Dear Senator

I strenuously object to your intention to (a) treat the qualifications and skill base of Clinical Psychologists and Registered Psychologists as equal, and renumerate them as such under medicare, and (b) cut the number of sessions for Medicare Rebated Psychology from 18 to 10.

I am a Clinical Psychologist, Member of the APS College of Clinical Psychologists, and presently work within a Better Outcomes program in the Kimberley, Western Australia, delivering Focussed Psychological Strategies. I have 17 years experience in health service delivery, policy development, outcome evaluation, and clinical service delivery in a Mental Health Service environment (South Australia).

There are extremely significant differences between the clinical skill level of a Clinical as opposed to a Registered Psychologist. The training of the two groups of professionals are qualitatively and quantitatively different.

A Clinical Psychologist is required to undergo 5-8 years of training:- a 4 year Undergraduate Degree, 2 years Clinical Masters degree, followed by a further 2 years experience in a designated mental health environment, supervised by person who has themselves attained the qualification of Clinical Psychologist. Components of a Clinical Masters degree include training in Psychopathology and/or Assessment and Diagnosis of Mental Health conditions, and in the delivery of evidence based strategies such as Cognitive Behavioural Therapy, and mandatory placements in a mental health service environment. This enables Clinical Psychology interns to receive mentoring and supervision by Senior Clinical Psychologists, in addition to input from Medical Officers and Consultant Psychiatrists, while obtaining direct experience in the treatment of persons with complex mental health presentations.

Registered Psychologists, by comparison are required to have as little as 1 years formal training:- their 4 year undergraduate degree may include only 1 year designated study in Psychology (Honours of Grad Diploma). It is acknowledged in the Funding Guidelines for the provision of the *Better Outcomes Program* that Psychologists may not receive <u>any</u> training in Psychopathology and/or Mental Health Assessment and Diagnosis or Cognitive Behavioural Therapy during the course of that year. These practitioners are then required to gain two years supervised experience in the field – however this experience need not take place in a mental health environment, and supervision can be provided by a practitioner who themselves may have had no or limited experience in a mental health service environment. As a consequence, a Registered Psychologist may have extremely limited exposure to persons presenting with chronic mental health conditions such as Schizophrenia, Psychosis, BiPolar conditions, persons with Co morbid alcohol/substance abuse difficulties/personality disorder, or complex multiple trauma backgrounds.

Furthermore, until the introduction of the new Psychology Board of Australia (PBA) this year, Registered Psychologists were not required to undertake <u>any</u> professional development activities to maintain their registration as a Psychologist. To do so was voluntary. Clinical Psychologists have been required to undertake 90 units of accredited professional development bi-annually to keep abreast of emerging research and evidence in our profession in order to maintain their Clinical status. Therefore the skill base of the two groups was further widened post registration.

The Guidelines for the delivery of the Better Outcomes services (delivered by Divisions of General Practice) highlight the qualifications and experience required to provide treatment to complex mentally unwell individuals. These guidelines explicitly state that a 4 x 2 trained Psychologist is

unlikely to have obtained the requisite training and experience to adequately Assess and Diagnose an individual with a complex mental health presentation.

I witness the difference in skill level amongst my colleagues in the Kimberley, where the Divisions of General Practice have difficulty attracting and retaining staff. Here, practitioners who are relatively new graduates with a 4 x 2 background in Psychology (or with a base degree in Social Work) have been recruited, and have developed services which receive funding under the Better Outcomes initiative in the absence of a Clinical Governance Framework or any direction, guidance or supervision from a Senior Mental Health Professional within the organisation. Some of my colleagues demonstrate limited skills in Diagnosis and Assessment skills, advocate that a diagnosis is not necessarily required (and that we should defer to General Practitioners to diagnose a patient). The Better Outcomes service in this area has been significantly compromised as a consequence.

I am gravely disappointed that my professional body, the Australian Psychological Society, has not recognised the distinction between the training and experience required to attain the status of Clinical Psychologist, and lobbied more strenuously on our behalf. I perceive the APS as lobbying on behalf of the bulk of its members, who are Registered Psychologists, in order to maintain its membership base. In this manner the APS is contributing to the erosion of the skill base of Psychologists in this country.

The decisions being deliberated by the Senate at the present time will irrevocably change the skill base of Psychologists in this country. There will be no incentive to obtain higher level qualifications as a Clinical Psychologist, or pursue higher level study in the field. This will be to the grave disadvantage of the mental health of the Australian public.

The suggestion that Clinical and Registered psychologists have a similar skill base is erroneous, and the proposal that we should be re-bated equally is demeaning.

In addition, the move to reduce the amount of sessions rebated under Medicare is inconsistent with the evidence regarding the amount of sessions required to achieve an adequate treatment outcome. The evidence base strongly suggests that it takes at least 10 sessions to adequately provide CBT, for example, to a mild to moderately unwell individual. For complex presentations, this takes up to and often considerably more than 18 sessions.

It is my professional opinion that the Better Access service was poorly conceived, resulting in many persons who would previously have received services under a Private Health Insurance Policy now accessing services, at a reduced cost, via Medicare. I observed a tendency for my colleagues in the Public Sector to leave their positions in favour of setting up practices in the 'leafy green' suburbs – treating individuals who can afford to pay a gap for their services. State funded Public Mental health services in some cases elected to shift the cost of psychology treatment onto the Medicare system, reducing positions for Clinical psychologists in their services.

In combination, this resulted in a huge uptake of the services, and reduced access to services for those people most at risk: those from lower socio-economic backgrounds where the incidence and complexity of mental illness is far higher, and whose access to services is impoverished. It is this group who are most in need.

It is understandable that the Government should now wish to reduce excessive spending on the Better Access program. However the current measures reduces the efficacy of treatment outcomes for all.

In combination, the two measures suggested have profound implications;- suggesting that Registered Psychologists can undertake the role of a Clinical Psychologist, without training, and in less time, than an overwhelming body of evidence suggests.

I sincerely hope the Senate review these poorly conceived strategies on an urgent basis.

Yours sincerely,