Senate Committee Enquiry

I wish to address the proposed cuts to the Better Access to Mental Health Care programme as well as the implications of change to the two-tiered system for Medicare rebates. I am a clinical psychology registrant, having finished six years of study, all in psychology, the last two specifically focussing entirely on the assessment, diagnosis and treatment of mental disorders across the whole lifespan, as applied to individuals and family systems. I am now in my registrar year.

Although the government is seeking to make savings in health care, by "robbing Peter to pay Paul", it would seem to me to be a counter-productive plan.

1. Those most able to deliver psychological services to the numbers of the Australian population who are seeking them are psychologists in private practice who can develop a therapeutic relationship with each client. Government services are limited by the nature of bureaucratic imperatives: i.e. necessity for a greater part of their budgeting to be devoted to administration and tiers of management (rather than the delivery of psychological services), lack of diversity, staff movements generating a lack of stability; all of which leads to a reduction in service. Those consumers who are liable to be forced to use these government bureaucratised mental health agencies, will be the **most vulnerable**, those already having to navigate many other government agencies and never getting "the personal touch" - only available with a long term relationship with one individual, with whom they may develop a degree of attachment and safety within a therapeutic frame.
2. The government information attached to these proposals indicates that these most vulnerable of consumers will also have access to many psychiatric appointments. I believe it was the very real shortage of psychiatrists and mental health practitioners which prompted the initial Better Access initiative. This shortage has not been alleviated. It is

expected that these most vulnerable Australians, usually rendered into poverty by their mental disabilities will be able to pay gap fees of $200 and be seen without waiting three months.

Evidence would suggest that this is patently impossible and therefore the move to shift these services from psychologists to either the very few psychiatrists in the system and/or the bureaucratic state mental health services is undoubtedly a retrograde step and counter-productive, if Better Access is truly the government's goal.

3. As far as the questioning of the necessity of the two-tiered system is concerned, I believe the government to be under utilising clinical psychologists as the most qualified mental health practitioners that they are; the most able to deliver the services to satisfy the wider community need that psychiatrists, low in number, are unable to deliver. In fact without the prescribing rights which only psychiatrists have, clinical psychologists through their training and specialised focus on **mental illness** (assessment, diagnosis, treatment) are potential *defacto* psychiatrists, their training and specialty with non pharmacological interventions preparing them to deal with the most complex of cases and their scientist-practitioner focus preparing them to generate and use the latest research into aetiology and process in the diagnosis and treatment of mental illness. It is again a retrograde step to under-utilise and de-identify this particular group of mental illness specialists, differing in their focus from other psychologists (both non-specialist & of other specialisations), in the depth, breadth, rigour and regulation of their training to assess, diagnose and treat mental illness.