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To Whom It May Concern,

I would like to add my concern to the initiative to cut the funding from 18 to 10 sessions per year.

Many of my patients have been referred for the treatment of complex trauma, which if treated by a psychiatrist, would fall under a particular category with the recognition of a required extended treatment programme.

I have been qualified since 1977. I completed my Masters in Clinical Psychology in South Africa and completed my internship in a psychiatric hospital.

I worked as part of a psychiatric team and was on night duty with a GP in the local area. I considered that I had my training at the coalface of mental illness

and this has facilitated my ability to recognise, diagnose and treat a range of emotional and mental illnesses.

Upon completion of my training I was in charge of the first psychiatric halfway house in Johannesburg with visiting psychiatrists attending in an outpatient way.

As my training had fallen under the South African Medical and Dental Council, clinical psychologists were always seen as part of the medical discipline. In South Africa, referral to a clinical psychologist was seen as the first port of call, with evidence supporting the efficacy of psychotherapy. This can be seen today in an article by Dr Jonathan Shedler,

" The Efficacy of Psychodynamic Psychotherapy."

Working as a member of a multi-disciplinary team, our work was facilitated by the referrals and the ongoing regular contact between our medical/psychiatric colleagues and ourselves as clinical psychologists

Because of the nature of my clinical work both in South Africa and since immigrating to Australia, I have sought ongoing clinical training of an intense nature with weekly consultations with other colleagues, training and diverse study.

With intensive clinical treatment, many of my patients have been able to return to work and have avoided hospitalisation. Avoiding this costly option would have not been possible without the 18 sessions.

Many patients have been in extended treatment as it has enabled them to remain functional, even if they have not returned to work. They may have suffered significant trauma, such as childhood sexual abuse,

chronic and debilitating illness, living with violence, living with family members having a personality disorder or themselves having a personality disorder. I have been working with families with terminally ill parents or children.

Referrals have often been made by psychiatrists wanting to prescribe the medication, but not provide the psychological therapies.

Psychological therapy is the treatment of choice for children and adolescents. When I arrived in Australia in 1989, I was incredibly distressed as many young people were being sent to psychiatrists as there was no funding for treatment by clinical psychologists. Many young people were given medication without weekly reviews. This was considered unsafe and irresponsible and was noted within the past two years in both psychological and psychiatric journals. My consultant, an adult analyst and child psychiatrist and I have discussed this in depth.

Hence I do believe that as a clinical psychologist I have been trained in the management of complex mental health disorders.

I have been trained in the diagnosis, assessment and formulation for effective review of psychological and behavioural components of illness and treatment.

As I have committed to a specialist training in my field, I am amazed that Medicare recognises the difference between the GP and Specialised Physicians, yet with psychologists, we should now all be treated as "the same." I do not believe that all psychological training is the same. Just as there are specialisations in the field of medicine, my training as a clinician should be recognised and be available for the public should they express a need for a

"specialist clinical psychologist."

I sincerely request that you will take my comments into consideration as you review and assess the proposed changes to the current system.

Kind Regards

Tamara Wolpert