

(a) the Government's 2011-12 Budget changes relating to mental health;

I am a private practicing psychologist. I use "evidence-based" "focussed psychological strategies" with all my clients. My clients are generally referred through GP's via ATAPS (Division of GP's - Dept Health), a Mental Health Care Plan (Medicare's Better Access), or they are self-funded (rare).

My ATAPS clients are generally those who are low SES - on Centrelink benefits of some kind. ATAPS only fund 12 sessions per year and this is not adequate considering the types of conditions that this demographic tend to have (substance abuse, eating disorders, personality disorders, bipolar, major depression etc.). I would encourage the committee to seek advice on "evidence-based" therapies for these types of conditions (from a source that does not have a vested interest in a particular therapy modality). In my experience and knowledge of the research, the amount of damage done to a client by failing to continue treatment after the 12th session (see research on the importance of attachment style in the therapeutic relationship) is often more damaging than not seeing that client in the first place.

My clients who are referred through the Better Access scheme do generally benefit from 10 to 12 counseling sessions. The demographic is generally low-middle income. I do have a few clients who require more sessions (perhaps 20% of those referred). They are rarely able to afford these sessions without the Medicare rebate (particularly lower SES clients). In some cases I have dropped my fee to \$20 per hour session (less than my old job stacking shelves at Coles) to ensure continuity of care. It is very rare that I see a client for less than 10 sessions (if they stop earlier it's usually for non-therapy related reasons). I do not know of any "evidence-based" or "focussed psychological strategy" that has long-term effectiveness in less than 10 sessions. Perhaps the committee could review the evidence supporting psychological interventions of 6 sessions or less (as proposed in the budget).

The proposed budget change - from 12 Medicare funded sessions to 6 - will result in me only taking on those clients who can afford to self-fund the additional 6 sessions they are likely to need. This will rule out anyone on a low income (who are also likely to be on too high an income to qualify for ATAPS). Once again, I fear that stopping therapy after only 6 sessions will do more harm than good for a majority of clients with a psychological condition (due to the breaking of the therapeutic relationship).

Self-funded clients are very rare. They are usually those clients who require a psychological assessment. Medicare and ATAPS do not fund psychological assessments despite evidence (and common sense) suggesting that treatment is usually better targeted and more efficient following such an assessment.

My only other concern is with regard to the two-tiered rebate structure under the Medicare scheme. After completing a Bachelor of Science degree in 1998 I discovered my passion of psychology and proceeded to pursue a Bachelor of Psychology degree commencing in 2000. I completed that degree with "honours" in 2003. I was then presented with the choice between continuing with a 2-year Master's degree, or, beginning work in the real world while under the supervision of an experienced practitioner. Since 2003 I have completed numerous training courses, read volumes of research articles and books, and I have a reputation that allows me to run a successful full-time private practice.

At the time of graduating in 2003, I was told (by the APS) that both choices (4 + 2 with supervision and 6 years with Masters) were equivalent. I was shocked in 2008 when I learnt that my qualifications had suddenly rendered me inferior to my colleagues who had chosen the Masters degree option. I am currently sharing an office space with 6 "clinical" psychologists who, until 2008, were considered my equals. We all use similar therapeutic techniques, we are all equally experienced, equally professional and equally enthusiastic. We all achieve similar results with our clients (I believe that this is backed up by the recent research into the Better Access scheme which compared the results of "clinical" versus "generalist" psychologists). We are all referred similar clients. Yet, for reasons I cannot explain to them, my clients receive a Medicare rebate of \$81.60 per session, while my colleagues' clients (who could have equally been referred to me) receive a rebate of (approximately) \$120. Our office now has a seemingly unethical situation where clients are disadvantaged if they happen to phone for an appointment at a time when I answer the phone compared to when my colleagues answer the phone - not because they will receive an inferior service (I spend considerable time teaching my "clinical" colleagues techniques and theory - and visa versa) but because they will receive an inferior rebate. I can understand how this situation is supported by those organisations which have a vested financial interest in encouraging student's through their Masters degree. I am frustrated, however, that this position is supported by the Government.

I am now in a position where I am considering a return to university to complete a Masters degree - which teaches subjects that I have already mastered through my own continuous personal development. I have not

seen any evidence that completing a Masters degree will make me a better therapist. On the contrary, the recent evaluation of the Better Access scheme suggests that I would be no better off. So, do I take two years off to complete an ineffective Masters degree in order to regain parity with my peers? Or do I spend those two years continuing to serve my community while carefully investing in targeted training opportunities in order to actually improve my professional skills? I would like the committee to consider how they would like me spend my next two years.

Many thanks for considering my humble concerns.