27th July 2011

RE: Commonwealth Funding and Administration of Mental Health Services

I would like to thank the Commonwealth Government on their efforts of trying to improve and increase the awareness of mental health in Australia. Mental health has long been a neglected area of concern within the broader health agenda for Australia. The changes made to mental health in 2006 by the then sitting Government have been a significant step forward in supporting individuals and families who suffer from mental health problems who could not afford self-funded psychological services.

I support the need to review and re-evaluate services and programs to ensure that the desired outcomes are being met. Indeed, we are taught this very philosophy in our psychology training at both undergraduate and postgraduate levels – it is the hallmark of the scientist-practitioner paradigm.

I am currently a psychology postgraduate student completing the PhD (Clinical Psychology) degree at a Government University. My submission is to urge for the following:

1. Retain the two tier Medicare system in which the specialisation of Clinical Psychology is to be clearly recognised.
2. The annual number of rebated sessions to be retained or increased.

The Two Tier System:

I find it perplexing that the Government is entertaining the notion of removing the two-tier system of rebate and essentially classifying general psychologists and clinical psychologists as an equal service. A general psychologist gains the right to offer psychological services through a pathway of four years of tertiary study plus two years of supervision. In contrast, to achieve Clinical Psychology status, a minimum of six (Masters), seven (Doctorate) or eight (PhD) years of study are required, accompanied by a further two years of supervised practice. Most likely the postgraduate study needed to obtain Clinical Psychology status will occur at a Government University.

The postgraduate training is exhaustive; it covers in-depth training covering many different theoretical underpinnings of psychopathology across the lifespan, building skills for assessment and diagnosis, and how to provide treatment of therapies which are empirically supported (e.g., Cognitive-behavioural therapy, Interpersonal therapy, etc). Above and beyond the content of the postgraduate training, we are importantly taught how to refine our hypotheses, question our approach, in order to meet the needs of our clients.

This type of training is not achieved through the alternative pathway when becoming a general psychologist. More importantly, to gain entry into these postgraduate programs is competitive. It is

based on undergraduate achievement, interviews, past experience, and referee reports. Universities receive hundreds of applicants a year and can only take on a small percentage of these applicants. Moreover, the University pathway provides a safeguard of ensuring a standardised training procedure. Indeed, other countries such as the United States, United Kingdom, and New Zealand, all require postgraduate training for their clinical psychologists. We should be doing the same.

The Number of Rebated Sessions to be Retained or Increased:

I am very concerned with the proposed cut-backs to the number of sessions that are able to claimed through the Medicare rebate system. The introduction of the Better Access Initiative was an important piece of legislation that enabled individuals suffering from mental health issues to access help and support. To now go back and reduce the number of sessions from an already restricted 12 sessions (with a maximum of 18) to a maximum of 10 sessions throughout the course of a year is confusing.

I understand this decision is based on a piece of research conducted by Medicare, which has since been criticised for its lack of methodological rigor. I wish the Senate Inquiry to consider other research which has shown that for 50% of clients, improvement starts after 10 sessions and clinically significant changes are only observed for 50% after 14 sessions. About 70% of clients with moderate to severe symptoms only gain clinically significant results after 20+ sessions (Harnett, O'Donovan, & Lambert, 2010).

I would argue that the number of sessions needed to treat any one person with a mental illness should be determined on a case-by-case basis, as is the case with medical illnesses. We trust medical physicians to determine the appropriate provision of care for their patients. Why do we not trust psychologists to determine the appropriate provision of care needed for our clients? Based on research of individuals with mental disorders we know that while for some clients, 10 sessions may be sufficient, for others it will not be adequate. Having such restrictive guidelines for administering psychological services will not benefit a significant proportion of those most in need.

In Summary:

I hope the Senate Inquiry takes into consideration the above arguments. I urge you to retain the two-tier Medicare system and to retain, or even increase, the number of rebated sessions.

References

Harnett, P., O'Donovan, A. & Lambert, M. (2010). The dose response relationship in psychotherapy: Implications for social policy, *Clinical Psychologist,* 14(2), 39-44.