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Specialist Relationship/Individual
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Senate Committee Submission 1st Aug 2011

Commonwealth Funding and Administration of Mental Health Services

Dear Sir/Madam,

I have a Professional Doctorate in Counselling Psychology. I work in Melbourne under the Better Access program. I have worked as a fully registered psychologist since 2001 and under the Better Access funding program for the past 4 years. I am writing to express my disappointment in the position of the Federal Government over recent years in relation to the division between Clinical and Counselling Psychology.

PROBLEMS WITH THE DISTINCTION BETWEEN CLINICAL & COUNSELLING PSYCHOLOGISTS

I take great offense to the fact that the financial differences in Medicare payments between Counselling and Clinical Psychologists sets up an assumption in General Practitioners and/or the public that Counselling psychologists are less competent or less well trained than our Clinical counterparts.

TRAINING IN COUNSELLING PSYCHOLOGY AMPLY INCLUDES CLINICAL PSYCHOLOGICAL EDUCATION

Firstly, my training, lasting the equivalent of 6 full course work years (9 yrs because I took some part time options) amply included subjects on psychopathology, diagnostic tools such as DSM IV, ICD-10, psychological assessment of clinical psychological disorders etc etc.

Secondly, not only did I receive ample psychopathology training in my Swinburne University coursework program I also received significant added clinical supervision on my external placements. Whilst much of my supervision was from Counselling Psychologists my supervision frequently revolved around the impact of psychopathological issues such as depression/anxiety/personality disorders/obsessive compulsive disorder/ and it's assessment including clinical interventions for. My Supervisors themselves had scores of years working in Clinical environments dealing with the same range of clinical presentations as clinical psychologists.

COUNSELLING PSYCHOLOGY TRAINING ARGUABLY EQUIPS PRACTITIONERS WITH A WIDER VARIETY OF TOOLS LEADING TO GREATER QUALITY OUTCOMES

My study also focused on how to provide assistance for client concerns relating to general psychology of the workplace, the family, relationships and general life effectiveness. These domains of study, when added to the already sufficient psychopathological tools/theories taught in my course arguably require the student psychologist to have a more wholistic and comprehensive model of psychological intervention than from the clinical training program.

The Clinical training program arguably focuses more on 'what is wrong with people' (the 'negative psychology' model) as opposed to the Counselling Psychology training which gave me a dual appreciation of 'positive psychology' (how to make people more satisfied) AND 'negative psychology'. Put simply I did not want to study Clinical Psychology because of it's over reliance on diagnostic labels and 'negative psychology' methodologies that make it a 'sibling' of the more 'medicalised' Psychiatric tradition.

THE LABEL CLINICAL PSYCHOLOGIST NOW PROVIDES A BIASED UNFOUNDED MARKETING ADVANTAGE TO A GROUP OF PROFESSIONALS WHO IN FACT HAVE NO SIGNIFICANTLY BETTER TOOLS OR APPROACHES THAN COUNSELLING PSYCHOLOGISTS

What leads to success as a psychologist is re-referrals and word of mouth networking which rewards those psychologists who provide high quality care. In an evenly and fairly set up market place this is what happens. In the current marketplace I believe clients are being falsely steered to Clinical Psychologists in some cases because they are a "Clinical Psychologist" and for no other reason.

Some GP's assume Clinical Psychologists are the real psychologists and others are phony's or less well trained. I have had some several clients in the past year coming to see me after having first seen a clinical psychologist who they found to be "too Clinical". When pressed one client complained "the clinical psychologist wanted to spend the first 2 sessions assessing and diagnosing me and my situation before setting up a plan or beginning to work on my issues".

As I suggested to my client, "assessment is very important but can be done at the same time as providing assistance and psychological tools and support".

Having worked with and attended professional development with Clinical Psychologists I am very aware that the bag of "tools or tricks" of the Clinical Psych is in fact NO different to that of the Counselling or Generalist Psychologist.

I CALL FOR THE IMMEDIATE IMPLEMENTATION OF 1 TIER OF MEDICARE PAYMENTS OF \$100 FOR COUNSELLING & CLINICAL PSYCHOLOGISTS TO IMPROVE QUALITY OF CARE/OUTCOMES AND EQUITY TO REALIGN THE PSYCHOLOGY INDUSTRY

Counselling psychologists to move from a medicare rebate of \$81.60 to a rate of \$95 and Clinical Psychologists to drop from \$110 to \$95.

This change may help limit the current fracture in the psychology industry which is getting bigger by the day as the APS apparently seems to be splintering with other professional groups vying to more effectively represent each group of psychologists generalist versus clinical.

MY VISION FOR PSYCHOLOGICAL TREATMENT AND THE LENGTH OF TREATMENT

If we continue to align our psychological treatments ONLY in the direction of repairing what is wrong in people (THE CLINICAL MODEL) we will end up promoting the generation of fragmented treatment approaches. We will also see the rate of prescriptions increase when natural approaches may have sufficed.

We must promote training of psychologists with the skills to enhance recovery of negative psychological states whilst at the same time enhancing positive psychological states. This does NOT mean clients have to have twice the number of sessions. Skilled clinicians can achieve these 2 outcomes simultaneously if they are trained wholistically. Enhancing positive as well as recovering from negative states will produce more sustainable recovery rather than simply reducing clinical disorder scores. The latter is a superficial recovery at best.

Approx 20-30% of my clients are so distressed or suicidal on presentation and their situations are so entrenched that 10 sessions in a calendar year is simply inadequate and inhumane. Additional sessions must be done on a case by case approach to ensure seriously unwell clients receive adequate protection from self- or family harm. Dehospitalisation of the 1980's was a great idea but only if we are prepared to correctly care for some clients in the community.

Kind Regards

Dr Dan Riddle

GP Mental Health Care Review	Date: (4 weeks to 6 months from date of Plan)
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Patient Name:		Outcome Tool K10	Result
DOB:		Gender:	Date:
GP Name:			

PROBLEM / DIAGNOSIS		
	Goal	Progress on Actions and Tasks
Number 1:		
Number 2:		
Number 3:		

FOLLOW UP RELAPSE PREVENTION PLAN

RE-REFERRAL SECTION (if further Allied Health Practitioner sessions required - maximum of six further sessions)

RECORD OF PATIENT CONSENT
<p>I, _____, (patient name – please print clearly) consent to this Care Plan to proceed and I agree to information about my mental health being recorded in my medical file and being shared between the GP and the counsellor(s) to whom I am referred, to assist in the management of my health care.</p> <p>_____ (Signature of Patient) _____ (Date)</p> <p>I, _____, (GP) have discussed the proposed referral(s) with the patient and I am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these.</p> <p>_____ (Signature of GP) _____ (Name of GP) _____ (Date)</p>