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Submission to the Senate for Commonwealth Funding and Administration of Mental Health Services

I would like to preface my submission to the Senate by stating that, as at 31 July 2011 I have closed my psychology practice in Brisbane and relocated to Europe due to marriage. I am no longer practising and therefore have no investment in this matter, financially, but rather wish to draw attention to the personal and political aspects of this issue.

1) **The two-tiered system and the politics of class and privilege**

Clinical Psychologists constitute a small percentage of the psychology workforce. Due to the cost of Masters Degrees or Doctorate Degrees, Clinical Psychologists are often those who, whilst possessing aptitude, are *also those who can afford to undertake a Masters Degree*. *The two-tiered system is a system that favours those from privileged socioeconomic backgrounds.* I would argue that, in preference to this system, the additional funds provided to Clinical Psychologists, and to General Practitioners, could be redirected in to financial assistance to support greater numbers of Honours graduates in completing Masters training.

I believe my personal history provides some insight in to the way in which the two-tier system derives from, and commences at, the stage of training of psychologists in Australia. The ability to become a Clinical Psychologist is not solely the result of aptitude or motivation but of financial means.

I am a generalist psychologist. I am from a working class background. I achieved a first class honours in psychology at University of Sydney. I ranked 10th in my year and was also one of a few students selected to complete their data collection alone due to outstanding achievement in undergraduate years. I achieved the highest marks of any student in a number of my undergraduate Psychology subjects including Perceptual Systems and the History and Philosophy of Psychology. At the completion of my second year at university, I was offered a guaranteed sponsored place after my fourth year in Masters of Educational Psychology due to my outstanding academic performance. I declined as my career goal was directed toward clinical psychology. *I was also unaware that I would be unable to afford to support myself in undertaking a Masters in Clinical Psychology after my Honours year.*

Whilst I was studying my undergraduate degree I worked as a trainee applied behavioural therapist with children with autism which was tantamount to a placement. I also undertook the Lifeline telephone counselling course. After my 4 year degree, I successfully gained a place in the prestigious Masters of Clinical Psychology program at UNSW. However, despite my evidenced aptitude, I did not have the financial means to support myself whilst undertaking a Masters. As a result, and with disappointment, I undertook the two year supervised registration program. I have therefore studied 6 years to earn my registration as a psychologist.

Whilst undertaking theoretical components of training, I undertook, at one time, three internship placements at a psychiatric hospital, a women's health centre, and at an AIDs Council. The minimum placement hours were 16 per week. I undertook 24-32 hours of placement per week. These placements were undertaken on a voluntary basis and I worked in the evenings in menial jobs such as telemarketing and dish washing. I was eventually offered a position in a single placement enabling me to work in a full time paid position as an intern psychologist for much of the two year internship. I was supervised by a Clinical Psychologist for much of my two year internship, bar the last two months, and was also working under Senior Clinical Psychologist at one placement.

In 2005 I attended an interview for potential admission in to Masters of Clinical Psychology at the University of Queensland. At that interview, I was asked how I would support myself given the only method of completion was full time. I noticed that other candidates were discussing this in the tea room prior to interviews. Each of the individuals there were younger, had just completed their degree and stated that they had the fortunate circumstance of living at home with parents who were willing to support them financially for the duration of the two year Masters degree. Supervisees I have worked with since my registration that move from the 4+2 to Masters path are also those who are supported financially by family to do so. That is, they are from a higher socioeconomic status. I hark from a working class background and therefore do not come from a circumstance in which my parents could support me. I had utilised all of my government assistance in receipt of Austudy whilst undertaking my 4 year degree. *The issue of completing my Masters degree was a foregone conclusion as my socioeconomic status did not support this route to registration.*

Now I am eligible to provide "Focussed Psychological Strategies". The Medicare rebate of $81.60 applies per 50+ minutes of my psychology services. A Medicare rebate of $117.65 per 50+ minutes applies for Clinical Psychologists' services. And so, the socioeconomic inequality continues.

Even as a single woman, solo practitioner, and with less income than Clinical Psychologists, I bulk billed 80-90% of my clients. When I discussed bulk billing with my Clinical colleagues they ALL indicated that they did not bulk bill and that I was foolish to do so. “We have to eat too,” one remarked. “Yes, but how fat do you want to be?” I retorted. Yes, this income did not cover all my time and expenses in practising but, from a wage of $10 per hour washing dishes, or, $27.50 per hour for provision of psychological services within the public health system, $80.20 seemed rather comfortable. After having this discussion with a colleague in the same office suites, she commented: “Yes, but Psychologists who bulk bill are often not very good psychologists.”

I made arguments in support of bulk billing, pointing out to my Clinical colleagues that, despite their obvious lack of personal experience with financial hardship, there are many people who just cannot possibly afford the gap, let alone a bus fare to attend a psychologist. I know, because when I was on Austudy, I could not afford to attend the Doctor on occasion as I could not afford the $20 payment. My lived experience provided me with a compassionate base on which to rationalise my bulk billing practices. *And, after all, isn’t that why the Australian government introduced the Medicare system for psychology – to enable those who cannot afford services to access those services without economic burden? The reticence and arrogance of those who refuse to provide bulk billing to their clients, especially those Clinical Psychologists who receive 30 plus more dollars to provide the services, is an important issue at hand here. Yes, there are Clinical Psychologists who do provide bulk*

billing but the recent outcomes study has shown that they are fewer and further between than Generalist Psychologists who, paradoxically, receive LESS fee for service from Medicare.

In the last year of my practice, bulk billing was unsustainable for me, with the lag between provision of services and payment from Medicare being as much as 4-6 weeks. No problem, I had a full client load, was turning full fee paying clients away BUT I also had to turn many people away who could not afford my services. In my experience, when I was bulk billing, many clients were relieved, stating that they just could not find any bulk billing psychologist for help. *To deny clients the option of bulk billing and, thus logically, the option of treatment, is UNETHICAL.*

In short, a lateral solution to these problems is to:

Require Generalist AND Clinical Psychologists to provide a quota of bulk billing places for those in need to remain true to the ethos of a Medicare system

Abolish the two-tiered system, reduce payment to GPs for the completion of care plans and provision of FPS, and redirect these funds to provide financial support to new graduates for their completion of Masters training

2) **Generalist Psychologists as the red herring - General Practitioners with 26 hours of training in Focussed Psychological Strategies are providing the same services as Generalist Psychologists with 4+2 years of training and receiving HIGHER RATES OF PAYMENT**

I would also like to point out that, after 26 hours minimum required training in Focussed Psychological Strategies (including only 12 hours of face to face training); General Practitioners are accredited to provide the same service as generalist psychologists. The difference is that GPs who have completed the 26 hour minimum training requirement attract a rebate of $84 for the provision of a 40 minute session and $120.25 for a 40+ minute session. *Nowhere is this important inequality mentioned by my Clinical colleagues.*

I find it odd that this issue does not attract more attention from the Clinical Psychologists who seem so intent on casting aspersions on their Generalist colleagues' training, accreditation and abilities. *How does a General Practitioner's 26 hours of training justify their receipt of greater remuneration for the same services provided by Generalist Psychologists with 4+2 years of training? Why is the issue of "public safety" not a matter of discussion when considering GPs providing FPS and yet, is an ongoing, false basis for rejecting Generalist Psychologists right to equal Medicare rebates?*

Should this matter be of concern to clinical psychologists? Of course, but there are dual roles to consider. GPs are our referral bases so voicing concern over this matter requires an exercise of principle and integrity rather than concern about referral base (and money). However, the 'hand that feeds you' might soon be feeding itself if this issue is not addressed and many more GPs join the ranks of the FPS accredited and have no need or incentive to refer even to Clinical Psychologists!

Why is there a rift occurring in our own profession, with clinical psychologists making 'intemperate criticism' of, and presenting unsubstantiated information about, their generalist colleagues' training, qualifications and abilities, when this other, primary issue demands to be addressed?

Am I the only individual who perceives generalist psychologists as the red herring in this situation?

In short, if the safety of the public is an issue at hand then cease acceptance of the provision of FPS by GPs who have 26 hours of training and redirect the disproportionate funds provided to GPs for this service to psychological services provided by Generalist and Clinical Psychologists

Further, that an equalisation of rebates for Generalist and Clinical Psychologists will allow for all Psychologists to afford the professional development required to maintain quality service provision. Indeed, one may argue that funds gained from the abolition of the two-tier system and GP Focussed Psychological Strategy provision could be used to fund improved professional development opportunities for ALL Psychologists. If Clinical Psychologists are concerned about Generalist Psychologist service quality then surely they would be on board with this strategy.

3) **"Unless you can find some sort of loyalty, you cannot find unity and peace in your active living" Josiah Royce**

   "You've got to give loyalty down, if you want loyalty up." Donald T. Regan

As a Psychologist I am interested in the psychological impact of circumstances on individuals and groups. I assume all of my colleagues hold this interest too. The two-tiered system has created a divide between two groups within the profession of Psychology. Our profession is in turmoil. The financial inequality and the consequent, and artificial, construction of differences in skill and ability and ongoing aspersions cast on Generalist Psychologists by Clinical Colleagues have been a source of stress and concern to me since early 2010.

Funding and income aside, the morale of a workforce, any workforce, impacts the adequate provision of service and there Is no way that the turmoil in the profession that has come of this two-tiered division has not reduced morale. Though my services remained consistent and outcomes positive in my practice, ongoing exposure to aspersions cast by my Clinical colleagues upon my skills and abilities and the lack of unity and cohesion in my profession have caused me to lose faith in my profession and, logically to question my abilities and right to practise as a psychologist.

It is a happy accident that I have married a Spaniard and move to the Northern Hemisphere away from the profession of Psychology in Australia. I loved my job, which was not just a job but a vocation, a calling. I have changed many lives over my years of practise. I have evidenced positive outcomes and reduction in symptoms in the anxious and the depressed. I have used outcome measures such as the Depression and Anxiety Scale to observe such changes. I have assisted people to define their psychological maladies and to acquire skills to manage, alleviate and obliterate such maladies. But as the turmoil in the profession has escalated and I was privy to public derogation of my skills and abilities on programmes such as ABC Life Matters and, now, in the Senate Inquiry, I have increasingly lost faith in or loyalty to, my profession and my vocation. I am relieved to have ceased practising for a time, and to have escaped the in-fighting and intemperate criticisms of my Clinical colleagues and Professional body, the Australian Psychological Society.

The aetiology of the increasingly poor morale and lack of support in a profession, where one undeniably does require support and morale to assist individuals in progressing from serious psychological issues, can be found in the two-tier system and consequent inequality and divisions.

We need our psychologists in Australia, all of our Psychologists in Australia, to be mentally fit to provide services to people in serious crises. If morale is poor, then the quality of these services will decline.

In short, the elimination of the two-tier system may assist in restabilising the profession thereby assisting Generalist practitioners to get on with the business of improving lives, as opposed to the business of wondering if their Medicare rebates will be abolished, if their referral bases will redirect clients to “endorsed” Psychologists, if they will get a job in the public system where they are “unendorsed”, or if they will have to shut shop.