Ms. Kylie McCardle

To: Committee Secretary
Senate Standing Committees on Community Affairs
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CC: Minister for Mental Health
ministerbutler@health.gov.au

17 July 2011

To whom it may concern,

RE: Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services

I draw your attention to the following *terms of reference* relating to proposed mental health reform, currently under scrutiny as part of the Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services:

(b.iv) The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule

"Mental illness is the single largest cause of disability in Australia … and remains the biggest risk factor for suicide … psychological therapies such as cognitive behaviour therapy are internationally recognised to reduce the impact and duration of … mental illness ... Such therapies present an alternative or … an effective adjunct to pharmaceutical management". (Department of Health and Ageing, 2011, pp. 2–7)

In light of the Australian Government's apparent concern for people affected by mental illness, as reflected in the statement above, I am perplexed by any suggestion that 'Better Access to Mental Health Care' be reduced. By reducing both the Medicare rebate amount and the maximum number of rebated sessions, access to quality mental health care is considerably diminished for its most vulnerable, impoverished, and needy consumers. This hardly seems consistent with the concept or spirit of Medicare.

The reduction of rebated sessions overlooks the *dose-response effect* as it applies to psychology. The dose-response effect holds that the degree to which psychological services are effective partly relies on the number of sessions clients attend (Harnett, O'Donovan, & Lambert, 2010). Although some clients will not require more than a few sessions to significantly improve, others may require extended treatment options.

Defined as the partnership shared between a client and their therapist, the *therapeutic relationship* determines the effectiveness of psychological therapies (Lambert & Barley, 2001). By reducing the number of Medicare sessions from 18 to 10, underprivileged clients with chronic mental health conditions will not be able to sustain a therapeutic relationship with the same psychologist, leaving them severely disadvantaged at critical stages of their treatment.

It should be up to the individual client and their psychologist to decide when it is appropriate to terminate or suspend therapy. However, without the freedom to make this decision beyond a 10 session limit, the subsequent discontinuity of service provision is likely to prove the most damaging and costly of all the proposed reforms to mental health care.

If any change is to be made to the *Better Access Initiative*, the rebate amount should be raised and the maximum number of rebated sessions increased to accurately reflect the lifetime prevalence rates of mental illness in Australia – up to 45% of the population aged 16–85 (Australian Bureau of Statistics, 2008) – and meet the high demand for mental health services.

(e.i) The two-tiered Medicare rebate system for Psychologists

While I acknowledge that all registered psychologists make an outstanding contribution to the profession, *psychologists with specializations* deserve a rebate that reflects the scope of their particular domain (Clinical Psychology Negotiating Committee [CPNC], 1998). A registered *generalist psychologist* demanding the same endorsement and rebate as a *specialist psychologist* is the equivalent of a GP claiming they should be endorsed and receive the same rebate as a psychiatrist, simply because GPs also have an undergraduate degree in medicine and often utilize similar assessment and treatment strategies in working with people affected by mental illness. Registered *generalist psychologists* have by definition not completed specialised training and therefore should not be endorsed or rebated as specialists in their field. Any suggestion to the contrary is simply unjustifiable and does not reflect a rational assessment of the universal realities of professional qualification standards.

The *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative* (Pirkis, Harris, Hall, & Ftanou, 2011) indicated that *GPs*, registered *generalist psychologists* and *clinical psychologists* are about equally effective in treating affective disorders. However, several glaring methodological limitations are apparent, chief among which are:

1. Relapse rates by type of psychologist were not tested
2. The sample was not randomised and therefore cause and effect cannot be reliably determined
3. There was an over reliance on self-reporting data
4. The article was not subject to peer review.

In light of these limitations, any qualitative differences in the therapeutic efficacy of registered *generalist psychologists* and *clinical psychologists* cannot be reliably inferred. Furthermore, it does not logically follow that mental health reform should limit all clients, regardless of their psychopathology, comorbidity or complexity, to the least qualified, lowest paid clinicians for the shortest time frame (Rounsaville & Carroll, 2002).

Beyond psychiatry, *clinical psychology* is the only profession that deals exclusively with the assessment, diagnosis and evidence-based treatment of the full range and complexity of psychopathology across the lifespan, and which simultaneously encompasses clinical psychometric evaluation, case formulation, psychotherapy, and advanced research methodology (CPNC, 1998).

(e.ii) Workforce qualifications and training of Psychologists

Psychology is in a state of gradual transition from one training and accreditation system to another. In the process, it is important to ensure that seasoned and highly competent registered psychologists who are qualified under the previous system (of 4 years of undergraduate study followed by two years supervision) are not unfairly disadvantaged (to which end an interim competency based evaluation or bridging accreditation system is appropriate).

No matter how experienced or skilled a registered psychologist might be, there must be a standardized system of education and training. The fact remains, however jarring, that some standards of education and training supersede others.

The argument that a registered *generalized psychologist's* training is equal to *specialised* postgraduate study is ambitious to the point of being irrational. It is tantamount to saying that there is no such thing as a specialist within the field of psychology, and that anyone who has finished four years undergraduate study plus two years of supervision should automatically be recognised as having completed another four years of postgraduate study as well (the length of a typical clinical Doctorate).

It has also been proposed that because most psychologists (supposedly 80%) are not qualified as *specialists*, those who are should be denied professional endorsement. This is reminiscent of a child insisting that, if he or she cannot have something then nobody else should be allowed to have it either. To obtain a specialization in almost any discipline it is universally regarded as necessary to complete a relevant higher degree program.

If we are to accept the premise that experience is equal to Masters or Doctoral level postgraduate study, then I suggest the Australian Government immediately abandon international academic standards, dismantle the postgraduate tertiary education system and replace it with on-the-job training, as this will free up enormous amounts of funding that can be injected into improving mental health care services.

Thank you for taking the time to read and consider my arguments.

Kind regards

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