Secretary Senate Standing Committees on Community Affairs
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Dear Secretary,

I am writing to express deep concern about Term of Reference (TOR) points that you will be addressing concerning mental health workplace issues [item (e) in your TOR list]. These issues are regarding the two-tiered Medicare rebate for psychologists [item (e)(i)] and its related workplace qualifications and training of psychologists issue [item (e)(ii)]. Another related TOR point is the adequacy of mental health funding and services for disadvantaged people [item (f)].

No one else does what Clinical Psychologists do. They are trained intensively in assessment and treatment of psychiatric and psychologist disorders in Clinical Masters or Clinical Doctorate courses for 2 or 3 years respectively. Several clinical practice placements under close supervision are required, and there is a major clinical research requirement. Hence, there is a vast training difference between Clinical Psychologists and Generalist Psychologists who only have a Bachelors/Honours degree, which does not usually include specifically clinical subject matter other than sometimes an undergraduate course in Abnormal Psychology.

My own work is a good example of just how specific are the skills of Clinical Psychologists. I have particular expertise in treating Obsessive-Compulsive Disorder (OCD). Many of my referrals come from psychiatrists (about 1/3 of my patients) who do not have the training to carry out Exposure/Response Prevention, the behavioural treatment of choice for OCD, nor training in the relevant cognitive strategies for OCD. I also get referrals, also many from psychiatrists who do not have relevant cognitive behavioural skills, to help patients needing exposure and cognitive work with Complex Post Traumatic Stress Disorder (Complex PTSD). My training has included a wide base of knowledge in cognition, behaviour, attachment theory, and

developmental processes. I am typical of Clinical Psychologists in this way. Even further, many of us have particular expertise in areas of interest, such as my expertise in treating OCD.

Further, people with complex issues such as OCD and Complex PTSD need more than just 10 sessions per calendar year. I do not want to help only wealthy patients. With the Clinical Psychology rebate I am able to bulk bill disadvantaged patients. At the moment I bulk bill about 2/3 of my patients. This would not be possible at a lower rebate amount. I am of course also deeply concerned that the patients I see who need more than 10 sessions will not be able to afford further treatment. This is many in my practice because I see very complex patients, and because sometimes their mental health problems make it difficult for them to work fully. They won't be able to find a psychiatrist who has the relevant skills to help them. The wait time for public health help is often quite long, and they may still not be able to get the help they need in this way. Indeed, two of my recent patients were referred to me from public health because of my particular expertise—one with OCD and the other with Dissociative Identity Disorder.

Any diminishing of the support for Clinical Psychology Medicate items, whether it be eliminating the two-tiered system, or lowering the number of allowed sessions, will seriously compromise the mental health of patients.

Yours Faithfully,

Dr Lisa Storchheim, Clinical Psychologist in Private Practice