To the Senate Community Affairs Reference Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services,

I am writing in relation to proposed changes to the two -tiered Medicare rebate system for psychologists, and also in relation to proposed changes to the number of rebated sessions per annum under the Medicare Better Access Initiative.

Firstly, as someone who has both practised as a 'Generalist' Psychologist and later furthered my training and skills to become a Clinical Psychologist, I feel that I am in an informed position to comment on the validity of the two- tier system.

I graduated with Honours from The University of Sydney in 1988. At that time, it was widely recognised that Clinical Psychologists were Specialist Psychologists who had received additional academic and practical training in psychological assessment, and in diagnosis and evidence based treatments of psychiatric disorders. The widely recognised pathway to becoming a Clinical Psychologist included a postgraduate degree in Clinical Psychology, and following completion of the academic training, two years of supervised practise at an appropriate clinical setting.

Following graduation from my Honours Degree, I applied for entry into the Clinical Psychology Masters course at The University of Sydney but places were limited and my application was rejected. I consequently obtained employment as Psychologist, working with clients with chronic mental illness, mainly psychosis including Schizophrenia and what was known at the time as Manic Depressive Disorder, now Bipolar Disorder. During two years of employment in this field, I developed skills and knowledge in relation to managing this particular client group and gained promotion to Psychologist/Coordinator. However, my experience and skills were limited to that field and to the specific parameters of the job.

Two years later, I applied for and obtained a position in an Acquired Brain Injury Rehabilitation Team working for the Commonwealth Rehabilitation Service. There, I developed skills in the understanding and management of issues for people with an acquired brain injury. My prior experience and knowledge of psychosis served me well, as I was able to recognise symptoms and to inform other members of the Brain Injury Team on issues pertaining to dual diagnosis and management of psychotic disorders. Yet my skills and knowledge were limited to psychosis and acquired brain injury and to interventions that I had learned from working in the field and from professional development workshops.

Despite the skills and knowledge I had developed through my four years of undergraduate training and subsequent work experience, I was acutely aware of the limitations of my expertise and knowledge. Whilst I had acquired a wealth of experience and therapeutic skills, I had not been specifically trained in the diagnosis of the full range of psychiatric disorders nor did I understand the myriad of complex presentations or corresponding evidence based therapeutic approaches for their treatment.

During my employment with the CRS Acquired Brain Injury Team I gained entry into the Clinical Psychology Masters course at The University of Sydney. My motivation to pursue entry into the course was my desire to become a specialist Clinical Psychologist in order to develop important knowledge and skills to be able to diagnose and treat psychiatric disorders.

My acceptance into the course was based on consideration of my work experience and sound professional reputation in addition to having the prerequisite undergraduate training. I studied part-time completing the Clinical Masters Degree over four years.

It was only after the completion of all academic training and placements that I believed I was qualified to apply for a position as Psychologist at a private psychiatric hospital where under supervision from two Clinical Psychologists employed at the same hospital, I dealt with patients with severe mental illnesses including severe anxiety and mood disorders, dissociative disorders, Posttraumatic Stress Disorder, and complex trauma.
The Master of Psychology Degree included a strong and intensive academic program. As part of the requirements of the Masters Degree, I also completed many supervised placements, during which I assessed and treated well over seventy-five clients with a wide array of psychiatric presentations. As a component of the Masters course I also designed and conducted research.
In summary, following my undergraduate training and despite practical experience and supervision and ongoing participation in workshops and professional reading, I did not feel equipped to diagnose or to deal with complex psychiatric presentations. It was recognition of these limitations and my desire to develop specialist skills that led to my decision to complete the Masters of Psychology Course and a subsequent two years of supervised practise at a psychiatric hospital.
I am aware that there is currently a very vocal group of Generalist Psychologists that have sought to undermine the specialist field of Clinical Psychology. It seems to me that the capacity to acknowledge the limits of one's knowledge and training is a mark of wisdom. It concerns me that they would argue that more is less, that further qualifications and training offer no value, and that *all* four year qualified psychologists have an equivalent knowledge and skill base to their colleagues who have sought further structured and intensive training in the field of Clinical Psychology.
I do not dispute that there may be Generalist Psychologists who have developed the academic knowledge base and experience required by the discipline of Clinical Psychology, just as there may be General Medical Practitioners, for example, who have developed the same in a specialized branch of medicine. However, as in other professions, the claim to specialist skills and knowledge cannot be automatically accepted and must be regulated by a professional body with the credentials and ability to assess proficiency.
I have no doubt that my clients have greatly benefited from my decision to engage in further training to become a Clinical Psychologist, and do not believe that I could have arrived at the specialist skills I now possess without having fulfilled the necessary prerequisite training and experience required by the profession. As such I believe the two-tiered system is appropriate and should be maintained.

The second issue I would like to comment on is the proposed change to the number of sessions that clients will be able to claim under Medicare from November 2011. I understand the need for budget cuts at such hard times. However, it worries me that it is always the most disadvantaged in our society that suffer when the need to tighten the purse strings arises. Whilst I recognize many valuable proposed changes in the Federal Budget, the reduction of Medicare funded sessions is not one that I consider compassionate or just.

Whilst it is true that individuals with mild psychiatric disorders can generally be treated in six to twelve sessions of focused therapy, many of my clients are individuals with chronic and or multiple psychiatric disorders. These clients often require many more than the maximum 18 sessions per year currently funded by

Medicare. Nevertheless, even working within the present system of 18 sessions, the impact of therapy on such client's lives can be dramatic. It is often reflected in their ability to gain employment after years of struggle, or to function more effectively within their current employment. It is reflected in outcomes such as in increased ability to develop meaningful relationships and social supports, or to become more effective parents shielding the next generation from further suffering. It is also reflected essentially in their experience of relief from hopelessness and endless pain and suffering. Increasingly, Psychiatrists refer clients for psychological therapy in recognition of the enormous benefit of targeted psychological interventions for the chronically psychiatrically ill.

It is well documented that individuals from low socioeconomic and disadvantaged backgrounds are over exposed to trauma stemming from poverty and related social problems. It is not unusual for individuals to be referred to me by a General Medical Practitioner for treatment of chronic depression or anxiety, and upon clinical assessment be found to suffer from a myriad of psychiatric problems including Posttraumatic Stress Disorder, anxiety disorders, eating disorders, impulse control disorders, mood disorders, drug and alcohol abuse etc., as well as complex personality dysfunction, emotion dysregulation and social adjustment issues. For a great number of these clients this has been their first opportunity to access appropriate and effective diagnosis and treatment. It would be tragic in my opinion, that after finally making significant inroads to offer appropriate interventions to some of our most disadvantaged citizens we should withdraw or diminish this valuable service. I fully support Anthony Cichello's (Specialist Clinical Psychologist and Chair of the National College of Clinical Psychologists) in his statement that "it is abundantly clear that the obvious significant gap in mental health service provision is for those in the community presenting with the most complex and severe presentations. This is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices."

Yours faithfully,

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