

August 2nd, 2011

To: The Senate Community Affairs Committees
Re: Commonwealth Funding and Administration of Mental Health Services

I am making this submission as I wish to highlight a number of issues relevant to this enquiry. I am aware that these issues are impacting on many psychologists, particularly those who graduated from university some time ago.

1.0 PROFESSIONAL CREDENTIALS:

I am a psychologist, educated in Sydney, with qualifications from Macquarie University. I completed my undergraduate training in psychology in 1978. As a mature age student, I then completed the course work of my post-graduate Masters in Counselling in 1991. In 1992, I was granted conditional registration as a psychologist by the NSW Psychology Registration Board. Following the completion of my thesis I gained full registration in 1996. Hence, I have been practising as a psychologist for over 15 years and have over 30 years of experience in the human services sector.

I work in both the public sector and private practice. I have extensive experience working across a range of government departments – forensic (adult and juvenile), education and development (university and TAFE), as well in health services (community health, mental health and drug health). In addition, since 1997, I have had a part-time private practice.

Attached are two letters from university-educated counselling clients (both wishing to remain anonymous), one seen in the public hospital, another in private practice.

2.0 INFORMATION RELATING DIRECTLY TO THE SENATE ENQUIRY SECTION (e) (ii) WORKFORCE QUALIFICATIONS AND TRAINING OF PSYCHOLOGISTS:

I have been advised and encouraged, by AHPRA staff, to bring the following issues to the attention of the Senate Enquiry as I am told that the board feels “their hands are tied”.

2.0.1 Qualifications and Endorsements:

Despite having a Masters in Counselling, both the Australian Psychological Society (APS) and the government registration board (AHPRA) fail to recognise these qualifications for endorsement as they are not deemed equivalent to a 6-year university qualification. Hence, I am registered only as a “generalist” psychologist. So, although I have called myself a counselling psychologist for well over a decade, I am no longer legally allowed to do so.

2.0.2 APS endorsement for Clinical Psychology and APS Individual Bridging Plans:

Currently, Clinical Psychology endorsement is necessary to gain the higher Medicare rebate for clients. The Senate Committee should note that the APS is a non-government organisation with voluntary membership.

Australian Psychological Society (APS) members seeking endorsement were required to apply for membership of the APS Clinical College. However, when granting “Individual Bridging Plans” (IBPs) to psychologists the APS has repeatedly demonstrated a lack of consistency and fairness. IBP plans have been given to only certain psychologists seeking endorsement. As a result, many psychologists, including myself, paid the APS in the apparently mistaken belief that our applications would be fairly assessed. Within the psychology profession is a widespread belief that the APS have repeatedly “changed the goal posts” and have not been open or transparent in their assessment processes. Although applicants were required to address a comprehensive range of criteria, it would seem they are only interested in our university qualifications.

The APS wrote to me in response to my application for Clinical College membership. They stated: the *“MA (Counselling) degree undertaken at Macquarie University is unusual in that it is Australian Psychology Accreditation Council (APAC) accredited as equivalent to a 4th year psychology degree while the NSW Psychology Registration Board has assessed it as equivalent to a 5th year in psychology”*. In fact, I have a 3 year undergraduate degree plus the Masters. The course work for my Masters was 3 years part-time. It was a requirement that students have concurrent relevant employment, and also experience, in order to be accepted into the course. There were approximately 12 participants per annum and entry was highly competitive. Macquarie University’s Masters in Counselling course was held in high regard and, I am told by AHPRA staff, was considered at that time to be a superior course to their Masters of Clinical Psychology.

2.0.3 The Australian Psychological Society (APS) and the Australian Psychology Accreditation Council (APAC):

The Senate Committee should note that Australian Psychology Accreditation Council (APAC) is part of the APS.

APAC is “responsible for accrediting education providers and programs of study for the psychology profession”.

2.0.4 “Gate-keepers” of the profession and the lack of a “grandfather” clause”:

There is no “grandfather” clause which could enable older psychologists (with considerable experience and trained to high standards in their day) to be endorsed by the government board (AHPRA).

As the requirement for endorsement is now a 6-year degree, the current system is inadequate as it relies on the APS to assess and “gate-keep” endorsement of psychologists

within the profession. The APS purports to represent ALL psychologists but has shown an academic and elitist stance towards generalist psychologists and are age-ist in that those who completed their training more recently have been granted simpler, less onerous IBPs.

2.0.5 The “Medicare Assessment Team”:

APS is the watchdog for Medicare.

It is the APS “Medicare Assessment Team” that determine who will be granted Clinical Psychology status. This does not seem appropriate.

2.0.6 Lack of “Recognition of Prior Learning” (RPL):

The APS and AHPRA do not take into account Recognition of Prior Learning (RPL) UNLESS IT HAS BEEN UNDERTAKEN AT A UNIVERSITY.

Thus, records showing 30 years of extensive and ongoing professional development, participation in (as well as provision of) clinical supervision and continuous employment have been totally discounted. **NO CREDENCE IS GIVEN TO EXPERIENCE ON-THE-JOB.**

2.0.7 No minimum standards to set up private practice:

In a profession like psychology, life experience should be of paramount importance. Whom would you rather see for counselling – a text book expert or someone who is qualified AND has real life and world experience?

Currently, recently qualified graduates with a degree in Clinical Psychology are able to set up in private practice once they have completed 2 years of supervised internship. . In the USA, I understand from overseas students whom I have supervised, that 5 years of experience is required as a minimum prior to opening a private practice. **These matters are directly relevant to the issues with the current two-tiered Medicare rebate system.**

2.0.8 Endorsement Applications – one individual’s attempts:

Firstly, I would like to state that I see little or no value in seeking endorsement as a *Counselling Psychologist* - other than being legally allowed to use the title.

At great expense, with extensive effort and considerable time involved, I have made applications to both the APS (>\$500) and AHPRA (>\$200) for accreditation/endorsement as a ***Clinical Psychologist***. It should be noted that my application to the APS was initially rejected. It appears that the APS did not read my academic transcript even though they required an original from the university (a further expense). The APS rejection letter claimed that I had not undertaken subjects that were in fact part of the MA course and were on my transcript.

With encouragement from colleagues who are Senior Clinical Psychologists, I sought a review for which the APS had stated would cost a further \$1000. Although I did not pay the

fee, it did take time to gain any reply to correspondence in which I pointed out to the APS that I had in fact:

- (a) Undertaken subjects they claimed were not on my academic record, and**
- (b) Shared most of those classes with Clinical Psychology students in my post-graduate course.**

As a result, I was eventually granted an “Individual Bridging Plan” (IBP).

2.0.9 An impossible plan:

The bridging plan I have been granted to gain Clinical Psychology endorsement is however, I believe a “mission impossible” plan due to lack of:

- (a) Availability, and**
- (b) Accessibility** to the course subjects they require me to undertake.

A cost-benefit analysis and time factors, render the APS bridging plan unfeasible. I have been unable to find any universities, let alone in Sydney, currently able to offer single subjects, especially within the timeframe stipulated by the APS bridging plan. Indeed, 6 universities tell me they have been inundated with enquiries because of these APS bridging plans. Flying from Sydney to Townsville to attend university block placements (if I can gain course entry) seems ludicrous especially at this stage of my career. Certainly study leave from my current workplace would not be supported as the subjects are irrelevant in my current position.

I find it offensive that the APS seemingly discount the thesis from my Masters plus work projects (which include program evaluations) that I have already undertaken. They now require me to undertake yet further research.

2.0.10 Subjects not a requirement in current Masters Clinical Psychology coursework:

More significantly, my university, Macquarie University, **DOES NOT REQUIRE CURRENT CLINICAL PSYCHOLOGY STUDENTS TO EVEN UNDERTAKE THE SUBJECTS THAT THE APS HAS TOLD ME I MUST COMPLETE**; they are optional subjects in their Clinical Psychology course. In fact, I already have well over a decade of experience working with children and adolescents, the client group they now want me to return to university to study.

2.0.11 Lack of Confidence in the Competence of the APS and Lack of an Independent arbiter:

I believe that the APS is not adequately overseen by any statutory authority.

I do not have any confidence in the APS assessment team to fairly evaluate any work I am required to submit to them as part of my bridging plan. They have already demonstrated that they did not read my original application. They have shown a lack openness and a lack

of transparency, they have set and change the “goal posts” and they hold all the power – any appeals go back to them for an internal review.

I also believe their agenda may be to limit the number of clinical psychologists and hence retain the self-interest and the exclusivity of the status of clinical psychologists who make up only 20% of the profession. Their claims of superior academic qualifications do not acknowledge those who have a doctorate (PhD) – IF they do not also have a Masters in Clinical Psychology.

2.0.12 Unsubstantiated claims of the superiority of Clinical Psychologists:

Further, given claims by APS that clinical psychologists “possess superior skills” in assessment and diagnosis of complex clients, I would like to point out there is evidence to show that approximately 80% of clients with drug and alcohol issues have one or more co-existing mental health conditions, usually depression, anxiety - often Post Traumatic Stress Disorder, and with psychosis sometimes an additional feature. Although I am not an endorsed psychologist, most of my clients have complex “co-morbid” conditions. Unlike many Clinical Psychologists, I am thoroughly aware of the complexity of these cases and their conditions **and** the confounding factors involved. So I am reluctant to make any rash diagnoses. At a recent APS conference it was demonstrated that most Clinical Psychologists were shown to over-confident in their diagnostic capabilities. Also, unlike many clinical psychologists who believe they have expertise in diagnosing and recommending medications, I prefer to give provisional diagnoses and leave psychiatrists to properly assess and diagnose, as well as prescribe any medications. My expertise is in engaging, educating and empowering clients through counselling and therapy.

2.0.13 In summary:

Both psychologists and clients are being disadvantaged as a direct result of the current 2-tiered Medicare scheme. Financial disadvantage is only one aspect.

The current system also disadvantages more experienced psychologists; we have much to offer clients and the profession by providing younger psychologists with training or supervision.

3.0 INFORMATION RELATING DIRECTLY TO THE SENATE ENQUIRY SECTION (b) CHANGES TO THE BETTER ACCESS INITIATIVE, INCLUDING: (i) THE RATIONALISATION OF GENERAL PRACTITIONER (GP) MENTAL HEALTH SERVICES:

When referring to any other specialists, GPs simply write a short letter. They do not get paid for doing assessments or making referrals:

In my experience, GPs are unhappy with, and confused by, the current referral systems under Medicare. I have facilitated a number of meetings on behalf of the Mental Health

Professional Network where GPs have vocalised these concerns. Some GPs stated they are reluctant to refer their patients due to their perception of the requirements under the Better Access to Mental Health or Enhanced Primary Care Schemes. I have found that GPs rarely complete the recommended referral plan, let alone discuss any plan with patients they refer. Often the information is barely more than the client's name and occasionally it may include their current medications. Referrals have frequently been hand-written and difficult to decipher. Indeed, some of my clients have gone to new GPs due to their own doctor's refusal to provide them with a referral to a psychologist. This was also the case with a client who has been suicidal and in the past self-harmed on more than one occasion. Some clients have reported they were declined a referral for therapy and offered medication instead - without any say in their own treatment. This is in direct opposition to the intention of the Medicare Better Access to Mental Health Schemes.

3.0.1 The source of referral:

The following situation highlights the type of questions the Senate enquiry is raising.

When new clients contact me directly, I frequently suggest they seek an assessment and referral from their GP in order to access the Medicare benefits. I have been told by one GP that I am not "referring clients" to him but simply "recommending" him. This discussion led me to seek legal advice as he was requesting I pay him for referrals to me. I was informed that he could not legally charge me money for what was considered to be a "spotter's fee". However, as there was no witness to this conversation and no written evidence, no further action could be taken.

3.0.2 The number of counselling sessions:

The following is relevant in terms of the number of sessions and the proposed reduction to 6 + 4 instead of 6 + 6 (with potential for another 6 i.e. 18 sessions in total).

The requirement for psychologists to report back to the GP after the first session with a completed assessment also seems of limited value as assessments often require more than one session. . Whilst acknowledging a client has attended is significant, this should not require a written report but merely a short note, email or phone call. A report after a few sessions would be of greater value for both the client and the GP, and less onerous for psychologists.

In conclusion, I am willing to make myself available to attend the Senate enquiry to provide further evidence or assistance if required.

Yours sincerely,
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Psychologist,
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