4 August 2011

I wish to make comments on the Government's funding and administration of mental health services in Australia, with particular reference to:

the two-tiered Medicare rebate system for psychologists

and

the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule.

Firstly, with regard to the two-tiered Medicare rebate system for psychologists, I wish to make the following comments:

I fully agree with scrapping the two-tiered Medicare rebate system for psychologists in favour of a single-tiered rebate system.

I graduated with a four year Honours degree in Psychology in 1980, and have had thirty years of experience. I have now been in full-time private practice for the last six years. Over the course of my thirty-year career, I have treated thousands of clients with a wide range of problems, many highly complex. Much of my work has been in clinical settings, and I have treated adults, children and adolescents. I have treated a wide range of disorders including: depression and suicidality; bipolar disorder; anxiety disorders including complex Post Traumatic Stress Disorder, Obsessive-Compulsive Disorder, panic disorder and phobias; dissociative disorders; adjustment disorders; eating disorders; schizophrenia and other psychotic disorders; and personality disorders. I have always placed a strong emphasis on assessment and have always used assessment tools, and relied heavily on the Diagnostic and Statistical Manual of Mental Disorders – (now) Fourth Edition- Text Revision.

At the time I graduated there was no requirement to do a Masters Degree, and it was not commonly done.

I have thoroughly enjoyed being a psychologist and have always placed a high value on ongoing training and updating my knowledge and skills. I have attended numerous one-, two- or three-day workshops or seminars every year over the last thirty years (many hundreds of hours) as well as much training within the workplace setting. Most of the training I chose to do was in

the field of clinical psychology, and pertained to clinical assessment, psychopathology, and clinical treatment. I chose this not because there was any requirement to do it, but because I was keen to continually update my skills and knowledge, and to know about the latest research and evidence-based treatments, in order to most effectively treat my clients. In addition, I have been continually spurred on to carry out my own private research when, regularly, a client has sparked my curiosity about how to improve my understanding of his or her particular issues or disorder, and how to improve my skills to provide the best possible treatment for that client.

I do not agree that the knowledge and skills provided in a Clinical Masters degree are only able to be attained through that degree. The material studied is readily available to other psychologists, and much of it is in the public domain. I am aware that there are other psychologists like myself, labelled as “generalists”, who conscientiously seek out such information, and regularly seek out clinical supervision and experiential training to enhance their skills, and compliment their knowledge.

I believe that the two-tiered Medicare system has been highly unjust for psychologists such as myself with many years of experience in clinical roles, but who have not been deemed to be regarded as “clinical” psychologists because they have not done a Clinical Masters degree or joined the APS Clinical College.

I believe the two-tiered system is discriminatory. It has been highly misleading to prospective clients, referring doctors and the broader community, and grossly unfair financially to “generalist” psychologists and their clients. It has caused division, anxiety and mistrust within the profession of psychologists, and has led many psychologists to feel devalued, and other psychologists to mistakenly believe they are superior. It has fractured support for psychologists who already have a difficult job. We are all seeing the same clients. Many of us, both “clinical” and “generalist” are attracting and successfully treating highly complex cases. Some of us, usually the less experienced, in both camps, are not.

I fully believe that adequate practice standards need to be maintained. I would be happy, if necessary, to be regularly audited and to sit regular examinations to demonstrate my skill and knowledge level. I believe the administration of this monitoring of practice standards, if it were to be carried out, should be done by an independent body, associated with the Psychologists' Board of Australia, and where independence from any political agenda is paramount.

Secondly, with regard to the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule, I wish to make the following comments:

At this time, amongst my case-load, I currently see a small number of clients who require eighteen sessions per year, and who would be severely affected should the number of sessions per year be capped at ten. One of these clients suffers from depression and Borderline Personality Disorder, and would be at risk of suicide should she not have access to an adequate number of sessions. Whilst she has made good progress and is becoming more emotionally resilient, at this time she continues to be vulnerable. Another of my clients has chronic Post Traumatic Stress Disorder as a result of childhood sexual abuse and further sexual assaults as an adult. She struggles significantly with trust, and would be greatly disadvantaged should she not be allowed to have eighteen sessions per year. For the sake of these clients and one or two others, I would strongly advocate to retain the current number of sessions available to clients under the GP Mental Health Care Plan system.

Thank you for considering these views and for the opportunity to express them.