I am a Counselling Psychologist (that is, with Counselling endorsement) in private practice. I have been in full time private practice since 2000. Prior to that, from 1987 I had a part time private practice while being employed as a lecturer at Monash University. My comments relate to my experiences. I cannot comment on the experiences of those with other endorsements.

I wish to address the two issues being considered by the Senate Committee:

1. Cuts to the Medicare Better Access scheme

Part of the justification in the Federal Budget papers for the cuts to Better Access is that it is 'more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are provided with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services Program' (ATAPS).

Leaving aside the dubious logic of this statement, there is a problem that is not being addressed. In the Peninsula GP Network, which administers the ATAPS program in my area, eligibility for ATAPS is determined by possession of a health care card, that is, low income. ATAPS is effectively means tested. Whether that is the case in other Divisions, I do not know.

So where does this leave those with 'advanced mental illness' who do not qualify for services under ATAPS? Certainly they can get the 10 sessions under Better Access, but what then? Surely this is an anomaly that should be urgently addressed.

To confuse matters, however, in a General Practice Victoria document dated July 2011 which was sent to my practice by the Peninsula GP Network, several points were made:

i. 'Tier 1 ATAPS is *not* targeted at people with the more severe end of high prevalence disorders' (p.1). It goes on to quote from the 2010-2011 Department of Health and Ageing Operational Guidelines for the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program, which says 'ATAPS in its current form is particularly suitable for providing short term psychological services to individuals with mild to moderate common mental illness'.

ii. Patients 'cannot be treated under both programs or transfer from one to the other to "top up" with extra sessions' (p.2)

Quite clearly then, there are serious anomalies. Better Access is for people with mild disorders. The assumption is that ATAPS will pick up the more severe cases. People cannot use Better Outcomes and then go on to ATAPS. But ATAPS and the Department of Health see ATAPS as being for people with mild to moderate mental illness. So where are the more serious cases treated? A more serious problem is what happens to those with serious disorders who cannot get ATAPS sessions because they do not have a health care card. They can only receive the 10 sessions under Better Access, and are then abandoned. Is this the kind of mental health care system we want?

2. The two-tiered rebate structure for psychologists

Currently psychologists with Clinical endorsement are obtaining commercial advantage on the basis of what seems to me fallacious logic. Clinical psychologists are being

portrayed as somehow having higher qualifications or superior knowledge than other psychologists.

I believe that part of the problem lies in the language being used. To the general public, a Clinical Psychologist is a psychologist who works in a clinic. Legally, it is a psychologist who has a clinical 'endorsement', or specialty, on their registration. Because of these differing definitions, the waters are muddied when it comes to professional issues such as the two-tiered funding.

Firstly, may I make it clear that Clinical Psychologists are NOT more highly qualified than all other psychologists? Here I remind the reader that I can only speak for Counselling Psychologists. There are other endorsements.

While registration as a psychologist only requires the '4 + 2' path, endorsement as both Counselling and Clinical Psychologists normally requires a Masters degree. Both endorsements can be obtained by other paths, but they are not the norm. Some psychologists of course, both Counselling and Clinical, have doctorates, but that is not a requirement as yet. So the educational level is exactly the same.

Yes there are Masters courses labelled as either Counselling or Clinical, but the content is similar and I defy anyone to prove that one is superior to the other in terms of preparedness for working with clients. Counselling Psychologists are trained in assessment, diagnosis and therapeutic approaches, as are Clinical Psychologists.

I suspect that some of the problem lies in history. When I was first training, if someone wanted to work in a counselling setting, one became a Counselling Psychologist. If one wanted to work in a hospital setting, one trained as a Clinical Psychologist. Masters qualifications in those days tended to be by research. Course work Masters were very rare, and a 'real' Masters, and indeed Doctorate, was by research, producing a thesis. An example is my own case, I did my Masters in the Department of Psychiatry at the Royal Melbourne Hospital, doing my research on a clinical population from the psychiatric ward there and producing a thesis. Because I wanted to work in a counselling practice, not a hospital, I became a Counselling Psychologist. I know there are Clinical Psychologists with qualifications similar to mine.

Over time this has changed. The lines have now blurred. Preferred Masters courses are by coursework and Clinical Psychologists now work in Counselling practices. But to suggest that they are somehow superior, have superior qualifications, or are more effective therapists than Counselling Psychologists, is inaccurate and insulting. In fact, in the recent review of the Better Access initiative, the outcomes delivered by various Psychologist groups were found to be similar.

Secondly, when it comes to Professional Development (PD), and the requirements for continued specialist endorsement, again, they are the same in terms of the hours required for PD and peer supervision. Some of the PD courses and workshops offered, in fact, quallify for both Counselling and Clinical PD. It is therefore possible for psychologists with Counselling or Clinical endorsement to maintain that endorsement with exactly the same Professional Development.

In much of the literature discussing the two-tiered issue, a distinction is made between 'Clinical' and 'generalist' psychologists. This is an inaccurate portrayal of the

profession, and is quite offensive to those of us who have specialist endorsement other than Clinical. It is also confusing to members of the public. I have even spoken to GP's who are labouring under the misapprehension that Clinical Psychologists are more qualified.

A more accurate distinction is that there are those with specialist endorsement, such as Counselling of Clinical etc, while there are those without endorsement, who could be described as 'generalist'. The distinction is similar to that in the medical profession. There are specialist medical practitioners, and there are those in general practice.

So to continue to differentiate between Clinical Psychologists and Counselling Psychologists in terms of Medicare rebate in the Better Access scheme is nonsensical. It also disadvantages clients and provides an unjustified commercial advantage for Clinical Psychologists. The rebate for a Counselling Psychologist is $81.60. For a Clinical Psychologist it is $119.80. A difference of nearly $40. For those of us trying to run a business, with overheads including staff wages and the cost of premises, it is impossible to charge $81.60 a session and maintain a viable business. Although I must add that I, and many of my Counselling colleagues, do bulk bill in specific cases. Reluctantly, however, we are forced to usually charge the client a co-payment. Because of the higher rebate they receive, Clinical Psychologists can afford to bulk bill Better Access clients. Clients are therefore forced to pay extra to see the Psychologist of their choice, if that choice is to see a Counselling Psychologist. Certainly on the Peninsula where I work, there are not enough Clinical Psychologists to service client needs.

I believe that one solution to this dilemma is to combine Clinical and Counselling Psychologists into the one group. Differentiation cannot be justified on any logical grounds. If the two-tiered structure is to remain, then the distinction should be made between those with specialist endorsement, for example Counselling or Clinical, on the one hand, and those who do not have specialist endorsement, that is, generalist psychologists. I believe it is appropriate to acknowledge the higher qualifications of those with specialist endorsement.

There is one other issue I believe should be examined by the committee. There is great dissatisfaction amongst rank and file members of the Australian Psychological Society (APS) with the APS's representation of those who are not Clinical Psychologists. Many of us feel that our interests are not being addressed. There is an over-representation of Clinical Psychologists on both the APS and Psychology Boards. I wonder if decisions are being made that benefit Clinical Psychologists, and myths perpetuated, because the interests of Clinical Psychologists are the focus. I hope the Senate committee considers this when making decisions.

Thank you for taking my submission.