



THE AUSTRALIAN
CLINICAL PSYCHOLOGY
ASSOCIATION

Submission to the Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services

Community Affairs References Committee

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Commonwealth Funding and Administration of Mental Health Services

Senate Inquiry: Community Affairs References Committee

The Australian Clinical Psychology Association (ACPA) represents clinical psychologists with accredited post-graduate qualifications in the speciality, in accordance with the standards established by the Psychology Board of Australia (PsyBA). Qualified clinical psychologists undertake a four year undergraduate degree in the science of psychology, followed by an accredited Masters (two year) or Doctoral (three year) degree in clinical psychology that focuses entirely on assessment, diagnosis, formulation, treatment, outcome evaluation, and research in mental health that incorporates supervised training in hospital and clinical settings. This is followed by a formal period of supervised practice to bring post-graduate training to a total of four years.

ACPA was established in April, 2010, in response to deep concerns about the growing lack of value of accredited training in the speciality of clinical psychology by those who have not undertaken this training and those who represent them. No other professional organisation represents the interests of this highly qualified group. We thank the Senate for this opportunity to address the issues raised in this important inquiry.

Clinical psychologists:

Although often grouped with Allied Health for administrative purposes, Clinical Psychologists differ in many ways from other Allied Health professionals. No other allied mental health professional receives as high a degree of education and training in mental health as the Clinical Psychologist. Other than psychiatry, Clinical Psychology is the only mental health profession whose complete post-graduate training is in the area of mental health. Furthermore, it is the only discipline whose complete training is in psychology, that is, both at the undergraduate and post-graduate level. In other words, the Clinical Psychologist is completely trained in a science intrinsic to mental health.

(1998, Work Value Document, Western Australia Clinical Psychology Health Sector, p.30).

SUMMARY:

Services for those with Mental Illness

Changes to services for those with a mental illness

The package of measures announced in the May 2011 Federal Budget for funding mental health included the headline figure of \$2.2 billion, but only \$583 million is to be spent over the forward estimates (the next four years). In the 2011-12 financial year the total amount to be spent is only \$47 million. It appears the Government is cutting mental health funding by removing \$580.5 million from GP mental health services and allied health treatments sessions from the Better Access Initiative.

Major changes to mental health funding were made in a non-transparent process without consultation with major stakeholders, and were not guided by the evidence relating to the efficacy of treatments or service delivery models. There is an urgent requirement for the development of a well considered, model of service delivery that is comprehensive, wide-reaching, integrated and based in sound evidence to drive decisions regarding policy and funding decisions. Currently, decisions appear to be made in an ad hoc manner in relation to particular interests and economic pressures, rather than by careful planning, based on a well articulated, evidence-based vision for mental health.

Under the 2011 Federal Budget, funding was transferred to specific public health child and youth programs at the severe end of the spectrum, without adequate representation on the decision-making committee of private service providers, alternative evidence-based programs for children and youth, or other mental health services, and without consultation with key stakeholders.

Qualified clinical psychologists are amongst the most highly trained stakeholders in the provision of mental health services, having advanced training in assessment, diagnosis, formulation, treatment and outcome evaluation of a wide range of mental health problems, at all levels of severity and complexity across the lifespan. Post-graduate training in clinical psychology is evidence-based and focuses entirely on developing a sound theoretical and applied knowledge of mental health problems and their management. This expertise should assist in the guidance of Government decision-making processes regarding policies for mental health service provision, and the allocation of funding within both the private and public health sectors.

As the national professional body representing clinical psychologists with accredited post-graduate training in the speciality, ACPA was not consulted at any time about the research regarding effective interventions, and service models, or the potential impact of the proposed changes to the provision of services for patients with mental illness within the private and public health systems. Indeed, when ACPA approached the Minister for Health and Ageing, her advisors, and the Minister for Mental Health for a meeting, that request was declined.

Many experienced qualified clinical psychologists are providing services currently under the Better Access Initiative. One of the strengths of this scheme has been the patient's ability to choose their practitioner, which enables access to clinical psychologists who can tailor treatment to the patient's needs at an advanced level. Under current proposals, individuals with more severe mental illnesses are to be referred to (a) the ATAPS program, which is limited in focus, restricted in choice for the patient, and often delivered by those without accredited training in mental health; (b) to psychiatrists, where there is a distinct shortage, particularly in low SES and rural areas, where many are primarily focused on prescribing and monitoring medication, and often work in collaboration with clinical psychologists who provide most of the psychological interventions, and where there can be significant co-payments; or (c) to the public sector, which treats only those with the most severe and persistent mental health problems, usually psychotic disorders.

The proposed reduction in the number of services provided under the Better Access Initiative will affect approximately 86,000 people annually with more severe mental health problems annually. Those with 'mild-moderate' mental health problems will also have their treatment seriously curtailed. Evidenced-based practice (e.g. Cognitive Behavioural Therapy) requires 10 to 20 sessions to treat a single disorder in the absence of co-morbidity (Andrews et al, 1994; Australian Centre for

Posttraumatic Mental Health, 2007; The National Institute of Mental Health in the USA (<http://www.nimh.nih.gov/health/publications/depression/how-is-depression-detected-and-treated.shtml>).

Furthermore, in making flawed distinctions between 'mild', 'moderate' and 'severe' mental health problems, the Government demonstrates a lack of understanding of the complexity of mental health presentations. They have failed to account for chronicity at all levels of severity, and have avoided the difficulties presented by more than one diagnosis and personality disorders, which complicate the treatment of all disorders, regardless of the level of 'severity' of those being specifically targeted.

A survey undertaken by ACPA found that those patients referred for treatment for mild-moderate presentations were, in fact, far more complex than this classification suggests. There were high levels of co-morbidity (37% had more than one mental health diagnosis (70% had more than one co-morbid problem) and chronicity (25% presented with symptom duration of more than 5 years; 16% of 2-5 years). This flawed distinction in levels of severity prevents referrers from adequately determining into which category a patient belongs, and thereby to which services they would be entitled.

A national mental health commission is urgently required to develop a mental health plan for the nation that is based on a sound evidence-based model of service delivery and treatment efficacy, to ensure appropriate services reach the largest number of individuals with mental health problems. The model needs to provide services based on need and utilise high levels of expertise amongst service providers to ensure the best access and least restrictive and intrusive means of service provision for all with mental health problems. Such a commission needs to be transparent in decision-making and widely consultative with all key stakeholders in mental health.

Other issues

In working with children, adolescents and families, adequate assessment requires sessions with parents without the child or young person being present. It is very clear that early intervention in evidence based parenting strategies, particularly for at risk children, can decrease the risk of later mental health problems. Parents also need to be able to access services providing psycho-education about parenting and parent training without the child or young person being present. Provision needs to be made for this in the private health funding of mental health care for children and adolescents.

People with a mental illness living in rural and remote areas are severely under-serviced. Incentives are required to attract providers to these areas. Outreach services need to be provided by psychiatrists and clinical psychologists via technology, to radically enhance service delivery. Use of technologies, such as Skype, Healthlink and Telepsychology might also be considered for direct service delivery to remote and rural areas, and also for the supervision and training of service providers.

Online or remotely-delivered services have considerable potential for improving access to effective and safe treatments for those living in rural and remote areas. However, there is limited systematic evidence to indicate that online services are clinically effective, acceptable, or safe for consumers in

rural and remote locations. Without clear evidence demonstrating that online protocols work in everyday clinical practice, and clear evidence for the minimum levels of training and support required to safely and effectively deliver online services, the possible benefits of such services should not be overstated. Moreover, attention must be paid to how such services integrate seamlessly, with existing services. Indeed, the promotion of such services is premature and likely to be dangerous.

Access to services for culturally and linguistically diverse communities is severely curtailed by the lack of available on site interpreters in the private health system to facilitate effective clinical engagement and ensure confidentiality of private information. Guidelines are required for managing cultural issues in relation to mental health problems and these need to be developed for a range of cultures present in Australia.

Finally, it is important to note the serious flaws inherent in The Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) survey, which purported to evaluate the efficacy of the Better Access Initiative. This survey was seriously deficient in design and implementation, such that its results cannot be relied upon as valid or reliable and it should not form the basis of decision-making regarding policy or funding. The survey breached virtually all fundamental guidelines for treatment outcome research.

Standards for psychology training and workforce issues

The two-tiered Medicare rebate system needs to be retained as it recognises the value of accredited post-graduate training and specialisation in clinical psychology. State and federal legally based awards differentiate between clinical and other psychologists. They not only lay out different pay scales, but also describe the differences in skill sets and the nature of work done by the two groups. Industrial Relations Tribunals also recognise the distinction. The Psychology Board of Australia (PsyBA) has affirmed this distinction through the establishment of standards for endorsement of clinical psychologists and other psychology specialists based on accredited post-graduate qualifications and a formal period of supervised practice, resulting in four years of post-graduate training. We are deeply concerned about the lack of recognition of the value of accredited post-graduate clinical training by those who do not hold these qualifications and those who represent them.

Australia has the lowest standards of entry to the profession for both psychologists and specialist psychologists in the Western world. Around eighty five percent of psychologists currently practicing in Australia would not be permitted to practice as psychologists in any other equivalent first world English-speaking country, such as the USA, UK, Canada, or NZ. We acknowledge that people with a 4 year undergraduate qualification in the science of psychology followed by two years of an unaccredited supervision program (known as the 4 + 2 model) make a significant contribution to the workforce outside of mental health (for example, the Department of Education and Training, Centrelink, the Department of Ageing, Disabilities and Home Care, the Department of Defence etc.); however, this training route needs to be re-structured to meet these specific workforce needs and the resultant workforce re-titled to properly reflect the lack of accredited professional qualifications in psychology. Australia needs to move away from entry level requirements for professional practice as a psychologist that include no accredited training or qualifications to accredited training at

Masters level. Specialisation needs to move to Doctoral training to bring Australian specialist psychologists into line with basic entry standards for the profession in the rest of the developed English speaking world.

Government has recently introduced the term 'endorsed' in lieu of 'specialist' to differentiate those psychologists with accredited clinical training from those without it. The public does not understand the concept of 'endorsement' or that this rests in psychology on the requirement for accredited post-graduate training in a specialised area of psychology. Furthermore, with the recent establishment of the Psychology Board of Australia (PsyBA), a significant number (estimated at 2,000 or more) of practitioners without the requisite postgraduate qualifications in clinical psychology were "grandparented" into endorsement as clinical psychologists.

This has led to a substantial downgrading of standards for all specialist psychologists in Western Australia, where for over 30 years Specialist Title was awarded in any area of specialisation only to those with Masters or Doctoral degrees. This system had provided a clear capacity for referring GPs and for the public to identify those psychologists with accredited post-graduate training in clinical psychology and other areas of specialisation. Use of Specialist Title needs to be re-instated in Western Australia and extended nationally to enable the public to clearly identify those clinical psychologists who meet the standards of accredited post-graduate training established for practice as a clinical psychologist by the PsyBA.

Australia has the largest workforce of psychologists in the Western world. At 1: 782 per capita it is higher than New Zealand's 1:1,193; and well above Canada's 1: 2,011 (in 2006); the United Kingdom's 1: 3,351 and the USA's 1: 3,580. Both the Tolkein Report (2010) and The Mental Health Workforce: Supply of Psychologists (2008) state there is no shortage of psychologists.

However, there is a shortage of qualified clinical psychologists. While the number of clinical psychologists who meet the PsyBA's minimum standard for endorsement as a clinical psychologist is not known, there are 1: 5, 174 endorsed clinical psychologists (including those without the requisite qualifications). This is well below the 1: 3,088 in New Zealand, although higher than the 1: 6,873 in the United Kingdom. Numbers for Canada and the USA were not obtainable.

Funding of places in post-graduate clinical programs, as well as students undertaking Doctoral degrees, falls well below international standards. Post-graduate specialist programs in psychology operate at a financial loss in universities, needing to be subsidised from other areas. Unlike Masters students, Doctoral students are not granted Centrelink living allowances, despite both undertaking post-graduate degrees in the same area of specialisation. This provides a disincentive to training to an international standard and needs to be rectified.

Summary of Recommendations

- Government decision-making regarding changes to programs delivering services to those with mental health problems needs to be transparent, supported by the research evidence, and only undertaken after consultation with all major stakeholders.
- A fully articulated model of mental health service delivery, based on evidence, and taking account of varying levels of expertise in the workforce, needs to be developed to guide Government decision-making regarding appropriate levels and types of treatment for all individuals with mental health problems.
- To ensure balance in decision-making, the Government needs to ensure proper representation of all stakeholders on committees and working groups. As key service providers in mental health, in both the private and public health systems, clinical psychologists need to be represented in policy direction and decision-making processes.
- The vital role of GPs in primary mental health care requires further acknowledgement, and GPs should be appropriately represented in all decision-making processes.
- Value needs to be added to mental health services by ensuring that clinical psychologists are engaged to provide higher level services under all programs. This would make best use of the expertise of this group.
- In recognition of clinical psychology specialist training, GP's need to be enabled to refer to clinical psychologists without the requirement of a Mental Health Treatment Plan, as occurs already for referrals to psychiatrists.
- GPs should continue to provide Mental Health Treatment Plans for those patients to be seen for Focussed Psychological Strategies by psychologists and other professionals who do not have accredited post-graduate qualifications in mental health.
- Enable all patients with mental health problems, regardless of severity, complexity, and chronicity, to access their choice of practitioner under the least restrictive circumstances offered by the Better Access Initiative.
- Determine the optimum number of sessions required for effective treatment for all levels of chronicity, complexity and severity.
- Determine the level of expertise required to effectively treat patients at all levels of severity, chronicity and complexity.
- Allocate patients by level of chronicity, complexity and severity to the appropriate number of sessions and level of expertise of service provider in all programs.
- Re-develop the ATAPS program to provide more intense, advanced, tailored treatment where required by clinical psychologists and psychiatrists working with GPs.
- Parents need to be permitted to claim Medicare rebates for assessment, psycho-education and training in parenting strategies under their child's referral and Mental Health Treatment Plan.
- Special incentives need to be provided to GPs, mental health nurses, clinical psychologists, and psychiatrists to work in rural and remote areas in terms of higher rebates tied to area.
- Outreach services need to be provided by psychiatrists and clinical psychologists via technology.

- Use of developing technologies, such as Skype, Healthlink and Telepsychology, also need to be considered for direct service delivery to remote and rural areas, and also for the supervision and training of psychologists.
- Careful evaluations of online services need to be conducted to examine: the expected clinical benefits when protocols are administered in everyday practice; the negative effects of not completing the treatment protocols; the minimum type and amount of contact required to support consumers to safely and effectively complete the protocols, and the training and supervision requirements for staff who support consumers; and the data management and risk management requirements for service providers who wish to administer such protocols.
- It needs to be recognised that in many rural and remote areas educational standards are often low and there are high levels of illiteracy. This limits the application of online programs.
- Consumers should be properly informed about the limited evidence base for online services.
- The method of seamless integration of online services into existing models of care needs to be determined, since creating an independent model of service provision is unlikely to be in the best interests of consumers.
- Greater access to on site interpreters in the private mental health system needs to be provided to those from culturally and linguistically diverse backgrounds.
- Guidelines for managing cultural issues in relation to mental health problems need to be developed for the range of cultures present in Australia.
- The success to date of the indigenous postgraduate scholarship program in clinical psychology should be reviewed, and any required adjustment or expansion implemented.
- Research into the efficacy and suitability of Narrative Therapy approaches to mental health problems amongst Indigenous people requires funding.
- Greater access to support is required for those suffering disability, regardless of cause.
- A national mental health commission is urgently needed to develop a comprehensive, sound and integrated model of service delivery, based in best practice, utilising appropriate levels of expertise to guide policy and funding directions in mental health. Such a model requires transparency and wide consultancy with all key stakeholders in its development.

Professional issues

- The two-tiered Medicare rebate system should be retained as it recognises the value of the accredited post-graduate mental health training of clinical psychologists.
- Specialist title needs to be granted to those who meet the post-graduate training requirements established by the PsyBA to enable the public to clearly differentiate those with accredited post-graduate specialist training, particularly in clinical psychology.
- The minimum requirement for registration as a psychologist needs to be raised to Masters level within six years.
- The “4 + 2” model of training needs to be re-structured to meet workforce needs and this workforce re-titled to properly reflect the lack of accredited specialist professional qualifications.
- The standard qualification for specialist registration of clinical psychologists should be raised to Doctoral level within the next five years.

- Funding for post-graduate university places in clinical psychology needs to be reviewed as a matter of urgency, and appropriate levels of funding made available.
- The same level of Centrelink funding needs to be provided to post-graduate students undertaking Doctoral level training in psychology specialities as provided to those undertaking Masters level training.
- There needs to be provision of postgraduate scholarships for clinical psychology tied to a period of work in underserviced areas.
- Clinical psychology trainees should have parity with the Undergraduate Scholars and be eligible to apply for the Clinical Placement Scholarship.
- It is inappropriate for professional associations, such as the Australian Psychological Society, to make decisions regarding Medicare provider eligibility, type of rebate, or compliance with requirements for Continuing Professional Development for Medicare Australia. This should be devolved to the PsyBA, as the national registration body for psychologists, or managed by Medicare Australia itself.

1. The Government's 2011-12 Budget changes relating to mental health

The package of measures announced in the May 2011 Federal Budget for funding mental health included the headline figure of \$2.2 billion, but only \$583 million is to be spent over the forward estimates (the next four years). In the 2011-12 financial year the total amount to be spent is only \$47 million. It appears the Government is cutting mental health funding by removing \$580.5 million from GP mental health services and allied health treatments sessions from the Better Access Initiative.

There are serious concerns regarding the decision-making process and the evidence-base for the decisions taken by the Government, which have not been fully delineated in the Budget documents, despite the assertion that the Government's "comprehensive strategy is founded on the evidence of what works, and follows extensive consultations with the mental health sector and the community" (Health Budget 2011-2012: Delivering National Mental Health Reform). The evidence base for the decisions taken has not been provided: no clear, comprehensive, integrated, model of service delivery has been explicated, and consultation with stakeholders, particularly those most involved with the delivery of services under the Better Access initiative, was minimal.

Members of ACPA are major contributors to the public and private mental health sectors, and evidence-based psychological therapies are developed, refined and evaluated for the most part by clinical psychologists. However ACPA was not consulted at any time about the research regarding effective interventions, service models, or the potential impact of the proposed changes to the Better Access Initiative. Indeed, when ACPA approached the Minister for Health and Ageing, her advisors, and the Minister for Mental Health for a meeting, that request was declined.

We understand that the changes relating to the re-distribution of mental health funding were not a result of the Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) survey, but were based on recommendations made by the Minister Butler's Mental Health Expert Working group. While this group includes eminent mental health professionals whose knowledge and direction may be generally useful in determining policy, the group was dominated by public sector interests, and under-represented by those working within the Better Access Initiative, which was the program most affected by the changes made. The recent resignation of Dr Christine McAuliffe, who represented GPs within this group, is of considerable concern.

ACPA is strongly supportive of the public health system and applauds any additional funding made available for public programs. However, we believe that a balance should be maintained between public and private services in mental health to deliver choice to consumers, as well as the best, least restrictive, and most efficient delivery of services. This is achieved through both strong private and public health systems. To ensure balance in decision-making, the Government needs to guarantee adequate representation of all sectors and stakeholders in all mental health decision-making processes.

Additional investment in child and youth mental health is vital, but we are concerned that 85% of the \$491.7 million funding to boost services for children and young people has been allocated to two models of care - EPPIC and Headspace – to the exclusion of a more extensive range of programs for

children and youth, which may have a more substantial evidence-base. It also excludes other treatment programs which may also be of significant value to the broader community.

Additional funding for those patients with severe and persistent mental illness is another important initiative, but it is disappointing that the value of services provided by private clinical psychologists to these individuals under the Better Access Initiative has been overlooked. We believe that there are significant gaps in the government's 'expanded' mental health care program, with no mention made of the needs of the substantial portion of patients with moderate – severe mental health diagnoses, who require more advanced therapies than the Focussed Psychological Strategies (FPS) available under ATAPS, and do not necessarily need or want to access public health or psychiatry services. These patients may be better served by clinical psychologists under the Better Access Initiative.

Qualified clinical psychologists have extensive accredited post-graduate training in mental health followed by a formal supervision period, matched only by psychiatrists, yet there is generally little recognition and utilisation of this expertise within the structures of Government funded mental health programs. While they are granted a higher Medicare rebate in recognition of their advanced training and expertise, clinical psychologists, unlike psychiatrists, are not funded to properly exercise this expertise with people with more chronic, moderate and severe presentations that require advanced treatments over a longer period of time. The expertise of clinical psychology is underutilised, which leads to inefficiencies in expenditure as such people are referred to more costly alternatives.

Recommendations:

- Government decision-making regarding changes to programs delivering services to those with mental health problems needs to be transparent, based on the research evidence, and only undertaken after consultation with all major stakeholders.
- To ensure balance in decision-making, the Government needs to ensure adequate representation of all stakeholders in all decision-making processes and advisory groups.
- As key service providers in mental health, in both the private and public health systems, clinical psychologists need to be represented in policy direction and decision-making.
- A fully articulated, integrated, evidence-based model for mental health service delivery based on patient needs, and matched to the expertise within the workforce, should be developed to guide Government decision-making policy and funding arrangements for mental health services.
- The role of qualified clinical psychologists needs to be re-assessed to ensure their expertise is effectively utilised in mental health assessment, diagnosis, formulation and treatment, in outcome evaluation, and in the supervision and training of other health professionals. This specialised expertise needs to be made available to patients with more moderate-severe and chronic presentations who may require more advanced treatments over longer time periods.

2. Changes to the Better Access Initiative:

(i) The rationalisation of general practitioner (GP) mental health services

We believe that comment on this initiative is best left to GPs, who have a greater understanding of their own needs. However, we are deeply concerned that the GP representative on Minister Butler's Mental Health Expert Working group, Dr Christine McAuliffe, has resigned in frustration due to the cutbacks in the Better Access Initiative (<http://www.medicalobserver.com.au/news/gp-adviser-quits-over-mental-health-rebate-cuts> ; <http://abc.gov.au/rn/latenightlive/stories/2011/3273683.htm>), when GPs are major providers of mental health services and are central in the referral system to other service providers.

GPs in rural and remote areas have indicated to our members that the cut in the consultation fee under the Better Access Initiative may be financially unsustainable and will also force them away from bulk billing, and thereby reduce consumer access to psychologists.

Recommendations:

- The vital role of GPs in primary mental health care needs to be acknowledged, and GPs working in all programs should be appropriately represented in all future decision-making processes and groups.
- GPs and psychologists working in rural and remote areas require higher levels of funding tied to area, to attract professionals, and to ensure that consumers have adequate access to services.

(ii) The rationalisation of allied health treatment sessions

The Government claims the Better Access Initiative has been successful in providing greater access to psychological treatment for those suffering from mental health problems. However, altering the target population and number of sessions available to those using this scheme has a high probability of reducing this access. Many patients, regardless of the severity of their problems, prefer private treatment by their choice of practitioner and will not take up services under other more restrictive programs. One of the strengths of the Better Access Initiative has been the patient's ability to choose their practitioner.

There has previously been no distinction made under the Better Access Initiative between mild, moderate or severe presentations of mental illness. In shifting the focus from providing psychological services to all those with mental illness, to those with only mild to moderate presentations under this scheme, the Government has failed to recognise the complexity of mental health presentations. They have failed to account for chronicity at all levels, and have avoided the difficulties presented by more than one diagnosis and personality disorders, which complicate the treatment of all disorders presented, regardless of the level of 'severity' of those difficulties being specifically targeted.

The description of 'mild-moderate' mental illnesses is deceptive. A survey undertaken by ACPA conducted on 503 patients seen within a one-week period in May 2011, by 33 of those members

who provide services under the Better Access Initiative, found that patients referred for treatment of mild-moderate problems were, in fact, far more complex than this would imply (see Appendix A). Amongst these patients there were high levels of co-morbidity (70% had more than one mental health problem, including: co-occurring medical conditions, intellectual disability, developmental disorder, domestic violence, various forms of child abuse history, child neglect and childhood domestic violence history, and trauma during adulthood), and chronicity (25% presented with symptom duration of more than 5 years; 16% of 2-5 years).

It is extremely difficult to provide clear and practical definitions of 'mild', moderate' and severe' mental illness to enable referrers to determine to which group a patient belongs, and thereby to which service they would be entitled. Moderate to severe, complex, co-morbid or chronic presentations usually do require more advanced services tailored to their needs, but under the changes announced these patients will be provided with fewer options, greater restrictions and poorer access. These patients are to be referred to (a) the ATAPS program; (b) to psychiatrists; or (c) to the public sector.

Patients with severe mental health difficulties receive services under ATAPS organised through the Medical Locals or GP Divisions. Under ATAPS, access to choice of practitioner is lost, with referrals going only to providers with developed arrangements with the Divisions. It seems somewhat prejudicial to allow individuals with mild to moderate difficulties to access a range of practitioners, including clinical psychologists able to provide advanced programs tailored to individual needs, while those with severe difficulties can only access a restricted range of practitioners. This restricted range of practitioners currently includes a large proportion currently providing Focused Psychological Strategies (FPS) without accredited training in mental health.

The ATAPS program is specifically restricted to the provision of FPS (2010-2011 Operational Guidelines for the Access to Allied Psychological Services Component of Better Outcomes in Mental Health Care Program, p. 5). These strategies provide lower level treatments, particularly with practitioners who do not have formal, accredited training in their theoretical underpinnings, research base, and application with a wide range of disorders that enable advanced programs tailored to individual needs. There appear to be no safeguards for ensuring the practitioner is adequately qualified to provide services at the more severe end of the spectrum under the ATAPS program. Patients with more chronic or severe mental health problems require services provided by those with advanced knowledge of assessment, diagnosis, formulation and treatment modalities in mental health, such as clinical psychologists and psychiatrists. Currently under ATAPS there is no provision for advanced, tailored services provided by clinical psychologists or psychiatrists.

There is also a significant shortage of psychiatrists in private practice, only a very limited number bulk bill, and there can be significant co-payments. Many psychiatrists are primarily focused on prescribing and monitoring medication and a number work in collaboration with clinical psychologists who provide the psychological interventions. Greater utilisation of the expertise of clinical psychologists in mental health will produce cost benefits for patients and savings for Government, while meeting a need left unmet by the shortage of psychiatrists in the workforce. Finally, the public health system only takes the most severe and persistent presentations, usually psychotic disorders. The group of patients disadvantaged by cutbacks in the number of sessions

available under the Better Access Initiative would not meet criteria for these services. This situation leaves patients with more chronic, moderate to severe or complex mental health problems unable to access services. Under the Better Access Initiative the public system has made good use of private providers to refer patients for ongoing treatment after acute issues have been addressed. The changes to the Better Access Initiative will reduce the availability of this important referral pathway from the public to the private system.

Recommendation:

- Those patients who require more sessions than the number (ten) available under the changes to the Better Access Initiative need to be referred to clinical psychologists working in the private health system, with access to psychiatrists and the public health system where required. These patients require expert assessment to determine the best available service for their level of difficulty or for longer term treatment. This is cost-effective and makes best use of the expertise of clinical psychologists.

(iii) The impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GP

In order to reduce the cost burden of mental health services, demands on GPs, duplication of services, and to increase access to advanced treatments for those who require them, the expertise of clinical psychologists needs to be better utilised. Given their expertise in assessment of mental health problems, clinical psychologists are in a position to develop their own Mental Health Treatment Plans for patients.

Qualified clinical psychologists have extensive knowledge of mental health and advanced training in the assessment, diagnosis, formulation, treatment, and evaluation of treatment outcomes of mental health disorders, akin only to that of psychiatrists. Clinical psychologists develop, refine and evaluate psychological treatments. Furthermore, clinical psychologists, along with psychiatrists, have developed and revised all commonly utilized diagnostic taxonomies, such as the Diagnostic and Statistical Manual of Mental Disease IV (DSM IV), the International Classification of Diseases 10 (ICD 10), and the Psychoanalytic Diagnostic Manual (PDM).

As a result, clinical psychologists are arguably more suited to providing diagnoses and Mental Health Treatment Plans for patients than the General Practitioner (GP). Many clinical psychologists provide training to GPs, or have devised programs for their training in mental health assessment, diagnosis, and treatment. The current system of having a GP complete a Mental Health Treatment Plan for a clinical psychologist leads to unnecessary duplication of services, as clinical psychologists would be irresponsible to rely on a plan devised by a generalist provider, such as a GP. As mental health specialists, clinical psychologists currently conduct their own assessment, make a diagnosis, and devise an appropriate treatment plan. ACPA members report that while GPs can adequately identify anxiety and depression, they frequently do not identify co-morbid disorders and personality disorders, or the presence of less frequently occurring severe mental disorders with psychotic features, which complicate treatment and demand more advanced and individualised approaches.

We believe, however, that it is important for GPs to continue to provide Mental Health Treatment Plans for those patients seen by psychologists and other health professionals who do not have the requisite accredited post-graduate training in clinical psychology.

Recommendations:

- GPs need to be encouraged to refer patients with mental health problems to qualified clinical psychologists without the requirement of a GP Mental Health Treatment Plan, as is the case with GP referrals to psychiatrists, in recognition of the advanced expertise and training of clinical psychologists in mental health.
- Engaging clinical psychologists to provide services at higher levels under all programs will provide added value to mental health services and make best use of the expertise of this highly trained group.

(iv)The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule

The decision-making process

It is unclear on what basis the decision was made to reduce the number of psychology treatment sessions a person with a mental health disorder can receive each year under the Medicare Benefits Schedule from a maximum of 18 to 10. No evidence base supporting the reduction in number of sessions was provided. The Mental Health Expert Working group did not appear to be instrumental in guiding this decision as the organisations represented by some members of the group (e.g. the AMA and APS) have spoken out strongly against this decision.

If these decisions were made on the basis of the Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) report, that basis is seriously flawed. The survey does not meet the most basic and fundamental standards of research design and implementation for treatment outcome studies. It failed on a number of counts as it did not: (1) take a prospective approach, which is standard in outcome research;(2) utilise an adequate sample size to ensure proper representation of service providers; (3) identify the nature, diagnosis and complexity of the patients seen by psychologists with differing levels of training; (4) identify the nature or type of psychological intervention that was, in fact, provided; (5) control for adherence to treatment guidelines by providers or patient compliance; (6) examine the role played by medication in outcome; (7) have a valid criteria measures related to a broad range of diagnoses with inbuilt algorithms to account for severity and complexity of presentation; (8) determine drop-out rates and the reasons for these; (9) undertake follow-up evaluations; (10) determine relapse rates by treatment type and by psychologist training; and, (11) it was not subjected to peer review. Furthermore, the evaluation used a self-selected sample of psychologists who then selected their own patients for the study, and who administered the research questions personally in treatment sessions. The risk of multiple and significant bias thus introduced to the results is unacceptably high.

As this survey breached multiple research design guidelines for treatment outcome studies, it has limited validity or reliability and cannot be utilised for decision-making. No recommendation was

made by the authors to reduce the number of sessions patients received or change policy to enable only mild-moderate mental health problems to be treated under the Better Access Initiative. The manner in which the inadequate data may have been interpreted in order to arrive at recent policy decisions is unclear.

A well-designed prospective study, grounded in the research base for outcome evaluations, and based on sound methodology is required. Such a study needs to generate specific hypotheses and select the appropriate methods and measures to test particular suppositions.

The impact of these decisions

The Government has argued that the changes to the Better Access Initiative will not affect large numbers of patients, as only approximately 13% of Better Access patients receive more than 10 sessions. This, however, equates to around 86,000 patients per annum (Lyndel Littlefield, LifeMatters, Radio National, 21/06/2011).

People with diagnosed major depression and anxiety disorders make up the bulk of presentations to GPs and psychologists. Evidence-based practice of Cognitive Behavioural Therapy requires 10 to 20 sessions to treat a single disorder in the absence of co-morbidity. The National Institute of Mental Health in the USA (<http://www.nimh.nih.gov/health/publications/depression/how-is-depression-detected-and-treated.shtml>) reports that 10 – 20 sessions represent a 'short-term' requirement for treatment for depression. Taking examples of specific anxiety disorders, panic disorder and agoraphobia require 19 group sessions (Andrews et al, 1994); post traumatic stress disorder requires 10 – 20 sessions (Australian Centre for Posttraumatic Mental Health, 2007); social phobia requires 10 -20 sessions; while Obsessive Compulsive Disorder requires intensive treatment over several weeks, followed by 12 months of follow up (Andrews et al, 1994).

The most recent reported re-referral figure of 43% of patients under the Better Access Initiative, (September, 2009, Council of Australian Governments National Action Plan for Mental Health 2006-2011, Second Progress Report, covering implementation to 2007-08) highlights the potential short-term benefit and limited cost-effectiveness of short term treatments. While the reasons for this high rate of re-referral has not been examined, it is likely many of these patients require additional sessions due to the nature of their mental health problems, but have reached their session limits under the Better Access Initiative, or they have relapsed due to the limited treatment provided. Many patients require longer term evidence-based treatment tailored to individual needs. There are simply not sufficient psychiatrists who conduct psychotherapy to meet this need; qualified clinical psychologists are suitably trained to do so.

Recommendations:

- Enable all patients with mental health problems, regardless of severity, complexity, and chronicity, to access their choice of practitioner under the least restrictive circumstances offered by the Better Access Initiative.
- Determine the optimal number of sessions required for effective treatment for all levels of chronicity, complexity and severity.

- Determine the level of expertise required to effectively treat patients at all levels of severity, chronicity and complexity.
- Allocate patients by level of chronicity, complexity and severity to the appropriate number of sessions and level of expertise of service provider in all programs.

3. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program

The services provided to people with mental illness under the ATAPS program are limited, despite the more generous provision of session numbers compared to those available under the Better Access Initiative, as ATAPS funding is restricted to the provision of Focused Psychological Strategies (FPS) (2010-2011 Operational Guidelines for the Access to Allied Psychological Services Component of Better Outcomes in Mental Health Care Program, p. 5). These are delivered largely by those psychologists and other allied health professionals with little or no accredited qualifications and training in mental health.

FPS may have some limited effectiveness with select milder presentations, but are strictly limited in what they can achieve with more chronic, moderate and severe or complex cases, particularly when delivered by practitioners who do not have extensive training in the theoretical underpinnings, research evidence, implementation and evaluation of these methodologies. Given the additional cost of employment of clinical psychologists, many Divisions have chosen to employ less qualified practitioners at a lesser cost. There appear to be no safeguards for ensuring the practitioner is adequately qualified or experienced to provide services at the more severe end of the spectrum under the ATAPS program. Thus, to have patients with more moderate and severe presentations treated under ATAPS can result in more vulnerable people being treated by a workforce that does not have specialist qualifications and training, utilising short-term strategies with limited effectiveness for those requiring more advanced treatments. Clinical presentations are best managed with an adequate number of sessions provided by practitioners who have expertise in assessment, diagnosis, and treatment of mental disorders, such as clinical psychologists and psychiatrists. Such services are not properly provided for under ATAPS.

At present clinical psychologists are not strongly attracted to the ATAPS program, due to its restrictions of practice, both clinically and administratively. This reduces the availability of greater expertise to the populations being served under this program. Furthermore, the experience of clinical psychologists within the program has been highly variable and seemingly dependent on the role the clinical psychologist plays within the Division of General Practice in the provision of services. Those clinical psychologists whose expertise is recognised and who are enabled to work with greater independence express greater satisfaction with the program than those who are managed more closely by the GP.

Major barriers to the optimal functioning of the clinical psychology workforce within mental health include: the management of psychological services by non-psychologists, limited opportunities to develop and implement psychological interventions and the 'misuse' of complex psychological interventions, and the lack of recognition of the specialised skills of clinical psychologists compared

to those of other mental health providers (Blaszczynski and Renner, 2004). The current operation of the ATAPS program does not facilitate optimal functioning of the clinical psychology workforce.

Recommendation:

- Re-develop the ATAPS program to provide more intense, advanced, tailored treatment where required by clinical psychologists and psychiatrists working with GPs.

4. Services available for people with severe mental illness and the coordination of those services

A comprehensive, integrated system of service provision in mental health that provides least restrictive services to those with all levels of severity of presentation of mental health problems is essential. Without this, individuals with severe mental health problems can readily lose access to services as they do not meet the differing criteria for the range of programs on offer, or programs are not tailored to their needs. If these individuals are not suffering psychosis but, for example, another Axis I disorder or personality disorder, and require high levels of care on an ongoing basis, they are not managed by the public health system. They cannot always access private psychiatrists due to the shortage of psychiatrists, particularly those undertaking psychotherapy, and there can be significant co-payments; services under ATAPS are too restrictive for their needs, and the Better Access Initiative as currently constituted does not cater for their requirements.

Substance abuse, early trauma, eating disorders, chronic and/or severe depression or anxiety, bipolar disorder, personality disorders, or co-morbidities require longer-term treatment and support. While Community Mental Health Services do manage many of these individuals, many more move from service to service seeking longer-term treatment to alleviate their suffering. Many of these patients now present to university training clinics where post-graduate trainees are just commencing their practical training, as opposed to seeking more experienced practitioners. This is because university training clinics can often provide longer term treatment at low cost. However, such patients are not necessarily suitable as training cases at this early point in training.

Mental Health Teams respond well when crises occur and can assist in co-managing, with private clinical psychologists and psychiatrists, those people most at risk as needed. However, there are very few programs available to provide the necessary advanced and longer-term treatments for patients with more complex presentations in a mix of the public and private systems. This mix would be, for many with mental illness, the least stigmatising and most cost effective management strategy.

5. Mental health workforce issues:

(i) The two-tiered Medicare rebate system for psychologists

The two-tiered Medicare rebate system recognises the value of accredited post-graduate training in the speciality of clinical psychology for the provision of high quality services to those members of the public suffering from mental health problems. Qualified clinical psychologists are trained to be

experts in the prevention, assessment, diagnosis, formulation, treatment, and evaluation of treatment outcomes for a wide range of mental health problems, at all levels of severity, across the lifespan. Only qualified clinical psychologists and psychiatrists have these levels of advanced training in mental health. State and federal legally based awards differentiate between clinical and other psychologists. They not only lay out different pay scales, but also the differences in skill sets and the nature of work undertaken by the two groups. Industrial relations tribunals recognise this distinction. The Psychology Board of Australia affirmed this distinction establishing a post-graduate Masters or Doctoral degree plus a formal period of supervised practice to bring the post-graduate training of specialist psychologists, including clinical psychologists, to four years, as the standard for endorsement.

ACPA is deeply concerned about the lack of regard for accredited post-graduate clinical training within the profession by those who have not undertaken such training, and those who represent them. We are concerned that any attempt to reduce the distinction between those with accredited post-graduate training in clinical psychology and those without this training will act to remove incentives for such training, further undermine standards, and lead to an exodus from the profession of the best trained clinical psychologists. Importantly, such a result would subject the public to a lack of trained and qualified clinical psychologists in the future, thereby increasing risk to the public. The mentally ill are amongst our most vulnerable members of society and require a high level of expertise in their management.

Skill levels of different psychologists within the workforce:

The Management Advisory Service to the National Health Scheme (1989) differentiated the health care professions according to skill levels. Skills in this sense referred to knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills as follows:

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

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 (p. 6).

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. They went on to argue that clinical psychologists are the only professionals who operated at all three levels and, "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists from other disciplines" (p. 6).

This is consistent with other reviews which suggest that what is unique about clinical psychologists is their ability to use theories and concepts from the discipline of psychology creatively to solve complex problems in clinical settings.

Clinical psychologists in the workforce:

The responsibilities of Clinical Psychologists have increased very considerably since the mid to late 1980's. Clinical psychology has, during this time, become more fully established as a profession which provides highly specialised and autonomous mental health services to individuals across all developmental stages. The profession provides specialist diagnostic and complete psychobiosocial assessments, treatment services in areas as complex and diverse as psychotic illness, severe personality disorders, co-morbid disorders (e.g. depression within borderline personality disorder), psychological and behavioural components of serious medical conditions, and problems specific to different age groups, including recent significant developments within the areas of children and family, youth mental health, the elderly, mental health disorders within medical conditions, quality assurance and research and evaluation (Western Australia Clinical Psychology Health Sector, Work Value Document, 1998, p.317).

Clinical Psychology has also taken an increasing responsibility in the treatment of less prevalent mental disorders within the psychotic spectrum, bipolar disorder and the more intractable personality disorders. The roles and responsibilities of Clinical Psychologists have increased through the development of psychological therapies which address components of these disorders, and in specific psychological interventions targeting other mental disorders which are very often co-morbid with psychotic conditions, such as depression, anxiety and substance use disorders. Along with providing treatments to these patients, Clinical Psychologists have been increasingly called on by Psychiatrists, to provide additional diagnostic information, to assist with differential diagnoses of complex cases (Ibid. p.18).

Another area of increased responsibility within Clinical Psychology is in the role of teaching and informing other professions of evidence-based development in treatment for mental health disorders. Clinical Psychologists have a growing role in providing education and training to professionals including Medical Officers, Psychiatric Registrars, Mental Health Nurses and Social Workers. Areas in which Clinical Psychologists frequently contribute in this way include responding to suicidal and chronically self-harming individuals, and psychological treatment of depression, anxiety, social phobia, obsessive-compulsive disorder, eating disorders and substance use disorders. With the recent application of psychological therapies to disorders in the psychotic spectrum as well as the treatment of other mental health problems co-morbid with these disorders Clinical Psychologists are called upon to provide workshops and seminars in these areas

(1998, Work Value Document, Western Australia Clinical Psychology Health Sector, p.19).

Recommendation:

- We strongly recommend the retention of the two-tiered Medicare rebate system in order to recognise post-graduate training in mental health undertaken by qualified clinical psychologists.

(ii) Workforce qualifications and training of psychologists

Psychologists:

Australia has the lowest levels of training in its psychology workforce in the Western world. Around eighty five percent of psychologists currently working in Australia do not meet the standards required to practice as a psychologist in other first world English-speaking countries, such as the United Kingdom, the United States of America, or Canada, where Doctoral level training is required; or in New Zealand where a Masters degree is required for entry to the profession. The European Federation of Psychologists Associations (EFPA) currently has a minimum standard (Europsy) of a 5 + 1 level of training, most generally undertaken as a three year Bachelor degree, plus a two year Masters degree, plus one year of supervised practice. It is our understanding that EFPA is moving towards a standard requiring Doctoral level entry to the profession (Personal Communication, Professor Ingrid Lundt, EFPA, July 2, 2010).

In Australia, a four year undergraduate degree majoring in the science of psychology, with little or no clinical application of this science to clinical practice, plus a two year unaccredited supervision program (known as the 4 + 2 pathway) is required for registration as a psychologist. Pachana and Helmes (2006) state, "No other major jurisdiction of which we have knowledge permits the independent practice of psychology with only knowledge of the scientific core of psychology without structured coursework in applied or clinical practice" (p. 105).

In its submission to the Psychology Board of Australia's Consultation Paper on a National Psychology Examination, the Australian Psychology Accreditation Council (APAC), the accreditation body for psychology programs, states that the practical training components of the 4 + 2 pathway, and the proposed 5 + 1 pathway, that includes an additional year at university, are "not currently subject to adequate quality assurance or accreditation processes" (2011, p. 3).

APAC points out:

The quality of the training provided relies on each individual supervisor's suitability, skills, diligence, and on the nature of the training opportunities and work environment(s) available to the trainee and supervisor, without involving any direct independent external scrutiny of the quality of supervision and other training undertaken. This arrangement leaves open the possibility that there is a high degree of variability in the quality of the supervision and training received, as well as in the level and breadth of competency candidates attain, despite the requirements and reporting measures set down by the PBA for this training.

An additional problem with any system which relies so heavily on a primary supervisor as both mentor and competency assessor is the conflict between these roles (May, 2011, APAC Submission to the Psychology Board of Australia, p. 3).

In October, 2009 the Psychology Board of Australia proposed the minimum standard for registration of psychologists be set at 6 years of university training, incorporating a four year Bachelor degree plus a two year Masters degree, which would equate to standards in New Zealand. It is a serious concern for ACPA that the Australian Health Ministers' Advisory Council (AHMAC) rejected this proposal, citing workforce shortages as the reason. This argument is highly questionable given that

Australia has the largest psychology workforce in the Western world (see 5. iii). Shortages only apply in clinical psychology. Furthermore, we note that workforce shortages in other health professions (e.g. Medicine) do not result in a complete lack of accredited professional clinical qualifications being required for practice. The same should apply for psychology, especially given its unique professional responsibilities and duty of care requirements of the most vulnerable people in our society.

While we support the Psychology Board of Australia's attempts to increase the oversight of the 4 + 2 pathway, by incorporating basic skills in this training and introducing a national examination for those completing this route to registration, we believe the unaccredited supervision program remains inadequate as a means of training for working with people who have mental health disorders. The recently proposed 5 + 1 training route to registration offers a higher level of training, with a 1-year diploma requiring accreditation by APAC, as opposed to the two year Masters training included in the European 5 + 1 model. Hence, this remains the lowest standard of professional entry training in the Western world.

We acknowledge that people with a 4 year undergraduate qualification in the science of psychology followed by two years of an unaccredited supervision program make a significant contribution to the workforce outside of mental health (for example, the Department of Education and Training, Centrelink, the Department of Ageing, Disabilities and Home Care, the Department of Defence etc.); however, this training needs to be re-structured to meet these specific workforce needs and the resultant workforce re-titled to properly reflect the lack of accredited specialist professional psychology qualifications.

Recommendations:

- The minimum requirement for registration as a psychologist needs to be raised to Masters level within six years.
- The "4 + 2" model of training needs to be re-structured to meet specific workforce needs and the resultant workforce re-titled to properly reflect the lack of accredited professional qualifications in psychology.

Recognition as a clinical or other specialist psychologist

Australia also has the lowest standard for the training of clinical psychologists and other speciality psychologists in the English speaking Western world: currently a Masters degree followed by two years of supervised practice is the minimum standard for endorsement. The UK, USA, and Canada all require a minimum standard of a Doctoral level training for clinical psychologists, while New Zealand requires a Masters degree plus a further one year Diploma in clinical psychology before an individual can practice as a clinical psychologist in mental health. In these countries other specialities in psychology also require the same level of training, although in the USA this applies only to clinical, counselling and school (educational) psychologists, with other specialities only requiring a Masters degree.

In October, 2010, the Psychology Board of Australia proposed to AHMAC that the standard for specialist registration under the National Registration and Accreditation Scheme be established at Doctoral level. This was rejected by the Ministers' Council, but endorsement of specialities was

agreed to on 31st March, 2010. The minimum standard for endorsement was established as a Masters (two years) or Doctoral (three years) accredited training in the speciality, followed by a period of supervised practice to bring the total number of years of post-graduate training to 4 years. This standard now applies going forward and has the support of the majority of the profession.

Clinical psychology

Standards for clinical psychology have, however, been seriously undermined in Australia by the “grandparenting” into endorsement of a large number of psychologists who do not meet the minimum standard set down by the PsyBA. This leaves referrers and the public unable to distinguish those clinical psychologists with accredited qualifications in clinical psychology, as opposed to those endorsed as clinical psychologists without these qualifications.

It is not normally the case that we provide comment publicly on other organisations representing psychologists. However, the current situation is exceptional in that the issues relate directly to standards of training for clinical psychologists, which is of vital importance for the community and subject to this Inquiry.

With the introduction of Medicare rebates for psychologists under the Better Access Initiative in November, 2006, the professional body for psychologists, the Australian Psychological Society (APS), was given the authority to determine the requirements for the higher clinical psychology rebate, for those meeting the entry requirements for the College of Clinical Psychologists. At this time entry requirements for the College reflected those that have subsequently been established by the PsyBA for endorsement of clinical psychologists and applications for membership were assessed by the College itself.

The APS withdrew the authority to assess applications for membership from the College and established the Medicare Assessment Team to review all applications. Using the “extraordinary route” of entry to the College that had been established to enable those who had made an exceptional contribution to the development of clinical psychology to become members, the APS admitted to the College those with post-graduate training in specialities other than clinical psychology and those without accredited post-graduate training. More than 90% of the membership of the APS as a whole is made up of psychologists without accredited training and qualifications in clinical psychology.

Some individuals were admitted directly to the College on the basis of Continuing Professional Development (CPD) they had already undertaken; some were required to undertake “Individual Bridging Plans” consisting of a small number of unaccredited courses and/or written case studies; some were required to undertake a small number of accredited courses; and some were rejected. A number of those required to undertake a small number of accredited courses applied for and were admitted to post-graduate programs in clinical psychology, but withdrew from these programs after completing the APS required courses, despite the universities not being willing to grant them degrees in clinical psychology based on their level of training.

The exact number admitted to clinical psychology practice via the “extraordinary route” of membership of the College of Clinical Psychologists is not known. Estimates vary from 1,200 to more than 2,000. It is known that over 300 were admitted via this route in 2006-2007 alone

(http://www.psychology.org.au/Assets/Files/newsletterACT_Nov07.pdf downloaded, 25th July, 2011), with a culmination of 1,000 applicants waiting for assessment on 30th June 2010. This is a large proportion of the current total of 4,375 clinical psychologists. It was this practice that led directly to the formation of ACPA to represent those clinical psychologists with post-graduate qualifications in the speciality.

Specialist title

In October, 2009 the Psychology Board of Australia proposed to the Health Ministers' Advisory Council (AHMAC) that specialist title be granted to the psychology specialisations to enable referrers and the public to differentiate those psychologists with accredited specialised training at post-graduate level in recognised specialist areas. This was rejected by the Ministers in March, 2010, in favour of specialist endorsements. Endorsement is not understood by the public and has enabled those without post-graduate qualifications in the specialities to be "grandparented" into the specialities. Specialist title is a well-established concept that is readily understood due to its widespread usage in medicine and dentistry.

In Western Australia formal recognition of specialist training in clinical psychology operated for approximately 30 years prior to the introduction of the National Health Practitioners Registration Scheme. This was a scheme of specialist registration that was clear and distinct in the requirements for specialist practice. These requirements were largely identical to those established for endorsement by the Psychology Board of Australia. Only those clinical psychologists who successfully completed accredited post-graduate programs in clinical psychology followed by a supervision program could practice as clinical psychologists. The public and other health professionals were clear that those who operated under specialist title met this standard. However, with the entry of Western Australia into the National Registration and Accreditation Scheme in October 2010, these standards were substantially undermined, as psychologists granted 'clinical' status via entry to the College of Clinical Psychologists of the APS were endorsed as clinical psychologists under the new scheme.

Western Australian specialist psychologists were permitted a notation on the national register, such that if they had previously been granted specialist title, they could continue to use these titles until 2013. They were promised a review of the status of specialist title within that timeframe. It is now 18 months out from those titles being revoked and no review has commenced. Specialist title needs to be granted for all specialist psychologists nationally in order to enable the identification of those who hold post-graduate specialist qualifications and training.

Training of Clinical Psychologists:

Given that the international standard for training in clinical psychology is at Doctoral level, and we need a well-qualified clinical psychology workforce, Centrelink living allowances for students undertaking training at the Doctoral level needs to be made available. Currently, only those students undertaking Masters level training are permitted access to Centrelink living allowance payments, providing a significant disincentive to training to the international standard. If at a minimum students were permitted the same two years of Centrelink living allowance payments as those undertaking Masters degrees in clinical psychology, this would be a positive step forward.

Clinical psychology and other psychology specialities

Some other specialities claim that they have sufficient training to undertake work with the mentally ill; however, training in no other psychology speciality program meets accreditation standards established for clinical psychology by the Australian Accreditation Council (APAC), the accrediting body for psychology programs. Post-graduate clinical psychology programs are the only psychology programs that provide training exclusively in mental health for their duration.

Some specialities claim that all endorsed specialities are equal and should be enabled to work at a more advanced level in the mental health area; however, other than clinical psychology, most specialities have very little mental health training, and some, such as sports psychology, have virtually none. Claims of equality have only emerged since the two-tier Medicare payments came into effect.

Claims to 'clinical' status of some psychologists without accredited clinical training

It is in the public interest to know that some psychologists without accredited clinical training are objecting to the regulation of the speciality under the National Health Practitioner Registration Scheme. These psychologists have previously declared themselves to be 'clinical' psychologists without any accredited training as clinical psychologists. With the introduction of national registration and endorsement for clinical psychologists based on an accredited post-graduate Masters or Doctoral degree in clinical psychology, plus a formal supervision program, these psychologists have no longer been able to hold themselves out as clinical psychologists.

We understand that there has been lobbying by some psychologists to persuade Government to lower standards for Medicare service provision in order to enable access to the privileges inherent in the speciality of clinical psychology to those without the requisite training. Given the current minimum standards for training in clinical psychology in Australia, and the responsibilities and demands on clinical psychologists in applying their expertise with this vulnerable population, it is in the best interests of public protection to not reduce standards further by allowing psychologists without accredited training in clinical psychology entry to the speciality of clinical psychology.

Recommendations:

- Specialist title needs to be granted only to those who meet the post-graduate training requirements established by the PsyBA to enable the public to clearly differentiate those with accredited post-graduate specialist training, particularly in clinical psychology.
- The standard qualifications for endorsement or specialist registration of clinical psychologists should be raised to Doctoral level within the next 5 years.
- The same level of Centrelink funding needs to be provided to post-graduate students undertaking Doctorates in clinical psychology as those undertaking Masters degrees in the speciality.
- In the interests of maintaining training standards, professional status decisions need to reside with the legally recognised national registration body, PsyBA.

(iii) Workforce shortages

Australia has the largest psychology workforce in the English speaking Western world, but there is a distinct shortage of qualified clinical psychologists that meet the Psychology Board of Australia's minimum standards for endorsement in the speciality.

There is no accepted international benchmark for the per capita requirement of psychologists to adequately supply services to a population; however, the Nordic countries aspire to 1: 1,000 (Personal communication, Dr Judy Hall, EO of the National Register of Health Service Providers in Psychology, July 2, 2010). Actual numbers appear below.

Psychologists

As of May 2011, Australia had **28,945** registered psychologists, equating to **1: 782 per capita** (based on an Australian population of 22,639,628). These figures contrast with **1: 1,193** per capita in New Zealand; **1: 2011** per capita in Canada in 2006; **1: 3,351** per capita in the United Kingdom and **1: 3,580** per capita in the United States (see Appendix B).

The Tolkien II Report (2010) states that two months after Medicare opened to psychologists in 2006:

- 1,000 clinical psychologists and 6,000 psychologists had registered under the Better Access Initiative
- A conservative estimate of the supply of services based on 0.4 FTE/psychologist = 4.5 million services/year.

Their conclusion was that this was a sufficient workforce to meet demand.

Based on an estimated workforce from psychologist registration board data for 2004-05 with 22,175 psychologist registrations in Australia (excluding the Australian Capital Territory and the Northern Territory), and APS estimates of 24,986 in 2006, it was concluded:

- There is no shortage of psychologists in the workforce
- The numbers in the profession are increasing
- Further monitoring and analysis on the psychology labour force is warranted
- There is no evidence of a shortage of specialists.

The Mental Health Workforce: Supply of psychologists (February, 2008).

It may be that in employing large numbers of psychologists without accredited clinical training, the Better Access Initiative has exacerbated the need in the community for psychology services.

Clinical Psychologists

Australia has **4,375** endorsed clinical psychologists, equating to **1:5,174** per capita (see Appendix C). This contrasts with **1: 3,088** in New Zealand and **1: 6,873** in the United Kingdom (see Appendix B). The numbers of clinical psychologists for Canada or the United States are not available.

However, the above number of endorsed clinical psychologists in Australia is misleading, as a large number do not meet the minimum standard set by the PsyBA as they were “grandparented” into endorsement at the introduction of national registration and do not have accredited qualifications in clinical psychology.

The training of clinical psychologists at post-graduate level is, by necessity, extremely intensive and requires small class sizes to cater to needs, particularly in the development and assessment of skills. Despite the Government wishing to increase training numbers in clinical psychology, funding for places in post-graduate programs is poor, and universities are forced to supplement costs from other programs, as they run at a distinct financial loss.

However, any effort to remove post-graduate clinical training from the university setting is highly likely to lead to reduced standards as classes in private organisations are enlarged to make programs profitable, as has occurred in the United States. This will also lead to a two-tier post-graduate training scheme of differing quality and standard.

Recommendations:

- We recommend that funding for post-graduate university places in clinical psychology be reviewed as a matter of urgency, and appropriate levels of funding be made available.

6. The adequacy of mental health funding and services for disadvantaged groups:

(i) Culturally and linguistically diverse communities

Culturally and linguistically diverse communities are severely disadvantaged when seeking treatment for mental health issues. Their access to the variety of services, particularly in the private system, is seriously curtailed by the lack of available on-site interpreters. Patients are required to take relatives or friends to service providers to provide communication. This is not acceptable as friends and adult relatives are made privy to private information, and children can be traumatised and family dynamics distorted when children are asked to fulfil these roles.

Good service provision also requires an understanding of how mental health problems are viewed within different cultures and how these views impact treatment and outcomes when not managed in a culturally sensitive manner. Guidelines for managing cultural issues in relation to mental health problems need to be developed for a range of cultures present in Australia.

Recommendations:

- Greater access to on site interpreters in the private mental health system needs to be made available to those from culturally and linguistically diverse populations.
- Guidelines for managing cultural issues in relation to mental health problems need to be developed for a range of cultures present in Australia.

- Greater training and education opportunities need to be offered for psychologists from non-English speaking backgrounds and diverse cultures to service the needs of the culturally and linguistically diverse.

(ii) Indigenous communities

Indigenous people do not proactively access mental health services for many reasons. As a result, they are over-represented in terms of psychiatric admissions in the public health system, as Indigenous people are generally seen when in crisis or after a long period of psychiatric symptomatology (Vicary, 2002). Many Non-Indigenous service providers are reticent about working with Indigenous people (Westerman, 2002). This may originate from a variety of factors including limited contact with Indigenous people, concerns about causing offense, and limited knowledge about ways of effectively working with Indigenous people (Wingard & Lester, 2001). It has been suggested that Australian training in psychology does not equip psychologists to work in a culturally appropriate manner with Indigenous people (Ford, 2003). Present practices may have led to psychologists having an increased awareness of the role of culture, but there is little understanding of how to transform this awareness into a workable, effective and sustainable therapeutic relationship.

Recently there has been recognition of the need for Indigenous people to determine their own mental health care provision (National Aboriginal and Torres Strait Islander Health Council, 2004).

Culturally appropriate services for Indigenous people are virtually non-existent (National Aboriginal Health Strategy, 1989) and there is a lack of empirically grounded conceptual frameworks that have proven their efficacy with Indigenous people with specific mental health issues (Westerman, 2004). Indigenous communities' deep distrust of state mental health services, exacerbated by police involvement in involuntary hospitalisations, contributes to a situation where those with severe disorders are coming into contact with services in a traumatic way, whilst those in need of early intervention are not accessing services at all (Lette, Wright & Collard, 2000).

There has been some indication that Narrative Therapy "works in different parts of Australia as more appropriate to Aboriginal culture than the more conventional Western mental health approaches" (Aboriginal Health Council newsletter, 1995). Narrative Therapy has been suggested as a culturally sensitive approach to substance abuse problems in Indigenous communities (Bacon, 2007). While this approach shows promise, there has been no systematic study of the efficacy and sensitivity of this approach within Indigenous communities.

Recommendations:

- Review the success to date of the indigenous postgraduate scholarship program in clinical psychology and implement any required adjustment or expansion.
- Fund research into the efficacy and suitability of Narrative Therapy approaches to mental health problems amongst Indigenous people.

(iii) People with disabilities

People with injuries sustained in motor vehicle accidents (MVAs) are well supported by the Lifetime Care Authority; however, there is little available for those not injured in this way who may sustain equally significant injuries. We understand the insurance and legal systems dominate in this area, but we recommend equal treatment of those who have been injured through any means.

Recommendation:

- Greater access to support needs to be offered to all those suffering from injuries, regardless of how they are sustained.

7. The delivery of a national mental health commission

A national mental health commission is essential to provide transparency, consultation and sound decision-making that can be supported by research evidence. Such a commission is essential to enable the integration of services, programs and service providers to ensure people with mental health problems are enabled to access appropriate levels of service and can move when necessary between the public and private systems. This body requires representation of major stakeholders, including qualified clinical psychologists, at all levels. It is important to note that the APS primarily represents psychologists without accredited post-graduate training in clinical psychology, while ACPA is the national body representing qualified clinical psychologists.

Decisions regarding policy and funding of mental health programs need to be based on a comprehensive, integrated, well articulated model of service provision, with support from the evidence base, and treatments based on best practice that ensures the expertise of the workforce is properly utilised.

In the attempt to delineate ‘mild’, ‘moderate’ and ‘severe’ mental illness in the allocation of mental health services, it appears that the Government is endeavouring to implement a poorly considered stepped care model that allows only those with ‘mild-moderate’ mental health problems to be treated by their choice of practitioner, in least restrictive and intrusive circumstances, while those with more severe problems, requiring longer-term or more advanced treatments are not adequately provided for.

Stepped Care models

Stepped care models have the potential to deliver effective and cost efficient treatments (in terms of both money and human resources) to large numbers of people (Blaszczynski and Renner, 2004).

Better access to psychological therapies is associated with redesigning primary care mental health services to follow a stepped care model whereby patients assess least intrusive interventions, in a timely fashion but are stepped up to more intensive interventions or down depending on progress and need.

The National Institute for Mental Health in England, 2007, p. 2.

Such a model assumes those requiring services are enabled to move between services and to remain in programs on the basis of need and the level of care required, regardless of the severity of their presenting problems. The least intrusive services within current structures are currently within the private sector under the Better Access Initiative. Where the private sector is incapable of managing a patient and a team-based approach is required, patients need access to a properly designed ATAPS program that utilises psychiatrists and clinical psychologists with accredited training working closely with GPs to enhance their management at a more intense level. Where this system is inadequate, they need access to the public system. Patients also need to be able to move to less intrusive levels of treatment where possible. In such a model, clinical psychologists and psychiatrists would work at all levels, with all populations, in an attempt to bring least intrusive services for all patients with mental health problems.

No such program of integrated services exists and decisions about policy and funding are seemingly being made on special interest and economic grounds. None of the current programs adequately utilise the expertise of clinical psychologists in mental health.

Recommendation:

- A fully articulated, evidence-based model for mental health service delivery that is based on patient needs, matched to expertise in the workforce, and aims to provide least restrictive services to all with mental health problems needs to be developed to guide Government decision-making policy and funding arrangements for mental health.

8. The impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups

Many Australians, particularly those living in rural and remote conditions, experience difficulty accessing evidence-based mental health services. Online or remotely-delivered services have considerable potential for improving access to effective and safe treatments.

Australia is a world leader in the development and delivery of internet-delivered treatment protocols for people with mental disorders. Recent meta-analyses confirm the efficacy of such protocols in the treatment of several anxiety disorders and depression (Andrews et al., 2010; Andersson & Cuijpers, 2009; Cuijpers et al., 2009). Moreover, an increasing body of research indicates that internet treatments produce similar outcomes as face-to-face treatments.

Emerging evidence indicates that online services are attractive for many consumers, including those unable to receive mental health because of lack of local providers, and those unable to attend treatment during regular clinic hours. Online services may also appeal to those who avoid traditional services for reasons relating to stigma and lack of knowledge. Indeed, the efficiency with which such services can be delivered provides further compelling arguments for the broad provision of such services. This is reflected in the increasing number of service providers offering online treatment.

However, several urgent and pragmatic issues need to be addressed before online services are promoted, including the following knowledge gaps:

- There is limited systematic evidence to indicate that online services are clinically effective, acceptable, or safe for consumers in rural and remote locations.
- There is little evidence that online services are clinically effective, acceptable, or safe for hard to reach groups.
- Many rural and remote locations have poor internet access. While the NBN represents an important initiative, there is uncertainty as to whether it will be broadly available, affordable, effective, and reliable. Telephone-delivered services have considerable evidence of effectiveness and in many locations they may be more reliable than online services.
- There is little or no published evidence from systematic clinical trials about the effectiveness of online treatment protocols when rolled out in clinical services.
- The existing data indicates such roll outs are associated with very low completion rates or limited clinical benefits. Little is known about the effects on consumers of beginning but then failing to complete such treatment protocols. Thus, little is known about whether failing to complete such protocols is outcome neutral, or whether it has negative consequences, such as increasing symptoms, reducing self-esteem, or reducing subsequent help-seeking behaviour.
- Little is known about the minimum training and supervision required for providing such protocols.
- The proposed or ideal relationship between online services and traditional mental health services has not been empirically determined. Consumers should have access to seamless services, indicating the importance of clear pathways for stepping patients up from online to face-to-face services as required.
- There are no recognised standards for the safe delivery of such services, particularly with respect to management and secure storage of data.
- In many rural and remote areas educational standards are often low, with high levels of illiteracy. This limits the application of online programs.

Without clear evidence demonstrating that online protocols work in everyday clinical practice, and clear evidence for the minimum levels of training and support required to safely and effectively deliver online services, the possible benefits of such services should not be overstated. Moreover, attention must be paid to how such services integrate seamlessly, with existing services. Indeed, the promotion of such services is premature and likely to be dangerous.

In many rural and remote areas there are high levels of unemployment. In some areas this can be as high as one in four adults being dependent on the Government, and three generations of unemployment are common. Public transport is very poor and voluntary transport services are over-stretched and cannot meet the demand for services. In this context, funding for mental health is completely inadequate.

Psychiatrists are not available in many of these areas and GPs and psychologists provide the bulk of services. Most psychologists in these regions are not clinically trained; they are young and

inexperienced, and do not receive adequate supervision. In essence, GPs are the central, long-term, mental health care providers, and work cooperatively with psychologists through the Better Access Initiative to manage extremely complex cases, typically with high levels of co-morbidity with chronic physical health problems, against a background of significant social disadvantage.

Financial barriers exclude people from adequate services. Unless the health practitioner bulk bills, many people are excluded from fee for service as they cannot afford the co-payments. Many psychologists in these areas do not bulk bill and expect "up front" co-payments which would take up a significant proportion of the person's pension.

Public mental health services are not adequately staffed. These are often nurse based services as there is a severe shortage of psychiatrists; yet there is also a shortage of mental health nurses. Typically, mental health nurses provide an "outreach" service to towns and so are not readily available to patients between these times. Months often pass between contacts with patients who are accepted by the public mental health service and community services. GPs and private psychologists deliver services between these contacts. Mental health nurses often work in isolation with little support. There are only a very few psychiatric beds.

Although not always available without problems in remote and rural areas, use of developing technologies, such as Skype, Healthlink, and Telepsychology, also need to be considered for direct service delivery and also for the supervision and training of psychology service providers and GPs. Outreach services need to be provided by psychiatrists and clinical psychologists via Healthlink and other technologies. This would radically enhance service delivery to those requiring it in these areas.

Special incentives need to be provided to mental health nurses, GPs, clinical psychologists, and psychiatrists to work in rural and remote areas in terms of higher rebates tied to area, and provision of postgraduate scholarships for clinical psychology tied to a period of work in underserved areas is indicated.

The Clinical Placement Scholarship is one of the suite of scholarships under the Nursing and Allied Health Scholarship Support Initiative (NAHSSS). The scholarship is a qualifying scholarship, that is, the applicant must not already hold a qualification in the proposed discipline of study. Currently clinical psychology trainees are not eligible to apply for a Clinical Placement Scholarship. This is inequitable as these trainees are also studying to gain a qualification in specifically in clinical psychology.

Recommendations:

- Careful evaluations of online services should be conducted. These evaluations should consider:
 - The expected clinical benefits when protocols are administered in everyday practice
 - The negative effects of not completing the treatment protocols
 - The minimum type and amount of contact required to support consumers to safely and effectively complete the protocols, and the training and supervision requirements for staff who support consumers

- The data management and risk management requirements for service providers who wish to administer such protocols
- Discussion and evaluations should also occur to determine how such services can seamlessly integrate into existing models of care. Creating an independent model of service provision is unlikely to be in the best interests of consumers.
- In the meantime, Consumers should be properly informed about the limited evidence base for such services.
- Use of developing technologies, such as Skype, also need to be considered for direct service delivery to remote and rural areas, and also for the supervision and training of psychologists. Outreach services need to be provided by psychiatrists and clinical psychologists via technology.
- Special incentives need to be provided to mental health nurses, GPs, clinical psychologists, and psychiatrists to work in rural and remote areas in terms of higher rebates tied to area.
- Provision of particular postgraduate scholarships for clinical psychology tied to a period of work in underserved areas is indicated.
- Clinical psychology trainees should be eligible to apply for the Clinical Placement Scholarship.

9. Other related matters

Evidence-based child and adolescent therapy sessions with identified patient not present

Clinical psychologists have extensive training in the provision of evidence-based therapies for a broad range of patient groups and their carers, including infants, children and adolescents. Assessment and treatment of disorders of childhood and adolescence require sessions with parents alone to adequately assess the presenting problem, and to provide psycho-education and training in parent management. There are a range of circumstances where it is, in fact, inappropriate or potentially psychologically harmful for a child or adolescent to be present during these sessions.

Currently sessions with parents alone do not meet Medicare requirements when the identified child/adolescent patient is not present, creating significant obstacles to treatment. Of particular concern is the fact that limiting treatment to sessions where the child/adolescent identified patient is present can result in vital information regarding patient safety not being provided to the clinical psychologist, with potentially serious consequences.

Under the ATAPS program two sessions per annum are available for parents where the child/adolescent patient is not present. While this is insufficient in many cases where ongoing parent training can be the best intervention for the infant, child or adolescent, even this provision is not extended to the Better Access Initiative.

Together with other professionals in all health domains, ACPA believes that more emphasis on prevention and early intervention is required in the Australian context. Mental health statistics commonly show significant amounts of poor functioning in younger age groups. Intervention at the earliest point possible, including prenatally, is critical to ensuring reduction in the long term rates of mental health problems in adults. From a cost-effective perspective, it is also the area of greatest impact.

Recommendation:

- Parents need to be enabled to claim Medicare rebates for assessment, psychoeducation and training in parenting strategies under their child's referral and Mental Health Treatment Plan.

Submitted with ACPA Board approval and gratitude for this opportunity to provide information to the Community Affairs References Committee Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services by:

Dr Judy Hyde
President,
Australian Clinical Psychology Association

Appendix A

Survey of patients seen by ACPA members under the Better Access Initiative

In response to the Government's announcement of the rationalisation of allied health services in the Budget, ACPA has compiled current data relating to clinical severity, co-morbidity and treatment needs in patients seen by clinical psychologists under Better Access.

Members of ACPA in the private sector who have been seeing patients under the Better Access Initiative were asked to document a range of variables for all patients seen over a one week period. These variables included impairment (as rated on the Global Assessment of Functioning Scale), diagnoses met, duration of symptoms, and associated difficulties including medical illness, intellectual disability, social impairment or history of trauma. The clinical psychologists were also asked to indicate whether they believed that each patient would require more than 10 psychological therapy sessions.

Thirty-three clinical psychologists completed the survey data within a specified one-week period in June 2011, and completed data on a total of 503 patients. Table 1 lists the characteristics of patients based on the variables assessed.

Table 1

	Percentage of Mild-Moderate patients N = 210	Percentage of ALL patients N =5 03
Global Assessment of Functioning Scale		
Severe- Extremely severe impairment	N/A	30%
Moderate impairment	N/A	36%
Mild/Minimal impairment	N/A	31%
Mental health diagnoses		
1 or more <i>additional</i> diagnosis	37%	42%
1 comorbid diagnosis (i.e. 2 diagnoses in total)	30%	28%
3 or more diagnoses (i.e. 2 or more additional diagnoses)	8%	14%
Comorbid Axis II / Personality Disorder diagnosis or features	21%	30%
Duration of presenting symptoms		
2 – 5 years	16%	20%
5 years or more	25%	33%
History of trauma present		
Childhood emotional abuse	37%	43%
Childhood physical abuse	19%	22%
Childhood sexual abuse	9%	11%
Childhood neglect	22%	23%
Witness of domestic violence in family of origin	21%	25%
Significant traumatic event as an	31%	38%

	adult		
Co-morbid Problems*			
	At least one co-morbid problem	70%	73%
At least one co-morbid problem* and/ or co-morbid mental health diagnosis		80.5%	83.4%

*Co-morbid Problems include a co-occurring medical condition, intellectual disability, developmental disorder, domestic violence, child abuse history, child neglect and childhood domestic violence history, or trauma during adulthood.

Table 1 indicates that a significant proportion of the patients seen across the one week of reporting were significantly impaired by their mental health problem, and for many, this problem had affected them across many years. Furthermore, the majority of patients had more than one mental health diagnosis, with 30% of the sample presenting with comorbid personality disorder symptomatology. It is also of note that 73% of clients had at least one significant comorbid problem, such as a medical condition, intellectual disability, social impairments or trauma and or abuse histories. Table 1 also indicates significant experience of trauma; it is well recognised that trauma has a broad range of cognitive, behavioural, emotional, physiological and relational sequelae, such that these patients may require a significant level of ongoing psychological support and intensive trauma-based psychotherapy.

In the clinical opinion of the treating clinical psychologists 85% of the clients in the ACPA survey would require more than 10 psychological therapy sessions, of whom approximately half would require more than 18 sessions. Clinician recommendations for a higher number of sessions were associated with greater duration of primary diagnosis, greater severity at initial presentation and the presence of significant comorbid issues.

While this survey does not represent a methodologically rigorous study of the use of all clinical psychology services under Better Access, it does provide a useful indication of the characteristics of patients seen by a representative sample of members of ACPA. This snapshot of clients seen by clinical psychologists demonstrates the complexity of many patients seen by clinical psychologists in the private sector, and therefore the need for psychological intervention at least at the level currently provided for under the Better Access Initiative for clients referred to clinical psychologists in the private sector.

APPENDIX B: *The number of registered psychologists per capita in first world English speaking countries*

Country	Population	Source searched 02.07.2011	No of registered psychologists	Source searched 02.07.2011	Per capita
Australia	22,639,628	http://www.abs.gov.au/ausstats/abs@.nsf/94713ad445ff1425ca25682000192af2/1647509ef7e25faaca2568a900154b63?opendocument searched 02.07.2011	28,945	(Psychology Board of Australia, May 2011, Data Tables)	1: 782
New Zealand	4,407,519	http://www.stats.govt.nz/tools_and_services/tools/population_clock.aspx searched 02.07.2011	3,599	http://www.psychologistsboard.org.nz/search-the-register?letter=Z	1: 1,193
Canada (2006)	31,612,897	http://en.wikipedia.org/wiki/Canada_2006_Census	15,751	Canadian Institute for Health Information: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=hpdb_psych_e#	1: 2,007
United States of America	311,671,000	http://en.wikipedia.org/wiki/List_of_countries_by_population	93,000 (est)	http://www.apa.org/support/about/psych/numbers-us.aspx#answer	1: 3,351
United Kingdom	60,394,259	http://www.trueknowledge.com/q/what_is_the_population_of_great_britain_2011	16,869	The Health Professions Council: http://www.hpc-uk.org/publications/index.asp?id=449	1: 3,580

APPENDIX C: The number of registered *clinical* psychologists per capita in first world English speaking countries

Country	Population	Source searched 02.07.2011	No of registered clinical psychologists	Source searched 02.07.2011	Per capita
Australia	22,639,628	http://www.abs.gov.au/ausstats/abs@.nsf/94713ad445ff1425ca25682000192af2/1647509ef7e25faaca2568a900154b63?opendocument searched 02.07.2011	4,375	(Psychology Board of Australia, May 2011, Data Tables)	1: 5,174
New Zealand	4,407,519	http://www.stats.govt.nz/tools_and_services/tools/population_clock.aspx searched 02.07.2011	1,427	Ms Ann Culver, Deputy Registrar Psychology Board of NZ email communication 04.07.2011	1: 3,088
Canada (2006)	31,612,897	http://en.wikipedia.org/wiki/Canada_2006_Census	Not available		
United States of America	311,671,000	http://en.wikipedia.org/wiki/List_of_countries_by_population	Not available		
United Kingdom	60,394,259	http://www.trueknowledge.com/q/what_is_the_population_of_great_britain_2011	8,787		1: 6,873

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