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I would like the Senate Committee to know that most 4 + 2 psychologists in Australia believe the Psychology profession as it now stands is in grave danger of becoming an elitist play-thing of the various groupings of Clinical Psychologists and Government agencies. Also the new PBA arrangements are confusing for all stakeholders, including the profession itself, the medical profession and the general public, and down grades the 4 + 2 psychologist to the status of a mere technician. We are in danger of becoming the dental nurse to the dentist. And as the vast bulk of the psychology workforce in this country, this is absolutely and utterly retrogressive.

I offer some points systematically below.

Better Access and GPs

The Better Access to Mental Health initiative has been a resounding success. I understand that the Committee has seen the Better Access research provided by the APS showing that psychologists are at the forefront of this endeavour and doing a sterling job. The initiative works because the model that Psychologists use, the bio-psycho-social model, allows for the therapeutic relationship to be created in which lasting change can occur. Psychological issues cannot be fixed in a GP consult, even an extended one, because doctors are trained in a different model, the outdated medical model, which even their own medical researchers have called for to be abandoned (Pincus, 2000) and because they lack the necessary training. Doctors are not Psychologists anymore than Psychologists are not Doctors. Our quite discrepant domains should be respected.

Psychologists generally work within a 1 hour time frame so that work can be done effectively and clients are given time to explain their issues. Human issues are by nature complex and require a careful and graded approach so that individuals are not overwhelmed. GPs do not have the time for this and do not have the training. To think that a GP can go through a basic counselling course of a few hours which then supposedly makes them the equivalent of a registered Psychologist is laughable, insulting and frankly, outrageous. Furthermore, every GP I have spoken to is glad of the Better Access initiative as they can get on and do what they do best, ie., practising medicine, and leave the psychological therapies to the experts. GPs do not go into medicine in order to do counselling or work with clinical issues in the psychological realm.

Better Access and Funding

The recent budget changes to Better Access have been well-intentioned but are entirely misplaced. The reduction of sessions to 6 + 4 is, in every psychologist's

mind, a retrograde step, as many people are not able to continue in therapy and will have to be excluded form treatment if they cannot get the Medicare rebate. The extra two original sessions can make all the difference in the world, and the provision of eighteen sessions in special circumstances was a shining beacon for the provision of Psychology services. Human problems and certainly diagnosable mental disorders are complex issues and need complex solutions that often take time. This decision should be reversed.

As for re-directing funding away from Better Access to early psychosis, I believe this is also a huge mistake. No-one is suggesting that early psychosis programs do not need more funding and better management. They need more on the ground people and psychiatric hospitals need more staff to cope with the demand in acute situations. However, the vast bulk of the Australian population will never become psychotic even once, so to pull funding form an existing extremely successful program such as Better Access and to downgrade it for the sake of a huge minority who will suffer psychosis is irrational and unfair to Australians. Fund the early psychosis programs by all means, but don't do it by diminishing Better Access, a program through which Australians from all walks of life have found help and resolution via a well-trained and experienced psychology workforce (the vast bulk of which are 4+2 Psychologists).

Clinical versus Non-Clinical Psychology

The two-tiered Medicare system has been utterly discriminatory from the outset. There is clear evidence that the work of 4+2 Psychologists is identical to that of the so-called Clinical Psychologists. The vast majority of the psychological workforce in this country is a highly trained and experienced 4+2 regime. I count myself one of them and I defy any clinical psychologist to say that how I treat my clients, the modalities I use, my ongoing Professional Development is inferior to anything that they do. In fact, over the years, I have lectured in the Clinical Masters program to students who will all have higher rebates to their clients than mine. As a 4 + 2 I spent a full two years in on the job training after University in order to gain the necessary expertise and experience. Clinical masters do a few weeks placement each year of their course and have to spend a massive amount of their time doing a research project which will teach them about becoming better research psychologists not clinicians. Any young kiddy coming out of University with a Clinical Masters degree is simply not in the same league as well-experienced 4+2s and for the Government to then discriminate against us by paying their clients a higher Medicare rebate is utterly unjust. It takes years of experience working with people to gain the confidence and expertise to work at our level, so the Psychology culture in this country should reflect this. I have nothing against the Clinical Masters students or their studies, but I do not agree that their training is anything superior to my own; merely a different route. Formal enrolment in a university course is not the only way to obtain that knowledge. Clinical Psychologists who state otherwise are being entirely too precious. The

discrimination of the two tiered Medicare system should end and our clients should all be paid exactly the same rebate.

Mental Health Plans

Money could be saved by abandoning the need for Doctors to have to do Mental Health Care plans. These are unnecessary and take up a lot of a GP's time. No self-respecting Psychologist would just barge ahead in a first session without doing their own carefully considered MHP after first identifying issues and choosing the best modalities to effect lasting change. GP MHPs are duplication in effect of what Psychologists do as our stock in trade. Instead, GPs could assess the need for referral exactly the way they do for other types of referrals, ie., by clinical interview and examination, and when referring to Psychologists, by also administering the Kessler 10 as a quick and easy empirical support for their decision. This would save an enormous amount of time and money.

Endorsed versus Unendorsed Psychologists

The PBA's decision to mark every Psychologist as 'endorsed' or 'unendorsed' is a travesty on both clinical and financial accounts. Any unendorsed Psychologist is going to lose out to endorsed Psychologists when a member of the public looks up who to see for their problems. If I were seeking help and didn't know the difference (as is the case for the general public), I would not choose to see someone unendorsed in a million years over someone who *was* endorsed. Yet unendorsed Psychologists are nothing more than non-members of APS Colleges or have no specialty attached to their name. I happen to be an endorsed Psychologist; a member of the APS College of Counselling Psychologists, yet I do more than counselling and find the whole labelling thing galling for the profession. My 4+2 colleagues in my own Practice are all unendorsed and do just as good a job at clinical work as I do. This nomenclature is cruel and unnecessary as it harms the reputations of fine clinicians and can do serious damage to people's livelihoods. This nomenclature should be abandoned immediately.

The term registered psychologist is still perfectly good. It means, as it always has, that a person has fulfilled the training requirements mandated by the PBA and is an ethical clinician of good character and therefore able to use the restricted title 'Psychologist.' We should return to this usage for *all* psychologists.

Continuing Professional Development

While I have always taken CPD seriously my entire career and spent a small fortune in gaining it, I do resent the rather paternalistic view and excessive demands for CPD taken by the PBA since the inception of the new order. We are now beholden to three different entities to stay registered and acceptable to the APS: the PBA, Medicare and the APS. Making us write out reflective thughts for every hour as was originally mandated took me back to my intern years and even

further back to my previous teaching profession when I was an intern then and had to write up lesson plans. Truly, this has all gone too far. And I understand that the other professions have not had the same requirements for CPD placed upon them. Please, we are hard working clinicians who truly carte or our clients and go the extra mile for them whenever we need to. How about the Government start supporting us by a fairer system and stop putting up these monstrous hurdles in our way constantly that just cause burn-out and stress to good people.

Personal

I am 52 years of age. I have nine degrees over a lifetime of study including a PhD in Psychology, a Masters degree in Educational Psychology and an Honours degree in Psychology. I have been working in this profession for almost twelve years and have spent multiple multiple thousands of dollars in post University training and professional development. I am a published author in peer reviewed journals and have my first monograph being published in 2012. I am a member of the APS and as stated above, a Member of the College of Counselling Psychologists. I have worked for some years as a Committee Member of the local branch of the APS. Yet I am seen in today's Australia as a second rate Psychologist, someone who is not as good a clinician or as knowledgeable as young twenty somethings who have just graduated with a Masters degree. This is not fair and it does not characterise the truth of my worth as a Psychologist. My bookings are solid, so my referring Doctors must think that I do a pretty good job as they keep on sending me plenty of their patients, and I am not spared their hard ones either. They would ditch me soon enough if this were not so. I think the Government should bring back some fairness to the Profession and to value its experienced workforce.

References

Pincus, T. (2000). Challenges to the biomedical model: Are actions of patients almost always as important as actions of health professionals in long-term outcomes of chronic diseases? *Advances in Mind-Body Medicine, 16,* 276-294.