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Senate Standing Committees on Community Affairs
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I started to study Psychology in 1989 in Queensland. At this time, my lecturers advised me that people who did not have Masters level training would not and should not be allowed to practice for much longer, and that the world standard was to have 6 years full time training (four years with Honours degree and two years full-time Masters degree) followed by two years supervision as a Clinical Psychological Registrar. This is frequently referred to as 6 by 2.

I duly pursued Postgraduate Training at the University of Western Australia, where Psychologists had been trained since the 1930's. I was a Clinical Psychology Registrar at Royal Perth Hospital, and subsequently worked there for some years as well as having a Private practice. Many of my undergraduate colleagues from Queensland left after the four years and started to practice, often with no supervision.

Specialist Clinical Psychology Status- a two-tiered system predicated on Work Value.

In 2001, after extensive consultation, the Industrial relations Commission (IRC) acknowledged that Specialist Clinical Psychological training and supervision provided a third tier of skills and evidence based practice in distinct contrast to the basic skills gleaned in an academic undergraduate degree (which is comprised purely of introductory units to the various fields of interest within the broader profession of Psychology).

Work Value Document - an IRC (Industrial Relations Commission) endorsed **articulation of the calling of Clinical Psychology in Australia and the higher**

industrial Work Value than the calling of Psychology. This is now embedded within Australia's Industrial Relations Awards. This is very relevant to any review of the two tiers Medicare system predicated on Work Value

Clinical Psychologists are trained to assess, diagnose and formulate treatments for the complex presentations of moderate to severe mental health Disorders. This training allows Clinical Psychologists to work effectively with Medical and Psychiatric practitioners to provide evidence based Mental Health care and treatment. This point becomes extremely salient when considering the **chronic severe shortage of Psychiatrists in Australia.** Should we not be asking for more specialist, skilled mental health staff to help meet the shortfall in specialist Psychiatric mental health care? Should we not expect the highest possible standards of Mental Health Care for our citizens?

The trend in the developed world is to encourage, indeed insist on more education and specialisation, rather than a generalist mentality that assumes that every discipline will provide the same quality, focus, and degree of expertise in their mental health service provision.

Rather than levelling the two tiers playing field to one, should we not be expecting under-trained and under-qualified Psychologists to upgrade their qualifications and education?

A mountain of first class outcome research consistently indicates that evidence-based Psychotherapy has a similar twelve week outcome to (effective) modern antidepressants, with of course, far fewer side-effects, risk and down time. And, longer term follow-up shows that evidence-based psychotherapies have added benefits over time as cognitive restructuring, psycho education and coping and problem-solving skills generalise and value-add to the patient's life. This is true for Major depressive Disorder, and all the Anxiety Disorders including Panic and Post Traumatic Stress Disorders. The incidence and prevalence of these Disorders are increasing, and the **associated costs are rising.**

Psychiatrists generally have no training in Psychotherapy. Their core skill is prescribing Psychopharmacology, and assessing risk. **Drug costs represent tremendous impost on our Pharmaceutical benefits Scheme, and Medicare and the Health budget.** Drugs, have serious side-effects, teach nothing and do not show people how to intervene to prevent relapse, or to self-care to maximise health and self-agency. Psychiatrists are really underrepresented per capita (there should be around 1 for every 10,000 persons, and currently there are under 3,000 for 20+ million people), and the gatekeepers are reluctant to increase training numbers. Psychiatrists' Medicare rebates are very expensive given that the average time spent upon patient review is 15 minutes, and the number of clients seen each day can be between 20 and 40. There is no ceiling on the number of sessions a person may have with a Psychiatrist.

Members have advised us that DoHA has had to follow a government imperative to demonstrate cost savings and that this is non-negotiable. However, it is abundantly clear that there the obvious significant gap in mental health service provision is for those in the community presenting with the most complex and severe presentations. This is the unique specialized training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices.

Costs blow-out from G.P. Mental Health Care Planning

General Practitioners may have (if at all) only been exposed to only a unit or two of Psychopathology in their Bachelor of Medicine degree. Why should untrained General Practitioners need to do Mental Health Care plans for Specialist Psychologists whose core business is assessing, diagnosing and treating clients with Mental Health problems? If there is a reduction in costs to be made, this is a great place to do it. No Medical Speciality asks a GP to do a treatment plan for them. They just require a referral note. Given that many delegate this to their Practice Nurse anyway, how could this be better and more economically implemented? Why can't Clinical Psychologists be acknowledged as able to assess and diagnose, treat and

evaluate client progress without the intermittent input of the GP? Of course, regular reporting and collaboration would still be in place to facilitate team care.

The Specialist Medicare rebate of (currently) \$119.80 acknowledges the difference in work value between a generalist Psychologist and a Specialist Clinical Psychologist. Specialist Clinical Psychological training can also be seen as an affordable and effective adjuvant to Psychiatric treatment. Rather than reviewing patients for side-effects and symptoms, we facilitate real and quantifiable change in personal social and employment functioning.

I have had many clients referred to me after being “treated” by a Generalist Psychologist. When I ask what they did with their previous therapist, they generally say-“he or she was a nice person, but all we did was chat.” Clients most frequently really want to learn more adaptive ways of coping, thinking, motivating and succeeding- there is far more to mental health treatment than being a friendly face. Is this not what GP’s have provided for many years, their waiting rooms full of people coming in for a weekly chat?

Specialist Clinical Psychological care implements skilled third tier evidence-based Psychotherapies (that Generalists have no idea about). The old saying applies- the less you know the more you know- they would have no difference between their practice and a Specialist’s.

I ask you to consider the longer term consequences of **benchmarking mediocre and sub-standard training** by negating and denying the benefits and differences between mediocre and Specialist evidence based training and education in the scientist-practitioner model. Surely if an undereducated cohort is protesting that there is no benefit from accessing postgraduate education, this should alert us to the problems inherent in a reactionary and close-minded sub-group who do not want to meet standards that have been held up as being increasingly necessary for the past 20 years. **Please keep the two-tiered system of rebates so that clients can immediately know the level of training their Clinician has undergone, and so the core skills and expertise of the speciality are acknowledged.**

I also ask you to consider removing the cap on sessions for Clinical Psychologists especially when treating moderate to severely disordered clients.

I ask you to consider removing the need for GP driven Mental health Planning for Clinical Psychologists, and by introducing a standard referral letter, similar to that written to introduce a client to any other Medical Specialist.

I thank you for the opportunity to submit to this Standing Committee.

Yours sincerely

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Specialist Clinical Psychologist