Establishing a National Register of Mental Health Practitioners

A submission to the Inquiry by The Senate Community Affairs Committee into Commonwealth funding and administration of mental health services

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Quality of practice in mental health care across professional disciplines

Evidence clearly suggests that there is no difference in clinical outcomes between the higher and lower tiers of service provision through the Better Access initiative of Medicare[1]

This implies that there is not one professional group or speciality offering mental health treatment and care that should be given preferential treatment in the context of clinical practice opportunities and support. Providing primary mental health care is not a "one size fits all" service.

The evidence of *no difference* in outcomes between mental health practitioner groups stretches much further than the current findings relating to the Medicare Tiers for the Better Access programme. As Andrews (2000, p.62) states, "there are minimal data that suggest that our (*sic*: psychologists) interventions with adults or children are any better than the effects obtained by a variety of types of counsellors (professional and paraprofessionals), social workers, psychiatrists, and nurses.''[2]

Research has continued to demonstrate that all psychotherapeutic disciplines across such fields as psychology, social work and counselling have the capacity to contribute effectively in the area of mental health treatment and care.[3,4,5,6,7,8,9,10,11,12]

As a consequence, we believe that differentiating one form of psychotherapeutic speciality over another is an outdated approach that only serves to undermine and depreciate both the service scope and efficacy of mental health care services and is compounded when public and private mental health funding sources, notably the Better Access to Mental Health Care (Better Access) Allied Psychological Services (ATAPS) programmes, do not recognise the full range of primary mental health service provision.

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[1] Pirkis, J., Ftanou, M., Williamson, M., Machlin, A., Warr, D., Christo, J., Castan, L., Spittal, M. J., Bassilios, B., & Harris, M. (2010). *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative. Component A: a study of consumers and their outcomes. Final Report.*Centre for Health Policy Programs and Economics. The University of Melbourne.

[2] Andrews, H. B. (2000). *The myth of the scientist–practitioner*: A reply to R. King (1998) and N. King and Ollendick (1998). *Australian Psychologist, 35*, 60–63.

[3] Atkins, D. C., & Christensen, A. (2001). Is professional training worth the bother? A review of the impact of psychotherapy training on client outcome. *Australian Psychologist, 36*, 122–130.

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[6] Charman, D. (2005). What makes for a "good" therapist? A review. *Psychotherapy in Australia, 11*(3), 68-72.

[7] Christensen, A., & Jacobson, N. S. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science, 5*, 8–14.

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[10] Minami, T., &Wampold, B. E. (2008). Adult psychotherapy in the real world. *Biennial Review of Counseling Psychology, 1*, 27–45.

[11] Okishi, J., Lambert, M. J., Nielsen, S. L. & Ogles, B. M. (2003).Waiting for supershrink: an empirical analysis of therapist effects. Clinical *Psychology and Psychotherapy, 10*, 361-373.

[12] Wampold, B., & Brown, J. (2006). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*(5), 914-923.

The current limited capacity of trying to differentiate between treatment modalities, disciplines and outcomes runs counter to the reality that the specialities of psychology, counselling, social work and other related disciplines, as a consequence of sound training, all have the capacity to offer highly valid and effective services in the treatment of mental health issues.

Similarities of training in mental health care across professional disciplines

There is a generic and internationally recognised knowledge base and skill base that each profession of psychology, counselling, psychiatry, social work, mental health nursing and occupational therapy draw on when training students in the speciality of psychotherapeutic treatment strategies for primary mental health care.

Key texts and resources on best methods of psychotherapeutic intervention and treatment strategies are used in common across all programmes of psychology, counselling, psychiatry, social work, mental health nursing and occupational therapy at both undergraduate and postgraduate levels when focused on training specifically in the area.

Furthermore, ongoing professional development programmes offered around Australia and the world on best methods of psychotherapeutic mental health care and treatment are utilised concurrently by counsellors, social workers, psychologists, psychiatrists, mental health nurses, general practitioners and occupational therapists who choose to focus in these areas through their chosen disciplines.

Ultimately this means that psychologists, social workers, counsellors, psychiatrists, mental health nurses, general practitioners and occupational therapists are all taught from the same pool of research knowledge and evidence based practice strategies in relation to psychotherapeutic treatment approaches for effective primary mental health care. They just happen to occupy different, and often overlapping, sections of that pool.

Nevertheless, against this shared professional background, each speciality also offers a complimentary focus of approach whereby each profession contributes to the broader area of primary mental health care with specific nuances and perspectives shaped from the origins of each profession.

Qualitative reform of the primary mental health workforce – the next steps

Before presenting the proposal it is important to clarify that the Better Access initiative, and other strategies of approach set up to deal with mental health, are all welcome steps in that all initiatives by government clearly aim to work to improve mental health services for the benefit and welfare of the community. We particularly welcome that both the Government and opposition have recognised a badly unmet need and are advocating policies and programmes to do something effective about it.

Building on this bipartisan determination to improve primary mental health services and service delivery, the next big step of reform should focus on *qualitative improvements* to current systems and processes that are *already in place*. Thus the reform proposed by this submission is of a *qualitative nature* bringing the best out of current resources within the mental health community.

Specifically, the qualitative reform that we believe is both necessary and overdue is to establish a collaborative alliance between mental health care professionals to ensure current expenditure can go further towards achieving a more accessible and affordable mental health care system for the community.

Ultimately, the provision of primary mental health care, through evidence-based psychotherapeutic intervention, is something that can and should be offered by psychiatrists, psychologists, social workers, counsellors and other related professions collectively and equally in the context of a *collaborative working alliance*.

Supporting a collaborative approach to mental health care Hickie and McGorry (2007, p. 100) state, "To date, the professions have not placed enough emphasis on systematically adopting evidence-based forms of collaborative care".[13]

Rosenberg, Hickie and Mendoza (2009, p. 193) emphasised this view even further suggesting that a key area requiring urgent action and reform is in providing "Preferential national funding for new organisational models of collaborative practice" within the field of mental health.[14]

To achieve this, we propose a policy strategy that can bring together the various specialities within the mental health field to facilitate a collaborative working alliance between all sub-disciplines of psychotherapeutic practice whereby each become equal stakeholders in the provision of primary mental health care within Australia.

The proposal – a National Register of Mental Health Practitioners (NRMHP)

Specifically, we propose that the Commonwealth, State and Territory governments, in conjunction with the range of mental health professions, should work towards establishing a National Register of Mental Health Practitioners (NRMHP) that sits above the psychotherapeutic mental health care fraternities to establish clear pathways that allow psychologists, counsellors, social workers, occupational therapists and other areas of mental health care practitioners including Indigenous mental health workers and other related sub-disciplines, to become registered and thus practise equally in the mental health care arena as mental health practitioners.

This register would involve bringing together practitioners belonging to the Australian Psychological Society (APS) and its related colleges, The Australian Association of Social Workers, The Australian Register of Counsellors and Psychotherapists (ARCAP), which brings together the Australian Counselling Association (ACA) and the Psychotherapy and Counselling Federation of Australia (PACFA) which accumulatively represent over 40 counselling and psychotherapy associations across Australia and other related bodies, for example Occupational Therapy (OT) and Mental Health Nursing, to collaborate on what requirements should be in place to create bridges for their members to gain registration into this national register of mental health practitioners.

From there, the mental health profession can be brought under the National Board structure administered by the Australian Health Practitioner Regulation Agency (AHPRA). At the moment, only psychologists are covered by AHPRA.

How to get there

Clearly, this result cannot be achieved overnight. There will need to be a lead time of between two and five years to identify, harmonise and define training and professional registration requirements for the wider primary mental health workforce, including the establishment of a single National Register of Mental Health Practitioners.

This national registration development process would draw together those mental health professional bodies within Australia that currently self-regulate, (including the AASW, ARCAP, PACFA and other related sub-disciplines), and the Australian Psychological Society (representing psychologists who already are subject to registration). The process would facilitate a professional cooperation between practitioners, teachers and researchers within the related disciplines to converse and formulate a consensus on standards of training, boundaries of practice and related ethical guidelines within the area of psychotherapeutic treatment.

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[13] Hickie, I. B. &McGory, P.D. (2007) General practice and policy - Viewpoint: Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?*The Medical Journal of Australia, 187*(2), 100–103.

[14] Rosenberg, S., Hickie, I. B., & Mendoza, J. (2009).National mental health reform: less talk, more action. *The Medical Journal of Australia,190*(4), 193-195.

It is an important goal to achieve whereby professional silos and self-interests are set aside and current resources pooled to ensure a collaborative working alliance across sub-disciplines for the benefit of mental health and for the welfare of the community.

Qualitative reform of this nature will ensure the best possible outcome for current resources already in place, both public and private.

Matching training standards and boundaries of practice with community and client need

The public policy goal of establishing a NRMHP is to harness the current level of knowledge and expertise already there across the different sub-disciplines of mental health care provision - found within the fields of psychology, social work, counselling and other related sub-disciplines - to ensure training standards and boundaries of practice match community need.

Specifically this can be achieved through successfully linking current mental health care services with the right level of professional competence.

Professional competence is successfully achieved through the type of training acquired and the quality of ongoing professional development and supervision accessed. Thus Individual practitioners across all related fields would be required to register at a specific level of professional competence in order to be considered qualified to service that particular level of community mental health need.

The NRMHP would base levels of registered competence to practice psychotherapeutically on the *level and type* of training attained and the type of ongoing professional development and supervision accessed.

It is important to point out that the *appropriate level and type* of training attained for achieving a particular level of registered professional competence should *not* be determined by whether or not the training was completed within the discipline of psychology, social work, counselling or other related sub-discipline.

Such a deterministic process only serves to exasperate professional jealousies and unproductive practice silos, inhibiting the full potential of the current level of training and expertise in the mental health workforce across all sub-disciplines of psychology, social work, counselling and other related areas, trained to deal with the full range of mental health challenges.

It is therefore important to stress that professional competence *should be* determined by the specific *type* of training completed within any of these sub-disciplines of psychotherapeutic mental health care and that the level of training should be determined through the Australian Qualifications Framework (AQF) and delivered by accredited providers of Higher Education (HE) and Registered Training Organisations (RTO).

Dual taxonomy of training standards and community need

For the reasons we have outlined, the key to changing approaches and attitudes is to register mental health practitioners not simply based on their professional discipline, but on their ability to provide mental health services safely and competently within their areas of professional practice.

The best way to achieve such results, in a way that recognises both commonalities and differences across the mental health disciplines, is to see mental health need and services as being a part of a continuum of mental health care.

Doing this opens up the recognition of professional skills, but more importantly helps to assure mental health clients about the appropriateness of the services to their needs and the quality of those services.

Definitions

The following definitions that we have adopted are taken from the World Health Organisations (WHO) world health report of 2001,[15] and the Commonwealth Department of Health and Aged Care's National Action Plan for Promotion, Prevention and Early Intervention for Mental Health.[16] The definitions present *community mental health need* as a continuum that spans across three key domains of social support, mental health problems and mental illness.

A taxonomy of mental health service, based on such a continuum, reflects that the efficient delivery of mental health services cannot be defined by professional badges, but rather should be defined by a practitioner's qualification and expertise in key areas across the continuum, if services are to be cost-efficient and embrace the whole mental health workforce.

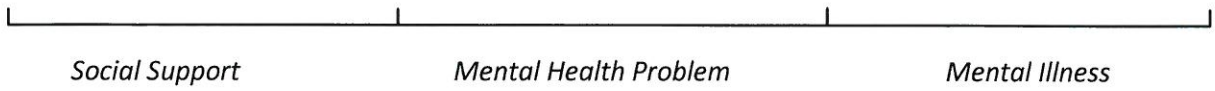

Figure 1: Continuum of community mental health need

Social support is a lower-intensity community mental health need that is currently serviced by such things as, for example, crisis call lines, various support and community groups and other related social welfare services. Among other things, effective social support is a sound preventative measure that can be used to abate the onset of other, more serious, mental health issues.

Mental Health Problem covers those within the community who are not diagnosed with a mental illness but who do have difficulties emotionally responding effectively to life's challenges which, if not addressed professionally, could lead to full-fledged mental illness and its social and health consequences. Such problems could involve issues around self-esteem, bullying, body image issues, identity, relationships, burnout, stress, shyness, adjustment to new environments, coping with loss, to name a few.

Mental illness is the area of *community mental health need* that requires psychotherapeutic treatment as opposed to psychotherapeutic aid or social support. It equates to conditions defined through the current DSM-IV-TR and ICD-10 and requires effective psychotherapeutic treatment.

Levels of professional competence should match such community need whereby professional expertise can range from providing social support at one end of the continuum, through offering psychotherapeutic aid in dealing with mental health problems, to providing psychotherapeutic treatment for mental illness or disorders.

Ultimately, psychologists, social workers, counsellors and related sub-disciplines all have the potential to provide social support, psychotherapeutic aid or psychotherapeutic treatment.

Recognising the continuum for professional accreditation

The potential of a mental health practitioner to provide a service on the continuum of mental health need should be based on their level of training and annual ongoing professional development and supervision, rather than on whether the training was through a psychology programme, social work programme or counselling programme. Otherwise, the provision of mental health services and the current potential of the skills and qualities of the mental health workforce will continue to be undermined and underplayed by a silo- and demarcation-based professional culture to the detriment of community wellbeing.

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[15] World Health Report. (2001). *Mental Health: New understanding, new hope*. Geneva: World Health Organisation. Retrieved July 22, 2011, from: http://www.who.int/whr/2001/en/.

[16] Commonwealth Department of Health and Aged Care.(2000). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*.Canberra, ACT: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.

For example, social workers traditionally have been relegated to the ranks of social support while counsellors working with mental health problems may compliment – but are not seen as substitute for - the work of a psychologist in the provision of psychotherapeutic treatment for the mentally ill. Even within the ranks of psychology there is strong division over the type of psychologist speciality that is most appropriately trained or the psychiatrist who is most competent to treat the mentally ill.

Such divisions should not be made. Instead whether psychology trained, social work trained or counsellor trained, mental health care professionals should be registered under a National Register of Mental Health Practitioners (NRMHP) according to the degree in which their training equips them to offer social support, psychotherapeutic aid or psychotherapeutic treatment.

All aspects of community mental health need across social support, psychotherapeutic aid and psychotherapeutic treatment should be considered equally in this model. This recognises the important role social support and psychotherapeutic aid have in early detection and prevention towards the onset of mental illness.

Also, as pointed out earlier, research clearly demonstrates that all psychotherapeutic disciplines of psychology, social work, and related fields all have the capacity to contribute effectively in the area of mental health care across the continuum of community mental health need. As a consequence, differentiating one form of psychotherapeutic speciality over another only serves to undermine and depreciate both the service scope and efficacy of mental health care services.

This is especially so when funding, under Better Access, ATAPS, private health insurance or other public or private sources, is based on considering only some segments of the primary mental health workforce as being appropriate providers of funded services. This is a major weakness in current policy and funding arrangements, and can be overcome by concerted and determined action as part of pursing a new national mental health "road map".

Confirming training standards for optimum provision of mental health services

Training standards should relate to the Australian Qualifications Framework (AQF) which is delivered by appropriately accredited and registered training bodies (i.e. Higher Education Institutes and Registered Training Organisations). To summarise precisely, AQF recommended qualifications fall within 10 categories from Certificate I to doctorate.

The 10 levels of qualification are:

AQF Level 1. Certificate I
AQF Level 2. Certificate II
AQF Level 3. Certificate III
AQF Level 4. Certificate IV
AQF Level 5. Diploma
AQF Level 6. Advanced Diploma & Associate Degree
AQF Level 7. Bachelor Degree
AQF Level 8. Bachelor Honours Degree, Graduate Certificate, Graduate Diploma
AQF Level 9. Masters
AQF Level 10. Doctorate

Ultimately, mental health practitioners should be assessed according to the level of qualification attained according to AQF standards, more-so than by their affiliation with a particular discipline of psychology, social work, counselling, occupational therapy (OT) or other related mental health discipline.

Therefore assessment of training as a mental health practitioner along the continuum of mental health care could be determined as follows:

AQF Level 1-4: Social support
AQF Level 5-7: Psychotherapeutic aid for mental health problems
AQF Level 7-9: Psychotherapeutic treatment for the mentally ill.
AQF Level 10: Specialist academic science/research focus across the continuum of mental health care

Social work, counselling, psychology, OT and other related sub-disciplines offering psychotherapeutic mental health care can collaborate through the NRMHP to confirm the content of training within each AQF level to ensure practitioners are equipped accordingly to service that particular area of need proficiently.

Concluding statement

Through establishing a national register of mental health practitioners (NRMHP) that includes the sub-disciplines of psychology, social work, counselling and other related fields, there is a tremendous opportunity to obtain greater clarity of training models that can equip all sub-disciplines of psychology, social work, counselling and other related fields equally to practise along the continuum of mental health care.

A major benefit of this approach is that it utilises much more fully and cost-effectively the current workforce in mental health by encouraging a collaborative approach that brings down the silos of competitiveness between sub-disciplines by ensuring that the best standards of training are matched most appropriately with the related level of community need.

As a direct consequence of utilising the current workforce across mental health services greater opportunities for regional services in mental health open up, waiting lists are lowered, opportunities with service provision through Better Access, ATAPS and other programmes increase, a greater number of culturally aware and indigenous mental health practitioners become available and there is increased consumer safety from the establishment of a National Register of Mental Health Practitioners (NRMHP) minimising potential for harm.

This submission is aimed to promote further discussion and debate on the best way forward in *qualitative mental health reform* in the context of current systems and processes in place. We hope that it will stimulate constructive and positive discussion between the disciplines of psychology, social work, counselling and other related psychotherapeutic disciplines, along with those disciplines with the medical profession (especially psychiatrists and general practitioners) to ensure the best possible solutions can be achieved for optimum mental health and community wellbeing.

Recommendations

On the basis of our submission we recommend that a round table forum be set up as a ***first step*** to bring together representatives from each key body in the mental health field to discuss, clarify and confirm the underlying premise of this proposal. Specifically it would require a leadership directive from Government to encourage each professional body's cooperation to attend and participate in such a dialogue.

Effectively, that would mean Governments (not just the Commonwealth but States and Territories) declaring in principle that a continuum-based approach to professional recognition and accreditation, and to eligibility for programme and funding support, is a desirable policy outcome that should be explored in the best interests of people with mental health challenges, their families and carers.

The discussion forum would need to clarify the following:

1. Defining qualities of community mental health need across the continuum of social support, mental health problems and mental illness
2. Defining qualities of training and professional development required to be appropriately equipped to effectively service each area of community mental health need across the continuum
3. A survey of current professionals in the field across all sub-disciplines of mental health to clarify where each sub-discipline and speciality currently sit in their capacity to service each area of community mental health need along the continuum.

It is from the three key areas of discussion above that the founding guidelines for a National Register of Mental Health Practitioners (NRMHP) could be forged.

It is important that the following bodies be represented in the round table forum and future development of the NRMHP:

1. Australian Psychological Society and related colleges
2. Australian Association of Social Workers
3. Australian Register of Counsellors and Psychotherapists (ARCAP), which brings together the Australian Counselling Association (ACA) and the Psychotherapy and Counselling Federation of Australia (PACFA) which accumulatively represent over 40 counselling and psychotherapy associations across Australia
4. Australian College of Mental Health Nurses
5. The Association of Occupational Therapy (OT) Australia
6. The Royal Australian College of General Practitioners
7. National Institute of Practising Psychiatrists
8. Other key stakeholders, including mental health consumer, carer and advocacy groups.

Once standards are confirmed, those mental health professionals specialising in psychotherapeutic treatment across the spectrum of community mental health can be brought under a National Board structure administered by the Australian Health Practitioner Regulation Agency (AHPRA). At the moment, only psychologists are covered by AHPRA.

We also recommend that pursuing the recognition of a continuum of primary mental health care provision, and national mental health practitioner registration, be incorporated into:

- The Commonwealth Government's 10-year National Mental Health Roadmap.
- Eligibility criteria for Medicare-linked primary mental health subsidy programmes, notably better Access and ATAPS; and
- Ongoing cooperation and dialogue between Commonwealth, State and Territory governments and the mental health provider, consumer and carer communities.

Finally, we believe that a related and positive supporting recommendation by the Senate Community Affairs Committee in its report on this Inquiry will go a long way to stimulating practical and cultural change *for the better* in planning and delivering an effective multi-disciplinary primary mental health workforce, and in meeting client needs with the most clinically and cost-effective modes of support. Indeed, what we propose is relevant to the wider scope of the Committee's terms of reference for this Inquiry.

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