

I am an endorsed Clinical Psychologist who works in a public health service (not W.A)

T.O.R:

b. (4) Reducing the number of sessions makes very little sense to me. Most best practice guidelines for conditions such as depression and anxiety have frameworks of 10-20 sessions (other conditions even more). Given that psychological interventions often are supported by psychiatrists and psychopharmacology there needs to be a least some similarity between the two treatment streams if the goal is stable improvement. For someone with significant depression/anxiety seeing a psychologist once every month or two would not constitute an appropriate or defensible "dose".

In essence this is a political and not a clinical problem. The political decision was to put money into a private-public Medicare system and then when the cost blew out (apparently there is a great need) cost-saving initiatives were the next political decision.

What may make political sense does not make clinical sense and the two should not be confused. I would like to see a new political decision that diverts more funds back into public health and attracts clinicians back into public employ.

e, (1) I do not see a problem with having a two tier remuneration system in place for Medicare rebates. The problem for me is, what does the two tier system imply?

I support the principle (followed in many industrial jurisdictions) that longer periods of education are rewarded with increased remuneration levels.

I am not convinced that the two tier system should in some way definitively discriminate between the competencies of generalist psychologists (4+2 year contra 6 years trained). Nor do I think there should be a presumption that the scope of practice of clinical psychologists is significantly different to other sub-specialties.

Science and Best Practice and Evidence are terms bandied about in this debate but the problem for me is that most of this "science" is promoted by lobby groups, special interest groups, and people protecting their income. I would like to see some form for robust independent outcome research, preferable commissioned off-shore. Too much of this debate has been overly simplistic and lacking in consideration of complexity. There has been no attempt to look at competencies as a result of life-long learning nor consideration of the complex mix of university training and skill and competencies accrued over time as a practicing clinician.

e. (ii), (iii) The two pathways to generalist registration (4+2 or 6) are a systemic condition of the Australian University system. There are not enough places being

offered in masters programs to meet the need. I have not seen any indication of changes at Universities to massively increase uptake in masters programs. Whilst I would personally support a 6 year university minimum we are a long way from that. Until such time that structural changes to universities occur then we should work with a practicing clinical workforce that is made up of certified (registered) competent clinicians who have gained their skill, competency and expertise in one of two ways.

If any are concerned about the 4+2 pathway and the quality of the supervised 2 years of practice then they ought to be engaged in working with that group as supervisors and/or supporting initiatives to improve the training. I believe that Mental Health (and Health generally) in my state ought to be actively supporting high quality training of the 4+2 and that senior graded clinicians ought to be required to supervise the 4+2 program as well as masters placements. Mental Health at a state level ought to be commissioning clinical training elements that approximate those provided in universities and be making these available to the Mental Health workforce (ie supervisors and those undertaking 4+2). I also think that PsyBA/APS could contribute to this kind of training until such time as Australia is able to provide sufficient masters program places to meet the workforce need.

I am concerned about some of the ramped up claims made about endorsement. As I understand it only W.A psychologists can claim to be specialists and this was a (political and legal) concession to them in the negotiations for a national registration scheme. The Chair of PsyBA at a meeting in my state stated that endorsement does not make one a specialist and to claim to be a specialist (unless from W.A) would be a breach of protected title. The confusion and dispute around these qualification, award and category issues is unhealthy and creates a fractured workforce of no benefit to the discipline nor the consumer.

Mental Health services are often narrowly defined in public health. In my public health area there is a shortage of psychologists working directly in Mental Health but also in related services (Drug and Alcohol, Sexual Assault Services, Brain Injury, Chronic and Complex Care, Palliative Care Services to name just a few services working with debilitating MH problems). In part this shortage is the result of public clinicians moving full-time or part-time across to be private (Federally funded) Medicare based providers. Another reason is the poor use of psychologists' specific skills in Mental Health services, with many psychologists carrying excessively high case loads which mean they can not do the therapeutic work they are trained to do. The maintenance of "generic positions" and the generic construct results in down-skilled services which psychologists are not happy to remain in. Lack of good quality professional development opportunities is another reason for psychologist leaving public employ. An ever increasing bureaucratic documentation component leaves an ever decreasing time

for clinical work, the ensuing decrease in work satisfaction leads individuals into the private sphere or other fields.

j) In my experience the private providers have made an extremely valuable contribution to mild to moderately distressed people with a wide range of mental health problems. A reasonable civilised and wealthy country like Australia ought to be able to provide this service for its citizens.

I do not find that the private providers are generally able to provide adequate care to the severely mentally distressed, those with chronic mental illnesses and those in acute crisis. Nor do I find the private providers have a business plan that adequately accommodates individuals (families) with complex needs where co-ordination, shared care and interventions need to occur across multiple providers. In all these instances well funded and supported public health with updated and integrated models of care would provide more appropriate, efficient and effective care.

Public Health in my state is currently limited by a funding crisis, by silos of care within the Health Department, by poor modeling of integrated care across: community to ED to inpatient and back. Lack of electronic records across site, stream, team, department is a major hindrance to good quality care. Poor utilisation of discipline specific skills is another factor in low quality service design resulting in suboptimal outcomes. In my Area Health service there has been years of using a strategy of not backfilling community health positions as a method of creating funds to prop up budget overruns in inpatient facilities. This strategy has decimated community health services and led to clinician burnout, and apathy. For all the talk of early intervention, hospital avoidance, patient focused care the reality has been to strip resources from the very services that provide these kinds of services to fund the hospitals. This is a political and clinical no-brainer.