

Please consider the following points in your inquiry into Commonwealth Funding and Administration of Mental Health Services.

I am a Clinical Psychologist. I completed my Master's Degree in 1998. I would like to address the two-tier (Clinical/Generalist) issue.

Firstly, I specifically trained in Clinical Psychology to develop knowledge and skills for treating clinical psychopathology. I was also accepted into other Masters courses, such as Community Psychology, but my research clearly indicated Clinical Psychology was the optimum training to adequately skill me up for the complexity of clinical presentations.

I did not need to do a Master's degree to become registered as a Psychologist as I had already completed one out of two years of supervision to meet registration criteria under the 4+2 model, and I could have continued on this pathway. Although I was being supervised by a clinical Psychologist, and I did not have to pay, it was clear to me that the pathway to registration was woefully inadequate and would not have prepared me for treating clients in a clinical setting, such as private practice. Thus I undertook a Masters in Clinical Psychology which unquestionably prepared me well for clinical work.

Over the last thirteen years I have run my own private practice with another Clinical Psychologist. We have several Clinical and Generalist Psychologists working with us. I believe all our Psychologists are competent practitioners, but there are differences. The following points illustrate my personal observations:

-Clinical Psychologists are more confident in treating clinical conditions. Generalist Psychologists are more likely to say they cannot see certain presentations as they do not have the training. I fully accept this and it would not be ethical for them to take on such a client. Thus, they will be seen by a Psychologist with the Clinical training.

-The Generalist Psychologists come from a range of work experience backgrounds. We have interviewed many registered Psychologists who have had little or no experience treating individuals with mental health issues, but they could join us and see clients under Medicare. This is a severe contrast to Clinical Psychologists who have definitely had some clinical experience with individuals in their training. The latter is simply essential given the complex presentations that are possible under Medicare.

-Clinical Psychologists are trained to work with psychopathology, rather than non-clinical presentations that require other interventions and approaches. Treating Clinical psychopathology is complex. This is a vulnerable population that deserves appropriately trained Clinicians. Generalists may be competent, but their pathway to registration is so broad and variable that it is impossible to assess their competency for clinical psychopathology. My current caseload has multiple cases of Obsessive Compulsive Disorder, Severe Depression, Personality Disorders, Post Traumatic

Stress Disorder, Panic Disorder and so on. I feel well prepared to work with these presentations because of my training.

-A clinical Psychological condition is a serious matter. Hospitalisation, self-harm, suicide, homicide, family breakdown, and child neglect and abuse are some possible outcomes. I treat serious psychological and behavioural disturbances under Medicare. The cases are often challenging and multiple people are effected by the mental health disturbance; the client, partners, family, friends and society. To place the clients care in the hands of inadequately trained clinicians is highly questionable if not negligent and dangerous.

-Not all referrals under Medicare are Clinical cases. That is, some do not actually reach DSM IV criteria for a clinical condition. These are presentations that include people struggling with transitions, need decision making support, life dissatisfaction etc. Theoretically, they do not meet the criteria for Medicare funding, and thus should not be seen. However they do get referred by G.P's and are seen. These cases do not need clinically trained Psychologists, and we are not actually trained for this population. I do believe this population could be seen by non-clinical Psychologists. This is a separate issue, but illustrates the point that there is different training and preparation for different groups of clients within mental health.

-I strongly propose that the one piece of research/evaluation undertaken for Medicare outcomes NOT be considered in this inquiry due to its numerous weaknesses. One thing all Psychologists should know, regardless of their training, is that research requires sound methodology, such as 'double blind' research. The evaluation undertaken appears to be inadequate on many levels. The major weaknesses include: inadequate design, absence of crucial information regarding treatment, absence of longitudinal data post therapy which is critical for treatment outcomes, Psychologists were self-selected and self-selected clients who answered the questions in session, with the Psychologist.

Finally, I expect to be appropriately remunerated for my specialised clinical training and skills. The lower rate set for general Psychologists is simply unacceptable for my contribution based on my training. I strongly believe clients referred under Medicare with clinical level psychopathology are greatly assisted by Clinical Psychologists. I am willing to provide this service if I am adequately remunerated, but could not justify my contribution based on the lower generalist rate. Over 50% of my clients are low income, and thus I bulk-bill them. This is unusual for many practices, but being accessible to all people in the community who require mental health treatment has been a hallmark of my practice since I established it, thirteen years ago. I fear the inadequate remuneration will threaten the viability of my practice, which would be a great loss to my local community and the GP's whose clients I treat. If one extrapolates from my private practice situation just outlined, I suspect no-one will bulk-bill, which means the dire situation of 'those who can't pay' will miss out, and those who can pay (the gap) will be supported. This undermines the objective of the Medicare scheme, which is 'access to all'.

Thank you for your consideration.

