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### **Submission to Commonwealth Funding and Administration of Mental Health Services Committee Inquiry**

This submission is in relation to items concerning the proposed changes to Government funding and administration of mental health services in Australia:

(b) Changes to the Better Access Initiative

(ii) the rationalization of allied health treatment sessions

(e) Mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

(ii) workforce qualification and training of psychologists

#### **The rationalization of allied health treatment sessions**

We contend that the reduction of allied health treatment sessions from 18 to 10 is a wholly inadequate period of time allocated for the treatment of individuals with complex needs such as those diagnosed with borderline personality disorder (BPD). BPD affects 1-2% of the population (Grant et al., 2008), and while not a high prevalence disorder, the condition brings with it considerable cost. The severity of burden associated with BPD is significant: individuals experience extreme difficulty forming and maintaining stable relationships, intense fears of abandonment, feelings of inner-emptiness, identity disturbance, intense and rapid mood changes, problems with anger, dissociative and paranoid ideation and frequent impulsive behavior and self-mutilation (e.g. breaking bones, cutting, burning, overdoses, ingesting objects) and suicidal behavior. Suicide rates are estimated between 4 and 10 percent (Beatson, Rao & Watson, 2010). Despite these difficulties, and the intense anxiety often aroused in those who treat these people, they do respond to a variety of treatments (Zanarini et al.) including Dialectical Behaviour therapy (McMain et al, 2009), Psychodynamic Psychotherapies (Giesen-Bloo, 2006; Korner et al., 2006), and Schema Therapy (Farrell et al., 2009; Giesen-Bloo, et al., 2006). However, to be effective, these psychotherapies require more than 10 sessions. Individuals with BPD most often have co-morbid disorders such as anxiety disorders, depression, bipolar disorder and eating disorders (Beatson et al., 2010) and will

frequently present to their General Practitioners for treatment of these presentations . The Better Access evaluation shows that many of the people accessing this program show high to very high levels of distress on the K10. It is likely that they will be referred for treatment under the Better Access Initiative. However, with only 10 sessions available annually, it is unlikely that treatment for such complex needs will be successful. One might argue that people with such complex difficulties should be seen in the public mental health system, however their access to this system is often restricted (Beatson et al., 2010), and in cases where case management is provided this does not mitigate the need for adjunctive psychotherapy treatments.

### **The two-tiered Medicare rebate system for psychologists**

As far as we are aware there is no evidence to suggest that clinical psychologists achieve better outcomes than psychologists without this specialist title. The Better Access Evaluation showed that clients of both clinical and generalist psychologists improved on the outcomes measured in the evaluation. This is consistent with international research which has found that therapists professional degree , or self-ascribed theoretical orientation does not have a direct impact on client treatment outcomes (Anderson, Ogles, Patterson, Lambert & Vermeersch, 2009; Huppert et al., 2001; Lambert, 2009; Okiishi et al., 2006; Okiishi, Lambert, Nielsen & Ogles, 2003; Wampold & Brown, 2005). Thus, as the Better Access evaluation shows, the psychological therapies provided by clinical psychologists, generalist psychologists and other trained mental health professionals are effective; where differences do exist, professional training or type does not explain these differences.

It is not a matter of the two-tiered system being unfair to non-clinical psychologists, but rather we contend that the claim that clinical psychologists provide superior service is unfounded and has no empirical basis.

### **Workforce qualification and training of psychologists**

For some years there has been a push for higher standards in psychology training, specifically for psychologists to have six years of university training and to bring the profession in line with international standards. On the whole we support this move. From our point of view, however, there are large inequities in how this transition to higher standards is taking place.

In 2010 psychology registration moved from state-based to national registration with AHPRA Psychology Board of Australia. Mixed in with this change was the reintroduction of specialist titles, called areas of endorsement. Those who were members of APS colleges were given endorsement in the new system; psychologists with a Masters or Doctoral qualifications were also able to gain endorsement in the area of their training. This left a large body of generalist psychologists 'unendorsed' in the new registration system. Avenues to endorsement other than through Masters or Doctoral training ceased as of September 2010. There are several problems with this transition. First, only APS members were informed that the non-standard pathway to college membership – and therefore endorsement – were closing. We know personally of non-APS members who missed the opportunity to apply as they were unaware of the changes. Second, the APS retained the right

to reject applications for college membership without providing any rationale for this. The process lacked transparency and fairness. Thus psychologists who either missed the application date (because they were not informed) or whose applications were rejected now have no means other than to complete a Masters or Doctoral degree in order to gain endorsement. They may therefore now have qualifications which, during the period of transition from state to national registration, have diminished in value - not as a result of any evidence suggesting they perform inadequately in their job, but because of political and systemic change.

Being an endorsed psychologist is important. A generalist psychologist working in mental health is now very restricted in their career path. The new public health sector multi-enterprise agreement (medical scientist, pharmacists and psychologists, 2008-2011) now stipulates that “only psychologists who are endorsed by the PBA to practice as clinical psychologists or clinical neuropsychologists shall be employed at the [P3 – senior psychologist] level or above in mental health services” (p. 123). We, like most of our colleagues, are not endorsed in these areas, yet we have worked in mental health services, including specialist mental health services, for many years. Despite our experiences and expertise in mental health, we will no longer have opportunities to work in mental health services (outside our current positions). Career paths have therefore been truncated, and psychologists will be dissuaded from continued work by virtue of low salary ceilings. The net result is that clients will miss out on receiving the services they need. There are many qualified generalist psychologists who will no longer have opportunities to work in mental health. We expect that Mental Health will lose many trained and experienced psychologists because of the inadequate handling of the transition to national registration and the restrictions imposed on career trajectories. We contend that the Psychology Board should endorse those psychologists, with full registration as of 2010, in the area in which they are experienced. This would adequately value their training and experience and make a fairer transition to the new system which emphasizes university postgraduate training.

Yours faithfully,

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