



Response to the Productivity Commission 2019

Mental Health Draft Report

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PART 1 SUMMARY OF RECOMMENDATIONS

The Australian Clinical Psychology Association (ACPA) commends the Productivity Commission (the Commission) on the comprehensive review of Mental Health that includes the systems of care and support services documented in the Draft Report (Productivity Commission, 2019). We recognise the enormity of this undertaking and appreciate the scope and depth of the work. We are pleased to respond, to assist the Commission in developing the vision to address the mental health of Australians.

Despite the high level of investment in mental health, the Draft Report paints a bleak picture of the current utility and scope of the mental health system and the accompanying structures that provide support to those suffering from mental health disorders. As noted in the Draft Report, the mental health system “is broken” and is “failing the community” (Productivity Commission, 2019, p. 882). This places excessive pressure on the surrounding services and organisations that support people with mental health problems and disorders.

The considered recommendations provided by the Commission are welcomed. They aim to improve the central mental health system and support services, along with the experience of the consumer, to enhance outcomes for Australians at risk of, or suffering from, mental health disorders. The recommendations are broadly consistent with comments included in the ACPA Submission of April 2019, and provide the opportunity for profound improvements to Australia's mental health policy, programmes and systems. Of great value is the broad-view linking and aligning of services outside the health system to wrap around consumers and their carers in response to need.

ACPA specifically endorses recommendations concerned with: conducting a review of MBS-rebated psychological therapy (draft recommendation 5.4); universal access to suicide attempt aftercare (21.1); building a stronger evaluation culture and strengthening monitoring and reporting (22.5); supporting student mental health and wellbeing in tertiary education institutions (18.2); and supporting integration, expansion and promotion of supported online treatments (6.1 and 6.2). ACPA's responses to these recommendations are summarised below, and expanded upon in Part 2 of this document.

Specifically endorsed recommendations

Draft Recommendation 5.4—MBS-Rebated Psychological Therapy

ACPA endorses the proposed evaluation of MBS-rebated psychological therapy (Better Access), the trial of additional sessions and the recommendation to change the period from a calendar year to a 12-month period. MBS is well recognised as the 'work-horse' of Australian psychological services and has successfully increased access to psychological care. However, Better Access has not been subject to robust evaluation and little is known about the outcomes of this important funding program. A robust evaluation will provide opportunity to strengthen the performance of Better Access in the interests of consumers, funders and service providers.

Draft Recommendation 22.5—Building a Stronger Evaluation Culture

ACPA strongly supports the Commission's commitment to improving the monitoring, reporting and evaluation of the Australian mental health system and specific services. Reporting systems across Australian mental health services primarily measure activity rather than outcomes, and consequently, little is known about the magnitude of symptom improvement or change in functional ability following treatment.

ACPA endorses the view of the Commission that such changes represent a profound reform, one that will be long term and requires considerable planning to ensure success. As the ACPA membership are significant providers of psychological services, ACPA would be pleased to contribute and support national efforts to plan, test and introduce systems for monitoring, reporting and evaluating consumer outcomes across its members. ACPA is committed to ensuring systems for monitoring, reporting and evaluation are fit for purpose, administratively efficient and enhance the clinical experience of consumers without creating unnecessary burden.

Draft Recommendation 18.2—Student Mental Health and Wellbeing Strategy in Tertiary Education Institutions

ACPA strongly endorses the recommendation to require all tertiary education institutions to develop and deploy a student mental health and wellbeing strategy. Across the world, significantly higher

levels of psychological distress and disorder are found in students in tertiary institutions compared to the general population, yet service responses appear limited to traditional counselling models which invariably have significant waiting lists (Auerbach et al., 2018). ACPA recommends that future student mental health and wellbeing strategies include specific actions targeting different stages of distress, including prevention, access to treatment, crisis management and post-crisis management. Such strategies should also include an approach that is aligned with a staged care model, including self-help, online interventions, and referral pathways to group interventions, therapist-guided and specialist-guided interventions.

However, it is essential that strategies and service models are grounded in evidence, or committed to generating evidence to inform future improvements. One noteworthy example of an innovative service model targeting tertiary students is the online anxiety and depression treatment program (Dear et al., 2019) currently in use at Macquarie University, Sydney. This program integrates an online, therapist-guided treatment program as part of a stepped-care model, which also comprises self-help, group and individual treatments. The program has now been used by the student wellbeing services at Macquarie University with more than 1,000 students. Importantly, the program includes routine measurement of patient-reported outcomes and experiences, which demonstrates outcomes at least as good as traditional models of care.

Draft Recommendations 6.1 and 6.2—Supported Online Treatment Options Should Be Integrated and Expanded; Information Campaign to Promote Supported Online Treatment

ACPA strongly endorses the recommendations to expand, integrate and promote supported online treatments and services such as the MindSpot Clinic (Titov et al., 2017). The benefits of services such as MindSpot are identified in the Commission’s Draft Report and include increased access to consumers across Australia, provision of clinical and cost-effective care, and integration with primary care.

ACPA supports the expansion of services such as MindSpot which are built on a strong research evidence base, but which also monitor, report and evaluate outcomes as part of routine care. ACPA encourages the Commission to use the characteristics of evidence-based, strong governance, integration with primary care and routine measurement of clinical outcomes and experiences as minimum criteria for funding the expansion of online treatment services.

Summary of additional recommendations

Additional recommendations are summarised below and expanded upon in Part 2 of this document.

Whole-of-government, whole-of-system reform

In support of [whole-of-government, whole-of-system reform](#), ACPA agrees that an overarching Intergovernmental Agreement to “better align their collective efforts and to improve government accountability through clearer articulation of responsibilities and more transparent reporting of performance” (Productivity Commission, 2019, p. 891) is essential.

Accountability: The capstone of policy development and service delivery

To ensure [accountability](#) within the system, the National Mental Health Commission (NMHC) should be tasked, not only with “monitoring and reporting on whole-of-government implementation of a new National Mental Health Strategy” (Productivity Commission, 2019, p. 48), but also to report on the performance of the whole system and track the progress of reforms. The NMHC should “be afforded statutory authority status to support it in evaluating significant mental health and suicide prevention programs” (Productivity Commission 2019, p. 3), as described in the Draft Report.

[Monitoring, feedback and evaluation strategies](#) must be incorporated into program development *prior to* the introduction of new mental health treatment services.

[Routine outcome monitoring](#), including patient-reported outcomes, is required in the implementation of evidence-based treatments, to inform treatment and improve outcomes. All **standard measures currently utilised need to be reviewed** to ensure comprehensive and consistent outcome assessment for the range of mental health problems or disorders. Selection of new measures should be guided by experts in the relevant field. Measures assessing symptom severity and functional impairment need to be used across all levels of service delivery in order to align resources across primary, secondary and tertiary services. These include psychology and psychosocial services.

Conditions of **housing** for long-term supported residents need to be fully supported, ensuring proper hygiene, and availability of laundry and cleaning services, and healthy food for residents, as well as access to appropriate mental health services.

Providers of psychology services under Better Access should face regulatory mechanisms if **clinical audits** find they do not provide evidence-based *psychological* interventions according to the stipulations of the Medicare rebate system. The Department of Human Services needs to include auditing of websites of providers of psychological services in its random audits of administrative requirements.

The **headspace service model** requires a thorough independent review of its data to determine which young people are most likely to benefit. In the meantime, young people with moderate to severe mental disorders need to be directed to Better Access or Community Mental Health service providers.

ACPA recommends removal of all requirements for **Primary Health Network (PHN) funding** to be directed to specific service providers such as headspace centres—instead, specifying the population and level of care for which the funding is to be utilised. Decisions should be based on efficacy and efficiency of services, and available evidence that they are delivered with safety and quality. Clinical outcomes data needs to be utilised in the determination of the value of services and outcomes need to drive choice of services being commissioned.

All new **MBS items** need to embed monitoring, feedback and evaluation of clinical treatment outcomes to ensure safety, efficacy and efficiency of the resources allocated.

Better Access: Staged care and improved efficiencies

A **model of stage-based care** requires additional clinical thresholds to be established via expert input and outcome evidence.

The **qualifications and expertise of service providers** of psychology services must align with the intensity and complexity of services required. Referral pathways for psychological services need to be refined to best utilise the expertise of providers at the appropriate stage of service delivery.

The workforce delivering psychology services

Within a model of stage-based care, **psychologists with general registration** are most suited to provide Focussed Psychological Strategies (FPS) for consumers requiring primary health care services.

Given the low levels of training for psychologists generally in Australia, in comparison to international standards, the expertise of **psychologists with area of practice endorsement** across all areas of practice related to mental health adds value to mental health service delivery and needs to be supported. Higher remuneration of psychologists with area of practice endorsement within their areas of specialised practice is needed to motivate trainees into undertaking the advanced training, to specialise in these areas of psychology and upskill the psychology workforce.

Clinical psychologists are the most appropriate psychologists to provide specialised services to those with moderate to severe mental health disorders.

In response to **Information Request 7.1**, an MBS item number for clinical psychologists to undertake comprehensive assessment, diagnosis, formulation and treatment recommendations for those with mental health disorders will support appropriate triage and/or complement assessments undertaken by psychiatrists, providing assistance and alleviating burden on the capacity of the psychiatry workforce. The fee for such an assessment would include the cost of a written report that supports the diagnosis, provides supporting evidence for a formulation and guides treatment.

The **contribution of trainees in clinical psychology** needs to be acknowledged by the Productivity Commission and supported by governments, in recognition of the expanded workforce capabilities this training brings.

The value of the education and training of **clinical neuropsychologists** in the assessment, diagnosis, treatment and rehabilitation planning for those individuals suffering brain dysfunction needs to be acknowledged. Clinical neuropsychology services need to be expanded nationally across relevant service areas and supported by specific MBS items.

Counselling psychologists' specialised skills have value within services in mental health to support carers, families and friends of those with mental health disorders through psychoeducation and counselling.

Educational and developmental psychologists are the most appropriate psychologists to provide specialised services within the education system. Psychometric assessments by educational and developmental psychologists for children and adolescents need to be made more affordable for the public. Educational and developmental psychologists should be utilised to provide teacher training in mental health.

The specialised skills of **forensic psychologists** need to be recognised and utilised within the legal and justice systems, in particular to enhance assessment and recommendations for patients with mental health disorders within these systems.

The specialised skills of **health psychologists** need to be recognised and utilised within the health system, particularly in areas of health promotion, public health and prevention of mental health disorders.

The work of **occupational therapists and social workers** needs to be extended across the mental health spectrum *within their scopes of practice*. The regulation of social work under the National Law via the Australian Health Professions Regulation Authority is essential for the profession to work in mental health.

Improvements to Better Access: Staged care

A **system of co-payments between state and federal governments**, administered by PHNs as suggested by the Commission, needs to be developed to provide adequate treatment for those presenting with moderate to severe, chronic and complex presentations.

A **three-tier system defining treatment session numbers**, as outlined by the Australian Psychological Society (2019), supports recovery and management for all patients. The number of sessions provided needs to be aligned with the severity of disorder/s present and the expertise of service providers. Patients should be allocated to the appropriate intervention stage at the initial general

practitioner (GP) assessment, or following reassessment and review after each 10 sessions of treatment. Patients with moderate to high intensity psychological needs need to be independently evaluated for allocation to the necessary stage of care. Both psychiatrists and clinical psychologists should undertake biopsychosocial assessments to determine the level of staged secondary care required. PHNs should be tasked with promoting and monitoring GP assessment and referral practices in line with a staged-care model of mental health.

In **stage 1 of the three-tiered system**, up to 10 sessions of FPS on one referral need to be provided for mild to moderate presentations that are not suited to online treatments and do not require more extensive treatment and services.

In **stage 2 of the three-tiered system**, up to 20 sessions should be provided annually by a clinical psychologist for patients with moderate to severe disorders who would be expected to be unresponsive to 10 sessions of FPS.

In **stage 3 of the three-tiered system**, up to 40 sessions need to be provided annually by a clinical psychologist for patients with severe, chronic, highly complex disorders that have significant impacts on functioning. Psychologists need to be provided with incentives to offer staged care within a multidisciplinary team via provision of a Medicare item number for referral (including a report) to another colleague with the level of expertise required. Shared care plans that incorporate a mixture of clinical psychology treatment planning and oversight of work undertaken by another mental health worker need to be considered to provide efficient and effective care. All new items and systems need to be monitored and evaluated as they are introduced to ensure both efficacy and efficiency.

Provision of independent Medicare items for clinical psychologists, other psychologists, social workers and occupational therapists is recommended to allow **multidisciplinary care** for patients with severe, chronic, complex and high-risk disorders.

Other **adjustments to Better Access to improve efficacy and efficiency** include the following:

- (i) Include family interventions on the list of acceptable psychological therapies approved for use by clinical psychologists for MBS-rebated psychological therapy.
- (ii) Allow sessions for parents to be seen without the child patient being present.

- (iii) Move from determining the number of sessions a patient receives by calendar year to a 12-month rotation of services, beginning from the date of the initial referral.
- (iv) Remove the need for a review, unless clinically warranted, within that period.
- (v) Remove the barriers to group therapy for consumers as indicated.
- (vi) Allow all consumers to access MBS psychological treatments via videoconferencing and remove the identified barriers to this treatment.
- (vii) Advise consumers at referral that they can use an *equivalent* alternative to any provider mentioned in a referral for psychological treatment.

ACPA recommends [**changes to the requirements of Mental Health Treatment Plans \(MHTP\)**](#), relating to [**Information Request 5.2**](#):

- (i) GPs should refer directly to the stage of care required, linking the referral to the level of provider qualifications required
- (ii) MHTPs should specify the type of treatment for which the referral is made—Focussed Psychological Therapy or Psychological Therapy Services.
- (iii) MHTPs need to be retained for those mental health practitioners that do not have advanced accredited education and training in the assessment of mental health disorders.
- (iv) MHTPs for *clinical psychologists* should be *optional* for GP referrers but a medical history needs to be provided at the time of referral to a clinical psychologist.

Appropriate [**clinical thresholds**](#) need to be developed to assign patients to appropriate intensities of treatment aligned with provider qualifications.

In regard to [**psychological therapy review**](#), clinical psychologists should provide a report of progress and an updated formulation and treatment plan to the GP at each 10-session completion point. A Medicare item for this assessment and report preparation should be provided to clinical psychologists in lieu of payment for an MHTP review by the GP. Independent assessment by a clinical psychologist or psychiatrist may be requested at any point in treatment by a GP if concerned about a patient's progress. A case conference meeting can be called to assist in ongoing treatment and service planning for patients who are not recovering with psychological therapy.

[**MHTPs and MHTP reviews**](#) should be provided to the consumer to facilitate transparency. Patients need to be informed that they are able to change to an alternative provider who offers the level of psychological intervention required (i.e. FPS or psychological therapy). GPs, psychiatrists,

paediatricians and consumers need to be fully informed of the differing levels of treatment provided by mental health treatment providers (i.e. FPS or psychological therapy), and the differing levels of accredited training in mental health undertaken by providers of FPS and psychological therapy, to enable referral to appropriate staged services.

Whole-of-services staged care

ACPA conditionally supports the proposal that “the State where a patient would normally reside should meet the cost of services where its resident receives [**hospital treatment in another jurisdiction**](#)” (Productivity Commission, 2019, p. 894) to manage cross-border hospital activities.

The final report of the Productivity Commission would be significantly strengthened if the [**‘secondary care’ sector**](#) was identified *specifically* in relation to the problems currently faced in obtaining adequate mental health treatment, inter-governmental psychosocial services and supports, and carer and consumer input.

Until a full illness develops, [**early intervention**](#) for those ‘at risk’ of developing a mental illness must be confined to support and psychoeducation, particularly for infants, children and adolescents. Evidence-based parenting programs need to be made widely available at points of childhood and adolescent transitions.

Privacy of children’s and adolescents’ health records, including their mental health record, must align with legal requirements for all institutions and be mandatory. The [**health records of children and adolescents in schools**](#) should comply with the privacy and health records legislation of the state in which they reside.

PART 2 BACKGROUND AND RATIONALE FOR RECOMMENDATIONS

Whole-of-government, whole-of-system reform

Stronger governance and a broader vision by governments are vital in addressing mental health needs of Australians. As demonstrated throughout the Productivity Commission's Mental Health Draft Report (2019), current policy development across all systems is poorly integrated and developed, driven by political agendas rather than evidence and expertise, and rolled out without robust trials and ongoing accountability. Services are siloed, misaligned, inconsistent, fragmented and uncoordinated, leaving major service gaps and overlaps.

A new Intergovernmental Agreement (IGA) is *essential* to bring about coordination and “to better align their collective efforts and to improve government accountability through clearer articulation of responsibilities and more transparent reporting of performance” (Productivity Commission, 2019, p. 891). This agreement needs to be placed on “the same administrative footing as the *National Healthcare Agreement* and the *National Health Reform Agreement*” (Productivity Commission, 2019, p. 891); “clearly define responsibilities and take a whole-of-government approach to [mental health and] suicide prevention activities” (Productivity Commission, 2019, p. 892). All national agreements and strategies need to explain how they can be shown to affect mental health outcomes and contribute to meeting the aims of the *National Mental Health Strategy*. The agreement must bring coherence to the services provided, include the role of the public sector and be focussed on outcomes.

The mental health system

Fundamental reform of the mental health system is crucial. Central to this is further development and expansion of the reforms proposed by the Productivity Commission (the Commission) (2019). A whole-of-service, whole-of government model for an integrated person-centred approach that provides *access, safety, quality, efficacy and efficiency* of services, staged to the level of care needed, is necessary to provide a blueprint for the future. This requires the foundational components of all systems to be redeveloped and operationalised to ensure positive outcomes of services that

continue to evolve as new evidence shapes policy via feedback. The Commission has clarified many of the necessary components of this blueprint.

A new whole-of-government’s “National Mental Health Strategy that aligns the collective efforts of health and non-health sectors to improve mental health outcomes” (Productivity Commission, 2019, p. 881) will enable continuance of the work of the Commission, allowing for greater integration of services and ultimately greater efficiencies and better experiences and service provision, resulting in proven positive outcomes. Such an explicated vision is essential to drive reform.

As the Draft Report emphasises, the strategy must “clarify responsibilities and ensure consumers and carers participate fully in the design of policies and programs that affect their lives” (Productivity Commission, 2019, p. 882). The overarching model needs to mean the consumer, carer and expert are informed, and be driven by evidence and feedback to improve safety, quality, efficacy and efficiency. Models of service delivery need to be trialled and rigorously evaluated before roll out, with ongoing collection of progress and outcome data providing a feedback loop to improve services.

As stated, reform is only possible if there is proper oversight and responsibility for the implementation of this plan by an independent body. Realistic targets need to be established. Brief review and reporting on the steps taken towards implementation and realisation of the strategy and targets need to be undertaken annually, with a more sweeping review and recommendations for improvements every five years.

An overarching Intergovernmental Agreement to “better align their collective efforts and to improve government accountability through clearer articulation of responsibilities and more transparent reporting of performance” (Productivity Commission, 2019, p. 891) is essential.

Accountability: The capstone of policy development and service delivery

The Commission is clear that both governments and service providers must be accountable to the public in their decision making. Decision making by governments, service providers and consumers needs to be informed by monitoring of quality, by evaluation and by research.

As the Commission points out, governments need to be held individually accountable for mental health outcomes. Accountability is paramount for all policy development and service delivery, not only in affording clinical safety and quality evidence-based services to produce strong positive clinical outcomes, but also in the fiscal management of taxpayer investment. Monitoring and evaluation must form the capstone of design and drive policy.

“Monitoring, evaluation and reporting can be used to promote innovation and continuous quality improvement, and ultimately improve outcomes for people with mental illness and their carers.” (Productivity Commission, 2019, p. 991)

Unfortunately, it is true that for “large, long-standing programs in particular, the incentives may be weakened by factors such as potential political risks. Such programs may be seen as an accepted part of service delivery, with strong opposition to any proposed changes from evaluations (Anthony Jorm, sub. 45)” (Productivity Commission Draft Report, p. 1028).

It is such political expediency that makes it imperative that an independent body is appointed to provide an objective, high-level “overarching framework that guides and unifies monitoring, evaluation and research in mental health ... to generate the right information to drive continuous improvement and promote accountability” (Productivity Commission, 2019, p. 992).

The National Mental Health Commission (NMHC) should be tasked, not only with monitoring and reporting on whole-of-government implementation of a new National Mental Health Strategy” (Productivity Commission, 2019, p. 48) but also to report on the performance of the whole system and track progress of reforms.

The NMHC should “be afforded statutory authority status to support it in evaluating significant mental health and suicide prevention programs” (Productivity Commission, 2019, p. 3), as described in the Draft Report.

Monitoring, feedback, and evaluation strategies approved by the NMHC must be incorporated into program development *prior to* the introduction of new mental health treatment services.

Appropriate collection and utilisation of data

Governments are responsible for developing and implementing services that are safe and effective, with proven efficacy and efficiency. This is not just within mental health, but also across all sectors where public money is invested.

“The collection of data is important, but what matters most is the use of this data to improve policy development and implementation” (Productivity Commission, 2019, p. 696). In mental health and every associated sector, and at every level, the Commission identified a lack of accountability and responsibility for using data to support safety, efficacy and efficiency of outcomes, and to drive policy development and implementation. Policies are developed and programs rolled out without ensuring that investments made on behalf of the public are safe or have any value.

In every case where a program is recommended for development or expansion, the Commission stresses the importance of monitoring and evaluation to ensure safety, efficacy and efficiency. This imperative *must* drive decision making. Currently, as the Commission repeatedly points out, such drivers are absent within the mental health system.

Monitoring to identify harms and improve outcomes

All interventions carry risks of harm. These are offset by the potential efficacy of treatment. Without monitoring of harms within outcome measurement, harms are ignored, to the detriment of the patient and future patients. Harms are readily acknowledged for medical interventions; however, psychological therapies can have significant iatrogenic impacts (just like medications). Long-term

adverse outcomes and harm from therapy occur in approximately 5% of patients (Firth, Barkham, Kellett & Saxon, 2015; Lambert, 2013; Cahill, Barkham & Stiles, 2010; Smith, Glass & Miller, 1980, all cited in Hardy et al., 2017). Furthermore, another 57% of patients do not reliably improve with treatment (Cahill, et al., 2010; Firth, et al., 2015; Smith, et al., 1980, all cited in Hardy et al., 2017). Patient-reported outcome measures (PROMs) are central in identifying harms or lack of reliable improvement from treatment (Williams, Sansoni, Morris, Grootemaat & Thompson, 2016).

Therapists working beyond their competence with a lack of supervision are particularly likely to be associated with adverse patient outcomes (Hardy et al., 2017, p. 3). Furthermore, “Unfortunately, clinicians tend to hold overly optimistic views of their clients’ treatment progress in relation to measured change” (Walfish, McAlister, O’Donnell & Lambert, 2012). Clinicians frequently overlook negative changes and have trouble accurately gauging the final benefit clients will receive during treatment, particularly with clients who are failing to improve (Lambert, Whipple & Kleinstäuber, 2018).

Routine outcome measurement improves treatment outcomes (Lambert, Whipple & Kleinstäuber, 2018). A recent meta-analysis found that feedback from monitoring practices reduces deterioration rates and nearly doubles clinically significant/reliable change for those patients who are expected to have a poor outcome (Lambert, et al., 2018). This accumulation of research evidence makes monitoring and feedback a critical feature of an effective mental health system.

All psychologists who undertake accredited training in professional psychology are taught to monitor outcomes of therapy as a component of best practice. Unfortunately, routine monitoring of therapy progress and outcomes can be lost as graduates succumb to pressing clinical, business, and administrative demands.

An example of an evaluation culture of service delivery in psychological interventions, that continually feeds back into the system, is that of the Centre for Clinical Intervention (CCI) in Perth, Western Australia. This Centre of Excellence develops treatment programs for psychological disorders and employs supervision to ensure fidelity to best practice. Monitoring and evaluation provide feedback on the efficacy of programs and drive program improvements. The CCI also provides training for the mental health workforce. This model of service delivery is exemplary and capable of informing best practice standards for all services.

Routine outcome monitoring, including patient-reported outcome measures, is required in the implementation of evidence-based treatments to inform treatment and improve outcomes.

Consistent measures across all services and all levels

Consistent measures ensure comparable data and rigorous evaluation. Measures need to be selected to monitor and measure specific outcomes, including clinical symptoms, functioning and quality of life, as well as service delivery experience. These measures need to be embedded into all systems providing mental health services and support services for those suffering from mental health disorders.

The Commission identifies flaws in the Australian Mental Health Care Classification (AMHCC) that require review, such as the Health of the Nations Outcome Scales (HoNOS) and the Adult Disability Assessment Tool (ADAT), particularly in terms of capturing episodic disability due to fluctuations in mental health disability. These scales need to be reviewed and, once reviewed, those professionals with the expertise to assess the target problem should administer them.

The review of scales needs to be extended beyond their application to severe mental illness to provide differentiation of levels of severity, functional capacity and complexity between primary and secondary patient presentations. This will enable allocation of adequate resources, and prevent over and under servicing, which is particularly important for the successful introduction of staged care.

If it can be *mandated* for data to be routinely collected in specialised public health services, via the National Outcomes and Casemix Collection, the mandate should include data collection for *all* services. Measures need to be reviewed for their value across the various forms of service delivery, including the private mental health system.

All measures currently utilised need to be reviewed to ensure comprehensive outcome assessment for the range of mental health problems or disorders. Selection of new measures should be guided by experts in the relevant field.

Measures assessing symptom severity and functional impairment need to be used across all levels of service delivery in order to align resources across primary, secondary and tertiary services. This includes psychology and psychosocial services.

Expertise and evidence to drive system and program development

Governments have the responsibility to provide access to services that are safe, of high quality, effective and efficient. All programs need to provide a sound return on taxpayers' investment. It is imperative that government policy is driven by sound clinical and fiscal management that is guided by expertise and evidence. Programs need to be trialled and rolled out cautiously with attention to these principles, and with inherent data collection and analysis to ensure safety, quality, efficacy and efficiency. The system itself needs to provide feedback to ensure that services meet the driving principles at a viable cost before being expanded further.

Sound guiding principles, expertise and evidence are not currently driving program development, resulting in patients being put at risk, and poor fiscal and societal returns via unsound investment in services. The current political drivers prioritise costs and access over safety, quality, efficacy, and efficiency.

This is a flawed approach and is inadequate to meet the needs of those suffering from mental health disorders. In mental health, poor quality services do not simply lead to lack of improvement, they lead to significant harms as symptoms increase and disability becomes entrenched.

Providing appropriate housing and support to meet needs

As the Commission describes, deinstitutionalisation was undertaken without robust monitoring and evaluation, and sees our most vulnerable turn to drugs and alcohol to 'self-medicate'. This has also allowed low-level crime to survive. Accommodation may be provided in the community but there is little doubt that, for many of the most vulnerable, homelessness and incarceration have replaced asylums.

It has been more than 40 years since deinstitutionalisation resulted in severely ill patients with mental health problems largely fending for themselves. Little has changed in the meantime, with replacement services within the community being fragmented, poorly resourced and poorly supported.

The Commission appears to support staged care in providing housing for those with mental illness, with supported long-term housing in units with on-site care. However, the services required for accommodating patients with high intensity needs extend beyond basic housing and mental health care.

Currently there are many long-term residents of supported housing who live in squalor. Cleaning services that are provided can be inadequate, unreliable and unaccountable for their performance, and so hygiene can be compromised. Good quality food is often not provided—patients turn to fast food which leads to physical health problems, such as diabetes and heart conditions, adding to personal disability and healthcare costs for many years.

People requiring high levels of support are often not capable of addressing these issues, cooking, cleaning or doing laundry for themselves, and adjust to living in sub-standard, unhygienic conditions. A return to fully supported and safe housing options may be required for those who are unable to care for themselves.

Conditions of housing for long-term supported residents need to be fully supported, and ensure proper hygiene, laundry services, cleaning services, and access to healthy food for residents, as well as access to appropriate mental health services.

MBS Better Access for psychiatrists, psychologists and general practitioners: Prioritising access over accountability

“A significant increase in Medicare funding of psychological services since the early 2000s has not led to a clear improvement in population mental health (Anthony Jorm, sub. 45)” (cited in Productivity Commission, 2019, p.130). The provision of inadequate treatment “affects the outcomes achieved from the mental health care treatment, as well as the return on the large scale [sic] investments made by government in mental health”, and for “those experiencing mental illness, their families and carers, poor practices have devastating results” (Productivity Commission, 2019. p. 130).

Monitoring and evaluation of Better Access

Mental health services should be “funded only if their effectiveness – preferably through outcomes data – can be evaluated” (Productivity Commission, 2019, p. 1004). The lack of monitoring and evaluation of this costly program is problematic and needs to be addressed as a matter of urgency.

Audit of psychology services under Better Access

Under the Better Access program, payments are made for evidence-based treatments and scopes of practice of providers with different levels of training in mental health are clearly delineated. However, these are not being adhered to. The Commission cites alarming statistics that demonstrate most Australians who access services are receiving inadequate psychological treatment. A quick search of the Internet reveals many psychologists are advertising Medicare rebates for practices that are dedicated to, or include, non-psychological interventions (such as yoga or Hakomi) or practices where the evidence base is still developing but has not yet reached the threshold for acceptability for evidence-based treatment, such as Neurofeedback.

Psychologists who do not hold clinical psychology endorsement, social workers, and occupational therapists whose scope of practice is defined under Better Access as specified Focussed Psychological Strategies (FPS) frequently appear to disregard the scope of practice requirement. Many advertise as providing advanced psychological therapies—which are restricted to provision by clinical psychologists—as the main or a major component of the work they undertake under Better Access. As far as we are aware, such practitioners are not audited nor held accountable. If MBS medical items were misused in the same way, it would be addressed as fraud.

Although clinical audits are important, they are not sufficient to ensure widespread adherence to best practice and fidelity to the model of treatment being delivered. The best solution to ensuring positive outcomes, to protect the public and ensure treatments offer value for the subsequent monetary expenditure, is to embed monitoring and evaluation.

ACPA supports the conclusion of the Commission that “national benchmarking and public monitoring and reporting at the service provider level would improve service quality and outcomes for consumers and carers. Australian, state and territory governments should actively address barriers to

implementing service provider public reporting and benchmarking" (Productivity Commission, 2019, p. 1027).

Providers of psychology services under Better Access need to face regulatory mechanisms if clinical audits find they do not provide evidence-based psychological interventions, according to the stipulations of the Medicare rebate system.

The Department of Human Services needs to include auditing of websites for providers of psychological services in its random audits of administrative requirements.

headspace: Prioritising access over efficacy and efficiency

headspace centres are increasing youth access to services but are unable to provide evidence of adequate mental health outcomes relative to costs. Reliable clinical change for psychological distress of headspace clientele is 9.4% but this is offset by reliable clinical deterioration of 4.9% of service users, leaving an overall outcome of efficacy of 4.5%. This is poor by any standard and highlights the principle that there is no justification for taxpayers funding ineffective services.

The Commission's Draft Report recommends that headspace utilise a stepped-care model to ensure that the right services are accessed according to individual needs. It is recommended that funding be linked to the proportion of young people directed to low intensity care, given that outcomes are particularly poor for those with psychological distress in the mild to moderate range (University of New South Wales, 2015). These are sound recommendations.

Despite the poor performance of headspace centres in terms of mental health outcomes, the government has announced the rollout of mental health hubs similar to headspace for adult mental health. These hubs are designed to provide access to services without stepped care incorporated into the model. The continued support for services models which have demonstrated low levels of clinical effectiveness, in the absence of a thorough independent review of who is likely to benefit from this approach, is fiscally irresponsible and may well lead to worsening mental health problems and disorders.

headspace centres do vary in their capacity to address the mental health needs of their consumers. Yet, despite headspace routinely collecting a large amount of data via both headspace Centres Services Application and headspace Centres Finance Application, this does not appear to be routinely analysed and utilised to guide best practice or program development. Nor does the data contain adequate clinical outcome measurement.

Utilising outcome data to design, shape and evaluate mental health services must be a government priority. Much hope has been placed in the Commission's review to ensure evaluation and ongoing monitoring of all mental health services from all sectors of mental health care, and to be a key guiding force for all government policy decisions.

The headspace service model requires an independent review of its data to determine which young people are most likely to benefit.

Primary Health Networks funding

As the Commission points out, "Primary Health Networks (PHNs) are required to commission headspace centres, but the rationales for this are weak and inconsistent with the flexibility they otherwise have" (Productivity Commission, 2019, p. 967). Such prescriptive requirements for implementing a program that has proven to have generally low efficacy in mental health outcomes is a poor utilisation of taxpayer investment. It also blocks innovative approaches that might better suit the area in which the funding is utilised and prevent opportunities for funding mental health treatments with proven efficacy. We therefore support **Recommendation 24.2**, giving regional autonomy over service provider funding.

Remove all requirements for PHN funding to be directed to specific service providers such as headspace centres; rather, specify the population and level of care for which the funding is to be utilised.

Decisions should be based on efficacy and efficiency of services as well as available evidence that they are delivered with safety and quality.

Clinical outcome data needs to be utilised in the determination of the value of services and outcomes need to drive choice of services being commissioned.

Eating disorder items: Prioritising access over safety, quality and efficacy

It is to be commended that the federal government has rolled out 40 sessions of treatment under the MBS for those seriously impacted by an eating disorder. However, the structure and rollout of the items potentially places patients at risk of receiving ineffective, poor quality and unsafe treatments. Despite recommendations stemming from the National Eating Disorders Collaboration (2018), the new items provide ready access to treatments for extremely unwell patients that are delivered in private practices, potentially by inappropriately qualified clinicians who self-assess for competency. There is no requirement for monitoring, feedback or evaluation that might offer some protection for these high-risk, highly vulnerable patients.

MBS Standards for treatment providers

Under the existing Better Access scheme, GPs, occupational therapists, social workers and psychologists, who have not undertaken advanced training in mental health for endorsement as a clinical psychologist, have been authorised to provide Focussed Psychological Strategies (FPS) only. These evidence-based strategies were selected to reflect their value in addressing many mental health issues at lower severity levels and the competencies of providers, acknowledging lower levels of accredited training in mental health. Psychological Therapy Services (PTS) have been restricted to clinical psychologists in recognition of their advanced education and training in the assessment, diagnosis, formulation and treatment of mental health disorders across the spectrum of severity.

A concerning change occurred with the introduction of the MBS Eating Disorder items, which are provided for advanced psychological therapies. The items were introduced without any restriction to practitioner accredited training levels. It is stated that, “It is expected that practitioners providing services under these items should have appropriate skills, knowledge and experience to provide eating disorders treatment” (MBS Online, 2019). This allows *all* providers of services under the Better Access scheme to deliver advanced psychological therapies to a high-risk population regardless of accredited training in the delivery of these therapies or the psychological management of complex patients.

Providers self-select as competent to provide these services, potentially coming from professions and sub-disciplines with no accredited education and training in the psychological treatment of

serious mental health disorders. No insurance has been offered that providers delivering these services have the expertise to safely and effectively deliver the specified advanced psychological therapies, and there is no capacity to ensure compliance with the specified list of advanced psychological evidence-based treatments. This places highly vulnerable patients at high risk, and undermines efficacy and efficiency of services, as described below.

Expert advice of the National Eating Disorders Collaboration

The National Eating Disorders Collaboration released the National Practice Standards for Eating Disorders (the Standards) in 2018 to guide government and providers in the evidence-based identification, assessment and treatment of eating disorders.

The Standards explain that eating disorders are a group of disorders that are:

highly complex, serious mental illnesses with significant physical complications and impairment including chronic heart and kidney disease, osteoporosis and diabetes and diseases associated with obesity. Physical health problems are often severe enough to warrant urgent medical care, although this is often not sought (Bravender et al., 2016). Individuals with eating disorders have significantly elevated mortality rates (Arcelus et al., 2011) ... All eating disorders are serious illnesses with high levels of psychological distress, risks of long-term mental illness, medical complications, and an increased risk of premature death due to medical complications and to an increased risk of suicide. Eating disorders have been shown to have one of the highest impacts on health-related quality of life of all psychiatric disorders (AIHW, 2008). (Cited in National Eating Disorders Collaboration, 2018b, p. 2)

“Anorexia nervosa has the highest death rate of all mental illnesses” (Department of Health, 2005). Death from physical causes is five times that expected in this age group. Death by suicide is 31 times that of the general population (National Eating Disorders Collaboration, 2018a). “Eating disorders are one of the 12 leading causes of hospitalisation costs due to mental health, with 11% of these admissions being due to life threatening complications” (National Eating Disorders Collaboration, 2018a).

Common reasons for hospitalisation include medical complications (rapid weight loss, a very low weight, cardiac irregularities, hypoglycaemia, electrolyte imbalance), extreme and disordered behaviour (for example, several days of no nutrition intake), psychological complications (such as suicidality or active self-harm) and lack of response to outpatient treatment in very underweight patients.

Treatment requirements

“Eating disorders are a distinct group of complex illnesses with treatment requirements different to other types of mental illness. The complexities of eating disorders require *a long term multi-disciplinary team approach* [emphasis added], integrating medical, nutritional and psychological treatment delivered in a supportive environment” (National Eating Disorders Collaboration, 2018b, p. 2). The Standards state, “Health professionals delivering eating disorder specific treatment that is safe (addressing all aspects of illness) and delivered through a collaborative multi-disciplinary team or shared care approach” (2018b, p. 9). The eligibility criteria for patient access to the newly released 40 sessions of psychological therapy ensure only seriously unwell, high-risk patients access these treatments (MBS Online, 2019).

Recognising and treating comorbidities

Comorbidities of mental health disorders increase the treatment challenges of disorders classified as severe and complex, such as eating disorders. Complex and severe disorders are accompanied by multiple comorbidities, each of which may be classified as severe and complex.

The Commission specifies, “Eating disorders tend to have a high rate of comorbidity with mood and anxiety disorders” (Productivity Commission, 2019, p. 149). Blinder, Cumella and Sanathara (2006) found that 97% of individuals diagnosed with an eating disorder also receive a diagnosis for at least one more psychiatric diagnosis, including depression, anxiety disorders, substance use disorders, obsessive-compulsive disorder, posttraumatic stress disorder and schizophrenia/other psychoses. Psychiatric comorbidity of anxiety and depression, and personality disorders is linked with increased severity of the eating disorder (Spindler & Milos, 2006).

Failure to recognise and treat comorbidities in anorexia nervosa, where mortality is 18 times higher when another significant psychiatric disorder is present (Kask et al., 2016) has catastrophic repercussions. Furthermore, if comorbid conditions of all eating disorders are not treated concurrently, a revolving door of treatment occurs, leading to relapse and worsening of the eating disorder itself.

The National Standards for treatment providers for eating disorders

The Standards are clear on the requirements for safe and effective treatment requirements. “Safe treatment for eating disorders addresses all of the aspects of illness assisting people to meet their physical, psychological, behavioural, nutritional, occupational and social needs. Treatment is provided by a multidisciplinary team who work in partnership with the person, their family, and other health and support providers, including treatment of co-morbid issues” (National Eating Disorders Collaboration, 2018b, p. 5). Treatment for eating disorders needs to be provided by professionals trained in the area of specialisation and working *within professional scope* [emphasis added]” (National Eating Disorders Collaboration, 2018b, p. 9). “*Selected staff are skilled to provide assessment and/or treatment intervention as part of a shared care team*” [emphasis added] (National Eating Disorders Collaboration, 2018b, p. 9).

Service providers must be able to “Describe *the roles of key professions in the multidisciplinary team* [emphasis added] including: GP, Psychologist Psychiatrist, Dietitian, Dentist, Mental Health Nurse, OT, Social Workers, Paediatricians” (National Eating Disorders Collaboration, 2018b, p. 11) and “Know the limits of personal expertise and when to seek advice or refer on; Utilize relevant tertiary services for professional training, case conferencing, supervision and referral. (National Eating Disorders Collaboration, 2018b, p. 11). Furthermore, the Standards state explicitly that clinicians need to “Refer people with eating disorders for treatment of comorbid conditions where appropriate” (National Eating Disorders Collaboration, 2018b, p. 11).

Available training for service providers in eating disorder treatments

Given the potential iatrogenic effects of therapy and inconsistent regard for fidelity to evidence-based treatments, existing opportunities for professional development training available for providers wishing to utilise the eating disorders psychological therapy items are inadequate. This

exacerbates the risk for this vulnerable population if providers believe the training undertaken adequately prepares them to deliver a range of advanced psychological therapies to this high-risk group, without specific training in the prescribed treatments or comorbidities.

The Standards explicitly state, “In any service context, professionals providing treatment for eating disorders require specific training in the treatment of eating disorders *supported by supervision and ongoing professional development* [emphasis added]” (National Eating Disorders Collaboration, 2018b, p. 12). “Wherever treatment occurs in the continuum of care from early intervention to recovery support there must be access to tertiary-level expertise for consultation, supervision, guidance and referral if required” (National Eating Disorders Collaboration, 2018b, p. 6).

Organisations, such as the Australian and New Zealand Academy for Eating Disorders and the Australian Centre for Eating Disorders are rolling out short courses of 2 to 5 days for professionals to identify and treat eating disorders. Such courses are inadequate to build the expertise required to undertake safe and effective treatment with this population.

This unaccredited training does not provide advanced training in delivering the specified treatments for eating disorders; nor does it provide ongoing supervision, and none is required to access the items. No pathways for consultation have been provided. The training does not appear to address the frequently severe comorbidities that accompany eating disorders. Practitioners can work in siloed private practices without necessary supports for patient care.

Monitoring, feedback and evaluation

The Standards specifically state, “Research and evaluation are integral to the design and delivery of health promotion, prevention, early intervention, and treatment approaches for eating disorders” (National Eating Disorders Collaboration, 2018b, p. 5). For safe practice, it is necessary to “Monitor progress and measure outcomes (relevant to own professional discipline)” (National Eating Disorders Collaboration, 2018b, p. 13).

Despite the risks to patients with severe eating disorders, and the cost of extended treatments, the government has incorporated no consistent monitoring of the safety, quality, efficacy or efficiency of the items. This places patients at risk, at large cost to the taxpayer.

The MBS eating disorder items appear contrary to a stepped-care model. Providers can deliver advanced psychological treatments in which they have inadequate or no training, based on their self-determined level of expertise, with no guarantee that they are adhering to the prescribed evidence-based approach. This approach can delay the delivery of expert care, and risks further entrenching the disorder/s being treated. Governments need to responsibly roll out new items for psychological therapies based on a *staged-care* (as opposed to stepped-care) model of expertise to ensure safety and quality of services, particularly for more complex and high-risk populations.

A solid health care system requires all practitioners to be valuing and utilising their specialised skills to provide quality, integrated and accessible services. Changes to the MBS Mental Health Items must be grounded in solid evidence and a comprehensive understanding of the professional standards and areas of practice of the providers delivering these services.

All new MBS items need to embed monitoring, feedback and evaluation of clinical treatment outcomes to ensure safety, efficacy and efficiency of the resources allocated.

Better Access: Staged care and improved efficiencies

Staged care of psychology services

A staged-care model of service delivery to meet the needs of all consumers presenting with mental health problems and disorders at all levels of complexity and severity, can ensure appropriate, safe and quality services that aim for recovery, which is more than just the absence of symptoms but full mental wellbeing. The recognition of expertise of service providers needs to be aligned to qualifications to ensure safety and quality, and the number of sessions increased for treatment of moderate to severe disorders. These changes need to be evaluated for efficacy and efficiency.

Staged care based on assessment of the patient's clinical presentation and functional domains improves clinical and social outcomes (Hickie, 2019). Additional clinical thresholds need to be established via expert input and outcome evidence to identify each level of required intervention: self-management, low, medium and high intensity, with provider qualifications and expertise matched to the level of severity.

Clear clinical thresholds need to be developed to differentiate those who would benefit from online treatments from those requiring face-to-face FPS; those requiring FPS from those requiring psychological therapies provided by a clinical psychologist; and those requiring multidisciplinary care.

A model of stage-based care requires additional clinical thresholds to be established via expert input and outcome evidence

Ensuring access to the right level of care *by the right provider*

Other English-speaking developed countries equivalent to Australia do not allow practitioners with less than two years of accredited training in the assessment, diagnosis and treatment of mental health disorders, founded on an undergraduate degree in psychology, to practise independently as psychologists in the treatment of mental health disorders (Appendix A). The Improving Access to Psychological Therapies program in the United Kingdom utilises practitioners with lower levels of training, but ensures the delivery of manualised evidence-based therapies via specific training in the

treatment model being utilised, close supervision by clinicians with advanced training in the delivery of these therapies, and ongoing measurement of progress and outcomes.

Australia has taken the step of allowing psychological treatments to be delivered independently by practitioners with little or no accredited training in mental health or psychology, including to people with eating disorders and high-risk complex patients. Furthermore, there has been no attempt to properly evaluate the safety, quality and efficacy of such treatments.

Given the varying levels of training for providers of psychological interventions, psychological treatments need to be closely aligned with provider qualifications for proper care and efficiency of services. The MBS rebates psychological services according to the provider's level of qualifications that reflect accredited competencies, yet they do not stage care accordingly. There are no guidelines to ensure those with the more complex, severe and high-risk mental health disorders are treated by those with the highest level of expertise, or that those with higher levels of expertise are not treating only patients with low-intensity needs.

To have those with the lowest levels of training treating the most complex, severe and chronic disorders is unsafe, inefficient and likely to lead to poor outcomes. To have highly trained clinicians treating only mild conditions is wasteful. Targeting needs to ensure that *the right people are receiving the right treatment from the right providers*.

Referral pathways to psychological services need to be refined to best utilise the expertise of providers at the appropriate level of service delivery. Without these pathways, referrals do not match the needs of the patient to the level of expertise required for treatment, resulting in both under and over servicing.

The qualifications and expertise of service providers of psychology services must align with the intensity and complexity of services required.

Referral pathways for psychological services need to be refined to best utilise the expertise of providers at the appropriate level of service delivery.

The workforce delivering psychology services

Psychologists: Training, utilisation, challenges and future directions

Psychologists of all levels of training have a central part to play in mental health services. Paramount in the allocation of psychologists to service delivery, is protection of the public through recognition of accredited training and allocation of expertise to the right level of intervention for patient needs. The interests of the public must drive this allocation, not professional politics.

As pointed out by the Commission, Australia has one of the largest per capita workforces of psychologists in the world. Since 2010, the number of psychologists in Australia has increased from 28,881 to 38,029, or by 32% (derived from Psychology Board of Australia: Statistics), which is twice the rate of increase of the Australian population. However, the minimum required training standards for registration as a psychologist in Australia falls below international standards (Appendix A).

Psychologists with general registration

The scoping exercise undertaken by the Commission to define the training of all professions providing services within the mental health workforce is extensive, the various training pathways for psychologists have been clearly identified. However, a comparison with international standards of training for psychologists has not been explicated to identify training differentials in the preparation of psychologists to work independently with patients with mental health disorders.

All countries rely on accreditation of training programs to ensure practitioners are prepared with the knowledge and skills to implement best-practice assessment, diagnosis and evidence-based treatment, with fidelity to the model/s being implemented. Australia currently holds the lowest minimum standards of training for registration or licensure of psychologists in the world (Appendix A; Psychology Board of Australia, 2018).

The Psychology Board of Australia has announced the retirement of the lowest level of training, the '4+2' route to registration, that will somewhat remedy this situation (Psychology Board of Australia, 2019a). This route provides training in mental health via supervision rather than an accredited

tertiary education program. Regardless, Australia will remain the only English-speaking developed country to allow psychologists to register or be licensed to practise independently in mental health with only one year of accredited post-graduate tertiary education and training (the ‘5+1’ pathway). The minimum international standard outside of Australia for independent practice is two years of accredited post-graduate training in the practice of psychology (Appendix A). New Zealand recognises and regulates psychologists with general registration with an undergraduate degree in psychology plus a 2-year Masters degree in psychology practice, as do South Africa, Malta, Crete, etc.

A staged-care model calls for a workforce made up of practitioners with various levels of training and expertise to deliver evidence-based interventions appropriate for the stage of care indicated by the presenting condition. It is important to recognise the various levels of training of psychologists and their respective roles in the mental health system.

Psychologists with general registration are an important workforce that ensures the provision focussed psychological strategies (FPS) for consumers requiring primary health care services.

Upskilling the psychology workforce

There is an imperative to increase the level of accredited training of psychologists wishing to provide psychological interventions in mental health to a two-year Masters degree, followed by a registrar program of supervision, to meet minimum international standards for this area of practice. Such a move is unlikely to be undertaken until completion of the current PsyBA review of general practice and Areas of Practice Endorsement (AoPEs) competencies. Nevertheless, this move needs to be promoted and supported.

The minimum standard of training for psychologists to practise independently in mental health needs to be raised to be comparable to the minimum international standard of two years of post-graduate accredited education and training in mental health.

Psychologists with Area of Practice Endorsement (AoPE)

Significant improvements have been seen in the level of education and training of psychologists over the past nine years since the establishment of the National Registration and Accreditation Scheme.

The number of psychologists who have undertaken advanced training for endorsement in a specialised area of psychology has increased by 127% during that time (derived from Psychology Board of Australia: Statistics). Higher degree pathways that lead to area of practice endorsements (AoPE) are now the preferred registration pathway (Psychology Board of Australia, 2018; Psychology Board of Australia: Statistics, September 2019). In particular, clinical psychology has seen a rapid expansion in numbers since their specialised training in mental health has been recognised and valued via higher Better Access rebates. Similar advances are required in other specialised areas to enhance the quality and safety of services.

The expertise of psychologists holding advanced accredited tertiary-level education and training in areas of practice endorsement need to be recognised and utilised in specialist roles within the appropriate services for which they train. Definitions of the skills of these practitioners are provided by the PsyBA (Psychology Board of Australia, 2019b). Their roles include providing specialised services, supervision, oversight of the work of other professionals with lower levels of training, and expert consultation.

Clinical psychologists, clinical neuropsychologists, educational and developmental psychologists, forensic psychologists, health psychologists, and counselling psychologists all undertake specialised training that offer higher-level services to the public within mental health and areas aligned with mental health services. These services need to be utilised as specialist services to best utilise their expertise.

The expertise of psychologists with AoPE across all areas of practice related to mental health adds value to mental health service delivery and needs to be supported.

Higher remuneration of psychologists with AoPE within their areas of specialised practice is needed to motivate trainees to undertake the advanced training to specialise in these areas of psychology and upskill the psychology workforce.

Clinical psychologists

Clinical psychologists undertake specialised education and training in mental health. Clinical psychology has seen the largest increase in numbers within the psychology profession over the past nine years in Australia. Driven by differential rebates that recognise the value of advanced education and training in mental health, particularly under Better Access, the number of clinical psychologists has risen from 3,907 in November 2010 to 9,210 in September 2019 (derived from Psychology Board of Australia: Statistics)—an increase of 136% to 36:100,000 of population. This has brought the number of clinical psychologists above that of other developed countries (Appendix B).

Clinical psychologists are *trained* and *paid* to provide specialised services. The advanced education and training of clinical psychologists in mental health is acknowledged via higher rebates provided by the MBS and other awards (Appendix C).

Clinical psychologists are the most appropriate psychologists to provide specialised services to those with moderate to severe mental health disorders.

Improved utilisation of the expertise of clinical psychologists

The Commission has posed a specific question about the freeing up of psychiatrists for people who need them most. **Information Request 7.1** asks, “What additional steps, if any, should be taken to support private psychiatrists to increase the number of consultations involving new patients?”

Both psychiatrists and clinical psychologists have *advanced* training in the assessment, formulation, diagnosis and treatment of mental health disorders. Psychiatry is founded on a medical degree and focusses on the medical management of mental illness. Clinical psychology is founded on a psychology degree and focusses on the psychological management of mental health disorders. Hence, clinical psychologists have high levels of advanced expertise in the psychological management of mental health disorders.

Clinical assessment

Clinical psychologists undertake the same depth of training in assessment and diagnosis of mental health disorders as psychiatrists. Biopsychosocial assessment of mental health disorders is utilised by both professions, albeit with a more medical focus for psychiatrists and a more psychological focus for clinical psychologists. Diagnostic taxonomies have been developed jointly by psychiatrists and clinical psychologists in recognition of their shared and complementary roles in diagnosis of mental health disorders. Treatment tends to be differentiated according to expertise, with clinical psychologists generally providing the bulk of psychological interventions and psychiatrists providing medical management.

The cost of an assessment undertaken by a psychiatrist is \$500 (MBS Online, 2007), while that of a clinical psychologist is \$126.50, as there is no separate item for clinical psychologists for undertaking assessments. Introducing a separate item for a clinical psychology assessment would relieve the workforce burden on psychiatry. A separate item for a clinical psychology assessment would include the cost of a written report that supports the diagnosis, provides supporting evidence for a formulation and guides treatment.

In response to Information Request 7.1, an MBS item number for clinical psychologists to undertake assessment, diagnosis, formulation and treatment recommendations for mental health disorders is recommended, as this will support appropriate triage and/or complement assessments undertaken by psychiatrists, thereby providing support and relieving the psychiatry burden.

Clinical team leadership

Psychiatrists and clinical psychologists commonly work closely together on the treatment of moderate to severe mental health disorders. Clinical psychologists also have the expertise to coordinate and manage multidisciplinary clinical teams. Enhancing the role of clinical psychology in services, particularly in public mental health services where the recognition and utilisation of the advanced training and expertise of clinical psychology is vastly underutilised, would reduce costs and provide relief for the psychiatry workforce. This would allow psychiatrists to be utilised more

efficiently in consultation services to provide medical expertise in the treatment of mental health disorders.

Addressing the needs of rural and remote communities through training

Rural practice in clinical psychology needs to be developed as an area of advanced specialisation for clinical psychologists. The Commission points out that the period of training for health professionals is accompanied by trainees building lives within the communities in which they are based. Incentives and enhancement schemes exist for many health professionals but these are very limited for clinical psychologists.

Rural training is a valuable experience at all levels of training. It requires a wide spread of skills and is ideally suited to clinical psychology trainees towards the end of their training, given the demands of working as a trainee, with supervision often provided at distance and with limited face-to-face contact. However, the major disincentive to clinical psychology students attending rural placements is lack of funding.

Incentives offered to other professionals—such as funded positions, supervision via teleconferencing and by visiting professionals, higher incomes, and supported housing—are critical to the success and student uptake of rural and regional clinical psychology placements. For registrars and more permanent staff, paid attendance in cities for continuing professional development and paid supervision would enhance uptake.

Professional isolation in rural and remote workplaces can be alleviated to an extent by videoconferencing, particularly for supervision, professional development opportunities and conferencing with peers. ACPA provides a professional network for members via a freely accessible listserv that enables communication about clinical issues, professional development opportunities and video learning.

Demands for payment for training placements

The Commission raises the issue of supervised placements for clinical psychologists, with increasing demands from placement providers that education providers pay for placement days. Despite the costs of organisation of placements, many educational institutions do not charge for placements undertaken outside the education setting when embedded within the post-graduate degrees. This is to keep costs to the trainee manageable. However, with some organisations discussing payment, this may change in the future.

It is vital to recognise that clinical psychology trainees entering external placements are work ready—having completed intensively supervised training within each educational institution’s psychology training clinic—and registered with AHPRA. The training of clinical psychologists provides low-cost mental health services to the community. This is estimated at 400,000 occasions of service annually, with a cost saving to governments of \$40,000,000 (Appendix D).

While training costs are beyond the scope of the Commission’s enquiry, the offering of these services by trainee clinical psychologists needs to be recognised and supported within the mental health system. The supervision of trainees within the education institution’s psychology training clinic is intense, with up to an hour of supervision that includes video or live review of sessions being offered for each day of work undertaken. Within the workforce, the requirement reduces to 1 to 2 hours per week to cover 8 to 10 occasions of service.

The costs of training in clinical psychology are high, and include tertiary education fees, costs associated with professional practice in placements and cost of living. The demands of training are rigorous and extensive, leaving little time to earn an income. To burden these trainees further with payments for placements reduces accessibility to education and increases inequity. In particular, the profession of clinical psychology benefits from broad ethnic, social and cultural diversity, and it is important to maintain this diversity.

The contribution of trainees in clinical psychology needs to be acknowledged by the Commission and supported by governments in recognition of the expanded workforce capabilities this training brings.

Clinical neuropsychologists

Clinical neuropsychologists specialise in disorders of the brain (Psychology Board of Australia, 2019b). Their work is highly specialised and unique. Clinical neuropsychologists work broadly within the health system to diagnose and develop treatment and rehabilitation programs for brain dysfunction. There are currently 702 clinical neuropsychologists nationally, an increase of 117% in nine years (derived from Psychology Board of Australia: Statistics).

The skills of clinical neuropsychologists have not been broadly valued within the health system other than in some neurology, brain injury and dementia units. This limits access for the public to better diagnosis, and individually tailored treatment and rehabilitation programs.

The value of the education and training of clinical neuropsychologists in the assessment, diagnosis, treatment and rehabilitation planning for those individuals suffering brain dysfunction needs to be acknowledged. Clinical neuropsychology services need to be expanded nationally across relevant service areas and supported by specific MBS items.

Counselling psychologists

Counselling psychologists are specialists in “helping individuals and groups develop positive strengths and wellbeing, and to assist the resolution of problems and disorders” (Psychology Board of Australia, 2019b). These psychologists are ideally suited to provide specialised services in mental health in support for carers and families, and through psychoeducation to carers and friends of consumers requiring information about specific mental health issues.

There are 993 counselling psychologists nationally (Psychology Board of Australia: Statistics), an increase of 55% in nine years. While this represents the second largest AoPE after clinical psychology, it has experienced the lowest increase in numbers of any AoPE. This may be due to some confusion emerging around the unique skills and focus of counselling psychologists following claims by counselling psychology professional groups that their scope of practice encompasses the diagnosis and treatment of mental disorders.

Counselling psychologists' specialised skills have value within services in mental health to support carers, families and friends of those with mental health disorders through psychoeducation and counselling.

Educational and developmental psychologists

Educational and developmental psychologists provide assessment and assistance in learning and academic performance across the lifespan, and in assessing and supporting emotional, social and behavioural development “in helping people lead more fulfilling and productive lives” (Psychology Board of Australia, 2019b, p. 20).

There are currently 694 educational and developmental psychologists (Psychology Board of Australia: Statistics) who provide specialised psychology services in education. This is an increase of 108% in nine years (derived from Psychology Board of Australia: Statistics).

Psychometric assessments for capability and learning are a current high-level, out-of-pocket expense for the public, as identified by the Commission. Many parents seek these services via psychology training clinics at educational institutions. Psychology training clinics provide these services at a considerable rebate as they are delivered by trainees under the supervision of psychologists who have an AoPE with the necessary expertise to oversee the assessment. However, these services are located primarily in major cities and not everyone has access to them.

Educational and developmental psychologists are the most appropriate psychologists to provide specialised services within the education system.

Psychometric assessments by educational and developmental psychologists for children and adolescents need to be made more affordable for the public.

Educational and developmental psychologists should be utilised to provide teacher training in mental health.

Forensic psychologists

Forensic psychologists have an important role to play as expert psychologists within the legal and justice system. Forensic psychologists provide assessment, diagnosis and management planning that are central to assisting those within the legal and justice systems suffering from mental health disorders.

There are 608 forensic psychologists nationally, an increase of 108% in nine years. Forty-three percent of forensic psychologists also hold area of practice endorsement in another area of psychology. Overwhelmingly, this is in clinical psychology. This combination of AoPE enables high levels of expertise in assessment, diagnosis and treatment of forensic patients with mental health disorders.

The specialised skills of forensic psychologists need to be recognised and utilised within the legal and justice systems, particularly to enhance assessment and recommendations for patients with mental health disorders within these systems.

Health psychologists

Health psychologists “foster health promotion, public health, and clinical assessments and interventions relevant to health and illness (Psychology Board of Australia, 2019b, p. 25).” There are currently 331 health psychologists, an increase of 94% in the past nine years. Forty-seven percent of health psychologists also hold area of practice endorsement in other areas of psychology, primarily in clinical psychology.

The specialised skills of health psychologists need to be recognised and utilised within the health system, particularly in the areas of health promotion, public health and prevention of mental health disorders.

Occupational therapists and social workers

These two professions have valuable roles to play at all levels of service for those at risk of or suffering from mental health disorders. Their scopes of practice provide much-needed psychosocial supports and need to be utilised more widely in mental health, within their scopes of practice.

Social workers and occupational therapists provide FPS via Better Access to support interventions within their scopes of practice. For example, occupational therapists are ideally suited to deliver Individual Placement and Support (IPS) programs to those who require assistance in obtaining and retaining employment. FPS can assist in the support of these patients to take advantage of the IPS program.

In working within mental health, all professions require registration for the protection of the public. The anomaly of social workers not requiring independent regulation is of concern.

The work of occupational therapists and social workers needs to be extended across the mental health spectrum *within their scopes of practice*.

The regulation of social work under the national law via the Australian Health Professions Regulation Authority is essential for the profession to work in mental health.

Improvements to Better Access: Staged care

A simple stepped-care model does not necessarily provide immediate access to the right level of care on initial access to services, and can require consumers to undertake lower levels of treatment and support that need to be proven ineffective before higher levels of care are provided. This entrenches clinical disorders, leaves unwell patients highly vulnerable and extends suffering. It is apparent from the Commission's Draft Report that staging care to meet the needs of the patient at referral and each review is recommended, although this is not explicitly stated in these terms.

While different levels of health service provision are differentiated between state and federal governments, the Commission points out that "A strength of the Better Access program is its ability

to fund services at comparatively low cost. It provides psychological therapy services at a much more economical per-session rate than a block funded service without financial incentives to drive efficiency.” (Productivity Commission, 2019, p. 20). It concludes, “Because of this efficiency, Better Access should continue to be the delivery vehicle for most individual psychological therapy, pending a new, rigorous evaluation of its effectiveness” (Productivity Commission, 2019, p. 223).

Stages of care

The current standard of undifferentiated, time-limited psychological services provided by a broad workforce with indistinguishable, yet highly variable, skill sets is inefficient and highly likely to be ineffective. Better Access, as it currently stands, is capable of responding only to the needs of those requiring primary care (which is the responsibility of the federal government), not secondary care (which is the responsibility of the state and territory governments where specialist and hospital care is required).

The role of clinical psychologists in the treatment of moderate to severe, complex and chronic disorders

The advanced education and training of clinical psychologists in mental health best prepares them to provide psychological services to patients suffering from moderate to severe, complex and high-risk mental health disorders, both in private care under Better Access and within specialist community and hospital mental health services. The specialised skills of clinical psychologists need to be properly utilised for these patients to ensure efficacy and efficiency of service provision. More effective services can be delivered by a three-tier, staged-care system, as per the Australian Psychological Society (2019) white paper, with the number of sessions aligned with patient needs and expertise of providers.

The three-tier system defining session numbers outlined by the Australian Psychological Society (2019) supports recovery and management for all patients.

Patients should be allocated to these sessions at the initial GP, paediatrician or psychiatrist assessment, or following reassessment and review after each 10 sessions of treatment.

In addition, a MBS item number for clinical psychologists to undertake assessment, diagnosis, formulation and treatment recommendations for mental health disorders should be established and utilised to support referral to the appropriate level of staged care.

The number of sessions provided need to be aligned with severity and complexity and the expertise of service providers.

Primary Health Networks (PHNs) should be tasked with promoting and monitoring GP assessment and referral practices in line with a staged care model of mental health.

Stage 1

As the Commission points out: many people do not wish to undertake online treatment, even when therapist supported; there are times when online treatment requires integration with face-to-face treatments; or, a patient with mild to moderate presentations does not respond to online treatment. If that is the case, referral to general psychologists can then be provided for FPS for mild to moderate mental health disorders, delivered via Better Access. Up to 10 sessions of FPS for low intensity treatment of mild to moderate disorders need to be provided in one referral, on an annual basis starting from the date of referral.

In stage 1 of the three-tiered system, up to 10 sessions of FPS on one referral should be provided for mild to moderate presentations that are not suited to online treatments and do not require more extensive treatment and services.

Stage 2

The gap in secondary care treatment has led to moderate to severe mental health disorders largely going untreated, and has prevented recovery. “The Commission estimates that, as part of a stepped care model, approximately 10% of the people who are best treated through the Better Access program would benefit from an increase in the session cap” (Productivity Commission, 2019, p. 21). Extended specialised psychology treatments are required to provide adequate services for moderate to severe mental health disorders.

These are the patients who have not fully responded to their 10 sessions of psychological treatment, and it is this underservicing that brings them back to the GP with nowhere to go. These are the patients who revolve through the Better Access program annually without receiving the level of care required for recovery or to minimise harms from the impact of their illness. Current research indicates that many mental health problems require at least 20 sessions for recovery.

In stage 2 of the three-tiered system, up to 20 sessions should be provided annually by a clinical psychologist for patients with moderate to severe disorders that would not be expected to gain sufficient benefit from 10 sessions of FPS.

Stage 3

Chronic, severe and highly complex disorders require high-intensity treatment for a substantial length of time, followed by ongoing less-intensive treatment, relapse prevention and monitoring. This has been provided through the MBS for those suffering from severe eating disorders and needs to be extended, with greater attention to practitioner and training requirements, to other severe, complex and chronic conditions.

A small percentage of patients with highly complex, high-risk disorders and/or chronic entrenched mental health conditions require more intensive treatment than 20 sessions annually, as is recommended by the Mental Health Reference Group (2019). Patients suffering from severe pervasive personality disorders—particularly borderline personality disorder, complex trauma, entrenched severe obsessive-compulsive disorder, chronic severe depression and bipolar disorder—and other disorders that seriously impact relationships, social functioning and capacity to work would all benefit from 40 sessions annually.

This is the group that is most likely to present at emergency departments, most likely to be hospitalised and most likely to lead lives highly compromised by their mental health disorder/s. These are also the patients, along with those who attempt suicide, who require intensive community care and support services.

In stage 3 of the three-tiered system, up to 40 sessions should be provided annually by a clinical psychologist for patients with severe, chronic, highly complex disorders that have significant impacts on functioning.

Psychologists need to be provided with incentives to offer staged care within a multidisciplinary team via provision of a Medicare item number for referral (including a report) to another colleague with the level of expertise required.

Shared-care plans that incorporate a mixture of clinical psychology treatment planning and oversight of work undertaken by another mental health worker need to be considered for providing efficient and effective care.

All new items and systems need to be monitored and evaluated as they are introduced to ensure both efficacy and efficiency.

Multidisciplinary practice

Patients whose needs fulfil criteria for Stage 3 require multidisciplinary treatment. The eating disorder items have allowed for both psychological treatments and those delivered by dieticians. However, while they allow occupational therapists to provide psychological therapies, they do not provide for targeted occupational therapy treatment when required.

Shared care can also be effective. For example, it may be necessary for a clinical psychologist to develop, review and adjust a treatment plan and exposure hierarchy for patients suffering from moderate to severe obsessive compulsive disorders or other avoidant disorders, yet it is not necessarily cost effective for clinical psychologists to undertake all exposure sessions for these patients.

While Better Access allows independent session numbers for dieticians, psychiatrists and psychologists, it does not allow for shared care by a clinical psychologist and another psychologist who does not hold clinical psychology endorsement. This limits the capacity for shared care to improve efficiency of treatment.

Team-based shared models of treatment need to be explored and incentivised. They can be best offered where clinical psychologists, other psychologists, dieticians and occupational therapists work closely together within their scopes of practice. Clinical psychologists and other psychologists can share supervisory arrangements from an independent supervisor for specific patients. Psychologists are required to undertake at least 10 hours of supervised practice annually and many psychologists

undertake regular supervision beyond this requirement. The supervisor can assist in management of staged care.

Integration of occupational therapists and dieticians into clinical psychology practices, or close alignment of these professionals, are also needed where care is provided for those with complex presentations, such as eating disorders.

Provide independent Medicare items for clinical psychologists, other psychologists, social workers and occupational therapists to allow multidisciplinary care for patients with severe, chronic, complex and high-risk disorders.

Other adjustments to Better Access to improve efficacy and efficiency

In addition to the broad systemic issues addressed above, ACPA also supports certain specific adjustments to Better Access to improve efficacy and efficiency. These include the following:

- a) Change the item descriptors for psychological therapies and FPS, as recommended by the MHRG, to allow sessions with family members, guardians, carers and/or residential staff where: the identified patient is not present; the primary focus is the identified patient's treatment or assessment needs; and, the decision for sessions to be used as outlined above is made by the identified patient (or the patient's guardian if the patient is a minor or if guardianship is in place; or the patient's nominated representative if the patient does not have legal capacity to provide informed consent).
- b) Move from determining the number of sessions a patient receives by calendar year to a 12-month rotation of services, beginning from the date of the initial referral.
- c) Remove the need for MHTP review, unless clinically warranted, within that period.
- d) Remove the barriers to group therapy for consumers as per recommendations made by the MHRG to (i) reduce the minimum number of participants in group sessions, and (ii) add a new group item for psychoeducation in larger groups.
- e) Increase accessibility and efficacy by allowing all consumers to access MBS psychological treatments via videoconferencing, and remove the identified barriers to this treatment.

- f) Advise consumers at referral that they can use an *equivalent* alternative to any provider mentioned in a referral for psychological treatment.

The role of the GP and Mental Health Treatment Plans (MHTPs)

The vital role of GPs in identifying and managing physical health comorbidities, referring to, and liaising with, appropriate stages of mental and physical health care cannot be underestimated, within both primary and secondary care. Of critical importance at all stages of care is communication and collaboration between the coordinated care provider, treatment provider and the GP. Without this crucial integration of health services, the risk of siloed physical and mental health services that again lead to service gaps, duplication and fragmentation is extremely high.

Implementation of mental health hubs must not diminish coordination with GPs for all levels of mental health intervention. GPs need to retain their gatekeeper role for referrals for services that require face-to-face psychological treatment under the MBS.

The Commission has posed a specific question in regard to the MHTP (**Information Request 5.2**), namely, “How should the requirements of the Mental Health Treatment Plan (MHTP) and MHTP Review be changed to ensure that GPs assess, refer and manage consumers in line with best practice (as laid out in the Australian Department of Health’s guidance)?”

What should be added to the MHTP or MHTP Review to encourage best-practice care?

The MHTP needs to identify the stage/step of care necessary to meet the patient’s needs and specify the appropriate treating clinician type/s for that stage/step of care. Referrals need to align treatment intensity with provider qualifications.

Referrals need to be made directly to the level of care required: Focussed Psychological Strategies provided by a GP, psychologist, social worker or occupational therapist, or Psychological Therapy Services provided by a clinical psychologist. The type of treatment for the referral needs to be specified within the MHTP.

Patients need to be advised that they can change provider as they wish, within the scope of practice for which the referral is made.

ACPA has a number of recommendations in response to Information Request 5.2 regarding recommended changes to the requirements of Mental Health Treatment Plans.

- 1. GPs should refer directly to the stage of care required, linking the referral to the level of provider qualifications required.**
- 2. MHTPs should specify the type of treatment for which the referral is made: Focussed Psychological Strategies or Psychological Therapy Services.**
- 3. Patients should be informed that they can change to another provider within the specific scope of practice of the referral.**

Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?

In line with best practice, clinical psychologists will complete a thorough mental health assessment before commencing treatment. Clinical psychologists have four years of accredited post-graduate education and training in the assessment, diagnosis and treatment of mental health disorders, and will, in line with best practice, routinely undertake a comprehensive assessment of all patients who are referred to them. It is likely that a thorough MHTP and the clinical psychologist's assessment represents a duplication of assessment that adds to the cost burden of mental health services.

We are also aware that some GPs request, under certain circumstances, that clinical psychologists undertake an initial assessment and bill the patient privately, and then advise the GP regarding the patient's diagnosis and suitability for referral under an MHTP. This appears to be an issue particularly where the identified patient is a child, as mental health assessment and diagnosis with children can be particularly complex and specialised, and may require more than one session.

However, clinical psychologists **do** benefit from the medical component of the GP assessment. Patients frequently do not accurately recall the details of their medical history and medication regime. Provision of the patient's medical history and current treatment by the GP can certainly

be of assistance, even where these components of the assessment are routinely assessed by the clinical psychologist.

The development of an MHTP may also assist GPs in determining the level of severity of the mental health diagnoses to determine the level of intensity of treatment required. This understanding is essential in guiding referral for staged care of psychological treatments.

MHTPs need to be retained for those mental health practitioners that do not have advanced accredited education and training in the assessment of mental health disorders.

MHTPs for *clinical psychologists* should be *optional* for GP referrers, but a medical history needs to be provided at referral to a clinical psychologist.

Are there additional or alternative clinical thresholds (to a mental disorder diagnosis) that a consumer should meet to access Psychological Therapy Services or Focussed Psychological Strategies?

Staged care of any type requires a thorough assessment of the patient, which includes measures of severity of presentation to align appropriately with the intensity of treatments and provider expertise.

There are potential problems with specific diagnoses being required to determine access to Medicare-funded psychology sessions. Requiring specific diagnoses may lead to diagnostic distortion, as we have already seen with the new eating disorder items, where existing Better Access consumers who were accessing treatment focussed on other primary conditions (e.g. complex trauma and personality disorders) are now seeking an eating disorder diagnosis and treatment plan in order to have access to additional sessions. Ideally, criteria should be developed that are not related to diagnoses, through assessment of overall levels of mental health impairment.

Should an MHTP Review be required to access additional sessions instead of just a new referral?

An MHTP Review should be required at the completion of 10 sessions of FPS to determine if further treatment is warranted at a higher level of intensity with a provider with more advanced qualifications. However, an MHTP Review is not warranted where a patient is under the care of a clinical psychologist. Instead, the clinical psychologist should update the referring medical practitioner regarding the patient's treatment and progress after each 10-session block, or more frequently if clinically necessary.

Psychological therapy review

The current requirement for the clinical psychologist to refer patients back to the GP for review of progress is costly and unnecessary, as the review is conducted by a practitioner with generally lower levels of training in mental health. Clinical psychologists need to provide a progress report with an updated formulation and treatment plan after each 10-session block. GPs need to have the capacity to refer for an independent assessment of progress, or undertake a case management meeting, to enable ongoing treatment by the same provider if they are concerned about the patient's progress.

In regard to psychological therapy review, clinical psychologists should provide a report of progress and updated formulation and treatment plan after each 10-session block to the referring medical practitioner.

A Medicare item for this assessment and report preparation by clinical psychologists should be established.

Independent assessment by a clinical psychologist or psychiatrist may be requested at any point in treatment by a GP if concerned about a patient's progress.

A case conference meeting can be called to assist in ongoing treatment and service planning for patients who are not recovering with psychological therapy. An MBS item for case conference meetings should be established.

What information should clinicians be required to give the consumer when completing an MHTP or MHTP Review? Should they be required to give the consumer the completed and reviewed Plan?

Transparency in patient care should always be encouraged and, therefore, consumers should be provided with a copy of their MHTP or MHTP Review, unless there is a strong clinical rationale for not doing so. The Plan should be explained to consumers, along with the type and qualifications of service provider for the level of treatment to be accessed.

MHTPs and MHTP Reviews should be provided to the consumer to facilitate transparency.

Patients need to be informed that they are able to change to an alternative provider who offers the level of psychological intervention required (i.e. FPS or Psychological Therapy Services).

GPs, psychiatrists and paediatricians need to be fully informed of the differing levels of treatment provided by mental health treatment providers (i.e. FPS or Psychological Therapy Services).

GPs, psychiatrists and paediatricians need to be informed of the differing levels of accredited training in mental health undertaken by providers of FPS and Psychological Therapy Services to enable referral to appropriate staged services.

Whole-of-services staged care

Not only does the mental health system need to provide coordinated, monitored and evaluated, staged care, but all services need to adopt this model and to link together to provide necessary supports at all levels. “Care pathways for people using the mental health system need to be clear and seamless” (Productivity Commission, 2019, p. 3). This requires mental health professionals to work cooperatively and mutually in the interests of the consumer and not their professional status. Seamless connections between different stages of the system involve shifting levels up and down as required until recovery.

The mental health system

Acute and tertiary care

The aim of the mental health system should be to provide adequate services at primary and secondary levels to reduce the need for acute and tertiary care. This not only reduces costs but allows patients to be matched to services that meet treatment needs and provide for the best quality of life for those with more serious disorders. However, acute and tertiary care services will always be required, regardless of how effective lower-intensity services become.

Current acute services in the health system are not suited to the needs of those in crisis with mental health disorders. As the Commission points out, the current emergency department (ED) is designed for physical health crises, not mental health crises. A parallel system of EDs, designed specifically for those suffering mental health crises, is required. Such a model would offer supervised ‘safe suites’ in quiet environments, staffed by mental health nurses and overseen by psychiatrists. Until this is provided, triage and fast responding to provide follow-up services is urgent.

While EDs are costly and ineffective for patients with moderate to severe mental health disorders, they are currently a lynchpin for treatment. Every effort needs to be made to triage those presenting for acute care at EDs to the right level of care to reduce their burden of illness as quickly and effectively as possible.

Emergency departments (EDs)

Mental health disorders left untreated worsen and suffering increases. Without adequate, properly allocated resources, those with moderate to severe mental health disorders, termed the ‘missing middle’, become acutely unwell and turn to EDs in acute crisis. The Commission paints a dire picture of EDs for these patients, underscoring the poor responsiveness and intrinsic unsuitability of EDs for those with mental health problems.

Within EDs, mentally unwell patients are stabilised and discharged back into the fragmented, gap-ridden, under-resourced, poorly-aligned mental health services that saw them untreated or

inadequately treated in the first place. They are rarely followed up and remain in limbo until their next crisis takes them back to the ED.

A ‘whole-of-service’ approach to mental health problems that aligns care via all services to the level of need is necessary. Such an approach sees EDs in health, or future mental health EDs, as gateways to rapid staged care and follow-up treatment to address the whole-of-person needs.

A whole-of-service approach

As the Commission points out, a whole-of-service approach, in which every service acts as a gateway to properly aligned rapid staged care is essential. Nowhere is this more essential than in EDs. Apart from reducing suffering, such a model dramatically reduces costs. This can be evidenced in the Project Air Strategy model.

The Project Air Strategy for Personality Disorders is an internationally recognised leader in research, education and treatment. Personality Disorders (PDs) are high prevalence, severe, long-term mental health disorders characterised by inflexible and maladaptive personality traits that result in significant distress and impairment for the person and usually others around them. “Population prevalence of PDs are found to be around 6% with an estimated 40–50% of psychiatric inpatients having a PD (Grenyer, Lewis, Fanaian & Kotze, 2018). The most common PD is Borderline PD (BPD), with around 30% of inpatients and similar percentages of outpatients having this diagnosis. Patients with BPD present in significant emotional crisis, with or without self-harm injury, or suicidal threats or attempts” (Grenyer, Lewis, Fanaian & Kotze, p, 2).

Project Air subjected a whole-of-service stepped-care strategy incorporating staging to a randomised controlled trial (Grenyer, Lewis, Fanaian & Kotze, 2018), utilising a cost-neutral design. The model diverted patients from inpatient units and emergency departments, when not helpful. Psychological clinics were established at the intervention sites to respond rapidly (within 36 hours once acute suicidality was stabilised) and triage patients into brief and longer psychological therapies, based on their level of need and capacity to respond to treatment. The brief intervention was manualised and focussed on crisis management, symptom reduction and psychosocial improvement, and was accompanied by access to carer education, fact sheets, videos and other clinical resources. Basic training in the management of BPD was given to all staff in a 2-hour session.

The outcomes speak for themselves: “Evaluation of the stepped care approach, compared with treatment as usual showed presentations to Emergency Departments significantly reduced by 22%, and the number of days spent in the inpatient unit significantly reduced from an average of 13.46 days to 4.28 days – a significantly larger reduction than the TAU site (12.98 to 8.44 days). As a consequence, the mean cost saving for implementing personality disorder psychological treatment is estimated to be USD \$2,720 per patient per year in this sample” (Grenyer, Lewis, Fanaiain & Kotze, 2018, p. 9). Such approaches need to guide triage for all moderate to severe disorders where appropriate. The Strategy utilised by Project Air incorporates rapid follow-up from admission that is known to reduce suicide risk (Milner, Carter, Pirkis, Robinson & Spittal, 2015).

It is notable that this program was required to develop clinics to provide brief interventions for this group of patients, and that waiting lists for longer-term treatments were excessive, often greater than one year. This underscores the gaps in services for the “missing middle”—those who require services beyond primary care, but are not sufficiently acute for hospitalisation.

Hospital care across boundaries

Further clarification is required to determine whether hospital treatment provided to out-of-state visitors is included in models. There is a potential for residents to travel interstate for specialist hospital treatments that are either unavailable or considered inferior in their resident state. In the best interests of the patient, evaluation of this potential is worth consideration.

ACPA conditionally supports the proposal that “the State where a patient would normally reside should meet the cost of services where its resident receives hospital treatment in another jurisdiction” (Productivity Commission, 2019, p. 894) to manage cross-border hospital activities.

Secondary care: The ‘missing middle’

“The main focus of Australia’s mental health system is providing primary, acute and specialist care to people with mental illness” (Productivity Commission, 2019, p. 186). However, “Up to one million people typically have symptoms that are too complex to be adequately treated by a GP and the limited MBS-rebated individual sessions with allied mental health providers (predominantly

psychologists). But their condition also does not reach the threshold for access to State or Territory funded specialised mental health services, private psychiatrists or private hospitals due, for example, to long waiting lists or very high out-of-pocket costs. Too often, the necessary services exist but are being absorbed by people whose needs would be met just as well by lower intensity services” (Productivity Commission, 2019, p. 18). This is the ‘missing middle’.

This group of patients falls at “the interface between Australian Government and State and Territory Government responsibilities” (Productivity Commission, 2019, p. 45), and between the gaps of uncoordinated siloed services. The bulk of problems identified by the Commission within the current mental health system and its associated services—such as fragmentation, poor continuity of care, duplication, gaps, underservicing (lack of clarity of responsibility, lack of funding, lack of cohesion, lack of strategy, and lack of proper governance)—impact on this sector (the ‘missing middle’) of consumers and are related to serious shortcomings.

However, in the Draft Report there is no cohesive analysis of ‘secondary care’ as there is for preventative, primary and acute care.

The final report of the Commission would be significantly strengthened if the ‘secondary care’ sector was identified *specifically* in relation to the problems currently faced in obtaining adequate mental health treatment, inter-governmental psychosocial services and supports, and carer and consumer input.

Prevention and primary care

Prevention, early screening and early intervention

In a recent press release, the Citizens Commission on Human Rights International (CCHRI) expressed alarm in response to the Commission’s recommendations to implement wide-spread screening in the perinatal period and of infants and children for signs of “at risk” behaviour and emotion, “mental illness” and “emerging mental illness” (Citizens Commission on Human Rights International, 2019). The concern is that this leads to prescription of drugs for ‘prevention’, rather than other interventions that do not potentially adversely affect brain development.

The CCHRI cites data that shows “Australia has the fourth highest rate of antidepressant use in the world and the number of children and teens taking these have increased by 60% in the past five years” (Citizens Commission on Human Rights International, 2019). Of greatest concern is Australia’s embracing of the highly controversial ‘Psychosis Risk Syndrome’ (PRS) that supports the prescribing of highly potent anti-psychotics to children and adolescents.

According to the cited Cochrane report, there is only weak evidence to show that *any* early intervention has an impact on transition to psychosis, and that “adding antipsychotic drugs to supportive-care packages did not seem to make much difference in terms of transition to full illness” (Bosnjak , Kekin, Hew, Rojnic Kuzman & Buljak, 2019). According to the report, there is some weak support for the use of Omega 3 to reduce transition to psychosis but this result was reliant on a small study only.

While a prodromal stage of psychotic illness has long been recognised, the identification and diagnosis of prodromal features have proven unreliable with low sensitivity. The International Classification of Diseases, 10th edition, acknowledges a prodromal stage of schizophrenia, but does not allow a separate diagnosis for the prodrome. PRS is not included in the latest version of the Diagnostic and Statistical Manual of Mental Disorders. Instead, a category of ‘Attenuated Psychosis Syndrome’ has been identified for further research (Kontaxakis, Havaki-Kontaxaki, Kollias, Ferentinos & Papadimitriou, 2013).

Early intervention for those ‘at risk’ of developing a mental illness must be confined to support and psychoeducation until a full illness develops before medical treatment is prescribed, particularly for infants, children and adolescents.

Early childhood

Parents routinely undertake birthing classes, and there are supports for new parents in managing their newborn, but little is routinely provided to educate parents on positive parenting strategies that build resilience and self-esteem, and underpin family relationships that are protective against mental health disorders. Parenting programs are routinely required at periods of transition to enable parents to adapt to age-appropriate needs of their child. Parenting programs need to be made widely available. They need to become embedded as routine in the culture of parenting at points of

transitions, such as during infancy, in preschool, at school entry, as the child reaches adolescence, and early adulthood. Parenting classes need to enable referral to professional treatment where population-based education is insufficient to meet family needs.

Evidence-based parenting programs need to be made widely available at points of childhood and adolescent transitions.

The education system

The Commission correctly states, “The education system is not a suitable setting for long-term treatment of mental illness” (Productivity Commission, 2019, p. 691). However, educational and developmental psychologists are well equipped to select and oversee implementation of prevention and resilience programs that have proven efficacy for school-aged children, and to monitor and evaluate outcomes for these. They are also capable of providing teacher training in mental health. ACPA agrees with the Commission’s recommendation that “State and Territory departments of education should use the national guidelines to accredit social and emotional learning programs delivered in schools” (Productivity Commission, p. 678). There is growing evidence supporting effective prevention programs for mental health and well-being in school populations. For example, an online universal prevention program tested in a large multi-school randomised controlled trial was effective in the prevention of substance use problems, depressive symptoms and anxiety in adolescence (Teesson et al., 2020).

Privacy of health records for children and adolescents

The Commission has identified a major and ongoing problem in that “principals and other teaching staff can access files and, in some schools, counsellors must share files and cases with teaching staff who have training in mental health” (Productivity Commission, 2019, p. 683). This is unacceptable.

Health records are protected by federal and state legislation. The education system must not be exempt from these legal obligations. Furthermore, there are state-based age levels at which the young person is provided the same rights to their health management and records as adults. These stipulations must be applied in all jurisdictions.

Privacy of children's and adolescents' health records, including their mental health record, must align with legal requirements for all institutions and be mandatory.

The health records of children and adolescents in schools should comply with the privacy and health records legislation of the state in which they reside.

Conclusions

In conclusion, ACPA commends the Commission for the production of a draft report that is broad in scope and raises a range of critical issues in regards to the provision of services to support the mental health and well-being of all Australians.

In this response, the Australian Clinical Psychologist Association has focussed on matters that pertain to the role and contribution of clinical psychologists to mental health care and service delivery, and where we have been able to draw on our expertise and the research evidence.

ACPA has identified a number of issues that it believes should be priority areas for change. In particular, the introduction of valid and reliable outcome assessments to be used consistently across all publicly funded services. Only with such comprehensive assessments can we know what works, and for whom. Such measures ensure responsible fiscal management of public resources.

In addition, ACPA supports the implementation of a staged-care model of mental health service provision. This could include innovative evidence-based approaches that have been shown to improve mental health outcomes in cost-effective ways, including supported online interventions. The first stage will use focused psychological intervention to address milder levels of problems, while the second and third stages will permit 20 and 40 sessions, respectively, of specialised intervention by clinical psychologists for moderate and severe problems respectively.

Finally, ACPA argues that recognition and acknowledgement of the differing specialist areas of psychological practice that have relevance to mental health delivery, as defined by Areas of Practice Endorsement, will add value to health service delivery by ensuring that workforce skills and expertise are used to their full potential.

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Appendix A: Minimum standards of training in mental health for psychologists with general registration

Psychology is a very broad discipline, with widespread applications outside of health systems.

Competencies for registration as a *psychologist with general registration* cross *all* areas of professional psychology, from sport performance, organisational work (such as job selection and human resources management), educational development, emergency assistance to communities in crises, health promotion and psychological management of physical illness, neuropsychology, counselling to manage life events and transitions, to mental health.

Australian Standard			International Standard	
All psychologists undertake an undergraduate program in the science of psychology				
Psychologists with general registration*	'4+2' pathway	2 years of (unaccredited) supervised practice	<ul style="list-style-type: none"> Most psychologists with general registration in Australia have trained via 4+2. The lowest standard in the world for registration or licensure of psychologists. Phased out in the 1970s in the UK. National Standards first established by the PsyBA in 2010. 4+2 pathway will be closed by 2027. 	Not accepted for independent practice in any other regulated jurisdiction
	'5+1' pathway	1-year accredited Master degree + 1-year (unaccredited) supervised practice	<ul style="list-style-type: none"> 5+1 was introduced in 2013. 	Minimum requirements for registration as general psychologist: UK, Canada, USA: Do not register or licence <i>general</i> psychologists for independent practice. UK: Allows those with this level of training to work in

	<p>+ National psychology exam</p> <p>Introduced in 2013 to mitigate risk of unaccredited and short pathways to registration. Only undertaken by new registrants (i.e. 2013 onward).</p>	<p>mental health using manualised treatments under the supervision of clinical psychologists, with ongoing monitoring and evaluation.</p> <p>USA: A few states allow 2-year Master-level trained clinicians to work in specific areas, such as behavioural management or family therapy. They are not permitted to work in mental health.</p> <p>NZ: 2-year Master's degree for general practice.</p> <p>Indonesia: 4-year undergraduate + 2-year Master's degree in clinical psychology to work in mental health.</p> <p>EuroPsy (Basic): 5+1—taken as 3-year undergrad degree in science of psychology + 2-year Master's degree focussed on mental health.</p>
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*Note: Australia has the lowest standard of training for psychologists with general registration of any regulated jurisdiction.¹

¹Psychology Board of Australia (2019). Retirement of the 4+2 internship pathway to general registration. <https://www.psychologyboard.gov.au/News/Media-Releases.aspx> accessed 21/12/2019.

Education and training standards for Area of Practice Endorsement (AoPE) in Australia

Competencies in the **advanced** knowledge and skills relevant to different sectors requiring specialised training (e.g. clinical psychology, clinical neuropsychology, counselling psychology, health psychology, forensic psychology, community psychology, educational and developmental psychology, and sport and exercise psychology).

Clinical psychology: Specialisation in *Mental Health*

Minimum qualifications in Australia

2-year professional Master's degree + 2-year registrar program of supervised practice. Provides broad specialised knowledge and skills training in assessment, diagnosis and treatment of mental health disorders to enable identification and management of comorbidities, serious, chronic and complex disorders. Areas of specific diagnostic specialisation are undertaken within the registrar program.

International comparison: Clinical psychology is an internationally recognised area of specialisation that is required for independent work in mental health as a psychologist

- **USA & most of Canada (3 remote provinces allow 2-year Master trained psychologists to work in mental health):** 4-year doctoral degree
- **UK:** 3-year doctoral program
- **NZ:** 3-year Master degree + 1-year Diploma (i.e. 3 years of clinical psychology training)
- **South Africa, ASEAN countries, etc.:** 2-year Master's degree
- **EuroPsy:** 1.5 years of post-EuroPsy (Basic) accredited training for psychotherapy specialisation (not necessarily in mental health).

References

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<https://www.psychologyboard.gov.au/Endorsement/Registrar-program.aspx>

Canada: <https://cpa.ca/practice/practiceregulation/>

EuroPsy: <https://www.europsy.eu/quality-and-standards/europsy-basic>

<https://www.europsy.eu/quality-and-standards/europsy-specialisation>

Indonesia: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4346028/>

New Zealand: <http://www.psychologistsboard.org.nz/scopes-of-practice2>

UK: <https://www.bps.org.uk/psychologists/society-qualifications/qualification-clinical-neuropsychology>

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USA: <http://psybook.asppb.org/>

<https://www.apa.org/support/licensure>

Appendix B: Size of the psychology workforce

Table 1. Number of psychologists and clinical psychologists per 100,000 population

Country	All psychologists	Clinical psychologists	Psychologists with advanced training for sectors <i>other than</i> mental health
Australia ¹	151	37	17
Western Europe ^{2,3*}	100-150 (est.)	Unable to be determined	Unable to be determined
New Zealand ⁴	67	36	31
Canada ⁵	51	Unable to be determined	Unable to be determined
United Kingdom ⁶	36	21	16
USA ⁷	31	Unable to be determined	Unable to be determined
South Africa ⁸	15	Unable to be determined	Unable to be determined

* Estimate based on highly variable data including extrapolations, invalid inclusions, and age. The report is based on the national reports sent to the Commission in 2014 and on discussions at a meeting of the Commission held on 6th March 2015. The register of those holding EuroPsy qualifications¹ returns only 9,936 psychologists, with 7,622 of these in clinical and health psychology across 37 member countries.

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¹ Australia: Psychology Board of Australia (September 2019). *Statistics*.

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² European Commission (2016). Mutual evaluation of regulated professions: Overview of the regulatory framework in the health services sector – psychologists and related professions.

<https://ec.europa.eu/docsroom/documents/16683?locale=en> accessed 28/08/2019.

³ European Federation of Psychologists' Associations: EuroPsy Register.

https://www.europsy.eu/search-psychologist?family_name=&fields_of_practice=all&type_of_certificate=all&op=Search&form_build_id=form-SfHS-SVe9mp4jTFdKLCUMu1OogF179Ocd2hJMkI4Gto&form_id=psychologist_search_form searched 20/08/2019.

⁴ New Zealand Psychologist Board (2019). By email 22/05/2019: gina.giannios@nzpb.org.nz

⁵ Canadian Institute for Health Information (2019). *Canada's Health Care Providers: Provincial Profiles, 2008 to 2017 — Data Tables* (Jan 2019). <https://www.cihi.ca/en/psychologists>

⁶ Health Care Practitioners Council United Kingdom (March 2019). By email Ref: **FR06055**

⁷ American Psychological Association. (2018). *Demographics of the U.S. psychology workforce: Findings from the 2007-16 American Community Survey*. Washington, DC: Author.

⁸ Health Professionals Council of South Africa. <https://www.hpcsa.co.za/Publications/Statistics> accessed 26/08/2019.

Appendix C: Support for existing governance and recognition of specialist knowledge and skills of clinical psychologists in Australian states and key organisations

Clinical psychology is recognised as providing advanced specialised expertise in the assessment, diagnosis, formulation, evidence-based treatment and outcome evaluation of mental health disorders, beyond that of psychologists who do not hold this qualification. Recognition of this specialised training is evidenced both nationally across a broad range of institutions and services within Australia, and internationally as a speciality.

Recognition within Australia of advanced knowledge and skills of clinical psychologists

The Department of Social Services contracts clinical psychologists to conduct disability medical assessments for mental health problems (<http://guides.dss.gov.au/guide-social-security-law/acronyms#dma> downloaded 27/03/2015). Diagnosis of a disability can be made by a medical practitioner or clinical psychologist (<http://guides.dss.gov.au/family-assistance-guide/1/1/d/80> downloaded 27/03/2015). Diagnosis of mental health problems for Mental Health Function assessments for Disability Services are only permitted to be made by a psychiatrist or medical practitioner with evidence from a clinical psychologist (<http://guides.dss.gov.au/guide-social-security-law/3/6/3/50> downloaded 27/03/2015).

Centrelink only allows clinical psychologists or psychiatrists to provide a medical assessment or an assessment for Disability Services. Generalist psychologists are not accepted as assessors (<http://agencysearch.australia.gov.au/search/search.cgi?query=clinical+psycholog&form=cus tom&profile=humanservicesportfolio&collection>).

The Department of Veteran Affairs has separate fee schedules for clinical psychologists and other psychologists, with clinical psychologists paid at a higher rate in recognition of their advanced training (<http://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules>).

The National Framework for Rights and Services for the Victims of Crime 2013–2016 (Standing Council on Law and Justice, p. 16) permits psychological assessments to be conducted only by a psychiatrist or clinical psychologist.

The standard for assessment for hormone replacement therapy and gender reassignment in Australia follows international standards established by the World Professional Association for Transgender Health (www.wpath.org). The Standards of Care (http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926 downloaded 29/03/2015) accept the minimal qualification credentials for mental health professionals who work with adults presenting with gender dysphoria as an accredited Master's degree or a more advanced degree in a clinical behavioural science field.

Most private insurance companies cover psychology services in their Extras packages. Many—such as Medibank Private Health Insurance (<https://www.medibank.com.au/health-insurance/extras-cover/>), Medibank Health Solutions and Garrison Health Services, providing health services to the Australian Defence Force (<https://www.medibankhealth.com.au/ghs.asp?id=947&t=Schedule+of+Fees+Allied+Health+providers&cid=130>), HBF (<https://www.hbf.com.au/health-insurance/products/essentials/essentials-standard>) and CUA Insurance (https://www.cuahalth.com.au/#_extra)—only provide cover for clinical psychology services.

The Find a Professional Directory of beyondblue differentiates clinical psychologists from other psychologists. This directory requires registration as a clinical psychologist by the Psychology Board of Australia.

Universities also pay higher rates to clinical psychologists in their counselling services under the Higher Education General Staff Award 2010 as at least Level 8, requiring a post-graduate degree.

State government awards

In Western Australia, for over 30 years up until the implementation of the National Law in October 2010, specialist recognition of clinical psychologists rested on a Master's or Doctoral degree in clinical psychology, plus a period of supervised practice. During this period, the public and other health professionals had full confidence in the qualifications and training of specialist clinical psychologists, and qualifications were rigorously assessed and readily identified on the register with rates of pay awarded in Health based on the specialist standard. The implementation of Area of Practice Endorsements under the National Law saw an influx of clinical psychologists who had been given an AoPE via alternative pathways, without the benefit of accredited training in the area of speciality. Standards are now confused and the means of identifying those with the required qualifications and training for clinical psychology practice are confounded and difficult to utilise. In response, the Clinical Psychology Reference Group for the Department of Health in Western Australia has produced templates for advertising clinical psychology positions and the Clinical Psychology Job Description Form (May 2013) in Health to ensure that the department employs only those clinical psychologists who meet the standards previously deemed essential under the award.

This requires a clinical psychologist to hold a “Masters [sic] or Doctoral Degree in Clinical Psychology and eligibility for full registration and endorsement in Clinical Psychology with the Psychology Board of Australia”. It clearly states that no degree or part degree in another AoPE, nor any ‘equivalent’ degree is acceptable. Endorsement in clinical psychology is an additional requirement, not a substitute, for accredited post-graduate qualifications. Nor do an individual’s professional practice skills substitute for the required degree in clinical psychology.

The Western Australia Department for Child Protection and Family Support offers careers in psychology and recognises the advanced training of clinical psychologists through higher responsibilities and pay rates:

(https://www.dcp.wa.gov.au/Organisation/employment/Documents/Psychology%202pp%20A4_2014.pdf downloaded 28/03/2015).

Workcover WA allows only clinical psychologists to provide psychological services:
(<http://www.workcover.wa.gov.au/health-providers/allied-health-providers/>)

The New South Wales Crown Employees Psychologists Award (2012), that covers Family and Community Services, TAFE Colleges and Schools, Universities, Health, Justice (including the NSW Police Force and Corrective Services, Juvenile Justice, Emergency Services etc.), state-owned corporations, etc., reclassified clinical psychologists as Specialist Psychologists with the potential progression to Senior Specialist Psychologist.

The Amended Schedule A of the Crown Employees (Public Sector – Salaries 2008) Award, handed down by the Industrial Relations Commission of New South Wales in 2014, differentiates clinical psychologists from other psychologists in detailing levels of pay for managerial positions, and also provides for differing pay rates through advancement from Clinical Psychologist to Senior Clinical Psychologist to Principal Clinical Psychologist.

The Health and Community Employees psychologists (State) Award established by the Industrial Relations Commission of New South Wales in 2012
(http://www.lawlink.nsw.gov.au/lawlink/irc/ll_irс.nsf/pages/IRC_procedures_legislation_awards_index_all) stipulates a Masters qualification or higher is required to hold a clinical psychologist position. The award thus differentiates qualified clinical psychologists from other psychologists, with

higher pay rates in recognition of their expertise. Under this award, clinical psychologists have a structure of advancement to Senior Clinical Psychologist or Principal Clinical Psychologist.

The Motor Accident Authority in NSW recommends treatment for Brain Injury Rehabilitation Programs by a psychiatrist or clinical psychologist (Motor Accident Authority, 2013, p. 22).

The Victorian Public Community Health Sector Enterprise Agreement 2012-2016 (Victorian Hospitals' Industrial Association 2012) and the Victorian Institute of Forensic Mental Health Enterprise Agreement 2012–2016 (Victorian Institute of Forensic Mental Health) only permit psychologists who are clinical psychologists, forensic psychologists or clinical neuropsychologists to be classified above a Grade 2 and provide for an allowance for higher-degree qualifications.

The Children's Court Clinic in Victoria employs clinical psychologists, forensic psychologists and psychiatrists to undertake assessments
(<http://www.childrenscourt.vic.gov.au/jurisdictions/criminal/childrens-court-clinic>).

The Relations Commission Health Practitioners' (Queensland Health) Certified Agreement (No. 2) 2011 (HEB2) identifies clinical psychologists and clinical neuropsychologists as separate from generalist psychologists (<http://www.health.qld.gov.au/employment/conditions/awards-agreements/current/default.asp> downloaded 28/03/2015).

Workcover Queensland pays clinical psychologists at a higher rate than other psychologists for clinical psychology services
(https://www.worksafe.qld.gov.au/home/search?query=clinical+psychologists&collection=w_cq-internet&form=results&search_page_38364_submit_button.x=0&search_page_38364_submit_button.y=0 downloaded 27/03/2015).

Appendix D: A Hidden Workforce: Clinical Psychology

Trainees Specialising in Mental Health

Psychology is a very broad and diverse discipline with wide application within many disparate workforces, ranging from traffic planning through marketing, health promotion, sport, education and mental health. All psychologists have basic education and training in mental health to the level of a psychologist with general registration. Advanced education and training in psychological practice is designed to meet the needs of different sectors in which psychological practice is applied.

The area of advanced specialised education and training in mental health is 'clinical psychology'. Training consists of academic learning in the application of evidence-based treatments to a broad range of complex presentations, with supervised practice in their application, plus research skills. The minimum time to train as a clinical psychologist is eight years: a four-year undergraduate degree in the science of psychology; at least a two-year Masters degree focussed on assessment, diagnosis and treatment of mental health disorders; and then a two-year registrar program in clinical psychology. At the point of entry into the two-year Masters degree, if not before, candidates become registered with the Psychology Board of Australia.

The supervised training of clinical psychologists provides a workforce that delivers a broad range of high-quality, low-cost mental health services to the public. At least 1,000 hours of supervised, work-based practicum is required within the Master's degree. This delivers around 400 hours of direct patient contact per trainee. Trainees are unpaid. The only cost carried by the mental health system is for the supervision provided (for every hour of supervision provided, at least eight patients are seen). With over 500 clinical psychology trainees graduating annually, there are more than 1,000 trainees undertaking degrees at any one time. **The degree-based clinical psychology trainee workforce provides around 400,000 occasions of service, saving the health system approximately \$40,000,000 annually.** In addition, the registrar program provides 1,000 supervised clinical psychology registrars annually. Clinical psychology registrars are commonly remunerated at the generalist psychologist pay rate until they reach full endorsement in clinical psychology, **providing further considerable cost savings** for services provided to the public.

The psychology training clinic

As a component of their work-based practicums, clinical psychology trainees undertake at least six months of intensely supervised practice for at least two days/week within an education facility psychology training clinic. Sessions are recorded and viewed for the purposes of rigorous clinical supervision and feedback. The cost of training clinical psychologists is borne by the educational institution and comes from revenue raised through enrolments in undergraduate psychology courses.

Clinical psychology training clinics have filled the significant gap in mental health service provision associated with the current 10-session limit of the MBS Better Access scheme. Patients in the community who require ongoing therapy beyond 10 sessions are referred on to psychology training clinics, which operate at no cost to the health system. Fees are primarily charged on a sliding scale, from \$0 to \$50/session, depending on the SES area served.

Clinical psychology registrar programs

Following the clinical psychology degree, the minimum two-year clinical psychology registrar program ensures supervision by an accredited supervising clinical psychologist in mental health service delivery. It is within the registrar program that advanced training in specialised areas (e.g. eating disorders, psychosis, personality disorders, general clinical psychology practice, etc.) can be undertaken.

Recommendations

Mental health services, provided by trainee clinical psychologists, need to be recognised, protected and incorporated into the architecture of mental health services.

The registrar program for clinical psychology has the potential to be further developed to meet specific needs of the public, through providing identifiable qualifications or credentials designed for specialist areas.