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To: Committee Secretary
Senate Standing Committees on Community Affairs

I have deliberated for the past eight months on the issues of division within my profession and welcome the Senate Inquiry to the practice of psychology on the two counts of (1) a two tiered Medicare rebate system and (2) a reduction in session availability.

As an experienced Psychologist I feel I have a valuable contribution to add to this Senate Inquiry.

I have decided to voice my concerns about the inequity of the current system. The current system disadvantages the community and many of those within the profession who have not achieved recognition through endorsement. Due consideration has also not been given for the years of invaluable experience of those psychologists.

I have maintained active pursuits in professional development that have exceeded 50 hours over the past twelve months and over 1500 hrs throughout my lengthy (34 years) career as a Psychologist, in many cases this has been far in excess of the hours attended by my colleagues who are clinical psychologists. In both my government health position and my private practice I have been both a consultant to clinical psychologists and a recipient of their supervision. This also has been in excess of 1500 hours over the length of my career.

All of my extensive experience, professional development and supervision throughout my career received scant recognition by the APS and Medicare when my application for endorsement was submitted. Their rejection of the evidence submitted for my endorsement was not deemed to be sufficient, in the "core training areas off psychopathology, psychological assessment and mental health issues across the lifespan".

As a result, I feel that I have been discriminated against and deemed a less worthy member within my profession. The consequence of which was to be disadvantaged in the competitive world of private practice.

I would like to add that in seeking endorsement I sought to benefit my clients by way of their Medicare rebate, thereby putting myself on a competitive footing with my clinical psychologist colleagues.

Surely with an equal footing with the Medicare rebate there would be a natural development in terms of selection from the community as to which clinician provides excellence in therapy and treatment. In doing so we are following the principles of a

free market and encouraging the profession and the clinicians within it to raise its standards of treatment and efficacy in the provision of services.

Yet, in stark contrast to the rejection of eligibility for endorsement, I continue to apply criteria for "psychopathology and psychological assessment and mental issues across the life span" in both my government position and my private practice.

Within our government health service no distinctions are made in the allocation of referrals to psychologists and clinical psychologists nor do the clinical psychologists argue for the right of allocation of referrals by virtue of their specialist/expert status. If anything, the criteria that is given weight to in the allocation of these referrals is the experience of the clinician.

Yet the "complexity" of cases and the self proclaimed "higher status" of expertise by clinical psychologists, which is erroneously supported by the Medicare two tiered system, becomes a major argument for making a distinction for clinical psychologists in private practice.

Complex and co-morbid presentations have long existed and were treated successfully well before Better Access or the advent of clinical psychologists.

The current system of a two tiered Medicare rebate for the profession has only contributed to divisiveness within the profession. Sadly, factions within the profession have been prone to denigrate and submit inaccurate accounts to the community and other health workers and organizations of their prowess. The only valid measure of success comes from the clients themselves and too little store has been given to that data.

The system is calling out for *Practice Based Evidence**, a far more accurate measure of efficacy with clients than the posturing of clinicians claiming their superiority over other clinicians.

Variances in outcome between clinicians, whether clinical psychologists or psychologists is a given. The key factors for successful therapy are obviously the needs of the clients and their expectations being met, as well as having an alliance and connection to the therapist. There is no monopoly by one group over another in providing this formula. In essence, you either gel with your therapist or you don't.

On the matter of session availability again we are dealing with variability. There will always be those that require more sessions than others. There are complexities in cases and entrenched maladaptive coping strategies that have become patterns in lifestyle occasion greater application by therapy. These cases warrant additional sessions.

The question is more one of how do we determine the sessional requirements?

There is a consensus amongst our profession and professional bodies of what those cases are that require more sessions. Surely with an agreement determined through diagnosis between the GP and the clinician a set formulae for sessions could be

worked out beyond an established limit. An audit would always be the safeguard to any excesses.

What is paramount for this inquiry is to safeguard a profession that appears to be intent on imploding through avarice and elitism. It is in danger of losing sight of its purpose, to provide for the health and well being of the community. In this regard all genuine clinicians are of value, we wouldn't be in this profession if we did not care.

I believe that the intentions of the various bodies involved with profession of psychology, namely the APS, Medicare, AAPi and APHRA have attempted to honour and validate the profession as a whole.

Unfortunately, teething problems and mistakes were made along the way. The foremost mistake being that some organizations supported a two tiered Medicare rebate system, which naturally and obviously led to a division within the profession.

Other pitfalls are evident, such as APHRA and Medicare in off loading a duty to the APS for the logging of CPD and supervision requirements. This task is best served under the jurisdiction of APHRA. Not all psychologists are members of the APS. It could be construed that handing over responsibility of logging to the APS indirectly pressures for membership to that organization by offering this enticement.

I welcome the Senate Inquiry and I am hopeful that its findings will be fair and just and in so doing benefit the profession and those that it serves.

Yours truly,

Walter Kiris
Psychologist

- *Ref. "The Heroic Client" Barry Duncan. Scott Miller. Jacqueline A Sparks.*
- *Ref. CD "Outcome Informed Clinical Work" Scott Miller.*

  "…Scott Miller teaches clinicians how to use outcome measures in routine clinical practice to inform and improve service delivery and outcomes. Research to date shows that the steps outlined in detail on the program significantly improves outcome and retention in behavioural health services."