

July 26 2011

The Senate Standing Committee

I am a Clinical Psychologist registered to practise throughout Australia. I have worked as such in both the Public and Private sectors for the last 20 years and as a general and educational psychologist for seven years before that. I am currently both in Private Practice in NSW and am also contracted to _____ on a consulting and supervisory basis in both _____ and in remote communities in the _____ region.

I'm writing today on two issues: namely the Government's proposed changes to the Better Access Initiative and associated cuts to the present service, and also a few words about the unfortunate controversy over specialisation within Psychology and the 'two-tiered' Medicare system of reimbursement.

1. Better Access to Mental Health Care Initiative:

I do believe that the Better Access Initiative as it is currently running has been a huge benefit to a great number of people who had otherwise simply been excluded from any psychological help. The term so-called the "worried well" is in my opinion a real 'misnomer' and seems to be being used as a disparaging term to describe people judged by others (not in the know) to be somehow not worthy of treatment. These people are often those who have generally coped well in life and who may have hit really difficult times and are struggling to maintain their homes and jobs with high levels of anxiety and associated depressive symptoms. Such people often do respond quickly to effective treatment and very often do not require more than a few sessions.

Then there are also those who suffer from more chronic and debilitating mental health conditions: these may be mood disorders such as bi-polar or severe depression and/or anxiety; pervasive autistic spectrum disorders which can need ongoing input just to keep things going without some disaster occurring; or personality disorders some of which can be severe and dramatically affect not

only individuals but their families also. Chronic trauma and intergenerational trauma is another area requiring more than just a few sessions to ameliorate; co-morbidities require a high level of expertise to both diagnose and treat; not to mention the gamut of severe eating disorders, self harm and suicidality. The list goes on.

It can be a real struggle to fit treatment into the current model of 2x6 (12) sessions let alone to think of reducing these to 10. The 6 additional 'Special Circumstances' sessions have been a lifeline for some – particularly in the first months of treatment when concentrated treatment is vital for real change to occur. In some of these chronic cases, clearly even this has not been enough. Other clinicians have put this case and the evidence for this more succinctly – I would like just to add my voice to these and to say that to REDUCE sessions is not only a real step backwards but it actually undermines the efficacy of serious work and ultimately of successful outcomes. Very depressing.

2 Clinical Psychology as a Specialisation:

I do not want to say much about this issue. I have worked as a four years trained psychologist for several years before thinking it worthwhile to invest a lot of time and money in getting myself better qualified at a post graduate University level. This training involved many supervised placements in hospitals and clinics serving a wide range of mental health presentations at the same time as bringing up a large family. It was also necessary, after graduation, to continue with ongoing rigorous supervision for an extended time before being assessed as reaching a specialist status. To imply this was not only unnecessary but didn't really bestow any extra expertise, is both a condemnation of our entire University system of post-graduate qualifications for psychologists as well as being rather insulting to intelligence! It is also very discouraging.

Yours sincerely