative of training systems where they can experience far more situated practice combined with a genuine reflective action research-oriented approach in which they can begin to develop their own practice.

Do clinical psychologists have additional training and expertise compared to other all other psychologists?

The Australian Clinical Psychology Association's [redacted] stated in 2015 that 'more than half of those clinical psychologists currently endorsed by the Psychology Board of Australia do not have qualifications in clinical psychology, although these are now required for endorsement going forward.' When the registration system for psychologists moved from the state-based systems to being federally managed by AHPRA, many members of the APS were endorsed in areas of their choosing. Therefore, many clinical psychologists hold the same level of training and qualifications as generalist or registered psychologists. Qualified

registered psychologists hold at least a four-year accredited undergraduate degree majoring in the science of psychology, plus at least a two-year supervised practice component.

Large portions of generalist psychologists hold postgraduate psychology qualifications such as Masters, doctorates (our research indicates 65% of generalists Psychologists). Many also have undertaken specific training in particular techniques such as EMDR, a WHO Gold Standard treatment protocol for PTSD. Some choose to become endorsed in their college, but many do not. Psychologists cannot be considered better trained or skilled by virtue of holding the title clinical psychologist or any other endorsed area. The quality, skills and knowledge of a psychologist cannot be deemed by endorsement status alone, nor are all clinical psychologists necessarily better trained.

There are three key reasons why all psychologists have equivalence in practice expertise:

1. All psychology pathways to registration and practice are subjected to rigorous development and stringent monitoring to ensure the same baseline competencies are upheld;

2. Expert clinical practice involves a complex mix of practice experience, supervision and professional development as key variables in treatment outcomes – beyond academic qualifications; and

3. Yearly registration ensures all psychologists have extensive formal requirements across practice experience, supervision and professional development to ensure practice expertise continues to build post-graduation.

Unlike specialities in medicine, the notion of clinical practice in psychology is not unique to clinical psychologists. Psychologists who have gained registration from many different training pathways are engaged in clinical practice every day in Australia, treating people across a very broad range of conditions and levels of severity. The skills to diagnose, treat mental illness therapeutically, and produce effective outcomes are not unique to one area of psychology. Once again, the scientific evidence highlights this. Importantly, there are a number of different pathways to registration to practice as a psychologist in Australia. Psychologists, participating in and completing these pathways, all experience advanced levels of training and supervised practice. All psychologists are required to complete Continuous Professional Development that is relevant to the scope of their practice and interests.

A notable research project commissioned by the Australian Government (Pirkis et al, 2011) incidentally provided evidence of equivalency among psychologists. Psychologists treating mental illness across both tiers of Medicare Better Access produced equivalently strong treatment outcomes (as measured by the K10 and DASS pre-post treatment) for mild, moderate and severe cases of mental illness.

There was no observed difference in treatment outcomes when comparing clinical psychologists treating under tier one of Medicare Better Access with the treatment outcomes of all other registered psychologists treating under tier two of Medicare Better Access.

Do clinical psychologists see clients with higher complexity or severity of mental illness?

Many psychologist colleagues and I have worked in mixed practices and found that clinical and non-clinically endorsed psychologists see very similar clients. Psychologists generally see clients based on their areas of interest and training, such as working with children or clients experiencing specific mental health conditions, clients with intellectual/developmental disability or certain health conditions.

Far from focusing on those high-intensity patients, the caseload of endorsed clinical psychologists in private practice closely resembles that of their lower paid colleagues in clinical practice who are, according to all available evidence, achieving the same or better outcomes.

Should there be two categories for psychological therapy?

There are two different categories for therapy under the Better Access program: Focussed Psychological Strategies (which covers what non-clinical psychologists can use with their clients, however OTs, GPs and Social Workers can also use these strategies); and Psychological therapy services (clinical psychologists only).

Fully registered and qualified psychologists should not be restricted to deliver the same services as other allied-health professionals who are not specifically trained in psychology. Every psychology degree includes a number of units of counselling and therapy and all psychologists are required to deliver interventions under supervision during their 4+2 / 5+1 internships or masters/doctoral programs. All psychologists completing their internships via these pathways must demonstrate competency in eight core areas of clinical practice, including ethical, legal and professional matters, psychological assessment and measurement and intervention strategies.

Does a higher rebate equal increased access to psychological services?

The justification for the two-tier system – that it would allow patients cheaper access to "specialist" psychologists with improved treatment outcomes has not happened, despite over ten years of operation. Nor has it led to endorsed clinical psychologists treating more serious mental health conditions than non-endorsed psychologists in clinical practice – a major point made by the original advocates for the two-tier system.

Consequences of the continuation of the two-tiered system

1. ***Reduced rebate for clients:*** Members of the public are accessing different rebates according to the type of psychologist they see, rather than by need. All registered psychologists are competent to assess, diagnose and treat mental illness and both clinical and other psychologists see complex, comorbid and demanding presentations. Generalist psychologists all have accredited training in professional psychology, including assessment, diagnosis, formulation and treatment of mental health disorders**.** Members of the public are entitled to fair rebates for services, this is not the current policy.

2. ***Financial consequences and sustainability***: From July 2015 to December 2016, the cost to government of psychological rebates was almost $485 million dollars. More than half of this was spent on clinical psychologists, who represented only a fifth of the workforce (Dept. Human Services, Medicare data). With their growth increasing at 10% per year, in the next 5 years, rebates for clinical psychology services will absorb almost the entire current Better Access funding for mental health.

3. ***Negative impact on psychology as a discipline:*** Among the direct, destructive consequences of the two-tier Medicare rebate system is the immediate, overwhelming bias it conferred towards clinical psychology degrees. It has inflated the demand from future graduates for a clinical degree, triggering an all-but-complete bias in Australian universities to offer clinical psychology programs. Students contemplating their financial future were naturally attracted to clinical psychology programs because of the higher Medicare rebate. Student (not client) demand for other degrees plummeted. The subsequent decline in teaching other specialist areas has profoundly impoverished mental health treatment in this country. As a result, Australia is heading towards a monoculture in the practice of psychology, which threatens its international standing within the profession. No such monoculture exists in the UK, US or European jurisdictions and Australia's bias to a single approach (medicated CBT) threatens the reputation of Australian psychology internationally.

The two-tier system has led to the unseemly public denigration of psychologists by some clinical psychologists, and consequent marginalisation of the majority of psychologists registered to practice in Australia, even though most psychologists have many years of experience and in many cases equal or even higher academic qualifications than their clinical counterparts. ***This is institutionalised discrimination and unfair work practice with no empirical justification.*** Many psychologists with advanced training in specific techniques and those who hold non-clinical post-graduate qualifications have clients who are being substantially financially disadvantaged by this process.

5. The Simple Solution: Continue with single rate

1. Maintain the number of Australians able to access psychological support.
   This is vitally important to people in rural and remote areas where clinical pathways psychologists are difficult to find.
2. Refute the baseless partisan bias that favours one group of psychologists over others – unprecedented in Western countries and unsupported by any evidence of superior outcomes.
3. Allow patients to choose psychologists on a therapeutic needs-basis rather than choosing a psychologist based on a higher rebate.
4. Utilise and uphold the extensive depth and breadth of clinical practice expertise found within the broad scientific community of psychologists registered to practise in this country.
5. Ensure an increased availability of affordable, effective psychological assistance and reduce numbers in the public health system.

Conclusion

All AHPRA Registered Psychologists, regardless of endorsement, have attained the competency to provide psychological treatment under AHPRA and there is no evidence to date of any difference in patient outcomes for endorsed clinical psychologists compared to other registered psychologists in clinical practice. Psychologists cannot be considered better trained than each other merely by virtue of holding the title clinical psychologist or any other endorsed area. The quality, skills and knowledge of a psychologist cannot be deemed by endorsement status alone.

I would like to address that the impact of applying a baseless and fictitious 2-tier divide within the profession of psychology, and what this has created, is a bitterness within the profession, which leaves many clinically endorsed psychologists, advising me of how embarrassed they feel about what has happened. Maintaining parity for all Psychologists, promotes equally, will at the heart of mental health service provisions in Australia.

I would like to thank SIRA for the current use of a one rate (one tier) schedule of psychology services related fees for all psychologists. It is the clear and unequivocal stance that this one rate or one tier system for psychology services continue. The scheduling of fees should remain consistent for all Psychologists.

Kind Regards

References:

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