Australian Productivity Commission
Inquiry into Mental Health

Dear Commissioners,

Thank you for this opportunity.

I am a registered Psychologist, Medicare provider and registered with the Australian Health Practitioner Regulation Agency. I am also a full member of the Australian Psychological Society, and APS Eye Movement Desensitisation and Reprocessing (EMDR) Interest Group.

I have a work history as a Secondary Teacher, Youth Worker, Rehabilitation Counsellor, Career Counsellor and Supports Facilitator working with children with Disabilities. In 2000 I retrained as a psychologist where I completed the required course work and two years of supervised practice to make up the 4 plus 2 registration. In this rigorous two years of supervised practice, I was deemed by my supervisor to have competence in all the key competencies required to be a psychologist. I then worked as a psychologist with young children in care with mental health issues and challenging behaviours. I have been working as a Private Practice psychologist for 11 years. In this time, building on extensive knowledge gained prior to being a psychologist, I have undertaken advanced training in working with trauma, such as Eye Movement Desensitization and Reprogramming (EMDR), Internal Family Systems, Ego States, the treatment of chronic pain and a myriad of therapeutic approaches and techniques to treat anxiety and depression. I have engaged in in-depth peer consultation and supervision by experts in the above competencies.

Feedback on Green Paper

- There are many sound recommendations in the Paper, however I strongly oppose the recommendation that relates to 'the stepped care delivery of psychological services'. In general, I think that this approach is impractical and will disadvantage clients/patients and will create greater professional unfairness and division among psychologists.

- Key points where I think this approach will fail are:

    1) Assessment and re-assessment of level of need – clients having to return to their GP multiple times and possibly having to chop and change their psychologist and retell/relive their story. Further, already GPs input (Mental Health Care Planning and Reviews) takes up a fair proportion of the Better Access funding and I believe to increase their input further disadvantages clients and makes the system unworkable and even undesirable for clients.

    2) Exclusion of non clinical college psychologists from treating severe level of need – many of whom have experience, training and competency that far exceeds many endorsed clinical psychologists.

3) There is no evidence to support better outcomes for clients who see clinical psychologists over generalists.

   https://reformaps.org/second-evaluation-of-the-pirkis-et-al-2011-study/

4) Limited access to psychologists with training and experience that will meet client's needs – solely due to the faulty assumption that endorsed clinical psychologists are more competent and achieve better outcomes than registered psychologists.

5) Higher rebates for services offered by a clinical Psychologist has already created a fracturing in the profession and will continue to do so as long as it exists and is seen to be unfair.

6) The model is unworkable, where the majority of the profession (the 70% non clinical) will be worse off because they are unable to use their competencies, fast losing faith in the APS as the voice of their profession - undermining its credibility - and perhaps leaving the industry for economic reasons. Meanwhile the remaining 30% (Clinical Psychologists) will be unable to meet demand. This leaves the door wide open for the argument for non psychologists to provide Better Access services, further undermining the profession.

7) I do not believe the proposed model will be funded because it will be too expensive.

Concluding statement

There are many who argue that the fundamental problem with the proposal goes back to the flawed process in creating AoPA for psychologists who do clinical work – in particular the poor grandfather clause that relied on academic training that was not available or needed. While the concept of clinical endorsement has great merit, it has been put in place in a way that has resulted in psychologists who have experience and competency being excluded from the clinical college and the college including some psychologists who are less experienced, competent and qualified.

We believe that the many problems that occur now and that seem set to befall the proposed approach could be avoided if this fundamental problem was acknowledged and dealt with in a fair way by recognising the experience and training of registered psychologists and expanding the requirement for clinical endorsement to take this into account.

This is also a transition time, where the majority in the profession are generalists. This will change over time as they retire and new graduates take their place. However if this is done poorly, the profession will be left without those practitioners with contacts and credibility, long years of expertise,

expertise in areas of psychology other than Clinical, such as neuropsychology. This will have a huge impact on the credibility of the profession generally and a gap in services for those who most need effective mental health services, the clients.

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