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, thus meeting the standards set by the Psychology Board of Australia (PsyBA). ACPA was established in April, 2010, in response to deep concerns amongst qualified clinical psychologists about the diminution of standards for entry to the speciality and the growing lack of respect for accredited post-graduate training in clinical psychology within the profession itself. 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

Major changes to mental health funding were made without consultation of major stakeholders in a non-transparent process that was not based in the evidence of the efficacy of treatment or delivery of service models. The changes bring a shift in focus from the provision of psychological services in the private sector with choice of practitioner to all with mental health problems, to only those with mild-moderate presentations. More severe presentations are to be referred to inadequate services that do not meet the needs of these patients. Funding was transferred to public health child and youth programs without adequate representation on the decision-making committee of either private service deliverers or alternative, evidence-based programs for children and youth.

Being amongst the most highly trained stakeholders in the provision of mental health services, qualified clinical psychologists need to be included in the guidance of Government decision-making processes regarding mental health. The expertise of qualified clinical psychologists needs to be better utilised within both the private and public health services. Qualified clinical psychologists need to be enabled to utilise their advanced training in assessment, diagnosis, formulation, treatment, and outcome evaluation of mental health problems.

The reduction in the number of services provided under the Better Access program will affect approximately 86,000 people with more severe mental health problems, transferring them to the ATAPS program that is restricted to the provision of Focussed Psychological Strategies that are not sufficient for more severe presentations; to private psychiatrists, of whom there are insufficient numbers, and who charge high co-payments; or the public health system, that caters only to the most severe and persistent presentations. Many people with more chronic or severe presentations currently receiving services tailored to their needs by clinical psychologists under the Better Access program will have their services seriously curtailed, potentially compromising very significantly the care provided, or be referred to services that do not meet their needs.

The efficacy of Focussed Psychological Strategies, as provided under the ATAPS program, in the short-term treatment of mental illness is highly questionable, given the 43% re-presentation rate of patients to the Better Access program. ATAPS only provides Focussed Psychological Services, which are not specialised and are only suited to the most mild presentations.

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 program was seriously flawed in design and implementation, such that its results cannot be relied upon as valid or reliable. This survey breached virtually all of the most fundamental and basic guidelines for treatment outcome research.

In working with children and adults, adequate assessment requires parental interviews without the child or young person being present. Parents also need to be able to access services providing psycho-education about parenting, parent training. Provision needs to be made for these needs in the private health funding of mental health care for children and adolescents.

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 and 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.

Use of developing technologies, such as Skype, also needs 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. This would radically enhance service delivery to those requiring it in these areas.

People with a mental illness living in rural and remote areas are severely under-serviced. Incentives are required to attract providers to these areas. Access to services for culturally and linguistically diverse communities are severely curtailed by the lack of available interpreters in the private health system. Guidelines are also required 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 the 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.

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. We are deeply concerned about the lack of respect for the value of post-graduate clinical training by those who do not hold these qualifications and those who represent them.

Australia has the most poorly trained psychology workforce in the Western world, with the lowest standards of entry to the profession for both psychologists and specialist psychologists. Around eighty five percent of psychologists currently practicing in Australia would not be able to practice in any other equivalent English-speaking country. Australia needs to move away from a much flawed training of 4 years in the science of psychology followed by two years of an unaccredited supervision program to a Masters entry level to the profession. Specialisation needs to move to Doctoral level training to bring Australian specialist psychologists into line with basic entry standards for the profession in the rest of the developed English speaking world.

The Australian Psychological Society has further undermined standards in clinical psychology by admitting to the College of Clinical Psychologists via an 'extraordinary route' many psychologists (believed to be between 600 and 1750) who do not meet criteria for endorsement as a clinical psychologist under the standards set by the Psychology Board of Australia. These psychologists have been "grandparented" into the speciality without post-graduate qualifications in clinical psychology, leaving GPs and the public unable to distinguish qualified clinical psychologists. This has also led to a downgrading of standards for clinical psychologists in Western Australia, where specialist title standards had been set for over 30 years at the standard now established by the Psychology Board of Australia. GPs and the public need to be able to distinguish those clinical psychologists with the minimum standard of training in the speciality established by the Psychology Board of Australia, via a separate register or the granting of Specialist Title to qualified clinical psychologists.

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 Psychology Board of Australia'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 that the 1 : 6,873 in the United Kingdom. Numbers for Canada and the USA were not obtainable.

Funding of both places in post-graduate clinical programs and students undertaking Doctoral degrees, in line with international standards, is very poor.

It is hoped that a national mental health commission with be fully representative and provide direction to address the issues in the psychology profession, the funding of services and the evaluation of outcomes.

Summary of 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 sectors and stakeholders on all committees and working groups.
- As key service providers in mental health, in the private and public health systems, clinical psychologists need to be included in policy direction and decision-making.
- The vital role of GPs in primary mental health care should be acknowledged, and the AMA should be appropriately represented on future Mental Health Expert Working groups. 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.
- We recommend that GPs are permitted and indeed, encouraged, to refer patients with mental health problems to qualified clinical psychologists without the requirement of a GP Mental Health Treatment Plan, as they would to a psychiatrist, in recognition of their advanced expertise and training in mental health. It is important that GPs continue to provide Mental Health Treatment Plans for those patients to be seen by psychologists who do not have accredited post-graduate training in clinical psychology.
- It would provide added value to mental health services to ensure that clinical psychologists are engaged to provide services higher levels under all programs. This would make best use of the expertise of this highly trained group.

- Parents need to be able to claim Medicare rebates for assessment, psychoeducation and training in parenting strategies under their child's referral and Mental Health Plan.
- 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 needs 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. This would radically enhance service delivery to those requiring it in these areas.
- Special incentives need to be provided to GPs, clinical psychologists, and psychiatrists to work in rural and remote areas in terms of higher rebates tied to area.
- Greater access to the 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 access to support needs to be offered to all those suffering from injuries, regardless of how they are sustained.

Professional issues

- We strongly recommend that a separate register of qualified clinical psychologists is established to enable the public and GPs to identify those clinical psychologists with the qualifications that meet the minimum standards set down by the Psychology Board of Australia. A review of the granting of specialist title for qualified clinical psychologists needs to be undertaken with some urgency.
- 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. 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.
- The Australian Psychological Society should be removed from all authority over psychologists and clinical psychologists within the Medicare rebate system. They should not

have the authority to assess psychologists for clinical rebates, as the Psychology Board of Australia endorses the speciality according to established guidelines and they should have no role in monitoring or logging Continuing Professional Development for psychologists and clinical psychologists.

(a) The Government's 2011-12 Budget changes relating to mental health

The package of measures announced in the 2011 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 in fact 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 their **"**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 and consultation with stakeholders, particularly those most involved with the delivery of services under the Better Access initiative, was minimal.

Evidence-based psychological therapies are developed, refined and evaluated for the most part by clinical psychologists. Members of the Australian Clinical Psychology Association (ACPA) are major contributors to the public and private mental health sectors, yet we were not consulted at any time about the evidence regarding effective interventions, or the potential impact of the proposed changes. Indeed, when ACPA approached the Minister for Health and Ageing, her advisors, and the Minister for Mental Health for a meeting, this meeting was declined.

There has previously been no distinction made between mild, moderate or severe presentations of mental illness under the Better Access initiative. However, in the 2011-2012 Budget funding was transferred from the provision of private psychological services for all age groups and levels of severity of mental illness, into public sector child and youth mental health programs for the most severely affected. The Better Access scheme now distinguishes between mild, moderate and severe presentations and removes those with greater need from access to private treatment in the community by their choice of practitioner. Individuals with more severe illnesses are to be referred to (a) the ATAPS program, which is limited in focus, more expensive, and restricted in choice for the consumer; (b) to psychiatrists, where there is a distinct shortage, particularly in low SES and rural areas, and significant co-payments are commonly demanded; or (c) to the public sector, which treats only those with the most severe and persistent mental health problems. Therefore, the more moderate – severe or chronic presentations require greater services, but under the changes announced will be provided with fewer options, greater restrictions and poorer access to services.

It is understood that the changes relating to 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, which recommended no such changes, but were based on recommendations made by the Minister for Health, Dr Butler's, Mental Health Expert Working group. While this group consists of extremely eminent and respected professionals whose knowledge and direction would be invaluable in determining policy, this committee was strongly skewed towards those working in the public health system.

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 needs to be maintained between public and private services in mental health to deliver choice to consumers, as well as the best 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 ensure adequate representation of all sectors and stakeholders on all committees and working groups.

While additional investment in child and youth mental health is vital, 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 other treatment programs which may also be of significant value to the broader community, and which may have a more substantial evidence-base. 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 program has been ignored. We also 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 mental health diagnoses of moderate severity, who require psychological therapy but do not necessarily need or want to access public health or psychiatry services, and may be better served by clinical psychologists under the Better Access program.

Treatment cost savings in mental health appear to have led to a re-referral rate of 43% under the Better Access program (September, 2009, Council of Australian Governments National Action Plan for Mental Health 2006-2011, Second Progress Report, covering implementation to 2007-08). These patients have either reached their session limits under the Better Access scheme but still require treatment, or they relapse due to the limited treatment provided. Such patients require longer term evidence-based treatment tailored to individual needs. There are simply not sufficient psychiatrists to meet this need; qualified clinical psychologists are suitably trained to do so.

Qualified clinical psychologists have extensive accredited post-graduate training in mental health followed by a supervision period (see below e (ii)), matched only by psychiatrists, yet there is little recognition and utilisation of this expertise within the structures of government funded mental health programs. While permitted to utilise their training in more flexible and complex ways, and granted a higher Medicare rebate in recognition of their advanced training and expertise, they are not funded to exercise their expertise, as are psychiatrists, with more chronic, moderate and severe presentations that require advanced treatments over a longer period of time. The expertise of clinical psychology and its utilisation within the health system has largely been ignored to date, leading to inefficiencies in expenditure as 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 sectors and stakeholders on all committees and working groups.

- As key service providers in mental health, in the private and public health systems, clinical psychologists need to be included in policy direction and decision-making.
- 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.

(b) changes to the Better Access Initiative, including:

(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 AMA was not represented on the Mental Health Expert Working group when GPs are major providers of mental health services and are central in the referral system to other service providers.

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

Recommendations:

- GPs and psychologists working in rural and remote areas require higher levels of funding tied to area, to attract professionals to these areas, and to ensure that consumers have adequate access to services (see below f (h)).
- The vital role of GPs in primary mental health care should be acknowledged, and the AMA should be appropriately represented on future Mental Health Expert Working groups.

(ii) the rationalisation of allied health treatment sessions

The rationalisation of allied health treatment sessions leaves many with mental health problems without adequate or appropriate services. Mental illness can present as acute or chronic at all levels of severity. Chronic and/or serious mental health presentations are being dismissed in the current structure of treatment services under all programs.

In changing the Better Access program from one that provided psychological services to those with mental illness, to those with only mild to moderate presentations, the Government has failed to recognise the complexity of mental health presentations. Despite wishing to delineate 'mild', 'moderate' and 'severe' mental health problems, they fail to provide a clear and practical definition of these categories that enable referrers to determine which group a patient belongs to, and thereby which service they are entitled to. 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 the those being specifically targeted.

In doing so it appears that the Government is attempting to implement a stepped care model that allows only those with 'mild-moderate' mental health problems to be treated by their choice of practitioner under the Better Access Scheme, while those with more severe problems, requiring longer-term or more advanced treatments are not adequately provided for.

Stepped Care models

As pointed out by Blaszczynski and Renner (2004):

> 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. For example, instead of delivering standard protocol driven CBT to all patients, Williams (2001) recommends that CBT treatments should be delivered across three levels:
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> - *Level 1:* Treatments should be routinely initiated by the provision of brief therapies such as self-help, delivered, for example, as structured written self-help or computer-based materials. These treatments could be widely offered in primary care alongside the wide range of self-help provided by voluntary sector groups and organizations
>
> - *Level 2:* Where the person has more severe or complex problems, or is at risk, more intensive therapist guided packages of care should be provided
>
> - *Level 3:* For more complex or treatment resistant cases, full specialist CBT could be offered by experts. (Blaszczynski & Renner, 2004, p. 28 – 29).

Focussed Psychological Strategies (FPS) fit within level two of this model and require little advanced training to be applied effectively. They are limited in both scope and duration. More chronic presentations and those with more severe presentations, or co-morbid mental and physical illnesses, require greater expertise to assess, diagnose, formulate and treat effectively. They also require longer treatment periods with the integration of advanced therapies and approaches.

Only clinical psychologists and psychiatrists have the level of advanced training to undertake this provision of service at level three. The treatments provided by clinical psychologists and psychiatrists frequently complement each other in providing sound psychological and medical management of mental illness and psychiatrists and clinical psychologists frequently work closely together to manage patients. With the shortage of private psychiatrists and the high co-payments required for their services, clinical psychologists are needed to supplement the workforce in all domains to provide appropriate these services to patients.

Currently, only the Better Access program enables clinical psychologists to provide tailored programs for those with more severe or complex presentations at level three within the private health system. Evidence that that these services are currently being provided by clinical psychologists under this scheme comes from a survey undertaken by the Australian Clinical Psychology Association (ACPA) conducted on 503 patients seen within a one-week period by 33 of those members who provide services under the Better Access program. Thirty percent of patients were rated in the severe to extremely severe range, while only 31% were rated in the mild-moderate range and there was a high level of co-morbidity (42% for two diagnoses; 16% with three or more diagnoses), and chronicity

(20% with symptom duration of 2-5 years; 33% of more than 5 years) of presentations. See Appendix A for greater detail. No other private system provides tailored clinical psychology treatments to these patients.

Greater utilisation of the expertise of clinical psychologists in mental health will lead to cost benefits for patients and savings for Government, while meeting a need left unmet by the shortage of psychiatrists in the workforce. Some of the major barriers to the optimal functioning of the clinical psychology workforce within mental health are: 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).

(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

While we do not wish to comment on the current changes to the Medicare rebates and the two tier rebate for clinical assessment and preparation of a care plan by GPs directly, we would like to suggest the following:

To reduce the cost burden of mental health services, demands on GPs, duplication of services, and 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 should be permitted, and indeed encouraged, 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. Clinical psychologists are thereby more suited to providing a Mental Health Treatment Plan for patients than the General Practitioner (GP). Many clinical psychologists provide training to GPs, or have devised the programs for their training in mental health assessment, diagnosis, and treatment, in the short courses they undertake to gain knowledge in this area. Furthermore, the current system of having the GP complete a Mental Health Treatment Plan for a clinical psychologist leads to duplication of services, as clinical psychologists would be irresponsible to rely on a plan devised by a generalist provider, such as a GP. Hence, clinical psychologists currently conduct their own assessment, make a diagnosis, and devise an appropriate treatment plan. Our members report that while GPs can identify anxiety and depression adequately, they frequently do not identify co-morbid complicating disorders and personality disorders, which complicate treatment and demand more advanced approaches.

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

Recommendations:

- We recommend that GPs are permitted and indeed, encouraged, to refer patients with mental health problems to qualified clinical psychologists without the requirement of a GP Mental Health Treatment Plan, as they would to a psychiatrist, in recognition of their advanced expertise and training in mental health.
- It would provide added value to mental health services to ensure that clinical psychologists are engaged to provide services higher levels under all programs. This would 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

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 does not appear to be instrumental in guiding this decision. Indeed, the APS is undertaking a campaign against the proposed changes, despite being represented on this working group, as is the AMA and ACPA.

If the 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) survey, this basis is fatally flawed. This survey does not meet the most basic and fundamental standards of research design for treatment outcome studies. It failed to: take a prospective approach, which is standard in outcome research; utilise an adequate sample size to ensure proper representation of service providers; identify the nature, diagnosis and complexity of the patients seen by psychologists with differing levels of training; identify the nature or type of psychological intervention that was, in fact, provided; control for adherence to treatment guidelines by providers or patient compliance; examine the role played by medication in outcome; have a valid criterion measure related to a broad range of diagnoses with inbuilt algorithms to account for severity and complexity of presentation; look at drop-out rates and the reasons for these; undertake follow-up evaluations; determine relapse rates by type of treatment type and by psychologist training; and it was not subjected to peer review. Furthermore, the evaluation used a self-selected sample of psychologists who then selected their own clients for the study, and administered the research questions in session.

This survey breached multiple research design guidelines for treatment outcome studies and therefore has limited validity or reliability. Furthermore, no recommendations were made by the authors of this survey to reduce the number of sessions patients received or to change policy to enable only mild-severe mental health problems to be treated under the Better Access Scheme. How this inadequate data was interpreted to arrive at the decisions made is unclear.

The most recent reported re-referral figure of 43% of patients under the Better Access Scheme, (September, 2009, Council of Australian Governments National Action Plan for Mental Health 2006-2011, Second Progress Report, covering implementation to 2007-08) points to the short-term

benefit of short term treatment strategies. It suggests existing inadequacies in the level and/or nature of services provided under the Better Access program that were not identified in the Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (May, 2011) survey.

Nevertheless, the APS states,

> The Government's own evaluation of Better Access demonstrated that it is a cost-effective way of delivering mental health care. The typical cost of a package of care delivered by a psychologist under the initiative is $753, significantly less than ATAPS which costs from two to 10 times that of Better Access per session. Successful treatment also reduces costs of hospital admissions and allows many consumers to return to work, with the associated productivity benefits. (APS, June 2011, Federal Budget cuts to the Better Access initiative Briefing Paper).

While this form of service delivery may be cost effective, it may not be clinically effective. What is required is a well-designed prospective study, grounded in the research base for outcome evaluations, and based on sound methodology. Such a study needs to generate specific hypotheses and select the appropriate methods and measures to provide evidence for or against these hypotheses.

The Government has argued that the changes to the Better Access Scheme will not affect large numbers of consumers, as only approximately 13% of Better Access patients receive more than 10 sessions. This, however, equates to around 86,000 (Lyn Littlefield, CEO, APS, LifeMatters 21/06/2011) patients per annum, all of whom are the more vulnerable amongst those with mental health problems. While the government states that these people may obtain services under the Access to Allied Psychological Services (ATAPS) program, the public health system, or from private psychiatrists, these options are not necessarily suitable for this group of patients and are exceedingly limited.

Apart from the fact that there has not been an adequate transfer of funding to the ATAPS program, this program is restricted to the provision of Focussed Psychological Strategies (FPS) that can be delivered by psychologists and other allied health professionals (2010-2011 Operational Guidelines for the Access to Allied Psychological Services Component of Better Outcomes in Mental Health Care Program, p. 5). Patients with more chronic or severe mental health problems require services provided by those with advanced knowledge of assessment, diagnosis, formulation and treatment modalities of mental health issues, such as clinical psychologists and psychiatrists, to ensure they receive more suitable evidence-based treatments tailored to their needs. These services are not provided for under ATAPS. Currently, to have those with more moderate and severe presentations treated under ATAPS, means to have the more vulnerable treated by a workforce that includes psychologists without specialist qualifications and training in mental health, utilising short-term strategies.

In their Federal Budget cuts to the Better Access initiative Briefing Paper (June, 2011), the APS states,

> The ATAPS program run through the Divisions of General Practice (DGPs) is not a viable referral option under current arrangements. There is simply not enough funding in ATAPS to provide services for anything like the number of 260,000 people (or 86,000 per annum). A major issue is that a significant proportion of the funding for mental health services received by DGPs is spent on administration rather than providing funding to the psychologists who are engaged to deliver the services. As a result, frequently more junior psychologists are selected to provide services and more experienced psychologists cannot viably undertake the work. (p. 3).

Furthermore, there is a significant shortage of private psychiatrists. Only a very limited number of psychiatrists bulk bill patients, making treatment costly, particularly as most tend to charge high co-payments. There is a particular shortage of psychiatrists in low SES and rural areas.

The public health system only takes the most severe and persistent presentations, and again, the group of patients disadvantaged by the cutbacks in the number of sessions available under the Better Access program would not meet criteria for these services. This leaves patients with more chronic, moderate to severe mental health problems unable to access services.

We do, however, support the limitation of the number of sessions to ten for those psychologists and other health professionals without accredited post-graduate training in mental health, who provide Focussed Psychological Strategies based on the approaches developed by clinical psychologists. Focussed Psychological Strategies are limited in what they can achieve, particularly for the more chronic, moderate and severe presentations in mental health.

Recommendation:

Those patients who require more sessions than the number (ten) available under the changes to the Better Access Scheme need to be referred to clinical psychologists working in the private health system, but with access to the public health system where required, for 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.

(c) 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 program, as ATAPS funding is restricted to the provision of Focussed 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 in the main by those psychologists and other allied health professionals with little or no accredited qualifications and training in mental health. Furthermore, it is our understanding that ATAPS tends to attract the younger and more inexperienced members of the psychology profession (APS, Budget cuts to the Better Access initiative Briefing Paper, June, 2011, p. 3).

People with major depression and anxiety disorders make up the bulk of presentations to GPs and psychologists. While Focussed Psychological Strategies, that to a large extent have been developed and refined by clinical psychologists, may well be effective with select mild-moderate presentations, these Strategies are limited in what they can achieve with more chronic, moderate and severe presentations. Such presentations are best managed with longer term services provided by those with advanced training in assessment, diagnosis, and treatment of mental disorders, such as clinical psychologists and psychiatrists. Such services are not properly provided for under ATAPS.

Much of the newly announced ATAPS funding is for the Tier 3 funding ("severe and persistent" mental illness). We have been advised by the College of Clinical Psychologists of the APS that, once programme-related overhead and administrative costs are deducted, there remains only provision for an approximately 0.8 EFT salaried clinical psychology position within a Division that can be dedicated to the Tier 3 program. Given the additional cost of employment of clinical psychologists, many Divisions choose to employ less qualified psychologists at a lesser cost. Thus, to have those with more moderate and severe presentations treated under ATAPS, means to have the more vulnerable treated by a workforce without specialist qualifications and training, utilising short-term strategies.

Fundamentally, 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 with the program has also 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.

(d) services available for people with severe mental illness and the coordination of those services

People with severe mental illness can readily fall between programs. If these people are not psychotic and requiring high levels of care on an ongoing basis they are not managed by the public health system; having greater vulnerability, they cannot always access private psychiatrists, as they cannot afford the co-payments; services under ATAPS are too restrictive for their needs; and the Better Access initiative does not cater to their requirements.

Substance abuse, early trauma, eating disorders, chronic and severe or chronic 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 people, 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.

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 no programs available to provide the necessary advanced and longer-term treatments for these 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.

(e) Mental health workforce issues, including:

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

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.

Skill levels of different psychologists within the workforce:

The Management Advisory Service to the National Health Scheme in Scotland differentiated the health care professions according to skill levels (Management Advisory Service (1989) Review of Clinical Psychology Services; Activities and Possible Models MAS, Cheltenham). 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.

The group 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 in a creative way to solve 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, comorbid 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.(1998, Work Value Document, Western Australia Clinical Psychology Health Sector, 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 comorbid 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 (1998, Work Value Document, Western Australia Clinical Psychology Health Sector, 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).

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 the majority of psychologists without this training. 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.

Recommendation:

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

(ii) workforce qualifications and training of psychologists

Psychologists:

Australia has the most poorly trained psychology workforce in the Western world. Around eighty five percent of psychologists currently working in Australia do not meet the standards required to practice 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 EFPA is moving towards a standard requiring Doctoral level entry to the profession (Professor Ingrid Lundt, EFPA, personal communication, 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).

The standard for registration as a psychologist in Australia is poor given international standards. 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, states that 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 have equated to standards in New Zealand. The Australian Health Ministers' Advisory Council (AHMAC) rejected this proposal, citing workforce shortages as the reason.

While we support the Psychology Board of Australia's attempts to increase the oversight of the 4 + 2 pathway, to incorporate basic skills in this training and to introduce a national examination for those completing this route to registration, we believe the unaccredited supervision period remains inadequate. The recently proposed 5 + 1 training route to registration offers a higher level of training, with a 1-year diploma requiring accreditation by APAC. However, until this becomes the minimum standard for registration as a psychologist, Australia retains the distinction of holding to the lowest standards in the Western world.

Australia's low standards of training required for entry to the profession places the public at risk. In February, 2010, we were informed by Mr Chris Ristevski from Aon Risk Services Australia Limited that Aon had been unable to insure psychologists at a profit from towards the end of 2006 (when the Better Access program made Medicare payments available to psychologists in private practice), as every dollar that came in went out in claims. Mr Ristevski informed us that this was due primarily to the unethical practices of psychologists.

Recommendation:

We recommend that the 4 + 2 pathway be phased out as a route to registration and that the 5 + 1 pathway be introduced for a transitional period only, with the requirement moving to Masters level registration requirement within 8 years.

Clinical Psychologists and other specialist psychologists:

Australia also has the lowest standard for the training of clinical psychologists and other speciality psychologists in the English speaking Western world: 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. In these countries other psychology specialities also require the same level of training, although in the USA this applies only to clinical, counselling and school (educational) psychologists, with other specialities 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 and those with Masters qualifications be "grandparented" into the appropriate speciality. This was rejected by the Ministers, 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) level accredited training in clinical psychology followed by a period of supervised practice to bring the total number of years of post-graduate training to 4 years.

The standards of training in clinical psychology have been further undermined in Australia by the "grandparenting" into endorsement, a large number of psychologists who do not meet this minimum standard. With the introduction of Medicare rebates for psychologists under the Better Access Scheme in 2006, the professional body for psychology, the Australian Psychological Society (APS), was given the authority to determine who met the requirements for the higher clinical psychology rebate, by meeting criteria for entry to the College of Clinical Psychologists. More than 90% of the membership of the APS is made up of psychologists without accredited training in clinical psychology.

At this time entry requirements to the College reflected those of that have subsequently been set by the Psychology Board of Australia for endorsement as a clinical psychologist. However, using the "extraordinary route" of entry that had been established to enable those who had made an exceptional contribution to clinical psychology to become members of the College, the APS began admitting to the College those with post-graduate training in other specialities and those without any accredited post-graduate training. These people were required to undertake "Individual Bridging Programs" consisting of a few unaccredited courses and, possibly written case studies. It is understood from several sources that the marking criteria for the case studies was lowered from the acceptance of the study by two markers to acceptance by one, as the standard was so low that 50% of case studies were being failed. The Psychology Board of Australia rejected the value of the Individual Bridging Plans devised by the APS.

Estimates of the numbers admitted to clinical psychology practice via the "extraordinary route" to the College of Clinical Psychologists vary from 600 to more than 1,700. This is a large proportion of the current total of 4,375 clinical psychologists. The exact number is not known as the APS refuses to disclose this information, despite repeated requests from Chairs of the College of Clinical Psychologists and other office-bearers of the College. This practice led to mass resignations in 2010 from the APS of the committees for the two states with the largest member representation of the College, Victoria and NSW, and a continuing exodus of individual College members.

During this time Western Australia had been operating for around 30 years with 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 qualified from accredited programs in clinical psychology could practice in clinical psychology. The public and other health professionals were clear that those who operated under specialist title met this standard and possessed at least a Masters level of accredited training in their speciality plus a period of regulated supervision, similar to that currently in place for specialist endorsement. However, with the entry of Western Australia into the National Registration and Accreditation Scheme in October 2010, these standards have been

substantially undermined, causing great confusion for the profession, other health professions and the public, as psychologists granted 'clinical' status via entry to the College of Clinical Psychologists of the APS were classified in the new scheme as clinical psychologists, despite not meeting the standards that had been set in Western Australia around 30 years previously. This has caused much anguish amongst clinical psychologists in Western Australia as they struggle to accept the downgrading of their qualifications in the loss of specialist title, and the entry into their specialities of those without the requisite standards they had previously held and that are currently set by the Psychology Board of Australia.

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, thus providing a significant disincentive to training to the international standard. If 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 specialities

Other specialities claim that they have sufficient training to undertake work with the mentally ill; however, training in no other psychology speciality programs meet accreditation standards established for clinical psychology by the Australian Accreditation Council (APAC), the accrediting body for psychology. Post-graduate clinical psychology programs are the only psychology programs that provide training exclusively in mental health for their duration. Claims of equality have only emerged since the two-tier Medicare payments came into effect. Prior to this all specialities took pride in their particular focus, skill set and differentiation from other specialities.

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

Some psychologists without accredited clinical training are objecting to the regulation of the speciality under the National Registration Scheme. These psychologists have previously declared themselves to be 'clinical' psychologists without any accredited training as clinical psychologists. With the introduction of endorsement, based on an accredited post-graduate Masters or Doctoral degree in clinical psychology, plus a supervision program, these psychologists have no longer been able to hold themselves out as clinical psychologists. This has led them to claim that they have been 'unendorsed', whereas, in fact, there had never previously been endorsement in the profession.

This group of psychologists have formed an organisation and claim to have 'members'. This group, however, has only one mission: to lobby to force Government to lower standards for clinical psychology in order to enable them to access the responsibilities and privileges inherent in the speciality without undertaking the requisite training. Given that the minimum standard for clinical psychology in Australia is the lowest in the Western world, and the responsibilities and demands on

clinical psychologists are high in dealing with the most vulnerable members of our society, it is in the best interests of public protection not to reduce stands further by allowing unqualified and untrained psychologists entry to the speciality.

Recommendations:

- We strongly recommend that a separate register of qualified clinical psychologists is established to enable the public and GPs to identify those clinical psychologists with the qualifications that meet the minimum standards set down by the Psychology Board of Australia. A review of the granting of specialist title for qualified clinical psychologists needs to be undertaken with some urgency.
- 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.
- The Australian Psychological Society should be removed from all authority over psychologists and clinical psychologists within the Medicare rebate system. They should not have the authority to assess psychologists for clinical rebates, as the Psychology Board of Australia endorses the speciality according to established guidelines and they should have no role in monitoring or logging Continuing Professional Development for psychologists and clinical psychologists.

(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 (Dr Judy Hall, EO of the National Register of Health Service Providers in Psychology, personal communication, July 2, 2010).

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) claims that two months after Medicare opened to psychologists in 2006:

- 1,000 clinical psychologists and 6,000 registered psychologists had registered under the Better Access Scheme
- 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 Australian Psychological Society estimates of 24,986 in 2006, *The Mental Health Workforce: Supply of psychologists* (February, 2008) concludes**:**

- 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.

It appears that in employing psychologists without accredited clinical training, the Better Access Scheme has amplified need in the community for psychology services, particularly as 43% of those taking up these services need to re-present for treatment the following year (September, 2009, Council of Australian Governments National Action Plan for Mental Health 2006-2011, Second Progress Report, covering implementation to 2007-08).

Clinical Psychologists

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

However, the number of endorsed clinical psychologists in Australia is deceptive, as many do not meet the minimum standard set by the Psychology Board of Australia as they were "grandparented" into endorsement at the introduction of national registration, many without any post-graduate qualifications.

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 loss.

However, any effort to remove post-graduate 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 is likely to lead to a substantial downgrading of standards and a two-tier post-graduate training scheme of differing quality.

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.

(f) The adequacy of mental health funding and services for disadvantaged groups, including:

(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 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 asked to undertake 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 the 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

(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 injury. We understand the insurance and legal systems dominate in this area, but we recommend equal treatment of those who have been injured through all means.

Recommendation:

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

(g) the delivery of a national mental health commission

A national mental health commission is essential to enable the integration of services, programs and service providers that 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 requires representation of major stakeholders at all levels, including qualified clinical psychologists. It is important to note that the Australian Psychological Society primarily represents psychologists without accredited post-graduate clinical training, as this group makes up more than 90% of its membership.

(h) 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 provide further compelling arguments for the broad provision of such services. This is reflected in the increasing number of services 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 and 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.

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.

Use of developing technologies, such as Skype, also needs 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. This would radically enhance service delivery to those requiring it in these areas.

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. Educational standards are often low, with high levels of illiteracy. 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 program 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 pay the co-payments required. 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 and do not communicate with other mental health professionals (including GPs and psychologists). They are highly selective in the referrals they accept and routinely exclude people with severe psychopathology because "they do not comply" or if "relatives are aggressive" and return them to their GP and psychologist for on-going care. Actively suicidal people are similarly returned to the GPs. There are only a very small number of psychiatric beds.

Special incentives need to be provided for mental health professionals to work in rural and remote areas.

Recommendation:

- 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 needs 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. This would radically enhance service delivery to those requiring it in these areas.
- Special incentives need to be provided to GPs, clinical psychologists, and psychiatrists to work in rural and remote areas in terms of higher rebates tied to area.

(j) 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, including 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 these sessions do not meet Medicare requirements when the identified patient is not present, creating significant obstacles to treatment. Of particular concern is the fact that limiting treatment to sessions where the identified patient is present can result in vital information regarding patient safety not being provided to the 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 child/adolescent, even this provision is not extended to the Better Access program.

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 Plan.

Appendix A

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

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 scheme 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 patients
Global Assessment of Functioning Scale		
	Severe- Extremely severe impairment	30%
	Moderate impairment	36%
	Mild/Minimal impairment	31%
Number of mental health diagnoses		
	1	42%
	2	42%
	3 or more	16%
Duration of presenting symptoms		
	2 – 5 years	20%
	5 years or more	33%
History of trauma present		
	Childhood emotional abuse	43%
	Childhood physical abuse	22%
	Childhood sexual abuse	11%
	Childhood neglect	23%
	Witness of domestic violence in family of origin	25%
	Significant traumatic event as an adult	38%

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 the Australian Clinical Psychology Association. This snapshot of clients seen by clinical psychologists demonstrates the complexity of many patients seen by clinical psychologists in the private section, and therefore the need for psychological intervention at least at the level currently provided for under the Better Access Scheme 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	44,07519	**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	44,07519	**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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