

On 25 March, 2019, the Australian Psychological Society (APS) presented to members a Green Paper as part of the APS MBS member consultation. This paper proposed a new model of delivery for psychological services under Medicare, a model that has resulted in much debate within the professional as it threatens both the mental health of consumers, and the livelihoods and mental health of over 30,000 practising psychologists, with no underpinning of research.

Today, on 6 April 2019, the APS president, Ros Knight, sent an email to all members of the APS regarding the debate surrounding the Green Paper model.

The email states clearly that the “current consultation phase is designed to make the model fit for purpose and future proof, and show the Government and other stakeholders what we, as a united and professional workforce, believe to be the best way forward for the delivery of psychological services to the Australian community.”

The purpose of this consulting phase is, as Knight says, to fairly consult with key stakeholders, including all paying members of the APS and the psychology profession. Consultation, by its very definition, must allow for varying views. It must respect those varying views as having been carefully thought out and considered, just as the Expert Committee members who formed the Green Paper have carefully considered their views.

“Ensure your views are formed based on the paper itself, and not the views or suggestions of others”
Ros Knight, President APS

Implying, as Knight did in her email, that any views that differ from that presented in the Green Paper are based on the views of ‘other people’, rather than APS members’ own carefully considered opinions, is undermining and unprofessional (let alone offensive towards thousands of highly trained, intelligent professionals).

“Please always remain mindful of the standards to which we hold ourselves individually, and as a profession, in the public sphere. Robust debate is a good thing but some of the debate around the proposed model has played out publicly in social media where clients, members of the public, the media, and government stakeholders are all watching on.” Ros Knight, President APS

While I agree that some members of the profession could reconsider their aggressive approach to providing feedback, it seems that the approach of ‘some’ has resulted in any and all feedback that differs from that of the Expert Committee being dumped into the same, largely ignored, pile. This Green Paper has huge ramifications for tens of thousands of APS members. For some people, entire careers built up over 20 years may be destroyed if some of these recommendations are passed. Directing APS members not to voice their opinion – opinions that are equally as valid as Knight’s – in public, is effectively silencing, and threatening long standing APS members. It is that very silencing and undermining that adds to the divisiveness that Knight is imploring us to prevent.

As Knight states, “we should never forget the commitment we have all made to never cause our clients and the community harm or distress.” The mandate of the APS is to fairly represent all psychologists. If members of the APS are feeling distressed as a result of the recommendations put forth in the Green Paper that distress must be heard, must be recorded as valid, and must be taken on board by the APS.

I asked the MBS Expert Committee to respectfully read and consider the Green Paper feedback and questions presented below:

1. Three-tiers

1a. If 'severe' includes OCD, trauma/PTSD, persistent depressive disorder, eating disorders, comorbid mental health disorders and/or combined with alcohol/drug abuse/opioid related disorders, bipolar disorder, personality disorders, schizophrenia spectrum disorders, severe high prevalence disorders (anxiety, depression), conduct disorder, and those assessed as complex, chronic or treatment resistant by the referring practitioner, what does that leave? What conditions fall under the 'mild' and 'moderate' tiers and what rebate are you proposing for these?

1b. Registration as a psychologist with AHPRA is based on equivalency of pathways to registration. How is it that a pathway that tens of thousands of practitioners chose to follow in order to practice as a 'fully-fledged' psychologist was acceptable at one point in time, but not now? Why are these registered psychologists paying for the decision to move the goalposts? This is like saying GPs can now only treat colds because the board has changed it's mind and decided that they no longer have the expertise to manage diabetes or asthma. Do you think, at the very least, that a grandfather clause would be appropriate for psychologists trained in the 90s for whom the 4+2 model was encouraged?

1c. I have read research that shows no difference in outcomes between different types of psychologists (Pirkis et al., 2011). On the other hand, there is no research that supports the assertion that clients gain better clinical outcomes from AoPE psychologists than they do from registered psychologists. How can the Expert Committee, in good faith, propose that clients falling in the severe range can only see AoPE psychologists under Medicare? Does this not go against the APS Code of Ethics? Already, psychologists cannot meet up with consumer demand due to rising mental health issues in Australia. How will those needing help be serviced when the number of psychologists deemed to be qualified (by the Expert Committee) to treat them is reduced by tens of thousands? It is not feasible.

1d. We know from research that client engagement and client-practitioner fit is one of the most important factors contributing to client outcomes. What will the mental health impact be on clients who - having spent months or in some cases years with the same psychologist - will have to be re-referred to AoPE psychologists because their psychologist (the one who they have connected with, the one who has been of greatest help to them), is no longer deemed qualified to help them? Creating doubt in the minds of clients regarding the qualifications of their psychologist will have detrimental impacts on their progress to date. Who is being left accountable for this decision that will lead to increased self-doubt at a minimum, exacerbated mental health issues and, in some cases, client suicide?

2. Competence

Psychologists are already legally bound to practice within their competence, and psychologists currently develop, maintain and expand their competencies to provide these services by undertaking additional education, training and experience throughout their career. AoPE courses do not universally provide expertise in areas such as the mechanisms of onset, maintenance and treatment of symptoms of complex and chronic mental health (Holmes et al., 2018). Also, AoPE does not universally ensure that a psychologist has competence to manage a particular chronic or severe mental health condition, or to manage that condition within a particular context or with a particular client population. Aligned with the National Health and Medical Research Council, all psychologists with additional training and /or experience for service delivery in the higher steps of the government's Stepped Care Model, regardless of their AoPE, should be allowed to deliver evidence-based interventions within their competence (Mogan et al., 2018). How can the Expert Committee ethically justify their recommendation that arbitrary practice restrictions be placed on psychologists based on AoPE?

3. Practice Certificates

The Green Paper States “These practice certificates will provide Medicare with the certainty that a minimum level of competence has been achieved.” Haven’t all psychologists already proven their competence via their degrees and meeting all of the stringent requirements of registration? If not, what was point of the recognised 6 year degree/supervised practice/stringent application of registration that required the fulfilment of rigorous criteria?

4. Improving provider engagement.

The Green Paper states that the recommendations will improve provider engagement. How does it improve engagement of 35,000 registered psychologists when it presents the fundamental assertion that they don’t have required expertise, despite completing all the same stringent requirements for registration that have been recognised for decades? Is anyone being held accountable for this decision impacting their practice, their sense of worth, their mental health, their financial security, and their family if they are forced back into study or forced to work in a rural location? It’s quite possible that this will lead to a class action.

5. Registered Psychologist Plus and RRR Psychologist Plus

Regarding the distinction between a ‘Registered Psychologist plus’ and an ‘RRR Psychologist plus’ – is the Green Paper suggesting different rules for the same thing based entirely upon location? Does the suggestion that visits to rural psychologists attracting a higher Medicare Rebate indicate that this higher rebate can actually apply to Generalists? If so, is that suggesting that in some situations, but only some, Generalists can be seen on the same level as and equal to other Psychologists?

6. GPs determining client severity

6a. Are GPs realistically going to be able to determine the severity level of a client when few are actually informed of the real issue, which is reflected in the Mental Health Treatment Plans I receive indicating nothing more than ‘adjustment disorder’, ‘anxiety’ or ‘depression’, when the reality is quite different?

6b. If the proposed three-tier system is accepted, it is highly likely that GPs will classify the majority of patients as ‘severe’ – even when in fact they may fall under the mild or moderate classification – purely so that their patients can receive a higher rebate and more sessions. Some time poor GPs are also likely to do this to reduce their own workload – alleviating the needs for patient to frequently returning to them for reassessment. No only will this lead to severely reduced workloads for non AoPE psychologists, but ‘severe’ labelling of this kind will have a detrimental impact on clients’ self-perceptions, not to mention their eligibility for life insurance, income protection insurance, and even travel insurance. What is the Expert Committee’s solution to this?

7. Offsets and compromise

7a. During the Telephone Town Hall Frances Mirabelli, CEO of the APS, referred, on several occasions, to the offset being provided to clinical psychologists for the Medicare rebate losses they will face when seeing clients falling in the ‘mild’ range. This offset is in the form of a 70% higher rebate. Where though, is the offset being offered to non-AoPE psychologists who, as a result of this proposed model, will receive drastically reduced referral and client numbers? The ‘severe’ list encapsulates the majority if not all of the clients that non-AoPE psychologists see on a daily basis. If these clients can no longer seek treatment from registered psychologists under Medicare, non-AoPE psychologist will be out of work. This is a given. How are you going to reimburse registered psychologists for lost wages and lost careers? What avenues are you providing? Again, do you think, at the very least, that a grandfather clause would be appropriate for psychologists trained in the 90s for whom the 4+2 model was encouraged?

7b. The majority of registered psychologists are mid-career and in their 40s. These are psychologists who spent 6 years studying, completed all rigorous and stringent requirements to become registered with the board through recognised pathways that were advised in the 90s, complete ongoing professional development and supervision each year, and in many cases have had papers published, have been invited speakers at conferences, have been called upon as experts, and who run their own busy practices. These psychologists will have to close down their practices because they will no longer be viable due to reduced clientele. As a result, thousands of psychologists, who have been establishing their careers over 20 years, who have families and financial obligations, will be unemployed. How can the APS ethically justify destroying the careers of 35,000 mid-career psychologists who gain registration through recognised and advised pathways? We know that unemployment leads to increased mental ill-health issues and in some cases suicide. Where is the care of the mental health of those who have spent their lives caring for the mental health of others?

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