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Submission to

Productivity Commission Review 2019: The Social and Economic Benefits of Improving Mental Health

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Introduction

The Institute of Clinical Psychologists (ICP) has a long and distinguished history, since it was established in the 1980's. The ICP has the overarching mission of promoting the delivery of high standards of clinical psychology practice to patients who attend private practitioners in Australia. All full members of the ICP are endorsed as Clinical Psychologists by the Psychology Board of Australia and all members work in private practice.

The ICP is the only body in Australia with a specific and comprehensive focus on, and representation of, Clinical Psychologists delivering services within the private sector.

We welcome the opportunity to contribute to review of the Social and Economic Benefits of Improving Mental Health in Australia 2019 (hereafter referred to as the Issues Paper).

Our contribution will focus upon:

- *Structural changes required to facilitate delivery of mental health services by psychologists.*

And two of the specific issues raised in the Productivity Commission Issues Paper (January 2019) which appear on page 17:

- *What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable?*

- *What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?*

We will address the third point first, as this forms the basis for our other recommendations.

Recommendations:

- Retain the distinction between the qualifications, scope of practice, and pay rates, for Registered Psychologists and Clinical Psychologists.

- Improve access to Clinical Psychologists in regional, rural and remote regions by supporting the extension of Telehealth services into these areas, support training of psychologists in the use of Telehealth technology, and provide the requisite infrastructure.

- Realign the number sessions of Medicare Psychological Therapy Services provided by Clinical Psychologists (MBS Items 80000 to 80020) in accordance with the complexity and severity of the disorder.

- Under the stepped care model, retain 10 sessions per annum rebated by Medicare for mild mental illness, to be delivered by Registered Psychologists and Clinical Psychologists (and retain the two tier system). For moderate mental illness, increase the number of clinical psychology sessions rebated by Medicare to 20 sessions per annum, to be delivered by Clinical Psychologists and Counselling Psychologists; for severe mental illness increase Medicare rebated sessions to 40 sessions per annum to be delivered by Clinical Psychologists only.

- Rationalize assessment and reporting requirements for MBS clinical psychology items 80000 to 80020 by i) replacing Mental Health Treatment Plans with a simple referral letter to the Clinical Psychologist; ii) removing the requirement for a review after 6 sessions; and iii) reporting to the referring medical practitioner upon completion of the course of clinical psychology therapy and where clinically indicated.

- Introduce structures that will allow Clinical Psychologists to refer patients directly to Consultant Psychiatrists for severe and complex mental illness.

The rationale for these recommendations is provided below.

A. Clinical Psychologists and Registered Psychologists: Scope of Practice

- ***Issues Paper Question (p 17): What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?***

Our response to this question will focus on the scope of practice of Clinical Psychologists and Registered Psychologists, and whether restrictions are warranted, with a view to safe delivery of psychological services for those in our community with mental health disorders.

The Psychology Board of Australia recognizes several different types of psychologist, in accordance with the specifics of their level of university education and type of training. Practitioners endorsed as Clinical Psychologists have advanced accredited training in mental health, having completed a four year accredited undergraduate university degree in psychology, followed by an accredited two-year Master's or three-year Doctoral degree in *clinical* psychology (which focuses on mental health), and then a two year registrar program working in mental health (in government clinics, hospitals and private practice) under the direct supervision of an accredited Clinical Psychologist supervisor. Registered Psychologists have a minimum of a four year *undergraduate* degree in psychology, followed by two years of supervision in practice. By definition, Registered Psychologists are not qualified or skilled to practice in an endorsed area of practice (Psychology Board of Australia).

By virtue of their training, Clinical Psychologists are equipped to diagnose and treat people with a range of clinical presentations, including moderate and severe mental illness. Registered Psychologists are equipped to treat mild or low risk mental health conditions.

Under the Medicare Better Access initiative, patients of both Clinical Psychologists and Registered Psychologists qualify for up to 10 rebated sessions per annum. Clinical psychology items attract a higher rebate than psychology items; and Clinical Psychologists are permitted to apply a wide range of therapies whereas Registered Psychologists are restricted to Focussed Psychological Strategies. These differences have created tensions within the profession, with some Registered Psychologists claiming they are being "discriminated against" and arguing for one rebate rate for all psychologists. The basis of their argument is that experience equips them to diagnose and treat patients at the same level as a Clinical Psychologist.

They use in their arguments an evaluation of the Better Access Initiative by **Pirkis et al. (2011).** However, **they have *misinterpreted* this study as evidence of no difference in treatment outcomes for Registered Psychologists and Clinical Psychologists.** This study reports a reduction in (self-reported) symptoms of distress from ostensibly high/very high levels of psychological distress to more moderate levels of distress (on the K-10, a simple screening measure) after psychological treatment; and it reports that patients recruited by Clinical and Registered Psychologists shifted from moderate or severe self-reported symptoms of depression, anxiety or stress, to normal or mild

levels (on the DASS-21, another screen that cannot provide a diagnosis). However, despite the research methodology precluding comparison of treatment outcomes of practitioner groups, this study has been misinterpreted as demonstrating equivalence in treatment efficacy for Registered Psychologists and Clinical Psychologists. By extension, it has been argued that experience as a practitioner improves treatment outcomes, levelling out differences in treatment delivered by Registered Psychologists and Clinical Psychologists. It is on this basis that groups of Registered Psychologists argue for equivalence in pay scales and collapsing the two tier rebate in Medicare's Better Access to one tier. This argument is fallacious as the methodology adopted by Pirkis et al (2011) prevented statistical comparison of treatment outcomes for the two groups of psychologist. **Substantial limitations in the research design mean that the outcomes of this study are neither reliable or valid**[1]. By extension, limited conclusions can be drawn from its findings. Misinterpretations such as this have confused policy making with respect to distribution of economic resources to treat mental health patients.

Research evidence <u>does not</u> support the contention that psychological treatment outcomes improve with greater experience. For example, in a comprehensive longitudinal investigation with 6,591 patients seen in individual psychotherapy by 170 therapists who had been practitioners between 0.44 to 17.93 years, Goldberg et al (2016) found improvements of about one standard deviation after psychological treatment. However, therapists did not improve with more experience, whether it was operationalized as time in practice or number of patients. Instead, therapists overall became slightly less effective over time, and this small reduction remained after controlling for patient-level, caseload-level, and therapist-level characteristics.

Instead, **research shows that training improves therapist knowledge and skill in delivering psychological treatment, but the *type* of training moderates this**. This is illustrated in a systematic review of studies on training in Evidence Based Practice for at risk and clinical populations over an 18-year period (1990–2008) by Beidas and Kendall (2010). They demonstrated that active learning and behavioural rehearsal (*of the type found in university <u>postgraduate</u> clinical training*) are essential components in training therapists to deliver evidence based therapies with fidelity, whereas didactic training (e.g. seminars, manual, and supervision) is not sufficient to produce proficient change in therapist adherence, competence, and skill. Further, Stein and Lambert (1995) conducted a large meta-analysis of the effectiveness of training, sampling 19,000 patients, and found a modest but consistent effect of level of training across all measures of patient improvement. In addition, well controlled studies using independent clinicians to assess patient improvement found **greater improvement in patients who had therapists with more training; a higher level of**

[1] Practitioners **selected their own patients** for the study introducing significant sampling bias; it did not take a prospective approach; inadequate controls were used (e.g. no control group, no comparison group to distinguish changes due to other factors (e.g. time, medications); inadequate determination of patient diagnosis or severity of presentation; no control over the type of psychological intervention/s across patients or psychologists; no measurement of treatment adherence or relapse rates). **This study contravenes basic research design principles required for robust research into treatment outcomes, and as such has limited validity or reliability** and should not for these reasons be used as a basis for evaluation of the relative efficacy of treatment outcomes. Refer to Allen and Jackson (2011) for a critique of this study.

training was associated with better patient engagement; and lower dropout rates of complex mental health conditions were evident with therapists who had more training.

Together, research provides firm evidence that formal training of the type delivered in postgraduate clinical psychology training programs is associated with better engagement of patients in therapy, lower dropout rates of people with complex mental health presentations, higher skill in delivering evidence based practice, and better treatment outcomes. **Experience as a therapist is not associated with better treatment outcomes**, and attendance at workshops or lectures, even when tied with supervision, does not produce better outcomes in patient retention, or therapy outcomes.

Based upon evidence such as this, the minimum training required for psychologists working in mental health in England, much of Europe, United States of America, and New Zealand, is six years of university training and two years internship. Australia's current requirements for Registered Psychologists working in mental health fall far short of these requirements, with the minimum qualification being a four year undergraduate degree majoring in psychology, and two years of supervised practice. Only the qualifications required for endorsement meet the minimum training requirements accepted by the above-mentioned countries. This alone demonstrates a difference in competencies of Registered Psychologists relative to those endorsed as Clinical Psychologists[2].

Summary and Conclusion

Registered Psychologists differ in their level of training to a Clinical Psychologist[3]. **A Clinical Psychologist has undergone the rigorous accredited training that has been shown, in research evidence, to produce better engagement of patients in therapy, lower dropout rates of people with complex mental health presentations, higher skill in delivering evidence based practice, and better treatment outcomes.** Research demonstrates that experience as a psychologist is not associated with better treatment outcomes, and attendance at workshops or lectures, even when tied with supervision, does not produce better outcomes in patient retention, or therapy outcomes. For these reasons, the evidence supports retention of the distinction between the qualifications, scope of practice, and pay rates, for Registered Psychologists and Clinical Psychologists. This evidence also projects added positive benefit to those in the Australian community with moderate to severe mental health conditions, when treated by a Clinical Psychologist.

For these reasons, the ICP recommends retention of the distinction between the qualifications, scope of practice, and pay rates, for Registered Psychologists and Clinical Psychologists.

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[2] This was recognized, for instance, in the Work Value Document 1998, submitted to the full bench of the Industrial Relations Commission in Western Australia, with a decision published 2001. The IRC agreed with the arguments put forward in the work value case, including the differentiation between clinical and general psychology, and extended and upgraded the career structure for Clinical Psychologists in WA.
(http://www.aph.gov.au/DocumentStore.ashx?id=495f9838-801e-46e4-a257-110d33228770)

[3] See Addendum 1 for the *Accreditation Standards for Psychology Programs*, 2019. Supervised practice takes place on top of, and after completion of, these university programs.

B. Mental Health Workforce Shortages in Rural and Remote Regions

- ***Issues Paper Question (p 17): What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable?***

Health workforce statistics demonstrate that most psychologists work in the public sector and in metropolitan areas (e.g. National Mental Health Workforce Strategy, 2011). The number of psychologists and more particularly Clinical Psychologists providing treatment in rural and remote areas is inadequate to meet the needs of the community. According to the Skills Shortage List, there is a shortfall of Clinical Psychologists in rural and remote areas across Australia.

Shortfalls are evident across various mental health professionals, including Psychiatrists, Mental Health Nurses and Psychologists. For instance, in 2015, the National Rural Health Alliance examined the prevalence of mental health professionals in country regions, in a submission to the Senate inquiry into the Accessibility and Quality of Mental Health Service in Rural and Remote Australia. They found there were 73 psychologists for every 100,000 people in major cities but only 25 psychologists per 100,000 in remote areas. For Psychiatrists, the spilt was 13 psychiatrists per 100,000 in major cities, and 5 per 100,000 in remote area; whereas for mental health nurses the split was 83 for every 100,000 people in major cities and 25 per 100,000 people in remote areas (https://mhsa.aihw.gov.au/resources/workforce/). These statistics demonstrate the inadequacy of access to mental health services, particularly psychiatric and psychological services, in rural and remote areas.

In accordance with these statistics, the ICP recognizes the need to resolve the problem of access to psychological treatment in rural and remote areas. Specifically with respect to the provision of psychological treatment services in rural and remote regions, the ICP recommends a combination of the following:

i) Improving access to Clinical Psychologists, who are equipped to treat more complex mental health conditions, through government programs supporting the extension of Telehealth services into regional, rural and remote areas. This would also entail support for training psychologists in the use of Telehealth technology, and provision of the infrastructure to make this work (many rural and even regional areas currently have unreliable internet connections).

ii) Rebating Telehealth psychology sessions through the Medicare Better Access initiative for people with moderate and severe mental health conditions (and elsewhere in this document we argue for an increase in the number of Medicare rebatable sessions for moderate and severe mental health conditions);

iii) where condition (i) above is not available, providing financially supported close supervision of Registered Psychologists working in these areas via Telehealth and telephone, with Clinical Psychologists who are approved by the Australian Health Practitioners Regulation Agency to act as clinical supervisors;

iv) developing grants to upskill Registered Psychologists working in rural and remote areas to support appropriate accredited clinical training delivered by a combination of external studies through university programs, tied with clinical supervision via Telehealth and telephone.

The ICP does not support the Australian Psychology Society's proposal to manage the shortfall in practitioners by awarding 'practice certificates' to Registered Psychologists in rural and remote regions. They propose award of these certificates after a minimum of 40 hours additional training (i.e. one week), with supervision and active assessments. They propose to use these certificates to enable Registered Psychologists in these regions to treat patients with moderate and severe mental health conditions. These certificates would not be recognized by the regulatory body, the Psychology Board of Australia (APS Green Paper, 2019). Use of practice certificates to work with moderate or severe mental health conditions will put the public at risk of harm from inadequately trained psychologists who are ill equipped to manage moderate to severe mental illness.

C. Structural Changes to Improve Delivery and Efficacy of Psychological Treatment

In 2011, the Australian Institute of Health and Welfare calculated mental health problems as the third highest burden to the Australian community. Mental ill-health has been estimated to cost the Australian economy almost $60 billion (RANZCP, 2016).

The ICP agrees with the proposition in the Issues Paper that the mental health of the community is directly connected to the social and economic health of the nation. Figure 1 of the Issues Paper appropriately captures this positive reinforcing feedback loop. When an individual's mental health is functional and they are happy, prosper, participate, and contribute to the social and economic health of the community. When an individual's mental health is compromised, this impacts not only the individual, but others in the community, including their family, support network and employers. By extension, effective psychological treatment for people whose mental health is compromised has ripple effects through families and the community, and impacts upon national productivity.

For instance, a report commissioned by Beyond Blue (2014) demonstrated that for every dollar spent on implementing an appropriate mental health intervention, on average there was $2.30 in productivity gains. Similarly, Layard et al. (2007) demonstrated that investment in psychology treatment has a cost benefit to the society. As noted in the Issues Paper, mental illness disrupts, like cancer, the ability of the person to participate in the workforce to earn a living to pay for treatment.

How then, to deliver cost effective and efficacious psychological treatment?

The stepped care approach to mental illness conceptualizes conditions as mild, moderate and severe. For those with mild mental health conditions, appropriate psychological treatment can be defined as 'rehabilitation' as it involves re-establishing the individual's cognitive, affective and behavioural skills to maintain mental health. For those with moderate and severe mental illness, it is more appropriate to focus on 'remediation', which is the *development* of cognitive, affective and behavioural skills which were not previously present.

Rehabilitation and remediation are on a continuum that mirrors figures 2 and 5 of the Issues Paper. At the level of mild mental health dysfunction, rehabilitation is often the focus. For moderate conditions, treatment may involve a combination of rehabilitation and remediation. For those with severe and/or complex conditions, remediation is the focus. Delivery of effective remediation is more complex, takes longer, and requires greater skill in formulation and delivery than rehabilitation.

The training of Registered Psychologists (described in section 1 above) provides the skill base to deliver rehabilitation, whereas the training provided to Clinical Psychologists equips them with the skills to deliver both rehabilitation and remediation.

Rehabilitation and Remediation within Evidence Based Practice

1. Treating and maintaining function in those who suffer intractable mental health disorders is labour intensive and cannot be manualized or managed with Focused Psychological Strategies.

2. Evidence Based Practice requires Clinical Psychologists to bring together: i) the best available research evidence on psychological conditions and therapeutic approaches; ii) their clinical expertise; and iii) the patient's values, characteristics, preferences and circumstances in their treatment and clinical decision making (Spring, 2007).

3. When these three aspects of Evidence Based Practice operate, the Clinical Psychologist is able to craft an individualised treatment programme based upon the best available scientific evidence that suits a specific patient's needs.

4. The Evidence Based Practice model requires a highly skilled practitioner who is able to read and understand scientific writing/research[4]; and the ability to evaluate this research and use

[4] Importantly, a major component of formal training as a Clinical Psychologist is completion of a substantive research project in a clinical area. This trains the ability to read clinical research and statistical arguments with a critical mind, thus developing the capacity to critically think about clinical work, and the ability to make differential diagnoses and apply therapeutic strategies. Registered Psychologists do not undertake this level of training in research and critical thinking, nor in the application to developing a treatment approach for an individual patient.

the elements that best assist the patient. This is requires a higher level of knowledge and skill than is required to follow manualized treatments or deliver Focussed Psychological Strategies.

5. To implement this process with fidelity, the practitioner must have had exposure to treating a wide diversity of patients with various complexities of mental health problems (Norcross, 2002). As well, the practitioner must be well trained to form an effective therapeutic relationship with the patient (Grenyer, 2014). Decades of research has demonstrated that an essential component of psychological therapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship (Lambert, Barley & Dean, 2001) and that the therapeutic relationship is a primary predictor of treatment outcomes (e.g. Lambert et al., 2001). Clinical Psychologists have been subjected to rigorous selection processes to gain entrance to postgraduate clinical training that includes close scrutiny of their academic abilities and interpersonal capacities. Registered Psychologists have not been through such processes, and completion of an undergraduate degree (or Ph.D.) does not imply effective interpersonal skills.

6. Clinical Psychologists are specifically trained in delivering Evidenced Based Treatment. Registered Psychologists are not (instead, their level of training restricts them to administering Focussed Psychological Strategies, and manualized treatments). They are not trained in, or required to understand research to the level of Clinical Psychologists; and are not required to integrate clinical expertise with patient needs. Their level of training restricts them to mild, low impact mental health disorders.

D. Structural Factors Compromising Cost Effective Delivery of Evidence Based Practice

Effective delivery of the Evidence Based Practice model requires not only the skill of the Clinical Psychologist, but also appropriate conditions within which to implement this model.

As noted on page 13 of the Issues Paper, past reforms have not led to improvements in population mental health. Structural weaknesses in implementation of past reforms goes some way to explaining this. We discuss some weaknesses below.

1. **Inefficiencies and unnecessary costs in assessment and reporting requirements for Medicare's Clinical Psychology items 80000 to 80020**

   Under Medicare Better Access, it is a requirement that a General Practitioner (GP) completes a mental health diagnosis and a Mental Health Treatment Plan (MHTP) for both psychology and clinical psychology items. Yet, Clinical Psychologists by the nature of their training, have considerable expertise in the assessment and treatment of mental illness. The MHTPs provided by GP's are of little assistance to Clinical Psychologists who have specific training in mental health diagnosis and are competent to develop and implement appropriate

treatment. Omitting this requirement would redirect funding from administration to treatment and improve patient care.

Also, it is a requirement that after 6 psychology treatment sessions the patient must return to the GP for review. This process disrupts treatment, redirects funding from treatment to administration, and provides little if any benefit in treatment planning for Clinical Psychologists. Omitting this requirement for MBS items for clinical psychology items would not compromise patient care, as Clinical Psychologists are trained and ethically bound to report to the referrer when clinically indicated, and at termination of treatment.

The ICP recommends rationalization of assessment and reporting requirements for MBS clinical psychology items 80000 to 80020 (which will reduce unnecessary expenditure) by:

- **i)** a simple referral letter to the Clinical Psychologist;
- **ii)** removing the requirements of a GP mental health treatment plan;
- **iii)** removing the requirement for a review after 6 sessions;
- **iv)** reporting to the referring medical practitioner upon completion of the course of clinical psychology therapy and where clinically indicated.

2. **Inadequate number of rebated sessions to treat moderate and severe mental illness**

The current Medicare rebate system, with only 10 rebated sessions per annum, removes one of the valuable tools from Clinical Psychologists in delivering treatment for people with moderate and severe mental health conditions. That is, sufficient TIME to deliver treatment in accordance with Evidence Based Practice.

Research demonstrates that psychological therapies provide relief of suffering and has economic benefits to the community (e.g. Layard & Clarke, 2014; Lambert 2013). Yet, it is essential that the therapeutic process is completed for these benefits to be realized.

Research on treatment efficacy demonstrates clearly that more than 10 sessions are required to properly treat moderate and severe presentations. For example, Cuijpers et al. (2010) conducted a meta-analysis of psychological treatments for chronic depression, covering 570 patients, and found the number of treatment sessions was associated with the degree to which symptoms reduced. That is, the treatment effect size was small for patients given 12 or fewer sessions, and significantly larger for patients given 18 or more sessions. Lincoln et al. (2016) examined the relationship between the number of sessions and general efficacy of cognitive behaviour therapy for 'psychosis' and found significant symptom improvement and reduced symptom distress by session 15. Importantly, their study demonstrated that a more appropriate treatment dose is a minimum of 25 sessions. Lambert (2015) provides a summary of the typical number of treatment sessions for different mental

health conditions. For instance, 12-16 sessions are recommended for Cognitive Behaviour Therapy for Panic Disorder, and 12-20 sessions for Depression.

When the Better Access initiative was introduced, 18 sessions were rebated per annum via Medicare for the treatment of mental health disorders. This was reduced to 10 sessions, with no apparent rationale, thereby removing the tool of time, which is essential to properly treat moderate to complex needs via the Evidence Based Practice model. This has been a significant structural change which compromises mental health treatment.

The current restriction of psychological therapy to 10 sessions per annum irrespective of mental health condition runs the risk of relapse and/or exacerbation of symptoms where treatment is left incomplete. For patients with moderate to complex needs it has created a situation where it can be unethical to even begin treatment, because it could not be properly delivered. It is akin to removing a cancer patient's treatment halfway through.

Recommendation: Realign the number sessions of Medicare Psychological Therapy Services provided by Clinical Psychologists (MBS Items 80000 to 80020) in accordance with the complexity and severity of the disorder.

Provision of additional sessions for more complex conditions will most benefit patients from lower socio-economic and disadvantaged groups who have limited capacity to pay for unrebated sessions once they reach the 10 session limit. These are the most vulnerable members of our community.

Effective and ongoing collaboration between Psychiatrists, Paediatricians, Geriatricians, and Clinical Psychologists in treating patients with more complex mental health disorders can be improved if the number of rebated sessions is better aligned. Psychiatrists in the private sector speak of long waiting lists and reduced capacity to implement psychotherapies due to their patient load (indeed, 13 psychiatrists per 100,000 in major cities, and 5 per 100,000 in remote areas speaks to this, https://mhsa.aihw.gov.au/resources/workforce/). Clinical psychology input to complex mental health conditions has the potential to ease the burden on Psychiatrists, Paediatricians, Geriatricians and the public health system, which is overstretched, thereby saving the public purse.

More specifically, the ICP recommends aligning the number of sessions permitted under MBS items 80000 to 80020 more closely with MBS item 306 (which permits 50 sessions per annum) in accordance with the individual patient's mental health needs. Provision of these additional sessions by Clinical Psychologists is appropriate given their training and expertise in the assessment and treatment of more complex mental health conditions. This will have the added benefit of reducing strain on the public health sector.

Patients with mild conditions can often be adequately rehabilitated within the 10 sessions supported by Medicare rebates for psychology items. However, as the research evidence

demonstrates, moderate and severe mental illness is not adequately treated within 10 sessions, and failure to continue treatment after 10 sessions risks failure to remediate the condition or deterioration of the patient's mental health. This mitigates against the ability of the patient to contribute productively in the community and is not cost effective.

Based upon treatment research, the ICP recommends:

i. Mild mental illness be supported with 10 sessions per annum rebated through the Medicare Better Access Initiative, with treatment delivered by Registered Psychologists, Counselling Psychologists and Clinical Psychologists.

ii. Moderate mental illness be supported with up to 20 sessions per annum rebated through the Medicare Better Access Initiative, with this treatment delivered by Clinical Psychologists and Counselling Psychologists.

iii. Severe mental illness be supported with up to 40 sessions per annum rebated through the Medicare Better Access Initiative, with this treatment delivered by Clinical Psychologists.

3. **Inability of Clinical Psychologists to admit patients to hospital or refer to Psychiatrists**

An additional structural impediment for Clinical Psychologists to treating patients with moderate to severe mental health conditions is their preclusion from referring patients to hospital or directly to Consultant Psychiatrists. As present the General Practitioner (GP) must handle these referrals. When in crisis, the patient's GP may not be available, or the patient may not have a regular GP who knows them.

The situation is worse when a patient is suicidal, psychotic or violent. Our experience is that emergency mental health teams do not have capacity to provide the services that are needed for acutely unwell patients. An alternative is to present to an emergency department, but if the patient refuses, the only way to manage is for the family to call police. This becomes traumatic for the family and the patient.

The ICP recommends that Clinical Psychologists, who are highly trained and skilled in mental health diagnosis, be given the capacity to write direct referrals to Psychiatrists who admit patients to hospital.

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Addendum 1 : ACCREDITATION STANDARDS: GRADUATE COMPETENCIES FOR PSYCHOLOGY PROGRAMS[5]

An APAC-accredited program must enable graduates to achieve the graduate competencies at the levels specified below.

1. *FOUNDATIONAL* COMPETENCIES

Graduates at this level have broad and coherent knowledge and skills in the scientific discipline of psychology.

Programs for foundational competencies typically comprise an APAC-accredited sequence in psychology either as part of a **3-year program leading to a Bachelor Degree** or as an equivalent stand-alone sequence of psychology units combined with a Bachelor Degree in a different discipline.

FOUNDATIONAL GRADUATES WILL BE ABLE TO:

1.1 Comprehend and apply a broad and coherent body of knowledge of psychology, with depth of understanding of underlying principles, theories and concepts in the discipline, using a scientific approach, including the following topics:
   - i. the history and philosophy underpinning the science of psychology and the social, cultural, historical and professional influences on the practice of psychology
   - ii. individual differences in capacity, behaviour and personality
   - iii. psychological health and well-being
   - iv. psychological disorders and evidence-based interventions
   - v. learning and memory
   - vi. cognition, language and perception
   - vii. motivation and emotion
   - viii. neuroscience and the biological bases of behaviour
   - ix. lifespan developmental psychology
   - x. social psychology
   - xi. culturally appropriate psychological assessment and measurement
   - xii. research methods and statistics

1.2 Apply knowledge and skills of psychology in a manner that is reflexive, culturally appropriate and sensitive to the diversity of individuals

1.3 Analyse and critique theory and research in the discipline of psychology and communicate these in written and oral formats

1.4 Demonstrate an understanding of appropriate values and ethics in psychology

1.5 Demonstrate interpersonal skills and teamwork

1.6 Demonstrate self-directed pursuit of scholarly inquiry in psychology

2. *PRE-PROFESSIONAL* COMPETENCIES

Graduates of programs at this level have basic knowledge and skills in the professional practice of psychology and the independent conduct and evaluation of scientific research. Programs for pre-professional competencies are typically a **Bachelor Honours Degree or Graduate Diploma (if the graduate competencies in research can be met)**.

PRE-PROFESSIONAL GRADUATES WILL BE ABLE TO:

2.1 Demonstrate successful (prior or concurrent) achievement of foundational competencies.

2.2 Demonstrate appropriate interpersonal communication and interview skills in situations appropriate to psychological practice and research. This includes active listening, clarifying and reflecting, effective questioning, summarising and paraphrasing, developing rapport, appropriate cultural responsiveness and empathic responding.

2.3 Demonstrate *basic* assessment strategies in situations appropriate to psychological practice and knowledge of psychometric theory and principles of the construction, cultural considerations, implementation and interpretation of some of the more widely used standardised psychological test instruments.

2.4 Explain how *basic* psychological intervention strategies can be applied across a range of contexts.

2.5 Investigate a substantive individual research question relevant to the discipline of psychology.

[5] Australian Psychology Accreditation Council (2019). *Accreditation Standards for Psychology Programs*, pp. 10-18. Doi: https://www.psychologycouncil.org.au/sites/default/files/public/Standards_20180912_Published_Final_v1.2.pdf

Addendum 1 : cont/d

3. *PROFESSIONAL* COMPETENCIES

Graduates of programs at this level will have advanced knowledge and skills for professional practice and research in psychology. Programs for professional competencies are typically a **Masters Degree (Coursework)** after successful completion of an APAC-accredited qualification that achieves foundational competencies and pre-professional competencies. Entry to the program also requires applicants to demonstrate suitability for the program through an assessment interview or other assessment processes.

Practice placements
Achievement of the professional graduate competencies is through a program of study which includes practice placement, with the latter designed to integrate theory and practice in an appropriate professional environment to prepare graduates to provide safe quality client care and service.

PROFESSIONAL GRADUATES WILL BE ABLE TO:

3.1 Demonstrate successful (prior or concurrent) achievement of pre-professional competencies.
3.2 Apply evidence-based and scientific methods to professional practice across the lifespan in empirically valid and culturally responsive ways.
3.3 Employ professional communication skills, in a culturally responsive manner, with a range of socially and culturally diverse clients.
3.4 Perform appropriate standardised psychological testing, as part of broader assessment, to assess and interpret aspects of functioning.
3.5 Identify psychological disorders using a recognised taxonomy.
3.6 Conduct professional interviews and assessments and synthesise information from multiple sources, including assessment of risk, to formulate a conceptualisation of the presenting issues to determine the most appropriate interventions, including management of risk.
3.7 Monitor outcomes and modifications based on evolving case formulation, including health and health concerns, family and support networks, and organisational, cultural or community contexts, with care given to the appropriateness of interventions for the client within their wider context.
3.8 Interpret and communicate findings in oral and written formats, including formal psychological reports, using culturally appropriate language.
3.9 Implement appropriate, empirically supported interventions, and monitor clients' progress and intervention outcomes.
3.10 Demonstrate respect for the skills and contribution of other professionals.
3.11 Work effectively with a range of professional and support staff in the workplace and communicate and collaborate effectively, within the bounds of ethical and legal requirements.
3.12 Operate within the boundaries of their professional competence, consult with peers or other relevant sources where appropriate, and refer on to relevant other practitioners where appropriate.
3.13 Rigorously apply professional practice policies and procedures, including as they relate to referral management and record-keeping, across a range of workplace settings and with recognition of different organisational cultures and practices.
3.14 Engage in self-reflective professional practice, taking account of the impact of their own values and beliefs, and taking appropriate actions as a result.
3.15 Evaluate the effectiveness of their professional practice, identifying areas for improvement and implementing changes where needed.
3.16 Critically evaluate contemporary scientific literature to inform practice.
3.17 Investigate a substantive individual research question relevant to the discipline of psychology.

PROFESSIONAL COMPETENCIES FOR <u>SPECIALISED</u> AREAS OF PRACTICE

The acquisition of graduate competencies in the *advanced knowledge and skills relevant to the endorsed areas of practice* within the field (e.g. Counselling Psychology, Health Psychology). Graduates of programs at this level have advanced knowledge and skills for professional practice in Psychology, as well as specialised knowledge and skills in at least one area of practice in psychology. Programs for professional competencies for specialised areas of practice are **typically a Masters Degree (Coursework) or a Doctoral Degree (Professional)**.

Addendum 1 : cont/d

Practice placements
Achievement of the professional graduate competencies for specialised areas of practice is through a combined program of study and practice placement, with the latter designed to integrate theory and practice in an appropriate professional environment to prepare graduates to provide safe quality client care and service. During placements the provision of safe, high-quality client care and service is always the primary consideration. It is recognised that a practice placement may be conducted in a number of locations and settings.

Content of programs – general
The discipline area of each specialised area of practice encompasses:

i. knowledge of the relevant current theories, principles, approaches, and practices of that domain of professional psychology, informed by a research evidence base;
ii. knowledge of the system within which the relevant area of practice is undertaken;
iii. knowledge of the requirements of regulatory and statutory authorities; and
iv. competence in the evaluation and application of research.

4.2 CLINICAL PSYCHOLOGY

CLINICAL PSYCHOLOGY GRADUATES WILL BE ABLE TO:

4.2.1 Apply advanced psychological knowledge of the following to their practice in clinical psychology:

- psychological theories of the aetiology, progression and/or recovery, precursors and sequelae of psychological disorders, including incidence, prevalence and predisposing, risk, protective and maintenance factors
- both developmental systems and biopsychosocial models of health as they apply to psychological disorders as well as the multiple factors that impinge on mental health across the lifespan
- psychopathology and relevant international taxonomies of classification of psychological disorders, including severe, complex and chronic mental illness
- psychopharmacology, particularly as it relates to complex psychological disorders.

4.2.2 Apply advanced psychological knowledge to culturally responsive assessment in the area of clinical psychology, including:

- evaluation of psychological disorders with reference to relevant international taxonomies of classification, including disorders of moderate to severe level and complexity
- use of assessment tools and processes related to a wide range of psychological disorders, and including psychometric tests, structured or semi-structured interviews, behavioural observations, measures of functionality and processes that enable collection of collateral information from multiple sources, including groups and systems relevant to the client
- integration, interpretation, and synthesis of clinical psychological assessment data with the knowledge of psychopathology to inform case formulation, diagnosis and intervention
- evaluation of symptom reduction, therapeutic outcomes, the therapeutic alliance and client progress throughout therapy.

4.2.3 Apply advanced psychological knowledge to culturally responsive interventions in the area of clinical psychology, including:

- selection, tailoring and implementation of appropriate evidence-based interventions on the basis of an initial case formulation, whether individuals, dyads or carers/dependents
- monitoring of outcomes and modifications based on evolving case formulation and intra- and interpersonal processes, with care given to the appropriateness of interventions for the client or clients within their wider context
- consultation and collaboration with other professionals regarding clinical planning and referrals, particularly in the context of complex case presentations
- evidence-based practice in the understanding and management of psychological disorders, including across the age range and across modalities such as e-health approaches.