

Committee Secretary
Senate Standing Committee on Community affairs
PO box 6100
Parliament House
Canberra ACT 2600
Australia

Dr L Priddis

30 July 2011

Dear Committee:

RE Commonwealth Funding and Administration of Mental Health Services

Thank you for the opportunity to contribute to this inquiry. I am a Member of the APS and hold endorsements as both a Counselling Psychologist and a Clinical Psychologist. My endorsements have come as a result of completing two separate Masters of Psychology Degrees one in each field and many years of specialist clinical practice in the WA Health Department. I also have a PhD in Psychology. For the past ten years I have taught in an academic programme in Counselling Psychology that includes supervision of placements and of research theses of Clinical Psychologist trainees as part of my workload. In addition I maintain my clinical skills in a small private practice that I have managed for over 20 years.

I feel reasonably well qualified to comment on two Mental Health workforce issues

1. **The two tiered Medicare Rebate system for clinical and counselling psychologists.**
 - a. I enjoy the privileges of the top tier in this system as a result of my clinical psychology endorsement. However, the skills I learned from my first Master's degree (counselling psychology) actually provided me more depth and equipped me the most for my work in the Health Department. The clinical psychology award earned me the privilege of employment by this Department. As my private practice has grown in reputation my speciality has become working with children and with young families in distress especially families with babies and infants including families where one or both parents have a mental illness. The expertise I developed for this work again came mostly from the teaching and supervision I received in my first M. Psych (Counselling), and from the research I undertook to complete my Masters of Clinical Psychology and my doctoral thesis. My expertise continued to grow as a result of the professional development I have undertaken over the years. My point is that a good M. Psych (counselling) training afforded me similar if not better teaching, placement and research experiences to equip me to work with extremely disturbed populations in the

WA Health Department and with a range of clients in private practice, but it has been the piece of paper awarded for my clinical psychology degree that has opened the doors. Whilst I can understand and indeed support a two tiered system (that separates 8 year+ trained from 6 year trained I see no reason for the seemingly arbitrary allocation today whereby clinical psychology is privileged and counselling psychology is recognised at a level equivalent to that of four year trained (4+2 yrs supervision) psychologists. Both clinical and counselling psychologists complete a minimum of six years formal education plus two years of supervision (6+2) and in my opinion there is little to discriminate between the programmes. Upon graduation trainees from both programmes frequently find they attend the same professional development activities and enjoy the same peer discussion groups. It frequently appears to me and my (clinical and counselling psychology) colleagues that the two tiered system is both divisive and arbitrary.

- b. In my academic teaching career I have seen both excellent and average students graduate from the Counselling Psychology programme I teach in. I have seen the same in the Clinical Psychology programme and in similar proportions. The counselling psychology programme offers students a solid therapeutic training. The students are taught advanced evidence based therapeutic skills for use with individuals, families, couples and groups, pharmacological interventions, assessment and diagnosis including within multicultural contexts and do the same research and assessment units as the Clinical Psychology students. They have the same number and length of placements as do the clinical psychology students. Those counselling psychology students I have supervised in community agencies have used evidence based interventions to manage and treat clients with extremely complex presentations. My point is that 20 years later I find there remains little to discriminate between the quality of preparation students receive in the two Master of Psychology programmes, but still there is rigid gate-keeping as in the current division of the two tiered system. The effect is to reduce the opportunity and restrict practice for counselling psychologists and reduce diversity and richness for clients and for systems that might otherwise employ them.

2. Better Access reduction in sessions

Internationally it is now recognised that the relationship a client forms with their therapist is of the utmost importance. All forms of evidence based practice teach that building the therapeutic alliance is vital. While for many clients this can occur within ten sessions and 'chunks' of psychotherapeutic work be completed, for those clients with complex presentations this is unlikely to be enough. I would argue too for an item to be included in "Better Access" that is for parent-

child relationships or family groups. Currently these clients present with depression or anxiety in one or both parents which may be treated individually and their concern (and that of the therapist) for their baby, infant or young child is given secondary importance. In my clinical practice working with young families I find we can frequently complete chunks of work within 10 sessions where the presentation is of a mild to moderate nature or there is a single traumatic event. Clients frequently return as new developmental stages present new challenges. In many cases of intergenerational trauma the mother's mental health is attended to concomitantly with that of the parent child relationship and in these instances more than 10 sessions are mostly required. The work that is done in building parent-child relationships will have long term cost benefits for society, so it is important this work be firstly supported and secondly given the chance to be extended when necessary.

Recommendations

1. If a two tiered system is to remain then counselling psychology and clinical psychology should be in the same tier.
2. Extended sessions in the Better Access system to be available for clients with complex presentations
3. The Better Access program be opened to include evidence based therapy for improving parent-child relationships where either the parent or the child present with symptoms or where the relationship is under severe stress.

Thankyou

Lynn Priddis (PhD)