12 July 2011

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

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

Dear Sir/Madam,

I wish to submit this letter to express my concern about changes suggested to the Better Access and other Primary Mental Health services. I understand two changes may be made under the 2011 budget; (1) reduction of sessions from 18 to 10, and (2) reduction from a two-tier system to one tier, where generalist psychologist and clinical psychologist referrals receive the same rebate for clients.

Firstly, let me explain my situation. I am a generalist psychologist who is completing the final year of a masters degree in clinical psychology, to become a clinical psychologist. Before commencing this postgraduate degree, I had the experience and training a generalist psychologist has with the base four year degree. I can say that the difference in knowledge of, and skills in evidence-based practice above the generalist training, is substantial. Clinical Psychology is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based psychopathology, assessment, diagnosis, case formulation, psychotherapy, evaluation and research across the full range of severity and complexity.

Reduction from a two-tier system to one tier

Under the changes, the obvious significant gap in mental health service provision is for those in the community presenting with the most complex and severe presentations. This is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices.

The changes to Better Access aim to provide better targeting of Better Access services to patients with mild to moderate mental illness, while patients with more severe mental illness will be provided more appropriate treatment under other programs such as the Access to Allied Psychological Services (ATAPS) program. ATAPS in my area, is administered by the local Division of General Practice (DGP). I understand their practice is to employ a generalist psychologist at a lower pay grade and with less training and experience to provide the services covered by this funding. So, clients who need it the most, are not receiving the assistance as it was intended. Other DGP's allocate the funding as it was intended, and provide services to clients to local private practitioners. The problem with employing a lower grade psychologist, is that clients lose the right to chose a psychologist, lose access to clinical psychologists, and lose access to chose a clinical psychologist specialising in the area they may require assistance with.

Reduction of sessions from 18 to 10

Regarding the study which this decision appears to be based on, my information is that the study did not meet fundamental standards of research design (it did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist; it did not identify the nature or type of psychological intervention actually provided; it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators; it did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients; it did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest; it did not determine relapse rates by type of psychologist; it was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session; it was not subjected to peer review); and what is needed is a well-designed prospective study aimed clearly at answering specific questions in accordance with principles of psychological research. This may be convincing proof that generalist psychologists have little critical clinical evaluation skill, the cornerstone of the specialised advanced evidence-based practice of a Clinical Psychologist.

In addition, it is accepted in allied health, that few clients present with a single problem which can be resolved by following a six-session therapy manual. They also need time to build rapport and trust with their therapist. The research supporting this is extensive, so I will not provide references, but please contact me if references are helpful. Clients present with many problems, almost never do they present with one problem that can be resolved by six treatment sessions. This point should be obvious to any who have experience in a health or clinical setting. The ramifications are that clients will come to a clinical psychologist for specialist assistance, and be left short of sessions. Further, those with severe psychiatric conditions will NOT meet criteria for assistance with public health services which, in my location, is psychotic illness without substance use problems. There are obviously many conditions which will not be covered by this criteria. Their scope is narrow, and clients with severe mental illness WILL fall into a black hole where there are no services.

These points, I believe (as a generalist psychologist), outline just a few reasons why clinical and generalist psychologists need to be placed separately on a two-tier system, and why clients need more than 10 sessions per year.