

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

27th July 2011

Re: Terms of Reference E (i) – Mental health workforce issues, including: The two-tiered Medicare rebate system for psychologists

I am a clinical psychologist and former university senior lecturer, who has also directed postgraduate training in clinical psychology for a number of years. In this capacity, I taught postgraduate coursework in core areas of clinical psychology practice such as psychological assessment, diagnosis, case formulation and evidence-based psychological interventions. In addition, I have provided professional supervision to registered psychologists who were Masters graduates in clinical psychology or generalist psychologists who achieved registration via a programme of supervised training.

I would like to address my comments on the two-tiered Medicare rebate system by referring to established contributing factors to effective psychological treatment. These factors include the therapeutic alliance, evidence-based practice and client-based factors.

Effectiveness in psychological practice is partially dependent upon a psychologist's ability to form an effective working alliance with clients. I believe that effectiveness in this area is a function of personality, effort, professional experience and good supervision. In this regard, the increased emphasis on therapeutic alliance in clinical psychology training in recent years is a positive trend. I believe that ability to form a good therapeutic is common to both clinical and generalist psychologists.

Effectiveness in psychological practice is also dependent on the use of effective interventions. An important development in psychological practice since the mid-1990s was the recognition of empirically-supported interventions. The helpful outcome of this particular emphasis has been the increased use of empirically-supported intervention packages for problems such as various anxiety disorders, depression, and other conditions. I believe that generalist or clinical psychologists who conscientiously read professional literature and attend professional development activities are capable of delivering effective empirically-supported interventions.

A more recent development in thinking about evidence-based practice followed the accumulation of debate and criticism from clinicians and researchers regarding empirically-supported interventions. An issue raised during this debate was that

empirically-supported interventions are generally validated in studies using clients who are diagnosed with one particular disorder. When psychologists in general practice are faced with the frequent problem where clients present with more than one diagnosable condition, there is little guidance from the literature concerning empirically supported interventions as to how one should proceed. Indeed, the problem may lie in deciding which empirically-supported intervention to use, when to use it and when to combine it with other interventions. Such choices are often necessarily based on careful assessment and case formulation. In response to the debate on issues around empirically supported interventions, the American Psychological Association issued a task force report in 2005 on evidence-based psychological practice (EBPP). One of the three core aspects of EBPP endorsed in the task force report is *clinical expertise*, which includes diagnostic judgment, case formulation and treatment planning.

Client-based factors constitute a third contributor to effective psychological intervention. Research supports the influence of multiple disorders, complex personal histories and particular relationship styles for psychotherapy outcomes.

There are differences in *clinical expertise* between generalist and clinical psychologists. Well-trained and well-supervised clinical psychologists are more equipped than generalists to assess complex client presentations, understand the relationship of multiple diagnoses to each other in relation to the client's history through case formulation, and to plan appropriate and appropriately-sequenced psychological interventions.

The specialist training of clinical psychology postgraduate programmes reflects an emphasis towards clinical complexity, with the majority of coursework being devoted to assessing, diagnosing, predicting, preventing and treating psychopathology. In addition, clinical training puts a strong emphasis on a critical approach to research literature. Indeed, no other specialisation within psychology rigorously examines mental health research and evidenced-based best practice like clinical psychology. For this reason, clinical psychology is recognised as one of several specialisations within psychology in the United States and Britain. In Western Australia, a work value document prepared by the HSOA Clinical Psychology Negotiating Committee, which led to a successful claim, noted that other than psychiatry, clinical psychology is the only mental health profession whose complete post-graduate training is in the area of mental health.

Removal of the recognition of the distinction between clinical and generalist psychologists would not only be out of step with international trends. Removal of recognition of the distinction may also lead to an exodus of clinical psychologists from the Better Access programme and with them, a diminution of the expertise required to provide effective psychological intervention for clients who have complex disorders and presentations. Such a development would have detrimental effects on members of the public who make use of the services offered under the Better Access programme.

I urge you to continue to recognise the difference between clinical psychologists and psychologists conceptually, industrially and financially and maintain the two-tiered Medicare rebate system for psychologists.

Yours sincerely,

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Clinical Psychologist