

As an Australian citizen, I am writing in response to the Senate Community Affairs Reference Committee's inquiry into the Commonwealth Funding and Administration of Mental Health Services. Specifically, to express my objection to the committee's proposal to reduce the number of psychology sessions entitled to Australians with current mental health conditions under the *Better Access to Mental Health Care Initiative* ('*Better Access Initiative*') as announced in the 2011 Federal Budget.

I encourage the senate to re-evaluate the economic and ethical impact of this decision on the broader health system, particularly in relation to the demonstrated effectiveness of the clinical psychologists in treating this challenging population. I therefore write to oppose any change to the two tiered system currently acknowledging clinical psychologists as specialists in the management of complex mental health conditions as per my argument below.

### **TREATMENT OUTCOME RESEARCH FINDINGS**

I struggle to comprehend the logic behind the proposed funding cuts given recent evaluation studies have shown the success of the *Better Access Initiative* in increasing help seeking in young people and adults. Furthermore, results have indicated that those who have accessed services have significantly recovered from their mental illness. Such data has dispelled the myth that only the "worried well" would access the initiative (i.e. those with conditions in the mild to moderate ranges), as those with severe rates of emotional distress have sought psychological assistance and their functioning has improved.

These outcomes have created significant change not only in individual's lives but the Australian economy as a whole by decreasing the utilisation of existing constrained acute health care services through prevention and treatment in primary care.

### **THE POTENTIAL IMPACT OF BETTER ACCESS CUTS**

Epidemiological studies show that worldwide, depression is the leading cause of disability (as measured by YLDs) and is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined. By the year 2020, depression is projected to reach 2nd place of the ranking of DALYs calculated for all ages and both genders. It is important that the Australian Government acknowledges the potential impact of this rise in prevalence in their health care budgeting and the impact on the broader Australian economy as a whole (i.e. increased family and relationship breakdowns, decreased work productivity, financial strains and substance abuse).

Research has shown that depression can be reliably diagnosed and treated in primary care, therefore reducing the burden on the acute mental health system. This includes admissions to public inpatient units but also emergency department admissions due to drug related injuries and suicide attempts. Barriers to effective care include a lack of resources, the lack of trained providers, and the social stigma associated with mental disorders in the community. It is in my opinion that the proposed cuts to the *Better Access Initiative* and the lack of recognition between clinical and generalist psychologists would exacerbate these barriers and increase crisis admissions to the public system. I therefore question the long term cost effectiveness of the proposed 2011 budget cuts.

The changes also conflict with current evidence based treatment guidelines as outlined by the Australian Psychological Society, the American Psychiatric Association and the National Institute for Health and Clinical Excellence. These recommend twelve sessions of cognitive-

behavioural therapy for symptom remission in standard cases (mild-moderate) of not only depression, but other mental health conditions itemised in the *Better Access Initiative*.

There is a substantial body of scientific evidence which further highlights the importance of relapse prevention being a fundamental component of therapy for all mental health conditions. Reducing the number of sessions under the *Better Access Initiative* to a maximum of ten per calendar year will limit the time clinician's spend on this area, placing clients at high risk of relapse and re-referral to mental health services. Therefore, it is in my opinion that those with moderate to severe conditions would be provided with less than adequate service provision if the number of sessions is reduced to ten per calendar year. This will further exacerbate the long term costs of mental health treatment to the Australian government and taxpayers.

### **THE CONTRIBUTION OF CLINICAL PSYCHOLOGISTS**

In Australia, anxiety, mood and substance use issues are the most commonly diagnosed conditions in adolescent and adult populations. Research has also shown that these conditions commonly co-occur. It is well established that psychological comorbidity has an impact on treatment engagement; often lengthening the treatment episode due to the complexity of the diagnoses and associated symptom profiles. I am concerned that the proposed cuts to the *Better Access Initiative* would impact most significantly on this high risk population.

It is my opinion that these complex conditions need to be managed by adequately trained mental health professionals. Taking into consideration the current and predicted changes in the prevalence rates of mental health conditions, it is of upmost importance that the two tiered system differentiating specialist clinical psychologists from generalist psychologists is upheld for these cases to be managed and current treatment outcomes to be maintained.

Clinical psychologists are highly trained clinicians with either a master's degree or doctorate in clinical psychology. In order to maintain registration with the APS clinical college and provide Medicare services under the *Better Access Initiative*, it is stipulated that clinical psychologists must remain up to date with evidence based practice by undertaking and actively contributing to continuing professional development. This ensures high standards of healthcare provision across the states and country.

Clinical psychology is the only mental health discipline, apart from psychiatrists, whose ENTIRE accredited training is specifically focused in the field of evidence-based assessment, case formulation, diagnosis and evaluated treatment of the full spectrum of lifespan mental health disorders across the full spectrum of complexity and severity, the cuts directly minimise the distinct contribution of the clinical psychologist to specialist mental health care in Australia. I therefore, urge the senate to consider the impact of this on the public health service and the readiness for generalist psychologists to manage the complexity of acute cases.

### **NATIONAL & INTERNATIONAL RECOGNITION OF CLINICAL PSYCHOLOGISTS**

Clinical Psychology is an area of specialisation that is internationally recognised, enshrined within Australian legislation, and is the basis for all industrial awards. The profession has 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.

All clinical psychology specialisations 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. No specialisation should be referred to in a manner that creates the appearance of the same level of skill and knowledge as the basic APAC accredited four year training of a generalist psychologist.

I perceive that the Australian Governments proposed cuts would also provide little personal and financial incentive for psychology candidates to challenge themselves academically and apply for the demanding clinical course. Clinical psychologists are already significantly underpaid if their length of study, the demanding nature of their work and the required skill set is taken into account. I studied full time for eight years to obtain this title and have accumulated a costly HECS debt. These coursework fees of the doctoral program are in excess of \$30, 000 plus 1000 hours of volunteer hours as part of the coursework (resulting in years of lost income, stress and burnout).

The abolishing of the two tiered system, leaves little personal and financial incentive for psychology graduates to enrol in clinical courses if the better access rebate is equivalent to that of generalist psychologists who studied for four years. I urge the senate to consider the impact that this decision will not only have clinically but on the exceptional research reputation Australian clinical psychologists currently uphold. It is in my opinion that our top clinical psychology graduates will relocate to other countries such as the United States or the United Kingdom where their expertise is acknowledged.

The American Psychiatric Association acknowledges the importance of differentiating clinical from generalist psychologists by recognising their 'specialty is the breadth of problems addressed and of populations served. Clinical Psychology, in research, education, training and practice, focuses on individual differences, abnormal behaviour, and mental disorders and their prevention, and lifestyle enhancement'.

The United Kingdoms' National Health Service Review of psychological services also recommended that the National Health Service differentiate health care professions according to skill levels. Skills were defined as knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills; Level 1- "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management), Level 2 - undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol and Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. The group went on to argue that clinical psychologists are the only professionals who operated at all three levels.

In the context of the above, I request the senate re-consider the seriousness of the consequences of the proposed cuts and lack of recognition of clinical psychologists by omitting a two tiered system. The profession has worked exceptionally hard over the past five years to achieve the

abovementioned outcomes related to the *Better Access Initiative*. It is vitally important that the two tiered system remains intact to remain up to date with current international protocol and standards governing the psychology profession as a whole.

I know many clients, family members and friends who have benefited so much from seeing a clinical psychologist and with the current financial burdens of the world, I am sure they would not have sought treatment if it was not government funded! Medicare is the best system to give consumers choice and we are moving forward professionally with gp's and psychiatrists because of this. Please consider the above mentioned data and seriousness of the consequences of these proposed changes.