PLEASE WITHHOLD NAME

The Community Affairs Committee of the Australian Senate
Enquiry into Commonwealth Funding and Administration of Mental Health Services

Dear Honourable Members of the Committee,

I am a "General Registered Psychologist" who in November 2006 was given the privilege by Medicare Australia to provide Focused Psychological Strategies to Australians suffering with psychological illness.

I have been a fully registered psychologist in my state for nearly 20 years. I am a full member of the Australian Psychological Society and met all supervision criteria to achieve this i.e. the skills to assess, diagnose and treat and to integrate theories of personality, neurosis and psychosis. Before the Psychology Board of Australia was commissioned, I was considered professionally competent in my state to assess, diagnose and treat as a 4+2 psychologist in the clinical area. I provided these skills across a diverse range of clinical areas and brought these skills to Medicare patients who were referred by their treating doctors.

Given the expansion of my private practice as a "Generalist Psychologist", I can safely say that I am considerably respected as Medicare psychologist in my district. I have provided 3092 sessions of Focussed Psychological Strategies since the 24/11/2006. I provide all of my referring doctors with pre and post-treatment mood-state test results along with personality testing so that they can judge me on the quality of my services to their Medicare patients. There are many other "Generalist Psychologists" like me who are aware of and adopt a "Scientist-Practitioner" approach to psychological treatment in the clinical area. Currently, I am not eligible for clinical endorsement under APS and PBA guidelines.

PREAMBLE

Whatever, political persuasion that the Honourable Members hold, it cannot be denied that the Howard Government's economic legacy has significantly contributed to tackling the mental health issues that face this country. The policy of this former Federal Government gave the mandate for psychologists in this country to provide their knowledge and skills to assess, diagnose and treat Medicare patients. From my personal experience, the medical practitioners who refer to me know that they will be given a comprehensive clinical insight into their Medicare patients and that if they don't significantly improve in their symptomatology they will be referred onto a psychiatrist.

Before discussing the inquiry issues concerning (1) Changes to Better Access, (2) other concerns about Medicare and (3) on the training and funding of psychologists, I wish to make comment on the "pseudo-scientific dogma" that is generally being postulated by my "Clinical Psychologist" colleagues in relation to the expertise of "General Registered Psychologists". It is imperative that the truth be presented to this enquiry about "Generalist Psychologists" and that if their current clinical capabilities and treatment outcomes are not given due credit and are dismissed, then the only people who are going to suffer in the future are the Australian Public.

One of the greatest psychologists of the 20th Century once said that in the realm of social and political attitudes, emotions and feelings sometimes get in the way of true intellect. This is a

perfect analogy of my "Clinical Psychologist" colleagues who are "whipping up a social hysteria" about the expertise of "General Psychologists" without one shred of objective scientific evidence. There evidence is built on "quicksand" and on assumptions that are based on (1) "logical fallacy" and (2) are "doctrinaire" in nature. Their assumptions are also based on "commonsense", which in the world of scientific psychology is nonsensical. Common-sense notions, based on experience, may have an intuitive appeal, but they need winnowing, testing, and validating before they can be accepted.

I will now address some of these assumptions. Firstly, we do not have sufficient evidence that "Clinical Psychologists" are superior in treating patients compared to "General Psychologists" and the research on Better Access outcomes confirms this. Another quote from one of the greatest psychologists of the 20th Century, ***"It is wrong, always, everywhere, and for everyone, to believe anything upon insufficient evidence"***. Secondly, "Clinical psychologists" claim that they have superior skills in assessment, diagnosis and treatment and unique in using their ability to use theories and concepts and integrate knowledge to understand psychopathology.

As a 4+2 psychologist, I was supervised to assess, diagnose and treat using the most scientifically valid and reliable theories of personality, neurosis and psychosis. This involved an integration of knowledge according to Einstein's dictum; ***"the grand aim of all science is to cover the greatest number of empirical facts by logical deductions from the smallest number of hypotheses or 'axioms'.*** I would like to inform the Honourable Members of this Senate Enquiry that it was mandatory as a part of 4+2 supervision that you addressed the criteria of assessment, diagnosis and treatment, theory integration, professional ethics, research and treatment interventions.

Your supervisor would not sign you off for full registration or Australian Psychological Society membership until these criteria was met. These supervisors also provided practical experience for Clinical Masters students and now their told by the "Academics" and "Clinical Psychologists" that their inadequate to supervise since the formation of the PBA. In relation to my supervisor, most of his supervisees went on to excel in diverse areas of psychology. In essence, a 4+2 psychologist can integrate knowledge learnt in supervision and understand psychopathology just as well as a "Clinical Psychologist".

The next "Clinical Psychologist" myth that I wish to dispel is their argument that they are the only ones that can do effective "Evidence Based Treatment". When a psychologist completes his or her fourth year, the majority have been trained in scientific method and assessment i.e. they are taught research methodology that adheres to rigorous scientific investigation. This involves a sound knowledge of different types of experimental approaches and statistical analysis. Evidence based treatment involves a pre and post-treatment measurement to see if there has been a significant reduction in mood-states, behaviours and even thought-content.

As Mao Tse-Tung once said ***"The only standard by which truth can be assessed is its practical results".*** General Psychologists like their "Clinical Psychologist" colleagues can objectively measure pre and post-treatment outcomes and evaluate their own treatment performance. In conclusion, I question the term "Evidence Based Treatment" when in scientific terms we have not devised a treatment theory that links spontaneous remission, placebo treatment, psychotherapy and behavioural therapies. When we do, it will make psychological treatment more scientific and effective

The final myth that has been postulated by my "Clinical Psychologist" colleagues is that "General Psychologists" don't deal with the more complex and severe cases of psychopathology. As a private practicing psychologist, I have from 1996 to early 2006, clinical data of the various types of psychological disorders that presented at my practice. I have further comprehensive clinical evidence since the Medicare rebates. I can assure the Honourable Members of this Senate Committee that I have assessed, diagnosed and treated disorders involving, the neuroses, the psychoses, the addictions, the mood-disorders and the personality disorders. There would be a considerable number of other private-practicing "General Psychologists" who have experienced the same practice history as me.

I would now like to report some statistics that the "Mindframe National Media Initiative" obtained off the Australian Bureau of Statistics on the 3/05/2011 under Catalogue Number 3303.0 "Causes of Death in Australia" by Suicide. Of particular note the term Age-standardization allows comparisons of suicide rates between populations with different age structures.

- Suicide is a prominent public health concern. Over the past five years, the average number of people dying each year by suicide is around 2,100.
- Rates of suicide vary from year to year. In 2009 2,132 people died from suicide in Australia, a rate of 9.7 per 100,000. This represented 1.4% of all deaths registered in that year.
- Since at least the 1920s, more males than females die by suicide each year. In 2009, 1,633 males (14.0 per 100,000) and 499 females (4.5 per 100,000) died by suicide. Thus, in 2009, 77% of people who dies by suicide were males and 23% were females.
- An examination of Australian suicide rates over the past 40 years suggests a peak in 1963 (17.5 per 100,000), with rates declining to 11.3 per 100,000 in 1984. After that, suicide rates climbed back up and in 1997 they reached the level of 14.6 per 100,000. Suicide rates have tended to decline since that time with 9.7 Australians per 100,000 dying by suicide in 2009.
- Since 2000, the suicide rate in Australia has fallen by 22%, with the suicide rate for males falling by 24% and that for females by 13%.
- The age-standardized suicide rate for males (14.9 per 100,000) in 2009 which is the second lowest rate in the last 20 years. As these data will be subject to revision over the next 2 years, caution should be exercised in interpreting this observed fall in rates.
- The age-standardized suicide rate for total females (4.5 per 100,000) in 2009 is slightly lower than the average over the past decade of 4.7 per 100,000.
- Suicide remains a major external cause of death, accounting for more deaths than transport accidents.
- Suicide ranks 14th in the overall causes of death in Australia in 2009, compared to 13th a decade ago.
- Suicide used to be rare among traditional Aboriginal and Torres Strait Islander people but has become more common in recent years, with the 2009 data suggesting that deaths by suicide account for a much higher proportion of all deaths among Aboriginal and Torres Strait Islander people (4.0% of deaths) compared to non-Indigenous Australians (1.4% of deaths).
- Research has shown that first generation migrants in Australia show similar suicide rates to those in their country of origin.
- Research has shown that people in any form of custody have a suicide rate three times higher than the general population.

As a private practicing "General Psychologist", I would like to think that along with many other private practicing psychologists that I have made a very small contribution to the National drop in suicide rates in this country. Over the last 22 years, I have observed a proliferation of private practicing psychologists in my district both before and after the introduction of the Medicare rebates. This can only be seen as a positive trend towards improving public mental health.

I know that there are many other Public Mental Health initiatives such as "Beyond Blue", "Headspace" and "The Black Dog Institute" that have made their contribution to the National fall in suicide rates. However, the impending changes to Better Access could lead to private practicing "General Psychologists" losing their profession and businesses and most importantly a valuable psychological service to the Australian Public. These suburban private practicing psychologists act as an adjunct to getting severe psychologically disturbed clients into the public mental health hospital system. I will now address the agenda of the enquiry.

(a) The Federal Governments 2011-12 Budget changes relating to mental health can be best described as short-term positive gain financially for long- term negative pain for mental health patients. Although saving money in the short-term, the cuts in the budget do not allow for the uniqueness of people requesting psychological treatment to be considered. It will be one set of treatment rules (6 sessions + 4 sessions for exceptional circumstances) for all and any psychologist I know would attest that this is not the case in the "real world" of psychological practice.

Feeling better and getting better are two different outcomes in psychologically treating people. One is restoring general mental health to commence to function daily the other is reinforcing the therapeutic strategies the patient has been taught so that they become autonomous. The 6+4 approach is too demanding on the patient to get well and the therapeutic effectiveness of the psychologist. We can't perform miracles.

(b) Changes to the Better Access Initiative;

(1) In recent times, General Practitioners have been obtaining qualifications so that they may apply Focused Psychological Strategies to their patients. The PBA, the APS and the Australian Federal Government have assumed that General Practitioners can do the work of "General Psychologists". This would have to be the ultimate betrayal to the generation of General Private practicing psychologists that I come from. How can a General Practitioner apply FPS when they are not fully trained in scientific method and assessment i.e. proper training in psychological theories of personality, neurosis and psychosis, psychological testing and clinical assessment? In scientific psychology, theories connect facts and are built on hypothetico deductive reasoning.

I can only say to the PBA, APS and the Federal Government, **"Please Explain"** to my generation of General Private 4+2 practicing psychologists who have been bypassed to obtain clinical endorsement yet the General Practitioners receive an "Honorary 4+2" qualification to treat our clients. It reeks of hypocrisy and the trained General Practitioners are going to psychologically treat the public with lesser sufficient evidence than the "Clinical Psychologists" that they will provide better treatment outcomes to the public than "General Psychologists".

In conclusion, the case load of psychiatrists and particularly General Practitioners could expand almost indefinitely. The potential for overloading the health services is only too plain to see. There potentially could be an increase in anxiety-allaying drugs, tranquillizers, antidepressants and antipsychotic medications. Although these drugs are fairly effective and safe in use, they often give rise to long-term dependence and they do not provide a cure; they are only a palliative.

(11) I have answered this in (a).

(111) No comment.

(IV) This is going to severely disadvantage patients of this clinical presentation because most people who suffer neurotic related symptoms of anger, anxiety and depression have a genetic predisposition to neurosis. This means that their symptoms can be reactivated by some internal or external stressor. If there are restrictions to the number of sessions this could mean a transfer into another stream of Mental Health care, which means that the patient has to develop rapport with another psychologist. This can be distressing for patients if they have to repeat their psychological history to another therapist. It must be remembered that people predisposed to high trait neuroticism can float in and out of neurosis from time to time.

(c) As explained above, the Federal Budget cuts will severely impact on the quality and quantity of service to people with mental illness.

(d) By cutting the Budget, it means that "General Psychologists" who are adequately trained cannot pick up these severe mental illness patients, fully access them, report to their General Practitioners and then if needed be referred onto the Mental Health Hospital system. I have experienced on occasions people who are psychotic or experiencing early stages of psychosis, which have resulted in effective medical treatment either by a General Practitioner or Psychiatrist.

(e)

(1) When the past Howard Federal Government initiated the Medicare Rebate System for Psychologists, it unfortunately bestowed (1) great faith in the Australian Psychological Society (APS) and (2) assumed that they would represent the best interests of all psychologists in providing these services. Instead, the APS campaigned and succeeded in developing a two-tiered rebate system that has severely disadvantaged experienced 4 + 2 year psychologists. The behaviour of the APS could only be perceived as (1) looking after the best interests of highly powerful and credentialed academics that sit on registration boards and (2) looking after the interests of specialist clinical psychologists who have a Masters or PhD.

When questioned about this mistreatment, the APS generally responded in their member communications by saying we will look after the best interests of the clinicians first and worry about the generalists later. With the recent introduction of the PBA and its policy of professional endorsement, this has become a "fait accompli". The initial actions of the APS were completed before those affected by them were in a position to query or reverse it. By the time, 4 + 2 year psychologists received the information about clinical college

eligibility or to provide clinical services through Medicare the terms and conditions had become "set in concrete" and virtually impossible to achieve.

The two-tiered Medicare rebate system severely discriminates against people in the lower socioeconomic status. In my district for me to survive in private practice, I have to charge $125 for a patient who works and they receive about $81.75 back from Medicare. If this patient was to attend a "Clinical Psychologist" he or she would possibly get $110 rebate. The two-tier system severely discriminates against "General Psychologists" that have a great deal of professional experience and knowledge as well as a patient of lower socioeconomic status. Unfortunately, I cannot bulk-bill because my practice would not survive.

In my opinion, the two-tier rebate system was devised to eventually rid Medicare of my generation of "General Psychologist" despite our prior learning and professional experience. Further evidence of this opinion has arisen from recent Budget cuts and the training up of General Practitioners to do our work. Under the new ATAPS rules I as a "Generalist Psychologist" with a significant amount of experience have to be judged by an Academic Clinical Psychologist under clinical governance to be given eligibility to practice in this area. Before this, I was in the ATAPS system. After the 1/11/2011, I can give Focused Psychological Strategies in the new system of 6 sessions + 4 sessions but have to meet clinical governance to do the same treatment in another system.

The two-tier rebate system should be abolished due to its discrimination against "General Psychologists" and discrimination against patients of lower socioeconomic status. There should be a set rebate for all Medicare psychologists. On the 2/02/2009, Associate Professor Tim Carey of the University of Canberra wrote, "There is no evidence that clinical psychology services provide better patient outcomes than general psychology services". He also mentioned that the Rudd Government at the time could be pouring millions of dollars down the drain on higher Medicare rebates for visits to clinical psychologists. Where is the objective evidence that specialist psychologists provide better patient outcomes than general psychologists?

(11) I admire any colleague who has aspired to a Masters or PhD across any area of psychology. My only complaint is that a generation of 4+2 "General Psychologists" from about age 30 to Baby-Boomer age are not getting the professional recognition they deserve given that before the PBA was formed, we were considered competent to assess, diagnose and treat in our state. In my opinion, psychologists of this generation should get automatic clinical endorsement or abolish endorsement all together.

In relation to training, over the last four years since the inception of mandatory Professional Development for psychologists, it has been my experience that the Clinical course content across such areas as mood disorders, anxiety disorders, criminology and the application of medication have been non-etiological and atheoretical. There is no central theory of personality, neurosis or psychosis taught that is based on empirical evidence, psychological theory and experimental support. It has been my experience that the courses I have attended have not been based on a combination of Idiographic (Correlational Psychology) and Nomethetic (Experimental Psychology).

Instead, we are expected to follow the highly subjective and scientifically meaningless categorical system of the DSMIV for assessment and diagnosis. Using this system does not

lead to a treatment plan whereas a "Scientist Practitioner" model of assessment and diagnosis based on a dimensional system can lead to individualized psychological treatment. The whole idea of using psychological testing is to impose objective reality on underlying subjective opinion, which you cannot do with the DSMIV. I attended a workshop where the lecturer/psychologist stated that she does not use psychological tests for assessment.

Instead of following a progressive scientific approach mentioned above, it has been my experience as a well-trained "General Psychologist" to sit through Professional Development workshops that are underwhelming and unscientific. They do not account for the professional experience of my generation, which means that I have to sit through a workshop that resembles a second or third year psychology tutorial. In essence, it's pretty mediocre and the people who are running them are making good money.

In conclusion, we have a current Allied Health Model of Mental Health Care heading towards a Medical Model of Mental Health Care, which could have disastrous effects for the Australian Public because the serious psychological science is eventually going to be removed. This science will be replaced by the DSM series of psychiatry, which was once described by another great psychologist as nothing more than a Chinese menu for diagnosis. We have the **"Scientist Practitioner Model of Psychology"** shifting into the **"Science by Consensus"** Model of the DSM series and the Psychiatry World.

> (111) We won't have a shortage of psychologists if we give due professional recognition to the "General Psychologists" already in the system as well as the 4+2 psychologists who are trying to finish off their supervision. Otherwise, we could have a shortage of psychologists. It could result in the ridiculous absurdity of desperate mental health patients waiting 3 months to see a "Clinical Psychologist" due to this shortage. I used to observe this with my patients waiting to see a psychiatrist. What the PBA and Federal Government doesn't realize is that when "General Psychologists" like me came into the Medicare system we picked up on a significant degree of hidden clients who had carried psychotic proneness for years and who had been missed or not directed into the Public Mental Health Care system.

(f) After reading the suicide statistics above there can never be enough funding and services for the disadvantaged groups in this country.

(g) From a psychologist position, we desperately require an independent national mental health commission that recognizes the value of all psychologists. I will now inform the Honourable Members of this enquiry what could be the potential consequences for Psychology as a field due to the PBA and APS actions and recommendations to the Federal Department of Health and Aging. Sternberg (2004) argues that psychologists should concentrate on psychological phenomena rather than subfields, and when this is done, we find that almost all subfields are likely to have something important to say about these phenomena. Such psychological phenomena as memory, intelligence, prejudice and aggression all can be studied from biological, cognitive, social, or clinical points of view.

"When we restrict ourselves to a single subfield as a basis for enquiry, we restrict our understanding." (Sternberg, 2004, p.13 "***Unifying the field of psychology", In R. J. Sternberg (Ed.), Unity in psychology: Possibility or pipedream? (pp. 3–14). Washington, D.C.: American Psychological Association.*** Sternberg (2004) further writes, ***"Psychology is***

becoming increasingly specialized, and at the same time it is increasingly fragmented. The cost is psychology's potential loss of identity as a field. Should psychology become increasingly fragmented, or should we attempt to stop this fragmentation before it goes so far as to be irreversible? (p.3)"

The comments of Sternberg (2004) (a former American Psychological Association 2003 President) are the tip of the iceberg because through specialization and endorsement recommendations by the PBA and APS in clinical psychology services, it potentially prevents psychologists from not only being an expert in one sub-branch of psychology but in several. If you read the comments in the Australian Association of Psychologists Incorporated petition, you will witness the extraordinary talent in Psychology that are now unendorsed and potentially face the loss of their businesses. Most importantly, we are losing a plethora of talent and clinical expertise to the Australian Public. The Colleges formed by the APS should have been "Interest Groups" not "gatekeepers" to University Clinical programs and who decide whether or not you become a member of their "Club".

(h) In my opinion, Psychology is about people and I would prefer to be directly in front of the person rather than talking online to them. Maybe we need a "Flying Psychologist Service" that allows access to people with mental illness in these rural and remote locations.

(j) In my opinion, the current number of allowable treatments of 18 sessions should remain for all psychologists in the Medicare system along with an extra 2 sessions that we do for initial clinical assessment. This would involve the use of various psychological tests for personality, mood-states, addiction, criminality and psychosis proneness. We could then provide this information under ethical guidelines to the theoreticians in Academia to improve our Mental Health Services to Australians. There would be an amalgamation of the suburban and rural practitioner with the universities and most importantly the provision of strong scientific psychological data for future research.

In conclusion, I have presented this submission to not only inform the Honourable Members of the enquiry of the good work that has been done by "General Psychologists" since November 2006, but to also refute the claims of treatment superiority by "Clinical Psychologists" whose argument has been built on "spurious orthodoxy". I would like to thank the Honourable Members of this Senate enquiry for allowing me to make this submission.