27 July 2011

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

Re: Government proposal to cut the 'Better Access to Mental Health Initiative' to 10 sessions.

Dear Senators

As a relatively new Clinical Psychologist, I am writing to express my objection about the Government's proposed changes to the *Better Access to Mental Health Care Initiative* (*'Better Access Initiative'*) as announced in the 2011 Federal Budget. Specifically, I am very disappointed by the proposal that from 1 November, 2011, the yearly maximum allowance of sessions of psychological treatment available to people with a recognised mental health disorder will be reduced from 18 to **10** sessions, and the possible changes to the two tier system.

Having recently worked in both public mental health and a private organisation, I think I've had fairly good exposure to a range of clients and some of the potential issues. One of the main problems with cutting the number of sessions to people with a mental health plan is that there will be nowhere else for them to go. My experience of working at my local mental health service was that a) due to funding it was quite difficult to receive support unless you were acutely unwell (i.e. suicidal), and b) the services offered to public mental health clients were more focussed on case management rather than on evidence based therapies. I worry that there will be a large gap and that clients that I currently see for 12-18 sessions under a mental health plan with significant distress will not meet the criteria for their local public health service or ATAPS. While it is true that most of the clients that I see in private practice are not as acutely unwell as people that I saw in the public system, it is like comparing apples to oranges. Most of the clients that I saw in the public system were chronically unwell and the goals of treatment were to a) keep them safe, b) facilitate medication reviews, c) link them in with local support networks, and d) return them to an independent level of functioning. This is very different to many of the clients that I see in private practice where my role is to diagnose disorders, devise treatment plans, teach strategies to improve psychological distress, help with new ways of thinking about situations, and return clients to a higher degree of functioning (e.g. fulltime work). While I have heard clients in this category referred to as the "worried well," I disagree entirely; from my perspective these are often people whose significant distress has an impact on their families and children, and can lead to detrimental consequences on the family unit's physical health, financial situation, and indeed all areas of functioning. Unfortunately 10 sessions, in my mind, is not enough to address most of these concerns.

Regarding the specialisation, after many years of studying and improving my skills and learning, I am extremely disappointed to think that the two-tier system would be revoked, and that clinical psychologists would be regarded as the same as generalist psychologists. We are the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. We are well represented in high proportion amongst the

innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions. Further, I worry that if there is no incentive to become a clinical psychologist, there will be less psychologists paying for a Masters Degree (or Clinical Doctorate), which will have a huge effect on the profession and reflect poorly on our standing in the international community. I do not believe that there is any credible evidence to suggest that clinical and generalist psychologists achieve similar outcomes and I am appalled at the divisive and inflammatory comments from the AAPi.

I trust that my feedback will be given due consideration.

Yours sincerely,

Anonymous
Clinical Psychologist