PATHS (VIC)
Peninsula Assessment & Therapy Services
ABN: 66 125 061 452

Dianne Summers
Psychologist & Educational Consultant
Dip.T.(Prim.),B.Ed.(Sec.), G.Dip.Adol.& Child Psych.,
M.Psych.(Child & Ed.), MAPS,
College of educational & developmental psychologists.

Submission to Senate Community Affairs Committee – Inquiry into Commonwealth funding and administration of mental health services.

Reference in particular to:

(a) the Government's 2011-12 Budget changes relating to mental health;

(b) changes to the Better Access Initiative, including:
(i) the rationalisation of general practitioner (GP) mental health services,
(ii) the rationalisation of allied health treatment sessions,
(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and
(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;

(e) mental health workforce issues, including:
(i) the two-tiered Medicare rebate system for psychologists,
(ii) workforce qualifications and training of psychologists, and
(iii) workforce shortages;

I am a registered psychologist with PBA endorsement for educational and developmental psychology, following initial registration via a 4 + 2 pathway, in addition to commencing and completing a Masters Degree whilst still a 'probationary psychologist'. I have worked across the school sector, mental health services (CAMHS) and private practice settings alongside psychologist colleagues who cover generalist (not endorsed), counselling, clinical, and educational & developmental areas of practice. I also provide supervision for Master of Psychology '**clinical**' placements in school settings.

I am vigorously opposed to the 2 tier medicare rebate system currently in place for rebates for the provision of psychology services and the impact that this has had on prospective training of psychologists; arbitrary divisions amongst psychologists who may be providing the **same** assessment, formulation, diagnostic, and evidenced based treatment services; inequitable access to services for community members with lower socioeconomic resources.

The ongoing dialogue between different psychology groups, the PBA and Medicare provides evidence of miscommunication about training and practice standards of the various contexts within which psychology is practiced. There is also frequent misrepresentation of what a PBA endorsed clinical psychologist is, compared to other psychologists. In reading numerous examples of prior submissions to the Committee made by PBA endorsed clinical psychologists who are also in receipt of 'clinical psychology' medicare rebates, I note frequent reference to themselves as the only psychologists with training and professional practice in the assessment, formulation, diagnosis and treatment of mental health disorders across the lifespan. This is easily demonstrated as erroneous upon reading the subject units of many of the Masters of Psychology course outlines provided across the Australian University sector; reviewing the APS literature regarding the specific and general psychological competencies required for membership of the 9 Colleges; perusal of the PBA case study competencies (see below) required to be demonstrated by 4 + 2 **generalist** psychologists prior to general registration (these are psychologists who are ineligible for endorsement areas without further study).

P.O. Box 446,
Mt Eliza. 3930.
Consulting room: **1321 Nepean Hwy, Mt Eliza**
☎ **9787 3185**
0419 524 618
disum @ ozemail.com.au

Case Study ID		
Has satisfactorily met the following specific requirements for case studies	**YES**	**NO**
Operates within capabilities and refers as necessary. Manages potential role conflicts	☐	☐
Case study structure follow Board's recommended format	☐	☐
Written expression is clear and succinct, without grammatical or spelling mistakes. Terminology is correctly employed without use of non-psychological jargon. Approx 2000 words per case study	☐	☐
Identifies number of sessions with client	☐	☐
Identifies reason for referral, background information, relevant client or organisational history	☐	☐
Presenting problems AND symptoms (mood, affect, cognition, behaviour) or organisational systems and issues are identified and described in sufficient detail to support the development of a formulation and diagnosis	☐	☐
Risk is assessed and any identified risks managed	☐	☐
Discusses relevant evidence based theories and models and how these guide diagnosis, formulation, treatment planning and intervention delivery	☐	☐
Formulation identifies and integrates vulnerabilities, triggering events, and maintaining factors based on client's presenting signs, symptoms, situation and history that account for the current problem or target behaviour. Client's strengths/supports are identified	☐	☐
Gives a formal diagnosis using a standard diagnostic/classification system. Organisational diagnosis is based on psychological tools and processes.	☐	☐
Correctly employs, interprets and integrates test data as appropriate	☐	☐
Discusses whether symptoms meet all diagnostic criteria using examples from client's presentation and explores differential diagnoses. Or organisational diagnosis is justified	☐	☐
Intervention plans are succinctly described	☐	☐
Plans are clearly linked with the diagnosis/formulation and relevant evidence based theories	☐	☐
Plans are realistic given the provisional psychologist's experience, complexity of issues and sessions available for treatment	☐	☐
Intervention is consistent with plan	☐	☐
Provides succinct summary of the intervention process, clearly demonstrating intervention skills in implementing the plan	☐	☐
Evaluates intervention outcome and reflects on practice, including lessons learnt	☐	☐
Discusses future modifications to their practice in light of this experience	☐	☐

Notes:

Case Study ID		
Has satisfactorily met the following specific requirements for case studies	**YES**	**NO**

Reference: PBA marking criteria for provisional psychologist case studies

It is abundantly clear from the above that even PBA generalist psychologists are required to demonstrate the skills and knowledge that PBA clinical psychologists claim are in their realm only, **prior to registration.**

As a psychologist with a Masters degree in educational and developmental psychology, I completed units of study that included psychopathology; advanced assessment; assessment and intervention for exceptionality; anxiety disorders; clinical behaviour therapy. I undertook clinical placement for 6 months in a mental health service where, under supervision, I completed crisis risk assessments; provided assessment, formulation and treatment for children and adolescents referred to the tertiary service; assisted psychiatric registrars with their formulation, providing them with a sound developmental context within which they needed to base their formulation. As a psychologist currently employed in schools and private practice I **receive referrals from** and work collaboratively with my PBA clinical, generalist, ed & developmental psychologist and psychiatrist colleagues in CAMHS and at Headspace. For PBA endorsed clinical psychologists to argue that I lack the skills and knowledge to assess and treat mental health disorders in children and youth is clearly erroneous, unethical (according to the PBA ethical guidelines) and unprofessional. It is just as erroneous for them to claim that they are the **only** psychologists who have competencies that are similar in level to psychiatrists.

Further evidence of the illogical and unsubstantiated nature of claims of a different level of competency between different psychologists is that there are both PBA generalist and ed & developmental psychologists employed by public tertiary mental health settings, particularly in rural areas. Some of these psychologists are employed at team leader and senior levels, in recognition of their skill level and ability to provide supervision and direction to others (including their PBA clinical psychologist and psychiatrist colleagues). According to the submissions made by some PBA clinical psychologists, if these **senior clinicians** were to move into private practice, their skill level would be such that they should be renumerated less than the very clinicians they may have been supervising in a mental health service setting. Further, those clients seeking the services of such experienced and competent psychologists would be further out of pocket, as the gap fee for the same(but possible less competent) service would be higher. Obviously, this is a ludicrous situation that needs to be addressed.

I also object to the confusing use of terms – as a Masters level trained and PBA endorsed psychologist, I am consistently referred to as a ‘generalist’ psychologist by my clinical psychology colleagues. I am not! Under the current medicare system, I am only able to provide focussed psychological strategies for medicare rebate services (despite my level of training and experience in providing clinical services in clinical settings) –this does not equal “generalist psychologist”.

The current medicare system is inconsistent across psychological services and the rationale for this has never been adequately explained. PBA clinical psychologists have received a higher rebate for services on the basis that their initial training was focused on the assessment and treatment of mental health disorders, and yet PBA **educational and developmental** psychologists were not afforded the same recognition of their training in assessment and treatment of **developmental disorders** under the Autism and subsequent Developmental Disorders packages. Instead, paediatricians were given the prerogative of ascertaining those psychologists with whom they worked and had a referral relationship with, who were competent in providing services to these children and families. Why could this not be the same for GPs, paediatricians and psychiatrists referring patients with mental health disorders?

Finally, the Senate Committee needs to carefully examine the **evidence** of training, competency and efficacy of service provision that it has access to – namely the requirements of registration for all psychologists (what competencies are all psychologist required to have prior to registration) and the outcomes of the Better Access Review. There have been many

anecdotal tales of individual experience with psychologists who were not successful in delivering a treatment plan.....I could furnish similar examples of misdiagnosis and incompetent assessments provided to me by my clients from PBA clinical psychologists. All this demonstrates is that no matter what level of training is provided there may still be individuals who are not professional in the application of their knowledge and we need to continue to be rigorous in the monitoring of our profession. It **does not** prove that one group of psychologists is more competent than another.

With regards

Dianne Summers