Inquiry into Commonwealth funding and administration of mental health services

Submission

I do not believe that generalist trained psychologists should be given funding under Medicare to treat persons with mental health conditions. This is a specialist domain and should only be open to those who have done the necessary preparation to be endorsed as Clinical Psychologists by AHPRA. I justify this assertion below and offer a way of getting government better value for money in training clinical psychologists and better quality services for the Medicare outlay.

A 4 year university training for a psychologist is completely insufficient preparation to treat people with mental health conditions. It includes very limited training in interventions and no supervised experience of their delivery. Whilst AHPRA are now setting a formal agenda to be covered in the 2 years of supervision that can gain a provisional psychologist full registration, many existing psychologists have gained their registration by being supervised in a very restricted field e.g. educational, vocational or rehabilitation and they should not be allowed to practise beyond these limits.

The situation where the universities have been unable to supply a sufficient number of persons qualified to be endorsed as clinical psychologists is entirely due to the undue sway that academic psychology has over the rest of the profession with a blind adherence to the scientist practitioner model. This model extends what could be a 4 year long training into 6 and increasingly 7 years of academic study. The only beneficiaries of this are the universities who receive the related funding and the academics who have a guaranteed supply of frustrated clinical psychologists to do the hack work of research for them. The situation has been compounded by the peak professional body APS supporting the scientist practitioner model and including all persons working in the discipline of psychology under their purview. Just imagine if medicine, physiotherapy, dentistry etc adopted the scientist practitioner model! If would massively increase tertiary education costs and decrease throughput.

The training routes into professional psychology are:
1) An arts degree which includes:
   - 191% load of irrelevance such as ancient civs and foreign languages.
   - Psychology subjects totalling little over 2 years but heavily given over to research methods and a substantial honours thesis.
   - Less than 2 of these 4 years are in any way relevant to the practice of psychology in a clinical setting and very little is directly relevant.

At this point graduates enter the workforce in various counselling roles or circumscribed areas of practice as psychologists in supervision e.g. with schools, Centrelink, or in generic roles in mental health and with CSO’s. These areas of practice are very limited. Through supervision (which will hopefully do much of what in an ideal world a university should be doing) they have the ability over 2 years to gain registration. Thereupon they will be able to be paid by Medicare perhaps treating for the very first time people with severe mental health conditions.
2) Students then commence higher degrees at great expense either masters or
doctorate. Graduates exit with a reasonable basic preparation but at high cost to
themselves and the government.
A masters degree lasting 2 years is made up of a 25% research load.
The master graduate can now embark on the route to endorsement as a clinical
psychologist with under 4 years of relevant training. This training will have been
given in large part by disinterested academics who spend very little or no time at all in
the practice of clinical psychology. Few of the staff will be familiar with current
practice and training in interventions is typically limited to parroting out what text
books say about CBT. Most clinical psychologists will report that when it comes to
interventions, their training only commenced after leaving university when they
started to attend professional development workshops delivered by clinicians with
direct relevant experience.

Those prospective clinical psychologists continuing to doctorate status will spend
another year at their own and the tax payer’s expense gaining very little that will
assist them in their practice.

Clinical psychology is a health profession - as the dictum goes: a healthy mind in a
healthy body. Yet the overall curriculum includes very little about health in general.
This is a major omission. Whether dealing with eating disorders, panic, OCD (think
contamination), depression, psychosis, bipolar (think rhythms) the causes and effects
of increasingly present metabolic syndrome, a knowledge of physical functioning,
health and wellbeing will remain a serious knowledge deficit that clinical
psychologists may or may not rectify by private reading and attendance at workshops.

Preparation for the profession of Clinical Psychology should be conducted in schools
of health science. It is entirely feasible that this can be completed in a 4 year degree if
the teaching is provided by persons with direct clinical knowledge who continue to
practise widely.

The profession of psychology in the schools and professional bodies is now so
inextricably linked to the scientist- practitioner model that it will not be parted from it.

I would propose that government which is paying for the training and the services
provided by psychologists under Medicare consider the creation of a new discipline
which would do what clinical psychologists do with the same clients and paid for by
Medicare and other funding agencies. This would free the government from the
stranglehold placed on the profession by academic psychology and APS. This should
not aim to supplant Clinical Psychologists, rather it should provide the graduates that
government wants to deliver Medicare services displacing those psychologists who
have not completed relevant training. In time the 2 disciplines could merge.

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1/8/2011