

Senate Community Affairs Reference Committee

Declaration: I make the below submission as an independent practitioner. The views expressed herein are my own and do not represent in any way the views of my employer, MidWest Area Mental Health Service, or its overarching organisation, NorthWestern Mental Health.

Re: Enquiry into Commonwealth Funding and Administration of Mental Health Services

Respected Members of the Community Affairs Reference Committee,

I'm making this submission to express my views and concerns about the matter before you regarding the future Commonwealth funding for delivery of mental health services.

As a clinical psychologist with 7 years experience working across both public and private mental health services in Melbourne's North-West, a growth corridor well known for its already high and growing demand but insufficient availability of mental health services, I believe I'm aware of some of the complexities and challenges of directing funding of appropriate services to where it is most needed. At present, I am the Area Senior Psychologist at MidWest Area Mental Health Service in Sunshine, overseeing the clinical work and career development of clinical psychologists on staff, and I run my own part-time private practice receiving referrals from local psychiatrists and GPs.

Having trained and worked both overseas and locally, I consider Australia to have one of the strongest and most advanced mental health systems, particularly since the introduction of the Medicare Better Access program in 2006 and its supporting initiatives such as the Mental Health Professionals Network, through which I co-ordinate a group of approximately 30-40 mental health practitioners from different disciplines working in private practice in our local area.

Having outlined the background from which I draw my experience and opinion, I would like to express my unprecedented and severe concerns about recent developments and suggested changes to the funding and administration of Mental Health Services by the Commonwealth. I refer specifically to

- a) the announcement that the number of Medicare rebatable sessions shall be reduced from 12 (or 18 under exceptional circumstances) to a maximum of 10 sessions as of November 2011; and
- b) the call from mental health practitioners with only basic training to abolish the difference in the Medicare rebate between those having generalist qualifications and those having advanced clinical training in the delivery of mental health interventions, i.e., clinical psychologists.

I believe that, if realised, these changes would lead to a terrible backset of Australia's mental health system with a significant decline in the quality and availability of suitably trained mental health practitioners particularly in areas of lower socio-economic backgrounds, such as Melbourne's North West, and resulting unreversible changes in increased and untreated psychological distress for years to come. The reasons for my concerns about these changes are outlined below:

a) Reduction in number of Medicare rebatable sessions

Psychological interventions are highly successful, cost effective and safe in treating both low- and high-prevalence mental health conditions (as recently documented in the Better Access evaluation). There is a significant percentage of patients reporting significant improvement after as little as 3-6 sessions. However, whilst significant progress can be made for a majority of patients within 10 sessions (as correctly alleged by the Mental Health Minister when introducing the suggested changes), there remains a large number of patients who require more than 10 sessions, i.e., those being treated under exceptional circumstances in the past few years. These are frequently patients with complex, comorbid presentations with multi-faceted difficulties including drug and alcohol use, intellectual disability, and personality disorders, as well as pressures related to their socio-economic background (financial, educational or relationship stressors) which contribute to their distress and associated risk, and complicate their treatment. Unfortunately, public mental health services are under-resourced and frequently underskilled to provide treatment for these consumers, and usually only pick-up those few with the most severe or chronic presentation, and even then still rely heavily on private service providers (often clinical psychologists) to undertake psychological therapy.

As a clinical psychologist, I'm often sought out to provide treatment and / or secondary consultation regarding the management of this complex client group. To my knowledge, there is currently virtually no evidence for psychological interventions delivered successfully within 10 or less sessions for patients with complex, comorbid presentations. In my opinion, a reduction of the maximum allowable number of Medicare sessions to 10 would lead to responsible and adequately trained practitioners committed to best-practice refusing to take on clients requiring more intensive psychological support given the impossibility to provide even close to the appropriate level of treatment this group requires. Therefore, it is this group of already vulnerable patients that would be left exposed under the proposed change and is likely to 'fall through the cracks' of the system, leading to patients' increased distress and risk of harm to self and others.

b) Abolishment of differences in Medicare rebate according to practitioner's training

Clinical psychology is a specialisation of psychologists in the provision of evidence-based mental health specific assessments and interventions. It is generally and world-wide regarded as the discipline best trained and equipped to provide

psychological assessment interventions in complex and multifaceted cases where treatment needs to be derived from a thorough formulation and knowledge of evidence-based interventions as well as the ability to apply existing knowledge in flexible and innovative ways. Clinical psychologists are also leaders in the advancement of research and development of new treatment models for psychological health. (For further information regarding the role of clinical psychology in Britain and the US, please see <http://www.apa.org/ed/graduate/specialize/clinical.aspx>, and <http://www.clinicalpsychology.org.uk/>.) Clinical psychologists, due to their extended training between 6 – 10 years and ongoing professional development, have a specialist skill-set, which sets them apart from most generalist psychologists who ended their training after 4 years. In Australia, this distinction has been previously investigated and established by the Management Advisory Service to the NHS (see attachment 1), and a Work Value Case in Western Australia (see attachment 2).

The difference in training and expertise of clinical psychologists as compared to other allied mental health professionals such as general psychologists, social workers, or OTs in the mental health field is recognised through a higher average salary level for employees and higher fees charged by clinical psychologists working independently in private practice. The Medicare Better Access program has acknowledged and validated the greater expenses, time and efforts clinical psychologists have invested in their training and the resulting level of expertise by offering a higher rebate for services provided by clinical psychologists. An abolishment of this difference and general introduction of a significantly lower rate than the current rebate for clinical psychology services would in my opinion lead to the following consequences:

- An reduced availability of psychological interventions and consultations provided by appropriately trained experts, i.e., clinical psychologists, in our local area for years to come due to a) the non-viability of running a private practice in an area where a large number of patients are unable to foot a significant out-of-pocket expense (resulting from a reduction of the rebate of clinical psychologists' interventions) and currently often need to be bulk-billed; b) consequently, a reduced interest or ability of students to pursue a career in clinical psychology due to its cost-prohibitive nature and the lack of reasonable possibilities to recover the time and cost of extended training; in other words, the psychological well-being of those Australians requiring mental health care would lie increasingly in the hands of practitioners with only 4 years of formal training.
- A potential risk of reduced quality in the provision of psychological assessment and treatment – as highlighted above, due to the cost-prohibitive nature to run a private practice in areas of lower socio-economic background if Medicare rebates for clinical psychologists were to be reduced, it would be likely that those clinical psychologists wanting to do so would be inclined to select clients based on the expected levels of (brief) length of intervention, (little) need for communication with other stakeholders, and (substantial) ability to foot co-payments. This would

for which clinical psychologists, due to their training, have particular expertise and advantages over other mental health care providers, i.e., those patients with complex, enduring and co-morbid psychological disorders.

- Clinical psychologists, trained as scientist-practitioners, are specialists and leaders in the ongoing research into the nature of psychological disorders and the development of new or the improvement of existing treatment programs and assessment tools. A reduction of research, development and analysis of current and new interventions resulting from a decline in the number of clinical psychologists is likely to lead to a halt in the discipline's development and the risk of Australia's mental health care system gradually falling behind other developed nations.
- Excessive demands on the already overstretched public mental health system, which is frequently unable to respond to the needs of consumers who fall outside its main area of expertise, i.e., identification, treatment and prevention of psychotic disorders. Furthermore, the reduced number of clinical psychologists graduating would also translate to a reduced presence of clinical psychology in public mental health service (where a master in clinical psychology is deemed to be the minimum level of training required to work proficiently in this area), which would further widen the gap between patients' needs and the system's ability to respond. Furthermore, given that many senior clinical psychologists in public mental health also work in private practice, it is likely that a reduction in income from private practice would pressure these senior clinicians into reducing their hours in public mental health (where income levels are typically lower than in private employment or consulting) to make up for the loss of income. This would compound even more the inability of public mental health services to provide appropriate supervision and expert input into psychological therapy delivery.

For all of the above reasons, I urge you to consider carefully the (in my opinion, devastating) long-term consequences that are likely to result from the proposed amendments to the highly successful Medicare Better Access initiative and in particular the marginalization of clinical psychology in the provision of expert mental health services in Australia. In line with what I know to be the opinion of many of my colleagues in the private and public mental health field, I recommend that the Medicare Better Access initiative be continued in its current form (i.e., 12 (up to 18) sessions per calendar year, and two-tier rebate system) and provisions be made for it to be continued on an ongoing basis into the future, ensuring that enthusiastic expert mental health practitioners committed to aiding the psychological wellbeing of their community are able to plan a career in private or public clinical psychology practice.

Respectfully,

Dr Carl Zabel
Clinical Psychologist
Essendon West, 11th July 2011

Attachment 1 – 1989 findings of the Management Advisory Service to the NHS

In 1989, the Management Advisory Service to the NHS differentiated the health care professions according to skill levels. Skills in this sense referred to knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills as follows:

Level 1- "Basic" Psychology - activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, stress management)

Level 2 - undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol

Level 3 - Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. The group went on to argue that clinical psychologists are the only professionals who operated at all three levels and (quote) "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists..."

This is consistent with other reviews which suggest that what is unique about clinical psychologists is his or her ability to use theories and concepts from the discipline of psychology in a creative way to solve problems in clinical settings.

Attachment 2 – 2001 Work Value case in Western Australia

Work Value Document

1998

Application No P39 of 1997

Increased Work Value:

The Case of Clinical Psychology

This Work Value Document has been prepared by the HSOA Clinical Psychology Negotiating Committee in support of Application No P39 of 1997 HSOA v Royal Perth Hospital & Others. The contribution of all those within the profession is acknowledged.

For further information please contact the Hospital Salaried Officers Association, 8 Coolgardie Tce Perth 6000. Phone 93285155, Fax 93289107

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Increased Work Value:

Overview

Introduction

In 1995 the British Psychological Society and the Royal College of Psychiatrists published a joint statement about the need for psychological therapies in the National Health Service (NHS) of Great Britain. This was a collaborative venture by the two professions who cumulatively provide most of the formal psychological therapy services for people with severe mental health disorders. The conclusion arrived at, after due consultation and review of evidence supported practice, was that psychological therapies were an integral part of both Psychiatry and Psychology and as such, are essential components of effective, co-ordinated mental health care. Other than Psychiatry, Clinical Psychology is the only other mental health profession whose complete post-graduate training is in the area of mental health. Consequently, due to their theoretical, conceptual, empirical and applied competencies, Clinical Psychologists are specialists in the provision of psychological therapies.

The term “psychological therapy” refers to all the therapies that draw on psychological theories and use psychological methods. The term “psychotherapy” is sometimes confused with psychodynamic psychotherapy, but in this work value document the term ”psychotherapy” it is quite clearly synonymous with the group of interventions covered by psychological therapies and does not specifically refer to one type of treatment.

A substantial body of evidence now documents the high prevalence of mental health problems in the community. This places enormous pressure on treatment facilities to provide appropriate interventions. A substantial body of evidence also acknowledges that:

- ❖ Psychological therapies are the treatment of choice for a wide range of psychiatric, psychological and emotional disorders.

- ❖ Psychological therapies are provided as stand-alone interventions or in conjunction with other methods of treatment, such as pharmacological management.
- ❖ Psychological therapies are constantly being improved and thus remain relevant to changes in the types of psychiatric conditions seen in public mental health service.
- ❖ Psychological therapies are extended to a broader range of mental health problems.
- ❖ Psychological therapies may play a preventative role in minimising disabling symptoms or preventing relapse in individuals experiencing severe mental health disorders such as those in the psychotic spectrum, bipolar affective disorder, major depression, psychosomatic disorders and substance misuse.
- ❖ Specialists in psychological services are highly experienced in clinical evaluation, psychometric testing, intensive functional analysis and the assessment of neuro-cognitive functioning.
- ❖ Specialists in psychological services are highly experienced in programme development, clinical audit, treatment and service evaluation, continual quality improvement and research.
- ❖ Specialists in psychological therapies also constitute a resource for consultation by other professional colleagues.

Prevalence of Mental Health Problems: Adult Populations

Epidemiological studies have recently quantified the prevalence of severe mental health problems in the community. An examination of the data clearly shows the large numbers of people within society struggling with hugely debilitating mental illness that requires treatment from individuals who have undergone very high levels of expert training in psychopathology and the delivery of psychotherapy in mental health settings. Clinical Psychologists have the required high levels of skills needed to provide the service.

Work on The National Mental Health Policy had brought about the realisation that data on the mental health of Australians is sparse (Henderson, 1995). This applied to three levels of morbidity; that of the general population, the mental health components in general practice and the use of specialist services. Most of the epidemiological data about mental health morbidity unfortunately comes from studies executed outside Australia, but still has a high level of applicability to Australia.

One recent epidemiological survey based upon a representative community sample has provided much needed prevalence information on the extent of mental health problems in Australia. The National Survey of Mental Health and Wellbeing of Adults was conducted between May and August 1997. The results of this study reported that during the 12 months prior to interview, one in five persons (18%) suffered from a serious mental disorder, the highest prevalence (27%) being amongst the young adult population (18 - 24 years). The prevalence rates reported were; anxiety disorders 9.7%, affective disorders 5.8% (of which depression was 5.1%) and substance use disorders 7.7% (of which 6.5% was alcohol related). This survey, however, did not report information about the prevalence of disorders such as schizophrenia and related disorders, or bipolar disorder.

Sumich, Andrews & Hunt (1995) have reported on the 12 month prevalence of significant mental health disorders and have included schizophrenia and related disorders. Schizophrenia accounted for 0.5% of their data set, affective disorders for 9.5%, anxiety disorders for 12.6% and substance used disorder for 9.5%. The

seriousness and chronicity. The definition of “serious mental disorder’ and “chronic mental disorders” were adopted from the US National Advisory Mental Health Council (1993) guidelines. “Serious mental disorder’ included all schizophrenia and related disorders, all bipolar disorder, 20% of major depressive disorder, and 20% of panic disorder and OCD, 10% of social phobia (that co-morbid with personality disorder), and 10% of substance use disorder (principally drug dependence). At this level these disorders are chronic and disabling, frequently lead to hospitalisation and require treatment by a specialist mental health service. ‘Chronic mental disorders’ were present, like the ‘serious mental disorders’, throughout the 12 month period and were associated with disability (i.e. ratings of less than 70 on the Global Assessment of Functioning Scale (GAF) which can be found in DSM-IV). They include 25% of all affective disorders, 17% of all anxiety disorders, and 21% of the substance use disorders.

Co-morbidity of psychiatric conditions is being increasingly recognised in populations treated in the public sector mental health service, and directly contributes to the changes in the work value of Clinical Psychologists. In the psychiatric literature the term co-morbidity is used narrowly to denote the co-morbidity of substance use disorder with a psychiatric condition. In this document, psychiatric co-morbidity is defined more broadly as the occurrence of more than one clinical disorder with a principal diagnosis at the same time.

Recent epidemiological studies have reported substantial co-morbidity amongst people with psychotic disorders, with an overall prevalence higher than 58% (Kendler, et.al.). The most commonly co-occurring clinical problems in the schizophrenic spectrum disorders and mood spectrum psychoses are; panic disorder (24%), obsessive compulsive disorder (24%), social phobia (17.7%), substance abuse (11.5%), alcohol abuse (10.4%), and simple phobias (7.3%) being the most frequent (Cassano, Pini, Sættoni, Rucci and Dell’Osso, 1998). Australian data show a comparative profile of comorbidity with anxiety disorders. One hundred consecutive inpatients with a psychotic disorder were examined. The prevalence of anxiety disorders in

and bipolar disorder were all relatively high with the proportion of people being 43-45% (Cosoff & Hafner, 1998).

The National Survey of Mental Health and Wellbeing of Adults conducted between May and August 1997 has demonstrated the common experience of comorbidity. Nearly one in three of those who suffered from an anxiety disorder also experienced an affective disorder, while one in five also suffered from a substance use disorder. Amongst people with anxiety disorder, 8.7% also had both affective and substance use disorders.

The prevalence of personality disorders in mental health settings and the community is difficult to estimate. Even when taking the methodological difficulties into account, the occurrence of personality disorders is extremely high. Unpublished data from a Perth teaching hospital estimated that 40% of admissions would meet the diagnostic criteria for a Personality Disorder, whilst another third would have some traits consistent with one of these disorders. The World Health Organisation has found that the most prevalent personality disorders in psychiatric inpatient and outpatient settings are borderline, schizotypal and histrionic personality disorders (WHO, 1997). People in these diagnostic categories are also the most likely to be hospitalised repeatedly due to deliberate self harm, suicidal behaviour, substance abuse or in response to frequent life crises (WHO, 1997). There is also significant comorbidity between many psychiatric disorders and personality disorders. A recent Australian study estimated that 67% of psychiatric inpatients in Glenside Hospital Adelaide with an Axis I diagnosis of schizophrenia, mania, affective disorder, and other diagnoses also met criteria for a personality disorder (Jackson, Whiteside, Bates, Bell, Rudd, & Edwards, 1991). The presence of comorbid affective and personality disorders was found to be associated with particularly heavy service usage in a recent Australian public hospital study (Kent, Fogarty, & Yellowlees, 1995).

Evidence exists which supports the notion that mental health problems reach significant proportions in this population. For instance for community residing elderly, the overall incidence of psychiatric disorders is 17% (Saunders et al 1993). Twenty% of older persons residing in the community experience

significant depressive symptoms warranting intervention (Blazer 1982). The incidence of significant levels of anxiety in older adults is around 5-10% (Flint 1994). Late onset paraphrenia has a lower incidence as age rises, at age 60 7% of all schizophrenia's and at age 70, 3% and paranoid suspicion in older adults has an incidence of 2.5 to 4%.

Although abuse of alcohol declines with age, it is a significant factor in admissions to hostels and nursing homes. It is also closely linked to external stressors common to this age group i.e. widowhood, social isolation and retirement. It has been estimated that between 5 and 15% of older adults either use regularly or have available Benzodiazepines (Sullivan et al 1985) with a concomitant risk of addiction due to their long term use.

In addition, there is a high incidence of mental health problems in older adults living in institutions. Zimmer, Watson and Trent (1984) suggest that 62-83% of institutionalised older people demonstrate behaviour problems sufficient to require "constant or active consideration" in their patient care plan. There is a 6-18% incidence of depression in nursing homes and 27-40% incidence of depression in hostels (Ames 1993).

While there has recently been much attention given to the high rate of youth suicide in Australia it is worthy to note that the highest suicide rate for any sex/age group is that of men aged 70 - 79 years (Human Rights and Equal Opportunity Commission, 1993).

For organic conditions such as Alzheimer's type dementia, there is a 5% prevalence rate at age 65 and 20% prevalence rate at 80 years. As Alzheimer's Disease constitutes only 70% of all dementias, other forms include vascular dementia, lewy body type, frontal dementia and subcortical dementia as seen in Parkinson's disease. These conditions are significantly linked to family and carer stress, grief reactions and behaviour problems which necessitate psychological intervention.

For each one of the mental health conditions described in this section, Clinical Psychologists have been involved in

internationally recognised research about the mechanisms underpinning psychiatric disorders, and the practice of evidence-supported effective treatments.

Prevalence of Mental Health Problems: Child, Adolescent and Youth.

In the early 1990s Clinical Psychologists at the WA Institute for Child Health provided information regarding the incidence of child and adolescent mental health problems in WA which culminated in The West Australian Child Health Survey (1996). The survey indicated that more than one in six (18%) of children were identified as having a mental health problem, half of these serious enough to warrant professional attention. In terms of problem type these were identified as delinquent or conduct problems, problems with strange thoughts, behaviours or obsessions, social problems with peers or adults, somatic complaints, aggressive behaviours, anxiety, depression and socially withdrawn behaviours. 16% of adolescents reported having suicidal thoughts with 5% deliberately trying to harm or kill themselves. Information was not available about the incidence of eating disorders.

Given the high prevalence of mental health problems amongst these population, the survey also recognised that very small numbers were receiving treatment. Less than 2% of children and adolescents identified as requiring professional assistance were seen in Child and Adolescent Mental Health Services, highlighting the need for population based strategies as well as specialist services.

Information on the pervasiveness of childhood disorders is also now available. It is now recognised that childhood depression is similar in nature to adult depression, that it rises in prevalence in adolescence and a proportion of those diagnosed at this time also go on to later develop bipolar disorder as well as depression. Both depression and conduct disorder are associated with significant difficulties in psychosocial functioning with conduct disorders in children carrying an increased risk for depressive symptoms early in adult life.

Recent long term follow up studies show a greater proportion of persistence of emotional disorder in childhood into adult life than was previously thought. Obsessive compulsive disorder is now understood to be highly consistent between childhood and adulthood and to have a high level of comorbidity with other

conditions. Conduct problems in childhood show a consistent and pervasive association with social malfunction in adulthood; the strongest correlation is with antisocial personality disorder, but there is also an increased range of emotional disturbance (Rutter, 1995). There are some indications that the mechanisms underlying anxiety and depression are similar and that some childhood anxiety may convert to depression in adolescence and adulthood, or appear as comorbid. Different mechanisms underlie conduct disorder. This has led to recognition of the importance of comorbidity in childhood disorders and of the importance of targeted intervention.

Demand for Clinical Psychology Skills

The recognition of the need for clinical psychology services is seen in the high value attributed to this profession by the mental health system and the community of consumers and their families and carers. The support for this comes from:

- ❖ the recommendations of the State Mental Health Plan and the Ministerial Taskforce
- ❖ the multitude of successful psychological evidence-supported treatments reported in the scientific literature for many severe mental health disorders
- ❖ the cost effectiveness of psychological treatments
- ❖ positive consumer evaluations of Clinical Psychology services

The 1989 – 1990 National Health Survey demonstrated a high demand for Clinical Psychological services. 43,000 Australians consulted a psychologist over a two week period and required 63,000 consultations (Jorn, 1994). The skills and quality of services provided by Clinical

Psychologists have also been recognised

services in West Australia, General Practitioners and consumers.

As part of the workforce reform currently being undertaken within the Mental Health Division of the Health Department of Western Australia managers and senior Psychiatrists were consulted about their views of expanding the career structure of Clinical Psychologists by creating a number of senior specialist positions (McDonald, 1998). Many of the people surveyed noted that Clinical Psychologists provided a valuable service, and were very supportive of proposed changes to career opportunities for Clinical Psychologists so that experienced clinicians could be retained in the public sector.

General Practitioners are the primary source of referrals to mental health clinics. In December 1996, the Clinical Psychologist of Osborne Park clinic conducted a survey of the General Practitioners in the North Metropolitan Region. Of the 58 General Practitioners who responded to the survey, 58% indicated a preference for Clinical Psychology services for patients referred to Osborne Clinic, and 87% considered individual therapy to be an appropriate treatment option.

Consumer groups were also consulted by McDonald (1998) as part of the workforce reform described above. The feedback from these groups was hugely supportive of the services provided by Clinical Psychologists, finding the work completed with Clinical Psychologists extremely useful. Additional to this West Australian information, a recent survey of the readership of a leading consumer magazine in America reported that most of the respondents who had received psychotherapy were satisfied with their treatment and thought that it had improved the quality of their lives (Consumer Reports 1995).

Effectiveness of Treatment by Clinical Psychology

The current economic and political climate demands increased accountability and cost effectiveness from mental health services. Health Service effectiveness is often seen in terms of savings in bed days per patient and/or DRG, and of a decrease in outpatient activity (increased throughput and decreased recurrence and relapse).

Professor Schwartz (1997) has reported the outcome of his studies of the cost effectiveness of psychological therapies. He cogently presented his argument in terms of the expenditure of the health dollar and the benefits measured in dollars. This is difficult to analyze in psychotherapy, therefore he uses the concept of qualified adjusted life years or QALYs to help determine effectiveness. A QALY expresses in a single number a person's individual tradeoff between the length and quality of life. Because a QALY is not tied to a specific condition, health authorities can use it to compare disparate conditions. This analysis has provided some data to show that psychological therapies are effective. Schwartz (1997) has also presented other promising preliminary findings from the industry and health care areas. An Equitable Life Assurance study in America found a \$5.52 increase in productivity for every \$1 spent on Cognitive Behaviour Therapy for stress-related disorders. Health maintenance organisations in the USA found that including psychological therapy as a benefit reduced monthly medical costs by \$9.41 per patient.

Data has been collected within health services that show cost reduction, decreased inpatient bed days and reduced utilisation of costly medical services with the provision of Clinical Psychology services. Data from the Department of Clinical Psychology at the Austin Hospital, Melbourne, discovered savings of between \$185.00 to \$16,346.00, which translates to an average saving of \$4,161.00 across a sample of ten patients (Milgrom, Walter & Green, 1994).

The Department of Health's Manpower Planning Advisory Group of the United Kingdom published its review of Clinical Psychology in June of 1990 after it had commissioned research by the Management Advisory Service to the NHS. The conclusions of this report is published in a briefing paper published by The British Psychological Society. The conclusion of the Management Advisory Service is summarised in the following way; "There is evidence to show that brief psychological interventions can reduce the use of other health services, making savings which are greater than the cost of providing psychological services, the medical off-set phenomenon (The British Psychological Society).

Interventions that have been either developed by, or implemented by CLINICAL PSYCHOLOGISTS can have a major impact upon the physical (Touyz, Blaszczynski, Digiusto, & Byrne, 1992). and psychiatric health of individuals (Watts). Professor Barlow (1996) in a recent article presented in a special issue of the American Psychologist in which psychotherapy research outcomes were evaluated, has summarised the many areas in which psychological treatments (cognitive behaviour therapy, interpersonal psychotherapy, family systems interventions, and brief and longer term psychodynamic interventions have proven efficacy (Anderson & Lambert, 1995). These include such disorders as clinically severe anxiety disorders (including obsessive-compulsive disorder and post-traumatic stress disorder), depressive illness, chronic pain syndromes, eating disorders, chronic personality disorders, substance misuse, as well as the management of symptoms associated with schizophrenia (Chambless et al, 1996, King & Ollendick, 1998).

A review of interventions with young children adolescents and their families has substantiated the positive contribution of Clinical Psychology. The Watts (1989) review into the efficacy of clinical applications of psychology discusses the results of a number of research reviews which support the clear conclusion that children and adolescents who receive treatment fare better than those who are not treated or are treated via other means than psychological therapies and that psychological therapies are the treatment of choice for this age group. Jensen, Hoagwood, & Petti (1996) documented positive mental health outcomes for psychological therapies as did The American Psychological Association's Division of Clinical Psychology who constituted a taskforce in 1993 to define empirically validated treatments, review the effectiveness of such treatments and educate the public about effective psychotherapies.

The Innovative Health Services for Homeless Youth (IHSY) Programme funded the YouthLink Evaluation Report (Matrix & Other-Gee, 1997) which emphasised the cost-effectiveness of the service in addressing the mental health issues of at-risk young people through Clinical Psychology driven community based

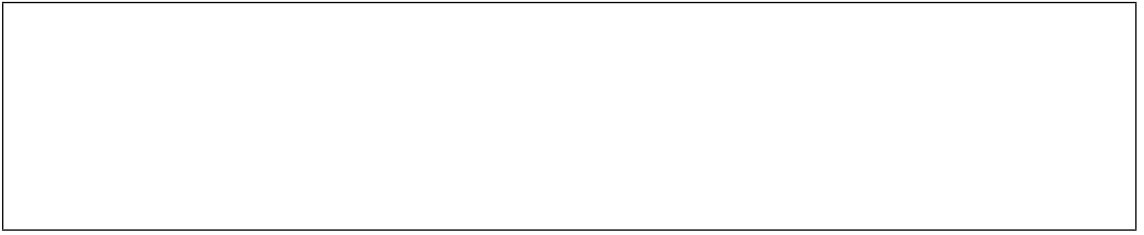
behaviour, chronic self-harming behaviour, substance abuse, depression, offending and sexual abuse issues.

Many of the psychological therapies developed for such clinical problems as anxiety and depression, chronic pain, adjustment to physical and intellectual disabilities have been adapted for elderly populations. Experience in behavioural interventions for challenging behaviour, dementia i.e. wandering, incontinence, verbal and physical aggression, sexual disinhibition with special reference to applied behaviour analysis and cued recall, have also been shown to be effective. Effective specialised therapies for the elderly including reality orientation, reminiscence, validation therapy - both individual and group formats have also been reported.

The Work Value Case for Clinical Psychology: In Summary

The work value case for Clinical Psychology is based on the following argument, which is presented here in summary, and will be developed in depth throughout this document. This work value statement will clearly present the evidence for an increase in the work value of Clinical Psychology in terms of:

- ❖ effectiveness of treatment of mental health disorders by Clinical Psychologists (see pp.12-14).
- ❖ the implications for Clinical Psychology of the increase in multi-morbidity problems of the patients seen in the public sector (see pp. 6-1).
- ❖ the extension of the role of Clinical Psychology, i.e. into community based treatments (see section seven).
- ❖ advances in the treatment of mental health disorders by Clinical Psychologists (see section seven).
- ❖ innovative new areas in which Clinical Psychologists are now applying their skills (see section seven).
- ❖ the additional breadth of activities assumed by Clinical Psychologists (see section seven).
- ❖ the additional scope of responsibility undertaken by Clinical Psychologists (see pp. 16-20).



Responsibility and Impact of Clinical Psychology

The extent of responsibility taken by Clinical Psychology, and the scope and breadth of extended work value is demonstrated by:

- ❖ responsibility for use of specialist psychodiagnostic procedures by Clinical Psychologists
- ❖ the continual expansion of the basis of psychological knowledge
- ❖ the evidence provided for efficiency and effectiveness of discrete focused psychological interventions and long term psychotherapy
- ❖ key responsibilities of Clinical Psychologists the care of complex (mutli-problem) mental health disorders
- ❖ leadership demonstrated by the number of direct referrals to Clinical Psychology
- ❖ leadership of Clinical Psychologists in clinical trials of psychological interventions
- ❖ the responsibility of Clinical Psychologists for the development of psychological treatment and service initiatives.
- ❖ the provision of community education and training by Clinical Psychologists .

The responsibilities of Clinical Psychologists have increased very considerably since the mid to late 1980's. Clinical Psychology has, during this time, become more fully established as a profession which provides highly specialised and autonomous mental health services to individuals across all developmental stages. The profession provides specialist diagnostic and

complete psychobiosocial assessments, treatment services in areas as complex and diverse as psychotic illness, severe personality disorders, comorbid disorders (e.g. depression within borderline personality disorder), psychological and behavioural components of serious medical conditions, and problems specific to different age groups, including recent significant developments within the areas of children and family, youth mental health, the elderly, mental health disorders within medical conditions, quality assurance and research and evaluation.

An examination of recent prevalence data relating to mental health disorders and problems indicates that very significant percentages of Australians suffer from serious mental health problems, most of which are treatable by psychological therapies and systems interventions. The treatments of choice for serious affective disorders, significant clinical anxiety disorders, substance misuse disorders and personality disorders for example, are often (usually) psychologically-based and implemented by Clinical Psychologists. Given the high prevalence rates noted earlier for mental health conditions such as these, it is most appropriate that in planning for service delivery, provision is made for this to be undertaken primarily by Clinical Psychologists.

Clinical Psychology has also taken an increasing responsibility in the treatment of less prevalent mental disorders within the psychotic spectrum, bipolar disorder and the more intractable personality disorders. The roles and responsibilities of Clinical Psychologists have increased through the development of psychological therapies which address components of these disorders, and in specific psychological interventions targeting other mental disorders which are very often comorbid with psychotic conditions, such as depression, anxiety and substance use disorders. Along with providing treatments to these patients, Clinical Psychologists have been increasingly called on by Psychiatrists, to provide additional diagnostic information, to assist with differential diagnoses of complex cases.

The process of diagnosis, assessment and formulation is essential for the effective management of complex mental health disorders. Clinical Psychologists are

of specialist psychological and neuropsychological tests that can only be validly interpreted by psychologists and no other mental health profession. These specialist tests are being continually revised. Take for example only one test of many, the Wechsler Adult Intelligence Scale (WAIS), which has been revised again in 1997. This test is most appropriate for many applications and a core test in Neuropsychology. Clinical Psychologists have the specialist skills to adapt their knowledge of the previous application of the WAIS to the newly published test.

Clinical Psychologists are the only mental health profession that has the depth of psychometric and empirical training, and consequently, the responsibility to reliably and validly apply and interpret tests essential to effective and ethical mental health practice. An examination of the mental health literature in the last decade will find a plethora of tests and inventories that have been exponentially developed. Clinical Psychologists as a result of their training have the specialist expertise to evaluate and determine whether these new assessment tools may be correctly and ethically applied to mental health problems and whether one can trust the outcome of studies using these instruments.

The advances in evidence based psychological treatments has provided additional support for one of the core competencies of Clinical Psychologists, interventions with a wide range of mental health disorders. Clinical Psychologist direct and assume primary responsibility for interventions. The advances in treatment are described in summary in section seven. A completely comprehensive review is beyond the realms of a document such as this “Work Value Statement”. In recognition of the confines of this task, a limited but yet comprehensive set of references has been provided. Many mental health service providers report the outcome of the treatments, in case reports, self help manuals, uncontrolled clinical trials and controlled randomised clinical trials. Clinical Psychologists have the training in psychometrics and research methodology to evaluate this information in an informed manner and as a result of their evaluation, guide the mental health service with whom they are employed.

Section seven attests to the continual expansion of the basis of psychological

efficiency and effectiveness of discrete focused psychological interventions and long term psychotherapy. Clinical Psychologists have a commitment to the provision of effective treatments that empower patients, increase their quality of life, and of course, decrease the problem for which they have presented. In order to achieve such goals, clinically oriented and practical research must be carried out. The West Australian Institute for Psychotherapy Research (WAIPR) is a programme established late in 1997 to provide the community with such a resource. It is staffed by Psychiatrists, a Social Worker and primarily by Clinical Psychologists, with the Research Director being a Senior Clinical Psychologist. This initiative illustrates how the profession of Clinical Psychology applies its research and clinical skills in a practical way within the public sector. The main aim of WAIPR is provide excellence in the clinical management of adult psychiatric disorders within the public mental health service. It achieves this responsibility with its own within house programme of clinically oriented research and the research it is conducting with other institutions , such as the Department of Psychology at the University of Western Australia and the Department of Psychiatry at the University of Western Australia. It also achieves this in collaboration with other public sector mental health programmes.

Another area of increased responsibility within Clinical Psychology is in the role of teaching and informing other professions of evidence-based development in treatment for mental health disorders. Clinical Psychologists have a growing role in providing education and training to professionals including Medical Officers, Psychiatric Registrars, Mental Health Nurses and Social Workers. Areas in which Clinical Psychologists frequently contribute in this way include responding to suicidal and chronically self-harming individuals, and psychological treatment of depression, anxiety, social phobia, obsessive-compulsive disorder, eating disorders and substance use disorders. With the recent of the application of psychological therapies to disorders in the psychotic spectrum as well as the treatment of other mental health problems comorbid with these disorders Clinical Psychologists are called upon to provide workshops and seminars in these areas.

Clinical Psychology has also been the profession which had had the greatest

development of a number of new and innovative services and approaches to service delivery. Two recent developments have occurred in the areas of youth mental health and neuropsychological predictive testing. The development of YouthLink for example has been informed and driven almost entirely by Clinical Psychology, particularly in the development of the style of service delivery which has been targeted to improve access to services for the most marginalised and at-risk young people. These young people have in the past been very poor users of more ‘traditional’ mental health services, in spite of their often extremely high rates of mental health problems, particularly suicidal and self-harming behaviour, substance use disorders and emerging personality disorders.

An area in which Clinical Psychology is currently at the forefront in developing improvement in treatments and service delivery is Aboriginal mental health. The training of Clinical Psychologists equips them with the skills to collaborate with Aboriginal people to research and develop more culturally affirmative. An example of this has been the Aboriginal Community Development and Liaison project at YouthLink, which through collaboration with Aboriginal agencies, workers and communities, has led to changes in service delivery to Aboriginal young people, and has resulted in increased utilisation of this youth-specific mental health service by this group.

Clinical Psychologists are especially well trained to provide expert skills to mental health services in terms of quality improvement, evaluation and accountability because as a profession they bring with dual domains of necessary skills; clinical acumen and empirical and statistical training. Given the escalating pressure on funding bodies to provide financial support to a range of health care providers it has been necessary to increase the focus on health care outcomes and improved quality of care. In recent time there has been a trend towards greater accountability in health services, and a greater interest in evidence supported approaches to health care. Clinical Psychologists bring a number of skills to the process of evaluating mental health programmes including knowledge of clinical assessments and interventions, understanding of research methodology and analysis. Clinical Psychologist engage in the following continual improvement activities:

- ❖ **Assessment of the relevant population health demands and supply (consumers and service providers)**

- ❖ **Assessment of the needs/expectations of the relevant stakeholders**
- ❖ **The evaluation of existing health care practices and the identification of information/data gaps**
- ❖ **Identification of useful and appropriate clinical indicators and outcomes (for consumers and service providers)**
- ❖ **Development of a framework to ensure that the continual improvement process is maintained**
- ❖ **Development of service evaluation framework**

Clinical Psychology: Legal Accountability

The level of responsibility and the impact of the decisions made by Clinical Psychologists are highlighted in the following. Current legal opinion, outlined below, advises that the employers of Health Sector Clinical Psychologists, especially Clinical Psychology Registrars, are legally vulnerable to civil action regarding claims of professional incompetence by disgruntled patients. Employers are advised that one probable consequence of the exodus of Senior Clinical Psychologists, and Clinical Psychologists who can supervise registrars is significant vulnerability to such a claim. Unless retention issues are addressed, employers will need to factor these costs into their operating budgets each year.

“ 3. The Nature of Supervision

The (Psychologist) Board (of Western Australia) considers that effective supervision involved:

....

- 1.6 Accepting legal responsibility for areas of work where a provisionally registered (Clinical) Psychologist is not yet competent or responsible

In circumstances where the supervisee acts negligently (which necessarily embraces incompetence) any loss or damage suffered by a client as a result will undoubtedly lead to action being brought in the first instance against the supervisee. It would then undoubtedly be argued that the employer of the supervisee is vicariously responsible for the acts of the supervisee. In a general sense, therefore,

that would lead to the employer also being the subject of the claim.”

Recruitment and Retention of Senior Clinical Psychologists: A Major Issue

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Clinical Psychology: Distinction from other Allied Health Professionals

Clinical Psychologists are often grouped with “allied health” for administrative purposes and this has led to a mistaken belief that there is sufficient commonality between this profession and other allied health professions to treat all groups similarly. Clinical Psychologists differ markedly from other allied health professions.

The training of Clinical Psychologists differs in many ways from other allied health professionals. During the minimum of eight years of training, the emphasis of Clinical Psychology is on severe mental health problems. Clinical Psychologists have extensive training in the theoretical and conceptual understanding of mental health problems, the correct diagnosis and clinical evaluation of these problems and on effective management and treatment. The training of allied health professions is geared towards general medical, general health or general community problems, with a short elective in mental health.

No other allied mental health professional receives as high a degree of education and training in mental health as the Clinical Psychologist. Other than psychiatry, Clinical Psychology is the only mental health profession whose complete post-graduate training is in the area of mental health.

Clinical Psychologists are trained as scientist-practitioners. This added emphasis on the scientific in university training enables the profession of Clinical

empiricism to human service delivery and thus increase accountability. The formal scientific training of Clinical Psychologists does not make research the end in itself, but is applied to the delivery of psychological services and to contribute to the knowledge upon which mental health services are based. Empirical training equips the Clinical Psychologist with the skills to understand and contribute to new research, evaluate interventions and apply these empirical skills to their own treatment of patients and that of the mental health services themselves. This formal training also carries with it the obligation to provide to the betterment of the wider society within which the Clinical Psychologist works.

Clinical Psychologists have a minimum of six years full time university training with two additional years of mandatory professional supervision under the auspices of The Psychologists Board of Western Australia (the State registration authority). Within the last few years more and more students are completing either a Doctorate of Psychology with an additional formal year of training at the university, or a PhD in Clinical Psychology and thus adding a further two years to their formal university training.

As a result of their training, Clinical Psychologists have a thorough understanding of varied and complex psychological theories and have the ability to formulate and respond to both complex disorders and to novel problems, generating interventions based on this solid knowledge base. This very high level of specialist competence of Clinical Psychologists is acknowledged by all private insurance companies who recognise Clinical Psychologists as providers of mental health services.

Post-graduate university level training programmes for Clinical Psychology must be accredited by the Australian Psychological Society. This requirement insures uniform standards of excellence in Clinical Psychology training throughout Australia. Once the graduate has completed an accredited programme of studies, s/he must register with The Psychologists Board of Western Australia to undertake a further two years of additional clinical work in supervision. When the individual has completed this period of supervised practice, and only when this has

Psychologists Board of Western Australia, is the individual accredited with the specialist title, “Clinical Psychologist”. To further ensure quality of care, it is a mandatory requirement of the Australian Psychological Society and The Psychologists Board of Western Australia that all Clinical Psychologists adopt the ethical code of professional standards of conduct.

Clinical Psychologists are senior staff in the health system with a high degree of professionalism and expertise in the mental health area. Clinical Psychologists have specialist psychological training relevant to the treatment of mental health patients and are able to take a senior role in organisational activities. Clinical Psychologists are key service providers in mental health service delivery. Independent inquiries such as the Human Rights and Equal Opportunity Commission (1993) in Australia and the N.H.S. review in Britain (1989), have found that mental health care systems need to make greater use of the distinctive skills and services of Clinical Psychology. In Britain the mental health system has already begun to implement the wider use of Clinical Psychologists and this is reflected in major restructuring of their classifications and remuneration.

The findings of the Human Rights and Equal Opportunity Commission of 1993 (the Burdekin Commission) with respect to Clinical Psychology were also clear cut. The Commission (pages 178-182), found that Clinical Psychologists have distinctive skills which differ from those of other types of psychologists and differ from those of other allied health professions. Further, it stated that Clinical Psychology services are currently under-resourced and under-utilised in the Australian mental health care system. Burdekin considered that this represented a failure to provide significant treatment options.

Increases in Work Value: Clinical Psychology

Advances in Specific Areas of Work Value

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Key Competence Areas of Clinical Psychology: Summary of Breadth of Activities

Diagnosis, Clinical Evaluation and Assessment

Clinical Psychologists are trained to conduct thorough assessment, clinical evaluation and diagnosis of individuals with complex mental health problems. The breadth and thoroughness of psychological assessment is encompassed in the psychobiosocial model of human behaviour. This model is central to the comprehensive understanding of the total person whereby behaviours, emotions, cognitions, social context and biology aggregate together. Clinical Psychologist assess across these parameters and from these, derive hypotheses of functioning that lead directly to treatment, empirical validation by continual psychological evaluation and accountability.

Clinical Psychologists and Neuropsychologists use state-of-the-art diagnostic tools that can establish the presence of brain damage, brain disease or developmental abnormality which have usually been designed and developed by Clinical Psychologists. Increasingly, physicians and other health care professionals turn to Clinical Psychologists for their diagnostic capabilities. They can identify the specific

assess the prognosis for improvement or deterioration in functioning. Clinical Psychologists and Neuropsychologists then apply these results toward the development of rehabilitative services for patients, working to assist the patient in becoming as functionally independent as possible and providing treatment recommendations to facilitate the greatest recovery of neuropsychological functioning.

Clinical Psychologists provide quantitative personality assessment of persons in whom diagnostic signs and management indications are complex or masked. As a result of the solid psychodiagnostic training of Clinical Psychologists, they make a major contribution to the development of screening and diagnostic instruments that evaluate mental health status. These instruments allow a deeper and more valuable understanding of an individual's mental disorder and directly impacts on treatment. Psychologists are the only profession trained and accredited in the use of psychometric assessment.

Clinical Psychologists assume key responsibility in the treatment of complex cases seen in psychiatric clinics. This carries with it advanced levels of clinical skill in highly evolved expertise in diagnostic clinical evaluation, neuropsychological and psychodiagnostic assessment, and comprehensive functional analyses. This work with very complex cases takes more time and needs more intense focus and better skills to disentangle the factors precipitating and maintaining the disorder. Because of the Clinical Psychologist's training in psychometrics s/he is in the best position to evaluate the constant array of new tests and inventories being developed for use in mental health services.

Clinical Psychologists understand the systems approach to assessment. There are situations in clinical practice whereby treatment of the identified patient only, may not be the most useful intervention. Clinical Psychologists provide thorough assessment of family systems, school settings, institutional and communities environments.

Psychological Treatments:

Clinical Psychologists provide valuable and effective psychotherapy services for the full range of mental disorders. These are detailed in Section Eight.

Psychological therapies offer individuals a treatment approach that in many cases is equally, if not more, effective than drug therapies. Such interventions are effective in treating a range of mental and physical disorders.

Psychotherapy treatments are known to be effective in reducing factors contributing to illness and in enhancing coping strategies and healthy behaviours. Psychotherapy can help people control high blood pressure and manage chronic pain or headaches. These treatments can help people change habits to reduce their risks for cardiovascular disease, cancer and HIV. Breast cancer patients who participate in group psychotherapy are known to survive longer than those who do not. Diabetic adolescents can be helped to maintain the discipline of diet and insulin treatments through psychotherapy.

The role of Clinical Psychologists is to provide specialist psychological interventions which speed recovery and reduce re-admissions in patients with severe mental health problems by developing their cognitive, emotional, behavioural, and relationship skills.

Alternatives to drug therapies are particularly valuable to elderly populations, who are often suffering from over-medication and the numerous side effects of various drugs and drug interactions.

Clinical Psychologists through their specialised skills in functional analysis have long recognised the importance of co-morbidity in the exacerbation and persistence of mental health deficits, and are trained to devise treatment regimens that take such key factors into account.

Clinical Psychologist design and implement rehabilitation programmes for persons with chronic forms of severe disorders. Clinical Psychologists can provide psychological treatments to improve personality development and integration in long term patients. With increased resources the scope of this work would be widened, reducing the pressures that lead to frequent re-admissions.

Clinical Psychologists are widely involved in the design of rehabilitation programmes in their own departments and also as consultants to other government agencies.

Clinical Psychologists design and implement programmes for relapse prevention.

Apply their skills with individuals, families, communities and organisations. Often they work with nurses on the ward and with other professions a systemic fashion to implement interventions. Apply their skills in these traditional areas to state wide services

Research, Accountability and Evaluation

The increased demand by the current culture of accountability in mental health service provision has generated greater demand for skills of Clinical Psychologists in the areas of programme development, evaluation and quality improvement. A strong emphasis on scientific training is fundamental in post-graduate Clinical Psychology programmes, and as a result of this, Clinical Psychologists bring to the employer the benefit of strong analytic, research and conceptual skills. Clinical Psychologist's outputs and outcomes are usually clearly articulated.

Clinical Psychology has provided a well recognised contribution to the global movement towards evidence-supported health care. This actually represents a significant shift from one mode of clinical reasoning, based on intuition, clinical experience and theoretical pathophysiology, to a second mode based on empirical evidence of efficacy (McGorry, Curry, & Elkins. 1997).

In the area of mental health there are still large gaps in knowledge about disorders and the best available evidence to guide treatment of the many people suffering from severe mental health disorders. Clinical Psychologists are prominently seen working in the development of clinical practice guidelines and manuals specifically guiding psychological procedures.

Innovations in Specific Areas of Work Value

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**Recruitment and Retention: Entire Profession of Clinical
Psychology.**

***REMOVED DUE TO ATTACHMENT SIZE LIMITS IN
APS BULK E-MAILS***

What is Clinical Psychology?

What is Clinical Psychology?

Although often grouped with Allied Health for administrative purposes, Clinical Psychologists differ in many ways from other Allied Health professionals. No other allied mental health professional receives as high a degree of education and training in mental health as the Clinical Psychologist. Other than psychiatry, Clinical Psychology is the only mental health profession whose complete post-graduate training is in the area of mental health. Furthermore, it is the only discipline whose complete training is in psychology, i.e. both undergraduate and post-graduate. In other words, the Clinical Psychologist is completely trained in a science intrinsic to mental health.

Psychology is a scientific discipline and as such represents a very large body of accumulated, validated knowledge constantly being updated and when necessary, revised. From this academic discipline has developed a number of specialist sub-disciplines, such as Clinical Psychology. Clinical Psychology then, is a speciality of psychology and may be defined as the application of the principles and procedures of psychology to mental health care.

Clinical Psychologists are trained as “Scientist Practitioners” in recognition of the very strong links with the academic and scientific discipline of psychology. They are professionals who:

- ❖ are trained in scientific research and statistical analysis

- ❖ are trained in a scientist-practitioner approach to changing human behaviour and thereby use techniques with proven scientific effectiveness

- ❖ have a thorough understanding of varied and complex psychological theories and have the ability to formulate and respond to both complex disorders and to novel problems, generating interventions based on this solid knowledge base
- ❖ apply their knowledge and skills to children, adolescents, youth, adults and the elderly at the individual, family group, system and community levels
- ❖ are skilled in the use of psychological tests, behavioural observations and clinical and diagnostic interviewing. These skills are used to assess psychiatric disorders, specific aptitudes and cognitive deficits, personality, social functioning, adaptive behaviours and psychological issues pertaining to physical illnesses.
- ❖ are acknowledged experts in personality assessment
- ❖ have expert skills in piecing together the complex relationships between biological, social and psychological systems and transforming this analysis into effective treatments
- ❖ embrace the therapist-patient relationship as central to the effectiveness of all interventions together with the techniques of the various psychological therapies
- ❖ act as consultants and so work with and through others to bring about change of the individual, group, family, hospital or agency settings
- ❖ supervise the Clinical Psychologists in training programmes whilst on field placements (an essential component of university training) and Clinical Psychologist registrars (graduates in their first two years in the field)
- ❖ contribute to the teaching and education of other health care professionals such as psychiatric registrars, nurses, general practitioners, social workers and occupational therapists.
- ❖ are skilled in conducting research, planning service delivery systems, performing accurate evaluation, deciding on clinical indicators and implementing systems of accountability.

- ❖ through their close professional relationship with their patients, are uniquely able to assess, respect and enhance quality-of-life choices for each individual patient

**Clinical Psychology:
Training, Qualifications and
Professional Standards**

Clinical Psychology: Training, Qualifications and Professional Standards

Clinical Psychologists specialise in the prevention, diagnosis and treatment of serious physical and mental health problems to help people use their resources as effectively as possible.

Clinical Psychologists are required by law to be registered with The Psychologists Board of Western Australia before they can practice in this state.

The minimum requirement for a person to be registered as a Clinical Psychologist in WA is eight years of training, including six years of this at a recognised, accredited university programme. The person must then complete two years supervised practice as a Clinical Psychology Registrar. These six years of university training and two years of clinical practice under supervision, eight years in total, equips practitioners with the necessary skills applicable to the main areas of health service practice: assessment, treatment, research, accountability, evaluation, education and neuropsychological evaluation.

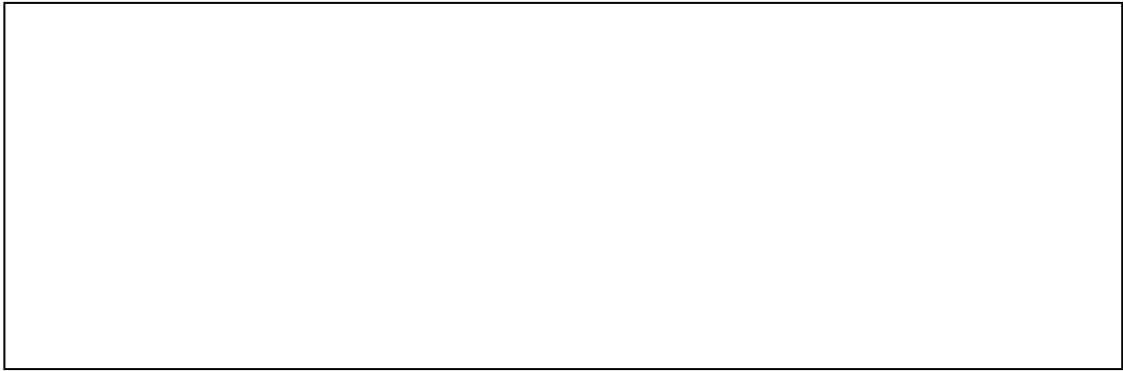
The University of Western Australia and Murdoch University have recently introduced a PhD in Clinical Psychology, thus extending the period of academic training for those persons interested in this path to the profession. It is expected that this will become the predominant degree within a short period of time and bears witness to the added need for training to suit the added work value of Clinical Psychologists.

Clinical Psychologists subscribe to, and are bound by, the Australian Psychological Society Code of Professional Practice that is endorsed by The Psychologists Board of

the conduct of Clinical Psychologists through its legal responsibility to protect the public. It disciplines psychologists found guilty of unprofessional conduct. In addition, public sector psychologists are expected to adhere to the Public Sector Psychologists Professional Practice Guidelines.

Therefore, the Act and Codes governing professional conduct are a powerful method of ensuring accountability for services and are complementary to practitioners' responsibilities to Health Department employers.

Clinical Psychology: Industrial History



Industrial History

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Psychologists / Clinical Psychologist

HSOA TABLE C6 SERVICE AS AT 9/10/89	HSOA BROADBANDING 10/10/89 BROADBANDING 10/10/89 PLUS 3%	PUBLIC			
Psychologis	26,483	L 3/5	25,103	L 2/4	25,103
t	28,177		26,498		26,498
Level 1	29,952		28,199		28,012
	31,779		29,976		29,904
	32,729		32,838		32,838
	34,623		34,750		34,750

NOTE: Four year qualification commences at the second year increment of Level 3/5.

Psychologist	35,561	L6	36,618	L5	36,618
t	36,513		38,005		37,882
Level 2	37,452		39,976		39,193
	38,458				40,554
	39,461				

Clinical

Psychologist	35,561	36,618	L6	L5	36,618
t	36,513	38,005			37,882
Level 1	37,452	39,976			39,193
					40,554

Clinical

Psychologist	39,461	L7	41,029	L6	42,743
t	40,531		42,365		44,231
Level 2	42,680		43,749		
	43,749				

Senior	45,370	L8	45,771		45,771
Clinical			47,429		47,416
Psychologist					
t					

Level 3

CONVERSION is on a point to point basis as follows:-

**C6 TABLE 9/10/89
10/10/89**

HSOA BROADBANDING

C6 1 Psychologist	Level 3/5
C6 2 Psychologist	Level 6
C6 1 Clinical Psychologist	Level 6
C6 2 Clinical Psychologist	Level 7
C6 3 Clinical Psychologist	Level 8

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APS BULK E-MAILS***

Current Grades and Rates of
Pay / Claim

The salary structure claim for Clinical Psychologists will provide recognition for clinical practise.

***REMOVED DUE TO ATTACHMENT SIZE LIMITS IN
APS BULK E-MAILS***

The criteria currently existing are as follows:-

CLINICAL PSYCHOLOGIST (REGISTRAR)

LEVEL 6 (6.1, 6.2)

CHARACTERISTICS

This level applies to the newly qualified Clinical Psychologist who is initially inexperienced in the practice of the profession but who is immediately capable of providing a clinical psychology service.

Under the professional supervision of a more senior Clinical Psychologist, the Clinical Psychologist exercises independent judgement concerning the selection and application of established principles, methods and techniques commensurate with professional development and experience.

ACADEMIC REQUIREMENTS

The Officer must possess an approved Master of Clinical Psychology or an approved equivalent qualification and eligibility for registration with the Psychologists Board of Western Australia as a Psychologist. *

GENERAL FEATURES OF DUTIES

1. Undertakes psychological assessments and interventions with clients and systems in accordance with psychological principles.
2. Provides advice to colleagues in multi-disciplinary teams as requested.
3. Undertakes approved research and evaluation.
4. Contributions to disciplinary and multi-disciplinary service teams.
5. Receives supervision and undertakes such duties as are necessary for achieving registration with the Psychologists Board of Western Australia as a Clinical Psychologist.

* Registration procedures must be completed on appointment.

CLINICAL PSYCHOLOGIST

LEVEL 6 (6.3)

CHARACTERISTICS

This level applies to the newly qualified Clinical Psychologist with at least 2 years supervised experience in the practice of the profession who is capable of providing a clinical psychology service.

Under the professional supervision of a more senior Clinical Psychologist, the Clinical Psychologist exercises independent judgement concerning the selection and application of established principles, methods and techniques commensurate with professional development and experience.

ACADEMIC REQUIREMENTS

The Officer must possess an approved Master of Clinical Psychology or an approved equivalent qualification and eligibility for registration with the Psychologists Board of Western Australia as a Clinical Psychologist. *

GENERAL FEATURES OF DUTIES

1. Undertakes psychological assessments and interventions with clients and systems in accordance with psychological principles.
2. Provides advice to colleagues in multi-disciplinary teams as requested.
3. Undertakes approved research and evaluation.
4. Contributes to disciplinary and multi-disciplinary service teams.

* Registration procedures must be completed on appointment.

SENIOR CLINICAL PSYCHOLOGIST

LEVEL 7/8

CHARACTERISTICS

This level provides for the proficient Clinical Psychologist who has a thorough knowledge of the methods, principles and practices of the profession.

Under general to limited direction the officer has an ability to practise psychology with a high degree of initiative and depth of experience.

ACADEMIC REQUIREMENTS

The officer must possess an approved Master of Clinical Psychology or an approved equivalent qualification and eligibility for registration with the Psychologists Board of Western Australia as a Clinical Psychologist. *

GENERAL FEATURES OF DUTIES

1. Provides specialist consultant advice.
2. Organises and undertakes a range of psychological assessments and interventions with individuals and systems.
3. Develops and undertakes research of a clinical, applied and evaluative nature.
4. Contributes to the provision of staff training and development.
5. Co-ordinates professional colleagues as required.

6. Contributes to policy development and to single and multi-disciplinary service and planning teams.

* Registration procedures must be completed upon appointment.

**Proposed
New Career Structure**

The previously described criteria were last amended in 1993. The Clinical Psychologists claim seeks to introduce expanded criteria that recognises properly the value of clinical practice. The criteria was developed after extensive consultation within the Clinical Psychology profession. The proposed criteria is as follows:-

CLINICAL PSYCHOLOGIST REGISTRAR - GRADE 1

CHARACTERISTICS

This level provides for the newly qualified Clinical Psychologist Registrar who is initially inexperienced in the practice of the profession but who is immediately capable of providing a clinical psychology service.

Under the approved professional supervision of a more senior Clinical Psychologist, the Clinical Psychologist Registrar exercises independent judgement concerning the selection and application of established principles, methods and techniques commensurate with professional development and experience.

ACADEMIC REQUIREMENTS

The officer must possess an approved Masters degree in Clinical Psychology, or an approved equivalent qualification, eligibility for registration with the Psychologists' Board of Western Australia as a Psychologist and be in approved supervision for the specialist title "Clinical Psychologist". *

GENERAL FEATURES OF DUTIES

1. Undertakes psychological assessment and intervention with individuals and systems in accordance with psychological principles.

2. Provides advice to multi-disciplinary service teams as requested.
3. Undertakes approved research and evaluation.
4. Contributes to disciplinary and multi-disciplinary service teams.
5. Receives supervision and undertakes such duties as are necessary for achieving registration with the Psychologists' Board of Western Australia as a Clinical Psychologist.

* Registration procedures must be completed on appointment.

CLINICAL PSYCHOLOGIST - GRADE 2

CHARACTERISTICS

This level provides for the Clinical Psychologist who has a thorough knowledge of the methods, principles and practices of the profession.

Under the general to limited direction the officer has an ability to practice psychology with a high degree of initiative and depth of experience.

ACADEMIC REQUIREMENTS

Approved Masters degree in Clinical Psychology or approved equivalent qualification and eligibility for registration with the Psychologists' Board of Western Australia with the specialist title "Clinical Psychologist".

GENERAL FEATURES OF DUTIES

1. Organises and undertakes psychological assessment and intervention with individuals and systems.
2. Provides consultant advice to multi-disciplinary service teams.

3. Undertakes programme development, evaluation and research.
 4. Provides advice on issues and policy within the employing agency.
 5. Contributes to staff development and training.
- * Registration procedures must be completed on appointment.

SENIOR CLINICAL PSYCHOLOGIST - GRADE 3

CHARACTERISTICS

This level provides for the Clinical Psychologist recognised as an expert in a major area of professional practice.

At this level the Clinical Psychologist is considered to be independent and work would not normally be reviewed on matter of professional judgement.

The individual would be expected to maintain his/her professional development at an advanced level in an area relevant to his/her specialist area.

ACADEMIC REQUIREMENTS

Approved Masters degree in Clinical Psychology or an approved equivalent qualification and eligibility for registration with the Psychologists' Board of Western Australia with the specialist title "Clinical Psychologist".

GENERAL FEATURES OF DUTIES

1. Organises and undertakes psychological assessment and intervention with individuals and systems in relation to complex issues requiring expert knowledge.
 2. Provides expert consultation.
 3. Undertakes programme development, evaluation and research.
 4. Provides advice on issues and policy within the employing agency.
 5. Contributes, at an advanced level to the training of Clinical Psychologists and other professionals.
- * Registration procedures must be completed on appointment.

SENIOR CLINICAL PSYCHOLOGIST - GRADE 4

CHARACTERISTICS

This level provides for the Clinical Psychologist, recognised as an authority in a major field of clinical psychology practice in Western Australia.

At this level the Clinical Psychologist would work independently, initiate significant contribution to clinical practice and act as a expert consultant at advanced level.

Professional standing would be demonstrated by contribution to clinical practice, completion of research or training projects, departmental reports or publication of papers assessed as contributing significantly to the development of psychological practice.

ACADEMIC REQUIREMENTS

Approved Masters degree in Clinical Psychology or approved equivalent qualification and eligibility for registration with the Psychologists' Board of Western Australia with the specialist title "Clinical Psychologist".

GENERAL FEATURES OF DUTIES

1. Initiates, organises and undertakes psychological assessment, interventions, projects and programmes requiring the highest levels of experience, judgement and competence with individuals and organisational systems.
 2. Provides expert consultation as an authority in the specialist area.
 3. Develops and co-ordinates significantly to clinical practice and/or research and evaluation.
 4. Provides highly expert advice on issues and policy across the public sector.
 5. Initiates, organises and provides high level education and training programmes to address current needs of psychological practice within the public sector.
- * Registration procedures must be completed on appointment.

CONSULTANT CLINICAL PSYCHOLOGIST - GRADE 5

CHARACTERISTICS

This level provides for the Clinical Psychologist recognised as an authority in a specialist area of clinical psychology practice in Western Australia.

At this level the Clinical Psychologist would take responsibility for clinical practice in a specialist area and/or research and act as an expert consultant at a highly specialist level.

Professional standing would be demonstrated by significant contribution to psychological practice, initiation of research or teaching projects and/or contribution to professional policy and practice.

The Clinical Psychologist would offer professional leadership in the specialist area.

ACADEMIC REQUIREMENTS.

Approved Masters degree in Clinical Psychology or approved equivalent qualification and eligibility for registration with the Psychologists' Board of Western Australia with the specialist title "Clinical Psychologist".

GENERAL FEATURES OF DUTIES

1. Provides leadership and highly expert advice regarding Clinical Psychology services in the specialist area in Western Australia.
2. Provides expert consultation regarding the application of clinical psychological practice to health service providers in Western Australia.
3. Directs significant programmes of clinical practice and/or research.

4. Contributes to health services policy development.

* Registration procedures must be completed on appointment.

Note: Progression from Clinical Psychologist Registrar - Grade 1 to Clinical Psychologist - Grade 2, shall be automatic on achieving the Academic requirements for Clinical Psychologist - Grade 2.

Progression from Grades 2,3 and 4 shall be subject to and in accordance with, guidelines agreed between the Union and the Employer, from time to time.

**INCREASED WORK VALUE:
ADVANCES,
EVIDENCE SUPPORTED
APPLICATIONS
AND INNOVATIONS**

***REMOVED FOR CLINICAL COLLEGE E-MAIL
DUE TO ATTACHMENT SIZE LIMITS***

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List of Contributors

Bright, Carolyn	Griffiths, Jenny (<i>Negotiating Committee</i>)
Christophers, Rob (<i>Negotiating Committee</i>)	Hart, Trish
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Fruin, Donna (Dr.)	Lucking, Sue
	Malgrem, Senia

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Moorcroft, David	Williams, Sandy
Morris, Eric	Wilmoth, Deborah
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O'Donnell, Meaghan	
Philp, Ros	
Preece, Minnette	
Putz, Gail	
Rees, Clare (Dr.)	
Roberts, Claire (Dr.)	
Rule, Trevor	

Appendices

Can be provided on request
