

Senate Committee Enquiry into Commonwealth Funding and Administration of Mental Health Services

Thank you for this opportunity to make an individual submission of my views for the Senate Committee's consideration.

I would like to address the following specific terms of reference:

- (i) the two-tiered Medicare rebate system for psychologists,
- (iii) number of Medicare sessions reduced from 18 to 10 per year.

Firstly, I must state that I am writing this choosing to withhold my name as a result of the ongoing and extremely unfortunate and aggressive attempts by a small organisation to manipulate and shame clinical psychologists for expressing our views. I am aware of many colleagues who will now not make submissions for fear of retribution from this group, which have already manifested ugly personal attacks, among other things.

Secondly, many of my colleagues have already made submissions on the issues dealing with the weight of evidence and tackling the misconceptions of the Medicare data analysis. This submission will focus therefore, on my own personal accounts to lend weight to my position on the various issues, as follows:

Summary

1. That there are very real differences between the qualifications, education, training and hence level of expertise of a clinical psychologist and those of a generalist psychologist. It is not in the Australian public interest to not make this distinction.
2. That serious consideration should be given to NOT reducing the Medicare funding via allocated sessions from 18 to 10 per year.

I am a clinical psychologist with more than a decade of clinical experience in both government and private sectors. It is worth noting that I spent almost a decade before gaining registration as a psychologist, training to become a clinical psychologist, a specialist in the assessment, diagnosis and treatment of mental disorders. I am heavily invested in, and passionate about, my profession. I am a member of the APS and of its College of Clinical Psychologists, and I have also been involved in the regulation of psychology through the relevant State Registration Board prior to July 2010, and now I serve as an appointed member on one of the Regional Boards of the Psychology Board of Australia (PBA).

Training and education to become a clinical psychologist

I have a 4 year undergraduate degree in Science, with a double major in psychology, completed an honours year, and then went on to enrol in a Masters in Clinical Psychology, before extending this to a Doctorate when this became available during my first year of Masters training. During this postgraduate training I underwent many hours of face to face didactic training, as well as small group workshops aiming to train us in the many aspects of practicing as a clinical psychologist. Everything from Professional Ethics, to the basics of counselling, clinical assessment and diagnosis, to various forms of therapy intervention were covered. On top of this academic training, clinical psychologists undergoing postgraduate training also attended professional, 'hands on' workplace training through attendance at a number of 'clinical placements' during our postgrad degree – for a Masters degree I completed 4 x clinical placements, and I completed a further 2 placements for the completion of the professional doctorate degree. These were invaluable industry experience in providing me a broad exposure to everything from inpatient psychiatry, to community mental health and drug and alcohol services, to a community based psychology clinic. Generalist psychologists not undergoing this structured university training simply cannot get the high level of training and expertise during their two years of post-honours industry training. I know this because I have supervised a number of 4+2 interns as part of various roles in the public service. I know that the quality of a 4+2 intern's psychology education is largely based on a) the quality of the supervisor's and b) the supervisor's available time to provide this training.

As an example, if we are to compare the training in cognitive behaviour therapy (CBT) received by a university postgraduate (Masters of doctorate) student, with that of a 4 + 2 intern in a busy private practice in the community, the difference in training is evident. I underwent no less than approximately 80 hours of didactic training in CBT (lectures), as well as a number of half day workshops, small group exercises and so on, all of which was examined formally to ensure my skill level and competence. In contrast, where is the 4+2 intern to gain even just these 80 hours of lectures from a specialist in CBT while working in a busy private practice where there is a commercial imperative for the intern and their supervisor to make money??? It is impossible. Four+2 Interns are left to fend for themselves all too often due to busy supervisors, and realistically are fortunate if they receive the subscribed number of clinical supervision sessions to complete their internship. Let's not forget that the Masters student has all of this training, ON TOP OF the industry based training and clinical supervision attained during their clinical placements. This is just a single example. The same applies to training in assessment, diagnosis, and other areas of clinical relevance.

I provide a lot of clinical supervision to what the PBA now term clinical registrars, those Masters and Doctoral students who have completed their degrees and are working towards PBA area of practice endorsement in clinical psychology through either 40 or 80 hours of supervised practice over 1 and 2 years respectively. I do not provide supervision for 4+2's because I do not consider that I would be able to dedicate the amount of time necessary to adequately train them as a competent psychologist in my practice. I am aware

that many 'supervisors' DO provide this supervision, and often turn out sub-standard psychologists. I know this because we see their reports and registration requests come through the Board regularly.

I also clinically supervise a number of senior 'generalist psychologists'. They attend supervision with me, in part, to gain more specialised, complex skills in assessment and diagnosis and treatment that are not in their clinical repertoire for various reasons. I have had a number of 'generalist' psychologist supervisees that could not make a PTSD, generalised anxiety disorder or even major depressive disorder diagnosis. I have too many examples to mention of instances where my generalist colleagues have referred clients to me from their practice due to the complexity of the presenting problems leading to the client being outside their level of competence to treat – eg personality disorders, trauma, etc.

The government needs to also concern itself with protection of the public, a responsibility it delegates to the PBA. This in mind, it is of utmost importance that the public not only has access to the higher level, more complex expertise of the clinical specialist where necessary, but it is critical that the public be able to discern which psychologists to turn to in order to effectively deal with their issues. A member of the public presenting to a generalist psychologist with a complex issue for which the generalist is not equipped to treat, will not only waste valuable, limited Medicare sessions seeing this person before (hopefully) being referred on, but in the worst case scenario may actually be put at risk.

I feel that it is ludicrous to suggest that there is no difference between the work value of generalist psychologists and clinical psychologists. The Medicare dichotomy is not a case of unfair discrimination. Rather it is reflective of clear and discernible differences in professional education, training, and hence level of clinical expertise. Critically, it is an important and necessary requirement in the ongoing mission to protect the public. It is also a valid acknowledgement of the further significant cost (financial and otherwise) incurred, and training and education undergone, by clinical psychologists compared to our generalist colleagues. Prior to November 2006 this Medicare dichotomy did not exist, nor did the protection of the public that PBA area of practice endorsements now provide. I sincerely hope that, having taken a positive step forward for the profession and the Australian community as a whole, we now don't take a massive jump back into the dark ages because of the need to simplify policy, or silence an outspoken minority.

Internationally the standard for psychology registration is far higher than in Australia. The standard for a clinical specialty in most of Europe and in America is a minimum of a doctorate qualification. The PBA should be commended for its forward thinking initiatives to propel the profession forward and at least attempt to come into par with international standards for the profession. To suggest that there is no difference between a generalist and clinical psychologist would surely lead to these higher degrees not being taken up. Longer term, this can only mean a poorer standard of psychological

service delivery to the Australian public, and, surely, more mental health related suicides and death as a result.

Most of my clinical psychologist colleagues have some kind of bulk billing policy. I personally bulk bill a significant portion of my current private practice case load, choosing to offer an affordable, quality service to the financially disabled and vulnerable members of our community. If the clinical (higher) rebate were to cease, I simply would not be in a position to bulk bill clients any longer. This would leave many disadvantaged and vulnerable members of the community unable to access clinical psychological services. While I applaud the expansion of ATAPS, this should not come as a consequence of loss of Medicare sessions, or the clinical rebate. The fact is that I personally have found it next to impossible to get myself onto an ATAPS provider list, and I am aware of a number of colleagues who have been turned away by Divisions of GP, being told that they were not currently 'recruiting' in that particular area.

I urge the Senate Committee to strongly consider the damaging consequences to the Australian public of reducing the two-tiered Medicare system for psychologists to a 'one size fits all' system before even contemplating going down this path. The damage to the profession, just 12 months into a new era with the establishment of the PBA and National registration, would be extreme.

Thank you for considering my submission.

Kind regards,

Name Withheld