

26 July 2010

# Senate Committee Submission

## Statement of intent

It is my intension to submit to the Senate Committee a response to a reference made recently, in the Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services, that:

*"The Senate Community Affairs Committee has concluded that there are no grounds for the two-tiered Medicare rebate system for psychologists and recommends the single lower rate for all psychologists including clinical psychologists....."*

It is my specific intension to provide my personal response, as well as my response as a Specialist Clinical Psychologist.

## Personal response

As a clinical psychologist, I take umbrage to the above statement from the Committee. For me to earn my qualification - as a clinical psychologist - I needed to first qualify as a psychologist and then to undertake postgraduate specialization as a clinical psychologist, which was two years full time, as well as two years postgraduate supervision by a Clinical Psychologist (this took over 4 years, in addition, in total). In addition, I have had to work to maintain this specialist qualification, I have needed to earn Specialist PD (Professional development) points for years in order to keep my specialist training up to date long before Generalist Psychologist was required to do so –I have had to meet registration requirements each year; and I have had to maintain College and Professional Body Memberships.

My specialisation meant that I needed to qualify for, and then meet all demands of, a Masters degree plus complete over 200 additional hours of clinical placement (unpaid and supervised work in clinical treatment facilities). I find it personally, and professionally, insulting that having spent many hours and a lot of money to attain this degree of specialisation, and then pay all the additional costs of maintaining that qualification (such as: annual payment for membership of the Clinical College; the cost of having to earn additional *Specialist* PD points for Continuing Professional Development and Education) your Committee may make my base degree an equivalent.

I have also worked for the last seven years in a Private Psychiatric facility in Sydney, The Northside Group of Psychiatric hospitals, in order to further hone my specialisation. For the last three years of my employment with the Northside Group, I was a Senior Psychologist, and Regional Therapy Services Coordinator across two of their three hospitals.

In no way do I see all this higher education and expertise and years of work experience in ONLY mental health services as equivalent to someone who has completed a four year degree with no specialisation and an ad hoc approach to two years of supervision.

Perhaps the equivalency should actually be extended to clinical psychologists being called Doctor of Clinical psychology, as in the UK, Europe, Canada and the USA? In Australia this currently requires a Doctorate (of Clinical Psychology) to be completed. The degree that I completed in the 1990's would earn me the title of Doctor of Clinical Psychology had I completed it in any of these countries, rather than in Australia. The reason Australian Masters of Clinical Psychology are not called Doctor is because we do not make lobbying the Government a main professional concern – our main concern are our clients. Our professional body has focussed on skills and knowledge development rather than political machinations.

## **Psychologists can easily attain Clinical Psychology Equivalence.**

There is a long-standing method which equates psychologist to clinical psychologist and that is the completion and attainment of a Masters of Clinical Psychology. This requires that two years of full time tertiary study are undertaken and that all of the requirements to be a Member of the Clinical College are fully met. This postgraduate degree provides the necessary specialization from psychologist to clinical psychologist.

Psychologists are not clinical psychologists just because they work in a clinic. Many clinical psychologists are expert in psychiatric medications, and yet would not refer to themselves as psychiatrists, simply because they have some knowledge and some working familiarity of psychiatric medications. Just as a clinical psychologist is able to complete a Medical degree, specializing in psychiatry, and thereby become a Psychiatrist; a psychologist is also able to complete a Masters of Clinical Psychology and become a clinical psychologist.

The decision by the Senate is based in part on the Better Outcomes Survey, which makes economic rationalism its main concern. The allocation of budgets and the meeting of psychological needs may be measured on different indicators. It is a mistake to assume that limited outcome data, that is typically based on a very generalised and brief assessment protocol (the DASS) that only measures three indicators (Depression, Stress and Anxiety) of psychological impairment, is any indicator of the equivalency of Practitioner qualifications. A psychologist and a clinical psychologist have not done the same work simply because they have maintained similar changes in the outcome measure. A psychologist and a clinical psychologist may use the same outcome measures, but they may not be measuring all aspects of intervention or the level of specialisation in providing that. The Better Outcomes study may simply be measuring the therapeutic relationship, a placebo effect, and some basic counselling skills. A more thorough measure of comparison between the two groups should include a longitudinal study of how well clients do post therapy, whether clients are leaving a psychologist because they feel better, then relapse and go to another psychologist. Without measuring what treatments are provided, and the degree of improvement through symptom reduction and maintenance of good health this study could be simply retitled *How well do you like your therapist! And/or Do you feel better by accessing help!*

There is a Constitutional reference to restricting specializations that has been part of the argument to equate psychologists with clinical psychologists. I do believe that this is one of the impetuses for change directed to your Committee. Clinical psychologists are specialists, the two year full-time teaching component of the clinical psychology Masters Degree is advanced clinical training in a range of psychological disorders. The two year placement (Supervised application of advanced skills) is further specialization. Clinical psychologists are specialised mental health professionals, who are taught diagnostic and treatment protocols in a supervised and carefully monitored way. Psychologists who may have earned experience, on the job, do not necessarily equate to formally trained, supervised and specialised practitioners. If you like, you could say there is no difference between an accountant and a Chartered Accountant! What is the point in completing post graduate training in a specialisation for any profession if that extra skill level is not benefited with commensurate income and status as well as demonstrating a level of expertise so the public can feel assured that they are getting standardised training and post graduate expertise in the area they are sourcing.

Psychologists have become a very active lobby group and one reason for this is the motivation towards increased income. This is in itself an unethical basis for psychological progress, however should an individual psychologist prefer a specialist pay scale then that individual should specialize (that is: they should complete the required tertiary education). Payment set at a specialised rate should not be determined by the strength of the lobbying of a small interest group, but of the actual objective assessment of specialised qualifications, maintenance of specialised memberships and registrations and the degree of ongoing Professional development and Clinical Supervision.

## **Skill level**

Attaining the specialized qualification and training of clinical psychologist means that a certain skill level has been achieved and professional criteria met. These skills are acknowledged as advanced within the tertiary education process and within the relevant professional bodies. The particular skills that are taught, and practised under strict supervision, are assessment protocols and treatment interventions. Specifically, assessment is ongoing and uses formal protocols (that is, strictly administered, marked and utilized questionnaires etc.) and less formal processes (for example observation, clinical interview and differential diagnoses) that are based in rigorously research and a solid theoretical background.

In 1989, the Management Advisory Service to the NHS differentiated the health care professions according to skill levels. Skills in this sense referred to knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills as follows:

Level 1 - "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management)

Level 2 - undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol

Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The Management Advisory Service to the NHS suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. The group went on to argue that clinical psychologists are the only professionals who operated at all three levels and:

"it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists..."

*Management Advisory Service to the NHS*

This is consistent with other reviews which suggest that what is unique about clinical psychologists is his or her ability to use theories and concepts from the discipline of psychology in a creative way to generate solutions to problems within the clinical setting.

Finally on this issue, is that if you decide that an extra four year specialisation specifically in mental health has no more value to the public than a generalist, than can you at least have the decency to recognise seniority in terms medicare rebates.

There is a huge difference in the public seeing a junior psychologist on any level with 1 or 2 years experience post University and a Psychologist such as myself, with over 10 years experience, ALL OF IT WORKING IN MENTAL HEALTH with the mentally ill! If the current two-tiered rebate model is not recognised than at least recognise the difference in skill level between a Junior (less experienced) Psychologist and a Senior (more than 10 years experience in the clinical field) Psychologist.

### **BUDGET CHANGES AND REDUCTION IN NUMBER OF SESSIONS UNDER MEDICARE**

The changes in Medicare number of sessions from a maximum of 18 to 10 reeks of tokenism, of playing at giving the public a few sessions so it looks like the Government is interested in Mental Health. One of the most evidenced based treatments for depression is Interpersonal Therapy which requires between 12-18 sessions to complete properly. The other evidenced based model is Cognitive Behaviour Therapy which takes approximately 12-18 sessions for moderate depression, and approximately 18-24 sessions for severely depressed people. Clinical Psychologists use evidence based therapies, and need to be allocated the right amount of sessions for their clients whether they need them all or not!

Again, I agree with other views that if you need to save money for the budget, then reduce the number of sessions if you must for less educated and trained professionals, including GP trained counsellors, but let the Specialists in mental health with 8 years training and supervision, use 12-18 sessions.

It would also be beneficial to screen more closely those psychologists who are registered but have spent little time working in mental health. Under the current system for Medicare all you need is four years academic two years of supervision plus two years work experience, which does not have to be in mental health. Why not only give provider numbers out to psychologists who have had at least 5 years experience in mental health. This would cut down on the number of clinically inexperienced psychologists working under Medicare.

## **Psychologist Contact details**

(...)

Thank you.

(...)

Specialist Clinical Psychologist