25 May 2005

The Secretary
Senate Select Committee on Mental Health
Parliament House
CANBERRA ACT 2600

Dear Sir/Madam

RE: Submission by Rudd and Jackson.

We would like to direct the Committee's attention to the fact that, as experienced Clinical Psychologists, we have concentrated in our submission on our own profession's role in the mental health system, for the following reasons.

First, it is the function with which we are most familiar, by virtue of accumulated experience, collegial network, and an ongoing interest in contributing to sound policy development for mental health services. We therefore feel able to make constructive suggestions in this particular area.
Second, Clinical Psychologists are, due to the nature of their core work activities, generally low profile. This contributes in some measure, along with the essentially personal and private nature of their clinical practice, to a lack of sufficient detailed community awareness of their particular role in mental health services. Efforts to improve that information situation are desirable, especially now Clinical Psychologists are eligible for some Federal part-subsidy via GP Divisions. The latter needs broadening to direct Medicare access for Clinical Psychology services, in order to make such services as widely available as possible.
Third, we have ongoing concern that service provision in mental health, being a frequently complex and very challenging role, needs to be underpinned by sufficient and adequate postgraduate professional training in clinical psychological skills delivery, and not by a lesser trained workforce. This is broad systems' and training issue requiring close attention both to current service configurations, and in relation to long term planning.

We are available to provide any further detail for the Committee, should that be required.

Yours sincerely

Raymond Rudd MSc (Clin Psych)
Clinical Psychologist

Henry Jackson MA (Clin Psych) PhD
Clinical Psychologist

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Submission by Raymond Rudd, MSc (Clin Psych) MAPS
Clinical Psychologist and Convenor, Professional Development, College of Clinical Psychologists Victorian Section; and Professor Henry Jackson PhD, MA (Clin Psych) FAPS, Clinical Psychologist and Head, Department of Psychology, The University of Melbourne.

Background

Raymond Rudd has worked as a Clinical Psychologist in public mental health services for 22 years, in both inpatient and community settings, and prior to that in tertiary Psychology education. He holds a MSc in Clinical Psychology from The University of Melbourne, have also supervised post-graduate trainees for a lengthy period. He has co-authored a number of publications in the mental health field, particularly in the areas of serious mental illness and its interface with personality disorder. He has also been an Honorary Senior Fellow in the Department of Psychology at The University of Melbourne.
He is currently a member of the College of Clinical Psychologists Victorian Section Committee, and Convenor of its Professional Development program, and was previously a member of the National Executive of the College of Clinical Psychologists for three years.
Ray's clinical work in adult public mental health services over an extensive period has focused on severe and complex patient presentations, and in supervising novice clinicians and students in this area. These patient presentations frequently include two or more comorbid diagnoses and other coping difficulties. The common patterns are serious mental illness, personality problems with marked emotional and behavioural risk factors such as substance abuse or aggression potential, limited social support networks, and reduced abilities with everyday coping skills.

Henry Jackson is a Professor and Head of the School of Behavioural Science (Department of Psychology) at the University of Melbourne. He is a Clinical Psychologist who worked from 1978 to 1991 as a full-time clinician. He was Head of Psychology at Royal Park Hospital from 1985-1991. He has been in academia since 1991 but retains strong links with the public mental health system and was until 1998 in charge of the Postgraduate Clinical Psychology training program at Melbourne University.

Henry's research contributions have been in the study of schizophrenia and early psychosis - especially psychological interventions and psychopathology

– and in the study of personality and personality disorders and their relationship to mental disorders such as depression and anxiety disorders. Henry has authored or co-authored over 110 papers in refereed journals and 11 book chapters. He has co-edited two books. Henry has given many papers at national and international conferences. He is and has been a Chief Investigator on grants from the NH&MRC, Victorian Health Promotion Foundation, the Australian Rotary Health Research Fund, and ARC (small), including the large NH&MRC Program and Clinical Centre of Excellence Grants on early psychosis awarded to ORYGEN in 2004.

Henry was made a Fellow of the Australian Psychological Society in 1995. He was Chairperson of the North Western Healthcare Network Research Committee and its precursors for a decade. He was Chair of the NH&MRC Project Grants Committee for Psychology and Psychiatry in 2003 and 2004 and a member of that panel in 2001 and 2002. He is an ex-National President of the Board (now College) of Clinical Psychologists of the Australian Psychological Society. Currently, he is a member of the National Committee for Psychology of the Australian Academy of Science.

Comment

1. The latest National Mental Health Strategy (NMHS) Report (2004) notes that "…surveys…of mental illness in the community have highlighted a high level of unmet need" (p.11). In addition, consumer and carer feedback emphasizes that "…the Strategy's vision of accessible, responsive and integrated mental health services has little resemblance to the current reality in many areas of Australia." (p. 31). And, in relation to child and adolescent mental health services, Professor Prior (Submission No 32) notes that "many clinicians…are significantly undertrained…lacking specialist postgraduate qualifications..." and "services for families and children…are totally inadequate in terms of quantity and quality". The current situation regarding provision of services for adults can be similarly construed, given the NMHS survey data for the adult population, with the additional factor of limited accessibility common across the age spectrum.

This situation indicates that there are likely identifiable "opportunities for improving coordination and delivery of funding and services…" (Term of Reference c.) and these can be tackled ongoing. One pressing example of need for service reconfiguration is in public mental health services, where a potential significant inefficiency factor exists in relation to best use of workforce professional skills. Clinical Psychologists job and career prospects as clinical practitioners are currently severely limited in many services by their having to adopt non-specialist or non direct-care management roles in order to access promotion, to the detriment of ongoing direct service provision. Ironically, it is direct service provision for which Clinical Psychologists are most extensively trained. This situation needs rectifying with action that acknowledges the critical importance and shortage of skills in clinical service delivery, by reconfiguring to the extent that a clear career

path for clinical practitioners through to senior levels is broadly instituted. This need also applies in other States besides Victoria. Apart from this one example, the overall position of Clinical Psychology services in mental health requires improvement.

It is a fact that Clinical Psychology occupies a unique place in mental health services. By virtue of scientist-practitioner postgraduate training, they can offer a relatively broad range of skill functions. These include detailed, evidence-based assessment and diagnosis and evidence-based therapy, particularly with complex cases, research, evaluation, primary, secondary and tertiary consultation, education, supervision and teaching. The profession has historically contributed a great deal in total for mental health relative to their numbers, especially in treatment and research. But, the position of the profession generally requires considerable improvement. Their workforce numbers are relatively small, there are increasing pressures to curtail rather than increase training places, and there are difficulties recruiting and retaining Clinical Psychology services particularly in the public sector due to limited and unattractive positions with poor career prospects, as noted above.

Service reconfiguration, while a necessary periodic initiative, is only part of the answer. Term of Reference c. also includes “opportunities for improving…funding…” The outcomes of better service coordination and integration are obviously limited if current overall funding, and funds’ targeting especially for workforce training, is not adequate.

In Clinical Psychology, many tertiary training institutes are now struggling to adequately fund courses. Clinical Psychology training, as with clinical training in Medicine, is relatively labour-intensive, and can therefore become a prime target for funding cut-backs when decision-making focuses predominantly or increasingly on cost factors, rather than recognized needs for community mental health services. Further, in overall workforce terms, there are currently relatively small numbers of postgraduate trained Clinical Psychologists in Australia (even though it can be demonstrated that as a profession they contribute a disproportionately large amount, both in direct mental health practice, and in research and training). Of the approximately 17,000 registered Psychologists in Australia, only approximately 1000 have the specialist postgraduate clinical training or equivalent required for correct use of the title “Clinical Psychologist”, and for membership of the specialist body, the College of Clinical Psychologists. Although Clinical Psychology is one of several practice specialties within the overall umbrella body, the Australian Psychology Society Ltd, and the need for such services well-recognized, the per capita ratio of Clinical Psychologists to population needs ongoing attention. Higher numbers, and most effective service utilization, means sufficient and accessible training places, and a primary emphasis on direct clinical care roles (where there are frequently complex cases which demand more specialized input anyway). Clinical Psychologists are trained in evidence-based practice, which extends to a range of complex, and

sometimes high-risk, disorders. These include paranoid conditions (psychotic or personality driven), clinical depression, borderline personality disorder (many with high self-harm potential and/or high usage of emergency services), and other high-risk conditions such as anorexia, psychopathic aggression, and PTSD. The reader is referred to Tarrier, Wells & Haddock (1998) for an overview of clinical psychological treatment with such disorders. Controlled research trials have demonstrated the efficacy of cognitive behavioural therapies (CBT) for many of these conditions, and it is Clinical Psychologists who have mostly driven the development of CBT approaches, both in Australia and overseas. CBT is now formally recognized by the Federal Government as an evidence-based treatment for clinical depression, and other mental health disorders (Australian Government Department of Health & Ageing, 2003).

There is also a wide field of CBT, evidence-based treatment for child and adolescent mental health problems, a critical area longitudinally. However, current availability is very limited, including for those young persons with high needs, such as child abuse clients who are likely to progress to ongoing problems in adulthood if not treated with adequate and timely intervention. We urge the Committee to accord a high priority to young persons' mental health service improvement nationally.

Indeed, at the broader level of care for younger persons, we now also require a fully developed, well-funded national program with standard benchmarks in assessment, treatment and support for all the major developmental domains including mental health. Overseas, similar programs already exist, and ensuring there are directive and review powers within their brief, as well as research, consultation and training, would be a significant and much-needed advance in the care and management of younger persons. For example, better integration of services is one of the prime aims of any national program. Some at-risk younger persons, such as victims of abuse/neglect, are known to have very high risk for long-term mental health problems, as well as difficulties coping with physical health issues, stable accommodation, adequate social networks and vocational skills development. Significantly enhanced integration of services for such persons is essential in the overall goal of best preventative practice. A national program can also assist with the current problem of access to adequate services, elaborated under point 2., below.

Another important factor in relation to the current limitations on workforce numbers in Clinical Psychology, in both training and best utilization/retention practices, is that there will be greater negative impacts as the need for mental health services generally increases, as official health projections suggest. For instance, in addition to the NMHS Report (2004) identifying a high level of "unmet need" (p.11), the World Health Organisation (WHO, Murray & Lopez, 1996) has also indicated mental health, and especially depression, as a rapidly increasing priority in the overall burden of disease worldwide (personal, social and economic) for the 21st century. It is an

unpleasant irony that, as projections indicate increasing need (particularly in relation to clinical depression over the next 10-20 years) there is mounting pressure on Clinical Psychology training places. In fact, it is Clinical Psychologists as scientist-practitioners who have been leaders, together with innovators such as Aaron Beck in Psychiatry, in developing and implementing psychological treatments for clinical depression in the first place, especially CBT.

We believe it is essential for the Committee, in considering workforce issues (Terms of Reference b., i., n.), to focus on the sufficiency of the existing, and projected, roles and numbers for Clinical Psychology, inclusive of research, innovation and teaching as well as direct patient care. The wide adoption of evidence-based practice, which is core training for Clinical Psychologists across a range of disorders, many of them high risk/cost to the community if poorly managed, will clearly improve "the adequacy of care…for people with a mental illness…" (Term of Reference b.). A review of workforce issues for Clinical Psychology needs to include the adequacy of current funding, and the identification of new means of supporting training and service provision. For example, it may be useful to consider additional methods of significant financial support apart from those already available, e.g., National Mental Health Strategy Scholarships, for intending postgraduate students who also agree to provide a period of mental health service post graduation in areas targeted as high need. In tandem, there needs to be a re-focus on the most effective clinical use of the existing workforce.

2. Apart from workforce supply and best utilization, the issue of "accessible" services (NMHS Report, 2004, p.31) requires addressing. Cost of services is a major barrier for many in need, and not just at the individual client level. For example, in Victoria, it has been reported that teachers with special needs students (including mental health difficulties) often find it difficult to access specialist Psychologist services because of lack of funding (Disabled students suffer… 2005). Improvements in the current approach to subsidizing Clinical Psychology services are required, including the mechanisms by which funding occurs. For example, in principle, the Federally funded Better Outcomes in Mental Health Care (BOIMHC) program (Australian Government Department of Health & Ageing, 2003) is a useful initiative. But, the program's current system of decision-making, including funding of particular mental health service providers solely via GP Divisions' choices, are unnecessary limitations on professional independent and clinically accountable practice by Clinical Psychologists, and a disincentive to take-up. In the first instance, Clinical Psychologists require more independent financing and administrative arrangements, which effectively translates to direct Medicare access. This is already suggested by many in the field, including important consumer/advocacy groups such as SANE Australia (part of Schizophrenia Australia). SANE Australia has senior professional patrons including medical specialists (see Submission No 133).

Accessibility of services, in both the public and private mental health sectors, is also determined by employment practices. For example, current employment practices in Victoria (and demonstrably in other States as well) in relation to best use of Clinical Psychology professionals is quite patchy. Employment decisions can be driven by lowest cost options, such as focusing on employing those with only a four-year general undergraduate degree rather than the required postgraduate Clinical Psychology qualification. The latter tends to create a vicious circle of ensuing reduced role expectations, and lower skills based service, which may then be hard pressed to sufficiently address the often complex, or even risky, mental health problems presenting for treatment. For new Clinical Psychologist graduates, the result is a significantly reduced incentive to take up positions, especially in publicly funded services (an observation already commonly reported), unless it is in one of the few specialist/research services, e.g., ORYGEN in Melbourne, for which jobs' demand always far outstrips supply.

3. The preceding points bear directly on the Committee's concern with "… reducing the effects of iatrogenesis…" (Term of Reference i.). As noted, mental health service provision is a complex and at times risky undertaking, which includes potentially life-threatening conditions for some clients, e.g., clinical depression (a major focus of the BOIMHC program). Thus, adequate practice by employers is to maintain a singular focus on the "best fit" of staff for the task. In professional Psychology, it is recognized internationally that mental health service provision requires postgraduate training in Clinical Psychology, and that lesser training, e.g., undergraduate education, or other postgraduate specialty, is not sufficient. To illustrate, within the BOIMHC program it is the case that many informed GP Divisions understand the important specialist role of Clinical Psychologists in mental health. Furthermore, the latest research shows that "…collaborative care involving GP's and Clinical Psychologists provides significant gains in patients' mental health" (Vines et al., 2004, p.1). It would be puzzling to suggest that Psychologists with nil or minimal clinical training would provide adequately comprehensive and skilled services delivery in mental health. Even the General Practitioners within the program identified their own lack of mental health skills as a concern, though they obviously already possess considerable training in clinical skills required for direct patient care. This is a recognition that mental health delivery skills are a specialized area of practice, and one that carries considerable complexity, and duty of care managing potential risk in particular.

4. Unfortunately, the legislation governing practice by Psychologists in most States is anachronistic, in that it still allows for registration of persons with an undergraduate degree (some of whom might even become mental health employees, depending on the agency's employment practices). The professional umbrella body itself, The Australian Psychological Society Ltd (APS) has since 2000 required at least six years University training, ie. a postgraduate degree, for basic membership. Further training and supervision for two years is required in order to be eligible for the particular specialist

College of the APS for which the postgraduate degree is relevant, e.g., College of Clinical Psychologists. Many practising professionals are concerned by this current mismatch between legislation and best practice, and have argued for some time that postgraduate training in any area of specialist professional practice, including mental health, should be a requirement of legal registration to practice. However, it is likely that this will occur only slowly, as the history of other such changes indicates, and the flow-on to service provision take even more time. It would therefore be helpful for any official review, such as the present Senate Committee, to consider ways in which it might assist in expediting a national uniform registration requirement. An outcome that has specialist Psychologist Colleges and their titles recognized in legislation on a uniform national basis would represent a significant advance for practicing Clinical Psychologists and especially for Clinical Psychology trainees, whose current attraction to public mental health services in particular is low. As noted previously, considerable anecdotal evidence indicates that reduced attractiveness is due predominantly to limited job roles and currently poor career prospects as a clinical practitioner. At this point in time only one or two States retain Specialist titles in legislation, and national uniformity is required. This would allow postgraduate trainees in particular to have far greater clarity as to identified skill expectations, and professional identity, as well as the attendant responsibilities, of their role and, importantly, clients or potential clients will be better served as to appropriate expectations and outcomes.

5. Also potentially related to iatrogenic effects in mental health services is a concern among Clinical Psychologists about the present lack of sufficient clear specification for many stakeholders of the essential differences between mental health trained Clinical Psychologists and other registered Psychologists. In fact, many clients still find it difficult to differentiate Psychiatrists and Clinical Psychologists, let alone the specialty of Clinical Psychology within the overall Psychology profession. As a case in point, the NMHS Report (2004) figures on workforce breakdown by profession do not separately identify Clinical Psychologist practitioners from other Psychologists, but include all within the one category of “Psychologist” (Table 3, p. 30). It is important to separately identify Clinical Psychologists who have comprehensive, formal specialized mental health training, in the same way that Table 3 identifies different types of medical staff, ie. “Consultant Psychiatrists” and “Other medical officers”, in the mental health area. Such an amendment provides more detailed information, particularly changes across time (Table 3 compares figures on staffing for 1994-95 and 2001-02). This is obviously important for better workforce planning, and for projections regarding tertiary training needs.

For instance, in common with many of our Clinical Psychology colleagues, we do not support the view that adequate training for highly sensitive and frequently complex (or life-threatening) mental health problems can be brief “top-up” input, e.g., one or two day workshop, for any professional group, whether it is nursing, occupational therapy, social work or psychology. Those

concerns have already been clearly expressed within the overall profession of Psychology itself (Pritchard, 2004). Brief training is no substitute for the kind of comprehensive training required for adequately delivering best evidence-based practice, including management of risk. Hence, first, the requirement for thorough training needs to be fully acknowledged at government level and across the community and, second, a longer term action plan instituted for systemically promoting best practice with adequate postgraduate Clinical Psychology training provision.

Overall, without clearer specification of a best practice training and skills base, and information clearly identifying the respective roles of different professionals in mental health, the eventual downside is a hampering of management targeting of “best fit” personnel for the job; and, a likely subsequent flow-on to less expert, or inadequate, service provision. Information for clients will also be less specific, itself a major concern regarding informed choice, and treatment expectations. For Clinical Psychologists, who are justifiably focused on risk reduction and trained to be mindful of duty of care issues, lack of functional specificity regarding particular professional roles is an unhelpful system risk factor, with potential negative flow-on effects for employee selection and training decisions, as well as negatively impacting on informed client choice. It is suggested that the Committee consider amending the overall situation of lack of specificity through detailed, and broad-scale, information dissemination to all stakeholders regarding training required to adequately deliver psychological services, and the kinds of evidence-based psychological services which can be expected in contemporary mental health care. This is in addition to providing support for common national benchmarks regarding skills' qualifications required in mental health professional practice generally.

6. The broad availability of clear specification of the roles of different mental health professionals is also closely related to the accuracy of evaluative feedback. It is unreasonable to expect informed and reasonably accurate feedback from service users without it. Informed feedback is a vital ingredient underpinning any accurate service evaluation. The Committee is clearly interested in “adequacy of data collection…” (Term of Reference o.). Clinical Psychologists have always played a significant role in research, education, and evaluation in mental health. Of course, this can only be maximally effective with adequate workforce planning, and funding for training and mental health employment of such professionals. It is demonstrable that the track record of Clinical Psychologists in research for mental health has to date been extensive and of high utility, and they have frequently been at the forefront in initiating and disseminating “new modes of service delivery…” (Terms of Reference n. & p.). For example, Clinical Psychologists have been the profession most responsible for developing research and practice in CBT over the last 30 years, to the point of its now being accepted by government as evidence-based treatment for a range of mental health disorders. Current constraints on funding for professional training therefore need urgent attention, because restrictions on

maintenance or growth of research functions and positions, as well as on direct care roles, will inevitably slow the further development and implementation of improvements in mental health service delivery.

7. From an overall services perspective, broadening and strengthening the role of the NMHS to directly input and consult regarding issues such as maintaining best practice in workforce employment decisions, and monitoring and advising regarding professional work demands, and staffing configurations, seems worth considering. For example, the NMHS Report (2004) identifies some large between-State variations in mental health spending, service configurations, and types of functions and professionals employed. Further national benchmarking and implementation would assist in quality improvement and maintenance across the range of mental health services currently provided in Australia.

8. We believe that, because of the prevalence of mental health disorders, potential cost of inadequate treatment to the community, and the accompanying current and future unmet need described in various documents, e.g., Murray & Lopez (1996), the country needs to formally adopt the evidence-based model of practice as the only acceptable model of mental health care. Allowing non-evidence-based practice and treatments is simply too risk-laden for a modern mental health system. The final, broad related issue is that the numbers of highly trained clinicians available is unlikely ever to meet demonstrated need. Thus, we strongly suggest take-up of an explicit levels of treatment model such as that identified by the APS (2001), comprised as follows.

Level One. Skills are characterised by the ability to deliver such basic interventions as supportive counselling and relaxation training. In addition to psychologists, medical and allied health professionals' training may include such interventions.
Level Two. Skills are characterised by the ability to deliver limited, specific behaviour change interventions, such as assertion training and other structured, e.g., manualised, approaches for limited personal problems. This level of intervention requires more training and time commitment than Level One. Psychologists and other health professionals with appropriate training may competently deliver these types of interventions.
Level Three. Skills are characterised by the ability to apply relevant psychological theory and research to solve complex clinical problems that require individually tailored interventions, such as CBT. Only practitioners comprehensively trained in clinical psychopathology and diagnosis, psychological theory, assessment, treatment, clinical research and evaluation, e.g., Clinical Psychologists, and arguably Psychiatrists with equivalent training, can competently deliver these interventions.

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