Submission by the Victorian Psychologists Association Inc to the Royal Commission into Victoria's Mental Health System 2019

EXECUTIVE SUMMARY

This Submission is made on behalf of the members of the Victorian Psychologists Association Inc, an association of psychologists who are employed in public health services in Victoria, including mental health services, and in services offered by private for-profit and not for-profit organisations.

The Victorian Psychologists Association Inc welcomes the opportunity to provide a Submission to the Royal Commission, with the aim of making recommendations that will improve the access, assessment and treatment of Victorians experiencing mental illness who present to Victorian public mental health services.

The Submission addresses the Royal Commission's Terms of Reference 2.1 through 2.5, that is:

> 2.1 Best practice treatment and care models that are safe and person-centred
> 2.2 Strategies to attract, train, develop and retain workforce including peer support workers
> 2.3 Strengthened pathways and interfaces between Victoria's public mental health system and other services
> 2.4 Better service infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements
> 2.5 Improved data collection and research strategies to advance continuity of care and monitor impact of any reforms.

Each Term of Reference 2.1 through 2.5 is addressed separately in the Submission. Recommendations in relation to each of these Terms of Reference are made throughout the Submission, and are linked to the main points which have been made in relation to each of the Terms of Reference.

These recommendations have been consolidated into a list which is shown immediately following this Executive Summary.

Psychologists working in public mental health services

In order to be registered as general psychologists with the Australian Health Practitioner Regulation Agency (AHPRA) through the Psychology Board of Australia, psychologists need to complete at least a four year sequence of study at tertiary level, plus a period of supervised practice.

Public mental health services seek to recruit psychologists who have completed a specialist master's degree or doctorate as the pathway to registration, because of the specialist skills and knowledge they bring to the assessment and treatment of patients.

In order to practice as clinical psychologists, clinical neuropsychologists or forensic psychologists, psychologists with higher degrees and general registration are required to be employed as Registrars and undertake a period of supervised practice in order to be endorsed in their specialist area of practice by the Psychology Board of Australia.

The dominant theme that runs through the Submission is that patient access to psychological services in public health services is quite restricted, and this is partly due to the model of case management which has been adopted in adult mental health services and child and youth services, and to a system which is under-resourced and underfunded.

Psychologists are alive to the societal and economic disadvantages of practices which compromise coherent use of multidisciplinary specialist clinical expertise, including their own and those of their colleagues in social work, nursing and occupational therapy. They report lack of time to implement best practice clinical assessment and intervention.

Public mental health services are able to attract entry level psychologists with general registration who are looking to exercise their skills and knowledge to assist people suffering from mental illness.

However, the services are experiencing difficulties in retaining experienced psychologists for a number of reasons including: heavy caseloads; lack of career progression; undervaluation and underutilisation of their skills; inability to enter the Registrar program; the attraction of private practice.

The Submission suggests that a substantial increase in funding will be required to boost the numbers of clinicians needed to meet current levels of demand on the public mental health system from people suffering mental illness, many of whom are turned away from public mental health services, and to deliver best practice mental health assessment and treatment to Victorians suffering mental illness. Increased funding needs to occur in conjunction with a restructuring of case management to ensure patients can access the specialist services they need, and the encouragement of research.

Consolidated recommendations of the Victorian Psychologists Association Inc

Term of Reference 2.1

Best practice treatment and care models that are safe and person-centred

- *Achieving access to public mental services should be easier to navigate both for potential patients and families in need and for health professionals referring them*
- *Delays in appointment times for patients at the commencement of and during contact with the particular service being used should be minimised, requiring greater numbers of clinicians to be employed in the public mental health system*
- *Changes should be made to the organisation of Area Mental Health Services and CYMHS to ensure that each patient receives the full benefit of multidisciplinary input to their assessment and treatment, and meeting their psychosocial needs, in order to improve their mental health*
- *Generic case management as the predominant model for employing non-Psychiatrist clinicians in Area Mental Health Services and CYMHS should be reconsidered*
- *Staffing levels need to be increased so that patients can routinely receive specialist clinician consultation as well as case management*
- *Comprehensive assessment should be provided to each patient, including comprehensive psychological assessment. There must be sufficient numbers of psychologists to allow this to happen*
- *All services should provide adequate test materials*
- *Comprehensive assessment should be provided to each patient, including comprehensive psychological assessment. There must be sufficient staff numbers, and provision of adequate test materials to make this possible*

- *Forensic Psychologists should be enabled to extend beyond Risk Assessment to encompass the assessment of other aspects of psychological functioning which can be engaged to support their recovery*
- *Where indicated, patients should have access to neuropsychology assessment*
- *All patients of public mental health services should have appropriate access to the full range of psycho-social treatment interventions that complement psychiatric pharmacology provided for sufficient time to recovery*
- *All patients and their families assessed as being in need of evidence-based psychological interventions should be able to access these, from psycho-education to various forms of individual and group psychotherapy, in both outpatient and inpatient settings*
- *Decisions about discharge, continuing care and follow-up/review should be based on the individual's demonstrated good recovery outcomes to date, and not simply on a timeline related to throughput of patients*
- *Such decisions should involve the patient and family, with a full explanation and discussion of appropriate options and what they involve for the patient and family*

Term of Reference 2.2

Strategies to attract, train, develop and retain workforce including peer support workers

- *Ensure that Registrar positions are available in all public mental health services – without Registrar positions psychologists with general registration will be unable to gain Endorsement and will be ineligible to progress to Grade 3*

- *Ensure that psychologists can access the career path provided for in the Public Sector Agreement*
- *Provide sufficient funding from the Mental Health Branch to ensure that mental health services will progress Grade 2 entry level psychologists who have completed the Registrar Program and gained Endorsement to Grade 3 after 5 years' experience – not only will this impact positively on the retention of individual psychologists but it will provide the necessary number of potential supervisors for students on placement, interns and Registrars. It will also provide a cohort of psychologists who can fill Grade 4 positions*
- *Review the generic case management structures to ensure psychologists (and clinicians from other disciplines) are not deskilled by being unable to provide patients (and their families) with specialist assessment, treatment and psychosocial assistance*
- *Reduce caseloads to reduce stress*

- *Adequate work spaces must be provided in which clinicians can conduct consultations with patients quickly and easily, and confidential telephone conversations concerning patients in quiet and private rooms*
- *Outreach work where the patient is seen in their normal surroundings should be implemented, particularly for young people*
- *Adequate administrative support should be provided to clinicians*
- *The full range of up-to-date test materials need to be available to psychologists at each service and location*

- *In-service training opportunities should be expanded and built into the annual calendar*

- *Public mental health services should make the information, tools, training, resources and expertise developed by the Centre for Mental Health Learning available to psychologists as part of in-service training*
- *Financial support for conference and workshop attendance including registration and travel should be provided to psychologists*
- *Mental health services must receive sufficient funding to allow psychologists and other clinicians to take professional development leave and to be able to backfill their positions whilst they are absent*

Term of Reference 2.3

Strengthened pathways and interfaces between Victoria's public mental health system and other services

- *Clinicians must have sufficient time to communicate effectively within and beyond the public mental health system around critical issues for their patients*
- *Consider the appointment of clinicians whose role is to liaise with other services and provide sufficient funding to allow these appointments*
- *Develop strategies for enabling efficient communication with services such as Centrelink, NDIS and the justice system*
- *Allow time for consultation by tertiary mental health clinicians to primary and secondary mental health services, to support early intervention for mental health problems and prevention of severity of disorder and progression to the tertiary system*

Term of Reference 2.4

Better service infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements

- *Establish a position of Chief Psychologist within the Mental Health Branch, to advocate for the discipline of psychology and to develop internal resources and reference material regarding the role of psychologists in public mental health services*
- *The position of Chief Psychologist within the Mental Health Branch should be a focus for information-sharing and consultation with psychologists employed in public mental health services*
- *A review of the governance of psychology services at public health services should be undertaken by the Chief Psychologist to develop and advocate for a best practice model*

Term of Reference 2.5

Improved data collection and research strategies to advance continuity of care and monitor impact of any reforms

- *The current data collection system used by public mental health services needs to be reviewed, including in relation to how data can be better analysed and used*
- *Evaluation of services should be ongoing in the public mental health service, and in such a way that clinicians themselves can use such research outcomes to continually modify practice at the local level*
- *The research expertise of psychologists can be used by mental health services to develop appropriate research and evaluation strategies to inform best practice*
- *Psychologists at Grade 3 and above must have access to sabbatical leave as of right, where they can demonstrate that they*

are undertaking research at an appropriate level, or propose to do so

- *All psychologists must have dedicated time to pursue research and should be encouraged to present posters or research papers to conferences and to publish their research*

Submission by the Victorian Psychologists Association Inc to the Victorian Government Royal Commission into Victoria's Mental Health System 2019

INTRODUCTION

The Victorian Psychologists Association Inc welcomes the opportunity to provide a Submission to the Royal Commission, with the aim of making recommendations that will improve the access, assessment and treatment of Victorians presenting to Victorian public mental health services.

The Victorian Psychologists Association Inc (VPA) is both an Association under the *Associations Incorporation Reform Act 2012* (Victoria) and a component association of the Health Services Union Victoria Number 4 Branch. The VPA represents persons employed or usually employed as Psychologists or Probationary Psychologists, and who are registered with the Australian Health Practitioner Regulation Agency (AHPRA) by the Psychology Board of Australia.

That is, the VPA Inc represents the interests of psychologists as employees, and does not represent psychologists in their private practice.

The objects of the Association include to represent the interests of psychologists who are employed in Victoria before courts, wage fixing authorities, and at conferences with other bodies of employers or employees; and to provide for all matters relating to the conditions of employment, status and welfare of its members and persons entitled to be members; and to amalgamate or affiliate with any other Association or body having objects similar to those of the VPA.

The focus of the VPA is the negotiation of the wages, career paths and terms and conditions of employment of its members who are employed in the public and private sector in Victoria, through its association and status within the Health Services Union, and to advocate for Psychologists in relevant fora.

Whilst the eligibility rules of the VPA are broad in relation to eligibility for membership, its members are predominantly employed in public health services in Victoria, including in acute, subacute, rehabilitation and community health services, across the age span, in both in-patient and outpatient settings, including in public mental health services. VPA members are also employed in the private sector in Victoria by not-for-profit and for-profit hospitals and health services and non-government organisations, in mental health and other services.

The terms and conditions of employment of psychologists employed in public health services in Victoria are mandated by the *Victorian Public Health Sector (Medical Scientists, Pharmacists and Psychologists) Single Interest Enterprise Agreement 2017-2021* (the Public Sector Agreement), which was negotiated by the Health Services Union Victoria Number 4 Branch and its component Associations including the VPA. The terms and conditions of psychologists employed at Forensicare largely mirror those under the Public Sector Agreement. For the purposes of this submission the term Public Sector Agreement is taken to encompass psychologists employed by Forensicare.

https://www.fwc.gov.au/documents/documents/agreements/fwa/ae426645.pdf

The Terms of Reference define the Victorian mental health system as any mental health services that are funded (whether wholly or in part) by the Victorian Government that support mental health and respond to mental illness. This includes clinical services delivered by area mental health services and community-based services that focus on activities and programs that help people manage their own recovery and maximise their participation in community life. It also includes

consumer-run services, forensic mental health services, as well as specialist mental health services.

For the purpose of this Submission, public mental health services are taken to encompass those inpatient and outpatient mental health services which are provided by public hospitals and their associated health services, and include the Victorian Institute of Forensic Mental Health ('Forensicare'). These services are funded by the Victorian Department of Health and Human Services.

https://www2.health.vic.gov.au/hospitals-and-health-services/public-hospitals-victoria
https://www.forensicare.vic.gov.au/

The submission does not consider the youth justice system or consumer-run services.

The Victorian Department of Health and Human Services website has a link to Victorian mental health services which are funded by the Department. The page has not been updated since 2015. It should be noted that child and adolescent mental health services now provide services to children and young people from 0 to 24 years, and are known as child and youth mental health services (CYMHS).

http://www.health.vic.gov.au/mentalhealthservices/

This Submission addresses Terms of Reference 2.1 through 2.5 of the Royal Commission.

Psychologists employed in the Victorian public mental health system work with clients across the age span, including infants, children, adolescents and adults, experiencing severe and complex mental illness. The Submission addresses the knowledge, skills and experience of clinical psychologists, forensic psychologists and clinical neuropsychologists working in public mental health services.

The emphasis is generally on mental health services provided to people who are being treated in the community by Area Health Services and Child and Youth Mental Health Services, that is, people who have not been admitted to inpatient units.

Section 1 of the submission describes the national system of training and registration and the nature of psychological knowledge and practice in Australia, the expertise of psychologists employed in the Victorian public mental health system, and discusses the evidence base which underpins psychological practice in mental health services.

Section 2 of the submission addresses Terms of Reference 2.1 to 2.5:

> 2.1 Best practice treatment and care models that are safe and person-centred
> 2.2 Strategies to attract, train, develop and retain workforce including peer support workers
> 2.3 Strengthened pathways and interfaces between Victoria's public mental health system and other services
> 2.4 Better service infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements
> 2.5 Improved data collection and research strategies to advance continuity of care and monitor impact of any reforms.

The submission draws upon views expressed by members of the VPA Inc through a survey, through interviews with members, and through commentary provided by members. The experiences of psychologists employed in the Victorian mental health system inform the submission, and its recommendations.

The recommendations in relation to each Term of Reference 2.1 to 2.5 are provided at the end of the discussion of each section.

Section 2 is followed by a Conclusion.

SECTION 1

What is the discipline of psychology and how do psychologists contribute to the treatment, care and support of people in the mental health system?

Psychologists are employed within a wide range of settings in tertiary mental health services in Victoria.

These services include Area Mental Health Services embracing specialist adult mental health services; aged persons mental health services; child and youth mental health services (CYMHS), state-wide and specialist services, and forensic mental health services.

Psychologists conduct their practice within an ethical framework set out in the Australian Psychological Society Code of Ethics (2007), and which has been adopted by the Psychology Board of Australia. The Code expresses psychologists' responsibilities to their clients, to the community and society at large, and to the profession, as well as colleagues and members of other professions with whom they interact.

https://www.psychologyboard.gov.au/Standards-and-Guidelines/Codes-Guidelines-Policies.aspx

Psychologists place a high priority upon safeguarding the mental health rights of the vulnerable citizens with whom they work. This includes a commitment to the highest possible standards of professional practice, and deep respect for, and the need to take account of, the individual perspectives of the patients and families with whom they work.

Psychologists must be registered in order to practice, and their education and scope of practice are regulated, through the Australian Health Practitioner Regulation

Agency (AHPRA) and by the Psychology Board of Australia (PBA). The PBA is one of a number of National Boards that has been established by AHPRA to regulate registered health professions.

Only registered psychologists are able to use the term 'Psychologist', and only psychologists with Endorsement from the PBA in the relevant area of practice (discussed below) can legally use titles such a Clinical Psychologist, Forensic Psychologist or Clinical Neuropsychologist.

Psychology training in universities is accredited and closely monitored by the Australian Psychology Accreditation Council (APAC). APAC is an independent not-for-profit company which is appointed under an agreement with AHPRA. The accreditation standards which must be met by higher education providers are developed by APAC and approved by the PBA.

Training of Psychologists

Psychologists have a minimum of six years of full-time training, including supervised practice.

To be registered by AHPRA psychologists must complete at least a four-year sequence of tertiary study in the science of psychology and successfully complete a period of supervised practice.

Psychological training uses a bio-psycho-social model of understanding to advance knowledge concerning human functioning in its behavioural and experiential aspects at every level of complexity. This body of knowledge is built upon the ongoing development of coherent psychological theories which generate hypotheses which are then tested by empirical research. How to employ scientific method in this broad field is the underlying theme of this training. This training includes the acquisition of knowledge and skills basic to the professional practice of psychology, such as the

technical foundations of psychological measurement and assessment, the processes of learning and behaviour change, and the process of normal psychological development from birth onwards.

After having completed a four year sequence of study in psychology, achieving general registration as a psychologist occurs through the completion of a two year internship program of supervised practice as a provisionally registered psychologist in a professional setting, supervised by a PBA approved supervisor (4+2 training).

At the end of the internship, the provisional psychologist is required to sit the National Psychology Exam before being able to apply for general registration.

The PBA announced in April 2019 that this pathway to registration will be phased out by 2029, with 30 June 2021 being the last day that applications for internships will be accepted.

https://www.psychologyboard.gov.au/Standards-and-Guidelines/FAQ/Retirement-of-4-2-internship.aspx

It is also possible to become a generally registered psychologist by undertaking a five-year sequence of accredited study – for example, a Masters of Professional Psychology – followed by a one-year internship (5+1 training). The PBA is currently reviewing this pathway to general registration.

However, training in the professional application of psychological knowledge and practice in Australia in order to gain general registration is currently most commonly undertaken at the postgraduate level, in specialist areas, in accordance with the scientist-practitioner model adopted in psychology worldwide (Navab, Koegel, Dowdy & Vernon, 2016; Newnham & Page, 2010; Johnson & Kaslow, 2014).

Specialist professional Masters (2 year) or Doctoral (3 year) programs are offered in nine PBA approved areas of practice – Clinical Psychology, Counselling Psychology, Forensic Psychology, Clinical Neuropsychology, Organisational Psychology, Sport and Exercise Psychology, Educational and Developmental Psychology, Health Psychology and Community Psychology.

Higher degree students must register with the PBA as provisional psychologists and the training includes placements at psychology services where their practice is supervised by a PBA approved supervisor.

Upon completing their higher degree in an approved area of practice including the supervised practice component, the graduate can apply to the PBA for general registration as a psychologist.

A psychologist who holds an APAC approved higher degree in psychology is eligible to commence a program of supervised practice as a Psychology Registrar to achieve Endorsement by the PBA in the area of practice in which their specialist training has been completed. Registrars must complete a certain number of hours of supervision in order to gain Endorsement, equivalent to one or two years, depending on whether the psychologist has a Masters or Doctorate.

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

Public mental health services prefer to employ psychologists who have completed a higher degree in Clinical Psychology, and/or Forensic Psychology or Neuropsychology (depending on the needs of the particular service and the people that it sees) rather than 4+2 or 5+1 graduates. Where possible, public mental health services will provide the necessary supervised practice that will enable the psychologist to complete the Registrar program and gain Endorsement in their area of practice.

Clinical Psychologists use their knowledge of psychology and mental health for the assessment, diagnosis, formulation, treatment, and prevention of psychological problems and mental illness across the lifespan. They research psychological problems, and use their psychological knowledge to develop scientifically based approaches to improve mental health and well-being.

Specific services of clinical psychologists include the assessment and treatment of a range of mental health problems, such as anxiety, depression, substance dependence, pain and somatic symptoms, schizophrenia, bipolar disorder, bulimia, anorexia, binge eating, conduct disorder, separation anxiety, attention deficit and hyperactivity disorder, autism spectrum disorders, borderline, antisocial and other personality disorders. Clinical psychologists also consult more broadly with the community on mental health programs, policies, and practices related to children, adolescents, adults and older adults.

Forensic Psychologists use their knowledge of psychology and the law, and have the forensic skills, to understand legal and justice issues and to generate legally relevant and useful psychological data.

Forensic psychologists are trained to work clinically with people in the justice system who have been identified as experiencing relatively severe psychological stress or behavioural disorder, often involving co-morbidity (two or more diagnoses). While psychological assessment is usually similar to that carried out by clinical psychologists, here specialised knowledge of the Justice system is required for treatment planning, and in some instances for the kinds of treatment that may be feasible in secure detention. Specialist skills in risk assessment are an important dimension of forensic psychology work.

Clinical Neuropsychologists use their knowledge of psychology and the brain, to research and diagnostically assess brain dysfunction in individuals. They also consult and design clinical interventions to assist persons with neuropsychological

disability and impairment. Clinical neuropsychologists generate psychological data that enable them to provide services to a variety of groups.

Problems for which neuropsychologists typically provide services include difficulties with learning, memory, attention, reading, language, problem-solving, decision-making, personality changes and impulse and behavioural control. Problems in these areas can arise from single or multiple factors, such as genetic defects, neurodevelopmental factors, infectious diseases, vascular injury, degenerative disorders, drug and alcohol neurotoxicity, psychiatric disorders, and physical traumas such as car accidents affecting the brain.

Employment of psychologists in mental health services in Victoria

As noted above, psychologists working in public mental health services are employed under the terms of the *Victorian Public Health Sector (Medical Scientists, Pharmacists and Psychologists) Single Interest Enterprise Agreement 2017-2021* (the Public Sector Agreement).

The Public Sector Agreement provides a career path for psychologists, from their employment under supervision as provisional psychologists (Grade 1) to Grade 5 psychologists who may head a psychology service or program, or is a recognised expert in professional practice, teaching, research, administration or policy and planning.

The entry level for generally registered psychologists including Registrars is at Grade 2.

Grade 3 psychologists have at least 5 years of experience, and undertake work requiring advanced knowledge and skill or may be required to implement research. At this level and above, a psychologist can clinically supervise

students on placement, Registrars and Grade 2 psychologists, subject to them being registered as a Supervisor by the PBA.

Grade 4 psychologists, in addition to undertaking work requiring advance knowledge and skill, meet one of a number of criteria including being the leader of a professional team of psychologists and/or other health professionals; being a clinical specialist in a specific area of psychology or mental health disorder; being a principal researcher.

The Public Sector Agreement provides that only psychologists who are endorsed by the PBA to practice as clinical psychologists, forensic psychologists or clinical neuropsychologists are to be employed at Grade 3 or above that in mental health services. However, the Agreement provides that psychologists without endorsement who were employed in mental health services as at 1 November 2011 are exempted from this requirement.

Of the VPA members who responded to the survey regarding working in public mental health, just over seventy percent held an Endorsement.

The Public Sector Agreement also mandates that psychologists are provided with clinical (professional) supervision by a more senior psychologist of at least 10 hours per annum, with Grade 2 psychologists receiving fortnightly clinical supervision and Grade 1 interns and Grade 2 Registrars receiving additional supervision in order to comply with the requirements of the PBA.

Clinical supervision can be defined as a formal professional relationship between two psychologists which facilitates reflective practice, explores ethical issues and develops skills. Clinical supervision is not operational supervision. The Public Sector Agreement states that the clinical supervisor should not be the psychologist's line manager.

Under the Agreement, psychologists are eligible for seven days paid professional development leave annually.

In order to maintain safe staffing and workload levels and appropriate clinical standards, services are required to backfill the positions of psychologists who are on a period of annual leave of more than two weeks; parental leave; long service leave; professional development leave and certain other forms of leave.

The Public Sector Agreement provides that psychologists may be able to access sabbatical leave but this is only available by mutual agreement between the employee and employer, not as of right. Under the Agreement sabbatical leave is only available to psychologists classified at Grade 3 and above, with more than six years' service with that employer.

Skills of psychologists working in public mental health in Victoria

Research expertise

Psychologists are trained in research principles, techniques and methods and their application. Those with postgraduate professional training will have in-depth research expertise in the specific area of practice in which they have studied.

Psychological assessment skills

Psychologists with clinical, clinical neuropsychology and forensic endorsement(s), working with patients in the mental health field, are trained to work across the lifespan, from infancy to old age. They are skilled in psychological assessment of individuals, adopting the strategies of the scientific method, and with unique deep knowledge of psychometrics, including the conduct and interpretation of psychological tests and similar instruments. All have specialised training in the

complex process of psychodiagnosis, including differential diagnosis, according to the internationally used systems of the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (American Psychiatric Association, 2013) and the International Classification of Diseases 11th Revision (World Health Organisation, 2018). Appropriate assessment of risk and safety issues relating to patients forms a central part of this process.

Holistic psychological assessment of patients' presenting problems leads to diagnostic formulation, whereby likely interacting factors underlying the presenting problems, as well as those triggering and maintaining them, are considered and spelt out. This holistic understanding of patients as individuals is grounded in such theories as that of Bronfenbrenner (2004), whose ecological model places the development of psychological life in a lifespan context (development from infancy to old age) and in the interlocking concentric contexts of the person's social systems (nuclear family, extended family, friends, school, community, society).

Intervention including psychotherapy skills

All Endorsed psychologists working in the mental health field have skills in planning and carrying out treatment interventions in their area of specialisation. Treatment options can be identified on the basis of a thorough psychological assessment, diagnostic formulation and knowledge of the theories underpinning the various psychological treatments. Options can then be discussed with the patient, possibly with the patient's family, and with other professionals involved. A treatment plan is able to be agreed, ideally including the viewpoints of the patient, which tailors interventions appropriately to the clinical and social context of the individual patient.

These psychologists can then implement the planned psychological treatment, which may take the form of psycho-education, behavioural modification, or psychotherapy. Cognitive behavioural therapy is one form of psychotherapy that uses principles and methods for which psychologists are specifically and uniquely trained. Many

psychologists have additional training in psychodynamic, interpersonal, group therapy and/or family therapy, for which their existing knowledge base prepares them very well.

Psychotherapy, sometimes called “talking therapy”, is a method of psychological treatment for mental health problems that has been developing world-wide for over one hundred and thirty years. New approaches are always emerging and being researched and evaluated, and the discipline of Psychology is in the forefront of this endeavour (American Psychological Association, 2019a, 2019b, 2019c).

Fundamentally, psychological treatment interventions involve the psychologist or psychotherapist offering a safe, predictable, and secure relationship within which the patient can feel free to speak frankly about his or her concerns, exploring the associated thoughts and feelings that are confusing, distressing and often frightening. A so-called “therapeutic alliance” is established between psychotherapist and patient. Research has now clearly demonstrated that this relationship between clinician and patient, developed over a number of therapy sessions, is a powerful agent, in itself, for psychological (including behavioural) changes (Kazdin, 2007).

The task of the psychologist is to listen to the patient in an unhurried way, allowing fulsome expression, to develop an interpretation of the central issue or issues involved; it is easy to see how a comprehensive psychological assessment prior to treatment can quickly facilitate the psychologist’s understanding. The psychologist then intervenes in a coherent and consistently planned way, tailoring interventions to the patient’s uniquely expressed concerns. A range of interventions are at the psychologist’s disposal. Specific, directive behavioural interventions such as various forms of desensitisation programs for anxiety and broader cognitive-behavioural interventions addressing depressive ideation are at one end of the spectrum. Working through of past trauma and its complications, and facilitating insight into patterning of thoughts and feelings (by discussing interpretations of the problem), constitute a psychodynamic approach which may be more appropriate. At the other

end of the spectrum is what is known as person-centred psychotherapy, wherein the patient is strongly supported in connecting with existing psychological strengths to find a pathway to mental health.

The evidence bases of psychological practice

Psychologists, as scientist-practitioners, take their commitment to scientific method into their work with patients. In assessment, they not only carefully gather evidence concerning the patient's presenting problem, history and current life circumstance, but also proceed to formulate hypotheses about the bases of the presenting problem, which they test out by gathering more relevant data, refining understanding of the problem and its course until a conclusion can be reached.

In addition, psychologists are grounded in a scientific approach to their actual tools in both formal psychological assessment and in psychological treatment in mental health practice. Further, psychologists have an ethical responsibility to remain abreast of constantly emerging evidence concerning the effectiveness of psychological assessment and treatment methods.

Psychological assessment

Depending upon the problems and situation presented by each patient, clinical psychologists use a combination of methods in the psychological assessment of individuals, including clinical interview with the patient and possibly the family, consultation with other health or mental health professionals involved, reference to historical files, and specialised techniques sometimes called psychological tests.

Specialised psychological assessment techniques, specific to the use of psychologists through their training (indeed in most cases proscribed by law), may involve standardised tasks or activities, or responding to a questionnaire protocol,

allowing comparison with responses by the wider population, that is, with population norms, often carried out in a range of cultures worldwide. The science of psychological measurement or assessment began with research in visual perception in the nineteenth century; it constitutes the backbone of psychology as a discipline, and it continues to expand and develop today on a very broad scale.

Today, in the areas relevant to mental health, psychological assessment techniques include (a) those relevant to intellectual functioning in all its aspects, for example, the Wechsler scales for each age group (Fletcher & Hattie, 2011), (b) a wide range of personality functioning, both objective techniques, for example the NEO-Five Factor Inventory (Costa & McCrea, 2010), and projective techniques, for example, the Rorschach Technique (Exner, 2003), and (c) specific mental health functioning and diagnoses, both broad, for example the Minnesota Multiphasic Personality Inventory-2 (Butcher et al., 1989) and specific, for example many scales relating to Depression or Anxiety (such as those of Beck (http://www.pearsonclinical.com)). Hundreds of such techniques are well established in mental health. Each one has a clear and extensive evidence base, meeting defined and internationally accepted research standards over a series of published trials.

Indeed, a vast array of literature sets out the research demonstrating the usefulness of each psychological assessment tool. Each is accompanied by a Manual. The Manual not only sets out exact instructions for the use and psychological interpretation of the results of the technique; it also describes the research methods by which the technique was first established and the subsequent research investigating and demonstrating the reliability of the technique (its capacity to arrive at the same result across time and across psychologists), as well as its demonstrated validity in measuring what it purports to measure, across as many contexts as possible. Complex statistical methods have been developed in this area. Critical summaries of this evidence base are available in a great range of articles and books (for example, Antony & Barlow, 2011; Cohen & Swerdlik, 2017).

The use of appropriately selected psychological assessment techniques, in combination with clinical interview, enables the psychologist, over just a few sessions, to develop a comprehensive and complex picture of the mental health functioning of the individual, and arrive quickly at an evidence-based in-depth diagnostic formulation of the presenting problem. This in turn generates recommendations for appropriate treatment options (Groth-Marnat & Wright, 2016).

Psychological treatment interventions in mental health

Psychologists have been aware since the beginnings of the discipline, in the early twentieth century, of the importance of documenting their treatment interventions with patients and noting the effects of those treatments.

Many case studies, or series of case studies, have related treatment effects to theoretical principles. Rigorous treatment research, especially in the area of psychotherapy, began in earnest in the 1940s and continues today, testing the effectiveness of psychotherapy in different clinical contexts, with different populations and age-groups and across different cultures.

Many individual studies compare the outcomes of a psychological treatment with those of pharmacological treatment, no treatment, "treatment as usual" (usually meaning case management), or with another specialised form of psychotherapy. In some instances, such research addresses the effectiveness of psychological treatment with a particular mental disorder (for example, Cuijpers, 2017; Goodyer et al., 2017; Fonagy, 1999; Hofmann et al., 2014; Leichsenring & Leibing, 2003; Norcross & Wampold, 2011b; Taylor et al., 2013), while in others more general effectiveness is tested (for example, Connolly & Strupp, 1996; Gudjonsson & Young, 2007; Kachele et al., 2016; Leichsenring et al., 2003; Norcross & Wampold, 2011a; Westen et al. 2004).

Studies have found psychological treatments (from individual psychotherapy, behaviour modification, structured group therapies, psychoeducation, family therapies) to be variously effective across all domains of mental disorder, though not effective with psychosis unless accompanying psychopharmacology. In some instances, psychological treatment is recognised as the treatment of choice (for example CBT with phobic anxiety disorder; and psychodynamic psychotherapy with borderline personality disorder), while in others combination with drug therapy has been found to be most effective (for example with depressive disorders).

Results of individual studies continue to expand this well and long-established body of evidence.

The body of evidence concerning the effectiveness of psychological treatment interventions is relevant to the design of the public mental health system notably:

- Psychological treatment provided to adult patients experiencing severe/complex mental disorder have been found to complement or even enhance the direct effect of pharmacological treatment (Cheng & Shepp, 2016; Craighead et al., 2015; Lasier, Beister & Bechdolf, 2014; Macneil et al., 2012; Maris, 2019; Ramos, 2013)

- Psychological treatment can assist the adult patient deal more effectively with the traumatic aftermath of an acute episode of mental illness, deal more effectively with social relationships and deal more effectively with complying with an ongoing medication regime (Dinnen, Simiola & Cook,2015; Dinnen et al., 2018; Gutemann et al., 2016)

- Psychological treatment, on its own, can be very effective in enabling recovery of children and adolescents from more severe mental disorders (Barrington et al., 2005; Muller et al., 2015)

- Psychological treatments at the family level can assist the families of patients, whether child, adolescent or adult, to understand and support themselves and the patient to prevent relapse (Jackson, 2018; Von Sydow, 2013).

SECTION 2: TERMS OF REFERENCE 2.1-2.5

Members of the VPA report working in the public mental health system because they are interested in helping those who are experiencing the most severe and complex of psychological problems. While these psychologists do derive satisfaction from this dedicated work, most note that the public mental health system is failing to deliver what they consider to be ethically appropriate services to the patient and their families.

Term of Reference 2.1
Best practice treatment and care models that are safe and person-centred

Access by the public to public mental health services

The role of the Intake function of area mental health services, or in the emergency department, is to ensure that only those manifesting the most severe of symptoms are admitted to the public mental health system. There is effectively a rationing system in place, where access to scarce public mental health services is triaged.

This means that the potential patient must be demonstrating high severity of symptoms, usually meaning psychosis (hallucinations and/or delusions). Extreme behaviours associated with self-harm, suicidal behaviours or even harm of others are not necessarily a criterion for admission to the public mental health service. This initial assessment of severity and the underlying complexity of the individual's disturbance is conducted by a mental health worker in emergency, or on the Intake team. Sometimes a Crisis Assessment Team (CAT team) may be sent to assess the person in the community.

Psychologists are not always involved in the intake function or CAT teams.

If the decision is to not offer a service, the gatekeeper will attempt to suggest an alternative service, which may or may not be available. Safety of potential patients is a consideration, but is difficult to assess over the phone.

Patients, families and referring professionals from outside the mental health system report to psychologists the frustrations that are faced in attempting to have someone accepted into the public mental health service.

Recommendation re access

- **Achieving access to public mental services should be easier to navigate both for potential patients and families in need and for health professionals referring them**

Waiting times for service

Once a person is designated as meeting service criteria, psychologists report that there is often a significant waiting time until a first appointment can be offered. The patient, or in the case of children, the family, will be allocated to a Case Manager, from a multidisciplinary team of clinicians from distinct disciplines - Social Worker, Psychologist, Registered Nurse, Occupational Therapist whose generic role is to coordinate assessment and treatment that can be offered within the multidisciplinary setting.

A Mental Status Examination is generally required when the patient is eventually seen. In adult services, a psychiatrist will be involved, to oversee and ensure that the medical model of practice, with medication at its centre, is appropriately carried out. In child, adolescent and youth services, medication is not so routine.

The Case Manager may refer the patient for assessment by other members of the multidisciplinary team, such decisions mainly guided by the immediate presenting problems of the patient. Delay is likely at this point. If referral is made to a psychologist for specialist investigation of, say, intellectual status, waits are likely to be very long indeed. In some circumstances, referrals may be made to a psychologist is private practice, at the patient's cost.

Waits before receiving any service, and waits at all other points of service delivery, all point to the clinical resourcing being inadequate to meet the needs of the numbers of people experiencing mental illness.

Recommendation re waiting times for a service

- **Delays in appointment times for patients at the commencement of and during contact with the particular service being used should be minimised, requiring greater numbers of clinicians to be employed in the public mental health system**

The medical model and the multidisciplinary team

Victoria's public mental health system is based on the so-called 'medical model' of mental health care delivery, whereby the medical (Psychiatry) hierarchy takes legal responsibility for the service provided, and provides leadership in clinical treatment as well as medical (pharmacological) intervention.

In psychology, the term medical model refers to the assumption that psychopathology is the result of biology, for example, physical/organic problem in brain structures, neurotransmitters, genetics, the endocrine system etc., as with traumatic brain injury for example. The medical model is useful as a guide for diagnosis, prognosis, and research. However, for most mental illness, exclusive

reliance on the medical model may lead to an incomplete understanding, and, frequently, to incomplete or ineffective treatment interventions.

In the public mental health sector, assessment by clinical neuropsychologists is used to determine possible brain injury or dysfunction, particularly dementia in the aged sector and neurologically-based learning difficulties among children and adolescents.

Most clinical psychologists accept the reasoning for the medical model being used as a basis for the organisation of mental health services, but they are critical of the emphasis (often the sole emphasis) of the medical model upon pharmacological treatment, and the frequent lack of recognition of the need of patients for other evidence-based treatment, especially psychotherapy, and psycho-social interventions generally.

The medical model is used almost exclusively in psychiatric inpatient settings, where very few psychologists are now employed, and where comprehensive psycho-social understanding of individual patients is not a priority.

Mental health services world-wide value the concept of “the multi-disciplinary team” as the basis from which to deliver service (Davey, Lake, & Whittington, 2015; Keady & Watts, 2011).

In adult Area Mental Health Services and CYMHS services in Victoria, teams of clinicians are drawn from social work, psychology, nursing, occupational therapy, as well as psychiatry. Speech pathology and dietetics may also be available. Many of these workers (but not psychiatrists) are employed as generic case managers.

Psychologists report that working with a mix of other disciplines can be rewarding, and has potentially important impacts on achieving best practice care for patients.

However, they also report that the benefit of multidisciplinary input is often lacking in practice. The case management model cuts directly across the operation of the multidisciplinary team. The generic work of the case manager involves administration of whatever assessment referrals are involved, arrangement of any case conferencing and coordinating of decisions about how the patient may or may not be offered a treatment program. This essential case management work gives clinicians limited opportunity to deliver appropriately to their patients the specialised discipline-specific services in which they are trained and skilled.

Psychologists also report that communication among colleagues within the team does not acknowledge the range of the discipline-specific skills in which they are each specialised.

In the generic model, social work, psychology, nursing and occupational therapy are considered interchangeable disciplines.

Psychologists report that the opportunity to exercise discipline-specific assessment or interventions is limited across all disciplines. For patients to receive discipline-specific services, the Case Manager usually arranges a referral to another staff member, or else must carve out time from generic work to deliver a specialised service themselves. The high caseloads of clinicians place severe limits on the implementation of these specialised mental health skills.

The Case Manager steers the patient, and in the case of a child the family, through the stages of contact with the service, and makes any contacts with other services previously attended or currently attended, or other services to which the patient is referred in conjunction with the mental health service or to be attended after discharge. Hospital or clinic based, the role requires interview appointments with patients and many phone calls concerning the private issues of patients.

Forensicare services present a somewhat different picture. Still operating within the medical model, a greater proportion of forensic psychologists are employed, as they have expertise in the all-important risk assessment. However, their broader assessment skills and their psychotherapeutic skills are underutilised, especially in inpatient unit.

Recommendations re multidisciplinary teams

- **Changes should be made to the organisation of Area Mental Health Services and CYMHS to ensure that each patient receives the full benefit of multidisciplinary input to their assessment and treatment, and meeting their psychosocial needs, in order to improve their mental health**
- **Generic case management as the predominant model for employing non-Psychiatrist clinicians in Area Mental Health Services and CYMHS should be reconsidered**
- **Staffing levels need to be increased so that patients can routinely receive specialist clinician consultation as well as case management**

Clinical assessment of the patient's mental health and treatment

In Area Mental Health Services, the generic Case Manager is responsible for ensuring that assessment is completed. Comprehensive psychological assessment, (described in Section 1 above) involves conceptualisation of mental health issues in the context of normal psychological development, identifying the individual's strengths as well as difficulties, and taking appropriate account of the family and/or other social settings in which the patient is living. Such assessment can yield a well-rounded, holistic picture of the patient, his or her psychological problems and their history, pointing to a diagnostic formulation and recommendations for the most appropriate lines of treatment. This is seen by psychologists as a basis for appropriately focussed, person-centred therapeutic work, and as best practice for

psychologists. However it is rarely carried out any more in public mental health settings in Victoria. In both adult settings and child and adolescent settings, there is insufficient time allowed to provide this for patients.

Even when the Case Manager is a Clinical Psychologist, the pressure of a high caseload, and the pressure to take new patients, and the pressure to therefore discharge patients each week mean that the psychologist is most unlikely to be able to conduct assessment at the level of best practice. The same can be said in respect of clinicians of the other specialised professions making up the multidisciplinary team.

The considered view of psychologists is that clinical practice in the public mental health setting is very limited in its use of the clinical assessment expertise of its highly trained specialist workers to benefit patients, due to under-resourcing. Consequently, assessment services are considered neither adequately person-centred nor family-focussed.

A special situation arises in the forensic setting, for forensic psychologists. Here, these experts are required to conduct a complex Risk Assessment with each patient, which they are well equipped to do, and such assessment aids the management of patients in the forensic setting. However, any broader psychological assessment which will throw light on the individual's overall capacity to respond to actual treatment options is generally precluded by overall caseload pressure.

In the public mental health sector, assessment by clinical neuropsychologists is used to determine possible brain injury or dysfunction, particularly dementia in the aged sector and neurologically-based learning difficulties among children and adolescents. However, again, the waiting lists for this specialist service can be long, so referrals will be limited, with patients missing out, when they could benefit from such assessment or when it is essential to recovery.

Recommendation re clinical assessment of patient mental health

- **Comprehensive assessment should be provided to each patient, including comprehensive psychological assessment. There must be sufficient numbers of psychologists to allow this to happen**
- **All services should provide adequate test materials**
- **Forensic Psychologists should be enabled to extend beyond Risk Assessment to encompass the assessment of other aspects of psychological functioning which can be engaged to support their recovery**
- **Where indicated, patients should have access to neuropsychology assessment**

In the adult mental health, forensic and aged sectors, medication is carefully planned by the Psychiatrists involved, and all other disciplines are required to support the treatment plan. Often, the Case Manager's main task will be designing a management plan that supports the patient to achieve compliance with that treatment plan. Patients with severe and complex mental illness may also struggle to understand the value of the prescribed medication and/or the necessity for regular taking of the drug/s concerned. The Case Manager will try energetically to engage the patient in a cooperative approach to the treatment which can be sustained.

In the child, where medication is used far less, it is nevertheless a critical goal of the case manager to meaningfully engage both the child and the child's family in the planning of any recommended intervention. The same is true for adolescents, although in some circumstances the family will be less involved.

Clinicians are well aware of the therapeutic value of reaching an agreement with the patient about all aspects of the service offered and put effort into arriving at this. Problems arise for the morale of clinicians when they are aware that the system does not offer a best practice service in respect of comprehensive person-centred

assessment, denying to patients the range of best practice therapeutic interventions that could be considered for and by them.

The medical model of mental health care underpinning the Victorian public mental health system ensures best practice in pharmacology, and it is led by psychiatrists, and supported by all other clinicians. The evidence base for the use of medications is carefully evaluated and employed.

However, it is generally recognised by all clinicians, including most psychiatrists, that to be fully effective, medication needs to be buttressed by psycho-social interventions involving a wrap-around, multidisciplinary approach. Such an approach has a better chance of helping patients to make psychological changes. Such changes can enable them to best manage and take advantage of their medication and beyond this, address the stresses in their lives and relationships with others, better regulate their internal emotions, thoughts and behaviour, and come to terms with the past or ongoing terrifying trauma of mental illness. Various psycho-social interventions may be appropriate, but forms of psychotherapy or “talking therapy” is best known. The evidence base for psychological therapies is discussed in Section 1 above.

Unfortunately, there is reportedly little opportunity for clinicians in Victoria’s public mental health system to deliver psychotherapy for these purposes. Thus, as for best practice psychological assessment, neither Clinical nor Forensic Psychologists have adequate time available to deliver evidence-based psychological treatment on any kind of scale. There are pockets of services where such therapy might be offered to selected individuals or families, particularly in child and adolescent services. However, generally, there is reportedly little consistent policy to consider such options for every patient, and no consistent policy to offer such options to patients who it is thought may benefit.

Length of any treatment offered is an issue raised by most psychologists. The patients of the public mental health system, being severely mentally ill, and whose disorder is likely to have developed either over a considerable length of time (usually years) or in response to a great depth of trauma, are unlikely to recover in a matter of months. Psychologists urge a longer term view, so that patient treatment is able to be ongoing as long as is needed. The current practice of episodic treatment (usually just case management) rather than ongoing treatment is forced by a situation of too few clinicians to meet community need, rather than by best practice principles. In short, the very high workloads of clinicians preclude best practice.

Few psychologists are employed within Inpatient mental health services in the public sector, where the medical model involving pharmacology is particularly emphasised. Psychologists note the lack of access to adequate psychosocial treatments (such as psychotherapeutic groups and individual treatment), as well as the brevity of available psychosocial inpatient treatment.

The state-wide Spectrum service is an exemplar of a service which has been designed to use evidence-based psychodynamic psychotherapy with adult patients diagnosed with Borderline Personality Disorder (BPD). Clinical psychologists have played a major role in this context. Increasingly, however, there is demand upon the service to advise other services, through secondary and tertiary consultation, on dealing with patients who have BPD combined with other co-morbidities. This consultation role, while extending knowledge and expertise to other parts of the mental health system, inevitably cuts into time for Spectrum itself to deliver its high quality service to more patients requiring psychotherapy.

Clinical psychologists report that public mental health services patients with psychotherapeutic needs are often referred out of the public mental health system to receive psychotherapy in the private sector, while remaining a public patient for medication purposes. The patient, of whatever age, may be referred to a private psychologist whose assessment and psychotherapy service attracts a Medicare

rebate for a small number of sessions (up to 10 per annum). Such a brief service, while evidence-based, is unlikely to provide sufficient input to meet the needs of patients with the most severe and complex of mental disorders. Patients would need to pay in full for each therapy session once the rebate ceases, which for many public patients and their families is not affordable.

Recommendation re treatment

- **All patients of public mental health services should have appropriate access to the full range of psycho-social treatment interventions that complement psychiatric pharmacology provided for sufficient time to recovery**
- **All patients and their families assessed as being in need of evidence-based psychological interventions should be able to access these, from psycho-education to various forms of individual and group psychotherapy, in both outpatient and inpatient settings**

Discharge, continuing care and follow-up/review

The overall public mental health system in Victoria, serving those with the most severe and complex mental disorders, recognises that many patients may need to continue with medication on an ongoing basis. Case Managers in Area Mental Health Services, across the age groups, find themselves in the invidious position of being obliged to achieve a steady throughput of patients, and trying to put in place supports in the community (such as by non-government community agencies), while knowing that their patients will probably be re-referred in crisis. Clearly a risk assessment is necessary at this point.

In making such decisions for discharge, Case Managers try to include the patient in detailing the plan, needing the patient or family to be able to follow the plan once discharged. This may prove difficult when, as apparently often occurs, few options are available for discussion. How effective this process is appears to be unevaluated

from the Case Manager perspective. Further, how easily practice can be tailored to the needs of the individual patient/family and to the presenting mental health problem is apparently unevaluated.

Recommendation re discharge, continuing care and follow-up/review

- **Decisions about discharge, continuing care and follow-up/review should be based on the individual's demonstrated good recovery outcomes to date, and not on a timeline related to throughput of patients**
- **Such decisions should involve the patient and family, with a full explanation and discussion of appropriate options and what they involve for the patient and family**

Term of Reference 2.2
Strategies to attract, train, develop and retain workforce including peer support workers

Attraction of psychologists to, and retention of psychologists in, public mental health work

Even though the generic case management model in Victoria's mental health system dictates that psychologists are so often restricted in the employment of their specialist skills, services are still able to attract new graduates to Grade 2 psychologist entry level positions. There are a number of reasons for this: Firstly, these new graduates are attracted by the clientele served by the mental health system. Principles of social justice in professional work are often satisfied by the knowledge of serving the most vulnerable people experiencing psychological problems. Further, the diversity and complexity of the mental health issues confronting this group of patients is considered interesting and challenging by clinical psychologists, forensic psychologists and clinical neuropsychologists alike. Mental

health is the field in which psychologists undertaking a clinical master's degree or a doctorate in clinical psychology in particular undertake their specialist training, and placements.

Psychologists with general registration and PBA approved master's degrees or doctorates see employment as a Grade 2 Registrar in a mental health service as an opportunity to gain the period of supervised practice necessary to obtain Endorsement from the PBA as a clinical psychologist, forensic psychologist, or clinical neuropsychologist.

As noted earlier, only psychologists with endorsement in these fields are able to progress in their career in mental health services to Grade 3 or above.

The conditions of employment in the public mental health system under the Public Sector Agreement are attractive to new graduates.

However, senior psychologists report difficulties in recruiting Grade 3 and Grade 4 psychologists into public mental health services, and that it is now difficult to retain Grade 2 psychologists for the five years necessary for them to progress to a Grade 3 level.

There are several reasons for this. Firstly, if they are recruited to a generic case manager position, psychologists can find disappointing (or even alarming) the underutilisation of their psychological skills, resulting in less than best practice being offered to their patients. It may also be the case that they are unable to be employed as a Registrar because of the shortage of Grade 3 supervisors, which then cuts them off from career progression within public mental health.

Secondly, many psychologists also see case management as potentially de-skilling. This underutilisation is coupled with lack of recognition as a specialist and with unrealistic caseloads requiring many psychologists to complete work out of paid

work hours – without being paid overtime as required by the Public Sector Agreement. The focus of work for some becomes survival in the position. After a few years many leave the public system, preferring to set up in private practice where remuneration can be higher, and where they may be able to use evidence-based practice with patients.

There was an exodus of psychologists from the public mental health system after Medicare rebates became available for private psychological consultations in 2009, significantly depleting the public mental health system. The attraction of private practice underpinned by the availability of the Medicare rebate to patients has continued to undermine the retention of Grade 2 psychologists in the public mental health system.

The statistics revealed by the survey of VPA members are instructive: while there is a large cohort of members who have worked in the public mental health system for more than 10 years (60%), only 13% of respondents have been employed for between 6 and 10 years, and 27% for up to 5 years. Further, 57% of respondents work part-time.

With so many psychologists leaving the public mental health system as they gain more experience there are fewer Grade 3 and Grade 4 psychologists available to supervise postgraduate students in placements in the public sector. Fewer students can therefore be brought into the system, thus reducing the pool of psychologists who have had a placement in a mental health service as part of their training, as well as reducing the number of provisional psychologists available to see patients under supervision.

There are also fewer more experienced psychologists at Grade 3 and above who are available to supervise Registrars (Nedeljkovic, Chaffey, Murray & Brennan, 2014). This means that either supervisors must commit increasing time to supervision, or

the service simply does not offer Registrar positions to new graduates, as is the case with some regional services and large metropolitan mental health services.

A good number of Grade 2 psychologists respond to their frustration with the public mental health system by changing from full-time to part-time employment, allowing them to maintain their skills outside the public system in private practice while remaining to serve the neediest patients within public mental health.

A third disincentive to remaining in the public sector employment is that career path opportunities there are minimal, and indeed non-existent, for most psychologists, despite the provisions of the Public Sector Agreement. Once having secured a Grade 2 position, a psychologist will usually remain there, reaching the top of the pay scale for a Grade 2 psychologist in four years.
Because of the reluctance of mental health services to reclassify Grade 2 Psychologists to Grade 3, there are a number of psychologists, particularly in case management positions, who have remained at the top of Grade 2 for 20 or more years.

This sends a clear message to newly recruited Grade 2 entry level psychologists that public mental health services do not provide them with a career path. While they may stay working in public mental health to gain clinical experience, many resign in their early career.

This reluctance to properly classify entry level Grade 2 psychologists as Grade 3 after five years' experience appears to be driven by budgetary considerations. Public mental health services actively discourage psychologists from applying to be reclassified as a Grade 3. Recently one service opposed the reclassification of a Grade 2 psychologist to Grade 3. The outcome was that a highly experienced and skilled psychologist has been lost to the public mental health system; not surprisingly the psychologist concerned resigned and went into private practice.

There is not a shortage of psychologists in Victoria: there were almost 10,000 psychologists registered with AHPRA at 30 June 2018 according to AHPRA's Annual Report.

https://www.ahpra.gov.au/annualreport/2018/registration.html

Working with severely mentally ill people is confronting for clinicians of all of the disciplines, engendering enormous psychological stress. Engaging emotionally with patients, with empathy, which is essential to the most cursory of assessment procedures, requires the clinician to engage with the deepest levels of fear, anxiety, sadness, and despair that human beings can experience. It is disruption by these frightening feelings that are part and parcel of mental illness. Engaging with patients and their distress repeatedly across the course of every day requires the clinician to develop appropriate methods of self-care.

There is a culture within each profession that supports such self-care. Psychologists report that supervision (individual and group) as well as being mentored by more experienced colleagues, are critical to such support. They report that, while supervision standards are maintained by the public mental health system, time for informal mentoring within the workplace is extremely limited, due to pressure of caseloads.

Psychologists often deal with the overwhelming stress of dealing with the severely mentally ill by reducing their hours of work, and/or moving into private practice.

Recommendations re attraction and retention of psychologists

- **Ensure that Registrar positions are available in all public mental health services – without Registrar positions psychologists with general registration will be unable to gain Endorsement and will be ineligible to progress to Grade 3**

- **Ensure that psychologists can access the career path provided for in the Public Sector Agreement**
- **Provide sufficient funding from the Mental Health Branch to ensure that mental health services will progress Grade 2 entry level psychologists who have completed the Registrar Program and gained Endorsement to Grade 3 after 5 years' experience – not only will this impact positively on the retention of individual psychologists but it will provide the necessary number of potential supervisors for students on placement, interns and Registrars. It will also provide a cohort of psychologists who can fill Grade 4 positions**
- **Review generic case management structures to ensure psychologists (and clinicians from other disciplines) are not deskilled by being unable to provide patients (and their families) with specialist assessment, treatment and psychosocial assistance**
- **Reduce caseloads to reduce stress**

Working conditions

The conditions under which psychologists work are often less than ideal.

While this varies between services and locations, inadequate administrative support is commonly noted by psychologists, as are difficulties with such practical matters as car parking.

Psychologists have reported that in any casework, including case management, it is often difficult to find appropriate physical spaces in which to conduct confidential clinical activities. In many work settings, access to a telephone is only available in an open-plan and noisy office, so that quiet and confidential phone calls on behalf of the patient are impossible.

In addition, most settings operate a system for booking interview rooms by the hour, leading to frequent problems in booking a room for a patient interview at a mutually convenient time. Securing predictable consistency for a patient of the room in which they share very intimate information is also difficult. Overcrowding and lack of privacy are not uncommon, as is seeing patients in windowless rooms without access to natural light. These problems can interfere with the therapeutic relationship, conditions which would not be countenanced by psychiatrists.

Many clinical psychologists, especially those working with adolescents, believe that outreach work, allowing consultation with young people in their normal surroundings rather than in an office setting, is essential; home visits, school or street consultations may be the best way to connect clinically with patients, at least from time to time. This is not possible in many service settings.

While there are exemplars, some work settings do not have a comprehensive Library housing the necessary range of specialised cognitive and personality psychological tests and other techniques that make up the assessment resources used in specialised psychological assessment.

Recommendations re circumstances of clinical work

- **Adequate work spaces must be provided in which clinicians can conduct consultations with patients quickly and easily, and confidential telephone conversations concerning patients in quiet and private rooms**
- **Outreach work where the patient is seen in their normal surroundings should be implemented, particularly for young people.**
- **Adequate administrative support should be provided to clinicians**
- **The full range of up-to-date test materials need to be available to psychologists at each service and location**

Training and professional development of psychologists

Most psychologists report adequate orientation and induction into the service in which they are commencing employment. No doubt this process has been aided by the placement experience provided in their postgraduate training. They arrive at the service very well prepared.

Professional development is built into case load allocations for psychologists – or should be – and yet psychologists report that in-service training offered by their employer is largely lacking. In some services, some initiatives have been taken by senior psychologists to provide opportunities for in-service education.

The establishment of the Centre for Mental Health Learning (CMHL) as the central agency for public mental health workforce development in Victoria does not seem to be well known by psychologists working in public mental health.

CMHL has been established to ensure skills and knowledge are shared widely, and mental health workers at every stage of their career have opportunities to grow their leadership capabilities. CMHL identifies and supports sharing of mental health learning and development resources across Victoria, allowing the sector to cut down on duplication and promote high quality resources within a culture of information sharing.

This represents an opportunity for mental health services to gain benefits from the provision of in-service training of psychologists at scale, especially smaller services.

https://www2.health.vic.gov.au/mental-health/workforce-and-training/the-centre-for-mental-health-workforce-learning-and-development

The PBA mandates that psychologists must complete a specified number of hours of professional development annually in order to maintain their registration. As noted

above, psychologists are entitled to seven days professional development leave per annum under the Public Sector Agreement. The Agreement does not restrict how the leave should be used: it can be used to attend relevant conferences or workshops, or for research or home study. Psychologists rarely receive financial support for professional development, such as payment of registration fees or travel (in contrast to that provided to Psychiatrists); very occasionally funding is available for presenting a Conference paper that is recognised as important to the service.

Psychologists also report that in some services it is very difficult to get approval to take professional development leave, despite the fact that it is a legal entitlement under the Public Sector Agreement, and that the service must backfill a psychologist who is absent on professional development leave. The services maintain that they cannot afford to allow psychologists to take leave, as it will impact patient care, despite the fact that such leave is mandated under the Agreement.

Recommendations re training and professional development of psychologists

- **In-service training opportunities should be expanded and built into the annual calendar**
- **Public mental health services should make the information, tools, training, resources and expertise developed by the Centre for Mental Health Learning available to psychologists as part of in-service training**
- **Financial support for conference and workshop attendance including registration and travel should be provided to psychologists**
- **Mental health services must receive sufficient funding to allow psychologists and other clinicians to take professional development leave and to backfill their positions whilst they are absent**

Term of Reference 2.3

Strengthened pathways and interfaces between Victoria's public mental health system and other services

Health and mental health clinicians value very highly the importance of building and maintaining links with services other than their own. Integration of the public mental health system with the overall health system through the structure of hospitals was welcomed for this reason. However, the reality of this integration appears not to have facilitated interfaces to the extent anticipated. Indeed, psychologists report that pathways for communication with services both within and beyond the public mental health system are generally surprisingly complicated and time-consuming.

Apart from receiving referrals from within or outside the system (discussed above), the most important interfaces between the public mental health system and other services concern communication and cooperation around casework, through case liaison. The clientele of public mental health - the children, adolescents and all adults deemed to have the most severe and complex of mental disorders – are usually likely to have multiple service needs, and involvement with multiple services. Initial assessment of the patient's mental health needs, possibly including medication, requires gathering of information about past and/or concurrent services. While some of such information may be read on the patient's electronic file, it is often necessary to make direct contact with other service providers to receive adequate detail.

One of the main aims of the case management approach within mental health is to coordinate with services beyond mental health to help meet the individual's psycho-social needs, especially when planning discharge or continuing care. Just as other health workers may find contact with the mental health service frustrating, in the prevailing context of services exercising economic restraint by limiting access by varying categories of patient, the expectations of Case Managers about options for support of their patients beyond their own service are often disappointed. They can

find a great deal of working time is spent, both on the telephone and on email, on attempting fruitless lines of enquiry.

Some services provide secondary or tertiary consultation to other parts of the health system, or to other parts of the mental health system (such as the Spectrum example), or to other government or non-government systems. Secondary or tertiary consultation involves discussion with another service concerning the specialised needs of the clientele of that other service. Such consultation can be integral to a specialist role, for example, psychologists in CYMHS gathering information from, and consulting to, a patient's school. Again, making contact for such communication is extremely time-consuming, and while it may be necessary, may not be possible in the context of an overly stretched caseload.

The extension of the clinical liaison system within health services to clinical liaison by a senior psychologist with external services, and services with which patients interact – such as schools, medical practitioners – has proved to be a good model. However, the major public mental health service which used this approach ceased the appointment due to budgetary pressures, despite the success of the program.

Psychologists have also suggested that there needs to be systems and processes developed to allow ready access to services such as Centrelink, NDIS and the justice system by case managers or clinicians.

Recommendations re strengthened pathways and interfaces between Victoria's public mental health system and other services

- **Clinicians must have sufficient time to communicate effectively within and beyond the public mental health system around critical issues for their patients**

- **Consider the appointment of clinicians whose role it is to liaise with other services and provide sufficient funding to allow these appointments**
- **Develop strategies for enabling efficient communication with services such as Centrelink, NDIS and the justice system**
- **Allow time for consultation by tertiary mental health clinicians to primary and secondary mental health services, to support early intervention for mental health problems and prevention of severity of disorder and progression to the tertiary system**

Term of Reference 2.4

Better service infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements

The aim of integrating the public mental health system with the overall public health system in Victoria was to provide a more coherent, more easily accessible set of services, generally based on geographic region. However, the overall perception of psychologists working in the system remains one of a fragmented system that is difficult to understand and negotiate for clinicians and the public alike.

It is striking that senior psychologists are largely unaware of initiatives to review or update infrastructure or governance policies in the system; they are certainly rarely consulted. Further, groups of psychologists or individual psychologists generally have no ready avenue for communicating to the Mental Health Branch of the Victorian Department of Health and Human Services their experiences of working in the system, of inequities for patients at all levels including funding of treatments, of obstacles in the working environment or of ideas for improvements.

Although a Heads of Psychology group has been formed by senior psychologists working in public health services (not just in mental health) and tries to address issues of common concern, psychologists working in different parts of the system

have little opportunity (and actually no time) for sharing information to support and learn from each other. The lack of communication inevitably impacts upon the professional identity, professional development, and capacity to be creative in work of psychologists generally.

Structural arrangements that relate to the employment of psychologists vary from service to service. There are very different approaches to clinical governance and the structure of psychology services across public health services. Some services have a Director of Psychology and a psychology department, which provided psychologists with professional recognition and status, and a means of raising issues and influencing senior management. It can also be the case that psychologists in such a structure have easier access to professional development and in-service training, and that clinical supervision is well organised, as well as regular meetings of psychologists employed across the service.

Some mental health services lack any structure in which psychologists have the opportunity to meet with peers, and psychologists can feel professionally isolated. Psychologists may be managed by Allied Health Departments within health services, in which psychology has little influence.

The lack of a Chief Psychologist for Victoria in the Mental Health Branch is seen by psychologists as a major disadvantage to addressing infrastructure and governance issues relating to psychology in mental health services.

The Mental Health Branch appears to have little interest in developing policies in relation to psychologists, their employment and their retention in public mental health services. The Department of Health and Human Services Workforce Branch has openly admitted that it knows very little about the work of psychologists in public mental health or the specialist skills that they bring to the assessment and treatment of mental illness.

In December 2016, the Secretary of the VPA met with a senior project officer from the Department of Health and Human Services to discuss the lack of understanding in the Mental Health Branch of the role of psychologists, and the concomitant lack of access by patients to psychologists in the public mental health system.

It was agreed that the Department would develop internal resources and reference material regarding the role of psychologists in public mental health services which would inform policy. However, nothing of substance has been done.

In the second half of 2018, the Department, under the auspices of the Mental Health Workforce Reference Group, set up the Mental Health Disciplines Project, to look at a number of non-nursing disciplines, including psychology. A working group was established for psychology, which included VPA representatives. The project was barely underway when it was 'temporarily placed on hold' in February 2019 due to other (unspecified) pieces of work taking priority. It remains 'on hold'.

This reflects the lack of importance the Department gives to psychology as a mental health discipline, and the lack of a voice within the Department to advocate for access to psychological services by patients of Victorian mental health services.

Recommendations re 2.4: Better service infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements

- **Establish a position of Chief Psychologist within the Mental Health Branch, to advocate for the discipline of psychology and to develop internal resources and reference material regarding the role of psychologists in public mental health services**
- **The position of Chief Psychologist within the Mental Health Branch should be a focus for information-sharing and consultation with psychologists employed in public mental health services**

- **A review of the governance of psychology services at public health services should be undertaken by the Chief Psychologist to develop and advocate for a best practice model to be adopted by all health services**

Term of Reference 2.5
Improved data collection and research strategies to advance continuity of care and monitor impact of any reforms

Psychologists are agreed that the present central casework data collection conducted within the system is very time-consuming and of no practical value to clinicians. Some psychologists are very critical of the software system in use as being very outdated and cumbersome, taking more time than is necessary to enter the data required.

While it is hoped that this data collection informs some kind of service planning by the Mental Health Branch, it is not evident to psychologists that this is so. In other words, psychologists generally are not aware of any use to which the central data collection is put.

There is no apparent overall research strategy in place within the public mental health system which is designed to inform best practice. According to VPA members, the central data collection conducted in the public mental health system has no evident impact to advance best practice or even practice with individual patients. In other words, it does not serve an evaluation research function relating to day-to-day practice. This is in spite of the fact that the appointment of a psychologist to oversee and implement such a research program has been demonstrated to be valuable at a local level.

Psychologists are generally not aware of any research strategies being used that are aimed at routine evaluation of the effectiveness of the outcomes for patients of

individual casework, or of practice principles or methods in the more general sense. While such research activity is carried out from time to time in relation to particular new programs that may be trialled, there is no ongoing evaluation strategy in place across the system. Such evaluation at both individual patient and overall service levels, and rigorous regular review of services, is considered by psychologists to be an essential component of best practice service delivery. A research strategy, with appropriate resourcing in terms of dedicated psychologist staffing, could easily be implemented and used for evaluation purposes within each service, or more broadly, to improve service delivery and link practice to evidence and outcomes for clients.

As pointed out earlier, psychologists are trained in all aspects of conducting and interpreting psychological research. However, the well-developed research skills of psychologists are rarely used in Victoria's public mental health system. They could be used to assist in improving data collection or in planning and implementing evaluation research projects. The Public Sector Agreement contemplates that psychologists at Grade 3 and above will be involved in research. It states that:

> At Grade 3 a psychologist may be responsible for implementing clinical research projects or pilot projects associated with service development, including data collection and analysis.
> A principal researcher or project manager, responsible for the design, implementation and publication of clinical psychological research as an author or co-author is classified as a Grade 4, and may be a major initiator of funding or required to acquit funding, or present research papers at professional conferences and seminars.
> And a Grade 5 research psychologist will:
>
> - Author a significant number of research publications with the psychologist as primary author, and which have been published in high impact, peer reviewed journals; and/or

- Be a major initiator of successful funding applications. e.g. to the National Health and Medical Research Council, or the Australian research Council; and/or
- Present papers as the invited keynote speaker or invited work shop presenter, which may include psychological research or issues of clinical development, at major professional conferences and seminars.

Research and evaluation of treatment is essential to the scientist-practitioner model adopted by psychology, but the opportunities to undertake research are limited and research is not valued or factored into clinicians' work.

Psychologists undertaking doctoral work in evaluating treatment and analysing de-identified patient data in their own service have been denied working time in which to undertake their research, leaving them to conduct research in their own time by reducing their hours; have been denied sabbatical leave; and have been denied paid leave to complete their research, forcing them to use their long service leave.

The employing health services are very happy to take credit for the research but rely on the willingness of the psychologist to deliver the research in their own time.

Pockets of research in which psychologists are involved do occur, but there is no general recognition or use made of this valuable resource. This is another example of the underutilisation of psychologist training and skills for the benefit of the patients served by the system.

Recommendations re data collection and research

- **The current data collection system used by public mental health services needs to be reviewed, including in relation to how data can be better analysed and used**

- **Evaluation of services should be ongoing in the public mental health service, and in such a way that clinicians themselves can use such research outcomes to continually modify practice at the local level**
- **The research expertise of psychologists can be used by mental health services to develop appropriate research and evaluation strategies to inform best practice**
- **Psychologists at Grade 3 and above must have access to sabbatical leave as of right, where they can demonstrate that they are undertaking research at an appropriate level, or propose to do so**
- **All psychologists must have dedicated time to pursue research and should be encouraged to present posters or research papers to conferences and to publish their research**

CONCLUSION

This Submission highlights the skills and expertise of clinical psychologists, forensic psychologists and clinical neuropsychologists who work in Victoria's tertiary public mental health system, serving individuals of all ages who are experiencing the most severe forms of mental disorder. However, despite the satisfaction psychologists derive from being involved in trying to offer useful and much-needed service, and from their comradeship with colleagues across the mental health disciplines, they point to many shortcomings of the overall system.

Central among the shortcomings they note are poor access to the system; poor resourcing in terms of numbers of staff in the system leading to very high clinical caseloads; a failure to consistently implement the principles of the multidisciplinary model in relation to all patients; underutilisation of specialist assessment and intervention skills of psychologists and indeed all of the disciplines involved in case management; difficulties in retaining psychologists in the system due to clinical, training and career opportunity issues; difficulties in communication concerning patients within and beyond the public mental health system; the disconnection between psychologists and the Mental Health Branch of the Department of Health and Human Services; and a paucity of reviews, research and evaluation of services.

The picture is of a drastically under-resourced and under-funded system, in which clinicians struggle to meet expressed patient need, let alone provide what they know from their specialised discipline to be best mental health practice. Psychologists are alive to the societal and economic disadvantages of practices which compromise coherent use of multidisciplinary specialist clinical expertise, including their own. They report, for example, lack of time to implement best practice clinical assessment and intervention, lack of continuity of treatment of patients using the system, short-funding horizons; and contracting-out of public psychology services to private psychologists.

A substantial increase in funding will be required to boost the numbers of clinicians in order to meet current levels of demand on the system from people suffering mental illness, many of whom are turned away from public mental health services, and to deliver best practice mental health assessment and treatment to Victorians suffering mental illness. This needs to be done in conjunction with a restructuring of case management to ensure patients can access the specialist services they need, and the encouragement of research.

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