Dear Committee Member,

I am writing to express my concerns about the some of the TOR for Commonwealth Funding and Administration of Mental Health Services Committee.

I understand the Committee is examining a number of changes to the Better Access Initiative, including:

(i) The rationalisation of the number of treatment sessions

I am 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 a maximum of 18 sessions to **10** sessions. The proposed cuts to the *'Better Access Initiative'* reflects the Federal Government's lack of understanding of the specific and varied needs of Australians with mental health disorders. This is simply not enough to meet the needs of people with complex mental health problems. Many of the clients I see under the Better Access Initiative struggle with severe depression, eating disorders, substance abuse and personality disorders. These clients require more than 10 sessions.

I appreciate that there are budget constraints. The high uptake of these services indicates the community need, not the need to cut services. However, taking a hard line on mental health consumers is not the answer.

I again urge the committee to have a long term view of the health of the nation and reject these proposals to cut funding immediately and instead maintain the current amount of treatment sessions available with a Clinical Psychologist under the *Better Access to Mental Health Care Initiative* to be 12, with an additional 6 sessions for 'exceptional circumstances'.

(ii) the impact of changes to the Medicare rebates

I am deeply concerned as to how much treatment gains will be adversely impacted if the funding for the *'Better Access Initiative'* is reduced. The uptake of items under the Better Health Care initiative indicates the high community need. Those presenting with only mild presentations are unlikely to be affected by the cuts to session numbers. This is unlikely to be the case for people with moderate to severe mental health needs.

I am concerned that these changes will increase the gap in mental health service provision is for those in the community presenting within the range of the moderate to most complex and severe presentations. The proposed changes imply that the same treatment outcomes can be achieved with half the amount of sessions. It is unrealistic to expect individuals in a vulnerable psychological state to immediately establish a rapport with a mental health professional even within the current 12-18 sessions – let

alone achieve treatment gains within 10 sessions. Clients do not need the added pressure or stigma of needing to recover quickly with the threat of financial hardship if they choose to continue to their mental health treatment.

The treatment of the moderate to severe range is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than ten 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. I believe that the decision to cut session numbers for the specialist clinical psychologist Medicare items should be reversed immediately.

(iii) the two-tiered Medicare rebate system for psychologists

I understand that the Committee believes there is no evidence for a two-tiered system. Essentially, the committee is insinuating that there is no difference in skills between a generalist psychologist and a clinical psychologist. A generalist psychologist has a basic APAC accredited four year degree. Plus, two years of supervised training. The breath and depth of that supervision will vary between practitioners. Unlike a placement undertaken during a postgraduate degree, there is no high standard of quality control for these two years of supervised practice.

In contrast, Clinical Psychology require a minimum of eight years training including a further ACPAC accredited postgraduate training in the specialisation leading to an advanced body of psychological competency in that field. Clinical psychology is a specialisation which is internationally recognised, enshrined within Australian legislation, and is the basis for all industrial awards. Clinical psychologists have been recognised since Western Australia commenced its Specialist Title Registration in 1965, and it is the West Australian model which formed the basis for the 2010 National Registration and Accreditation Scheme recognition of specialised Areas of Endorsement. Clinical psychology

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 and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. Clinical psychologists 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.

(iv) workforce qualifications and training of psychologists

If the two tiered system is removed. Australia will have lower standards than UK, Canada and the U.S.A. Australia should be aiming for excellence and moving forwards, not backwards. It is well documented that risk to the public is greatest when therapist are seeing clients whose problems are more complex than their level of training has prepared them to deal with. For example, an analysis of the NSW registration board found, that of those psychologist whose qualifications were known (*n* = 204), 53.4% had an undergraduate degree as their highest qualification (Grenyer & Lewis, 2011). Reports from the Victorian Psychologists Registration Board, which had accurate qualification data suggests more malpractice in psychologists with lower qualifications (Grenyer & Lewis, 2011). By removing the two tiered system for rebates, you are devaluing the qualifications of clinical psychologists and removing clear boundaries between problems for which it is appropriate to see a generalist psychologist and the work of clinical psychologists, thereby increasing the risk to the public.

(v) **the adequacy of mental health funding and services for disadvantaged groups**

I believe and support new investments in mental health care. However, they should not be at the detriment of existing mental health programs. For example, I understand that the Government has proposed to redirect funding from the *'Better Access Initiative'* to team-based community care (ATAPS). In my view this is duplicating the work of community mental health services.

Yours sincerely,

A concerned practitioner.

B.A. (Hons). D.Psy.