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Committee Secretary
Senate Standing Committees on Community Affairs
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To the Senate Standing Committee on
Commonwealth Funding and Administration of Mental Health Services

I would like to address three issues of the terms of reference.

Two-Tiered Rebate System: Reflecting back on my first year practising as a psychologist in 1981, I realize that I was not nearly as skilled or knowledgeable a psychologist as I am today. Experience, on going professional development and supervision have helped me to develop my skills and knowledge. I find it difficult to understand how a person who just completes their Clinical Psychology training would be more able than I am to counsel clients. This is in contrast to the two tiered system where clients receive more rebate from Medicare through a Clinical Psychologist than would the clients that I see as a Generalist Psychologist. My clientele have issues that involve ADHD, ASD, suicidal ideation, anxiety, depression, personality disorders, bi-polar, alcohol abuse, drug abuse, gambling addictions, sex addictions, domestic violence, physical health (cancer), and relationship and family issues and so on. Frequently I may be in consultation with a GP, Psychiatrist or Paediatrician in counselling clients.

An experienced Clinical Psychologist would say that they are more skilled in dealing with clients with serious mental health issues because of the university training that they have received. I would agree that they have received more university training than I have, but I believe that professionally I have continued to develop my skills and knowledge in a different way and I don't believe it is an inferior fashion. I chose not to undertake a Masters Programme, but instead attended many workshops and seminars conducted by esteemed people on various topics to better develop my skills and knowledge. For example, I have attended a five day course on suicide intervention (Applied Suicide Intervention Skills Training - ASSIST) regarded internationally as a benchmark in this form of training. This allowed me to also train other people in this area. Such skills training allowed me to help people at a high risk of suicide through a difficult time to the point where they were no longer contemplating suicide. I believe that I provided the appropriate care as would a Clinical Psychologist. A Clinical Psychologist has claimed that they offer more than simple relaxation techniques and general counselling as do I as a generalist Psychologist. As noted it sometimes entails keeping someone alive. During one week I would generally see at least one client who exhibits suicidal ideation and some at quite high risk and like a Clinical Psychologist this is stressful and demands a great deal of skill and responsibility, as well as high ethical standards.

According to the British Psychological Association http://www.bps.org.uk/careers-education-training/society-qualifications/society-qualifications I would be able to become a Chartered Psychologist through a planned training programme by working towards a Statement of Equivalence (SoE) in Clinical Psychology. http://www.bps.org.uk/what-we-do/benefits-belonging/membership/chartered-member-cpsychol/chartered-psychologist/chartered-

Chartered Psychologist status is the benchmark of professional recognition for psychologists and reflects the highest standards of psychological knowledge and expertise. If a professional is chartered it is a mark of experience, competence and reputation for anyone looking to employ, consult or learn from a psychologist. The title is legally recognised and can only be conferred by the British Psychological Society under our Royal Charter, which was granted in 1965 and gives us national responsibility for the development, promotion and application of psychology for the public good.

Qualifying for chartered membership status is a significant achievement, requiring high levels of academic attainment, periods of supervised practice and applied experience, a commitment to lifelong learning, and an engagement with the broader issues facing the profession. These foundations are further strengthened by our Member Conduct Rules and Code of Ethics and Conduct, which all Chartered Psychologists must follow. Chartered Psychologists use the letters CPsychol after their name. I believe that this method should also be available in Australia and monitored by the APS. It highlights the fact that there are a number of ways to develop the skills and knowledge required to be a Psychologist with high level skills and knowledge.

The method of ongoing professional development that I chose allowed me to attain the practioner skills I needed to best service my clients. I am certain that I would be able to match some of this professional development, if not all this learning, to the more formalized learning of the Masters in Clinical Psychology. (I am not saying that it would equate to the entire Masters Programme.) In Britain, as noted above, there is an alternative pathway to obtaining a position within their equivalent of the College of Clinical Psychologists. There is recognition of experience (RPL) and formalized study within the British system and I cannot see any reason that this could not be the case here.

I have been reviewing the distinction made between Clinical Psychologists and generalised Psychologists and believe that the distinction does not warrant a two tier system. In fact there should be no distinction between Clinical Psychologists and any member of the Psychology profession when it comes to the Medicare rebate. I believe that the two tier system does not help clients, but only creates confusion for them and division within the profession. This two tiered system is creating the impression that Clinical Psychologists are more skilled and knowledgeable and is disregarding 'non-clinical' Psychologist's experience, further on going professional development and/or formalised study. GPs and Paediatricians refer to me as well as to a clinical psychologist and are happy with the outcomes that I receive with their and my clients.

The Rationalisation of Allied Health Treatment Sessions: Clients with complex histories often require more time then 12 let alone 10 sessions. One example is of a man that I saw well past 18 sessions, charging him a small amount so that I could continue to see him. This man had experienced many losses in his life and the last ones – a much loved job and relationship- had resulted in him being high risk of suicide. His GP and I monitored him throughout this high risk period. If I was able to see him for only 10 sessions, I would have been extremely concerned that he may well have attempted to take his own life. He is now back working in a job that he likes and is continuing to sort out issues in his life. There are many such stories that I could detail here and it is these personal stories that need to be taken into account when making a decision about the number of sessions that a person can access. The data derived by the APS from its members highlights this point.

As a professional, I do not overservice clients as this would not be healthy for them or me. Overservicing creates a dependency and impacts on the clients regaining mental health. Referring to our Code of Ethics highlights the importance of developing good therapeutic relationships and so overservicing would be in direct contradiction to our code. Does there need to be a limit of the number of sessions? Do psychiatrists, GPs or paediatricians have a limit on the number of sessions they have with their patients? I don't think so as they have a Code of Ethics that they adhere to, as do Psychologists. Professionally there is no difference. I also realize that at times a Professional Code of Ethics has not been adhered to by some professionals in their dealing with clients, but I would think that this is in the minority. Surely a decision about the number of visits required by clients should be based on what is best for them.

If the client has not gained enough emotional equilibrium after 10 visits then I assume that they will be able to access the public hospital system. My understanding, however, was that the Government wanted people to be catered for more within the community. This philosophy seems to contradict the cutting of the number of visits from 12 plus 6 more for extenuating circumstances to 10 sessions.

If the main aim is to care best for clients then it should be up to the discretion of the Psychologist and client as to how many Medicare funded sessions are required. Since the number of sessions is being reviewed, rather than reducing the number of sessions available perhaps there should be no limit on clients with more serious mental health issues. More funding would be required for this and perhaps the abolition of the two-tiered system may recoup some monies to enable this to happen.

Mental Health Care Plan and GP Referral Process: Paediatricians, for example, are just required to write a letter to a psychologist to refer a client – why can this not be the case with GPs? I believe it would save GPs time and the government money. A paragraph in a letter often gives more information to me than a MHCP and this would cover the required letter and MHCP. The requirement to send a report after six weeks I do not believe is necessarily the best option. Is this required of specialists to GPs? I thought that it was an initial letter and a letter after conclusion of treatment. I would be in contact with people who refer to me be it GPs or other people to make sure that I am providing the best service I can to their and my client. This may be before the six week time frame when you are expected to write a written report. A written report is obviously required, but may be better served at the end of sessions with other forms of contact occurring during the focussed psychological strategy sessions.

The duration of the MHCP is somewhat confusing. I am aware that it can be for up to 12 visits and 6 more for extenuating circumstances in a calendar year. The confusion can come when the six or twelve visits extend from one year to the next. To simplify the process, perhaps the plan is automatically started again at the beginning of a new calendar year. This would alleviate the problem of this being your sixth visit according to the plan, but only the first in this calendar year. If that seems somewhat convoluted in my explanation then that is how it can become when you are trying to work out exactly the number of visits that a client has used in their Mental Health Care Plan.