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

CONTENTS-

1. Increased Work Value: Overview

1.1	Introduction	6
1.2	Prevalence of Mental Health Problems	7
1.3	Demand for Clinical Psychology Skills	12
1.4	Effectiveness of Treatment by Clinical Psychologists	13
1.5	Work Value Case for Clinical Psychology: In Summary	16
1.6	Responsibility and Impact of Clinical Psychology	17
1.7	Recruitment and Retention of Senior Clinical Psychologists: A major issue	22
1.8	Clinical Psychology: Distinct from other Allied Health Professionals	23
1.9	Increases in Work Value	25
1.10	Innovations in Specific Areas of Work Value	29
1.11	Recruitment and Retention: Entire Profession of Clinical Psychologists	32
	a. Report of the Ministerial Taskforce on Mental Health; March 1996	32
	b. Making a Commitment: The Mental Health Plan for Western Australia, 1996	34
1.12	Suggestions for change	36

2. What is Clinical Psychology? 37

3. Clinical Psychology: Training, Qualifications and Professional Standards 40

4. Industrial History of Clinical Psychology 42

5. Current Grades and Pay 49
5.1 Clinical Psychologist registrar 51
5.2 Clinical Psychologist 52
5.3 Senior Clinical Psychologist 53

6. Proposed New Structure 54

7. Increased Work Value: Advances, Evidence Supported Applications and Innovations 61
7.1 neuropsychology services 62
7.2 child, adolescent, youth and family mental health services 71
7.3 adult mental health services 88
7.4 remote and rural mental health 120
7.5 mental health problems in medical conditions 123

8. References 146

9. Contributors 162

10. Appendices 164

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 data was further described in terms of 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, Saettoni, 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 schizophrenia, schizoaffective disorder 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 or 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 and 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 by the managers of mental health 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 (IHSHY) 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 approaches to such problems as suicidal 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 especially trained and skilled in the use 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 knowledge and provides the data for the 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 role and responsibility in the 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 an 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

Effective psychological therapies are available for severe mental health problems (see section 7) and consumers and mental health service providers recognise the usefulness of Clinical Psychologists as an integral part of mental health care. Yet there is a major depletion of senior Clinical Psychologists in the workforce of the Health Department of Western Australia. This problem was recognised in the State Mental Health Plan (1996) and the Ministerial Taskforce (1996). Where senior positions are unfilled these are often occupied on a temporary basis by Clinical Psychology Registrars, in their first 2 years post qualification. This results in mental health service deplete of experienced staff and presents difficulties in providing adequate supervision and monitoring of standards of practice due to the lack of available senior staff.

In October 1996 the Clinical Psychology Taskforce reported on the results of a survey of the clinical psychology profession (60% of all Clinical Psychologists responded to the survey). 44% of the respondents reported that they were looking for alternative employment. Another 22% reported that they were uncertain how long they would be able to continue working in the HDWA. Finally, the respondents indicated that they were keen to, and would extend their commitment to the Health Department if salary and career issues were addressed.

The seriousness of this position is attested to by the following figures. In the three years prior to December 1994, 15 Senior Clinical Psychologists left the mental health service of the HDWA. From December 1994 to August 1996, 25 Senior Clinical Psychologists have left the mental health service of the HDWA.

The latest results from a survey conducted by the Mental Health Division in April 1998 attests to a crisis within the Clinical Psychology taskforce of the Health Department of Western Australia (HDWA). The survey noted an overall increase in the Clinical Psychology FTE positions due to the growth in mental health services, but most of the incumbents to these new positions have been at Clinical Psychology registrar levels. Furthermore, an investigation of the ratio of senior Clinical Psychologists to other Clinical Psychologists shows a marked decline from 1.9 to 1 in 1997 to 0.7 to 1 in 1998.

Comparison of Clinical Psychologists salaries with those of Great Britain again show a huge discrepancy in parity. The salary range for a Grade A Clinical Psychologists in Great Britain is £14,977 - £32,818 and a Grade B Clinical Psychologist is £31,554 - £52,542.

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 <u>only</u> 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 Psychologist to bring research and 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 subsequently been accepted by The 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

Mental health is a rapidly growing field of knowledge. It is by its very nature dynamic, interactive and expanding. The training that Clinical Psychologists undertake at universities and the hands on continual knowledge and training they acquire and develop further in their practice advance the treatment effectiveness of their interventions in the public sector service. In every mental health condition Clinical Psychology has made advances in treatment in tandem with new knowledge about diagnosis, conceptualisation of disorders, mechanisms maintaining disorders, treatment, evaluation and accountability. The disorders in which Clinical Psychologists are most often involved are: major depression, dysthymia, melancholia, adjustment disorder, schizophrenia, bipolar affective disorder, other disorders in the psychotic spectrum, obsessive compulsive disorder, panic disorder, agoraphobia, social phobia, acute stress disorder, sexual abuse, domestic violence, post-traumatic stress disorder, generalised anxiety disorder, specific phobias, disruptive behaviour disorders and aggression, poor social skills, eating disorders, chronic mental illness and the full range of personality disorders. These are described in detail in section eight of this document.

The position of the Clinical Psychologist has developed since the late eighties has evidenced increased levels of independence in their work. The very complex cases being referred for treatment in the public sector has necessitated an increased level of expertise in diagnostic interviewing, neuropsychological and psychodiagnostic evaluation, decision making about suitability of type of treatment, the application of interventions, monitoring of progress and discharge planning and community follow-up. All these tasks have augmented the level of independent professional competence of Clinical Psychologists.

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 area or areas of cerebral dysfunction and assess the prognosis for improvement or deterioration in functioning. Clinical Psychologists and Neruopsychologists 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

Child, Adolescent and Youth

The past ten years have seen significant changes in the research regarding child development and psychopathology; better understanding of the incidence, prevalence and adult outcome of childhood disorders; information regarding specific effective intervention strategies for disorders; focus on comprehensive intervention strategies which use levels of increasing skill and complexity in intervention with the more serious disorders; a focus on the more serious and comorbid end of the intervention spectrum within community mental health clinics; an increased role for consultation and intervention in medical settings; increased roles in teaching, training, and the provision of advice. All of these have added to the change in work value for Clinical Psychologists in Child and Adolescent (C&A) HDWA settings.

The area of "youth" has been seen as an important area that is now differentiated from the broad category of adolescence because of its different developmental requirements and special psychological and social needs. Clinical Psychology has been the profession at the forefront of the development of youth specific mental health services in Western Australia. Prior to 1992 there was an absence of services that focussed specifically on the prevention of severe mental health problems in populations of young people (both adolescents and young adults) who could be regarded as the most highly at-risk, through homelessness and disconnection from family, education and employment structures.

Primarily through the work of Clinical Psychology, youth mental health services as a specialised field of service delivery has been developed and now, well established in Western Australia. YouthLink has also begun a programme of clinically oriented research together with the West Australian Institute for Psychotherapy Research (situated in the community section of the Inner City Mental Health Service at Royal Perth Hospital) to develop age appropriate treatments and intervention models for the YouthLink clientele.

Neuropsychology

Significant changes in the duties and responsibilities of Clinical Psychology at Neurosciences have occurred due to a number of innovative new progammes which have begun.

- The Clinical Psychology Co-ordinator of Neurosciences has responsibility for the management and co-ordination of the new State-wide Predictive Testing Program. This new service has resulted in an allocation of recurrent funds by the Mental Health Division and a significant increase in FTE. Predictive testing for neurological diseases is not available in any other centre in Western Australia.

- The management and co-ordination of a new clinic providing multi-disciplinary services (including psychiatry and neurology) to people under the age of 65 with dementia and related disorders. Services are provided within the context of a multi-disciplinary team consisting of Neurology, Clinical Psychology, Social Work and Speech Pathology input.

- The management and co-ordination of a new project involving the provision of clinical services on a quarterly basis for families affected by Huntington's Disease who live in the South West Region of the state.

Adults

Clinical Psychologists make a considerable contribution to the treatment of persons with severe mental health problems, both in the hospital context and in the community. Psychological assessment is a distinctive resource for planning and carrying out both immediate treatments and long-term management. In hospital and in community based programmes, Clinical Psychology offers specialist services to multidisciplinary teams and mental health service organisations, in addition to direct services to individual persons who require treatment. These specialist services differ distinctly from those provided by other types of psychologists or by other allied health professions. Recent innovations in mental health services are provided by Clinical Psychologists in the following areas which are described in detail in Section Seven.

- direct treatment of psychotic symptoms
- the management of bipolar affective disorder
- the treatment of mental health co-morbid problems of people with disorders in the psychotic spectrum
- identification and treatment of early psychosis and prevention of disease progression
- alternatives to treatment in large institutions
- treatment of eating disorders

- direct effective treatment of people with disabling personality disorders
- mental health problems in older persons
- service development for aboriginal populations and people of non-English speaking backgrounds
- services for people with mental health problems who live in remote areas
- clinically oriented research at the West Australian Institute of Psychotherapy Research (WAIPR)
- severe mental health problems in medical conditions

Mental Health Problems in Medical Conditions

Changing patterns of illness during the twentieth century have increased the role for Clinical Psychology in medical conditions. Infectious diseases have been replaced by physical disorders that need extended care and in which behavioural habits play an important role in their development and maintenance. For example, the behavioural markers implicated in cardiovascular disease include smoking, inadequate physical activity, dietary habits and behavioural style [anger and hostility] all play a major role in physical disorders. Chronic diseases, illnesses that develop, persist or recur over the long term implicate psychological factors as causes (e.g. mood disorders, behavioural and cognitive aspects of personality disorders). Complex mental health issues, requiring highly specialised empirically based treatments are common in medical conditions.

Clinical Psychologists in Western Australia have increased their and breadth of work and scope of influence in work value in innovative new areas in the following medical conditions which are described in detail in section seven.

- HIV/AIDS
- sexually transmissible diseases
- autoimmune diseases
- hepatitis C
- cardiovascular illness
- cancer
- chronic pain
- rehabilitative medicine
- burns
- alcohol and substance misuse
- psychogynaecology
- somataform disorders

Recruitment and Retention: Entire Profession of Clinical Psychology.

In both the State Mental Health Plan and the Ministerial Taskforce the need for recruitment and retention of a highly skilled Mental Health workforce was recognised and there were specific recommendations with respect to Clinical Psychologists.

The mental health services for children, adolescents and youth have a predominance of non-senior experienced Clinical Psychologists. In all mental health services a crisis exists in the availability of senior Clinical Psychologists to perform the close supervision of the many clinical psychology registrars employed in the health department. Many Senior Clinical Psychologists have been given special permission by The Psychologists Board of Western Australia to take on more registrars than recommended by the Board in order that high standard clinical services are provided. This in turn, means that Senior Clinical Psychologists are taken away from direct clinical work with patients.

The State Mental Health Plan and the Ministerial Taskforce recommendations are included verbatim at this point.

Report of the Ministerial Taskforce on Mental Health; March 1996.
(the following is a direct quote;pp. 226-228)

There is however a clear description of significant and progressive trends in shifts from the public service to the private sector. This will result in increasing difficulties in the provision of adequate numbers of senior Clinical Psychologists for service positions. A concerning and related factor is the cumulative loss of senior and experienced Clinical Psychologists from the public sector and the lack of involvement of private sector psychologists within public sector work. It will be increasingly difficult to provide satisfactory undergraduate contributions to training from clinicians in practice and most concerning, extreme difficulties in fulfilling the supervision and placement requirements by a supervisor who has at least two years experience as a registered Clinical Psychologist.

Considerations of contributing factors to the loss of senior Clinical Psychologists from the public sector will be examined by other committees of the Taskforce. The Training Committee has received submissions and has had a meeting with a representative group of

senior Clinical Psychologists who have outlined the major problems related to the loss of senior Clinical Psychologists from the public service sector. These factors include:-

- limited salary increments
- loss of career structures with the abolition of the senior psychologist position
- relative absence of clinical career structures where clinicians have both designated management and clinical roles
- absence of recognition of acquired specialist clinical skills with associated salary and position increments
- absence of right of private practice so that a mixture of public and private practice can be achieved and consequent involvement of private practitioners in sessional public service
- lack of support for Clinical Psychologists increasing the professional knowledge base by attendance at professional meetings and specialist courses. Required support would include direct financial support for registration fees and travel expenses and the allowance for professional time involved.

It has been noted that the requirements for Clinical Psychologists are specific and that allocation of funds to a generic "allied health" fund would not meet those requirements.

The rural and remote services are a particular instance where the above support is necessary to retain the skilled practitioner who continues to develop and focus on appropriate clinical standards.

It is suggested that there should be development of joint appointments between the academic institutions and the clinical settings, e.g. University/Health Department.

Submissions received by the Training Committee have noted deficiencies in the support for the clinical practicums undertaken by the postgraduate clinical psychology students at different mental health settings. Most frequently this is a lack of facilities designated for the use of the postgraduate psychology student undertaking supervised clinical work.

RECOMMENDATION

19. *Review the range of the career structure for Clinical Psychologists within the public service. Salary increments to recognise development specialised clinical skills.*

20. *Introduction of a senior Clinical Psychologist position within the public service with the role to co-ordinate and develop the role of Clinical Psychologists with particular emphasis on education and training.*

21. *Introduction of the right of private practice for Clinical Psychologists within the public service and for sessional work by private Clinical Psychologists within the public service.*

22. *Appointments of Clinical Psychologists who will have both managerial function and continuing clinical practice role.*

23. *Introduction of direct financial support and leave for Clinical Psychologists to attend professional meetings and specialised courses.*

24. *Support for Clinical Psychologists in rural and remote areas to attend professional meetings and specialist courses through the provision of financial support and leave. Such support should include the facilitation of attendance by exchanges of staff between metropolitan, rural and remote settings.*

25. *Development of joint appointments between the university (academic) and mental health service positions.*
26. *Review of facilities in mental health settings which would allow support for postgraduate Clinical Psychologist trainees who are involved in supervised clinical work.*

<u>Making a Commitment: The Mental Health Plan for Western Australia, 1996</u>
(the following is a direct quote; p 54)

The organisational changes which have taken place in the health system over the past 5 to 6 years have had a major impact on Clinical Psychology.

This is exemplified in the scrapping of the Principal and Assistant Principal positions in clinical psychology carried out during the process of regionalisation of the Health Department. The removal of this focus for professional leadership, policy development and career opportunities has had a profound effect on the morale of this profession.

The impact was particularly damaging for Clinical Psychologists who, unlike the other mental health professions, did not have separate, profession-based departments in the teaching hospitals.

The result of this lack of career structure and focus for the profession has meant that a significant and growing number of highly qualified and experienced Clinical Psychologists have left clinical positions.

Many have moved to management, policy and research areas across the public sector. A further 20% of experienced clinicians have left the public sector to enter private practice over the past three years. This is a considerable loss of expertise to public mental health services and has resulted in their skills being largely lost to those with serious, persistent mental disorders.

There is particularly severe shortage of experienced Clinical Psychologists in country areas, which will worsen if the trend to move out of public sector clinical work continues.

<u>Development Program for The Clinical Psychologist Workforce</u>

Strategies need to be urgently implemented to attract and retain experienced Clinical Psychologists.

These strategies must include the development of:

- a career structure which provides a senior focus for the profession and which recognises advance practitioner standing;
- mechanisms to provide a 'professional focus';
- competitive and flexible conditions of employment including:
- the right to private practice which will keep experienced clinicians within the public sector;
- attracting back experienced clinicians from the private sector on a part-time or sessional basis; encouraging experienced clinicians who are in management/policy/research positions to continue to provide direct clinical services for some part of their working time;
- opportunities for positions within mainstream health services to bring a broader perspective to mental health and enhance their career opportunities within the public sector;
- the creation of scholarships for advanced training; and
- the establishment of additional incentives such as joint university/mental health service appointments

SUGGESTIONS FOR CHANGE

- In order to continue to provide the high standard to care which the Western Australian community deserves, three issues must be addressed:
  - the need to retain in large numbers the experienced senior clinicians in the public sector
  - the need to recruit the best and most suitable Clinical Psychologists into the Health Department, including not only the best recent graduates but also to entice back the experienced Clinical Psychologists who have moved into private practice
  - the need to provide the work environment in which the skills of the Clinical Psychologist can work to the maximum effective benefit of the patient and the Mental Health Service.
- Critical to the addressing of these three issues is the salary structure for Clinical Psychologists. Under the current structure only three levels of Clinical Psychologist exist.
  - The Clinical Psychology Registrar, Level 6.1 & Level 6.2, who is working under the supervision Senior Clinical Psychologist.
  - The Clinical Psychologist Level 6.3
  - The Senior Clinical Psychologist, Level 7/8
- There is both no incentive for, nor recognition given to, Senior Clinical Psychologists for their high level of clinical skills. Currently, the only way a Clinical Psychologist can earn a higher salary is to leave clinical work and take on other management positions for which their training and psychological skills provide a very sound grounding.
- The current public sector career structure does not meet the needs of the clinician Clinical Psychologist, because higher level appointments disproportionately demand managerial skills above clinical skills.
- A career structure is needed that is expanded upward so that progression through the higher levels of the public sector levels are based on clinical expertise (see section 6 for specific suggestions)

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 Western Australia. The Board monitors 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

Introduction

A brief examination of the industrial history of Clinical Psychology reveals a number of factors relevant to this workvalue claim.

Up until recent times the number of Clinical Psychologist positions covered by the Hospital Salaried Officers Award No. 39 of 1968, were relatively few. By far the majority of Clinical Psychologists within the public sector were employed directly by the Health Department of Western Australia. i.e. Commissioner of Health.

As such these positions were covered under the Public Service Award. Nevertheless the salary structure of HSOA-covered Clinical Psychologists mirrored part of the Public Service structure.

Of most significance was the introduction of Broadbanding in the Public Service in November 1985. In this section the industrial history of Clinical Psychology will be examined pre and post Broadbanding.

Pre-Broadbanding - up to November, 1995

- Prior to Broadbanding the salary classifications for professional occupations in the Public Service were determined by the Public Service Board in accordance with the provisions of the Public Service Act.

- Determinations were generally made every three years with the occupants of positions then having the opportunity to appeal the classification determined for their position.

- The salary structure for Clinical Psychologists remained unchanged from at least the early 70's up until 1985.

- The last determination prior to Broadbanding was in 1982.

- A copy of the Public Service Notices Vol. 4 Nos. 15 and 18 containing the determination of 1982 and that for all other professions is included as *Appendix A*

- At that time the Clinical Psychology structure contained eight(8) levels. In comparison, the Therapy structure contained 5 levels and the Social Work Structure 7 levels. Clinical Psychologists had access to 4 levels based on clinical practice and expertise.

- A level 4 Clinical Psychologist was paid at a rate higher than the maximum rate (Level 5) for a Therapist.

- Clinical Psychology positions covered by the HSOA's Public Hospitals Award, at that time, had access to the then Level 3 (prior to Broadbanding) only, however, this was due to the relatively small number of positions.

- The pre-Broadband structure provided for each professional group to be separately assessed. Structures were developed that reflected the needs of each professional group.

- Whilst by no means perfect, the salary structure at least provided for some advancement based on clinical practice, as well as management responsibilities.

Broadbanding - 1985 and Beyond

With the introduction of Broadbanding in the Public Service in November 1985 the career structure for Clinical Psychologists was destroyed.

Levels 2,3 and 4 translated to Broadband Level 6. The Public Service Board initially pegged positions at various salary increments within the Level 6.

Following the appeals process and negotiations between public service employers and the Civil Service Association, full access to the Level 6 band was achieved. Copies of background information relating to this matter can be found at *Appendix B*

Whilst full access to Level 6 was achieved, submissions for criteria progression to Level 7 were not accepted. This resulted in essentially a two level structure with no recognition for advanced clinical practice.

In addition positions of Principal Clinical Psychologist, Level 8 and Assistant Principals, Level 7 were abolished in 1989. Consultant positions were retained but these in turn were "decentralised" in 1990-91. This has resulted in increased responsibility for policy development, professional advice, support and co-ordination falling to Level 6 positions. No proper recognition has ever been given to these additional responsibilities.

Broadbanding was adopted in the HSOA's Public Hospitals Award in October, 1989. The HSOA broadband structure differed from that in the Public Service. The following table shows the conversion arrangements and a comparison with the Public Service rates.

Psychologists / Clinical Psychologist

HSOA TABLE C6 AS AT 9/10/89 10/10/89 PLUS 3%		HSOA BROADBANDING 10/10/89		PUBLIC SERVICE BROADBANDING	
Psychologist	26,483	L 3/5	25,103	L 2/4	25,103
Level 1	28,177		26,498		26,498
	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
Level 2	36,513		38,005		37,882
	37,452		39,976		39,193
	38,458				40,554
	39,461				
Clinical					
Psychologist	35,561	36,618	L6	L5	36,618
Level 1	36,513	38,005			37,882
	37,452	39,976			39,193
					40,554

Clinical					
Psychologist	39,461	L7	41,029	L6	42,743
Level 2	40,531		42,365		44,231
	42,680		43,749		
	43,749				
Senior					
Clinical	45,370	L8	45,771		45,771
Psychologist			47,429		47,416
Level 3					

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

C6 TABLE 9/10/89	**HSOA BROADBANDING 10/10/89**
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

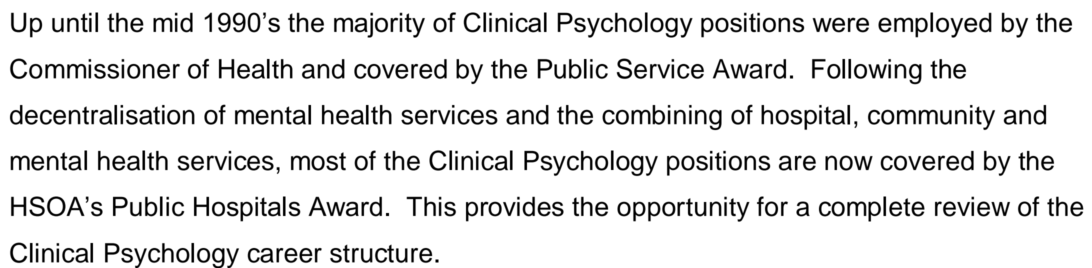
Extended negotiations between the HSOA and the HDWA resulted in the adoption of criteria progression for Clinical Psychologists in similar terms to that applying to public service positions. This was effective from 25th October, 1990. The criteria underwent minor amendment in 1993 to reflect further change in the public service. *Appendix C* contains copies of the correspondence confirming these arrangements.

It is important to note that in the years following the introduction of broadbanding quite specific issues relating to clinical psychology were pursued. These set it apart from other professional callings.

Further, it is argued that the issues regarding recognition of advanced specialisation were not adequately addressed during that time. This, coupled with the expanded role of clinical psychology, has been identified by both the State Mental Health Plan and Ministerial Taskforce, as leading to a crisis within the clinical psychology workforce. This crisis must be addressed by adoption of a new salary structure.

HOSPITAL AND HEALTH SERVICE INTEGRATION

Up until the mid 1990's the majority of Clinical Psychology positions were employed by the Commissioner of Health and covered by the Public Service Award. Following the decentralisation of mental health services and the combining of hospital, community and mental health services, most of the Clinical Psychology positions are now covered by the HSOA's Public Hospitals Award. This provides the opportunity for a complete review of the Clinical Psychology career structure.



Current Grades and Rates of Pay / Claim

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

A comparison of the current Award and Enterprise Bargaining rates with the rates claimed follows:-

EXISTING			**CLAIM**		
	AWARD	**EB**		**AWARD**	**EB**
LEVEL 6	40,433	44,414	GRADE 1	40,433	44,414
	41,897	46,060		43,977	48,400
	43,977	48,400			
			GRADE 2	47,961	52,880
LEVEL 7/8	45,090	49,651		50,096	55,280
	46,500	51,237		54,494	50,226
	47,961	52,880		58,353	64,566
	50,096	55,280			
	51,846	57,248	GRADE 3	61,597	68,214
				64,198	71,128
				66,823	74,091
			GRADE 4	70,436	78,154
				72,877	80,899
				75,661	84,029
			GRADE 5	79,871	88,764

Progression from Level 6 to Level 7/8 is by way of criteria progression.

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 experienced 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

Clinical Psychology

Neuropsychology Services

All CLINICAL PSYCHOLOGISTs have training in neuropsychological evaluation and continue their continual improvement in this area. The duties and responsibilities required by the position of Clinical Psychologist within the Mental Health sector are broad and of an extremely specialised nature. Clinical Psychologists working at this level have a wide range of influence and responsibility, and must exhibit a high degree of independence and initiative. Clinical Psychologists carry out the assessment of the functional neurological status of individuals and employ the essential tests to do this. The administration and interpretation of these tests can only be carried out by Clinical Psychologists and no other allied health profession. All Clinical Psychologists carry out such testing but the CLINICAL PSYCHOLOGISTs employed in the Neurosciences Unit and the Royal Perth Rehabilitation Hospital have advanced specialist expertise in this vital area of Clinical Psychology work practice. The following section outlines the bread and depth of work conducted by CLINICAL PSYCHOLOGISTs in their primary role in neuropsychology. The following section describes the Neurosciences Unit as an examplar of advanced work. The Unit is different from the work of Clinical Psychologists in the Mental Health Services of HDWA, because it provides a specialised, state-wide service for children, adults and elderly people. No other centre in WA or hospital departments are able to provide such a service, because of it's specialist nature. Referral problems are wide-ranging and complex, and require the integration of findings from clinical observation, background records, test results and the interview. Thus, diagnosis and intervention plans of new, complicated, varied problems are required to be formulated on a daily basis. The work of Royal Perth Rehabilitation Hospital is described in specific sections of chapter eight.

Nature and type of mental health activities

Clinical Psychologists in this setting are also required to fulfil a range of additional duties. The following list is an example of some of these, but is by no means exhaustive.

- Developing new assessment tools and protocols
- Coordinating referrals
- Monitoring standards

- Ensuring that quality assurance activities are monitored and objectively evaluated and that clinical indicators are attained
- Ensuring the responsiveness of services to consumer views and the appropriate involvements of consumers in quality assurance
- Working closely with non-government and private sectors, such as the Homes of Peace, Alzheimer's Disease Association and the Huntington's Disease Association (WA Branch)
- Coordinating and participating in Carer Support Groups (for relatives and friends of those who suffer from neurological diseases)
- Coordinating projects, such as a Memory Retraining Project
- Continuing neuropsychological assessment and sodium amytal testing for diagnostic purposes in relation to new surgical procedures for intractable epilepsy in children
- Provision of neuropsychological consultancy services to other professionals
- Coordinating professional development activities
- Supervising performance appraisals of all staff

Populations served by the service

There are currently five Clinical Psychologists at the Neurosciences Unit. They are responsible for providing state-wide services and diagnostic support to tertiary hospitals, secondary level public hospitals and community based facilities. In this context, they provide assessment to children, adults and elderly people with known or suspected brain impairment resulting from trauma, disease or genetic conditions, and intervention where appropriate. Psychologists at the unit also co-ordinate state-wide services for Huntington's Disease, Predictive Testing Programme for neurological diseases and other genetic disorders.

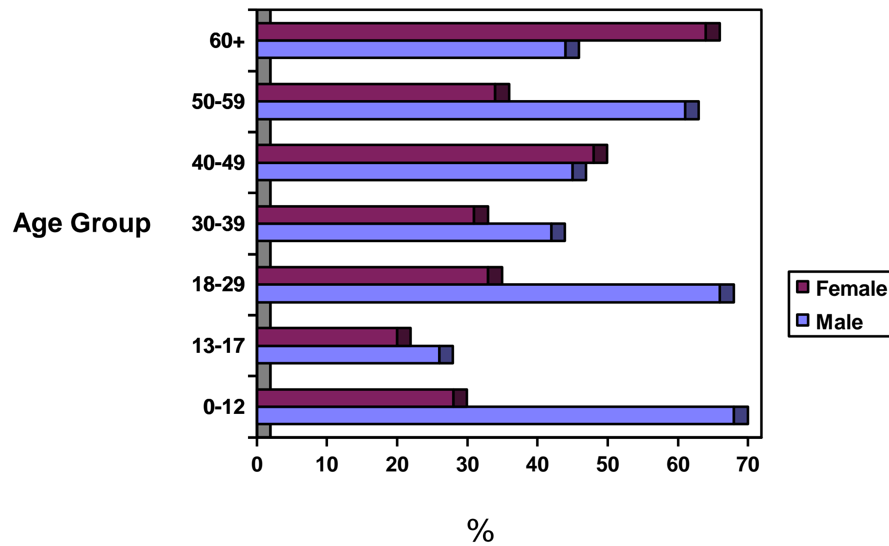
The following table outlines the number of patients seen by psychologists from different parts of Western Australia.

Table 1. **of clients from each Health Region In 1996/97 compared to WA Population Distribution.**

Region	%age of Clients	% Population in Region	Proportion Clients/ Region
	1996/97		**1996/97**
Metropolitan:			
North	37.7	**24.1**	1.6
East	22.6	**23.6**	1.0
South	22.8	**25.7**	0.9
Country:			
Great Southern	2.3	**4.0**	0.6
South West	5.4	**8.2**	0.7
Central	1.6	**3.0**	0.5
Geraldton	1.1	**3.9**	0.3
Goldfields	0.8	**3.3**	0.2
Kimberley	0.5	**1.5**	0.3
Pilbara	0.7	**2.7**	0.3

Psychological services are provided across the life-span to clients requiring assessment as a result of CNS disorder arising from accident, illness or genetic disease. Different sex and age groups vary in their risk for CNS disorder resulting from the different causes. Figure 1 provides a breakdown of age groups by sex for clients seen by Psychologists in 1996/97.

Figure 1. Age and Sex of Clients of the Neurosciences Unit



Based on 1996/97 clients (N=610)

Disorders treated

Psychological services are offered to people with various neurological and psychiatric disorders who often experience significant psychological sequelae as a result of these conditions. Examples of these disorders include epilepsy; multiple sclerosis; brain tumor; encephalitis; alcohol abuse; dementia; stroke; head injury; encephalitis; schizophrenia, personality disorders; and meningitis. Clinical Psychologists work with clients to help them overcome the psychological and social consequences of suffering from a neuropsychiatric disorder which includes assisting the patient with changes in cognition, personality and behaviour.

The following table demonstrates the main types of disorder treated by Clinical Psychologists at the Unit. Please note that these represent primary diagnoses only, and underestimate the number of people suffering from psychiatric/psychological problems.

Table 2 **Diagnostic Disorders of Clients**

Classification (ICD9 based)	1992/93	1993/94	1994/95	1995/96	1996/97
Organic Brain Damage	23.1	25.2	19.7	29.3	27.2
HD Confirmed/At Risk	20.4	19.7	20.4	16.8	16.1
Speech Disorders	8.7	13.0	14.4	9.4	13.9
Screening for CNS Disorder	6.4	7.4	9.5	11.4	12.5
Psychiatric Disorder	5.8	5.1	5.9	7.6	5.7
Accident and Injury	9.1	7.2	8.0	7.3	8.4
Epilepsy	3.9	3.9	3.0	1.9	1.8
Neurodevelopmental Disorder	10.3	7.9	6.7	6.4	4.6
Dementia	1.9	3.1	4.3	0.9	3.0
Other	10.5	7.4	8.0	9.0	6.9

The following table summarises the service linkages between the Neurosciences and agencies from which Psychologists took client referrals and provided consultation from 1992/93 to 1996/97.

Table 3. **Referring Agencies Between 1992/93 and 1996/97.**

Referral Source	1992/93	1993/94	1994/95	1995/96	1996/97
Specialists and GP's	24.5	27.4	28.9	32.8	33.8
Self, Family, Relatives	18.4	17.3	17.5	17.7	18.9
Teaching Hospitals	15.1	10.1	11.2	11.4	10.7
HDWA Hospitals	2.9	5.3	4.4	3.1	5.2
HDWA Child and Adolescent	13.2	11.0	10.9	11.3	10.5
Adult Psychiatric Clinics/Hosp	4.5	1.9	5.6	8.0	8.5
Other Government Depts	16.3	16.6	17.1	11.6	7.2
State Head Injury Unit	0.2	0.5	0.3	0.3	0.3
Non-Government Agencies	4.9	5.7	3.7	3.5	4.9
Other	0.6	0.5	0.4	0.3	0.0

Goals of the service

The main goals for Clinical Psychologists at Neurosciences are to continue to offer quality diagnostic and therapy services in all areas and to maintain and where possible improve current levels of service provision.

Clinical Psychologists work across the following sub-programmes:

1. Diagnostic Support: Provides diagnostic support to Tertiary and Secondary Hospitals and community-based facilities in the form of neuropsychological and psychodiagnostic assessment. Interventions are also offered where appropriate.

2. Predictive Testing Sub-programme: Provides diagnostic, psychosocial support and coordination of services for various genetic disorders, such as the Huntington's Disease Clinical Management and Predictive Testing Services.

3. Neurosciences Assessment and Care Clinic Sub-programme: Clinical Psychologists work with patients and families under 65 years of age with dementia and related disorders. Psychological services are provided by Clinical Psychologists within the context of a multi-disciplinary team.

4. Professional Support & Research Sub-programme: Clinical Psychologists provides clinical education support both internally and externally, consultative services and participate in research and evaluation activities. They are also actively involved in teaching at an undergraduate and post-graduate level

5 Additional Mental Health Disorders Treated within Neuropsychological Problems

As stated earlier, Clinical Psychologists at the unit work with people with neuropsychiatric disorders who also suffer a variety of clinical problems. Examples include patients suffering from: Clinically severe Depression, Anxiety Disorders, Post Traumatic Stress Disorder, Insomnia, Sexual problems, Adjustment issues, Survivor guilt, Challenging behaviours, Anger problems, Memory problems, Grief & Loss, Stress management, Marital/family conflict, Chronic Pain, and Social Skill Problems.

Evidence supported psychological therapies interventions are offered on an individual, couple, family or group basis. Working with cognitively impaired populations presents the clinician with many unique challenges, as there are many barriers to treatment. Therapy must be adapted in an attempt to overcome the patient's cognitive impairments, such as problems with memory, attention, information processing, and speech. Often the Clinical Psychologist cannot work with the client directly, but is required to work with family members, nursing staff (such as in a psychiatric hospital or nursing home). This may involve the implementation of behaviour modification programmes.

6. Quality Assurance

In addition to the ongoing structured service delivery data base kept at the unit and the continual evaluation of the service, the Neurosciences also runs internal Staff Development sessions, with special topics and invited speakers from other areas. The Staff Development sessions are open to other interested professional staff within the Health Department of WA, as well as non-government organisations. These are always well attended and well received.

Comparative data regarding service quality

A main objective of Clinical Psychologists at the Neurosciences is to provide a quality service. Since the Unit is largely a diagnostic support service those doctors, allied health and other professionals who request our services to help them manage a patient are an appropriate group to survey to identify whether this goal is being achieved. The first such survey was carried out in 1991/92 and it provided exceptionally positive feedback about the quality of Clinical Psychological services as well as some useful information on what improvements could be made. The suggestions made at the time were incorporated into our work practices. In the 1996/97 financial year the Unit again surveyed its referral sources. The results of the survey were most satisfying. Respondents indicated that they thought the quality of the psychology services provided and communication of results was excellent, and many stressed the need for such a service.

Whole of industry influence (include external interface)

As well as providing direct services to the public, CLINICAL PSYCHOLOGISTs at the unit provide education to health care professionals in affiliation with major tertiary institutions and contribute to knowledge in the area through participation in research and teaching. In particular, the unit is committed to educating medical practitioners and psychiatrists in the private and public sector with regard to the assessment, diagnosis and treatment of people suffering from neurological disorders and the psychiatric sequelae often associated with

these conditions. Extensive teaching also occurs at the under-graduate and post-graduate level to psychology, speech pathology and medical students at Curtin University, the University of WA and Murdoch University.

Scope of Influence – Line responsibility

All Clinical Psychologists at the unit are responsible to the Manager, who is a Senior Clinical Psychologist. The Manager has line responsibility to the General Manager of Graylands & Selby-Lemnos Special Care Services. The Manager's position at Neurosciences requires supervision of 17 staff members from various professional backgrounds. All Clinical Psychologists supervise post-graduate students who are training in the areas of Social Work, Speech Pathology and Clinical Psychology.

Neurosciences Contribution to Work Value Document

Significant changes in the duties and responsibilities of Clinical Psychology at Neurosciences have occurred due to a number of new programmes, including:

1. *Management and coordination of a new state-wide predictive (genetic) testing service.*

This new service was initiated because of:

- Recent discoveries of new genes involved in the pathogenesis of Alzheimer's Disease and other neurodegenerative conditions, including different forms of dementia in young people. There is also a high likelihood that more genes will be identified in the near future.
- Earlier diagnosis and growing recognition of the complexity and heterogeneity in the way these patients present, and how important it is to correlate symptoms with genotype analysis.
- An increase in the number of affected and at risk individuals with each generation as a result of births and migration to WA from other states and countries.
- An increase of referrals as the public and medical profession become better informed due to increased media coverage and public awareness campaigns.

- Recognition from the scientific community that analysis of gene tests is imperative in the medical care of people afflicted by neurodegenerative disorders, particularly as the genetic information will be useful in the future in predicting the response of new drug therapies as well as assisting couples with family planning decisions.

This new service has resulted in an allocation of recurrent funds by the Mental Health Division and a significant increase in FTE. Predictive testing for neurological diseases is not available in any other centre in Western Australia, and there are no other site locations where such programmes could take place. Predictive testing requires specialised and skilled health professionals experienced in this area and all staff are supervised by the this position (Co-ordinator / Clinical Psychologist) who also has specialist expertise.

The Clinical Psychology Co-ordinator has general responsibility for the co-ordination of the new Predictive Testing Program and duties include 1) Co-ordinating referrals. 2) Monitoring standards. 3) Ensuring that quality assurance activities are monitored and objectively evaluated and that clinical indicators are attained. 4) Ensuring the responsiveness of services to consumer views and the appropriate involvement of consumers in quality assurance.

2. *Management and coordination of a* ***new post-graduate teaching and research programme*** *due to allocation of recurrent expenditure by Mental Health Division. This will be in conjunction with the University of WA, who are setting up a new Post-graduate Neuropsychology Programme.*

3. *Management and coordination of a new clinic providing multi-disciplinary services (including psychiatry and neurology) to people under the age of 65 with dementia and related disorders. Services are provided within the context of a multi-disciplinary team consisting of Neurology, Clinical Psychology, Social Work and Speech Pathology input.*

4. 5. *Management and coordination of a): a new project involving the provision of clinical services on a quarterly basis for families affected by HD who live in the South West Region of the state. b) Coordinating a new dietary service for patients with HD.*

6. *Coordination of annual Neurosciences Conferences for medical specialists and health professionals in the private and public sector.*

Clinical Psychology

Child, Adolescent, Youth and Family Services

Work value changes in this sector can be understood as determined by-changes as a result of better information on the incidence and prevalence of

- childhood psychological problems.
- Information from research in child and adolescent development and psychopathology.
- Changes in diagnosis, assessment and treatment partly associated with this.
- Changes in the disorders seen, scope and role of Clinical Psychologists in the Health sector.

Increases in Work Value: Areas of Recognised Psychological Advances

Advances in Management Based on Recent Research in Child and Adolescent Development

During the last ten years studies have emerged refuting the previous work of Piaget on the developmental stages of children, in particular cognitive capacities and the processing of information, particularly in the middle childhood years *(For an example of new work in this area see Mayberry et al, 1995).* This new understanding has had a major effect on the development of new interventions and resulted in the emergence of the use of specific cognitively based therapies with children, targeting particular disorders, in addition to the previous relationship based therapies and behaviour modification strategies. An example is self-instructional training methods , some of which are possible to use with children from eight years of age upwards. An example of a specific successful cognitive approach with children is the Penn Depression program (Jaycox, 1994), referred to later. These methods require specific training and have in the last five years become widely used by Clinical Psychologists in Health Department child and adolescent settings.

The Australian Temperament Study, a large scale Australian study looking at the course of early temperamental traits has assisted clinicians to understand the development of sociability, emotionality and attentiveness, difficult and easy to manage babies, and to understand the complex play of these areas with disorders and explain this to parents. In a number of settings Clinical Psychologists now make this information routinely available to

parents using standardised instruments. (The study is a longitudinal study from which several papers have been published, eg Smith and Prior, 1996). Similarly information as to the development and course of behavioural inhibition (Kagan, 1988) has been instrumental in the development of interventions for anxiety in children and the development of protocols to assist parents.

The development of research and understanding in the nature of attachment in the past ten years has focussed the nature of intervention around relationship, particularly with mother-baby dyads seen as at risk, and Clinical Psychologists at PMH have now become involved in the area of neonate intervention.

3. Changes in Diagnosis, Assessment and Treatment: Effect on Advancing Work Value

In the late 1980's research became available that addressed a primary issue in the management of child and adolescent disorders. The question investigated was the following; is it more efficacious to treat these clinical disorders or let them take their course?

The Watts review into the efficacy of clinical applications of psychology (1989) discussed the results of a number of research reviews which support the clear conclusion that children and adolescents with psychological difficulties who receive treatment fare better than those who are not treated or are treated via non-psychological therapies. The Watt report also concluded that psychological therapies are the treatment of choice for this age group.

The Jenson review (1996) of the outcomes of mental health care for children and adolescents noted that to maximise impact, interventions must be scientifically based and well-explicated, calibrated to match the unique developmental needs of the child and family yet sufficiently comprehensive, flexible and engaging to fully address the child and family's environment and cultural context.

Current evidence suggests the addition of cognitive-behavioural therapy as an evidence supported treatment for problems with an emotional component (anxiety, depression, withdrawal, somatic complaints, aggression). Recent studies also demonstrated greater effectiveness when an intervention specific, family therapy component is included in treatment (Barrett et al, 1996). Clinical Psychologists are routinely trained in these approaches at advanced post-graduate university levels and now apply them widely in CAMHS settings.

In the late 1980's assessment tools measuring clinical levels of dysfunction such as Achenbach's Child Behaviour Checklist became available. This assessment tool allowed for the measurement of changes in dysfunction and the classification of problems into discrete categories for intervention, particularly as internalising and externalising disorders. It was introduced into child and adolescent settings by Clinical Psychologists and has become widely used to measure clinical levels, outcome and in Health Department research.

Assessment tools which measure severity and incremental change for specific disorders such as the Child Depression Scale also became available at this time allowing measurement of rate of change. These tools have increased the amount of specific information available to Clinical Psychologists and also allowed them to provide a more detailed assessment picture to other members of the multidisciplinary team who might consult for a psychometric or psychodiagnostic assessment, particularly by providing discrete information about the progress of a disorder or intervention. They are now in wide use in child and adolescent settings.

4. Advances in Specific Areas of Work Value

4.1. Anxiety Disorders-

The understanding and management of anxiety disorders in childhood and adolescence (c&a) has undergone significant change over the last decade. Increased precision in diagnostic criteria and assessment has emerged (Kendall, et al 1992, Kovacs, 1989). Some important discoveries have been: Kendall (1994) found separation anxiety disorder, social phobia and overanxious disorder could all be assisted as well by a group therapy specific program as by individual therapy and Barrett et al (1996) subsequently found CBT plus specific family therapy resulted in the most change.

These changes have required Clinical Psychologists working in c&a settings to significantly change their clinical practice through markedly increased clinical load for these disorders, development of specialist treatment groups and increased liaison, consultation and training of other professionals in these methods.
Recent research now suggests selective mutism, a particularly puzzling anxiety disorder, becomes social phobia as children become adults. An example of an intervention arising from this is the treatment protocol for selective mutism developed by the South Metro CAMHS Clinical Psychologists.

4. 2. Obsessive Compulsive Disorder

Obsessive compulsive disorder specific CBT is now routinely described as the psychotherapeutic treatment of choice for children and adolescents and given a skilful combination of medication and CBT most children can now be helped to resume a more normal developmental trajectory (March, 1996). Previous to the publication of this research in the last 5 years, Clinical Psychologists in CAMHS settings did not become involved in the treatment of this disorder.4.3. Depression-

In the past ten years there has been significant research in the area of childhood depression, in particular research that pointing to the differences between childhood and adult depression with the majority of depressed children evidencing additional symptoms such as irritability and somatic complaints. Adults with histories of severe depression frequently report histories consistent with childhood depression. Depression has greater prevalence in adolescence and is increasing in incidence (Rutter, 1995). It correlates with unemployment, which also currently shows greater incidence in adolescent populations than previously.

In the late 1980's cognitive therapies began to be reported in the literature as effective with children and adolescents.

The efficacy of cognitive behavioural treatment for depression is recognised in the National Health and Medical Research Council Clinical Practice Guidelines (1997) which list CBT as the treatment of choice over medication in young people. This has similarly resulted in a markedly increased workload in this area for Clinical Psychologists in CAMHS, and an increased involvement in the training of other professionals, such as GPs, in the assessment, early detection and treatment of suicide risk and depression in young people.4.4. Post-Traumatic Stress Disorder (PTSD)

Children and adolescents are now recognised as developing symptoms consistent with PSTD in the context of exposure to a variety of traumatic events. (Udwin, 1993; Parry-Jones and Barton,1995).

Clinical Psychologists have increasingly become involved in the individual and family treatment of PSTD resulting from exposure to war related torture and trauma, serious violent crimes (homicide, rape, domestic and community violence) and childhood sexual abuse. These clinical presentations have demanded the development of specialised skills

Clinical Psychologists working in health settings have also assumed a significant role in systemic interventions developed to prevent the development of PSTD including critical

incident management and debriefing and post trauma counselling. The change in role of other departments, such as family and children's services movement towards an assessment and brief intervention only model has seen a shift in the more intransigent of these problems to the Health Department facilities, both in inpatient and outpatient/community services.
An example of the changed role of Clinical Psychologists is the development of a trauma treatment program by Clinical Psychologists at PMH.

4.5. Disruptive Behaviour Disorders and Aggression

These include conduct disorder, oppositional defiant disorder and attention deficit hyperactivity disorder. Rutter (1995) has pointed to the poor prognosis for conduct disorder in long term outcome studies, particularly with onset before the age of ten years. Until the late 1980s interventions for conduct disorder did not show short to medium term effectiveness and this disorder was recognised as poorly treated by CAMHS services.
Since this time parent management training has been found by a number of psychological studies to be highly effective (Webster-Stratton, 1991; Dadds & McHugh, 1992). Child self instructional and problem solving training added to this has been found to produce greater improvement in problem-solving and conflict management skills (Kazdin,1992). Other effective interventions include behavioural family therapy, functional family therapy, a combination of family therapy and cognitive behavioural techniques, and multi-systemic therapy for antisocial behaviour among adolescents. The latter is a family-systems based approach which includes several different highly skilled interventions, including parent management training and cognitive problem solving skills training, in various complex combinations and various system contexts. Outcome studies show consistently effective results across problems, therapists and settings (Kazdin and Weisz, 1998).
Information as to effective interventions is too recent to involve long term outcome studies. All of these interventions, which often involve quite skilled and intensive intervention, now form part of the university training of Clinical Psychologists and are practised by Clinical Psychologists in CAMHS settings.

In Australia the Triple P Program (Sanders, 1994), a broad focus multilevel intervention program that incorporates parent management training which can be taught to other professionals for use with parents, has been developed. At higher levels of intensity, where indicated by assessment of pathology, it uses: skilled CBT and behavioural family therapy intervention targeting parents emotional and marital functioning (research now indicates these areas play a part in maintaining difficulties); applied functional analysis and family problem solving . WA Institute for Child Health Research evaluation has so far demonstrated the program to be highly effective in the short to medium term.

Clinical Psychologists in Health Department Child and Adolescent settings have trained in the higher level triple p training, which requires advanced skills, and supervise and train other professionals in the use of the program at levels of less intensity in community settings and homes. The more pervasive and serious difficulties are seen by Clinical Psychologists for intensive level 5 triple p intervention when detected by community based assessment.
The increased diagnosis of ADHD in recent years has required an increasing involvement in treatment by Clinical Psychologists in the Health Department. Guidelines on assessment, diagnosis and treatment call for comprehensiveness and in particular in psychological areas reliable behavioural data, ongoing monitoring, the use of parent management training and school based intervention. The high rates of comorbidity for this disorder (50%) also increase the complexity of psychological interventions and liaison with medical practitioners required.

4.6.Social Competence-

Children experiencing difficulty in their social functioning may do so by evidencing social withdrawal, aggression, relationship difficulties or social difficulties which arise out of anxiety such as social phobia and school refusal, or the withdrawal and hopelessness experienced by depressed children, or the difficulties thinking through social situations and perceived strangeness of those with psychotic features.

Beelman et al (1994) performed a meta-analysis of studies examining the effects of training social competence in children and adolescents. They refer to the importance of social competence training for mental health given that social problems in childhood have been reliably found in the literature to correlate with later disturbances. They found social competence training which was multi modal targeting social cognitive and social interactive skills, with developmental sensitivity to the type of modality and comprehensiveness of intervention was most effective. Of central importance in this area has been the recent work of Dodge (1990) who has identified the mechanisms by which children make social response choices.

Clinical Psychologists within CAMHS have developed group programs fitting these criteria and demonstrated their effectiveness using wait list controls in the past ten years. These programs have been presented nationally, are now widely used within CAMHS settings and taught as a basic part of a group training program to other professionals.

A Clinical Psychologist within CAMHS has also designed a joint child-parent group intervention program for aggression in children (BB Calm) which is showing good medium term outcome results and was the recipient of a innovations in mental health award.

These contrast with previous interventions ten years ago which whilst often delivered in group format, did not use the now understood developmentally appropriate skills and mechanisms, nor recognise the degree of complexity of intervention required and the need for adult involvement in maintaining change.

4.7. Eating disorders-

Research on outcome in anorexia nervosa supports a comprehensive treatment model incorporating psychological intervention. CBT has been extensively evaluated as a psychological treatment for bulimia nervosa and appears to be slightly more effective compared to other psychological treatments (Fairburn and Cooper, 1989).
An eating disorders team has been established at PMH in the last three years and Clinical Psychologists have assisted the team and the setting up of the outcome research design.

4.8. Chronic medical illness-

Since the late 1980Õs preparation for medical procedures and hospitalisations have advanced to the point where elements of effective intervention are well understood. Interventions for accompanying psychological maladjustment are still not well understood and intervention in this area remains complex (Wallander and Marullo, 1993).

Clinical psychology at PMH has altered significantly over the past ten years. From providing psychometric testing, Clinical Psychologists now provide clinical services (individual therapy, group therapy, family therapy, consultation and liaison, staff training and devising programs for particular behavioural medicine needs) across the Hospital and community. Examples of specialist programs include a coping skills package (video, handbook storybook) which was developed to enable immunology patients with needle phobia/medical trauma symptoms to be treated.

4.9. Psychosis and Bipolar Disorder-

The Health Department WA has moved towards an early and comprehensive community treatment model for early psychosis in the last few years. Clinical Psychologists within CAMHS have been involved in the psychological aspects of treating older adolescents with

early psychosis or suspected bipolar disorder discharged from the Bentley Adolescent Unit with CBT, family psycho education or social competence training. This requires informed, skilled intervention and was not part of their expected repertoire until the early 1990s.

4.10. Elimination Disorders-

Psychological interventions for elimination disorders have had an established efficacy over several decades (Doleys, 1989). Behavioural toilet training for enuresis is now well established, and many enuretics are now treated in general paediatric settings or specialist clinics staffed by other health professionals using methods initially established and validated by psychologists. These changes have meant referrals to psychologists in child and adolescent settings only occur for children with complex and treatment resistive elimination disorders.

Such cases are characterised by complex issues of family functioning, significant comorbidity and requirement for close collaboration with paediatric physicians, requiring a high skill component in intervention.(Hersov,1994) Although a small part of Health Department clinical psychology caseloads, they require a high degree of skilled intervention.

Change in scope of influence and role-

Research in child development, information on temperament and attachment, and discrete and specific treatment and assessment methods for childhood disorders have increased the workload of Clinical Psychologists in providing training programs for GPs in areas such as suicide prevention and child development, and in community health settings lectures to school and community nurses in development and intervention strategies.
Using their expertise, Clinical Psychologists in CAMHS set up training programs in family therapy and in particular in the last ten years group therapy with children and adolescents, which train psychiatrists, social workers, mental health nurses and occupational therapists. These two training programs along with the training program for Psychiatric Registrars, form the training program subcommittee of the CAMHS Policy and Planning Executive.

Involvement in outcome and evaluation research-

Clinical Psychologists have been recognised as having significant expertise and experience in evaluation applied research and the effectiveness of interventions. In c&a settings they

have been pivotal in developing service protocols and procedures for evaluating outcome of service delivery, such as pre and post measures.

With the move towards funding guided by the efficacy of service delivery and consumer satisfaction this has assumed considerable importance. This involves whole service as well as individual case outcome assessment. For example, SMCAMHS Clinical Psychologists are collecting outcome data using the Macmaster family scale, GAF, CBCL , and a consumer satisfaction survey to provide a model of service evaluation.

In the past six months Clinical Psychologists within CAMHS have also been instrumental in the establishment of a CAMHS wide service evaluation subcommittee to the CAMHS Policy and Planning Executive to design best practice models for the CAMHS sector.

Clinical Psychologists now constitute a significant proportion of the members of the CAMHS Policy and Planning Executive due either to their roles as managers of CAMHS units and/or their specialist expertise.

Psychological research in child and adolescent settings-

Increasingly, Clinical Psychologists have become involved in research undertaken to establish causal factors in the development of child and adolescent mental health problems or to establish the efficacy of specific intervention strategies. This has often involved collaborative efforts across government departments and joint initiatives with university departments of psychology. Specific examples include:

1. Involvement in the implementation and evaluation of the positive parenting programme (triple p) evaluating the longitudinal effects of early intervention in the development of mental health problems

2. Expert advice to and evaluation of the efficacy of structured group programmes in promoting improved coping skills and enhancing optimism in children and adolescents at risk of depression (Penn Depression Project: promoting optimism in WA)

3. Involvement in a reference group sponsored by the Mental Health Division HDWA implementing new initiatives on the prevention of internalising disorders in children and adolescents.

4. Joint psychological research between the UWA and South Metro CAHMS on the role of attentional bias in the development of anxiety disorders in children. A major change in the emphasis of intervention for children and adolescents has been the use of major population wide prevention programs for childhood disorders such as the Penn depression program based on the work of Seligman. These can involve Clinical Psychologists in a number of ways: providing supervision and support to other allied Health professionals providing the interventions where these are delivered as part of a school -based program, for example, and assistance with the detection of serious mental health disorder, or where level of intervention depends on level of pre-existing pathology such as in the case of triple p, providing supervision and support to those working at less intense levels, and intensive intervention at individual levels where indicated as necessary by assessment. The role in these programs is a major one.

The increasing efficacy of psychological treatments with children and adolescents has also meant the adoption of these techniques into specialised programs in tertiary settings. PMH Clinical Psychologists now find themselves:

1. Involved in the co-ordination of specific programs such as Grevillia House, school refusal treatment program, social skills program.

2. Involved as part of specialised multidisciplinary teams-ward 4h, day program, eating disorders program

3. Developing new treatment initiatives: trauma treatment program, BB calm anger management

4. Providing assistance on research design: diabetes, eating disorders, and neonate program

<u>NB: None of these roles were in existence five years ago.</u>

Change in work complexity and role-

The National Mental Health Strategy and the development of effective psychological treatments, the adoption of a secondary referral policy for CAMHS clinics whereby referral

does not come from the parent directly but via a GP or School Psychologist, and the move to treat in the community where possible has meant Clinical Psychologists see the more serious end of the spectrum since the early 1990s and this is reflected in figures below.

The complexity of the work is increased by the enormous growth in research findings, requiring constant reference to:

1. updated psychological information on normal development

2. psychological research clarifying dysfunction

3. improved psychological assessment methods

4. psychological research on the most effective treatment methods for widening conditions.

Studies referred to in the section above point to the rapid rate of change in the field - major work has been conducted in the last five years alone - and the complexity of the knowledge involved in understanding disorders, comorbidity, and the unique position of the child with regard to such areas as cognitive development, temperament, attachment, social competence and family functioning. Choosing, delivering and monitoring appropriate psychological intervention in these circumstances is a highly skilled activity .

Changes in work practice-

Evidence from the clinics 1988-1998-

Caseload statistics were analysed for Clinical Psychologists employed in three CAMHS services: Warwick, Bentley and South Metro CAMHS over the last three consecutive months. Caseload statistics were analysed for%age of cases seen by primary diagnostic category and the number and%age of cases with dual diagnosis.

The most common primary diagnostic categories were:

Anxiety Disorder- 30% (anxious and fearful, mixed problems major anxiety component e.g. hair pulling, adjustment disorder with anxiety, anxiety states, OCD, social withdrawal, hysteria, phobia and tics)

Depression- 23% (misery and unhappiness, adjustment disorder with prolonged depressive reaction, depressive disorder not otherwise specified, brief depressive reaction, neurotic depression)

Conduct disorder - 20% (unsocialised disturbance of conduct, mixed disturbance of conduct and emotions, socialised disturbance of conduct)

Estimates of ADHD varied between 9% on some sites and 30% on others. Family disruption as sole diagnosis accounted for 4%

Comorbid disorders accounted for 68% of cases (56-77% across clinicians)

Caseload statistics from the same period in 1988 provided the following data regarding diagnostic categories:

Anxiety disorders 5%Depression 4%Conduct disturbance-10%Family disruption alone 53%Comorbid disorders 10%

This suggests in contrast to the situation ten years ago the childhood disorders now seen by Clinical Psychologists are the most pervasive, severe and those most likely to persist into adulthood. They are usually seen in comorbid form, again suggestive of more serious difficulties. Family disruption alone, which would require less clinical psychology specialised intervention, is now rarely seen.

This is consistent with the move to see this more severe end of the spectrum suggested by the National Mental Health Strategy. The higher comorbidity rate also reflects the increasing complexity of cases seen by Clinical Psychologists in community mental health settings.

Summary-

The past ten years have seen significant changes in the research regarding child development and psychopathology; better understanding of the incidence, prevalence and adult outcome of childhood disorders; information regarding specific effective intervention strategies for disorders; focus on comprehensive intervention strategies which use levels of

increasing skill and complexity in intervention with the more serious disorders; a focus on the more serious and comorbid end of the intervention spectrum within community mental health clinics; an increased role for consultation and intervention in medical settings; increased roles in teaching, training, and the provision of advice. All of these have added to the change in work value for Clinical Psychologists in c&a Health Dept. settings.WA Institute for Child Health Research: Developing Health and Well-being in the Nineties. Australian Bureau of Statistics, 1995

Increases in Work Value: Areas of Recognised Psychological Innovation

The Development of Youth Mental Health Services

Clinical Psychology has been the profession at the forefront of the development of youth specific mental health services in Western Australia. Prior to 1992 there was an absence of services that focussed specifically on the prevention of severe mental health problems in populations of young people (both adolescents and young adults) who could be regarded as the most highly at-risk, through homelessness and disconnection from family, educational and employment structures.

In 1992, YouthLink (then known as the Troubled Youth Support Service) was established as the first youth-specific mental health service in Western Australia. It was funded jointly by the Commonwealth and State Governments under the Innovative Health Service for Homeless Youth (IHSHY) programme. Its goal was to respond to the mental health needs of homeless, at-risk and marginalised young people, and to support the youth sector through the delivery of expert consultancy and training services. The primary programme areas were provision of direct clinical services to young people throughout the Perth metropolitan area, consultancy to youth workers and a wide range of professionals throughout the State, on issues affecting service provision to the target group, education and training programmes to professionals and youth workers on issues such as working with suicidal or self-harming young people, and community development activities. An important broader role identified for the service was the building of links between the non-government youth sector and government mental health instrumentalities.

Since its inception YouthLink has been staffed almost entirely by Clinical Psychologists. At commencement, three of the four clinical staff including the Coordinator were Clinical Psychologists. Staff were selected on the basis of their capacity to provide specialist counselling and evidence-supported therapeutic interventions to the most at-risk section of

the youth population within a largely autonomous framework, and to function as agents of change within other sectors working with the target group. After six years of operation, six of the seven full-time equivalent clinical staff including the Programme Manager, are Clinical Psychologists. Psychiatrists have never been provided within YouthLink, but are accessed from external sources when required.

Clinical Psychologists within YouthLink have maintained primary responsibility for client assessment, treatment, case management and supervision of system-wide interventions involving multidisciplinary input, and consultation on client issues to other professionals and caregivers.

The level of responsibility, both clinical and legal, taken by Clinical Psychologists at YouthLink extends to decision-making around issues of extreme significance to client well-being, such as suicide risk assessment and management. This applies to clients as young as thirteen years, who may seek YouthLink's services independently, and for whom judgements regarding 'mature minor' status must be made.

Another other key role within YouthLink which has been the primary responsibility of Clinical Psychologists is the supervision of staff at YouthLink and a number of other agencies, and of Clinical Psychology Masters interns from university programmes. Clinical Psychologists have also taken primary responsibility for the design, implementation and evaluation of education and training packages to other professionals as well as consultancy to other agencies. A recently and increasing role has developed in providing consultation to government and non-government bodies in the area of policy relating to youth mental health.

Clinical Psychologists at YouthLink have taken a leading role in the application of principles of prevention and early intervention with a traditionally hard-to-serve yet highly at-risk population. YouthLink has built a reputation for providing services to young people with diagnoses such as Borderline Personality Disorder, who typically place heavy and costly demands on hospital and emergency services through repeated suicidal and self harming behaviour and other crises. The interventions provided by Clinical Psychologists at YouthLink with these very difficult clients are focused on maximising their capacity to cope with life difficulties, thereby reducing crisis behaviour, hospitalisations and involvement with emergency services such as ambulances and police. Through intervening rapidly with suicidal clients, YouthLink Clinical Psychologists have arguably had a very significant impact on reducing the cost (both emotional and financial) which suicide exacts on families and the community as a whole. In over six years of providing services to clients at risk of suicide, YouthLink has not had a client who has completed suicide.

Another significant saving to the community afforded by YouthLink is through provision of services to young people who have offended or are at risk of being repeat offenders. Through provision of flexible, mobile and client centred psychological services specifically tailored to young people, Clinical Psychologists have managed to engage and work successfully with many such young people to the extent that they have broken out of the cycle of offending.

Clinical psychology at YouthLink has also had a very active role in enhancing service delivery to at-risk young people within broader community context through a range of innovative community development projects and activities. These include the production of "Making A Difference: Youth Suicide Prevention Manual" (1994) and the Aboriginal and Community Development Liaison Project (1996), both of which have had far reaching effects on service delivery to at-risk young people within the youth and mental health sectors.

The success of Clinical Psychology in addressing the mental health needs of at risk young people has been acknowledged at a number of levels. An independent evaluation report completed in 1997 (Matrix and Other-Gee) noted the wide support and recognition amongst stakeholders, including young people who have used the service, of the value of YouthLink's clinical services. Stakeholders referred to the high level of professionalism and competence of staff who were predominantly identified as Clinical Psychologists. There is a widespread recognition of the direct clinical service as being the most important and highly valued of YouthLink's primary programme areas, and it is regarded by the majority of stakeholders (at all levels) as an essential service.

YouthLink has also been the recipient of two awards. The service received a prize from the XIX Congress of the International Association for Suicide Prevention (Adelaide, March, 1997), and a Bronze Award in Child and Adolescent Mental Health Services category was received at the Australian and New Zealand Mental Health Services Conference in August, 1997, "in recognition of the achievement in developing and implementing their initiative of providing an innovative service for homeless and at-risk young people in Perth".

Youth Therapy Service-

The Youth Therapy Service was established in 1996, as the second youth-specific mental health service in Western Australia. The Youth Therapy Service operates within the Swan Health Service. Like YouthLink, its development and service delivery approach have been

informed primarily by Clinical Psychology, and it has had Clinical Psychologists in the role of Coordinator/Programme Manager throughout its operation.

The Clinical Psychologist at the Youth Therapy Service is the clinician who takes primary responsibility for the diagnosis and treatment of referred youth with significant mental health compromise in the Swan Health Service area. Clinical decisions relating to client risk status, treatment mode and diagnosis type are made on the basis of recommendations of the Clinical Psychologist.

A review of patient diagnosis for the previous three months of 1998 reveal that the diagnostic criteria for 12 ICD 9 diagnostic categories were met by youth referred to the service. 29% of these patients had a clinically diagnosable depression and 18% having had a previous suicide attempt. Other diagnostic categories were: ODD and Conduct Disorders 19%, ADHD 8%, Self Harm 8%, OCD 5% and Sexual Deviations and Disorders 5%.

As is the case with YouthLink, the Clinical Psychologist positions at the Youth Therapy Service require the responsibilities of ongoing risk assessment and treatment of young people with complex mental health and psychosocial problems.

The Clinical Psychologist has the added responsibility of keeping abreast of general youth issues and concerns that may impact upon youth presenting to the clinic. This involves out of hours meetings and contacts within the clinic's catchment area.

The reluctance of youth with mental health issues to present to formal medical centres or clinics makes the task of the primary mental health practitioner (Clinical Psychologist) more complex in terms of delivery of a service which young people will access. The issues most often referred to the Clinical Psychologist requires intervention and this places added responsibility on the Clinical Psychologist to be creative, flexible and 'in tune' with the needs of youth reluctantly presenting to the clinic.

CONTRIBUTION OF CLINICAL PSYCHOLOGY TO YOUTH MENTAL HEALTH-

Clinical Psychology has the most significant contribution of any of the mental health professions to offer to at-risk young people. Their training provides the strongest emphasis on Cognitive Behaviour Therapy (CBT), which has repeatedly received empirical support as the treatment of choice for the widest range of mental health problems affecting young people such as depression and suicidality, (National Health and Medical Research Council, 1997),

anxiety disorders, post-traumatic stress disorder (Rothbaum & Foa, 1996), and more recently early psychosis).

There is also a strong emphasis in the training of Clinical Psychologists on an understanding of developmental psychology. The application of empirical enquiry and adoption of a scientist-practitioner role equips the Clinical Psychologist with the skills and competencies to adapt existing well formulated models of intervention, particularly CBT, to the needs and characteristics of the most at-risk young people, for whom the completion of developmental tasks is often severely disrupted. On a practical level, the training of Clinical Psychologists enables them to adapt treatments to clients who may be illiterate, extremely distrustful towards "traditional' medical-model clinic approaches, lacking in family and social supports, or who have developmental, intellectual or other disabilities. The recent development of a Clinical Psychologist youth specialist position within the Western Australia Institute for Psychotherapy Research will allow new approaches to working with at-risk youth to be empirically examined.

In summary, it is appropriate that Clinical Psychology has been at the vanguard of the recognition and development of youth mental health services as a new and specialised field of service delivery. The profession remains in the strongest position to promote the further development of this area, to undertake research into treatment and intervention models, to deliver and manage direct clinical services, and to provide consultation, education and training to other professionals working with youth.

Clinical Psychology

Adult Mental Health Services

Increases in Work Value: Complex Adult Mental Health Disorders

The following section demonstrates the breadth of work carried out by Clinical Psychologists in the area of complex adult mental health disorders. The section documents areas of recognised Clinical Psychology advances, demonstrating a high level of complexity of performance and increased scope of responsibility for service provision. Studies referred to in this section illustrate the rapid rate of change and development in the area of complex mental health disorders. Furthermore, the frequent occurrence of patients presenting to public sector services with more than one concurrent significant psychiatric disorder demands high level skills from the Clinical Psychologists who assess and treat people with these problems.

Clinical Psychologists are found in both hospital and community-settings. A feature of the National Mental Health Policy (1992) was the increased emphasis on community based services. The trend for community based management will increase as the number of psychiatric inpatient beds in West Australian hospitals declines. Clinical Psychologists have demonstrated their extension of work value in taking on additional roles and responsibilities for the management of severe mental health disorders in all community settings.

Clinical psychology contributes considerably to the treatment of persons with major psychiatric disorders, both in the hospital context and in the community. Clinical psychology offers specialist services which differ distinctly from those provided by other types of psychologists or by other allied health professions. Psychological treatment can directly modify some first-rank symptoms as well as a wide spectrum of co-morbid problems, and can directly modify significant determinants of relapse. For persons with disabling personality disorders, psychological treatment can be the primary modality for creating sustained improvement. Psychological assessment is a distinctive resource for planning and carrying out both immediate treatments and long-term management. In hospital based and in community based programmes, clinical psychology offers specialist services to the multi-disciplinary teams, in addition to direct services to individual persons who require treatment.

Disorders in the psychotic spectrum

The primary treatments for people with disorders in the psychotic spectrum are pharmacological. These treatments are essential before an inpatient with such a major psychiatric disorder can be given any other form of effective treatment. However, major psychiatric disorders are a complex amalgam of biological and psychological (i.e. behavioural, cognitive, social and mood related variables) factors and as such have active roles in determining the course of a disorder and the individual's quality of life. These psychological factors moderate variables such as the contributing conditions for the onset of a disorder; relapse rates; and the manifestations of individual psychotic phenomena. Psychological factors also moderate the presence and activity of co-morbid problems. A complete issue in the 1995 Schizophrenia Bulleting was devoted to treatment outcome research, including review of psychological interventions and family systems work, demonstrating at the international level the application and extension of clinical psychology work value.

Affective Disorders: Clinical Depression

The prevalence of clinical depression within the community is not only widespread (see p4-5 this document), but a major public health issue. A close examination of epidemiological data also shows the increased prevalence of the disorder in younger age groups. Together it is evident that depression negatively effects work productivity, healthy family functioning, is often accompanied by substance misuse and vulnerability for suicide.
Numerous studies and subsequent meta-analyses have demonstrated that any number of specific psychological interventions, (behavioural treatments, cognitive treatments, interpersonal psychotherapy, family systems interventions, and short-term dynamic therapies) either alone, or in some cases, in combination with pharmacological approaches, are more effective than control conditions such as a wait-list control or a psychological intervention based on inactive ingredients containing non-specific factors serving as "psychological placebos".

In many cases psychological treatments such as those procedures mentioned in the previous paragraph have been shown to be as effective or more effective than pharmacological approaches with proven efficacy, or they greatly enhance the effects of drugs. Recently published studies comparing medication therapy with psychological treatments have been found equal efficacy of outcome. The largest multi-cite research programme reported in the

literature is the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Programme tested the effectiveness of two brief psychosocial psychotherapies (cognitive-behavioural therapy and interpersonal therapy) for the treatment of outpatients with major depression. The conclusions reported showed no difference in the effectiveness of treatments using tricyclic antidepressants as compared to the two psychotherapies in the treatment of acute phase depression. In regard to follow-up over 18 months, cognitive behaviour therapy did appear to do somewhat better that the medication condition, a finding similar to others reported in the literature.

Recurrence and relapse of severe mental health problems

The clinical literature indicates that relapse and recurrence rates are a significant problem in severe mental health disorders. Often such reappearance of problems is significantly influenced by psycho-social factors. Psychological treatment can provide active self-management skills that sharply reduce relapse rates in some patients. Psychological treatment relevant to relapse include:

- Techniques for prodromal pattern identification and analysis.
- Specific techniques for modifying features of the prodromal pattern and for reduction of the risk of its acceleration from a sub-clinical state into a full-blown relapse.
- Individually designed coping skills training in a context of major disability.
- Social and familial skills relating to the presence of major psychiatric disorder.
- Stress and trauma in families and carers of persons with major psychiatric disorders.
- Relapse prevention training
- Appropriate use of booster sessions

Obsessive-Compulsive Disorder : Clinical Psychology Management Review

Obsessive Compulsive Disorder (OCD) is an anxiety condition which affects 2-3% of the population. This equates to around 450,000 Australians suffering from OCD at some time in their lives (I'Anson, 1997). People with OCD are troubled by unwanted and intrusive thoughts, images and/or impulses (obsessions), and are compelled to perform often lengthy behavioural and mental rituals (compulsions). Sufferers are usually aware that their obsessions and compulsions are irrational but feel unable to control them. This is a highly debilitating disorder in which outcome has improved with the application of psychological treatments.

Treatment of choice for the condition basically consists of behaviour therapy alone, pharmacotherapy alone or a combination of both. Anti-depressant drugs acting upon the

serotonergic neurotransmitter system are currently the most effective pharmacological interventions. These medications are effective anti-depressants but also have an effect on obsessive-compulsive symptoms. Pharmacological treatment may lead to a 30 to 70 per cent reduction in symptoms, however, cessation of the treatment generally produces a return of the symptoms.

Behaviour therapy has been demonstrated to be one of the most effective treatments for OCD (Rachman & Hodgson, 1980; Emmelkamp, 1982; Marks, 1987; Steketee & Cleere, 1990). Within this approach, exposure and response prevention has produced the most impressive results with 65-75% of OCD patients showing significant reductions in symptoms (Stekette & Tynes, 1991).

Psychological Treatments for Panic Disorder

Psychological treatments panic disorder compare favourably when matched against established pharmacological treatments (Margraf, Barlow, Clark, & Telch, 1993). For example, when compared to alprazolam, panic control treatment has resulted in 87% panic-free patients compared to 50% for a medication group (Klosko, Barlow, Tassinari, & Cerny, 1990). In addition, cognitive-behavioural treatments have been shown to be superior to a wait-list condition, brief supportive therapy, and a pharmacological placebo (Barlow, Craske, Cerny, & Klosko, 1989; Beck, Sokol, Clark, Berchick, & Wright, 1992; Klosko, et al., 1990).

Despite impressive success rates with this treatment, conservative estimates of successful alleviation of panic in participants indicates that 25% do not become panic-free. This has prompted a number of investigations into the individual components of treatment in an attempt to identify the most effective aspects and so improve success rates (Barlow, Brown, Craske, Rapee & Antony, 1991; Barlow et al., 1989; Craske, Brown & Barlow, 1991). The general finding of studies investigating the efficacy of cognitive behavioural treatment is that interoceptive exposure and cognitive therapy represent the essential components of treatment (Craske et al., 1991; Margraf & Shneider, 1991; Margraf et al., 1993).

Various types of relaxation-based treatments for panic disorder have also been investigated. The two major procedures compared have been progressive relaxation which involves the individual tensing and relaxing each of the major muscle groups and applied relaxation which involves the individual simply applying the technique of relaxation without tensing and relaxing each of the muscle groups. Taylor, Kenigsberg, & Robson (1982) found that progressive relaxation over 5 sessions was more effective than a pharmacological placebo, diazepam or a wait-list control. Ost (1988) compared applied relaxation with progressive

relaxation and found that the applied technique produced 100% panic-free patients compared to 71% for the progressive technique. A study by Clark, et al. (1994) compared applied relaxation, imipramine and cognitive therapy. At a 3-month follow-up cognitive therapy was superior to both imipramine and applied relaxation. However, at a 6-month follow-up cognitive therapy did not differ from imipramine but both were superior to applied relaxation. Finally, at a 15-month follow-up cognitive therapy was once again superior to both of the other treatments. It was also noted that between 6 and 15 months a number of imipramine patients relapsed.

Ost & Westling (1995) have conducted a recent investigation aimed at replicating the Ost (1988) study but comparing applied relaxation with cognitive behaviour therapy rather than progressive relaxation. The applied relaxation technique resulted in 65% panic-free patients compared to 74% for the cognitive behaviour therapy. An increase in the success of both treatments was found at a one-year follow-up with 82% of the applied relaxation group and 89% of the cognitive behaviour group being panic-free. The authors suggest that therapist variables such as experience with applied relaxation could explain the different success rates found for applied relaxation in this study compared to the earlier study. Overall, applied relaxation appears to be an effective treatment component but does not produce results as great as those obtained with cognitive behavioural approaches.

Generalised Anxiety Disorder

Generalised anxiety disorder (GAD) is a common problem, with the incidence of patients presenting at outpatient clinics being reported as high as 12%. It is only with the publication of DSM-111R that the status of GAD as a distinct disorder has been established. Previously GAD was merely a residual category of anxiety after all other anxiety disorders have been differentially diagnosed. An extremely high level of worry is recognised as a predominant characteristic of GAD. Individuals with this characteristic worry report feeling anxious or apprehensive most of the time and often present at medical settings with health related symptoms. The anxiety management approaches that are very effective for many anxiety disorders are also useful for this disorder, but must be carried out over a longer period of time. Short focussed treatments need considerable extension

Social Phobia

Social phobia is a disorder characterised by excessive fear of scrutiny by others, with subsequent avoidance of social situations, for example, meeting groups of people, and any performance situation. Social phobia has only relatively recently been entered the official

psychiatric nosology, and that its recognition has been enhanced. However, it is clear that the disorder still often goes unrecognised (James, 1997). Part of the reason for the failure of recognition lies in the very nature of social phobia, in that sufferers are impaired in their ability to communicate with others, and would feel embarrassed about broaching the subject with others, including health professionals. Also, health professionals themselves tend to focus on patients' presenting complaints, hence failing to elicit "hidden" symptoms, such as those of social phobia. Furthermore, there has been a tendency, until recently, to believe that social phobic symptoms are part of the individual's makeup, and are immutable and not amenable to treatment.

Recent epidemiological studies have underlined the fact that social phobia is common, with population prevalence estimates of the order of at least 10%. There is considerable psychiatric comorbidity with social phobia. A large primary care study (Lecrubier & Weiller, 1997), for example, found that patients with social phobia had high rates of symptom severity on the General Health Questionnaire, and were more likely to report poor overall health. Nearly two thirds of the social phobia group had experienced suicidal ideation, and 20% had actual suicide attempts (vs. 8% of non-social phobia controls). Over 50% of the social phobia group had comorbid depression (12% in controls), and there were also higher rates, than controls, of generalised anxiety disorder and agoraphobia.

Individuals with social phobia also tend to use alcohol to alleviate their anxiety symptoms. This can lead to alcohol dependence, with its concomitant social and medical burdens; indeed, rates of alcohol dependence in social phobia are of the order of 20-30% (Van Ameringen et al, 1991). Benzodiazepine abuse is also common amongst social phobia sufferers.

What is also clear is that social phobia carries with it considerable burden in terms of psychosocial dysfunction, as well as being associated with health service utilisation which is often inappropriate.(Davidson et al, 1994). Thus, studies have shown high rates of social disability in areas such as contact with others, adjustment to daily routine Lecrubier & Weiller, 1997). Sufferers are more likely than their general population counterparts to be unemployed or show an unstable work pattern, and a tendency not to fulfil their educational potential. Rates of marriage are also low. In terms of service utilisation, social phobia patients show high use of their general practitioners, often with minor ailments or non-specific .

The number of psychological treatment studies for social phobia has increased significantly in the last decade and provided the data from which conclusions about evidence supported interventions may be made. Researchers have conceptualised the problem in social phobia

in one of two ways; either as a behavioural deficit, specifically the lack of appropriately developed social skills or, as an anxiety based disorder. The first understanding has spurned a number of studies investigating social skills training programmes. The second general hypothesis assumed that anxiety about social situations was the cause of social phobia. The interventions receiving the most empirical investigation are exposure therapy and cognitive behaviour therapy. Each one is based on a different understanding of the primary factors that undergrid the disorder, yet each one attempts to help the individual reduce their anxiety state. A recent review has concluded that the multi-component treatments which include cognitive and behavioural aspects work equally effectively (Taylor, 1996).

Substance Misuse

There appears to have been a recent increase in the proportion of complex clients seeking drug treatment, and a concomitant increase in the expectations on Clinical Psychologists to assist in managing these clients. These clients include those with dual diagnoses (drug and psychiatric), particularly those with personality disorders, who are often using multiple drugs and engaging in other self-harming or suicidal behaviours.

The devolution of the WA Alcohol and Drug Authority, and the establishment of a number of Community Drug Service Teams, has raised the concern that there is insufficient depth of clinical skill amongst the team staff, none of whom are Clinical Psychologists. As a result there is likely to be increased pressure on Clinical Psychologists both within the WA Alcohol and Drug Authority and within Health Department clinics, to assist the teams to manage complex clients. This assistance may take the form of clinical consultation, supervision and training of staff, the development of protocols for managing specific clinical problems, or referral.

With increasing numbers of young people using heroin, there is likely to be increasing pressure on Clinical Psychologists working within the drug field, and the more general mental health field, to manage chaotic young drug users who are often at high risk of harm.

There is a developing recognition that the type of therapy a Clinical Psychologist is trained to engage in is more effective than the more general drug counselling engaged in by other counselling staff for those clients with psychological disorders. For example, research on methadone clients demonstrates that psychotherapy is more effective than general drug counselling for those clients who have psychological disorders and who chose to seek help (Ward, Mattick & Hall, 1992).

Within the WA Alcohol and Drug Authority, in the last year Clinical Psychologists have taken on the role of conducting regular group supervision sessions for counselling staff. This supervision involves education about clinical issues, and ongoing case supervision. Clinical Psychologists are also becoming involved in the education of general practitioners about alcohol and drug issues.

Post-Traumatic Stress Disorder

Post-traumatic Stress Disorder (PTSD) is a serious psychological disorder with disturbances to all areas of human intra and interpersonal functioning - psychobiological, behavioural, emotional and cognitive. Broadly, its sufferers are generally subject to horrifying memories of the traumatic experiences they have been through, avoidance of reminders of those experiences, and minds and bodies which are constantly on the alert and over-aroused. Nightmares are common. Subjectively, the individual feels irritable, anxious, over-whelmed and helpless, or becomes numb to a range of normal human feelings. Anger problems, agoraphobia and excessive substance use are common. Family stress is the rule.

PTSD is not uncommon. For example, it is estimated that 15% of Vietnam veterans in Australia suffer PTSD some twenty years after the war, and that a further 11% suffer from partial PTSD. This places PTSD on a par with mood disorder not only on the individual, but also his family and the community at large is immense. As such the accurate diagnosis and treatment of PTSD have far-reaching implications for the mental health of the nation.

Clinical Psychologists, because of their professional training in research methods, have been well placed to systematically study the factors mediating vulnerability to, and course of, PTSD in both military and civilian populations. Reliable and valid scales for assessing the effects of exposure to different degrees of trauma, fundamental to such research, have been developed. Through such research we are now better able to identify and direct treatment towards those individuals, who, by virtue of their vulnerability, are likely to have significantly impaired long term adjustment.

The training in normal human development that underpins subsequent specialisation in psychopathology has stood Clinical Psychologists in good stead as they seek to understand the impact of trauma on children and adults. This understanding, together with the observation that many of our patients have histories of childhood trauma, has led to a reconceptualisation of disorders such as borderline personality disorder, dissociative disorder, and a variety of aggressive behaviours against self and others as the likely

consequence of early traumatisation. This reframing has brought a culture of hope to a group of patients for whom chronic disability was seen as the norm.

The professional expertise of Clinical Psychologists in the diagnosis and assessment of PTSD is increasingly being recognised. For example, at Heidelberg Hospital in Victoria they now have admitting rights alongside psychiatrists.

As the initial description of its symptoms would suggest, helping people with PTSD is a complex process, but one to which Clinical Psychologists are particularly well suited. As noted, unlike much other medical and allied health disciplines, they have a strong research base in their training, which fosters a rigorous approach to understanding the aetiology of PTSD, its assessment, treatment programme development, and evaluation of its efficacy. In addition they are also committed to applying theories thus generated to the practice of counselling and psychotherapy.

The treatment of PTSD has changed since the Eighties largely because of the recognition that catharsis and abreaction, early therapy options, are by themselves insufficient and indeed potentially retraumatising for patients. Today the importance of understanding the meaning of trauma for the individual is stressed. people must be helped to find words for the 'wordless terror' of their experiences in order for them to become part of narrative history, instead of dissociated fragments that continue to intrude into their present.

Via their training, Clinical Psychologist are singularly possessed of a range of powerful techniques for encouraging the cognitive, emotional and behavioural changes necessary for such transformation. Since the nineteen eighties their treatment options have proliferated and therapists working in the area of PTSD now expected to be conversant with a wide range of interventions drawn from psychodynamic, cognitive-behavioural, and family systems approaches. Hypnosis and Eye Movement Desensitisation and Reprocessing (EMDR) are also becoming more widely advocated as potential adjuncts to PTSD treatment. These techniques are brought to bear on the whole array of behavioural and emotional problems that are now recognised to form part of the PTSD constellation. So for example, at the Hollywood Clinic, the PTSD programme for veterans includes supportive and / or expressive individual counselling and psychotherapy, and groups focussing on anger management, substance use, mood regulation, communication, social networking and relationship skills, relaxation and trauma processing. A group for partners is offered also. Clinical Psychologists are, by virtue of their training, able to run any of these groups.

It is increasingly being recognised that the families of PTSD sufferers commonly endure a kind of secondary traumatisation. They must frequently cope with domestic violence and emotional abuse, the financial hardship of their partner or parents' lost earnings, and stigmatisation because of society's ignorance and intolerance of mental disorder. Depression and anxiety are regularly observed in partners and children of the primary patient. For this reason, psychologists are now often required to provide couples and family counselling, in addition to individual work, or facilitate referrals for its provision.

Particularly in the field of war-related trauma, treatment commonly takes place in group settings. Thus the understanding of individual psychopathology must be coupled with knowledge of group process. For this reason many psychologists working in the area of PTSD are taking further training in group therapy.

Because increasingly successful treatment is leading to a renewed capacity for work in many PTSD patients, Clinical Psychologists involve themselves in liaison with rehabilitation providers. This interface with community services may also include advocacy and psychoeducation to raise awareness of the particular problems encountered by those with PTSD.

As the impact of trauma on the mental health of the individual, his family, and his community has come to be more widely appreciated so the role of Clinical Psychologists has increased in both its scope and depth. As a profession they have responded to the challenge of treating this complex disorder and form an important bulwark in the fight to raise the standard of mental health in the community more generally.

Clinical Psychology's role with Sexual Assault Trauma: The example of the Sexual Assault Resource Centre

The Sexual Assault Resource Centre (SARC) was formed by a concerned group of women wishing to provide assistance to women recently sexually assaulted. During the 1980's Clinical Psychologists were employed to provide counselling services to victims of sexual abuse and sexual assault.

In the early 1990's a review of the services provided by SARC was undertaken which resulted in an extension of services and mandate to professionalise services. Key duties of Clinical Psychologists now are:

1. Provision of education and training-

- to design, deliver and evaluate training for the induction of new staff and for the ongoing professional development of existing staff.
- To design, deliver and evaluate training for relevant Government and non-government agencies aimed at increasing awareness of and response to sexual abuse and sexual assault.

2. Provision of supervision-

- To provide clinical/administrative supervision to other staff members.
- To provide clinical/administrative supervision to clinical psychology students on placement and to new Clinical Psychologist registrars.

3. Consultation-

- to provide specialist input to other staff regarding research design, methodology, analysis and interpretation.
- to act as consultant to SARC staff on assessment, intervention and evaluation of intervention concerning intra-familial abuse, childhood sexual abuse and sexual assault.
- to act as consultant to Clinical Psychologists from other agencies on assessment, intervention and evaluation of intervention concerning intra-familial abuse, childhood sexual abuse and sexual assault.
- to act as consultant to metropolitan and rural agencies on assessment, intervention and evaluation of intervention concerning intra-familial abuse, childhood sexual abuse and sexual assault.

4. Clinical-

- to provide specialist knowledge of the benefits and limitations of psychological treatments for clients who have experienced sexual abuse and sexual assault.
- to provide counselling for an ever increasing number of clients with concomitant difficulties which are not “severe” enough for referral to specialist mental health, drug/alcohol or other agencies.
- To run psychoeducation and/or support groups for victims, parents and their families as required. These groups usually attract larger numbers if they are run out of work hours.

When Clinical Psychologists at SARC receive interagency referrals it is with the assumption that they have specialist knowledge and would be able to provide clients with specialist interventions for at least 6 to 9 months.

5. Clinical/legal-

- to interview and assess clients who have been sexually abused and sexually assaulted for the purpose of criminal injuries compensation.
- to produce criminal injuries compensation reports.
- to have an awareness of relevant legal processes in relation to sexual assault, sexual abuse and maintenance of safety (restraining orders etc).
- to provide expert witness testimony on behalf of clients during criminal proceedings.

At present Clinical Psychologists employed at SARC provide assistance to clients who present with a number of concomitant difficulties, these include polysubstance abuse, acute and/or chronic psychosis, personality disorder, affective disorder.....Provision of services to this client group frequently involves liaison with a number of metropolitan and rural professionals and agencies, as well as advanced evidence-based clinical skills.

Clinical Psychologists at SARC are expected to be up to date with current interventions, recently this has meant training in EMDR, Narrative Therapy, Family therapy, assessment for dissociative disorders and...... Recent changes to the Mental Health Act have meant that Clinical Psychologists have had to attend training in its implementation as frequently Clinical Psychologists and the Medical Practitioners at SARC may need to recommend hospitalisation or referral to mental health services.

SARC is a service which covers referrals of clients 10 years of age and above. As such Clinical Psychologists are expected to be familiar with interventions for children, families, adolescents, adults and the elderly.

Increases in Work Value: Areas of Recognised Psychological Innovation and Extension into New Areas of Work

Direct treatment of psychotic symptoms

In some patients, psychological treatments can directly modify some psychotic phenomena. Psychological treatments that directly target psychotic symptoms such as auditory and visual hallucinations, and delusions have now been developed and recent outcomes reported in the psychiatric and psychological literature, and experiences of Clinical Psychologists in hospital and community settings, in Western Australia illustrate the type of positive results that are possible.

In responsive cases, psychological modification of psychotic phenomena can reduce the need for a new hospital admission, or reduce the length of an existing admission. The particular skills and needs of the individual patient can indicate the use of psychological treatment. It is increasingly recognised that psychotic phenomena do not exist in isolation from a person's psychosocial and emotional functioning. Thus it is readily appreciated that some persons with a chronic disorder have marked psychological components that shape the frequency and nature of their psychotic phenomena. In some persons with a diagnosis of Brief Reactive Psychosis, psychological treatment can be a major component of the overall treatment. Physical complications in some inpatients can place constraints on medical treatment that may also indicate the use of psychological methods.

Bipolar affective disorder

This is a severe mental health disorder that presents with two disabling aspects, mania and depression. This use of adjunctive psychological therapy for this severe mental health disorder is a very recent innovation. It is estimated that bipolar disorder afflicts nearly 1% of adults and whilst some people may only experience a single episode of mania and depression in their lifetimes, over 95% of people with bipolar disorder have recurrent episodes. The probability of experiencing new episodes of depression or mania actually increases with each subsequent episode and the time between episodes decreases during the lifetime of the disorder. Prien & Potter (1990) estimated that an adult developing bipolar disorder in her/his mid 20's markedly reduces the quality of her/his life such that, given estimates of adult longevity, they effectively loses 9 years of life, 12 years of normal health and 14 years of work activity. Additionally, the suicide related mortality and the psychosocial

consequences for the ‘significant other’ and immediate family of the person with bipolar disorder is a major public health problem.

Pharmacological treatment is the first line treatment of this disorder. However, Joyce (1992) points out that even under optimal research conditions, prophylaxis will protect fewer than 50% of patients with bipolar disorder against further episodes.

The advent of psychological therapy for this disorder is a recent application based on two factors: firstly, the new conceptual paradigm of the disorder in which biomedical and psychosocial models have been combined, and secondly, the application of evidence supported treatments with previous demonstrated effectiveness for various aspects of the of the disorder, i.e. obstacles to treatment compliance, adjustment factors, loss and grief, interpersonal issues, sleep disturbance, stress related factors for vulnerability to relapse (Scott, 1995., Basco & Rush, 1996). The breadth of changed work value is demonstrated by Clinical Psychologists in the application of their skills to this new area.

Co-morbidity in Disorders of the Psychotic Spectrum

Persons with a major psychiatric disorder have a variety of psychological problems. Some of these may be secondary features and may remit once the primary features respond to treatment. However, many psychological problems coexist with the psychotic disorders and are largely independent of the major disorder. These are at times not diagnosed and nor treated.

Persons with major psychiatric disorders may also have psychological problems. They may have pre-existing psychological problems such as problems in pre-morbid personality. They may have problems that arose for reasons largely unconnected with the major disorder. For example they may be victims of assault; they may experience a stressful bereavement; or may experience interpersonal conflict, but may have to manage these problems with impaired coping resources. Co-morbid problems requiring psychological treatment may include:

- Adjustment disorders
- Anxiety and specific anxiety disorders
- Chronic pain
- Depressed mood
- Existential despair
- Personality problems
- Physical / sexual abuse history
- Post trauma reaction
- Sexual dysfunction
- Situational crisis
- Substance abuse
- Suicide risk

- Anger control and impulse control
- Anxiety states
- Hopelessness
- Marital dysfunction
- Panic
- Pathological guilt or shame
- Pathological grief
- Post-psychotic disorientation
- Self injury behaviour
- Sleep disturbances
- Suicidal intent
- Treatment non-compliance

New psychological problems can be created if the relapse itself acts as a psychological trauma: for example, a psychotic episode can be terrifying, leaving substantial post0trauma effects after the psychosis has remitted. The early episodes of a major psychiatric disorder represent an existential crisis: that of coming to terms with the likelihood of having a potentially incurable and socially stigmatising disability.

Psychological treatments developed for each of the above conditions are now being applied to these co-morbid condition with demonstrated effectiveness.

Prevention, Identification and Treatment in Early Psychosis

Early psychosis has become an identified area for improved clinical practice in Australian psychiatric services. Recently National Guidelines for the Early Psychosis have been released which emphasise a strong role for psychological interventions in treatment.

Early psychosis identification and intervention involves consumers experiencing early psychosis (i.e. the first episode of psychosis and the subsequent 2-3 years), this population consisting mostly of adolescents and young adults (between 18 and 35 years), with equal incidence in sex and a differential onset age between males and females (males typically developing a psychotic illness at a younger age than females).

The focus of early psychosis services is upon the identification and treatment of psychotic illnesses. The experiencing of a “first episode” may include a subsequent episode or two, depending upon the service. Thus these services do not service a particular disorder but rather a collection of psychiatric illnesses that have psychosis as a symptom (e.g., Schizophreniform Psychosis, Schizophrenia, Schizoaffective Disorder, Bipolar Disorder with psychotic features, Brief Psychotic Disorder, Delusional Disorder, Depression with psychotic features).

In addition to the psychotic illness there can be a number of disorders that develop as a consequence of psychosis. Thus it is not uncommon for Clinical Psychologists to be involved in the treatment of post-psychotic Depression and Anxiety (developing in up to 75% of cases), Post-Traumatic Stress Disorder as a result of psychotic experiences and/ or the experience of psychiatric treatment (e.g., involuntary admission to hospital), and Adjustment Disorders following an episode of psychosis. Similarly there are a number of co-morbid conditions that present with psychosis such as Substance Abuse problems, Social Phobia, and Personality Disorders. Clinical Psychologists may play a role in the assessment and treatment of these conditions as either a case manager or by providing an adjunctive treating role for the treatment team.

Consumers of mental health services experiencing early psychosis have historically been under-serviced by Clinical Psychologists. This has been due to a combination of factors:

(1) an adult mental health system that had adopted a cautious approach to the treatment of early psychosis - "waiting to see" if such individuals developed a chronic form of the illness, and then engaging in psychiatric rehabilitation

(2) a pessimistic view of the benefit of psychosocial interventions in the treatment and management of early psychosis, with a tendency toward using primarily biological interventions with minimal input from Clinical Psychologists

(3) a comparative paucity of effective psychological interventions in the treatment of psychosis, except for the area of behavioural family therapy and family psychoeducation. These evidence-based interventions, however, were not adopted into standard practice in adult mental health in Western Australia, possibly due to an underestimation of the importance of relatives and carers in the system.

Several changes have occurred since 1989 that have led to a greater role and increased responsibilities for Clinical Psychologists in the identification and management of early psychosis:

(1) a changing theoretical viewpoint of the nature of psychotic illness, with discoveries that schizophrenia is not a progressive deteriorating illness, disability associated with psychosis tends to occur within the first 5 years of illness, and such disability tends to be associated with social disruption rather than severity of symptoms. These discoveries contra-indicate a

delayed approach to rehabilitation and encouraging an increased role for psychological and psychosocial intervention in early treatment.

(2) technological changes in the development of psychological interventions for the management of psychosis, in particular for the positive symptoms such as delusions and hallucinations. Additionally there has been a refinement of family interventions for psychosis and the development of psychological models regarding the adjustment of the individual to experiencing psychosis, with a greater understanding of the factors that lead to disability.

(3) the development of early psychosis services, first initiated in Victoria with the EPPIC program, which advocate an integral role for psychologists and psychological methods in the identification and management of early psychosis

(4) changes in the focus of adult mental health services which increasingly acknowledge and assist the important role that families and carers play in the health of consumers, with this focus now enshrined in the 1996 WA Mental Health Act. This has led to an increased demand from consumers and carers for education and assistance in family management of mental illness, an area of clinical service for which Clinical Psychologists have well-developed skills and evidence-based interventions.

(5) an increased focus on prevention within the Australian health system. Early psychosis identification and intervention is designed to be a secondary prevention strategy, hopefully leading to a reduction in the incidence of chronicity, suicide and social disruption that has been associated with the onset of psychotic illness. This has obvious social and economic benefits to the health system and Australian society as a whole.
to provide services for long-term consumers with chronic psychotic illnesses as well.

Eating Disorders

Two eating disorders are covered in this section: Anorexia nervosa and Bulimia Nervosa. Anorexia Nervosa is defined as a specific form of eating disorder characterised by failure to maintain body weight at or above a minimum weight considered to be normal for the individuals age and height. Despite being underweight, anorexic individuals are characterised by a “relentless pursuit of thinness”. Individuals with Bulimia nervosa are characterised by episodes of uncontrollable eating binges, typically followed by self-induced vomiting, fasting or laxative abuse in order to avoid consequent weight gain. Anorexia Nervosa and Bulimia Nervosa are estimated to affect approximately 0.5% and 3% respectively, of adult women in western populations, whilst a further 55 of adult women and

as many as 13.3% of adolescent girls are believed to be suffering from sub-clinical levels of disordered eating.

Psychological therapies have been applied to these disorders especially since the mid 1980's and have involved Clinical Psychologists in an increased breadth of treatment and also in much needed research in understanding the mechanisms by which these disorders persist over time. The following psychological therapies have been reported in the literature to show positive effectiveness: family therapy, short-term psychodynamic therapy, cognitive-behavioural therapy, interpersonal psychotherapy, self psychology and intense inpatient treatment.

It has become increasingly apparent that the treatment of the overt behaviours exhibited in these disorders is not sufficient for effective therapy. Clinical Psychologists have extended the traditional approaches of nutritional management, inpatient treatment and pharmacotherapy to include treatments focussed on the very core issues maintaining these disorders, the overconcern with body shape and weight exhibited by these individuals, the way in which these women almost exclusively evaluate themselves in terms of this overvalued ideation, the very essence of the self that is involved in maintaining these disorders and the interpersonal complications between significant others and the immediate family.

Psychological therapies have been reported in the literature in controlled clinical trials. Cognitive behaviour therapy has been found to be as effective or better than supportive therapies, stress management and educational information alone. One meta analysis concluded that cognitive behaviour therapy for example, achieved a mean clinically significant reduction in purging of 79% and 57% in remission with similar figures for reduction in binge eating in Bulimia Nervosa (Craighead & Agras, 1991). Interpersonal therapy has been effective in decreasing the symptoms of bulimia nervosa (Wilfley, Agras, Telch, Rossiter, Schneider, Golomb Cole, Sifford & Raeburn, 1993). Immediate and longer term effects of psychological therapies such as interpersonal therapy, behaviour therapy and cognitive behaviour therapy have been studied with follow-up studies. It has been found that gains were maintained at six months and 12 months (Agras, Schneider, Arnow, Raeburn & Telch, 1989, Fairburn, Jones, Peveler, Hope, & O'Connor, 1993) and at 6 year follow-up (Fairburn, Norman, Welch, O'Connor, Doll, & Peveler, 1995). Whilst fewer controlled studies of Anorexia Nervosa have been published, systematic case studies have been reported.

Direct Treatment of Personality Disorders

In persons with severe personality disorders, psychological treatments can be the primary form of treatment. Although pharmacological treatments are often required concurrently, significant and sustainable improvements in personality functioning can be achieved through psychological treatment. Although treatment of these disorders is generally on a long-term outpatient basis, the crisis circumstances of a particular hospital admission can loosen previously entrenched cognitive patterns and create a therapeutic opportunity for a more rapid period of progress. The types of problems which are treated psychologically in persons with personality disorder include many of those already listed for major psychiatric disorders. Persons with personality disorder may additionally require treatment emphasis upon:

- Reduction of self-harm behaviours.
- The nature of the self-concept and development of the self-concept.
- The search for meaning and the meeting of other existential needs.
- Management of extreme emotional states.
- Management of conflicting emotions.
- Control of dissociative states.
- Working through early sexual trauma.
- Modification of self-defeating patterns of interaction with significant others.

Whether treated with medication or psychotherapy Personality Disorders have proven resistance to change (Beck and Freeman, 1990).

The diagnosis of a Personality Disorder has 3 common attributes that separates it from a symptom disorder. These characteristics are; rigidity, avoidance and long-term inter-personal difficulties. The rigidity refers to inability to be flexible in thinking and behaviour patterns. These patients frequently distort perceptions of their environment and misconstrue even benign events. Thus the person continually engages in a vicious cycle of self-defeating behaviour patterns. Avoidance in personality disorders is central to the point that thoughts and feelings can be completely blocked or avoided such as in symptoms of depersonalisation and derealisation. Finally patients with Personality Disorders, by definition, have inter-personal difficulties. These difficulties often interfere with the establishment of a collaborative relationship which is essential to any therapeutic endeavour whether that be via medication or psychotherapy. For a review see Young (1994).

The incidence of Personality Disorders in Mental Health settings is extremely high. Data from one teaching hospital in Perth estimates that 40% of admissions would formally meet the diagnostic criteria for a Personality Disorder, whilst another third would have some traits consistent with one of these disorders. This is consistent with DSM-IV data on the current frequency of Personality Disorders in clinic populations (Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, 1994).

One of the most commonly diagnosed PD, Borderline Personality Disorder (BPD) is a substantial public health problem that is difficult and costly to treat. The diagnosis of borderline personality disorder (BPD) applies to approximately 2-4% of the general population, 11% of all psychiatric outpatients and 19% of psychiatric inpatients (Gabbard, 1994: Widiger & Frances, 1989). These patients experience extreme distress and make extensive use of psychiatric and medical services. The main features of the disorder include affective instability, recurrent suicidal or self- mutilating behaviour, impulsivity in areas such as substance abuse, spending or binge eating, chaotic relationships, identity disturbance and distress related to fear of abandonment.

Segal and Blatt (1993) argued that cultural changes were likely to lead to the increases in disorders such as Borderline Personality Disorder. Given that society is more complex and the changes in traditional authority structure, then individuals are more likely to have a sense of uncertainty. Identity confusion is a core feature of Borderline Personality Disorders.

RECOMMENDED INTERVENTIONS

Methods for dealing with Personality Disorders that have received attention during the last 10 years can be categorised as Schema Focused, Dialectic Behaviour Therapy (DBT), and Self Psychology. Each has demonstrated empirical support for the interventions.

A Schema focused approach involves a model of therapy that focuses on understanding a person's core beliefs about himself or herself. It combines:

- Emotive techniques (Affect Bridge, Distress Tolerance, Imagery Techniques),
- Interpersonal (transference issues, reparenting),
- Cognitive (changing the way that information is distorted to maintain dysfunctional core beliefs), and
- Behavioural. (Desensitisation and In vivo techniques designed to challenge behaviours that maintain the person's symptoms).

The second treatment procedure shown to be effective with Personality disorders is a self-psychology model (Stevenson and Meares ,1992). The treatment model used is based on the notion that BPD is a consequence of a disruption in the development of the self. The principle assumption is that a certain kind of mental activity, found in reverie and underlying symbolic play, is necessary to the generation of the self. In early life its presence depends on the quality of the relationship with the caregivers, and development in person with BPD is disrupted by excessive impingements of the environment, often in the form of various kinds of abuse.

The aim of therapy is maturational. The patient is helped to explore his or her personal reality, and this really relates to inner life and has an affective core. The role of the therapist is to establish an enabling atmosphere for this exploration via empathic attunement and other means, and to deal with inevitable empathic failures in a way which facilitates the patient's experiential exploration.

The third approach, DBT is a manualized, behavioural treatment that includes concomitant, weekly individual psychotherapy and group skills training. DBT is based on the assumption that individuals with BPD lack important interpersonal, self-regulation and distress tolerance skills. It is also maintained that personal and environmental factors inhibit the use of behaviour skills the individual does possess and reinforce inappropriate behaviours. The individual DBT focuses on motivational issues and seeks to balance skills development with supportive, validating strategies aimed at providing acceptance. Weekly group skills training follows a psychoeducational format and focuses on skill acquisition. The treatment specifically seeks to reduce suicidal behaviours that interfere with quality of life. It aims to increase skills in emotion regulation, distress tolerance and mindful behavioural responses.

Successful psychological therapeutic interventions have been shown to occur with Antisocial Personality Disorder (Woody et al., 1985), Borderline Personality Disorder (Linehan et al., 1991; Linehan et al.,1993, Stevenson and Meares ,1992), and Cluster C Personality Disorders (Alden, 1989; Hardy et al., 1991; Shea et al., 1992).

Clinical Psychologists' Role

All of the models described above require a clinician to have a sophisticated understanding of complex models and a broad range of skills.

It is precisely this area that Clinical Psychologists have demonstrated their expertise. An independent review of Clinical Psychology services in Britain found that Clinical Psychologists differed from other health professions in the extent to which they could conceptualise complex issues and their breadth of knowledge of a broad range of psychological approaches.

Given the increasing extent to which the mental health service is asked to deal with Personality Disorders, the enormous cost and the enormous drain they place on resources, it is imperative that effective treatment services be delivered. Given their skills and knowledge, Clinical Psychologists are in the best position to provide efficient and effective service delivery.

Severe Mental Health Problems in Older Persons

INTRODUCTION

W.A. has an increasing ageing population with the proportion of seniors, i.e. aged 60+ years increasing to 22.5% of the total population by the year 2021 (Office of Seniors Interests and A.B.S. 1996). Over 90% of people over sixty years of age live in private dwellings with more than 20% of them living alone, three quarters of these are women. Only 7% live in institutions such as hostels and nursing homes. Evidence shows that family ties remain strong between older people and their adult children and provide care-giving at times of ill health.

Mental Health Issues for Older People-

There is now well established evidence that clinical psychology can improve the mental health of older people and their family members. Some of the best controlled studies demonstrating the effectiveness of Cognitive Behaviour Therapy have been conducted with the elderly (Hollon, Shelton & Davis 1993, Gallagher and Breckenridge 1987). Meta analysis of psycho-social interventions suggests such treatment can be described as ‘highly effective’ for geriatric depression (Scogin & McElreath 1994).

Preliminary research on the modification of problem behaviour in institutions is very promising (Burgio & Bourgeois 1992, Phillips-Doyle 1993). Recent research by Bird et al (1995) on the

use of cued recall to overcome behaviour problems in dementia patients suggests this is an effective method in addition to traditional applied behaviour analysis used for these problems.

While approximately half the 100,000 people with dementia in Australia live in institutions, the other half are supported at home (Flicker,1992). The psychological contribution in the latter group is great given the stress faced by family caregivers in the tasks they undertake. The association between caring for a person with dementia and increased prevalence of mental and physical health problems is well established (Graftstrometal, 1992).

Training caregivers to treat depressed spouses with dementia via behavioural techniques alleviates depression in carers and spouses (Teri 1994) and training care givers in behavioural management principles leads to disabled spouses remaining at home over a longer period (Schulz, Schulz & Greenwood 1992). Caregivers with depression can be successfully treated using either brief psychodynamic therapy or cognitive behaviour therapy (Gallagher - Thompson & Steffen 1994).

Community Expectations of Service Delivery to Older Adults.

Recent reviews of community opinion have deplored the current status quo in terms of the mental health services generally provided to older adults. For instance the “Burdekin Report” (Human Rights and Equal Opportunities Commission, 1993) noted that
“The elderly are more likely to receive drugs and less likely to receive psychotherapy” (1993, p.511) “The worst images associated with the old mental institution - for example patients being physically restrained or sedated - are still the case for many sick elderly people” (1993, p.928).

Such comments support the notion of improved services and diversity of approaches. As indicated above Clinical Psychologists can provide services and interventions to alleviate the deficiencies in the current mental health services provided to older Australians, of which the community is now aware.

The kinds of psychotherapeutic interventions employed by Clinical Psychologists whether cognitive behaviour therapy for disorders such as depression or phobic anxiety, behaviour modification for challenging behaviour or family counselling provides stabilisation and support the clients to remain in their own homes rather that be admitted for inpatient treatment. This is both less disruptive to the individual and less expensive for the health systems and the community than institutionalisation.

Specialised Assessment and Treatment Modalities with the Elderly

Over the past decade there has been a great increase in the breadth and depth of specialised knowledge in the field of the elderly. There is greater complexity of assessment with this age group (Hersen, Van Hasselt & Goreczny, 1993) and for the requirement for treatments to be significantly modified (Gallagher & Thompson 1981) and the case for specific skills is even stronger than previously.

Details of specialist treatment approaches, assessment instruments and significant texts are outlined below.

SPECIALISED TREATMENT APPROACHES WITH ELDERLY

- Familiarity with adaptations to psychodynamic, cognitive and behavioural therapies for elderly populations with clinical problems such as anxiety and depression, chronic pain, adjustment to physical and intellectual disabilities.
- Knowledge of specialised therapies for the elderly including reality orientation, reminiscence, validation therapy - both individual and group formats.
- 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.
- Interventions to alleviate caregiver stress including stress management training, grief counselling and training in behaviour management skills.
- Family consultation, education and systemic intervention for complex issues such as severe family discord and elder abuse and neglect.
- Clinical assessment, neuropsychological and functional evaluation for legal competence in older adults.

SPECIALISED ASSESSMENT INSTRUMENTS FOR USE WITH ELDERLY POPULATIONS

- Schonnell Graded Word Reading Test.
- Nelson Adult Reading Test.
- Mayo's Older American Norms for Wechsler Adult Intelligence Scale - Revised.
- Mayo's Older American Norms for Wechsler Memory Scale - Revised.
- Hulicka's Aged Norms for Wechsler Memory Scale.
- Mini Mental State Exam (Folstein & McHugh, 1987).
- Cognitive Scale of Cambridge Assessment of Mental Disorders of Elderly (Roth et al, 1986).
- Kendrick Cognitive Tests (Kendrick, 1985).
- Raven's Coloured Progressive Matrices.
- Clifton Assessment Procedures for the Elderly (C.A.P.E.) (Pattie & Gilleard).
- Middlesex Elderly Assessment of Mental State (Golding, 1989).
- Psychogeriatric Assessment Scales (Jorm & McKinnon, 1995).
- Revised Memory and Behaviour Problems Checklist (Teri et al, 1992).
- Hierachic Dementia Scale (Cole & Daastoor, 1996).
- Geriatric Depression Scale (Yesavage & Brink, 1983).
- Beck Depression Inventory (Gallagher et al, 1982).
- Cornell Scale for Depression in Dementia (Alexopoulos et al, 1987).
- Trig. Texas Revised Grief Inventory (Faschingbauer et al, 1987).
- Burden Interview (Zarit et al, 1980).
- Relatives Stress Scale (Green).
- Beck Anxiety Inventory Aged Norms (Wetherelle A reáu, 1997).
- Philadelphia Geriatric Centre Morale Scale (Lawton, 1975).

CHANGES IN WORK VALUE SINCE 1989

General Comment

In working with elderly clients, Clinical Psychologists require a degree of maturity and experience because often they work as sole practitioners, working with other professionals and para-professionals and work in isolation, independently of other Clinical Psychologists. In particular, new graduates are expected to work at a senior level. The practising Clinical

Psychologist clinician would be required to demonstrate a high level of sophistication in communication and liaison skills to communicate psychological ideas to all levels including lay people, care aids and para -professionals. This represents a change in practice with the increased requirement for community work. In recent years the balance of work has shifted from working in institutions, to community settings for example; day centres, hostels, nursing homes, individual homes.

Development of Community Services by Clinical Psychologists Working with the Elderly

Changes to Commonwealth policy and funding with an increased emphasis on community care for the elderly has led to an increased emphasis on working on psychological intervention in settings where people live. This requires Clinical Psychologists working with the elderly to intervene with individuals, couples, families and agencies and staff from different systems and at different levels. Following the institution of the National Action Plan for Dementia Care (1995) Clinical Psychologists have been involved in training staff in the identification and assessment for management of placement of elderly clients. Clinical Psychologists have been involved in training staff to develop frameworks and models for decision making in relation to planning services and future care for individual clients with dementia.

As members of Aged Care Assessment Teams Clinical Psychologists have been increasingly required to implement interventions to prevent admission to hostel and nursing home care. In addition Clinical Psychologists working with the elderly have been increasingly required to be involved in complex decision making in management and assessment of the functional residual skills of elderly person regarding future placement eg. returning home versus going into institutional care.

Psychological Assessment

There is increased recognition of the requirement for specialist skills in the comprehensive psychological assessment of the older person. Assessment is tailored to individual need and is sometimes difficult due to sensory impairments such as hearing and visual impairment and the presence of multiple medical/physical conditions. Assessment is conducted for the purpose of testamentary capacity and the preparation of reports for the Guardianship and Administration Board. In addition assessment assists decision making for management of client care in the least restrictive alternative, with differential diagnosis such as delineating dementia versus depression and the subtypes of dementia, especially with regard to new drug treatments that have become available recently for the treatment of dementia. This

provides information which becomes the basis of counselling for both individuals and family members on the nature of their organic disorder.

Another issue relating to appraisal is the assessment of the contribution of relative elements of the affective disorder versus the organic disorder in terms of the client's presentation. In addition, the Clinical Psychologists role is to monitor the effectiveness of treatment approaches such as medication.

Training Issues in Relation to Professional Standards in Clinical Psychology for the Elderly

Previously, Clinical Psychologists working with the elderly were trained through generalist adult programmes taught at a post-graduate level at university. As psychology services have become more distinct, as a discrete area of responsibility and skills and knowledge, practising clinicians in this area have been required to provide academic input to training programmes at a post-graduate university level. In practical terms, this has involved taking on lecturing, teaching and supervision responsibilities for Masters and PhD university students.

In recognition of the specialist requirements for this field, in 1996 Curtin University introduced a dedicated unit in the School of Psychology called Psychology of Aging. This was originally taught by Mr Ian Kneebone of the Osborne Park Restorative Unit. This programme has been continued in 1998. In addition, Edith Cowan University has a dedicated post-graduate training programme in clinical gero-psychology and input has been requested for training in clinical problems with the elderly.

Critical Issues in Service Delivery.

Increasingly Clinical Psychologists find themselves bridging the gap between Psychiatry and Geriatric Medicine in a liaison and consultation role in the management of clients and encouraging cross referral between services.

The scope and value of psychological work with elderly populations has been demonstrated by the increased number of positions created in geriatric medicine departments since the late 1980's. Somewhere between six and seven positions have been created across the metropolitan area depending upon the availability of funding.

As one of the most highly trained professionals in this setting and as a sole practitioner, there is increased expectation from other staff of the Clinical Psychologist role for involvement in conflict resolution, especially related to patient care, stress debriefing and crisis intervention in community, institutions and agency settings in the practitioners health region.

Clinical Psychologists have taken on a pro-active management role in the development of specialist programmes for elderly people residing in the community e.g. the memory clinic programmes. Clinical Psychologists have taken increased involvement in innovative research and evaluation programmes as e.g. the treatment of depression in nursing homes and treatment of memory-impaired older adults.

Not only have Clinical Psychologists been expected to take on leadership roles in these areas but also to contribute significantly to research design and participate in the evaluation process with other professionals such as psychiatrists and geriatricians.

Due to the present shortage of Psychiatrists, reluctance of this age group to be referred to psychiatric services and employment of Clinical Psychologists in general medical rather that psychiatric settings there is a general trend of involving Clinical Psychologists as specialist consultants in difficult management issues such as elder abuse, self harm and suicide and palliative care. These spheres of work are increasingly becoming the domain for psychological work and with an increasing ageing population these current trends are expected to continue.

With increasing health care costs related to an ageing population new roles in health promotion, early intervention in and prevention of mental health problems are expected to develop, thus further increasing the scope of influence and responsibility of Clinical Psychologists working in the area of the elderly.

Transcultural Mental Health Problems

The main target patient population of the Clinical Psychologist working within transcultural settings is the person of non-english speaking background (NESB). The breadth and depth of work involved with this patient group is quintessentially different from the work customarily carried out by Clinical Psychologists. Layers of extra complication are provided by:

- culturally tied health related beliefs
- Cross-cultural variations in the concept of “mental health”

- Cultural variations in explanatory models of mental illness
- Cultural differences in acceptance of treatment for severe mental health problems
- Cultural sensitivity needed in providing psychological interventions to the ethnic community patient
- Amongst the transcultural population a number of people will have experienced considerable stress resultant from discrimination and prejudice due to minority status and others may be refugees who have experienced catastrophic trauma in country of origin
- The stressfulness of migration to a new country, i.e. disruption of attachments and supportive networks
- The process of acculturation and concomitant tasks of adapting to the host country's cultural, social and economic systems.
- The person is faced with adjusting their own personal identities, including their new status as a member of a minority group

In view of such challenges the role of the transcultural Clinical Psychologist must necessarily encompass a broad spectrum. Within the clinical role individual and systems interventions are undertaken with NESB patients and carers, if and when necessary. Modalities used include cognitive-behaviour therapy, family therapy, behavioural therapy and general counselling. More often than not, an interpreter is essential. Home visits are also a regular component given the strong stigma attached to seeking help (particularly access of this help within a psychiatric clinic environment, and the fear of being seen by others in the community).

The range of disorders treated predominantly include anxiety disorders, acute stress reaction disorder, post-traumatic stress disorder, major depression and adjustment disorder. Acculturation issues may need to be addressed as part of the overall management of the patient. To facilitate resolution of these issues collaboration and co-operation are continuously sought and maintained between the Clinical Psychologist and other service providers who also specialise in NESB patient work. In this arena, clinical psychology, on behalf of allied health professionals working in transcultural mental health, has facilitated a co-ordinated approach to NESB mental health service delivery. Specifically, this has been achieved by formation of regular focus groups comprising key stake holders in the field.

A constant and desired outcome of any work undertaken by the Clinical Psychologist in a service like the Transcultural Psychiatry Unit, whether within the therapy context or otherwise, is to minimise the barriers to accessing timely help and thereby addressing the stigma attached to mental illness in ethnic communities. This is accomplished by way of two approaches; research

and education. Both have the objective of promoting utilisation and access of mental health services to NESB communities.

The research function of the Clinical Psychologist is vital to good practice and focuses on ;

- Accurate detection and quantification of mental health disorders among NESB people
- Factors that make NESB particularly vulnerable to mental health disorders
- Issues that need to be included in culturally sensitive interventions
- Culturally specific development of programmes
- Increased facilitation of access to mental health services
- Decrease the drop out rate from interventions
- Evaluation of the effectiveness of ethnospecific mental health services

Education and training programmes about psychological disorders and the nature of mental health available are developed for delivery to ethnic communities. Seminars and information sessions are also requested by other service providers (including NGO's) who identify a lack of awareness of multicultural issues in service delivery.

The Clinical Psychologist working in the Transcultural Psychiatry Programme (TPP) located at Royal Perth Hospital has responsibility for management of patients, education and training, programme development, programme evaluation and research. As the TPP is a state-wide service, the influence of the clinical psychology position is pertinent to programmes of research, education and training state-wide , including initiatives involving other service providers engaged in provision of mental health services to this population.

Clinical Psychology and Severe Mental Health Problems in General Practitioner Settings

Traditionally Clinical Psychologists work as specialists in mental health settings. However the people seen in mental health agencies are only a small proportion of those who experience similar problems in the community at large. It has been estimated that between a quarter and a third of all illnesses treated by General Practitioners (GP's) are psychiatric illnesses, and that in one year about 14 per cent of a GP's patients will consult for psychiatric disorders. (Marzillier 1992). This has been called in the literature the 'hidden psychiatric morbidity' because patients often present with insomnia, headaches when in reality they are suffering from a mental health problem.

Specialist clinically applied treatment research programmes: The example of the West Australian Institute for Psychotherapy Research, (WAIPR) based at Royal Perth Hospital.

This is a programme that had been initiated by Clinical Psychology in collaboration with Psychiatry and demonstrated increased work value in a totally new domain: research at the "coal face".

The West Australian Institute for Psychotherapy Research (WAIPR) is a special state-wide program that aims to provide excellence in the clinical management of adult psychiatric disorders. To achieve this aim, WAIPR is an interdisciplinary clinical research group involved in the theory, practice and development of evidence supported psychotherapies.

WAIPR aims to provide a scientific environment for interdisciplinary and intradisciplinary collaborative research within which evidence supported clinical practice and theoretical understanding of psychopathology is investigated with the aim of decreasing patient distress and increase patient empowerment.

Specific Objectives:

1. To provide specific, integrated and coherent evidence supported interventions for adults with severe mental health disorders.

2. To promote the scientific investigation of the processes and mechanisms that undergrid psychopathology at the molecular [biological] and molar [psychosocial] levels of analysis.

3. To implement interventions for complex mental health disorders.

4. To translate efficacy studies into "Real World' effectiveness interventions.

5. To provide an interdisciplinary teaching resource for psychological interventions.

6. To integrate research and health service delivery in alliance with community groups and university groups, in order to turn clinical research and clinical activity into public sector policy.

Works in progress:

- treatment of mixed anxiety - depression
- treatment of obsessive-compulsive disorder
- group treatments for adolescents (in collaboration with YouthLink)
- clinical evaluation and accountability of individual and group treatment
- the translation of efficacy studies to effectiveness "real world" studies: a review of issues
- investigation of co-morbidity of disorders in the psychotic spectrum (in collaboration with The Department of Psychiatry at The University of Western Australia)
- adjunctive psychosocial interventions with bipolar affective disorders (in collaboration with Inner City Mental Health Service / Royal Perth Hospital)
- the relationship between anxiety, depression and substance misuse (in collaboration with Inner City Mental Health Service / Royal Perth Hospital and The Department of Psychology at The University of Western Australia)

Quality improvement projects in progress:

- adaptation of the National Mental Health Standards to community programmes
- factors affecting the utilisation of mental health services (collaboration with IDP/ICMHS)
- evaluation report WAIPR treatment programme
- consumer evaluation of WAIPR programme

Clinical Psychology

Remote and Rural Mental Health

The need for improved services in the remote communities of rural Australia are a state and national priority. This has been clearly articulated in the draft policy statement on “a comprehensive framework for mental health services” circulated to all service providers by the Mental Health Division of the Health Department of Western Australia early in 1998. The special needs of remote and rural communities necessitate a specialist focus that not only improves the accessibility to services in a physical sense, but also understands the cultural and psychological needs of individual communities and the people within them.

The following brief description remote services (summarised from work carried out in the South West Region, The Gascoyne and Pilbara / Kimberley) provides an understanding of the work value of Clinical Psychologists working in Mental Health Services in remote and rural settings.

Populations Served

Adults, children, adolescents and families with mental health problems. These include areas of service which are huge in size. Take the Gascoyne region as an example, the service by the Clinical Psychologist covers an area over 150,000 square kilometres and involve five communities with a large Aboriginal populations. The Communities needing services are remote and isolated as is the Clinical Psychologist. In these areas the Clinical Psychologist has expended their mode of operating so that they take their service to the community that needs it. For example the Clinical Psychologist in the Pilbara / Kimberley Region also visits Karratha fortnightly and Tome Price, Paraburdoo, Newman and Broome as needed.

Nature of the Mental Health Activities.

- Assessment, treatment , liaison & consultation with community agencies for a full range of complex mental health problems

- Consultant and resource within the health system for community, public and hospital settings and in the wider community for other agencies such as the Education Department, Family and Children Services, Juvenile Justice, Community Corrections and the Aboriginal Medical Service.

- Policy development for mental health services

- Authorised Mental Health Practitioner under the Mental Health Act

- Emergency services for the police or inpatient admissions

- Emergency services for community needs

Disorders Treated

The full range of Mental Health Disorders seen in urban clinics are also treated in theses settings and they are treated with the full range of skills used by all Clinical Psychologists.

Scope of Influence

Clinical Psychology has a leading role not only with patients but also with staff for assessment/consultation with very difficult cases.

Supervision of Clinical Psychology Registrars out of hours.

High level of autonomous decision making with a very broad role and high workload.

Consulted by management on a range of issues.

Quality assurance implementation and collation of statistical information.

Administration & policy duties.

Clinical Psychologists living in remote and rural areas are penalised in a number of ways:

- Financial penalties include the very high cost of living, particularly travel costs which are nowhere near offset by the North-West allowance and the one free airfare per year. Employees in private enterprise businesses allow staff two airfares. All foodstuffs, hardware, clothing and meals attract a freight premium, as does the purchase of professional literature.

- In small country towns the possibility for social interaction is small, because of the nature of the work undertaken.

- Service demands are such that, particularly for the solo practitioner, the hours of work increase with no recompense. This particularly applies to such things as client attributable tasks, such as keeping abreast of the literature for example to the general demands from the community for information and education. An added complication for many in rural areas is the fact that frequently only one government department has a Clinical Psychologist in employment. Even greater demands are placed on this person, especially if they are appointed as an Authorised Mental Health Practitioner.

- Most Clinical Psychologists have the need to further their professional development through attendance at conferences, seminars, workshops and lectures. It is impossible for this to occur in small regional centres. The country clinician is therefore in terms of maintaining clinical quality assurance. The example of the Clinical Psychologist in Port Hedland illustrates the difficulties of maintaining clinical improvement. When he first arrived in Port Hedland, the contract allowed financial assistance for these activities, however due to budgetary restraints …. this allowance has been removed.

Clinical Psychology

Mental Health Problems in Medical Conditions

Changing patterns of illness during the twentieth century, and the ever increasingly clearer role of psychiatric & psychological influences on illness, have highlighted the efficacy of consult-liaison clinical psychology in illness prevention and treatment (Taylor, 1990).

The leading causes of illness have changed from infectious diseases to those that relate to high risk behaviour and lifestyle. Chronic diseases, illnesses that develop, persist or recur over the long term implicate psychological factors as causes (e.g. mood disorders, behavioural and cognitive aspects of personality disorders).

Complex psychological issues, requiring highly specialised empirically based treatments, frequently develop and change over the lifetime course of these chronic illnesses. Psychological interventions are used to treat a person's physical state (e.g. visualisation with cancer patients, CBT for pain control) with documented high rates of efficacy.

Accurate targeting of the multitude of factors sustaining illness and abnormal sick role behaviour translates into lower and briefer hospitalisation rates and helps cap the escalating cost of medical care.

Clinical Psychology provides the following functions within consult-liaison psychiatry: understanding psychological influences on maintaining health, reasons for people becoming ill, and how they respond to illness. It promotes evidence-based targeted interventions to recover from illness and maintain health. Examples include cardiovascular illness, cancer, pain, rehabilitative medicine, smoking cessation, diabetes, burns, eating disorders, alcohol and drug abuse, asthma, psychogynaecology, HIV/AIDS, sexually transmissible diseases, autoimmune diseases, and hepatitis C.

The Role of Clinical Psychologists

The increased awareness and formal recognition of psychiatric & psychological factors in health and illness over the past decade has seen more attention paid to the role of psychiatry in medicine, and increasingly the use of terms such as ‘biopsychosocial’ and ‘psychoneuroimmunology’. A concurrent burgeoning in the health applications of clinical psychology has opened up an area for the application of clinical psychology services, the benefits of which in relation to health outcomes, adjustment to illness, health promotion, and service costs are increasingly being recognised (Milgrom, Nathan, & Martin, 1996).

The scope of possible applications is broad:

- Psychological problems presenting as physical disease
  e.g. Somatoform Disorders, hypochondriasis

- Psychological problems secondary to physical disease
  e.g. acute stress, adjustment disorder, anxiety and depression associated with illness and disability

- Psychological factors exacerbating existing disease processes or interfering with recovery / rehabilitation
  e.g. the role of stress, coping styles and lifestyle on illness course *(adapted from Wallace & Bennett, 1992).*

Within this broad conceptualisation there are many possible areas of focus for intervention for example:

- Reducing anxiety and depression in medical contexts.
- Applying biopsychosocial models in identifying factors involved in “abnormal illness behaviour” and somatoform presentations.
- Promoting adjustment to chronic illness / disability.
- Trauma / acute stress / grief counselling.
- Enhancing compliance with medical and rehabilitation procedures, and modifying behaviours that are consistent with optimal health outcomes.
- Pain management.
- Increasing coping skills to manage medical procedures.
- Improving patient-staff communication.

Communication and consultation with medical teams and allied health is an essential part of the role of the liaison Clinical Psychologist. The Clinical Psychologist may join multidisciplinary teams on particular units, eg. Burns Units, having input into many aspects of service delivery and patient care including staff education and support, or in a consultation-liaison role, respond to requests in relation to specific problems from medical teams / units.

The example of Royal Perth Hospital

At Royal Perth Hospital there exists a combination of such service delivery with additional specialist services at Immunology and the WA Breast Clinical Psychology Cancer Services. Information directly pertinent to these later two services is presented elsewhere in this section.

There is one Clinical Psychologist working in a general Consultation-Liaison (CL) role based within the multidisciplinary CL Unit, formed around 1995, which serves the general hospital. The CL team consists of 2 consultant psychiatrists, 3 psychiatric registrars, a clinical nurse specialist, a social worker, a youth self-harm social worker, a drug and alcohol adviser, and a Clinical Psychologist. In the original plan for the CL Unit it was estimated that in fact 8 or more Clinical Psychologists should be involved in the CL service for a hospital the size of RPH.

Clinical psychology assessment procedures include cognitive-behavioural assessment; biobehavioural, psychophysiological, and psychosocial assessment based in a biopsychosocial framework; basic neuropsychological examination; mental status examination; and DSM-IV diagnosis. Modes of intervention include cognitive-behavioural therapy, individual psychotherapy, family/couples work, systems approach, and crisis intervention. Both inpatients and outpatients are seen. Interventions may involve assessment and recommendation only, referral to another agency, or a brief intervention or longer term psychotherapeutic work may be undertaken.

Decision Making

The Clinical Psychologist is required to make independent decisions in relation to referrals to clinical psychology, seek a psychiatric consultation when deemed appropriate, and give input into requests for psychiatric assessments working closely with other team members.

An incomplete assessment or a misdiagnosis could have the effect of unnecessarily prolonging patient suffering, slowing down recovery by not identifying barriers which may lengthen hospitalisation and hence increase service costs.

The Clinical Psychologist is seen to bring special skills in research and evaluation to the liaison context, with a scientist-practitioner orientation and methodological skills they have an important role in quality assurance, outcome assessment, and the development of research projects.

The Clinical Psychologist also has an important educative role, for example giving a presentation to the Surgical Specialties Division on the role of psychological factors in recovery from physical trauma.

The role of the Clinical Psychologist in liaison psychiatry is a new and exciting area of application, the unique benefits of which to health care services we may just be beginning to realise

Specific Areas of Service-Immunology

<u>HIV/AIDS -</u>

This service has radically changed from being that of a small community clinic & a mainly crisis service, responding to the public anxieties pursuant to the “Grim Reaper” campaigns of the mid to late 1980’s, to now providing a continuum of hospital-based services to a chronically ill population with significant rates of psychiatric & psychological co-morbidity. AIDS dementia complex (ADC), a diagnostic label introduced in the late 1980’s, describes the constellation of neuropsychological symptoms seen clinically in many AIDS patients; ADC has become a major component of clinical psychology’s assessment and intervention activities in the past several years. This population includes in- and out-patients within the main HIV/AIDS statewide treatment service (RPH) and also receives direct referrals from GP’s, whose management of patients’ mental health needs are then guided by the Clinical Psychologist’s assessments, recommendations and treatment.

Systemic Lupus Erythenatisys (SLE), Auto Immune Diseases and Bone Marrow Transplant

SLE - a multisystem auto-immune disease, other auto-immune diseases and Bone marrow transplant constitute new applications of Clinical Psychology since 1994. Clinical Psychology provides services to in- and out-patients within the main (RPH) SLE/auto-immune & BMTU statewide treatment service. GP's also refer directly for advice and recommendations, particularly regarding intractable depression, other mood disorders, neurological disorders, and related management of pain, fatigue and nausea.

Hepatitis C Infection

Since 1992, this has been another major new application of Clinical Psychology. Patients include in- and out-patients within the main Clinical Immunology state-wide treatment service (RPH), and direct patient referrals from GP's. A continuum of service is provided, particularly regarding the interactive problems of mood & personality disorders and symptomatology (e.g. pain, fatigue, nausea).

Sexually Transmittable Diseases (STD's)

This has developed from that of a crisis service (late 1980's), servicing worried non-clinical patients, to an evidence-based symptom reduction service, particularly regarding Recurrent Genital Herpes Simplex Virus (HSV) and Human Papilloma Virus (HPV). High rates of psychiatric/psychological co-morbidity have been noted in the literature - around 35%. The Clinical Psychologist consults with out-patients within main STD state-wide treatment service, and is the only mental health professional providing consult-liaison to the service.

Responsibility and Impact of Decisions

Clinical Psychology provides a permanently seconded consult-liaison service to the Department of Clinical Immunology & Bone Marrow Transplant Unit. This position assumes a state-wide, independent and primary responsibility for the mental health needs of approximately one thousand active clients within W.A.; the Clinical Psychologist assesses, treats, recommends and supervises system-wide inter-disciplinary interventions as appropriate. Clinical decisions, regarding patient management of mental health needs and patient treatment compliance issues, are made on the basis of his/her recommendations. His/her impact is that of maintaining the mental health, well-being and quality of life of Clinical Immunology patients state-wide.

Evidence based roles of Clinical Psychology

Within these areas, Clinical Psychology has state-wide field recognition as providing a pre-ordinate, state-wide, and evidence-based psychological counselling, assessment, therapy, training, supervision and research role. It operates as an independent mental health practitioner- providing patient diagnosis, treatment and case management. It recommends & supervises service-wide interventions to Consultant Immunologists, Gastroenterologists, Sexual Health Physicians, GP's, Community Nurses, Social Workers, Counsellors and others. Its work is not reviewed, and is regarded as a state-wide authority.

Since the late 1980's, Clinical Psychology in W.A. has developed a nationally prominent HIV treatments compliance-enhancement research programme; it sits as the sole W.A. member on, and consults about mental health issues to, the National HIV Treatments Compliance Taskforce - which develops and directs multi-sectorial national HIV treatments compliance strategies. It sits as a member of W.A.'s Immunodeficiency Foundation's Research Subcommittee, reviewing all social science research projects state-wide. It is regularly represented at international AIDS Conferences and delivers psychological/patient care presentations. It drives state-wide clinical research regarding SLE, hepatitis C and STD's. It contributes to relevant state-wide public health policy.

It offers state-wide consultation to professional colleagues, psychiatric, social work, counselling and volunteer services. Training/education responsibilities have proliferated significantly since the late 1980's and include that of GP's, nurses, case-managers, social workers, youth workers, practising and trainee Clinical Psychologists, counsellors, the Health Department's Case Management Programme (for recalcitrant HIV-positive patients), the West Australian AIDS Council, AIDS Pastoral Care, Silver Chain Nursing Service, Respite House, Womens' Health Care House, People Living With HIV/AIDS (PLWHA), the Lupus Group of W.A., Hepatitis C Council, HSV Support Group and volunteer carers / counsellors.

Co-morbidity of psychological factors complicates the course of illness, by disrupting treatment and increasing hospitalisations (Uldall et al, 1994). For example, studies have demonstrated a significant association between HIV-positive injecting drug users and antisocial personality disorder (Brooner, Greenfield, Schmidt & Bigelow, 1993), a significantly higher prevalence at 33% of personality disorder amongst HIV-positive men than their HIV-negative counterparts (Perkins, Davidson, Leserman, Liao & Evans, 1993). In addition, a further six% of the chronically mentally ill population are HIV-positive (Cournos, 1991; Empfield et al, 1993; Sacks et al, 1992).

There is a substantial body of research demonstrating effects of acute and chronic psychological stress on immune functioning with chronic illness including HIV (Cohen & Williamson, 1991; Herbert & Cohen, 1993; Jemmott & Locke, 1984; O'Leary, 1990). Specific links have been demonstrated with depression (Kiecolt-Glaser & Glaser, 1988; Schleifer, Keller, Bond, Cohen & Stein, 1989; Stein, Miller & Trestman, 1991; Zonderman, Costa & McCrae, 1989). Consult-liaison reduces complicated mood and stress disorders, and promotes better self-care behaviours.

Consult-liaison services are imperative in this patient population. Studies document a 16% prevalence of depression - even when somatic instrument items are omitted during assessment (Burrack et al, 1993), and an approximately 66% prevalence of adjustment disorder associated with anxious, depressed or mixed mood (Chuang, Jason, Pajurkova & Gill, 1992; O'Dowd, Natali, Orr & McKegney, 1991; Rundell, Paolucci, Beatty & Boswell, 1988). An estimated 43-48% of adults at risk for HIV infection, electing to undergo HIV testing, have a history of mood disorder (Perry, Jacobsberg, Fishman, Frances et al, 1990) - a rate seven times greater than their age-matched community samples. Thirty-three% of HIV-positive adults report a lifetime occurrence of depression (Williams et al, 1991); in another study, 47% of symptomatic HIV-positive gay men met the criteria for depression, even without somatic test items being utilised (Cochran & Mays, 1994; Karasu et al, 1993). Quite significant is the finding that up to 65% of people living with AIDS meet criteria for major recurrent depression (Atkinson et al, 1988), the majority having a premorbid diagnosis of depression.

Although depression may be a response to HIV-induced stressors (Ostrow, 1990), it often also results from HIV interference with the central nervous system or present in conjunction with an underlying substance abuse disorder (Maj, 1990). Higher rates of suicidal ideation and more frequent suicide attempts amongst HIV-positive adults, compared to their HIV-negative counterparts, have been well documented (eg. Brown and Rundell, 1989; Pergami et al, 1993; Perry, Jacobsberg and Fishman, 1990; Zamperetti et al, 1990). O'Dowd et al (1993) documented that being HIV-positive and symptomatic was as strong a predictor of suicidal ideation as was a prior history of suicide attempts. The risk of suicide in symptomatic HIV-positive adults has been documented as between 17 (Kizer, Green, Perking & Hughes, 1988) and 66 times higher than for non HIV-positive comparison groups (Marzuk et al, 1988). Risk for suicide is greatest among adults with pre-existing or co-existing cognitive and affective disturbances (Marzuk et al, 1988) and substance abuse disorders (Perry, Jacobsberg and Fishman, 1990). Significant rates of complex psychological problems exist within this patient population; they require the specific ability of clinical psychology to select and personally tailor evidence-based interventions.

Frequently presenting clinical issues include post-trauma stress disorder, complicated adjustment disorder, clinical depression, generalised anxiety disorder, social phobia, agoraphobia, specific phobias, panic disorder, obsessive-compulsive disorder, anger management, stress management, impulse-control disorders, dissociative disorders, relationship and sexual therapy, chronic fatigue, chronic pain, insomnia, chronic nausea, anticipatory anxiety, treatment compliance, complicated grief disorder, death and dying. Clinical Psychology's professional competencies are unique in that it is the sole profession trained to treat each of these problems in an evidence-based manner.

It also provides evidence-based treatment with complex patients, including those patients utilising the services who have comorbid personality disorders - mainly paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive, depressive, and self-defeating. New evidence-based cognitive therapies, developed since the late 1980's, and a regular component of clinical psychology training, mean that Clinical Psychology is in the unique position of directly influencing these patients' often complex and demanding behavioural, attitudinal and emotional problems, thus enhancing overall treatment efficacy.

Clinical Psychology intervenes in the link between poor self-efficacy and poor illness &/or treatment management. Studies demonstrate that a sense of personal control over HIV illness and other life stressors reduces psychological distress (Folkman et al, 1995; Remien, Rabkin, Williams and Katoff, 1992). Subjective experiences of personal control play a major role in the patient's psychological coping and self-care behaviours, such as treatment compliance (Reed et al, 1993; Remien et al, 1992), particularly given the uncertain prognosis of HIV illness. It is associated with greater hope for survival and quality of life (Rabkin et al, 1990) and is a causal agent in reducing psychological distress (Taylor et al, 1991). In contrast, HIV-positive adults who perceive that their prognosis is determined primarily by forces external to themselves experience poorer psychological adjustment, coping skills (Kelly, Murphy, Bahr, Koob et al, 1993) and somatic health (Hintz et al, 1990; Kalichman et al, 1995).

Furthermore, clinical psychology now offers neuropsychological screening, differential diagnoses for AIDS Dementia, HIV-related Encephalopathy, other dementias and encephalopathy, interventions for abnormal sick role behaviour, memory/cognitive retraining, first episode psychosis, chronic schizophrenia, and manic-depressive disorder. The diagnostic label, AIDS dementia complex, was introduced in the late 1980's to describe the constellation of neuropsychological symptoms in cases of AIDS (Price & Sidtis, 1992; Worley

& Price, 1992). Most HIV-positive people will develop infection of the central nervous system, and between 30 and 60% of all AIDS patients develop symptoms of central or peripheral nervous system damage (Collier et al, 1992). Impairment can be progressive and affect multiple cognitive, affective and motor abilities, and opportunistic illnesses may cause diffuse damage or focal lesions (Krikorian & Worbel, 1991; Markowitz & Perry, 1992). Clinical psychology can provide early detection and therefore symptom containment for a significant proportion of the overall patient population.

Since the 1980's, there have been major advances in the areas of cognitive-behavioural therapies, symptomatic reduction, treatment compliance-enhancement interventions, psychoimmunology, neuropsychology, differential diagnoses, case-management, cognitive therapy for personality disorders, and first psychosis treatment. The efficacy of psychological treatments for HIV-positive adults has been demonstrated, in evidence-based literature, by declines in depressed mood and emotional distress, increased treatments compliance, improved secondary prevention behaviours, more somatic coping skills, and better harm reduction skills (Markowitz, Klerman & Perry, 1992, 1993; Markowitz, Klerman, Perry, Clougherty & Josephs, 1993). Cognitive-behavioural therapy provides HIV-positive clients effective techniques such as stress management, cognitive restructuring, active coping, enhancing self-efficacy, behavioural management and relapse prevention skills (eg. Antoni, Baggett et al, 1991; Coates et al, 1989; Emmot, 1991; Kelly, Murphy, Bahr, Kalichman et al, 1993; Lamping et al, 1993; Mulder et al, 1992).

Clinical Psychology and Cardiovascular Disease

Until recently Clinical Psychologists have been traditionally employed in community mental health settings or psychiatric units attached to public hospitals with 70-90% of Australian psychologists being employed in the public sector and the remaining 10-20% within academic settings (Oldenburg & Owen, 1990). It would appear that this trend is changing with Clinical Psychologists beginning to recognise the broad implications of their skills and their ability to contribute significantly to the field of behavioural medicine. Moving away from illnesses of the mind, Clinical Psychologists have expanded their role to include health and wellness promotion and maintenance. Over the last ten years the medical community has come to recognise the importance of psychological factors in the prevention of and recovery from illness. Opportunities for Clinical Psychologists in medical settings has expanded to include significant roles in cardiovascular disease (Groth-Marnat, 1994).

The interest in health psychology has not only burgeoned clinically but also from a research perspective. A recent review of papers presented at Australian Behavioural Medicine Conferences indicated that cardiovascular disease, chronic pain, headaches, occupational health and chronic/terminal illness were the most prominent areas of research (Sheppard, 1982-1987).

The emergence of health psychology in the medical setting has led to an increase in behavioural research and the use of therapeutic interventions to facilitate effective psychological care for ill patients and their families. In addition to providing psychological care following the onset of illness health psychologists have made notable contributions to the field of health promotion and wellness.

Cardiovascular disease (CVD) clearly highlights the shortcomings of the medical model as the preferred mode of intervention. There is strong evidence to suggest that behavioural factors play a significant role in the development of CVD. Factors such as cigarette smoking, inadequate nutrition and sedentary lifestyle are just a few of the modifiable risk factors that contribute to heart disease. These factors challenge the traditional medical model approach to understanding disease which “views disease as a purely biological phenomenon, that is, the product of specific agents or pathogens and bodily dysfunction” (Krantz, Grunberg & Baum, 1985).

In 1994 CVD was responsible for 43.3% (54,886) of the total deaths (126,683) in Australia. In comparison to other causes of death, CVD was 63% more common than death from cancer, 28 times greater than death via traffic accident and 12 times more frequent that death from AIDS (Heart & Stroke Facts, 1996). Overall 2.3 million Australians currently have CVD. While researchers and practitioners have made a significant impact on reducing death and disability due to CVD it remains the number one killer in Australia and the United States(US). US data suggests that the decline in the death rate over the past 35 years has resulted as much from lifestyle modification as it has from the advances in medical technology(Allan, 1996).

There is increasing recognition of the importance of the link between the mind (psyche) and the body (soma). Along with this recognition is the emergence of the field of health psychology and more specifically ‘cardiac psychology’. There is demonstratable evidence of the link between the behavioural, and the psychological factors and the onset and progression of CVD (Zevallos, Chiriboga & Herbert, 1992). This innovative aspect of health psychology has the potential to revolutionise cardiac care, helping both individuals at risk of CVD and those with existing disease to reduce their risk by fostering a heart-healthy lifestyle.

Pekkanen et al., (1990) followed patients over a ten-year period and reported that individuals with a history of CVD are 20 times more likely to die from CVD than those without risk factors. These findings suggest that long-term survival depends primarily upon the modification of CVD risk factors and that patients with existing CHD should be a priority because the potential of preventive action is greatest in this group (Pyorala, 1994).

Programs assisting patients with CVD risk reduction have been traditionally known as cardiac rehabilitation programs and typically include a medical assessment, prescribed exercise sessions, risk factor modification strategies, cardiovascular disease education and behavioural and psychological counselling. Such programs are usually conducted a multidisciplinary team including general practitioners, nurses, exercise physiologists/physiotherapists, Clinical Psychologists and dietitians. Each of these health care professionals plays an important role in the rehabilitation of the patient. Clinical Psychologists, in particular, bring a unique set of skills to the field of cardiovascular disease (US Department of Health and Human Services, 1995).

Clinical Psychologists can play a vital role in both the primary and secondary prevention of heart disease with the latter domain being the more salient at present. Clinical Psychologists' role in secondary prevention can include assisting patients with psychosocial adjustment and lifestyle modification; developing and conducting behavioural research; developing and evaluating rehabilitation programs; developing health standards and providing input into the training of medical students.

From a mental health service perspective research indicates that 33-50% of cardiac patients reported being either anxious or depressed following a cardiac event. In a study examining 283 patients having experienced a myocardial infarction 18% had clinical depression and 27% had depressive symptoms (Ahern, et al.,1990; Frasure-Smith, Leperance & Talajic, 1993). Psychological counselling usually takes the form of individual, or group therapy and aims to increase self-confidence, and reduce levels of anxiety and depression.

The program development and evaluation is of particular importance given the recent shift of rehabilitation programs from the hospital setting to the community. With the sole focus moving away from clinical trials there has been an increase in funding awarded to behavioural research in the past 5 years. Clinical Psychologists are aware of the behavioural factors that impact on the prevalence and severity of CVD and can provide targeted interventions to modify health compromising behaviours.

Although patients are traditionally referred to a psychologist following a cardiac event they can also provide unique skills in the primary prevention domain. Areas of employment may include health promotion and health care policy. While these less traditional areas of employment are likely to provide less client contact they do provide ample opportunity for Clinical Psychologists to use their extensive skills.

Chronic and Acute Pain Management

There have been considerable advances in research into pain and its management over the last thirty years, but it is only in the last decade that such advances have filtered through to clinical practice. Thirty years ago the seminal work of Malzack and Wall (1965) on the Gate Control Theory of Pain was published. For the first time it was argued that psychological factors had a major role to play in both the experience and in the treatment of chronic and acute pain.

It was also around this time that the International Association or the Study of Pain (IASP) was formed and the very first Pain Clinic came into being in the University Hospital, Seattle, Washington, USA. For the first twenty years of their existence, Pain Clinics have been dominated by anaesthetists who administer a range of medical procedures aimed at pain reduction and cessation. However, it has always been recognised that such anaesthetic procedures as nerve blocks and epidurals were in many cases limited (Abram et al 1992), because the origins of pain are not always entirely physiological.

In the last decade Clinical Psychologists have been playing an increasing role in the management of pain and in 1987 the IASP published guidelines for the range of services that should ideally be offered in a Pain Clinic. Theses guidelines recommend the inclusion of Clinical Psychologists along with Physiotherapists and various medical specialists.

Where the work of Clinical Psychologists in the pain area is concerned, there have been significant changes in both the breadth and depth of work, as well as a general broadening of scope of influence.

Expansion in work value

Clinical Psychologists are becoming involved in the management of an increasing number of different pain disorders. Indeed, Clinical Psychologists working in this area are now expected

to be familiar with the psychological characteristics of all forms of pain disorder including pre and post operative pain, neuropathic pain, neoplastic disease such as cancer, inflammatory disease, headache, non-specific musculo-skeletal pain, visceral pain and pelvic pain. (Fields 1995, Main 1997). Familiarity with this range is expected for the purposes of both assessment and treatment.

Clinical Psychologists are now expected to understand the psychological impact of different types of pain. Pain syndromes particularly influenced by sex and gender; life span factors: psychological factors in the seeking of health care by patients; the economic and occupational impact of pain associated disability. It is also expected that Clinical Psychologists will be familiar with the range of psychiatric treatment, and skilled in the delivery of psychological treatment.

Psychological assessment has expanded greatly in recent years from the assessment of personality structure and detection of psycho-pathology to a number of wider psycho-social perspective's such as the influence on symptom presentation and response to treatment. Furthermore, psychological intervention has moved forward from individual psychological therapy to now include group treatment and interdisciplinary programmes. Clinical Psychologists commonly take on the managerial as well as clinical role in such programmes. This is the case in Western Australia where the teaching hospitals have group Pain Management Programmes, namely at Fremantle Hospital and Sir Charles Gairdner Hospital. It is the Clinical Psychologist who has the primary managerial role as well as a clinical involvement in the day to day running of the programmes. Clinical Psychologists are also responsible for the measurement of effectiveness of such programmes.

Advances in psychological assessment in particular, have been responsible for the increasingly accepted notion that psychological distress is one of the main factor's in the development of chronicity in pain disorders. The work of Bigos et al. (1991) clearly demonstrated the role of psycho-social factors in the development of low back pain in the work place, while the work of Main et al. (1992) has shown that psychological distress is possibly the single most important factor in pain disorders becoming chronic.

Scope of Influence

Clinical Psychologists working in pain management in the public sector will often receive referrals directly from both medical specialists and general practitioners alike as the psychological role in the management of pain is becoming more widely recognised. Currently, Clinical Psychologists working in teaching hospitals are increasingly requested to

prepare and participate in the medical education of junior medical staff. They are asked to prepare and participate in lectures, courses and teaching curricula on pain, including both introductory talks as well as specialised professional training in some cases.

A. Depth of the Clinical Psychologist's roles: the example of SCGH:

The Clinical Psychologist primarily functions as the coordinator and Clinical Psychologist for the group treatment program. This is a one-month multidisciplinary program for chronic pain patients who have exhausted medical avenues for pain management and are referred to the program to learn how to cope with pain. In short, the Clinical Psychologist treats patients in a program that is offered as a "last resort" for patients who have not improved in other types of medical or rehabilitation treatment (Turk, 1996). As such, the Clinical Psychologist treats the most complex clients, many of whom suffer in all aspects of their daily living (including personal hygiene and care, to emotional, physical, social and vocational functioning). The depth of this involvement may also include some individual therapy for personality disorder as well as concomitant problems including depression and post-traumatic stress disorder.

The Clinical Psychologist also assesses and treats individual patients regarding suitability for invasive medical procedures, or they may be assessed and treated for a myriad of psychosocial problems. Most require assistance in learning how to cope with pain and disability.

B. Breadth of the Clinical Psychologists' roles at SCGH:

The Clinical Psychologists' duties are very broad and have included the following:

1. Setting up and carrying out program evaluation: this includes discussion with program evaluation committee members to agree on outcome measures, supervising data entry, carrying out data analyses, and presenting research findings at a national conference on pain (e.g., Australian Pain Society annual conference in March/April 1998). For this aspect of the job, a PhD in Clinical Psychology is a necessity although the current hospital remuneration fails to acknowledge or reward this.

2. arranging and chairing program staff meetings and subcommittee meetings

3. formulating policies and procedures with staff input, collating documents in order to prepare for possible program accreditation by CARF or similar accreditation body

4. helping to develop and revise a brochure advertising our program

5. training clinical psychology students in the 360-hour practicum (5 students have been trained over the past two years)

6. the first Clinical Psychologist engages in supervision of the second Clinical Psychologist who has recently graduated from university

7. liaison with insurance adjusters, vocational counsellors, physicians and specialists regarding patient assessment and treatment

8. actively participate in Departmental meetings

9. direct the secretary to carry out related tasks

10. carry out related research activities (eg., present a summary of research findings regarding efficacy of pain management programs to insurers).

C. Scope of the Clinical Psychologists' influence and impact of decisions

All patients referred to the group treatment program are independently assessed by a Clinical Psychologist to determine their suitability. Psychometric testing is carried out to support interview assessment findings. A summary of her medico-legal assessment may be sent to insurers, lawyers, physicians and other program staff members. After completion of the program, a discharge report is sent to the same audience. These reports can be used to support or negate litigation, thus having a significant impact on the patient who is involved in a legal battle. Recommendations might be made to cease medical diagnostic activities and treatment where warranted.

Both Clinical Psychologists play a major role in challenging medical views that support a dualistic approach to pain management. That is, we encourage our medical colleagues to treat the whole person and to avoid saying that a patient who has no organic evidence of trauma is fabricating the pain. A search of the literature via Medline (a summary of medically-based research journals and books) demonstrates that psychological factors have been

widely considered in the medical study of pain: in 1987 there were only 96 references in which psychological factors were evaluated in the study of human pain. By 1997 this figure more than doubled to 200 references (Medline search with OVID).

Best practice medicine supports the inclusion of psychosocial assessment and treatment of patients by Clinical Psychologists or psychiatrists. The Head of Dept, Dr Roger Goucke, recognises this role and was instrumental in raising the profile of Clinical Psychologists in the Pain Department and ensuring increasing funding. As Dr Goucke (1998) has said in Pain: A Handbook for Health Care Professionals, "most chronic pain results from a combination of both physical and psychological factors" (p. 30).

Gamsa (1993) discussed psychological assessment of pain patients, concluding that it is "now an integral part of multidisciplinary pain management". She lists three purposes of such assessment: "1) to assess the likelihood that psychosocial factors will impede medical treatment efforts (such as medications or operations); 2) to evaluate the possible role of psychological intervention in the treatment plan; 3) to provide preliminary education about pain, and to give the patient support, and realistic hope." (p. 6).

As an example of the first purpose listed by Gamsa, patients are routinely screened by our junior Clinical Psychologist prior to an anaesthetist inserting a pump that administers morphine into the subdural space. We both fulfil the second and third purposes when suggesting group or individual treatment.

The multidimensional nature of pain has led to multidisciplinary assessment and treatment. Because of our close ties with medical professionals, we must have an extensive knowledge of pain-related medical diagnoses and prognoses, physiotherapy treatments, and occupational therapy treatments. Because of the diversity of human problems that pain patients present with, we must have a broad understanding of psychological disorders and their treatment. The pain Clinical Psychologist is now an integral part of most multidisciplinary pain management programs.

Rehabilitation Medicine

The Clinical Psychologist’s role has centred upon the issue of either the presence or absence of brain impairment and secondly upon the severity of such impairment. Although there have been significant advances in medical investigative techniques over the years the issue of the presence

and severity of brain impairment remains a significant component of the work and carries important ramifications in both the diagnosis, treatment and rehabilitation of patients. It is important to note that even the best imaging techniques available frequently do not provide sufficient evidence of anatomical pathology to explain the individual's clinical symptoms. With the immense variety of individual differences in cognitive processes as well the effects of a wide range of psychological, emotional, educational and other factors places a very high demand upon the clinical skills and experience of the individual Clinical Psychologist. The need for accurate and reliable cognitive assessment in relation to the effects of brain pathology as a guide to follow up medical services in terms of diagnosis, treatment and rehabilitation is most important. From a diagnostic standpoint, and as example, issues such as whether the patient is dementing or depressed has obvious important implications for the person, their family etc. Determining the degree and severity of cognitive impairment arising from head injury clearly also has important implications with respect to their medical management as well as their own and their family's psychological well being.

Following on from the above point it is important to determine the cognitive capacity of an individual who has suffered brain impairment in relation to the serious issues of their capacity to return to work and their safety, to both themselves and the community, to regain their driving licence. At times other issues relating to the safety of the individual or their family are of prime importance. Opinion is also sought with respect to their vocational and educational potential. Apart from the more immediate impact upon the patient and their family it is clear that the Clinical Psychologist's work role is also important with respect to the community as a whole.

The Clinical Psychologist also provides a significant level of consultative services to colleagues in Psychology as well as Neurologists and Psychiatrists. This has also been extended to community agencies such as Brightwater's Oat Street facility as well as to General Practitioners.

The Clinical Psychologist provides numerous educational seminars and courses to a variety of health professionals including Neurologists, Psychiatrists, Clinical Psychologists, Docotors in the medical training and other Health Professionals. The breadth of role for Clinical Psychology has expanded to include:

❖ The provision of neuropsychological services from 1990 for patients being considered as candidates for neurosurgery for treatment of their refractory epilepsy. Patients are seen pre and post treatment to monitor the nature of any cognitive decline arising as a result of the neurosurgical intervention.

- Since mid 1996 the Clinical Psychologist has also been involved in the pre-surgical evaluation of patients with Parkinson's Disease with the expressed intention of providing detailed assessment of referred patients as a means of screening out those patients from surgery in whom there is evidence of a co-existing dementing condition. Parkinson's patients commonly also have some concomitant cognitive impairment but which is not necessarily associated with a dementia. In view of these factors it is clear that there is a significant demand upon the need for skilled and careful cognitive examination.

- since 1980, the provision of comprehensive medico-legal reports as well as providing expert evidence at Court. This involves many appearances at the District Court as well as occasional attendance at the Supreme and Children's Court as well as providing opinion to the Public Guardian's Office over clinical matters with respect to their.

Women's Cancer

For the last forty years, researchers have noted the high incidence of psychiatric disturbances in people with both acute and chronic illness, (eg Razavi, Delvaux, Farvacques & Robaye, 1990). In the last decade, commentators have urgently stressed the massive under-reporting of co-morbid and pre-morbid mental illness in the seriously ill. For example, the prevalence of depression in cancer patients ranges from 5% to 58% depending on the stage of disease, and significantly, on the adequacy of assessment, (Lansky, List, Herman et al., 1985; Carroll, Kathol, Noyes et al., 1993)

Massive under-diagnosing of psychiatric conditions in the medically ill has real and grave consequences when one considers that depression and anxiety can directly affect patient comfort, quality of life, the ability to make appropriate treatment decisions, and compliance with treatment, thus survival. Clearly the importance of appropriate assessment and treatment of psychiatric conditions in the medically ill cannot be overstated.

There is now a growing body of psycho-oncological literature, (e.g. Seligman, 1996; Maisie & Holland, 1990), which documents the emotional and psychic responses a diagnosis of cancer can evoke. However, there has been a distinct lack in translating research findings into viable publicly funded psycho-oncological treatment programs, despite the increasing incidence of cancer in our communities, and the compounding interface between life-threatening medical conditions and complex psychiatric states.

Prior to 1996, there were no West Australian publicly funded specialist mental health programs in the cancer field. However, Clinical Psychology has recently started to directly contribute to the psychological health care of cancer patients, by designing and implementing a prototypic state-wide program for breast cancer patients. The objectives of the service follow:

- To ensure that Western Australian women have access to psychological intervention and support services which will assist their adjustment to having breast cancer;
- To ensure that Western Australian women have access to psychological intervention and support services which will assist their psychosocial adjustment to any treatment-related difficulties;
- To provide a specialist psycho-therapy and counselling service to whom surgeons, general practitioners and other health professionals may refer women affected by breast cancer;
- To provide psychological services to women from rural areas visiting Perth. To ensure flexibility and access at short notice;
- To link clients, especially women from rural areas to counselling and other support services near to their home as required;
- To compliment and provide expertise to the design and delivery of professional development programmes for nurses to enable them to develop appropriate counselling skills to assist breast cancer patients in rural communities, and
- To provide an expert resource, through case consultations, for nurses who wish to continue developing appropriate counselling skills to assist breast cancer patients in rural communities.

Scope

The scope of this work encompasses people at all stages in the ‘cancer career’ including the newly diagnosed, relapses, long-term residual distress, and those who are seeking better quality of life while living with cancer. A knowledge of medical and surgical systems is necessary, as well as familiarity with disease processes, and the ability to apply psychological interventions to achieve symptom control and optimise proactive health

behaviours and treatment compliance. The work also involves dealing with people who are coming to terms with disfigurement, and life-threatening illness as well as promoting motivation, and training people to manage their own anxiety and feelings of depression. Naturally, people with severe long-standing psychiatric illnesses such as Schizophrenia, Personality disorders, and chronic mood disorder also get cancer, and cancer can really exacerbate existing psychiatric problems, or precipitate mental illness in vulnerable people. In addition, the processes of chemotherapy can also precipitate and even induce quite serious mood disorder including suicidal impulses and ideation.

Research consistently indicates that family members experience similar levels of distress to those experienced by the cancer patient. Therefore, consultations are also provided to family members who are experiencing distress associated with their loved one's condition. To operate this service effectively, there must be a solid grounding in individual relationship and family therapies.

Field of influence

This service is run by a sole practitioner, who carries full responsibility for a client base which has a state-wide catchment area, spanning all hospitals and health regions in WA.

In a recent client evaluation, a massive 98% of respondents indicated that attending this clinic had significantly improved their quality of life, both in terms of cancer, and also generalising to other issues within clients' lives. People also reported being willing to use strategies learnt at the clinic in the future should they have problems, and it is suggested that this learning of new coping skills will eventually effect future service usage rates such as GP consultations, as well promote early intervention and reduce the prevalence of escalating psychiatric conditions.

Psychogynaecology, Obstetrics, & Cancer: the example of KEMH:

Population served

The Clinical Psychologists at King Edward Memorial Hospital provide services to women from adolescence through geriatrics as well as their families. These patients are from all areas of WA as KEMH is a Centre for Excellence for women's health issues.

Goals of Service Given

The focus of the clinical services by the Clinical Psychologists are in the application of Clinical Psychology within a specialised Consult-Liaison service. Problems are assessed in terms of the impact of psychological functioning on the medical condition or the impact of the medical condition on psychological functioning. As much as possible, a brief psychotherapeutic intervention is the main goal as a large number of patients have to be seen by a very limited number of staff.

Modalities Used

Individual, couples, and group therapy are used within the service as well as liaison with the psychiatrists for patients who also need medication.

The Clinical Psychologists is currently involved in the implementation of screening all antenatal patients for their risk for developing pregnancy related mental health disorders. This will be done in conjunction with the Obstetrics Clinical Care Unit and will involve the midwives screening for psychosocial factors as well as the administration of the Edinburgh at 14 weeks and 34 weeks. Patients scoring high on the Edinburgh would then be referred to the Clinical Psychologists for a clinical assessment to look at their risk for developing pregnancy related mental health disorders. The goal of this programme is to identify early those women at risk or already developing these disorders so that intervention can minimise the impact and severity of these disorders.

Breadth of Work

The services of Clinical Psychology at King Edward Memorial Hospital began in late 1989. During the earlier years of the service, 80% of contact by Clinical Psychologists within the Hospital was with staff in a consultative role. This focus has changed dramatically over the past 5 years with 90% of Clinical Psychologists' time being spent in direct contact with patients. When the service first began, most of the referrals were in the area of postnatal depression/anxiety during pregnancy.

The breadth of work in the service again has changed dramatically during the past 5 years. Obstetrics continues to be a major focus of referrals. However, besides pregnancy related depression/anxiety disorders, the service provides consult-liaison (CL) services to the Obstetric Clinical Care Unit in other areas such as needle phobia, anxiety regarding delivery

due to past trauma, and neonatal death. Clinical Psychology also provides a growing CL service to the Gynaecology Clinical Care Unit and has initiated a new CL service within the Pelvic Pain Clinic to help women with managing chronic pelvic pain. The Clinical Psychologists get an increasing number of gynaecological referrals covering a wide range of areas including difficulties coping with gynaecological procedures, menopause. There has been a very significant increase in CL services to the Oncology Unit within the Gynaecology Clinical Care Unit. Services are provided for women who are distressed about the news of a diagnosis of cancer, coping with the aftermath of surgery, adjusting to the loss of fertility as a result of the cancer, death issues. In addition, the staff assist the medical staff with management of personality disorder patients to minimise the impact of their acting out behaviour while in the Hospital.

In the early years of the service, there were very few inpatient referrals. In the last six months, the inpatient referrals equal the number of outpatient referrals. The referrals received each month continue to grow over the past 3 years with approximately 100 patients being referred a month currently. This dramatic increase in the breadth of work needs to be appreciated in the context that the service began with 1 FTE Clinical Psychology and currently has 2 FTE Clinical Psychology.

Depth of Work

The Clinical Psychologists complete a full clinical assessment on both inpatients and outpatients. This requires the psychosocial history, mental status examination, formulation of problem, and DSMIV diagnosis. The Clinical Psychologist then has to present the patient to the multi-disciplinary team with treatment recommendations. Each Clinical Psychologist serves as a key worker for identified patients which means they take over the case management aspects of the patient's care. Clinical Psychologists must provide a wide range of services including group and family therapy. They must be able to work with a wide range of age groups from early adolescence into geriatric populations. Psychotherapeutic interventions involve a wide gamut of problems including death and dying issues, postnatal depression, fetal death, phobias, anxiety disorders, post traumatic stress disorder just to name a few. The Clinical Psychologists must be able to provide effective brief psychotherapy to these patients and complete a formalised treatment plan for each patient involved in ongoing psychotherapy. They must also complete a discharge summary for cases that are closed. In addition, the Senior Clinical Psychologists provide supervision to Master's Students and Clinical Psychology Registrars. They also provide a case presentation at least once a year and provide a consultation liaison services to the community. Each Clinical Psychologist has a day as Duty Clinical Psychologist in which all calls from the community

are handled by the Duty Clinical Psychologist and again involves education, liaison, referral. Each Clinical Psychologist is required to attend a weekly administrative/professional development meeting and a weekly clinical team meeting. They are also encouraged to attend the daily Cardex Team Meeting. Each Clinical Psychologist is responsible for the input of their statistics within the Allstats programme.

Scope of Influence and Responsibility

The Clinical Psychologists at King Edward Memorial Hospital provide both outpatient and inpatient services. The inpatient services involve a thorough clinical assessment and treatment plan, which has to be completed within a very short period of time as most of our patients are in the Hospital for only two to four days. As stated earlier, the breadth of types of problems presented is quite diverse. Also, each of the Clinical Psychologists supervises either a Clinical Psychology Master's Student and/or Clinical Psychologist Registrar in terms of their clinical practice. The Clinical Psychologists are also utilised by the Hospital to provide educational programmes to medical students, nursing staff, medical staff. The Clinical Psychologists also provide community consultation through telephone contact.

References

Abram, S.E., & Hogan, Q.H. Complications of Peripheral Nerve Blocks. in: L.Saidman & J.Benumof (Eds), *Anaesthesia & Perioperative Compilations* C.V.Mosby, St Louis, 1992 pp.52-71.

Agras, W.S., Schneider, J.A., Arnow, B., Raeburn, S.D. & Telch, C.F. (1989). Cognitive behavioural and response prevention treatments for bulimia nervosa. *Journal of Consulting and Clinical Psychology, 57*, 215-221.

Ahern, D.K., Gorkin, L., Anderson., J.L., Tierney, C., Hallstrom, A., Ewart, C., Capone, R.J., Schron, E., Kornfield, D., Herd, J.A., Richardson, D.W., and Follick, M.J. (1990). Biobehavioural variables and mortality in the Cardiac Arrhythmia Pilot Study (CAPS). *American Journal of Cardiology*, 66, 59-62.

Alden, L. (1989). Short-Term Structured Treatment for Avoidant Personality Disorder. *Journal of Consulting and Clinical Psychology*, 37, *6,* 756-764.

Allan, R. (1996). Introduction: The emergence of cardiac psychology. In Allan, R. and Scheidt, S.(Eds.) (1996). *Heart and Mind: The Practice of Cardiac Psychology.* Washington: American Psychological Association.

American Psychological Association, Division of Clinical Psychology (Division 12) (1993, October). Taskforce report on promotion and dissemination of psychological procedures: Final Report.

Ames, D. (1993). Depressive disorders among elderly people in long-term institutional care. *Australian and New Zealand Journal of Psychiatry*, *27,* 379-391.

Anderson, E.M., & Lambert, M.J. (1995). Short-term psyhcodynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review, 15*, 503-514.

Antoni, M.H., Baggett, L., Ironson, G., LaPierre, A., August, S., Klimas, N., Schneiderman, N., & Fletcher, M. (1991). Cognitive-behavioural stress management intervention buffers stress responses and immunologic changes following notification of HIV-1 seropositivity. *Journal of Consulting and Clinical Psychology*, *59*, 906 - 915.

Atkinson, J.H., Grant, I., Kennedy, C.J., Richman, D.D., Spector, S.A. & McCutchan, J.A. (1988). Prevalence of psychiatric disorders among men infected with human immunodeficiency virus. *Archives of General Psychiatry*, *45*, 859 - 864.

Australian Bureau of Statistics (1996). *Projections of the populations of Australia, states and territories 1987 to 2031*. Canberra: Author

Australian Health Ministers (1992): *National Mental Health Policy* Commonwealth of Australia, Australian Government Publishing Services, Canberra.

Barlow, D. (1996) Health care policy, psychotherapy research, and the future of psychotherapy. *American Psychologist, 51*, 1050-1058.

Barrett,P; Dadds,M and Rapee,R : Family Treatment of Anxiety: A Controlled Trial. *Journal of Consulting and Clinical Psychology* 1996 vol 64 pp333-342

Basco. M.R., & Rush, J. (1996). *Cognitive behaviour therapy for bipolar disorder*. New York: Guilford.

Beelman,A, Pfingsten,U and Losel,F: Effects of Training Social Competence in Children:A Meta-analysis of Recent Evaluation Studies. *Journal of Clinical Child Psychology* 1994 vol 23, *no3*, pp260-271

Beck, A. and Freeman, A. (1990). *Cognitive Therapy of Personality Disorders*, New York, Guilford Press.

Bigos, S.J., Battie, M.C., Spengler, D.M., Fisher, L.D., Fordice, W.E., Hansson, T.H., Nachemson, a.L., & Wortley, M. A Prospective Study of Work Perceptions & Psychological Factors Affecting the Report of Back Injury. *Spine*, 1991, 16, 1-6.

Birchwood M., & Tarrier N (Eds) (1992): *Innovations in the Psychological Management of Schizophrenia* John Wiley & Sons N.Y.

Bird, M., Alexopoulos, P.R., Adamowizc, J. (1995). Success and failure in five case studies. Use of cued recall to ameliorate behaviour problems in senile dementia. *International Journal Geriatric Psychiatry, 10*. 305-311

Brooner, R., Greenfield, L., Schmidt, C., & Bigelow, G. (1993). Antisocial personality disorder and HIV infection among intravenous drug abusers. *American Journal of Psychiatry*, *150,* 53 - 58.

Brown, G.R., and Rundell, J.R. (1989). Suicidal tendencies in women with human immunodeficiency virus infection. *American Journal of Psychiatry*, *146*, 556 - 557.

Burgio, L.D., & Bourgeois, M. (1992). Treating severe behavioral disorders in geriatric residential settings. *Behavioral Residential Treatment, 7,* 145-168.

Burrack, J.H., Barrett, D.C., Stall, R., Chesney, M.A., Ekstrand, M.L., & Coates, T.J. (1993). Depressive symptoms and CD4 lymphocyte decline among HIV-infected men. *Journal of the American Medical Association, 270*, 2568 - 2573.

Carroll, B. T., Kathol, R. C., Noyes M.D., et al., (1993). Screening for Depression and Anxiety in Cancer Patients Using the Hospital Anxiety and Depression Scale. *General Hospital Psychiatry, 15*, 69 - 74.

Cassano, G.B., Pini, S., Saettoni, M., Rucci, P., & Dell'Osso, L. (1998). Occurrence and clinical correlates of psychiatric comorbidity in patients with psychotic disorders. *Journal of Clinical Psychiatry, 59*, 60-68.

Chambless, D.L., Sanderson, W.C., Shoham, V., Johnstone, S.B., Pope, K.S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S.R., Sue, S., Bentler, L., Williams. D.A., & McMurray, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*, 5-18.

Chuang, H.T., Jason, G., Pajurkova, E., & Gill, J. (1992). Psychiatric morbidity in patients with HIV infection. *Canadian Journal of Psychiatry, 37*, 109 - 115.

Clarkin, J.F., Widiger, T.A., Frances, A., Hurt, S.W. and Gilmore, M. (1983). Prototypic typology and the borderline personality disorder. *Journal of Abnormal Psychology, 92*, 263 - 275.

Coates, T., McKusick, L., Kuno, R., & Stites, D. (19890. Stress reduction training changed number of sexual partners immune function among men with HIV. *American Journal of Public Health, 79*, 885 - 886.

Cochran, S.D., & Mays, V.M. (1994). Depressive distress among homosexually active African American men and women. *American Journal of Psychiatry, 151,* 524 - 529.

Cohen, S. & Williamson, ,G. (1991). Stress and infectious disease in humans. *Psychological Bulletin, 109*, 5 - 24.

Collier, A.C., Marra, C., Coombs, R.W., Claypoole, K., Cohen, W., Longstreth, W.T., Townes, B.D., Maravilla, K.R., Critchlow, C., Murphy, V.L., and Hansfield, H.H. (1992). Central nervous system manifestations in human immunodeficiency virus infection without AIDS. *Journal of Acquired Immune Deficiency Sundrome, 5,* 229 - 241.

Conning A.M. (1991): The role of the psychologist in psychiatric rehabilitation. *International Review of Psychiatry 3. 83-93*

Cosoff, S.J., & Hafner, J. (1997). The prevalence of comorbid anxiety in schizophrenia, schizoaffective disorder and bipolar disorder. *Australian and New Zealand Journal of Psychiatry, 23*, 67-72.

Cournos, F., Empfield, M., Horwath, E., McKinnon, K., Meyer, I., Phil, M., Schrage, H., Currie, C., & Agosin, B. (1991). HIV seroprevalence among patients admitted to two psychiatric hospitals. *American Journal of Psychiatry, 148,* 1225 - 1230.

Craighead, L.W., $ Agras, W.S. (1991). Mechanisms of action in cognitive beahvioural and pharmacological interventions for obesity and bulimia nervosa. *Journal of Consulting and Clinical Psychology, 59,* 115-125.

Dadds,MR and McHugh,TA (1992): Social Support and Treatment Outcome in Behavioural Family Threapy for Child Conduct Problems. *Journal of Consulting and Clinical Psychology, 60,* 252-259

Dodge,KA, Feldman,E: Issues in SocialCognition and Sociometric Status. In; Asher,SR and Coie, JD (eds) *Peer Rejection in Childhood*. 1990 Cabridge University Press

Doleys,M: Enuresis and Encopresis. In: *Handbook of Child Psychopathology* Ollendick and Hersov (eds) 1989 Plenum Press NY

Elkin, I (1994) The NIMH treatment of depression collaborative research progra: wheree we bagan and where we are. In A.E. Bergin & S.L.Garfield. (Eds.) *Hanbook of psychotherapy and behaviour change.* 4th Edit. (pp 114-139). New York: Wiley

Emmot, S. (1991). *Cognitive group therapy for coping with HIV infection*. paper presented at the V11 International Conference on AIDS, Florence, Italy.

Empfield, M., Cournos, F., Meyer, I., Phil, M., McKinnon, H., Horworth, E., Silver, M., & Herman, R. (1993). HIV seroprevalence among homeless patients admitted to a psychiatric inpatient unit. *American Journal of Psychiatry, 150*, 47 - 52.

Fairburn, C.G., Norman, P.A., Welch, S.L., O'Connor, M.E., Doll, H.A., & Peveler, R.C. (1995). A prospective study of outcome in bulimia nervosa and the long term effects of three psychological treatments. *Archives of General Psychiatry, 52,* 304-312.

Fairburn, C.G., Jones,R., Peveler, R.C., Hope, R.A., & O'Connor, M. (1993). Psychotherapy and bulimia nervosa: long term effects of interpersonal, behaviour therapy and cognitive behaviour therapy. *Archives of General Psychiatry, 48*, 463-469.

Fava, G.A., Grandi, S., Zielezny, M., Rafanelli, C., & Canestrari, R. (1996). Four-year outcome for cognitive behavioural treatment if residual symptoms in major depression. *American Journal of Psychiatry, 153*, 945-947.

Fields, H.L. (1995) *Core Curriculum for Professional Education in Pain* (second edition) Seattle, IASP Press.

Flicker, L. (1992). The effects of caregiving for the demented elderly. *Australian Journal on Ageing., 11*, 9-15.

Fowler, D., Garety, P., & Kuipers, E. (1995). *Cognitive behaviour therapy for psychosis: Theory and practice.* New York: Wiley.

Frasure-Smith, N., Lesperance, F., and Talajic, M. (1993). Depression following myocardial infarction. *Journal of the American Medical Association*, 270, 1819-1825.

Gallagher, D., & Thompson, D. & Steffen, A. (1994). Comparative effects of cognitive behavioural and brief psychodynamic therapies for depressed family care givers. *Journal of Consulting & Clinical Psychology, 62*, 543 - 549.

Goucke, R., Ed., (1998). Pain: A Handbook for Health Care Professionals published by the Australian Pain Relief Association, Willoughby NSW A. Gamsa, (1993). The role of psychological assessment of pain patients in multidisciplinary treatment. *Rapport, 1*, 6-7.

Grafstrom, M., Fratiglioni, L., Sandman, P. O., & Winblad, B. (1992.) Health and social consequences for relatives of demented elderly: A population based study. *Journal of Clinical Epidemiology, 45*, 861-870.

Hardy, G.E., Barkham, M., Shapiro, D.A., Stiles, W.B., Rees, A., Reynolds, S. (1991) Impact of Cluster C Personality Disorders on Outcomes of Contrasting Brief Psychotherapies for Depression. *Journal of Consulting and Clinical Psychology, 63*, 997-1004.

Henderson, A. S. (1995). The mental health of Australians: Can informative data be found. *Australian and New Zealand Journal of Psychiatry, 29*, 6-13.

Herbert, T.R. & Cohen, S. (1993). Depression and immunity: A meta-analytic review. *Psychological Bulletin, 113*, 472 - 486.

Hersen, M., Van Hasselt, V. B., & Goreczny, A. K. (1993). Behavioral assessment of anxiety in older adults. *Behavior Modification, 17*, 99-112.

Hintz, S., Kuck, J., Peterkin, J.J., Volk, D.M. & Zisook, S. (1990). Depression in the context of human immunodeficiency infection: Implications for treatment. *Journal of Clinical Psychiatry, 51*, 497 - 501.

Human Rights and Equal Opportunities Commission. (1993). *Human rights and mental illness: Report of the inquiry into the human rights of people with mental illness.* Canberra: Australian Government Publishing Service.

Jackson, H.J., Whiteside, H.L., Bates, G.W., Rudd, R.P., & Edwards, J. (1991). Diagnosing personality disorders in psychiatric inpatients. *Acta Psychiatrica Scandinavica*, *83*, 206-213.

Jarrett, R.b., & Rush, A.J., (1994). Short-term psychotherapy of depressive disorders: current status and future directions. *Psychiatry, 57*, 115-132.

Jaycox,L; Reivich,K; Gillham,J; and Seligman,M: Prevention of Depressive Symptoms in School Children. *Behaviour Research and Therapy* 1994 vol 32 *no8* pp801-816

Jemmott, J. & Locke, S. (1984). Psychosocial factors, immunologic mediation, and human susceptibility to infectious diseases: How much do we know? *Psychological Bulletin, 95*, 78 - 108.

Jenson,P; Hoagwood,K and Petti,T: (1996). Outcomes of Mental Health Care for Children and Adolescents: 2. Literature Review and Application of a Comprehensive Model *Journal of the American Academy of Child and Adolescent Psychology*. *35,* 1064-1077

Jorn, A.F. (1994). Characteristics of Australians who reported consulting a psychologist for health problems: An analysis of the data from the 1989 – 1990 National Health Survey. *Australian Psychologist*, *29*, 212 – 216.

Joyce, P. (1992) Prediction of treatment response. In E.S. Paykel (Ed.) Handbook of Affective Disorders. (pp 453-464) London: Churchill-Livingstone.
Kagan,J, Resnick,JS and Snidman,N (1988): Biological Bases of Childhood Shyness, *Science 240,* 167-171

Kalichman, S.C., Sikkema, K., & Somlai, A. (1995). Assessing persons with human immunodeficiency virus (HIV) infection using the Beck Depression Inventory: Diseases processes and other potential confounds. *Journal of Personality Assessment, 64*, 86 - 100.

Karasu, T.B., Docherty, J.P., Gelenberg, A. Kupfer, D.J., Merriam, A.E., & Shadoan, R. (1993). Practice guidelines for major depressive disorder in adults. *American Journal of Psychiatry, 150(S),* 1 - 26.

Kazdin, AE, Siegal, TC and Bass, D : Cognitive problem-solving skills training and parent management training in the treatment of antisocial behaviour in children. *Journal of Consulting and Clinical Psychology*, 1992,Vol 60, *No 5*, pp733 - 747

Kelly, J.A., Murphy, D.A., Bahr, G.R., Kalichman, S.C., Morgan, M.G., Stevenson, L.Y., Koob, J.L., Brasfield, T.L., & Bernstein, B.M. (1993). Outcome of cognitive-behavioural and support group brief therapies for depressed, HIV-infected persons. *American Journal of Psychiatry, 150*, 1679 - 1686.

Kelly, J.A., Murphy, D.A., Bahr, G.R., Koob, J., Morgan, M., Kalichman, S.C., Stevenson, L.Y., Brasfield, T.L., Bernstein, B., & St.Lawrence, J. (1993). Factors associated with severity

of depression and high-risk behaviour among persons diagnosed with human immunodeficiency virus (HIV) infection. *Health Psychology*, *12*, 215 - 219.

Kendall,P Treating Anxiety Disorders in Children: Results of a Randomised Clinical Trial. *Journal of Consulting and Clinical Psychology* 1994 Vol 62 pp100-110

Kent, S., Fogarty, M., & Yellowless, P. (1995). Utilisation of inpatient and outpatient services I a public mental health service. *Psychiatric Services*, *46*, 1254-1247.

Kendal,P, Kortlander, E Chansky, T; Brady : Comorbidity of Anxiety and Depression. Treatment Implications. *Journal of Consulting and Clinical Psychology* 1992 vol 60 pp869-880

Kendler, K.S., Gallagher, T.J., Abelson, J.M., et al (1996). Lifetime prevalence, demographic risk factors, and diagnostic validity of nonaffective psychosis as assessed in a US community sample. *Archives of General Psychiatry, 53*, 1022-1031.

Kiecolt-Glaser, J. & Glaser, R. (1988). Psychological influences on immunity. *American Clinical Psychologist, 43,* 892 - 898.

King, N.J., & Ollendick, T.H. (1998). Empirically validated treatments in Clinical Psychology. *Australian Psychologist, 33*, 89-95.

Kizer, K.W., Green, M., Perkins, C.I., Doebbert, G., & Hughes, M.J. (1988). AIDS and suicide in California. *Journal of the American Medical Association*, 260, 1881.

Kovacs, M (1989): Affective Disorders in Children and Adolescents. *American Psychologist* , *44*, pp209-215

Krantz, D.S., Grunberg, N.E. and Baum, A. (1985). Health Psychology. *Annual Review of Psychology*, 36, 349-383.

Krikorian, R. & Worbel, A.J. (1991). Cognitive impairment in HIV infection. *AIDS, 5*, 1501 - 1507.

Lamping, D.L., Abrahamowicz, M., Gilmore, N., Edgar, L., Grover, S.A., Tsoukas, C., Falutz, J., Lalonde, R., Hamel, M., & Darsigny, R. (1993). *A randomised controlled trial to evaluate a*

psychosocial intervention to improve quality of life in HIV infection. Paper presented at the 1X International Conference on AIDS, Berlin.

Lansky, S. B., List, M. A., Herman C. A., et al., (1985). Absence of Major Depressive Disorder in Female Cancer Patients. *Journal of Clinical Oncology, 3,* 1552 - 1560.

Leff, J., Kuipers, L., Berkowitz, R., Eberlein-Vries, R., & Sturgeon, D. (1982). A controlled trial of a social intervention in the families of schizophrenia patients. *British Journal of Psychiatry, 141*, 121-134.

Linehan, M. (1993). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York, Guildford Press.

Linehan, M., Armstrong, H.E., Suarez, A., Allmon,D. and Heard, H.L. (1991). Cognitive behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1064.

Linehan, M., Heard H. and Armstrong H., (1993). Naturalistic follow up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry, 50*, 971-974.

McGorry, P., Curry, C., & Elkins, K. (1997). Psychosocial interventions in mental health disorders: evidence-based practice. *Current opinions in Psychiatry, 10,* 173-177.

Main, J.(1997) *Curriculum on Pain for Students in Psychology*. Seattle, IASP Press.

Main, C. J., Wood, P.L.R., Hollis, S., Spanswick, C.C., & Waddell, G. The Distress & Risk Assessment Method, A Simple Patient Classification to Identify Distress & Evaluate the Risk of Poor Outcome. *Spine*, 1992, 17, 42-52.

Maisie, M. J., Holland, J. C. (1990). Overview of Normal Reactions and Prevalence of Psychiatric Disorders. In Holland, J. C., Rowland, J. H. (Eds), *Handbook of Psychooncology Psychological Care of the Patient with Cancer.* New York, Oxford University Press.

Maj, M. (1990). Psychiatric aspects of HIV-1 infection and AIDS. *Psychological Medicine*, 20, 547 - 563.

Malzack, R., & Wall, P. Pain Mechanisms: A New theory. *Science*, 1965, *50*, 971-975.

March,J and Leonard,H (1996): OCD in Children and Adolescents:A Review of The Past Ten Years. *Journal of The American Academy of Child and Adolescent Psychiatry,* 34, *10*, 1265-1273

Markowitz, J.C., Klerman, G.L. & Perry, S.W. (1992). Interpersonal psychotherapy of depressed HIV-positive outpatients. *Hospital and Community Psychiatry*, 43, 885 - 890.

Markowitz, J.C., Klerman, G.L., Perry, S.W., Clougherty, K.F., & Josephs, L.S. (1993). Interpersonal psychotherapy for depressed HIV-seropositive patients. In G.L. Klerman & M.M. Weissman (Eds.), *New Applications of interpersonal psychotherapy* (pp. 199-224). Washington D.C.: American Psychiatric Press.

Marzillier, J. (1992). Clinical Psychology and primary health care. In Marzillier, J., & Hall, J. (Eds.) *What is Clinical Psychology?* (2nd. Edit.) (pp. 274-298). Oxford: Oxford University Press.

Marzuk, P.M., Tierney, H., Gross, E.M., Morgan, E., Hsu, M., & Mann, J. (1988). Increased risk of suicide in persons with AIDS. *Journal of the American Medical Association, 259*, 1333 - 1337.

Mayberry,M; Taylor,M andO'Brien-Malone,A : Implicit Learning: Sensitive to Age but not IQ . *Australian Journal of Psychology* 1995 vol47, no1,pp8-18

Milgrom, J., Nathan, P.R., & Martin, P.R. (1996) Overview and practice in a general hospital setting. In P.R. Martin & J.S. Birnbrauer (Eds), *Clinical Psychology : Profession and Practice in Australia*. Melbourne : MacMillan Education Australia.

Milgrom, J., Walter, P., & Green, S. (1994). Cost saving following psychological intervention in a hospital setting. The need for Australian based research. *Australian Psychologist*, *29*, 194-201.

Mulder, C. Emmelkamp, P.M.G., Mulder, J.W., Antoni, M.H., Sandfort, T. & Vries, M.J. (1992). *The immunological and psychosocial effects of group intervention for asymptomatic HIV infected homosexual men: The effects of cognitive-behavioural vs. experiential therapy*. Paper presented at the V111 International AIDS Conference, Amsterdam.

National Health and Medical Research Council: *Clinical Prctice Guidelines Depression in Young People*. Australian Government Publishing Service, 1997

National Heart Foundation (1996). *Heart and Stroke Facts*. National Heart Foundation of Australia

O'Dowd, M.A., Natali, C., Orr, D., & McKegney, F.P. (1991). Characterisitcs of patients attending an HIV-related psychiatric clinic*. Hospital and Community Psychiatry, 42*, 615 - 619.

O'Leary, A. (1990). Stress, emotion and human immune function. *Psychological Bulletin, 108*, 363 - 382.

Oldenburg, B., and Owen, N. (1990). Health Psychology in Australia. *Psychology and Health*, 4, 73-81.

Ostrow, D.G. (1990*). Psychiatric aspects of human immunodeficiency virus infection*. Kalamazoo, MI: Upjohn.

Parry G. (1998): Care for the future. *The Psychologist* 12. 10, 436-438

Parry-Jones,W and Barton, J : Post-Trauma Stress Disorder in Children and Adolescents. *Current Opinion in Psychiatry*, 1995, Vol 8, pp227 - 236

Pergami, A., Gala, C., Burgess, A., Durbano, F., Zanello, D., Riccio, M., Invernizzi, G., & Catalan, J. (1993). The psychosocial impact of HIV infection in women. *Journal of Psychosomatic Research*, 37, 687 - 696.

Pekkanen, J., Linn, S., Heiss, G., et al. (1990). Ten-year mortality from cardiovascular disease in relation to cholesterol level among men with and without pre-existing cardiovascular disease. *New England Journal of Medicine*, 322, 1700 -07.

Perkins, D., Davidson, E., Leserman, J., Liao, D. & Evans, D. (1993). Personality disorder in patients infected with HIV: A controlled study with implications for clinical care. *American Journal of Psychiatry*, 150, 309 - 315.

Perry, S., Jacobsberg, L., & Fishman, B. (1990). Suicidal ideation and HIV testing. *Journal of the American Medical Association*, 263, 679 - 682.

Perry, S., Jacobsberg, L., Fishman, B., Frances, A., Bobo, J., & Jaclbsberg, B.K. (1990). Psychiatric diagnosis before serological testing for the human immunodeficiency virus. *American Journal of Psychiatry*, 147, 89 - 93.

Phillips-Doyle, C.J. (1993). Social interventions to manage mental disorders of the elderly in long term care. *Australian Clinical Psychologist, 28*, 25-30.

Price, R.W., & Sidtis, J.L. (1992). The AIDS dementia complex. In G.P. Wormser (Ed.), *AIDS and other manifestations of HIV infection* (2nd ed., pp. 373 - 382). New York: Raven Press.

Prien, R., & Potter, W. (1990). NIMH workshop report on treatment of bipolar disorder. *Psychopharmacology Bulletin, 26, 409-427*.

Rabkin, J.G., Williams, J.B., Neugebauer, R., Remien, R., & Goetz, R. (1990). Maintenance of hope in HIV-spectrum homosexual men. *American Journal of Psychiatry, 147*, 1322 - 1326.

Razavi, D., Delvaux, N., Farvacques C., & Robaye, E. (1990). Screening for Adjustment Disorders and Major depressive Disorders in Cancer In-patients. *British Journal of Psychiatry, 156*, 79 - 83.

Reed, G.M., Taylor, S.E., & Kemeny, M.E. (1993). Perceived control and psychological adjustment in gay men with AIDS. *Health Psychology, 13*, 299 - 307.

Remien, R.H., Rabkin, J., Williams, J., & Katoff, L. (1992). Coping strategies and health beliefs of AIDS longterm survivors. *Psychology and Health, 6*, 335 - 345.

Rundell, J.R., Paolucci, S.L., Beatty, D.C., & Boswell, R.N. (1988). Psychiatric illness at all stages of human immunodeficiency virus infection. *American Journal of Psychiatry, 145,* 652 - 653.

Rutter,M Relationships Between Mental Disorders in Childhood and Adulthood. *Acta Pschiatrica Scandinavica* 1995 vol 91 pp73-85

Sacks, M.H., Dermatis, H., Looser-Ott, S., Burton, W., & Perry, S. (1992). Undetedted HIV infection among acutely ill psychiatric inpatients. *American Journal of Psychiatry, 149*, 544 - 545.

Saunders, P.A., Copeland, J.R., Dewey, M.E., Gilmore, C., Larkin, B. A., Phaterpekar, H., & Scott, A. (1993). The prevalence of dementia, depression and neurosis in later life: The MRC-ALPHA study. *International Journal of Epidemiology, 22*, 838 - 847.

Schleifer, S.J., Keller, S.E., Bond, R.N., Cohen, J., & Stein, M. (1989). Major depressive disorder and immunity: Role of age, sex, severity and hospitalisation. *Archives of General Psychiatry, 46*, 81 - 87.

Schultz, C. (1994). Caring for family Caregivers of dependant ageing persons: process and outcome evaluation. *Australian Journal on Ageing, 13*, 193 - 196.

Schwartz, S. (1997). Is Psychotherapy worth paying for: Economic analysis of psychological treatments. *Psychologically Speaking.*

Scott, J. (1995). Psychotherapy for Bipolar Disorder. *British Journal of Psychiatry. 167*, 581-588.

Segal, Z.V. and Blatt, S.J. (1993). *The self in emotional distress, cognitive and psychodynamic perspectives*. New York, Guildford Press.

Seligman, L. (1996). *Promoting a Fighting Spirit for Cancer Patients, Survivors and Their Families*. Prentice Hall.

Shea, M.T., Klein, M.H., Widiger, T.A. (1992). Comorbidity of Personality Disorders and Depression: Implications for Treatment. *Journal of Consulting and Clinical Psychology*, 60 ,*6,* 857-868.

Sheppard, J.L. (1982-1987). *Advances in Behavioural Medicine* (Volumes 1-4). Sydney: Cumberland College of Health Sciences.

Smith G.B., Schwebel A.I., Dunn R.L. & McIver S.D. (1993): The role of psychologists in the treatment, management and prevention of chronic mental illness. *American Psychologist 48, 9,966-971*

Stein, M., Miller, A.H., & Trestman, R.L. (1991). Depression, the immune system, and health and illness. *Archives of General Psychiatry, 48*, 171 - 177.

Stevenson, J. and Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry*, 149*, 3,* 358-362.

Sumich, H., Andrews, G., Hunts, C. (1995)*. The management of mental disorders. Vol 1. Handbook of management skills.* World Health Organisation

Taylor, S.E., Helgeson, V.S., Reed, G.M., & Skokan, L.A. (1991). Self-generated feelings of control and adjustment to physical illness. *Journal of Social Issues, 47*, 91 - 109.

Teri, L (1994). Behavioural Treatment of Depression in patients with Dementia. *Alzheimers Disease & Associated Disorders*, 8, *S3,* 66-74.

The British Psychological Society, Division of Clinical Psychology. *Purchasing Clinical Psychology Services. Using Clinical Psychology: A Briefing Paper.*

Touyz,S., Blaszczynski,A., Digiusto,E., & Byrne, D. (1992). The emergence of Clinical Psychology departments in Australian teaching hospitals. *Australian and New Zealand Journal of Psychiatry, 26*, 554-559.

Turk, D. (1996). Efficacy of multidisciplinary pain centers in the treatment of chronic pain. In M Cohen & J Campbell (Eds.), *Pain Treatment Centers at a Crossroads*. IASP Press, Seattle.

Udwin, O (1993): Annotation: Childrens' Reaction to Traumatic Events. *Journal of Child Psychology and Psychiatry,* 34, *2*, 115 - 127

Uldall, K.K., Koutsky, L.A., Bradshaw, D.H., Hopkins, S.G., Katon, W., & Lafferty, W.E. (1994). Psychiatric comorbidity and length of stay in hospitalised AIDS patients. *American Journal of Psychiatry, 151*, 1475 - 1478.

US Department of Health and Human Services (1995). Cardiac Rehabilitation: Clinical Practice Guideline Number 17.

Wallace, L. & Bennett, P. (1992) Clinical Psychology and physical health. In J. Marzillier & J. Hall (Eds), *What is Clinical Psychology*, 2nd Ed. New York : Oxford University Press.

Wallander,J and Marulo,D : Chronic Medical Illness. In: Ammerman, Last and Herson (eds) *Handbook of Prescriptive Trearments for Children and Adlolescents* 1993. Allyn and Bacon. USA

Ward, J., Mattick, R., & Hall, W. (1992) *Key issues in methadone maintenance treatment*. NSW University Press.

Watts,F : *The Efficacy of Clinical Applications of Psychology: An Overview of The Research* . 1989. MRC Applied Pschology Unit. Cambridge

Webster-Stratton,C : Annotation: Strategies for helping Families with Conduct Disordered Children. 1991 *Journal of Child Psychology and Psychiatry* Vol 32 pp1047-1062

Widiger, T. and Frances, A. (1989). "Epidemiology, Diagnosis and Comordbidity of Borderline Personality Disorder" in A Tasman, R Hales and A J Frances (Eds) *Review of Psychiatry, 8*, 8-24 American Psychiatric Press, Washington.

Wilfley, D.E., Agras, W.S., Telch, C.F., Rossiter, E.M., Schneider, J.A., Golomb Cole, A., Sifford, L. & Raeburn, S.D. (1993). Group cognitive behavioural and interpersonal psychotherapy for nonpurging bulimic individuals: a controlled comparison*. Journal of Consulting and Clinical Psychology, 61*, 296-305.

Williams, J.B.W., Rabkin, J.G., Remien, R.H., Gorman, J.M., & Ehrhardt, A.A. (1991). Multidisciplinary baseline assessment of homosexual men with and without human immunodeficiency virus infection. *Archives of General Psychiatry, 48,* 124 - 130.

Wirshing, W.C., Marder, S.R., Eckman, T., et al. (1992). Acquisition and retention of skills training methods in chronic schizophrenia outpatients. *Psychopharmacological Bulletin, 28*, 241-245.

Woody, G.E., McLellan, A.T., Luborsky, L., & O'Brien, C.P. (1985). Sociopathy and psychotherapy outcome. *Archives of General Psychiatry, 42*, 1081-1086.

World health Organisation (1997). *Assessment and diagnosis of personaltiy disorders: The ICD-10 International Personality Disorder Examination*. Cambridge, UK: The Cambridge University press.

Zevallos, J.C., Chiriboga, D., and Herbert, J.R. (1992). An international perspective on coronary heart disease and related risk factors. In I. S. Ockene & J.K. Ockene (Eds.), *Prevention of coronary heart disease* (pp. 147 - 170). Boston: Little, Brown.

Zimmer, J.G., Watson; N., & Trent, A. (1989). Behavioral problems among patients in skilled nursing facilities. *American Journal of Public Health, 74*, 1118 - 1121.

Zonderman, A.B., Costa, P.T., & McCrae, R.R. (1989). Depression as a risk for cancer morbidity and mortality in a nationally representative sample. *Journal of the American Medical Association, 262*, 1191 - 1195.

List of Contributors

Bright, Carolyn

Christophers, Rob

Cichello, Anthony M *(Co-Convenor)*

Clarkson, Liz

Connor, Carmela

Douglas, Bill (Dr.)

Downie, Ron

Ebsworthy, Greg

Edgar, Lorraine

El Hassani, Jenni

Follett, Denise

Fruin, Donna (Dr.)

Griffiths, Jenny

Hart, Trish

Hicks, Suzanne

Hunt, Michael

Jones, Margaret

Jonikis, Anthony

Kneebone, Ian

Kooperman, Rochelle

Krupenia, Zyron

Lamparski, Barbara

Lowe, Sue

Lucking, Sue

Malgrem, Senia

Marsh, Alison

Martin, Paul (Prof.)

Merryweather, David

Minchin, Lyn

Moorcroft, David

Morris, Eric

Nathan, Paula *(Co-Convenor)*

Nicoll, Denise

O'Donnell, Meaghan

Philp, Ros

Preece, Minnette

Putz, Gail

Rees, Clare (Dr.)

Roberts, Claire (Dr.)

Rule, Trevor

Russell, Craig

Smith, Carole

Swalm, Delphin

Sweetman, Ian

Williams, Sandy

Wilmoth, Deborah

Wright, Bernadette (Dr.)

Yap, Lai Meng

Appendices

A. Public Service Notices, Vol 4 No's15 and 18, April 21 and May 12, 1982

B. Proposed revision of Psychology and Clinical Psychology Classifications, HDWA 29th October 1987.
Criteria Progression - A proposal prepared jointly by the Heads of Psychology Services, August 11, 1987.

C. Clinical Psychologists Classifications and Criteria - Correspondence between HSOA and HDWA, 1992 - 1993.

D. Clinical Psychology, What is it?, What does it do?, How well does it do it?

E. The Psychologists Board of WA, 'Applicants Programme-Clinical Psychology'

F. Paul R Martin, 'Training in Clinical Psychology"

G. Curriculum on Pain for Students in Psychology

H. Psychological Treatments (Behavioural Interventions)

I. Position Statement on Pain, Australian Pain Society

J. Undergraduate Course Handbooks - University of WA, Curtin University, Murdoch University, Edith Cowan University

K. Postgraduate Course Handbooks - University of WA, Curtin University, Murdoch University, Edith Cowan University

L. The Australian Psychological Society Ltd, Code of Ethics