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An important challenge in mental health care is the lack or reduced access to mental health services by qualified psychologists. Individuals who wish to access mental health care will more than likely wait for extended periods or approach psychologists whose books are closed to new patients. Whilst this problem has been significantly exacerbated recently due increased demand associated with COVID and its aftereffects, it is by no means a new problem and is likely to continue after the current surge in demand has reduced.

There have been several short-term solutions proposed to address this difficult challenge, some of which are currently in the process of development and implementation through the Australian Health Practitioner Regulation Agency (AHPRA) and the Psychologists Board of Australia, however I want to propose how to develop the longer-term solutions.

One of the primary causes of the current problems with access to mental health care is the limited supply of tertiary trained and registered psychologists. The usual explanation given for this is that the current training model does not allow for significant increases in numbers of appropriately trained mental health manpower. This has been a complex issue due to the multiple entry points to professional registration through AHPRA with different levels of mental health care training of psychology graduates. Recently AHPRA has addressed this issue in part by discontinuing entry to registration for 4-year trained graduates. This has ensured that there is a consistency in the quality of mental health training, concurrently this has contributed to the problem by reducing the potential pool of registered psychologists.

Also, there are several other issues unaddressed.

1. The current training models select out the vast majority of 3–4-year psychology graduates in favour of a much smaller and select few who go onto Masters-level courses. The proportion who progresses varied from institution to institution, with the general rule being that the more prestigious the institution the smaller the proportion. These Masters-level courses vary in the extent of focussed mental health care training provided. For example, a Masters of Clinical Psychology course is entirely focussed on mental health care training in contrast to one with an organisational psychology focus or to a more generic one-year Master of Professional Psychology course. The clinical psychology training course have the highest demand but admit the least number of applicants. But it is worth noting that recent changes to the accreditation processes for these courses has meant that all these courses are required to provide a level of mental health training that ensures at least basic levels of protection of the public.
2. In contrast to psychology training is the very high levels of discipline specific training for other allied health professional in their 3-4 years of undergraduate training, there is a significant degree of variability in the inclusion and evaluation of basic levels of generic mental health knowledge and competency in the first four years of training. Only recently have some basic mental health care competencies been required in the fourth year.
3. There is a shortage of supervised practical training opportunities for Masters-level coursework psychology postgraduates, especially within the public health sector.
4. University departments of psychology have difficulties in changing the current models of professional training because of funding models do not adequately support the professional training Masters-level courses which are resource intensive and therefore costly. Academic staff within the Masters-level courses are often overloaded with the dual burden of the requirements of academic performance in research and teaching as well as the, arguably, more complex, and time-consuming work associated with practical and applied training. This has led to significant staff turnover due to these staff being undervalued and overworked.

(Contributing to this is that an academic psychologist can earn double their income in private practice.)

5. Academic psychology departments have developed and continue in an environment where incentives are oriented towards research inputs and outputs. This includes the prioritisation of scientific training, especially at 4th year, and therefore have intrinsic disincentives for practical training. This is a reality that generates tensions with the accreditation requirements of degree programs outline by the Australian Psychology Accreditation Council.
6. The response to increasing demands on practical training has included a shift from resource intensive person to person practical training towards less costly and resource intensive simulation-based training. Simulation based training of psychological care skills is useful at a basic level for training in procedural skills. However, it could be argued that there are limits to how effective simulation-based training is in adequately preparing a psychologist for real-world practice.

Taken together these factors in professional training contribute directly to restricted mental health workforce and variability in mental health care skill levels for the care of mental health problems.

To address these issues one solution is to reconfigure the training of psychologists from the current model of a 4-year generic undergraduate and honours model plus a selective entry master's qualification towards a training that is much more akin to the current allied health courses with practical and theoretical training throughout the degree.

Access to practical training could be made available through similar approaches utilised in training allied health. This includes integration of training (including interprofessional education), into current health care systems, particularly government health and mental healthcare, and potentially, schools.

To provide this face-to-face training, there are many psychologists employed in the public health care systems. However very few who are involved in training of psychologists. This contrasts with nursing, allied health, and medical. It could be argued that this psychology workforce is available to provide this practical training for psychology students, but it has not been fully utilised and deployed. There are some specific professional development training requirements to allow for this type of training, but these could be incorporated into work-based training. While public sector psychology manpower continues to be reduced due to the financial incentives of private practice, this will impede the training of new graduates, and retention of those graduates within the public sector. Therefore, creating more flexible work including private public hybrid models, better career pathways, and more real integration of training and service roles is also required.

There is arguably capacity within staff in university departments of psychology to deliver training within the first 4 years of a psychology degree, particularly as those involved in postgraduate training models are shifted to a four-year undergraduate course.

Instead of a 4-year undergraduate and honours followed by a one- or two-years masters I propose an integrated four-year degree that would be made up of three years foundational plus one-year advanced training instead of the 4+1-2. This four-year degree would provide an entry point to registration as a psychologist. An additional year of Specialised Masters level training would provide qualifications for Area of Practice endorsement.

This structure would reduce the minimum professional training from 5+ years to 4 and would also eliminate the bottleneck created by the separation of the 4-year degree and the masters and the associated loss of graduates.

Within the initial three-year foundational part, a range of topics required for training as a psychologist would be covered, and this would be complemented by skills training delivered using practical training, simulation technologies and observational placement experience. Like other allied health courses there would need to be a utilisation of simulation-based and observational training in the early years culminating in face-to-face practical training in the final year.
In the fourth year there would be advanced topics integrated with face to face (building on previous simulation) skills training covering assessment, testing, interviewing and intervention, as well as face to face placements. A research component could be incorporated across multiple years to replace the current model of a summative 4th year honours thesis.

Psychology subjects would also continue to be offered as part of a broader degree such as a Bachelor of Arts/Science for those wishing to pursue a research or alternative purposes or for introductory courses offered across disciplines. This would mean that psychology departments and undergraduate providers would continue to generate revenue from enrolments in psychology courses.

This proposal aims to address the manpower and mental health care skill shortage by changing and reorienting the model of training. It would achieve this by reorienting the training model to an undergraduate degree, rather than an undergraduate and selective postgraduate pathway. This would mean that the students lost in the current process of selective postgraduate training would be retained to complete a registerable qualification.

This approach would not require any significant increase in manpower and associated resources within tertiary education providers. Indeed, much of the required manpower capacity exists. However existing manpower will need reorientation including incentives to work within this new model. Also, there will need to be improved focus on retention of existing staff, and recruitment of new staff which should include joint university and public sector training positions.

However, there will need to be changes to funding of university training for psychology and changes to government policies relating to psychologist training and supervision within Government Health and Tertiary Education and similar settings, e.g., child health, justice, aged care, schools etc. This should include changes to work conditions and renumeration structures to ensure the retention of staff within tertiary education and public sectors to provide the capacity and capability for training future psychologists.

This proposal may not be received wholeheartedly within some tertiary training sectors as it may be viewed as challenge to existing models and reinforcers of work and training. However, there is no practical reason why research-focussed and other non-mental health focussed training cannot be accommodated alongside these proposed changes. Furthermore, this type and scale of change would not be unique within professional training. For example, the medicine degree at University of Queensland was radically restructured to address training needs. As a model this change was undertaken in a staged process over several years.

It is also important to state that such changes would take time to establish and would involve State and Federal government cooperation, as well the key agencies of Australian Health Practitioner Regulation Agency, Australian Psychology Accreditation Council, and the Tertiary Education and Quality Standards Agency.

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[redacted]

Traditional land of the Turrbal people and the Jagera people