Australia

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Introduction

The status of clinical psychology in Australia, and the health services and regulatory environment in which it operates, has been characterised by significant change across the past 5–10 years. There have been a number of catalysts for change, with the most significant being the introduction of government insurance rebates for psychologists in 2006, and the introduction of the Health Practitioner Regulation National Law Act 2009, which saw the registration and regulation of different health professions subsumed under the same legislation. This National Law also took registration and regulation from a State-based system, into a National Scheme. There are other characteristics of Australia which, although not unique, play a major role in the way in which clinical psychology services are delivered. Australia is a vast country, with an urban coastal fringe, and sparsely populated rural and remote communities. Large urban cities are in many cases huge distances apart. Australia has an indigenous population that is disadvantaged across a range of social, economic and political spheres, including access to health services. Post war waves of migration have culminated in a multicultural society resulting in a truly diverse population. Furthermore, the challenges for the profession of clinical psychology need to be seen in the context of the drive for mental health reform in Australia more generally. Five decades of mental health reform have not necessarily brought about significant improvements in the mental health and well-being of all Australians, with priority areas such as early intervention services for youth, community-based care for the acutely mentally ill, and development of services for rural and regional areas outstanding (Hickie et al., 2014). On the positive side, reforms have brought about a substantial increase in access to government funded psychology services, although

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this reform has not been without criticism. This chapter will aim to provide an overview of the profession of clinical psychology in Australia, including the historical context, training models and clinical practice, and the legislative framework under which these operate.

The Emergence of Clinical Psychology in Australia

The 1940s saw the emergence of the professional practice of psychology in Australia. It has been argued that clinical psychology in Australia has from its initial years of development, been afflicted by a lack of recognition as a specialist discipline and practice (Macmillan, 2011). Malcolm Macmillan, a Founding Member of the Australian Psychological Society, describes the very early years of growing recognition of the profession (Macmillan, 2011), when virtually all clinical psychology services were provided by state governments, and all training was at the undergraduate level. While bachelor degrees had a significant professional orientation, most psychologists learnt clinical practice in their jobs. Postgraduate training in clinical psychology was introduced gradually across the Australian states, starting with the University of Western Australia in 1956, and soon followed by the University of Sydney, in New South Wales, in 1959 (Martin & Birnbrauer, 1996). In Western Australia, clinical training was funded by the state government, with a specialist clinical professional pathway established in the public service. In Western Australia and New South Wales, a significant group of private practice clinical psychologists emerged. Specific training in clinical psychology took some years to emerge in other states, and at that time, as today, the majority of psychologists in professional practice have not completed postgraduate qualifications in a psychology specialty, such as clinical psychology.

Current training pathways in Australia have been described in detail elsewhere (see p. 5; Hunt & Hyde, 2013). Currently, the Australian model is characterised by a common undergraduate program that is seen to provide "broad foundational knowledge as well as strong skills in research methods, data analysis and report writing, upon which professional postgraduate training programs build" (p. 253, Cranney et al., 2009). Following this learning in the scientific knowledge foundation of psychology, there are different pathways to professional registration as a psychologist. Unfortunately, these multiple pathways have led to splits between those psychologists with, and those without, specialist training. For example, the 1970s saw an unsuccessful move to have specialist Colleges abolished within the structure of the Australian Psychological Society (Macmillan, 2011). Further tensions arose with the introduction of a two-tiered fee-for-service model aimed to increase access to psychology services in primary mental health care (*Better Access to Mental Health Care*) within Australia's national health insurance scheme, Medicare, in November 2006. Under this scheme, clinical psychologists are eligible for a higher rebate, and are able to provide evidence based psychological therapies based on their clinical assessment, as opposed as being restricted to a defined list of

Focused Psychological Strategies (e.g. motivational interviewing, cognitive behavioural therapy (CBT), problem solving therapy) that can be provided by non-clinical psychologists. This two-tiered system led to antagonism between groups of psychologists, those who supported the need for specialist training in clinical psychology, and those who maintained that such specialist training was not necessary for clinical practice or for the higher rates of rebate (e.g., Carey, Rickwood, & Baker, 2009; O'Kearney & Wilmoth, 2009). Given the continuation of different training pathways to registration as a psychologist, this tension is ongoing.

The Regulatory Environment

The Health Practitioner Regulation National Law Act 2009 (National Law), was enacted on 1 July 2010, and currently governs the registration, regulation and accreditation of the health professions. While the National Law sits within a broader context of State and Territory legislation, it has brought together 14 health professions under the same legislative framework, a unique scenario that has positioned Australia as a global leader in this design of the regulatory system. With the introduction of the National Law came the consolidation of 75 Acts of Parliament and 97 separate health profession boards across eight States and Territories into a single National Scheme. The Australian Health Practitioner Regulation Agency is the body that administers the functions of registration, regulation and accreditation of the professions falling within the National Scheme, with each profession governed by a National Board. In the case of psychology this is the Psychology Board of Australia (PsyBA). The PsyBA sets a minimum standard of professional practice, and sets the minimum standard of qualification and training to practise using the protected title of psychologist. The initial Consultation Paper arising from a review of the first 3 years of the National Scheme has reported that there is widespread consensus that the introduction of the National Scheme was a "positive step forward in the regulation of the more than 618,000 Australian Health professionals who are now listed on the national register" (p. 5, Australian Health Ministers' Advisory Council, 2014). A recently commissioned independent review of the National Scheme (Australian Health Ministers' Advisory Council, 2014) has concluded that although some changes are needed to enhance the efficiency of the Scheme, it remains recognised as among the most significant and effective reforms of health profession regulation in Australia and internationally.

Registration Standards

Under the current standards set by the PsyBA, there continue to be multiple pathways that lead to general registration as a psychologist, with the qualifications required being either (a) an accredited Master's degree; or (b) a 5-year accredited

sequence of study followed by a 1-year Board approved internship (5+1); or (c) a 4-year accredited sequence of study followed by a 2 year Board approved internship (4+2). While completing these pathways, trainees are listed on the register with "provisional registration" type.

Controversy over the 4+2 (and now 5+1) models has been longstanding, with numerous critics of this training pathway to clinical practice (e.g., Geffen, 2005; Helmes & Pachana, 2006; Helmes & Wilmoth, 2002). For example, the 2 years of supervised practice is characterised by an apprenticeship model and therefore this pathway is not subject to accreditation or other standardised process that might confirm its quality (Helmes & Wilmoth, 2002). Geffen (2005) has also raised the additional problems of there being no minimum standard of academic performance for entry into the 2 years of supervised practice, a reliance on one supervisor across the duration, and the lack of coursework or applied research as further arguments to abandon this pathway to clinical practice. Over the past several years, the PsyBA has introduced additional assessments for this supervised practice pathway, including externally examined case reports and a final examination that is required to be passed prior to full registration, yet the internship itself remains unaccredited and unstandardised.

The PsyBA has also introduced mandatory training for supervisors under each of the training pathways in an attempt to increase the quality of supervision for provisionally registered psychologists, yet these measures do not deal with the basic limitations of the 4+2 pathway. However, there are significant impediments to mandating Master's or Doctoral level postgraduate professional training for registration as a psychologist, including governments who wish to employ a less qualified and therefore less expensive workforce, and practitioners who do not hold these qualifications and wish to retain the status quo (Helmes & Pachana, 2006). However, a National Psychology Forum in December 2015 that brought together major stakeholders in the education and training of psychologists (the PsyBA, higher education providers, the accreditation authority, professional organisation representatives, and Commonwealth and State and Territory health and education departments) sought to bring about a major shift in the pathways to professional psychology practice towards establishing streamlined, fully-accredited training for registration. A joint statement of outcomes from the chairs of the PsyBA, the Australian Psychological Accreditation Council, the Heads of Departments and Schools of Psychology Association, and the Australian Psychological Society was issued as a PsyBA communique shortly following this meeting, The major outcomes noted were a keen recognition that change to the psychology training model was needed, including a need to work towards the withdrawal of the 4+2 pathway and the recognition that Masters level training is the preferred minimum standard for professional training. It was also acknowledged that development of models of training that ensured a sustainable workforce, sustainable funding paradigms, was essential for such change to occur.

The Communique from the National Forum of December 2015 also notes delegates' interest in exploring the development of specialised areas of practice. In the case of clinical psychology, there is currently no specialist register, instead a notation on the general register of psychologists indicates that a psychologist has endorsement

in clinical psychology as an approved area of practice. An unfortunate by-product of the move to national registration was that the recognition of clinical psychology as a specialist title in some states, such as Western Australia, was lost. According to the PsyBA, endorsement of a psychologist's registration is a legal mechanism under the National Law to allow the public to identify practitioners who have an additional qualification and advanced supervised practice recognised by the Board (http://www.psychologyboard.gov.au/). Therefore, clinical psychology is generally viewed as a sub-speciality, analogous to neuropsychology, forensic or health psychology, as opposed to being viewed (as it is in other countries) as the professional base on which further clinical specialisations are built (Pachana, Sofronoff, Scott, & Helmes, 2011). The standard pathway for an area of practice endorsement is the completion of an accredited Masters degree, followed by a 2-year registrar programme (a minimum of 2 years of approved, supervised, full-time equivalent practice with a PsyBA approved supervisor), or an accredited Doctorate degree, followed by a 1-year registrar programme. Therefore, training in clinical psychology is an 8-year requirement, half of which includes training in the discipline of psychology, and half directed to the assessment, treatment and prevention of mental disorders. Continuing professional development, including a component of peer supervision, is an ongoing registration requirement for all registered psychologists.

It is worth noting that clinical psychology is not the only approved area of practice in Australia, the other eight being counselling psychology, forensic psychology, neuropsychology, organisational psychology, sport and exercise psychology, educational and developmental psychology, health psychology and community psychology, with these separate areas following the structure of the College system of the Australian Psychological Society. It has been argued that the legitimisation of the clinically-focussed areas of practice as independent specialities (specifically clinical neuropsychology, forensic and health) has led to fragmentation of the profession, with clinical psychology left with a narrower focus and a less clearly defined identity (Lancaster & Smith, 2002). Furthermore, the inclusion of traditionally clinical domains into the scope of practice of other psychology specialties, such as counselling psychology, has led to demarcation disputes and a further threat to the distinctiveness of clinical psychology (Lancaster & Smith, 2002). However, clinical psychology training programs remain dominant in Australia, with clinical psychology courses offered by 37 higher education providers across the country in 2016, in stark contrast with four offering clinical neuropsychology, two offering health psychology, two offering forensic and three offering courses in counselling psychology.

Accreditation of Clinical Psychology Training

There is a long history of accreditation of clinical psychology training programmes, stemming from State-based registration boards requiring qualifications to be accredited by the Australian Psychological Society (APS). With the introduction of the National Scheme, the accreditation function is assigned by the PsyBA to an

independent body, currently the Australian Psychology Accreditation Council (APAC). At the present time, APAC is governed by a Board of Directors nominated by its members: the PsyBA, the APS, and the Heads of Department and Schools of Psychology Association. Currently, psychology programs are independently assessed every 5 years in accordance with clearly defined standards, which are consistent across Australia. This accreditation function is being increasingly regulated, and accreditation bodies must meet AHPRA's Quality Framework for the Accreditation Function, which outlines best practice in regards to its accreditation functions, particularly in the areas of governance, independence and effective management. At the same time, the international context is becoming increasingly important and relevant to Australian psychology, and Australian psychologists are actively involved in these forums such as the International Congress on Licensure, Certification and Credentialing of Psychologists.

Training Models, Assessment, and Clinical Practice

Since the beginning of postgraduate training for clinical psychology, Australian educators have embraced the scientist-practitioner model of training and practice, following the recommendations of the celebrated conference held in Boulder Colorado in 1949. Under such a model clinical psychologists are trained as scientists as well as practitioners, courses generally are run in university departments of psychology, and the pathway to practice includes learning in the scientific discipline of psychology, as well as training in assessment and therapy, a significant research component, and a significant clinical placement experience.

The current accreditation standards for clinical psychology postgraduate training requires 1000 h of supervised practice for a Master's level qualification and 1500 h of supervised practice for a Doctoral level qualification. These requirements appear to be below those required in other countries, such as the 12-month internships required by jurisdictions in North America and New Zealand (Helmes & Pachana, 2006). At first, students undertake practice under very close supervision in clinics that are run within the higher education institution, which allows the students to be work ready when subsequently undertaking placements in hospital and community setting that are external to the higher education institution. These psychology clinics provide clinical psychology services at low cost to the public and thereby make a unique contribution to mental health service delivery across the nation.

Until very recently, all accredited postgraduate training in clinical psychology has been run by universities, and the current accreditation standards have ensured that those minority of courses run outside of universities adhere to the basic scientist-practitioner approach. However, even though a scientist-practitioner model remains a core feature of the accreditation requirements, the model is not unique to clinical psychology and cannot be regarded as defining its identity as a speciality (Lancaster & Smith, 2002). Most clinical psychologists have expertise in CBT models, with a minority of others practise in psychodynamic therapy (Meadows, Farhall, Fossey, Grigg, McDermott, & Singh, 2012). This

situation is no doubt influenced by accreditation requirements to focus on evidence-based treatments, and CBT is the predominant modality taught in the higher degree training pathway. Particularly in the case of Doctoral level training where there is a requirement for greater depth of learning, higher educational providers will teach therapy models outside of CBT such as interpersonal therapy, dialectic behaviour therapy, or psychodynamic approaches. However, probably distinctive to clinical psychology training relative to other health professions in Australia is the formulation driven approach to understanding clinical presentations and treatment planning.

Consistent with the scientist-practitioner model, the development of knowledge and skills in research remains a key component of clinical psychology training. For example, agreement on the retention of the requirement for students to undertake an independent research project within accreditation standards was a stated outcome of the National Forum held in December 2015. Many university providers offer programs of study that combine professional training with a higher research degree or PhD, with the expressed aim to foster clinical psychologists with advanced research skills. However non-university higher education providers often need additional effort to maintain a sufficient research milieu to facilitate a strong research grounding in their graduates.

The most recent shift in clinical psychology training models has resulted from the implementation of the Australian Government's new Australian Qualifications Framework (Australian Qualifications Framework Council, 2013) which now requires the equivalent of PhD-level research within a degree in order for that degree to qualify for a doctoral title. Many universities have found it increasingly difficult to fund such degrees given the significant internal training and supervision needs and the need to cap enrolments due to limited external placement capacity. Even the most basic Master-level qualifications are not self-sufficient under current funding models, and the increased requirements for research training at the Doctoral level has made these degrees, for the most part, unsustainable. It is disheartening to look back and read persuasive arguments supporting doctoral-level training in clinical psychology in Australia (e.g., McGuire, 1998; Touyz, 1995), and witness the development of such training programmes in universities across Australia across the past 10–20 years, only to now see those programmes disappear.

Pleasingly, the standards against which psychology training is accredited are undergoing a major revision, away from the current emphasis on hours of training and mandated curriculum content (Pachana et al., 2011). In line with contemporary educational practice, the standards are being revised to be more focused on competencies and graduate outcomes, and therefore will be more flexible, allowing for greater innovation in the way that higher education providers can deliver clinical psychology training. Innovations that have been a particular focus of both AHPRA and the NRAS review include the use of simulation (already used to a great extent in professional psychology training programmes) and a greater emphasis on interprofessional learning. However, despite this shift in emphasis, the standards will retain the requirement for strong oversight of supervised practice and placement programs in the field, and a focus on the important role of accreditation in public protection across the training pathways.

The Clinical Psychology Workforce

According to the most recent registration statistics (AHPRA, 2016), clinical psychologists represent 22.4% (n = 7620 of 34,026) of all registered psychologists, with the remaining holding endorsement in other areas of practice (10.9%; n = 3725), registration without an area of practice endorsement (48.3%; n = 16,446), provisional registration (13.4%; n = 4558), or non-practising registration (4.9%; n = 1677). However, in most public mental health settings today, most psychologists are clinical psychologists, with neuropsychologists also playing a role in assessment and rehabilitation (Meadows et al., 2012). Psychologists without clinical or neuropsychology qualifications tend to predominate in non-government organisations and private practice (Meadows et al., 2012). The introduction of the *Better Access* scheme, with rebates for clinical psychology services being introduced, saw increasing numbers of clinical psychologist moving away from public sector roles, and into fee-for-service private practice. Despite the significant amount of public funds being expended, *Better Access* lacks an integrated system of evaluation that could be used to examine its effectiveness (Allen & Jackson, 2011; Hickie & McGorry, 2007).

One major criticism of *Better Access* is that it has not served populations in low SES or remote locations well. Registration statistics (AHPRA, 2014) indicate that as of January 2014, 78.5% of clinical psychologists declared that their principal place of practice was within metropolitan areas and major cities, 17.7% within outer or outlying suburban and regional cities, towns and areas, with only 2.6% locating their principal place of practice as in outer regional or remote areas. Consistent with these data are findings that point to lower subsidised clinical psychology service use rates by adults living in remote areas or areas of high socioeconomic disadvantage (Meadows, Enticott, Inder, Russell, & Gurr, 2015). For example, clinical psychology consultations funded by *Better Access* were 68, 40 and 23 per 1000 population in the highest, middle and lowest advantaged quintiles, respectively. Furthermore, "increasing remoteness was consistently associated with lower activity rates" (p. 192, Meadows et al., 2015). It is telling that one of the 25 reform recommendations recently proposed by Australia's National Mental Health Commission (2014) was to improve access to psychological services by altering eligibility and payment arrangements, to result in a fairer geographical sharing of these services.

Aboriginal and Torres Strait Islander (ATSI) mental health remains a national priority (National Mental Health Commission, 2014). There were only 23 ATSI clinical psychologists, of a total workforce of 145 ATSI psychologists, listed in the National Health Workforce Dataset for 2013 (Health Workforce Australia, 2013). An important scheme implemented by the Australian Psychological Society to redress the gaps in indigenous psychology education is the Bendi Lango initiative, established in 2006 to support students with ATSI backgrounds undertaking postgraduate psychology studies. The Australian Indigenous Psychology Education Project is another notable initiative, supported by a grant from the Federal Government's Office of Learning and Teaching (http://www.indigenouspsyched.org.au). This project aims

to increase cultural competence in the curricular of psychology training programmes, thereby allowing psychologists to work more competently with Indigenous communities, and to increase Indigenous participation in psychology education and training. It is hoped that these and other initiatives (e.g., Behrendt, Larkin, Griew, & Kelly, 2012) will overcome the lack of Indigenous psychologists, as well as currently low cultural competence among non-indigenous psychologists.

Challenges Facing Clinical Psychology in Australia

Clinical psychologists continue to struggle with a lack of recognition and status, particularly relative to their psychiatry colleagues. Furthermore it can be argued that without a secure identity base, clinical psychology has become more vulnerable to competition from other health professions, including nursing and social work, and from other areas of psychology practice, such as counselling psychology and educational and developmental psychology (Lancaster & Smith, 2002). The trend for public health settings to employ clinical psychologists in case manager positions that do not utilise their specialist skills further undermine the identity and status of clinical psychology (Lancaster & Smith, 2002). Furthermore, the 4+2 pathway to registration as a psychologist may well have contributed to lower perceived status of psychologists among other health professionals (Patrick, 2005). There have been numerous calls for clinical psychologists to become the specialists in the provision of psychological services, and adopt the responsibilities that this leadership role suggests including greater involvement in health policy development, increased engagement with (and education of) other health professionals, and the consolidation of all clinically-focused areas of practice under the specialist title of clinical psychology (Helmes & Wilmoth, 2002; Hunt & Hyde, 2013; Lancaster & Smith, 2002). Current efforts by government that delineate the requirements for a group within a registered health profession to gain specialist title recognition under the National Law may provide a critical opportunity for such consolidation and recognition to occur.

At this point in time, placement places for clinical psychology students has reached capacity, as the numbers of students taken into training places by higher education providers have increased, and the number of senior clinical psychologists in public sector positions have decreased. AHPRA (2016) figures indicate that over 5000 psychologists have PsyBA approved status to offer supervision to provisional psychologist enrolled in higher degree programs, yet clinical psychology placement coordinators from higher education providers across the country report a significant increase in the difficulty in placing their students in suitable clinical settings. Despite the significant volume of high quality services delivered by clinical psychology students and registrars under supervision, there is little recognition of their contribution to the mental health system, evidenced for example, by recent moves by public health authorities to demand payment for placements within their services (Scott, Jenkins, & Buchanan, 2014).

Summary

In conclusion, the field of clinical psychology in Australia continues to evolve. It is only recently that texts have been published for students and professionals that are written specifically for psychological practice in the Australian context (e.g. O'Donovan, Casey, van der Veen, & Boschen, 2013; Rieger, 2014). Dissatisfaction with the long established professional body, the Australian Psychological Society, in its lack advocacy for clinical psychology as a distinct speciality has led to the establishment of a new professional organisation, the Australian Clinical Psychology Association (ACPA). ACPA's stated mission includes supporting the recognition of clinical psychology as a clearly identifiable area of expertise in mental health, and advocating for clinical psychology to government, professional and academic organisations, other health professions, and the public (Australian Clinical Psychology Association, 2010).

Clinical psychology in Australia is in a time of transformation, and there will be many opportunities to develop further as a well-recognised and valued health profession. However, there is still work to be done to cement the recognition, particularly by the larger psychology profession, that specialist training is critical for clinical practice (Macmillan, 2011). Furthermore, new and innovative models of clinical science training may be required to make certain clinical psychology does not become marginalised, and caught in conventional training models and outmoded diagnostic systems (Levenson, 2014) and certainly, a greater shift towards the acquisition and assessment of clinical competencies is vital (Pachana et al., 2011) if we are to best prepare the next generation of clinical psychologists for our constantly changing health-care environment.

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