27/07/2011

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

The Community Affairs References Committee,

Re: Committee Hearing to occur 16/08/2011 Consumer Response

I am concerned that after close to 10 years of full time study in Psychology (6 of those involving specialist clinical psychology training), my specialisation may not be recognised if the two tiered system is abolished. I am also concerned about the Senate Committee inquiry into Budget changes to Better Access and other Primary Mental Health services. Many of my comments here echo what has already been said in previous submissions by my colleagues, but I would like to add to their concerns with my own contribution.

(1) The differentiation between Generalist and Clinical psychologists

I thought that firstly, it would be useful to outline how much discrepancy there actually is in the term Generalist Psychologist. As far as I see it, it could be anyone of the following:

(a) Someone who has completed an MPsych (Clin) and graduated.
(b) Or, has completed MPsych (Clin) study up to the point of thesis submission and then upgraded to a DPsych or PhD. This person will work as a Generalist psychologist until s/he completes additional clinical college requirements and graduates.
(c) Someone who has a Masters degree or PhD/professional doctorate in an area other than clinical psychology (e.g., counselling, health psychology). This person would need to complete additional assessments and supervision for the Clinical College to consider this person's clinical knowledge to be equivalent to an MPsych (Clin).
(d) Someone who has completed clinical training, but has chosen not to become a member of the Clinical College, so cannot use the title Clinical Psychologist.
(e) Someone who completed training at honours level (4 years), and then received 2 years supervision in a clinical setting such as a private practice or hospital.
(f) Someone who completed training at honours level (4 years), and then received 2 years supervision in a non-clinical setting, such as a school, where they may have completed assessments and engaged in counselling but have not specifically trained in clinical theory and practice.
(g) Someone who completed honours (4 years) and then applied to study an MPsych (Clin) and did not get into the program. Potentially, this person may have applied numerous times and been rejected. This person may then choose one of the other pathways to registration.

I am someone who fits into category B. I have clinical training and have met additional supervision requirements, but I will only be able to call myself a Clinical Psychologist once I graduate. Whilst this is confusing for patients when I explain it to them, I think it is fair to wait until I actually graduate to use this title. It is a specialist title and I have been looking forward to this as a reward after literally a decade of hard work. However, if the specialisation of Clinical Psychology is downgraded and the two tier system is abolished then my training will be completely undervalued.

In order to complete specialised clinical training in psychology, one has to firstly receive sufficient marks, since accredited clinical programs are very competitive. Secondly, each candidate has to make it through an interview process where one is assessed on factors such as how well one copes with stress, and how suitable s/he is to deal with clinical scenarios. I would like to emphasise that whilst Clinical Psychologists may be accused of being elitist against their Generalist colleagues, we need to consider the fact that there are very good reasons why some people are not admitted into a clinical program. This has nothing to do with bullying or elitism, but is as I see it, simply about protecting the public and ensuring an internationally recognised standard of quality health care.

Nevertheless, there will still be people who insist that they have the necessary skills, and find another pathway to becoming clinicians. The general public will probably never ask their psychologist if s/he ever applied to study an accredited MPsych (Clin) program, and will probably not ask why s/he was not accepted. For some patients, this may mean that the psychologist's lack of clinical skill and training will only come out later when s/he makes an error in judgement. As dramatic as it sounds, this could mean dismissing a patient's suicidal threats as attention-seeking, misunderstanding complex symptoms such psychosis, or actually believing a patient with Anorexia Nervosa when s/he presents saying s/he eats 3 meals a day yet still only weighs 38 kilos.

Cutting corners in the area of mental health training is potentially dangerous, and for people who do not have clinical training to claim that their experiences are equivalent is unfair. It would be very interesting if there was a licensing test introduced to see how much these people think they actually know about clinical psychology. I feel that abolishing the two tiered system may encourage the notion that training to be a Clinical Psychologist is easy, or that anyone can "have a go at it". Those of us who have set aside time, money, a social life, and family responsibilities to complete our clinical training deserve to be recognised. We were admitted to a clinical postgraduate program because we have the skills to deliver specialist services. We ought to be recognised for our specialist skills, and to be paid accordingly, just as any other allied health specialist is.

Why are Clinical psychologists different to other (Generalist) psychologists?

Clinical Psychology as a specialist field, and remains a specialist field in the USA and in the UK. Other than Psychiatry, Clinical Psychology is the only other mental health profession whose complete post-graduate training is in the area of mental health. Consequently, due to their theoretical, conceptual, empirical and applied competencies, Clinical Psychologists are specialists in the provision of psychological

therapies. They have been trained in the DSM-IV-TR which is the manual published by the American Psychiatric Association as an international guide for diagnosing psychiatric disorders. They are also more likely to have received training in the ICD-10 (World Health Organisation), which currently is used by Medicare as a reference for the psychiatric diagnoses that can be treated under a Mental Health Care Treatment Plan. Conversely, **a** Generalist psychologist may have had little to no exposure to the DSM-IV-TR or the ICD-10 and certainly no formal training in their use. This is despite the fact that assessment and treatment of psychiatric disorders under Medicare is informed by the ICD-10.

In theory, a Generalist psychologist can claim to treat a psychiatric illness without ever having opened a DSM-IV-TR or glanced at the ICD-10. They have never been formally tested on the manuals' contents, nor developed the skills needed in differential diagnosis to understand the difference between different patient presentations. How is this even acceptable? In terms of being able to assess and diagnose psychiatric illness, a little bit of information can be a dangerous thing here.

Clinical Psychologists have consistently been involved in internationally recognised research and the practice of evidence-supported effective treatments. They understand how to critically evaluate a treatment, and have had feedback in supervision about areas in which they may be making errors in treatment delivery. The risk with Generalist psychologists is that they may not be guided by rigorous principles of evidence-based practice and may instead engage in "do what you feel like" approaches. Without theoretical training, a Generalist psychologist may know superficially what approaches may be used to treat various disorders, but not have a deep insight into why you would use a particular approach.

Currently, psychologists are not required to justify their choice of treatment approach to their patients or the referring GP, or provide a rationale for choice of assessments. So long as one writes something that sounds like it's in the realm of CBT or IPT (which are Medicare approved treatment approaches) in communications back to the GP, this appears to meet the current requirements by Medicare. How can one possibly know what is the best treatment approach for an individual without ever receiving comprehensive specialist training in these treatment approaches?

Formal training from a specialised Clinical MPsych degree carries with it the obligation to provide the best possible treatment available for the individual and his/her needs, rather than a general "one size fits all" approach. Clinical Psychologists have a minimum of six years full time university training with two additional years of mandatory professional supervision to obtain Clinical College membership. The fact that some people are suggesting that there are no real differences between Generalist and Clinical psychologists is simply not true. Those who have not studied a clinical postgraduate degree are not equipped to make claims about what clinical training involves.

Clinical psychologists have training in specific skills such as the assessment of psychopathy, violence, and sexual offending behaviour. These are assessment skills that should be limited only to people with specialised training, who have been observed and supervised, and have completed an assessment more than once. Surely it makes sense that some of the most dangerous and severely impaired individuals in

our community are assessed and treated by people who have the specialised training to do so?. Surely the community would be disappointed to learn that someone who has no specific clinical training might come across an individual with psychopathy and completely miss it? It would e easy to do so, since to the untrained eye, an individual with psychopathy presents as friendly, charming, and perfectly reasonable. Yet, these are among the most dangerous people in our society. I would argue that there are limited opportunities to learn specifically about psychopathy, violence and sexual offending without specialised training.

Similarly, Clinical Psychologists have specific skills in the assessment and treatment of sexual abuse in children. Again, people who do not have the specific training in this extremely delicate area can potentially cause greater harm by being ill-equipped to manage this type of presentation. Determining if abuse has occurred is rarely straightforward and requires careful and measured consideration. Psychologists who are not trained in stringent evidence-based clinical practice may rely on hunches, their own emotional reactions, inferences or biased observations to determine their view. By retaining Clinical Psychology as a specialisation, we can potentially reduce further risk to individuals and families by ensuring that they have access to specialised assessment and care.

Furthermore, Clinical Psychologists are trained to understand specialised aspects of human behaviour such as:

- the difference between depression and grief
- the ways in which anger and anxiety can be closely related
- how to explain confusing and potentially frightening bodily sensations associated with panic and dissociation
- the different causes of unusual and intrusive thoughts and how to treat these thoughts, depending on different causes
- the difference between nonsuicidal self-injury, parasuicidal behaviour (behaviour that mimics suicide but is not intended as suicidal), and active suicidal ideation. Importantly, Clinical psychologists also know what to do when someone is actively suicidal.
- to differentially diagnose hallucinations and/or delusions from more common sleep problems or to consider referral for other problems such as temporal lobe epilepsy.
- to complete and interpret results from assessments of intellectual ability, personality, learning disability, and neuropsychological functioning
- to differentially diagnose substance intoxication, mania, and psychosis (which can all look like the same thing), and how to manage a person who is actively psychotic
- to consider the fact that alcohol intoxication and acquired brain injury may present in a similar fashion
- to consider the fact that symptoms of Attention Deficit Hyperactivity Disorder (ADHD) might be explained by anxiety, learning disorder or trauma.
- to effectively and careful handle complex situations such as severe trauma and dissociative symptoms

- to understand the ways in which commonly prescribed medications and herbal supplements may effect behaviour.

This is certainly not an exhaustive list, but gives some insight into the specialties that Clinical Psychologists have. Of course, there will be Generalist psychologists who are able to perform some of these duties, but without specific training in the clinical field, as a group their depth of knowledge and experience is always going to be variable.

No other allied mental health professional receives as high a degree of education and training in mental health as the Clinical Psychologist. Clinical Psychologists are trained as scientist-practitioners. This added emphasis on the scientific in university training enables the profession of Clinical Psychologist to bring research and empiricism together and communicate this effectively to the general public.

Regarding rebate of sessions

The current national recommended hourly fee for psychologists (as suggested by the APS) is $218.00, yet I do not know of many psychologists who actually charge this full fee. The current scheduled fee for the lowest Medicare rebate tier is $81.60. In my opinion, this hourly fee is not commensurate with the services that clinical psychologists provide, nor reflective of our qualifications. In my opinion it is not reasonable to expect psychologists to work for approximately 35% of the recommended fee.

Psychologists in private practice who are self-employed and who choose to bulk bill patients (myself included) do it because we believe in people's rights to low or no cost healthcare. Unfortunately, this means that if the patient does not turn up for his/her appointment, then we do not get paid. Despite popular misconceptions that psychologists must earn a lot of money, many of my friends and family have been surprised to learn that there have been days where I have not been paid at all. Sometimes, there are days when nearly all of my patients have cancelled or simply not turned up, meaning that I earned $0.00 that day. In my experience, this is simply the nature of bulk billing since some people abuse the fact that there is no accountability if they do not turn up. Similarly, some people are so unwell and coping so poorly that they cannot and will not get out of bed that day, or have relapsed back into drug and/or alcohol use. However, there are always patients who really genuinely value the fact that their treatment is free, and could never afford the fee themselves and these people make my work rewarding.

Despite these non-monetary rewards, psychologists should not be expected to work for free. Many people who work in a situation where they are employed would not be happy to turn up to work and not be paid. Similarly, many people would not complete overtime or out of hours work for free. Typically, self-emloyed psychologists working in private practice must still pay room and/or office rent, as well as other associated fees. To earn nothing after a number of patients do not show up without cancelling beforehand to allow other appointment changes, while still having significant overheads can be frustrating and can cause one to consider not

bulk billing at all. I know that I am not alone in this position, and many of my colleagues have had similar experiences.

Despite the fact that I am one of the most highly qualified professionals, I still earn less than someone with no university degree, such as a labourer. I sincerely mean this with no disrespect to other professions, but 10 years at university full time is a long time. As a self-employed psychologist in private practice I do not get sick leave, holiday leave or maternity leave and do not get paid to write notes, attend professional development or take phone calls from patients, their doctors, teachers or family members. Clearly psychologists do not enter the profession for the money, or if they do then they work incredibly hard to get it. As psychologists we are constantly being told anecdotally how much we are needed and valued in the community. I love my job with everything I have, and could not see myself doing anything else. It would be satisfying to have the government reward our hard work with fair and reasonable pay, so that bulk billing in private practice can remain a viable option.

Regarding proposed cuts to number of sessions

The American Psychiatric Association suggests that the current "gold standard" for treatment of mental illness using Cognitive Behaviour Therapy (CBT) requires a minimum of 20 sessions to make good progress with symptoms. If patients are only getting access to 10 sessions, then they are only receiving half of the treatment care that they deserve, which is not good enough.

Certain disorders such as Borderline Personality Disorder (which currently cannot be treated under Medicare), Anorexia Nervosa, Post Traumatic Stress Disorder, and substance abuse often require more than 12 sessions to treat effectively due to their complexity. For example, Dialectical Behaviour Therapy (DBT), which is effective in treating personality disorder requires a 12 month commitment to therapy.

I would like to at least see the 12 session model retained, with the addition of 6 sessions in special circumstances (a total of 18 sessions per year). It is true that not all patients need this, but for those that do, Medicare rebates allow them to access affordable care.

It is worth noting as others have, that Psychiatrists may see a patient 365 times within a calendar year, with fees approximately 4 times greater than Psychologists. Many Psychiatrists in Australia do not actually provide therapy *per se*, rather they assist patients with assessment of complex psychiatric symptoms and treat patients' pharmacological needs. This leaves Clinical Psychologists as the only professionals who have sufficient training in a high level standard of mental health care to care for the community. If I start to see an individual who has moderate to severe mental health problems shortly after Christmas (anecdotally a common time when people seek help), and I see him/her once a week (which is the standard provision of psychological treatment) then potentially I cannot keep treating them once Easter approaches. This is utterly ridiculous. For some patients, they will get better in six weeks and this is fine. For others, who have chronic needs I have to spread out their sessions to make sure that the patient can still access treatment from April through to

December. Patients regularly feel anxious and stressed when they cannot make an appointment every week, and restricting their access to a set number of appointments implies that they only have 18 weeks maximum to get well. This adds enormous unnecessary pressure on the patient and may contribute to relapse and suicidal ideation.

Referrals and current Medicare requirements

With reference to referrals, I would like to propose removing the GP Mental Health Care Plan and suggest that a referral note from a GP is sufficient, as is the norm in other health settings. Whilst some GPs provide a thorough assessment of the patient's concerns in completing the plan and it is appreciated, it is not really what they have been trained to do. All too often I receive plans with question marks next to a string of possible diagnoses, or vague lists of symptoms and experiences. Sometimes they just say something along the lines of "whatever you think". With respect to GPs, I think that it is actually our job as psychologists to inform the GP about psychological functioning in patients and propose treatment plans, not the other way around. I wonder whether GPs would actually appreciate abolishing the need for these sessions to complete a plan, and instead re-direct the focus to the intake session with a psychologist. In terms of communication, I do think that mandatory communication between the psychologist and GP is warranted, and this should occur after intake, midway through treatment, and at the end of treatment. However, it may not be essential for the patient to report to his/her GP at the sixth session. Rather, the GP and psychologist should have the choice of flagging whether or not this is necessary. For example, if a patient tells his/her psychologist that s/he has suddenly stopped taking medication then it would be appropriate for the psychologist to refer the patient back to the GP for review.

Thank you for your consideration.

Name withheld