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Senate Standing Committees on Community Affairs
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Please consider the following comments regarding: **The Government's funding and administration of mental health services in Australia.**

Topic One (ii) workforce qualifications and training of psychologists
I recommend to the Committee that a competency register be instigated to record the competencies of Australian Psychologists who practice in a clinical setting.

The register should include both currently designated Generalist and Clinical Psychologists and all listed under the heading of "Clinical Psychologists".

Competency is defined as the application of knowledge and skill to successfully complete a task. The competency register will include a list of all clinical conditions that the Psychologist has the ability to DIAGNOSE and TREAT.

The Fundamental Questions: The most significant information required by the referring GP, and by their patients is:

a) Does the therapist have the **ABILITY** to treat the presenting condition?
b) Is the therapist **WILLING** to treat the presenting condition? Some Psychologists for example choose not to take children and/or teenagers as clients, even though they have the skills to be able to do so.
c) Does the therapist have the **OPPORTUNITY** to treat the presenting condition ie are they **AVAILABLE**? A Sports Psychologist working at the AIS for example may have the ability to treat many conditions, yet is limited in what he can do by his role.

The register then is compiled by asking the following question of Psychologists working in a clinical setting.

ARE YOU COMPETENT , WILLING, AND AVAILABLE TO DIAGNOSE, AND SUCCESSFULLY TREAT THE FOLLOWING CONDITIONS?

What follows would be a full listing of all of the ICD-10 Chapter V and/or DSM-IV classifications. A few of the ICD-10 conditions are shown below for illustration purposes only.

The Psychologist would need to tick those they are competent, willing, and available to successfully treat. We, as Psychologists are bound by the APS code of ethics. One of the requirements of this code is that we only treat those conditions we are competent to. Under this code, no false claims are able to be made.

(F00–F09) Organic, including symptomatic, mental disorders

- (F00.) Dementia in Alzheimer's disease
- (F01.) Vascular dementia
  - (F01.1) Multi-infarct dementia
- (F02.) Dementia in other diseases classified elsewhere
  - (F02.0) Dementia in Pick's disease
  - (F02.1) Dementia in Creutzfeldt-Jakob disease
  - (F02.2) Dementia in Huntington's disease
  - (F02.3) Dementia in Parkinson's disease
  - (F02.4) Dementia in human immunodeficiency virus (HIV) disease
- (F03.) Unspecified dementia
- (F04.) Organic amnesic syndrome, not induced by alcohol and other psychoactive substances
- (F05.) Delirium, not induced by alcohol and other psychoactive substances
- (F06.) Other mental disorders due to brain damage and dysfunction and to physical disease
  - (F06.0) Organic hallucinosis
  - (F06.1) Organic catatonic disorder
  - (F06.2) Organic delusional (schizophrenia-like) disorder
  - (F06.3) Organic mood (affective) disorders
  - (F06.4) Organic anxiety disorder
  - (F06.5) Organic dissociative disorder
  - (F06.6) Organic emotionally labile (asthenic) disorder
  - (F06.7) Mild cognitive disorder
  - (F06.8) Other specified mental disorders due to brain damage and dysfunction and to physical disease
  - (F06.9) Unspecified mental disorder due to brain damage and dysfunction and to physical disease
    - Organic brain syndrome NOS
- (F07.) Personality and behavioural disorders due to brain disease, damage and dysfunction
  - (F07.0) Organic personality disorder
  - (F07.1) Postencephalitic syndrome
  - (F07.2) Postconcussional syndrome
  - (F07.8) Other organic personality and behavioural disorders due to brain disease, damage and dysfunction
  - (F07.9) Unspecified organic personality and behavioural disorder due to brain disease, damage and dysfunction
- (F09.) Unspecified organic or symptomatic mental disorder
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(F20–F29) Schizophrenia, schizotypal and delusional disorders

- (F20.) Schizophrenia
  - (F20.0) Paranoid schizophrenia
  - (F20.1) Hebephrenic schizophrenia (Disorganized schizophrenia)
  - (F20.2) Catatonic schizophrenia
  - (F20.3) Undifferentiated schizophrenia
  - (F20.4) Post-schizophrenic depression
  - (F20.5) Residual schizophrenia
  - (F20.6) Simple schizophrenia
  - (F20.8) Other schizophrenia
    - Cenesthopathic schizophrenia
    - Schizophreniform disorder NOS
    - Schizophreniform psychosis NOS
  - (F20.9) Schizophrenia, unspecified
- (F21.) Schizotypal disorder
- (F22.) Persistent delusional disorders
  - (F22.0) Delusional disorder
  - (F22.8) Other persistent delusional disorders
    - Delusional dysmorphophobia
    - Involutional paranoid state
    - Paranoia querulans
  - (F22.9) Persistent delusional disorder, unspecifie
- (F23.) Acute and transient psychotic disorders
  - (F23.0) Acute polymorphic psychotic disorder without symptoms of schizophrenia
  - (F23.1) Acute polymorphic psychotic disorder with symptoms of schizophrenia
  - (F23.2) Acute schizophrenia-like psychotic disorder
  - (F23.3) Other acute predominantly delusional psychotic disorders
  - (F23.8) Other acute and transient psychotic disorders
  - (F23.9) Acute and transient psychotic disorder, unspecified
- (F24.) Induced delusional disorder
  - Folie à deux
  - Induced paranoid disorder
  - Induced psychotic disorder
- (F25.) Schizoaffective disorders
  - (F25.0) Schizoaffective disorder, manic type
  - (F25.1) Schizoaffective disorder, depressive type
  - (F25.2) Schizoaffective disorder, mixed type
  - (F25.8) Other schizoaffective disorders
  - (F25.9) Schizoaffective disorder, unspecified
- (F28.) Other nonorganic psychotic disorders
  - Chronic hallucinatory psychosis
- (F29.) Unspecified nonorganic psychosis

OUTCOME: Once the register is compiled, the referring GP will be able to feel confident that the Psychologist to whom the patient is referred is competent to deal with the presenting issues.

BENEFITS: Under such a scheme, the debate about “complex” cases, and about Masters or PhD qualified Clinical Psychologists only being able to treat such cases will become a moot point.

Recommendation: It is time that a competency based system be used to recognise the actual skills possessed and being used by Psychologists in a clinical setting. The present qualification based system is outdated and has created an artificial divide between the minority group of APS endorsed Clinical Psychologists and the majority grouping of Generalist Psychologists. It is time that the actual clinical effectiveness of Psychologists be taken as the measure of effectiveness or competency rather than assumed because of the practitioner's title acquired through higher university qualifications. It is time to measure outputs rather than use qualifications (inputs) to determine clinical effectiveness.

Clinical effectiveness can easily be measured through the use of a comprehensive pre and post clinical tool such as the Symptom Checklist 90-Revised, administered by the therapist during the initial session and subsequently during the sixth and then the final session. The currently used, GP administered K10 is quite basic and more refined instruments are available to be used to measure clinical effectiveness.

Topic Two (e) mental health workforce issues, including:
(i) the two-tiered Medicare rebate system for psychologists,
(ii) workforce qualifications and training of psychologists, and
(iii) workforce shortages;

PATHWAYS TO ATTAINMENT OF CLINICAL COMPETENCIES: The assertions made by a number of members of the Clinical College in their submissions to this enquiry that they are better trained and therefore more highly skilled than 4 + 2 trained Psychologists are clearly not sustainable. The primary focus of the higher level courses is on attaining research skills and completing a research thesis, not on attaining higher level clinical skills. In fact the clinical placements required of such students were included so that the students could satisfy the on-the-job training required by State Registration Boards in years past, so that they matched up with the 4 + 2 trained Psychologists to enable them to work in clinical settings. A number of Masters and PhD level students I have spoken to perceived these placements as an unnecessary encumbrance which interfered with their prime objective of completing their research. The emphasis is clearly not on attaining higher level clinical skills then, it is on completing research.

Obviously, if the research is aimed at demonstrating the applicability of a particular technique to a cohort suffering from a particular disorder, the graduate would be able to claim specialisation in the treatment of that disorder. It cannot be assumed, however, that possession of the higher level qualification per se implies a higher level of clinical competency. Some research after all is quite academic rather than having any clinical applicability.

POST-UNIVERSITY COMPETENCY ATTAINMENT: As in any other profession, practical skills learning and development actually takes place "on-the –job", acknowledged by the fact that two years of supervision is required of all Psychologists. In the case of generalist Psychologists, this period of supervision takes place in the workplace. In the case of Masters or PhD students, this period of supervision takes place via "placements" in workplaces for blocks of time during the university academic year.

It seems paradoxical that a number of Clinical Psychologists are now arguing that their clinical skills are superior or more advanced that those of Generalists Psychologists when in fact the same people were frequently supervised by Generalists Psychologists during their placements, and developed their skills from

observation of, and consequently modelling the skills of the Generalist Psychologists they sat with.

I worked in a VVCS clinical setting for a number of years. Masters and PhD students routinely spent placements at this clinic and acquired skills in working with clients with Posttraumatic Stress Disorder – a condition claimed to fall into the category of a complex case and therefore more appropriated dealt with by Clinical Psychologists only. Interestingly all of the permanent full-time and part-time staff who transferred their skills and knowledge to these students were all Generalist Psychologists or Social Workers.

So how did the permanent VVCS staff acquire their competencies to manage these complex cases? Through acquiring skills and knowledge while employed in the workforce via attendance at conferences, workshops, and seminars. Their competency was developed through the application of this knowledge and skills in their places of employment.

Practising Psychologists are quite discerning in selecting courses, workshops, and seminars which demonstrate and provide competency in the application of practical, proven techniques, which will help them to better assist their clients. These workshops are often quite expensive to attend, and on completion, the attendee is often certified by the presenters as qualified to use a particular therapeutic technique. Examples include EMDR, ACT, Trauma Focused Therapy, Emotion Focused Therapy, Mindfulness-integrated CBT and other advanced CBT workshops, NLP, Dialectical Behaviour Therapy, Neurofeedback, Family and Relationship Therapy, and Schema Focused Therapy, to name a few of the multitude available. **Practising Psychologists thus develop their expertise in a particular area through post-graduate learning more so than during their university years, and thus become highly skilled specialists in a particular area.** Their competence is recognised by University Masters and PhD course supervisors who select clinics staffed by these experts for placement of their Masters and PhD students.

The argument that Clinical Psychologists are more highly skilled than Generalist Psychologists is thus based on a flawed premise.
Most of the arguments raised by Clinical Psychologists that their University Education has better equipped them to deal with complex clinical cases focus entirely on the content of the subjects listed in the course content and give no recognition to the mechanism whereby most of us have acquired the bulk of our most useful practical skills – attendance at professional development activities.

BIAS AGAINST GENERALIST PSYCHOLOGISTS AND OTHER NON-CLINICAL COLLEGE MEMBERS: The APS itself has created a divide between its members. The Clinical College of the APS has successfully promoted its members as the top echelon of Psychologists in Australia through its influence with Medicare and with AHPRA, to the detriment of not only the doomed Generalist Psychologists, but also members of other Colleges with similar qualifications such as Counselling Psychologists.

The majority of group practices of Psychologists which have been established in the last few years, when advertising for new staff now require membership of the Clinical College. Not because of an assumed higher competency level, but purely so that the higher Medicare rebate can be claimed for these employees, thus making the clinic more profitable. While this situation is allowed to prevail, the rest of us, including those with Masters and PhD level qualifications who do not qualify for membership of the Clinical College, are clearly disadvantaged in the job marketplace.

And there is no way out of this dilemma. When we as Generalist Psychologists apply for membership of APS Colleges, practical skills are generally dismissed, and we are required to demonstrate where and how any post university study and/or experience is equivalent to the content of Masters level university subjects. Even when this can be demonstrated we are rejected for membership because of the lack of formal research projects undertaken, or papers published in research journals.

It should be acknowledged that entry to Masters level and PhD courses are based almost solely on students' GPA's, so that the highest academic performers only are selected. Existing Generalist Psychologists, most of whom completed their university education more than 10 years ago, are thus precluded from entry to these higher level courses, and are thus doomed to remain branded as Unendorsed, with no possible way to gain any other endorsement .

During 2009, I applied to seven universities for entry into a Masters level course in 2010. Four of the seven told me not to bother applying since it had been more than 10 years since I completed my Graduate Diploma and my course results were thus out-of-date! Two of the other universities required a GPA of 6.5 to be considered for course entry, leaving one university which I was told had 186 applicants for 6 positions available.

Once classified under the derogatory tile of "Unendorsed" we are doomed to be perceived as the underclass of Australian Psychologists. Even though we possess a wide range and depth of competencies, some of which were considered significant enough to be asked to train Clinical Psychologists during their placements, and in some cases to continue conduct supervision sessions with them after their graduation. This is a reprehensible state of affairs.

The two-tiered Medicare system is flawed because it is based on false premise. If a competency based system was used, there could be an argument for a two-tiered system if some conditions eg Personality Disorders were considered to require a higher level of competency to treat successfully. Such a system should be competency based, however, not qualification based or College-membership based.

Topic Three: (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;

Medicare: Medicare is failing in supplying the best treatments to Mental Health Clients by restricting allowed therapies to the basic skills learnt while attending university. The more advanced, clinically useful skills acquired through professional development activities attended post-university are excluded from the list of Focused Psychological Strategies. Psychologists are thus limited to using less efficient techniques, or perhaps are using more effective techniques yet reporting that they are using the Focused Psychological Strategies only, thus propagating the myth that the FPS's are in fact the most effective.

There is in fact a huge discrepancy between the academically promoted FPS's which continue to attract research funding and thus become self-fulfilling, such as CBT and relaxation techniques, and the actual techniques used in the majority of clinics around Australia. It is also interesting that research conducted by the creator of Acceptance and Commitment Therapy, probably the most rapidly growing, and widely accepted therapy worldwide, has indicated through an independent component analysis that the cognitive component of Cognitive Behavioural Therapy

is in fact ineffective. It is high time that the reality of the situation was acknowledged. Of course for this to happen, research undertaken to prove or disprove this assertion would have to be acknowledged by decision makers, and not offhandedly dismissed as happened recently with the research completed in Victoria which failed to find any difference between the clinical effectiveness of APS endorsed Clinical Psychologists and Unendorsed Generalist Psychologists. The majority of submissions made by Clinical Psychologists suggesting that they possess superior clinical skills have conveniently ignored the findings of this research project.

Recommendation: That an independent body be established to research the effectiveness of a wide range of more recently developed therapies, compared to the Medicare endorsed FPS's. The range should include ACT, EMDR, and Neurofeedback. The body should be independent of the APS, since this body has encouraged and promoted the current FPS's to Medicare. It should also possibly be independent of the long-established "sandstone" universities who have almost exclusively promoted and taught CBT as the cornerstone of their Psychological therapies.(Although the University of Queensland has recently introduced an elective subject on Acceptance and Commitment Therapy into its Masters Psychology program).

Limited number of sessions: Medicare will do its clients a disservice by limiting the number of sessions to 10 in a calendar year. My clinical experience, and that of most of my colleagues, is that quite often a therapeutic breakthrough occurs somewhere between the 10th and 20th session. I believe that the effectiveness of a 6 + 4 session episode of care will be significantly less than that achieved under the present 6 + 6 + 6 scheme, and when the results are evaluated in November 2012, designers of the new scheme will be greatly disappointed with clinical outcomes, and in fact the field of Psychology will be greatly devalued as a consequence.
It would probably be better for the client to not commence therapy if it has to be terminated before a successful outcome is achieved. It would only give the client another experience of failure, and they would thus end up worse off because of the experience.

Recommendation: As mentioned above, a more rigorous instrument needs to be used to evaluate clinical outcomes. If an instrument similar to the SCL90-R is used and it is found that a particular therapy produces significant clinical outcomes in 10 sessions then the proposal will have been validated. The research cited to date which suggests that the majority of episodes of care consisted of less than 10 sessions failed to measure clinical outcomes, so no conclusion can be drawn about the relationship between clinical success and number of sessions attended (or required).