The Australian Psychological Society Ltd

Submission to the Senate Standing Committee on Community Affairs

Inquiry into the Commonwealth Funding and Administration of Mental Health Services

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Executive Summary

As the peak body for the profession of psychology in Australia representing more than 20,000 members, the Australian Psychological Society (APS) is pleased to provide this response to the Senate Inquiry.

The APS understands that the Senate Inquiry was primarily established to investigate the 2011 Federal Budget cuts to the Better Access initiative, the most significant of which was a reduction in the maximum number of sessions of psychological treatment allowed per client per year from 18 to 10 sessions. The Terms of Reference for the Inquiry have now broadened to encompass other aspects of the funding and administration of Commonwealth mental health services, but the APS urges the Senate Committee to focus its attention on the Federal Budget cuts to the Better Access initiative as these are due to come into effect on 1 November 2011 and will deny effective psychological treatment to an estimated 87,000 people per annum from this date.

The APS has been working with the National Mental Health Consumer and Care Forum (NMHCCF) to understand the impact of the 2011 Budget cuts on a personal level on people who will be most affected. NMHCCF has received a large number of responses that cogently illustrate the personal toll that arises when cuts are made to services that are already working well and the lack of other viable options for treatment. The feedback from Better Access consumers has been interspersed throughout this submission.

Since the Government announced the Budget cuts, the APS has undertaken a study of the nature and severity of disorders of the Better Access consumers who will actually be affected by these cuts. The APS research, conducted on a large sample of 9,900 people who received between 11 and 18 sessions of treatment from psychologists under the Better Access initiative last year, shows that these are overwhelmingly people with severe depression or anxiety disorders, including posttraumatic stress disorder.

The APS study demonstrates that 84% of these people had a moderate to severe or severe disorder at the commencement of treatment, with 65% having additional complexities such as a second mental health disorder, personality disorder, drug and alcohol abuse, or family/relationship breakdown. The research shows that by the end of psychological treatment only 3% remained severely affected, while for 43% of people their disorders were effectively reduced to either no symptoms or only a mild presentation.

These people would be denied the additional sessions of psychological care required for effective treatment through the Better Access initiative under the 2011 Budget funding cuts. The vast majority of these people would also be denied access to public sector mental health services as they have high prevalence disorders and are not necessarily in need of team-based care.

The Government has stated that people affected by the cuts can be seen under the Access To Allied Psychological Services (ATAPS) program run through the Divisions of General Practice (DGPs), but this is not a viable referral option under current arrangements. There is simply not enough funding in ATAPS to provide services for anything like 87,000 people per annum. In

addition, ATAPS costs from 2-10 times more per session than Better Access (the typical cost of a package of care delivered by a psychologist under the initiative is $753). The Government's own evaluation of the Better Access initiative (Pirkis et al., 2011) demonstrated that it is a cost-effective way of delivering mental health care. Successful treatment also reduces costs of hospital admissions and allows many consumers to return to work, with the associated productivity benefits.

The resounding evidence from the representative APS study of nearly 10,000 Better Access consumers who needed more than 10 sessions demonstrates that the Budget cuts to the Better Access initiative are misguided. The APS urges the Senate Committee to recommend that these funding cuts are reversed to enable those many thousands of Australians with serious yet all too common mental health disorders to continue to access the appropriate length of effective and cost-efficient psychological treatment under the highly successful Better Access initiative.

Introduction

As the peak representative body for the profession of psychology in Australia, the Australian Psychological Society (APS) is pleased to respond to the Senate Inquiry.

About the Australian Psychological Society

The APS represents over 20,000 members spread across metropolitan and rural Australia, and its functions are conducted through the National Office in Melbourne and through the 199 active member groups within the Society. There are 40 APS Branches throughout Australia, nine APS Colleges representing specialty areas within the profession (clinical neuropsychology, clinical psychology, community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology, organisational psychology and sport psychology), and 40 Interest Groups representing the wide range of special interests of the APS membership.

The APS has responsibility for setting professional practice standards for psychologists, providing ongoing professional development, and accrediting university psychology training programs across Australia. The APS also has in its charter the responsibility to promote community mental health awareness and psychological wellbeing, and to highlight the contribution of psychology to matters of community concern.

Like its counterparts in the US and UK, the APS offers advice and consultation to Government and public decision makers to promote and support community wellbeing. The APS is currently represented on a number of peak health bodies, taskforces and Government advisory groups.

About this submission

The APS understands that the Senate Inquiry was primarily established to investigate the 2011 Federal Budget cuts to the Better Access initiative, the most significant of which was a reduction in the maximum number of sessions of psychological treatment allowed per client per year.

The Terms of Reference (TOR) for the Inquiry have now broadened to encompass other aspects of the funding and administration of Commonwealth mental health services, but the APS urges the Senate Committee to focus its attention on the Federal Budget cuts to psychological services under the Better Access initiative (covered under TOR A and B on pages 6 to 11 of this submission) as these are due to come into effect on 1 November 2011 and will deny effective psychological treatment to an estimated 87,000 people per annum from this date.

This submission therefore focuses primarily on TOR A and B. A briefer response to each of the other TOR is also provided.

Response to the Inquiry Terms of Reference

A. THE GOVERNMENT'S 2011-12 BUDGET CHANGES RELATING TO MENTAL HEALTH

Although the Government is to be congratulated for delivering significant new investments in mental health in the 2011-2012 Budget, this is being partly funded through a redirection of crucial funding from the Medicare-funded Better Access initiative, the most successful national mental health program in the last 30 years.

In order to fund other significant new mental health initiatives, the Budget delivered changes to the Better Access initiative to apply from 1 November 2011, involving a reduction in the number of sessions of psychological treatment a person with a mental health disorder can receive each year from a maximum of 18 down to 10 (not from 12 to 10 as has been widely reported). The removal of these eight sessions will have a dramatic impact on many thousands of people with severe mental health problems, who will be denied effective treatment. The APS welcomes the increased funding for mental health but this should not be at the expense of consumers being able to access successful treatment under the Better Access initiative. The APS response to this matter is covered comprehensively under TOR B (4).

There is generally a low level of Government funding for mental health in Australia and a high level of unmet community demand, therefore there should only be new investments in mental health rather than cuts to existing successful mental health programs.

B. CHANGES TO THE BETTER ACCESS INITIATIVE

1. THE RATIONALISATION OF GP MENTAL HEALTH SERVICES

The 2011-12 Budget cuts to the Better Access initiative included a cut in the rebate for GPs preparing Mental Health Treatment Plans. In relation to this Budget change, the APS reasserts its longstanding position that, for people with mild to moderate and less complex high prevalence mental health disorders, the majority of GP referrals for psychology treatment services should follow the same procedure as any other GP referral and require only a referral letter to the treating psychologist. However, the GP should be appropriately reimbursed for the coordination of services for people with more complex and severe mental illness, as there should be recognition of the additional time and resources required to coordinate their care.

A further consideration is that the Better Access evaluation (Pirkis et al., 2011) reported that the GP Mental Health Treatment Plans were considered to be highly variable and in many cases of limited value to treatment. The APS therefore believes that the requirement and payment for the development of the GP Mental Health Treatment Plan should be better targeted, and proposes that the professions involved in Better Access service delivery be engaged in a dialogue to review and improve the use of Mental Health Treatment Plans as an effective tool to manage the coordination of Better Access consumers' care where it is required.

In addition, the APS believes that a range of medical practitioners should also be able to refer people for treatment under the Better Access initiative – currently referral is restricted to GPs, psychiatrists and paediatricians.

2. THE RATIONALISATION OF ALLIED HEALTH TREATMENT SESSIONS

Current arrangements under the Better Access initiative

- On referral from a medical practitioner, people can access up to 12 sessions of treatment from a psychologist per calendar year.
- The referring practitioner may consider that in "exceptional circumstances" the person requires an additional six sessions of psychological treatment (to a maximum total of 18 individual services per person per calendar year).
- Exceptional circumstances are defined as a significant change in the person's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services.

2011 Federal Budget cuts to the Better Access initiative

- From 1 November 2011, the yearly maximum allowance of sessions of psychological treatment will be reduced from 18 to 10, with no exceptional circumstances enabling additional sessions.

- The Government has stated that the cuts to Better Access equate to 13% of people treated by psychologists who are seen for more than 10 sessions.
- Medicare Australia session data indicate that in the first three years of the Better Access initiative (2007–2009) 2,016,495 unique individuals received services from psychologists under Better Access and 262,144 (13%) of these people received more than 10 sessions of psychological treatment.
- This represents a figure of approximately 87,000 people per annum who will be denied the additional sessions of psychological care required for effective treatment.

3. THE IMPACT OF CHANGES TO THE MEDICARE REBATES AND THE TWO-TIERED REBATE STRUCTURE FOR CLINICAL ASSESSMENT AND PREPARATION OF A CARE PLAN BY GPS

See response to TOR B (1) above.

4. 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

"If my suicidal ideation increases after my 10 sessions are up, what am I supposed to do? Other mental healthcare professionals who do not know my history are simply unable to assist me effectively in a crisis, which, in part, led to my last hospitalisation..."
Better Access consumer

"My concern is that if the current number of visits allowed to a psychologist is reduced to 10, it would have a dramatic impact on the mental health and coping ability of not only my two boys, and their education, but also on the mental health of the family unit...It would also have a significant impact on our already stretched finances."
Better Access consumer

"If I had not been able to access CBT on many occasions in the last few years I would be a suicide statistic. It's as simple as that."
Better Access consumer

The three quotes above from Better Access consumers cogently present the impact of the reduction in the number of allied health treatment services on people who are currently receiving effective psychological care under the initiative. The APS has been working with the National Mental Health Consumer and Care Forum (NMHCCF) to understand the impact of the 2011 Budget cuts on people who will be most affected, and these three voices represent just some of the many personal responses the NMHCCF has received. The voices of Better Access consumers illustrate the personal toll that arises when cuts are made to services that are already working well and the lack of other viable options for treatment. The feedback from Better Access consumers has been interspersed throughout this submission.

In the 2011-2012 Budget papers the Government provided the following rationale for funding cuts to the Better Access initiative:

> *"The new arrangements will ensure that the Better Access initiative is more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are provided with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program."*

As mentioned previously, the Government has stated that the funding cuts to Better Access amount to 13% of people treated by psychologists who are seen for more than 10 sessions. The Government's reliance on Medicare session usage data to inform the decisions that are made does not take into account the nature and severity of the mental health disorders of people who will be affected by the cuts. An investigation of the mental health disorders of past Better Access consumers, and recommendations for the Government's proposed alternative care arrangements for those who would be affected by the cuts, reveals that the Government's rationale for the funding cuts to Better Access is very questionable.

Budget changes will affect people with moderate to severe mental health disorders

"...After that time my illness had improved from extremely serious, to moderate with short bouts of deep depression. Often a short phone conversation (at no cost) with her [the psychologist] can lessen the depth of a bout. I have continued to see her once a week ever since. I am much improved but I am not cured..."
Better Access consumer

The Government's own evaluation of the Better Access initiative (Pirkis et al., 2011) indicated that 80 per cent of Better Access consumers reported high or very high levels of psychological distress, mostly associated with a 12-month affective, anxiety or substance use disorder. This demonstrates that Better Access is not a program servicing people with only mild mental health disorders.

Since the Budget cuts were announced, the APS has conducted a study designed to demonstrate the potential impact of the changes on clients who would have been affected by the reduction in the number of sessions of psychological treatment. The study involved an audit survey of Better Access clients seen by psychologists in 2010 who required more than 10 sessions of psychological treatment. Psychologists providing services under Better Access were invited to participate in the online audit survey and data on a large sample of 9,900 Better Access clients was collected from 1,182 psychologists.

APS research study results:

- The research indicated that the vast majority of Better Access clients who required more than 10 sessions of psychological treatment had moderate to severe high prevalence mental health disorders involving depression and anxiety disorders, including posttraumatic stress disorder. These disorders were frequently complicated by comorbidities.
    - On referral, 84% of Better Access clients were rated by the treating psychologist as having a moderate to severe (41%) or severe presentation (43%) and only 0.2% were rated as having a mild presentation.
    - 81% had an ICD-10 mental disorder involving depression or anxiety disorders, also known as 'high prevalence disorders'.
    - Only a very small number had a 'low prevalence disorder' – 2% had schizophrenia, 2% had another psychotic disorder and 5% had a diagnosis of bipolar disorder.
    - 65% of clients had additional complexities to their presentations, including 43% with comorbidity involving another ICD-10 mental disorder, drug and/or alcohol disorder or a personality disorder, and 22% with co-occurring family/relationship breakdown.

Budget changes will deny effective treatment to people with moderate to severe mental health disorders

"Thanks to the introduction of Better Access I have finally found a treatment plan that works. This consists of an incredibly adept psychiatrist and psychologist working collaboratively to provide my treatment... This collaboration is invaluable in helping me cope with an illness that has so far proven far from curable, ensuring that I will still be able to contribute to society at my full potential, despite my illness, reducing my symptoms from severe to manageable."
Better Access consumer

APS research study results:

- The research study showed that these clients with moderate to severe high prevalence disorders who required more than 10 Better Access sessions had treatment outcomes indicating very significant improvement, demonstrating that they received effective psychological care.
    - At the commencement of the episode of treatment, 84% were rated by the treating psychologist as having a moderate to severe or severe presentation and only 0.2% were rated as having a mild presentation.
    - At the conclusion of the episode of treatment, 43% were rated by the treating psychologist as having no residual symptoms (10%) or a mild presentation (33%), while only 3% retained a severe presentation.
- The research showed that up to 18 sessions of psychological treatment were required by clients with moderate to severe high prevalence disorders to achieve these effective outcomes.
    - 37% of clients required 11 or 12 sessions to achieve an effective treatment outcome.
    - 37% of clients required the additional 6 sessions under exceptional circumstances (to a maximum of 18 sessions) to achieve an effective treatment outcome.

Taken together, these findings indicate that the Better Access initiative is providing care for the very people it was designed to treat – those with high prevalence mental health disorders and significant levels of distress (not the 'worried well' as critics of the Better Access initiative frequently disparagingly refer to), who are being managed by GPs in primary care settings.

The APS research data have clearly demonstrated that the session cuts will affect those with moderate to severe mental health disorders who will be denied effective treatment under the initiative. The Government's own evaluation of Better Access demonstrated that it is a cost-effective way of delivering mental health care. Successful treatment also reduces costs of hospital admissions and allows many consumers to return to work, with the associated productivity benefits.

The Government's recommendations for people needing more than 10 sessions of Better Access psychological care are not viable

"A reduction in psychology services available under Medicare would, in my case, result in me returning to a higher level of care from a psychiatrist. This regime has proven to be less effective and would be more costly to the taxpayer. However it would be our only choice."
Better Access consumer

The APS believes the Government's recommendations for alternative care for people affected by the 2011 Budget cuts are misguided. For example, the Federal Budget papers state:

> *"The new arrangements will ensure that the Better Access initiative is more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are provided with more appropriate treatment through programs such as the Government's Access to Allied Psychological Services program."*

The Department of Health and Ageing Fact Sheet on the Budget measure states:

> *"People with severe and persistent mental disorders who require over 10 allied mental health services are still eligible for up to 50 Medicare Benefits Schedule consultant psychiatrist services per annum, or to access the specialised mental health system in each State or Territory."*

The Government's rationale that affected patients can seek alternative treatment through the ATAPS program, public mental health facilities or private psychiatrists is unviable as these avenues are not currently accessible or equipped to manage the large influx of affected people.

- There is simply not enough funding in the ATAPS program to provide services for anything like the estimated 87,000 additional people per annum who will be affected by the Budget cuts. In addition, ATAPS service delivery costs from two to 10 times more per session than Better Access (the typical cost of a package of care delivered by a psychologist under the Better Access initiative is $753; Pirkis et al., 2011). This alternative care recommendation would also disrupt continuity of treatment for those whose care would need to be transferred after 10 sessions and denies the importance of the therapeutic alliance within the psychological treatment.
- As the APS research study has indicated, the vast majority of these people would also be denied access to public sector mental health services as they have high prevalence disorders and are not necessarily in need of team-based care.
- The recommendation that these people should be referred to a consultant psychiatrist is not realistic as there is a significant shortage of psychiatrists and most charge a prohibitive gap fee (in 2009, the average copayment for consultant psychiatrist Better Access MBS items was $82 per session; Pirkis et al., 2011). There is significant inequity in the fact that psychiatrists are funded to provide up to 50 treatment services per year for each person given the cap on the number of allowable treatments that can be provided by psychologists.

C. THE IMPACT AND ADEQUACY OF SERVICES PROVIDED TO PEOPLE WITH MENTAL ILLNESS THROUGH THE ACCESS TO ALLIED PSYCHOLOGICAL SERVICES PROGRAM

The Access To Allied Psychological Services (ATAPS) program is implemented through the Australia-wide network of Divisions of General Practice (DGPs) which receive funding to purchase psychological treatment services.

The APS supports the Federal Government's continued funding of the ATAPS program, particularly where its flexible structure enables targeted populations to receive special attention as it is easier to administer targeted programs through DGPs. Thus, some rural and remote mental health treatment services are administered effectively through the ATAPS program due to the locations of particular DGPs. The Government has also successfully piloted some innovative targeted mental health initiatives through the ATAPS program. These include a trial of telephone-based psychological treatment in rural DGPs and a trial to specifically target intense support and treatment for people at risk of suicide or deliberate self-harm. The ATAPS program is also well suited to specific Indigenous mental health initiatives, as the provision of services through DGPs can be tailored to more community focused and less formal, time-driven services.

However, routine mental health treatment provision, particularly in metropolitan and regional areas, is less effectively provided through the ATAPS program in comparison to the Better Access initiative.

Crucial treatment funds are expended on administering the program through DGPs

A major issue is that a proportion of the funding for mental health services received by DGPs under the ATAPS program is spent on administering the program rather than delivery of the treatment services. As stated previously, ATAPS service delivery costs from two to 10 times more per session than Better Access and this difference is essentially due to administration costs.

The quality of treatment provided under the program is frequently compromised

Frequently the ATAPS mental health programs in DGPs are managed by under-qualified or administrative staff who are responsible for the selection and monitoring of ATAPS service providers. Often more junior psychologists are selected to provide services as they attract lower salaries and allow funding for the program to go further, but this can put the quality of the treatment services at risk. More experienced psychologists cannot viably undertake the work for the lower wages or fee-for-service offered, and these are the very psychologists that people with severe mental health disorders should be receiving treatment from. In addition, more expert psychology input is required in the selection and professional/clinical support of staff working under the ATAPS program within DGPs. ATAPS should not be solely managed by Divisions, but should have input from allied health bodies to ensure quality of allied health service provision.

Episodic nature of funding compromises service delivery

The episodic nature of funding of the ATAPS program through DGPs diminishes service continuity for those receiving mental health treatment. In addition, the unpredictable funding arrangements prevent security of tenure for psychologists providing services through the Divisions and results in the employment of less qualified and junior practitioners, who may not be able to find more secure work elsewhere. The irony is that if funding through the ATAPS program is meant to provide focused initiatives for the seriously mentally ill, the current funding mechanisms in a large number of cases mean that only less qualified practitioners are able to provide these services, which is not an appropriate arrangement.

Under the Government's health reforms DGPs are to become Medicare Locals, and it is hoped that this will facilitate significant changes to the way ATAPS is administered and funded to make service provision under this program more effective and attractive to experienced psychologists. However, until these changes are made it is not appropriate to move the care of people with serious mental disorders, particularly those that do not necessarily require team-based care, out of the Better Access initiative and into the ATAPS program.

D. SERVICES AVAILABLE FOR PEOPLE WITH SEVERE MENTAL ILLNESS AND THE COORDINATION OF THOSE SERVICES

Services to people with severe mental illness are currently limited. State-based mental health services generally only provide ongoing services to those with low prevalence disorders who are extremely unwell, usually those with psychotic symptoms. State-based services are chronically underfunded and opportunities to shift costs to the Commonwealth are frequently taken. People with severe psychotic illness who have stabilised are frequently referred to GPs for ongoing care in the community, and this is not always coordinated effectively due to the limitations within primary care settings. Increased funding for State-based mental health services for people with severe and chronic mental illness is urgently required to ensure access to effective team-based care.

People with severe mental illness involving high prevalence disorders such as depression and anxiety disorders have limited options for treatment services and these are primarily provided by the private sector i.e., those in independent practice under public health funding through the Medicare Benefits Scheme. These people are currently being serviced through the Better Access initiative, and their treatment will now be compromised due to the Budget changes involving a reduction of treatment sessions from an annual maximum of 18 to 10 sessions. It is ironic that these are the very people that the Better Access initiative was designed to provide services for.

E. MENTAL HEALTH WORKFORCE ISSUES

1. THE TWO-TIERED MEDICARE REBATE SYSTEM FOR PSYCHOLOGISTS

In the lead up to the introduction of the Better Access initiative in early 2006, the APS originally recommended to the Government that Medicare rebates should be available for services provided by "clinical and mental health specialist psychologists", based on competencies in terms of specified mental health knowledge and skills (in psychopathology [including assessment, diagnosis and case formulation], counselling skills and psychotherapy/psychological interventions) and specified supervised post-registration experience in mental health settings. These psychologists were primarily those with the appropriate postgraduate training and subsequent experience, although there was recognition of those who had achieved the equivalent level of specialist training and experience through alternative means. At that stage there was only one level of Medicare rebate proposed by the Government.

Informed by its own mental health advisors, the Government subsequently determined that access to providing services under the initiative would be limited to clinical psychologists. The APS argued vigorously that there were also many other psychologists who could provide effective psychological treatments to mental health consumers. The Government then decided that these psychologists would be funded to provide ‘general' psychology services to boost community access to affordable psychological care. Hence the two-tiered Medicare rebate system was established and the current definition of eligibility for the higher rebate as being exclusively for clinical psychologists has been an extremely divisive issue within the psychology profession since the Better Access initiative was introduced.

The medical model of the Medicare Benefits Scheme

The Medicare Benefits Scheme is a medical model of service provision which broadly recognises through a differential Medicare rebate those services provided by general medical practitioners and those provided by medical practitioners with additional specialist training. As the Better Access initiative is implemented through the Medicare Benefits Scheme this medical model of general and specialist levels of Medicare rebates has been adopted.

The APS sees the current two-tiered Medicare rebate system for psychologists providing services under Better Access as consistent with the broad medical model of the Medicare Benefits Scheme in its recognition of additional specialist training attracting a higher rebate. However, the APS believes that the current definition of those psychologists who are eligible to provide Better Access services attracting the higher rebate should be broadened beyond clinical psychologists, as there are other psychologists with additional specialist mental health training for high prevalence disorders who are currently denied access to providing these services under the higher rebate.

A broader definition of specialist skills in the treatment of high prevalence mental health disorders should be adopted

Under the current two-tiered rebate structure, the APS therefore believes that there should be a broadening of the upper tier to include services provided by other psychologists who possess specialist knowledge and skills in the treatment of high prevalence mental health disorders. The APS recommends that the essence of the original proposal submitted to the Government is used to provide a broader definition of psychologists who are considered to have the necessary skills to be considered a specialist in providing treatment for high prevalence mental health disorders, and hence to deliver services at the higher fee level under the current structure. This would recognise and value appropriate formal postgraduate professional degree education as the primary means of gaining specialist skills, provided these were in the specified mental health competencies. Currently there are a number of psychologists who are only eligible to provide services in the lower tier who hold Masters and Doctorate degrees, as well as some very experienced and highly skilled '4+2' psychologists, who could be considered to have the requisite specialist mental health training and supervised experience.

Allow the profession to determine the title, specialist competencies and how these are assessed

The APS recommends that the title given to psychologists providing services at the specialist rebate level, the specialist competencies and how these are assessed should be determined by the profession of psychology, as this was not the case when the Better Access initiative was first introduced and has resulted in major divisions within the profession. The APS believes that this debate can be sensitively handled within the profession to ensure that the most important outcome is achieved – the Government funds quality mental health services for people with high prevalence disorders.

2. WORKFORCE QUALIFICATIONS AND TRAINING OF PSYCHOLOGISTS

Psychology is a regulated profession in every State and Territory in Australia through the National Registration and Accreditation Scheme for the Health Professions. In Australia, psychology graduates are required to meet six years of professional training for full registration.

The APS supports the current qualifications and training of psychologists, as specified by the Psychology Board of Australia under the National Registration and Accreditation Scheme. The Psychology Board's standard for qualifications that lead to general registration as a psychologist in Australia are as follows:

a) an accredited Master's degree; or
b) a five year accredited sequence of study followed by a one year Board approved internship ('5+1' pathway); or
c) a four year accredited sequence of study followed by a two year Board approved internship ('4+2' pathway); or
d) a qualification that in the Board's opinion is substantially equivalent to either (a), (b) or (c).

Australian psychology training evolved during the 20th Century to encompass two pathways to registration. Both pathways require four years of undergraduate education that includes a sequence of psychology subjects accredited by the Australian Psychology Accreditation Council (APAC) followed by two years of professional training. Following the four-year undergraduate degree in psychology, one pathway is wholly university based and incorporates a professional postgraduate degree (Masters or Doctorate) with course work, applied research and supervised practice, whereas the other involves two years of supervised practice through a workplace internship ('4+2' pathway). In the last year a third pathway ('5+1' pathway) has been introduced, involving a five-year sequence of university psychology training and a one-year workplace internship.

The required two years of education and training in professional psychology following the undergraduate degree must also be accredited by APAC for the university postgraduate training pathway, or approved by the Psychology Board of Australia for the supervised workplace internship pathway. Both pathways require that during these two years of professional training, trainee psychologists achieve a set of core competencies in areas such as psychological assessment, treatment interventions, and ethical and legal matters. As part of meeting these requirements, trainee psychologists must undertake a specified number of hours of supervised psychological practice under the supervision of a registered psychologist.

The Psychology Board of Australia has stated a desire to work towards the introduction of a uniform pathway of registration for psychology involving a minimum qualification of a Master's degree. The APS supports this proposal, however, to ensure the sustainability of the workforce this must be accompanied by substantially increased funding to the university sector to enable considerably more student places in professional psychology Masters degree programs to be offered and for these places to be funded at a financially viable level. Currently the level of funding received by universities for training places in professional psychology Masters degree programs falls short by $8,600 per student per annum.

3. WORKFORCE SHORTAGES

The APS believes that an urgent increase in funding is required for postgraduate professional psychology training programs to meet the workforce demands. In addition, there will need to be an increase in available scholarships for postgraduate study, particularly for those least able to afford this, such as those from Indigenous and culturally and linguistically diverse (CALD) backgrounds. Australia's increasingly culturally diverse population requires a psychology profession with diverse practitioners to meet its needs.

F. THE ADEQUACY OF MENTAL HEALTH FUNDING AND SERVICES FOR DISADVANTAGED GROUPS

1. CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES

The APS supports initiatives that increase access to mental health services for people from culturally and linguistically diverse communities. Many of these communities require targeted mental health services that could be delivered from the Medicare Local or appropriate Non-Government Organisations within their geographic boundary through ATAPS and other mental health programs.

2. INDIGENOUS COMMUNITIES

The APS supports initiatives that increase access to mental health services for Indigenous communities. Psychological knowledge and practice has much to offer to address the disadvantage and associated high levels of mental health problems experienced by Australia's first peoples, who represent 2.4 per cent of the Australian population. More Indigenous psychologists are needed to contribute their unique understanding in areas of mental health policy, research and professional practice. There are currently about 40 Indigenous psychologists in Australia, and, if the numbers were proportional to the number of practising psychologists in the Australian population, there should be around 600 Indigenous psychologists.

The APS aims to increase the representation of Indigenous psychologists in the profession and has facilitated the establishment of the Australian Indigenous Psychologists Association (AIPA) under the auspices of the APS. AIPA is working closely with the Australian Government to develop and implement a range of initiatives to address Indigenous mental health issues including training in cultural competency and suicide prevention for non-indigenous psychologists.

3. PEOPLE WITH DISABILITIES

The APS supports initiatives that increase access to mental health services for people with disabilities. The APS has recently overseen the development of guidelines for the use of psychological interventions to reduce the use of restrictive interventions such as physical and pharmacological restraint, which can have a significant impact on the mental health and wellbeing of people with disabilities. The guidelines have been disseminated widely and promoted through the media.

G. THE DELIVERY OF A NATIONAL MENTAL HEALTH COMMISSION

The APS supports the establishment of a National Mental Health Commission to provide advice to Government on services based on evidence of effectiveness, and to enable accountability and transparency in measuring the performance of the mental health system. The APS believes that psychology should be represented on the Commission given that it is the largest profession within the mental health workforce. The APS is pleased that the Commission is being established under the Prime Minister's own Department and will give advice directly to the Prime Minister, which will help to ensure that mental health is given a high priority within the Australian Government.

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

The APS supports the development and utilisation of evidence-based online interventions, particularly to reduce the impact of isolation and poor access to mental health services in rural and remote communities. Online interventions have been shown to be effective for a range of mental health conditions including depression, anxiety disorders, alcohol and drug conditions, and eating disorders. Online interventions represent new ways of providing services that are accessible, safe and capable of enhancing self-care management practices, however further research is required to fully understand who can benefit most from online interventions as they will not be effective for all people, nor under all conditions. Face-to-face delivery of treatment will remain a critical component of treatment and support for the majority people with mental illness.

Online interventions can be used in a variety of ways within professional practice. For example, online counselling and/or prescription of online interventions can be provided through an online clinic with communication via email/skype/telephone, or online interventions can be used as adjuncts to supplement traditional face-to-face care. It is imperative that online interventions are evidence-based and disseminated with proper regard to appropriate service delivery standards and ethical matters associated with the therapeutic relationship. Many of these innovative ways of providing treatment will require the Medicare rebates currently available to medical professions for online treatment services to be expanded to include allied health providers.

Reference

Pirkis, J., Harris, M., Hall, W., & Ftanou, M. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: summative evaluation.* Melbourne: Centre for Health Policy, Programs and Economics.