2002 WAIRC 07218

HOSPITAL SALARIED OFFICERS' AWARD 1968

WESTERN AUSTRALIAN INDUSTRIAL RELATIONS COMMISSION

PARTIES	HOSPITAL SALARIED OFFICERS ASSOCIATION OF WESTERN AUSTRALIA (UNION OF WORKERS)
	APPLICANT
	-v-
	ROYAL PERTH HOSPITAL AND OTHERS
	RESPONDENTS
CORAM	COMMISSION IN COURT SESSION CHIEF COMMISSIONER W S COLEMAN SENIOR COMMISSIONER A R BEECH COMMISSIONER P E SCOTT
DATE	MONDAY, 16th DECEMBER 2002
FILE NO	P 39 OF 1997
CITATION NO.	2002 WAIRC 07218

Result	Application granted in part

Representation

Applicant	Mr D Hill and with him Ms C Thomas
Respondent	Mr G Edwards and with him Mr M Taylor

Reasons for Decision

THE COMMISSION IN COURT SESSION:

The Application

1 This is an application to amend the Hospital Salaried Officers' Award 1968 (No. 39 of 1968) ("the Award") in respect of the classification structure as it applies to clinical psychologists, to enhance the entry and exit points in respect of clinical psychologists on the basis of increased

work value. The amended Schedule B to the application was filed on 28 June 2001 and seeks to amend the Award with effect from 18 August 1997, the date the application was filed.

2 The amended schedule seeks to amend Schedule A of the Award so as to provide a new subclause (5) with definitions and grading structure for clinical psychologists as follows:

"(5) Employees engaged as Clinical Psychologists shall be graded, classified and paid in accordance with the following:

GRADE	SALARY
	Equivalent salary level and point in clause (3) of this schedule
Clinical Psychologist Registrar – Grade 1	Level 6 point 1
	Level 6 point 3
Clinical Psychologist – Grade 2	Level 7 point 3
	Level 8 point 1
	Level 9 point 1
	Level 10 point 1
Senior Clinical Psychologist – Grade 3	Level 10 point 2
	Level 11 point 1
	Level 11 point 2
Senior Clinical Psychologist – Grade 4	Level 12 point 1
	Level 12 point 2
	Level 12 point 3
Consultant Clinical Psychologist – Grade 5	Class 1

DEFINITIONS

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 Psychologists, 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 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 contributes 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 a leading 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."

3 Currently, the Award does not provide a separate structure for clinical psychologists or any other calling. The classification structure currently contained within the Award provides:

- a monolithic structure for employees other than those within "Specified Callings and Other Professionals". This structure sets out levels 1 to 12, with a varying number of increments within each level.

The only callings specifically referred to in that structure are medical typist and medical secretary, for whom there are definitions and provision for a medical terminology allowance;

- a monolithic structure for employees in "Specified Callings and Other Professionals". Clinical psychologist is one of 25 such callings listed. The only calling dealt with separately is that of engineer, and in that a separate subclause defines "experienced engineer" and the relevant qualifications. The structure sets out levels 3/5 to 12, with varying numbers of increments, and a paragraph describes only the entry points to the structure according to academic years of qualifications. There is no prescription regarding movement between the levels or from one increment to the next.

4 The Award appears to allow the employer to determine the duties of and qualifications required for any position and, subject to the qualifications for entry into the salary structure, the level for any position. Subclause 3(c) provides that "the employer and the applicant shall be responsible for determining the relevant acceptable qualifications for appointment for the callings covered by this subclause and shall maintain a manual setting out qualifications." The current structures and arrangements for the classifications of clinical psychologists are set out in correspondence between the parties in March 1992 (Exhibit A2, Volume 1, documents B 12 and B 13). This sets out arrangements for classification criteria for levels 6 and 7/8, the characteristics, the relevant academic requirements and the general features of duties.

5 The application seeks to insert into the Award salaries schedule the same types of prescription for those positions and beyond them to add new grades.

6 The granting of the application would mean that definitions of new grades of clinical psychologists and their classification structure would be uniquely provided for in the Award,

whereas other specified callings and professions have no such definition and structure, with the exception of definition of "experienced engineer".

7 The effect of the granting of the application would be as follows:

(a) to prescribe definitions, grades and levels for clinical psychologists;

(b) Clinical Psychologist Registrar (Grade 1) would enter the scale at the same point as currently applies (ie level 6/1), however, the second increment would be level 6.3 rather than level 6.2. There would be no third increment as currently applies. The effect would be to reduce by 1 year the time taken to reach the top of the level.

Clinical Psychologist Registrar (Grade 1) would be restricted to a person who has completed and satisfied the educational requirements of the Psychologists Registration Board and is undertaking 2 years' supervised practice prior to achieving recognition as a registered Clinical Psychologist.

(c) The current Senior Clinical Psychologist, described administratively, but not in the Award, would become Clinical Psychologist (Grade 2), and instead of entering the scale at level 7.1 and moving through 5 increments to level 8.2, would enter at level 7.3, have increments to levels 8.1, 9.1 and 10.1, skipping levels 8.2 and 9.2.

There would be automatic progression from Grade 1 to Grade 2 upon satisfaction of the registration requirements of the Psychologists' Registration Board.

(d) The creation of new classifications of:

(i) Senior Clinical Psychologist (Grade 3) encompassing Levels 10.2, 11.1 and 11.2.

(ii) Senior Clinical Psychologist (Grade 4) encompassing Levels 12.1, 12.2 and 12.3.

(iii) Consultant Clinical Psychologist (Grade 5) at Class 1. (The Award currently makes no provision for a classification of Class 1 although the enterprise bargaining agreement PSA AG 1 of 2002 provides Classes 1 to 4).

Progression to Grades 3, 4 and 5 would be in accordance with procedures to be determined between the parties, according to the schedule of claim. The applicant says that the Department of Health's existing criteria progression guidelines from the existing level 6 to level 7/8 constitute a useful starting point for discussion. Disputes regarding appropriate classification levels will be dealt with in accordance with the Dispute Settlement Procedure under the Award and the Enterprise Bargaining Agreement, with provision for an application to the Public Service Arbitrator pursuant to s.80E(2) if necessary.

The Applicant's Submission

8 According to the Clinical Psychology - Work Value Document 1998 (Exhibit A1), prepared by the HSOA Clinical Psychology Negotiating Committee in support of the application, "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 a scientist-practitioner approach to changing human behaviour and thereby use techniques with proven scientific effectiveness", using "scientific research and statistical analysis". They have "a thorough understanding of varied and complex psychological theories" and "the ability to formulate and respond to both complex disorders and to novel problems, generating interventions based on this solid knowledge base". They "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." They also "act as consultants and so work with and through others to bring about change of the individual, group, family, hospital or agency settings."

9 The applicant says that for at least 10 years, the work of clinical psychologists has been under valued, and that there have been significant changes in their work and skills, and in the context and environment in which that work is performed. It says that these changes constitute increases in work value which meet the Work Value Principle.

10 The applicant says that:

> "At its core, this application is for the reclassification of all Clinical Psychologist positions covered by the Award … (by) seek(ing) to create new classification bands for the various classes of Clinical Psychologist positions." "It does so by using existing salary points under the Award."
>
> (Applicant's Principle 10 Statement, paragraphs 9-11)

11 The history of the issue of the classification structure for clinical psychologists was addressed by the applicant in detail, providing copies of correspondence and documentation exchanged between the parties over the last decade. This history includes that in 1990, there were 14 clinical psychologists' positions in hospitals and these were covered by the Award. However, the vast majority of clinical psychologists in the public health sector were employed under the Public Service Award 1992 (No. PSAA 4 of 1989) and were employees of the Commissioner of Health in respect of psychiatric and mental health services. This changed after the Full Bench decision regarding union coverage (76 WAIG 1673), and now, all clinical psychologists within the public health sector, within public hospitals and health services, including those formerly employed by the Commissioner of Health, but excluding those covered by the Graylands Selby-Lemnos and Special Care Health Services Award 1999 (No. PSAA 1 of 1999), are covered by the Award.

12 In the early 1990s, it was intended that a working party be established to address the issues now sought to be resolved by this application. Those issues included the attraction and retention of allied health professionals, including clinical psychologists. One mechanism for addressing this issue was to have the classification structures revised. The applicant says that notwithstanding the establishment of a working party, the issues have not been resolved.

13 In 2001, an Allied Health Taskforce on Workforce Issues was established with the support of the Departments of Health and Disability Services. Its purpose was to investigate and address issues related to shortages in the allied health workforce (see Exhibit 2A, Volume 1, C12 and C13). The Taskforce was to address issues affecting attraction and retention of health professionals including clinical psychologists, but not to deal with classification structures. The issues of attraction and retention and of the classification structure have still not been resolved, according to the applicant.

14 The applicant refers to the decision of the New South Wales Industrial Relations Commission (in Health and Community Employees Psychologists (State) Award, [2001 NSWIRC 302]) which provided an improved career structure for psychologists and clinical psychologists, and it says that in addressing that issue, the NSW Commission addressed attraction, retention and career structure problems for those professions.

15 The claim for retrospectivity is said to be based on the lengthy negotiations which the parties engaged in. The applicant says that the respondents refused to agree to the claim or to make any counter proposal. The applicant says this justifies the consideration of retrospectivity.

16 The applicant addressed Principle 10 of the Statement of Principles and noted that the application is restricted to the public health sector and persons classified and employed under the Award. Part of the history of industrial coverage of clinical psychologists is dealt with by the Full Bench in its decision pursuant to s.72A (76 WAIG 1673) in respect of Award and

constitutional coverage of professional, administrative, clerical, technical and supervisory employees employed in mental health services, and at Graylands Selby-Lemnos Special Care Health Services. There is currently an award to which the applicant and The Civil Service Association of Western Australia Incorporated are parties. The applicant has sought from the employer an undertaking that the outcome of this matter would apply to clinical psychologists employed at Graylands Selby-Lemnos and, at the time of the hearing, the employer had indicated that it would consider the matter when this decision is known.

17 The applicant says that there is no history of linkage or flow-on of wage increases from clinical psychologists in the public sector to private sector awards and, in any event, Mr Hill for the applicant says that none is employed by a private hospital to provide clinical psychology services. In the main, those in the private sector operate in independent private practice. On this basis, the applicant says there is little prospect of flow-on. The applicant also says that if the claim is granted, it would not create any precedent on the basis that it is the particular circumstances, educational requirements, registration procedures and classifications which sets this group of professionals apart.

18 As to the cost of the claim, the applicant says that it has been difficult to obtain accurate information from the employers with respect to precise numbers of clinical psychologists and the levels at which they are currently paid. In the applicant's estimation, though, there are 135 positions involved and estimates that the cost would be $540,000, and some employees would gain additional increments over time. The applicant says that this is not a significant cost in the context of the state economy or the national economy. The claim does not have a significant impact given the size of the clinical psychology workforce in the Western Australian public sector. It is also not significant in the overall public health budget of $1.8 billion. The Health Department's Annual Report for 1999 - 2000 indicates that there are approximately 21,500

FTE's in the public health sector which, the applicant says, demonstrates that this group is a small one within that sector.

19 In respect of the issue of attraction and retention of clinical psychologists, the applicant says that this fits within the general thrust of the Structural Efficiency Principle and that by virtue of the work value changes that have occurred within the profession, by addressing career structure issues through work value, there would be a flow-on effect in terms of retaining numbers of clinical psychologists, particularly in senior and specialists positions. The applicant says that attraction and retention issues are consequential upon the provision of a proper career structure, with recognition of the work value increases.

20 The Ministerial Task Force on Mental Health – March 1996 (Exhibit A 2, Volume 2 tab F1) which addressed the issues for the mental health workforce generally, noted that there would be increasing difficulty in attracting and maintaining the appropriate staff resources. Some of the factors contributing to the loss of the workforce were limited salary increments, and loss of career structure with the abolition of senior psychologists' positions within the Health Department. These were positions of Principal, Deputy and Assistant Principal Clinical Psychologists. The relative absence of clinical career structures and structures for clinicians having both designated management and clinical roles, the absence of recognition of acquired specialist clinical skills with associated salary and position increments, and the absence of a right of private practice were identified as issues which needed to be addressed. These issues were identified again in 1997 and 2000. It was also noted that the focus to date had been on psychiatrists and mental health nurses as there were shortages in those professions. The Mental Health Reforms in Western Australian – the Report of the Government Reform Programme, October 2000 recognised that "the major difficulty in this field is the retention of senior clinicians". The report also noted that "current awards restrict salary and many experienced practitioners find private practice more attractive". There is said to be a serious

shortage of senior clinical psychologists, particularly within the child and adolescent services and services for older people. The report goes on to note "work with the Metropolitan Mental Health Service to create several positions for experienced and highly skilled clinical psychologists will provide clinical leadership and contribute to the development of expertise among the clinical psychologists work force". The applicant says that for the past four years, the Mental Health Division has been saying that there is a need to create these positions, yet they have not been created. These positions were to provide specialist advice and assistance and have a role in teaching in their respective specialist areas within the Mental Health Division.

21 The "major depletion of senior clinical psychologists in the workforce of the Health Department" is said to have lead to difficulties in providing adequate supervision and monitoring of standards of practice and in the training and supervision of more junior staff. From December 1991 to August 1996, 40 senior clinical psychologists left the Mental Health Service of the Health Department. It is noted that the ratio of senior clinical psychologists to other clinical psychologists has declined from 1.9 to 1 in 1997 to 0.7 to 1 in 1998.

22 The applicant says that the lack of a proper career structure, with more senior positions, has resulted in clinical psychologists moving into management, policy and research areas across the public sector. A further 20 per cent of experienced practitioners are said to have left the public sector to enter private practice over the last 3 years.

23 As to the operation of criteria progression, the applicant says that it is acknowledged by the employers that there is a lack of criteria progression for level 6 which needs to be addressed. The ratio or numbers of level 6 and level 7/8 or senior positions needs to be addressed.

24 The Work Value Document deals with a range of issues including the claimed increased work value; the prevalence of mental health problems in the community; the demand for clinical

psychology skills; increasing co-morbidity (the occurrence of more than one clinical disorder with a principle diagnosis at the same time); the effectiveness of treatment by clinical psychologists; research and innovations in diagnosis and treatment; the aging of the community; specific areas of increased work value in particular areas of practice; recruitment and retention, and suggestions for change.

25 The Work Value Document notes particular areas of specialisation, and sets out the conclusion of various reports and surveys as to the prevalence of mental health issues and the role played by clinical psychologists in dealing with them. These include reference to research that demonstrates that 20 per cent of older persons residing in the community were experiencing significant depressive symptoms warranting intervention. It was also reported that there were significant levels of depression and a 20 per cent prevalence at 80 years of age to Alzheimer type dementia. A 1997 survey reported that clinical psychologists have been involved in internationally recognised research about the mechanisms underpinning psychiatric disorders, and the practice of evidence–supported effective treatments. In respect of mental health problems involving children, adolescents and youth, the Work Value Document noted that the 1996 Western Australian Child Health Survey found that 18 per cent of children were identified as having a mental health problem; half of those were serious enough to warrant professional intervention, however, less than two per cent of them were seen by the Child and Adolescent Mental Health Services. It was noted that unresolved psychological problems can later develop into other psychological issues in adulthood.

26 The Work Value Document also reported that the 1989/1990 National Health Survey demonstrated a high demand for clinical psychology services, with 43,000 Australians consulting a psychologist over a 2 week period, requiring some 63,000 consultations.

27 The treatments provided by clinical psychologists were described by the Work Value Document as being very cost effective. The utilisation of clinical psychology services are said to have resulted in a reduction in the utilisation of costly medical services, medications and reduced in-patient bed days. Interventions that have been developed or implemented by clinical psychologists can have a major impact on the physical and psychiatric health of individuals. Such psychological treatments as Cognitive Behaviour Therapy ("CBT"), interpersonal psychotherapy, family systems interventions, and brief and long term psychodynamic interventions are said to have proven efficacy. Disorders such 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, and the management of symptoms associated with schizophrenia are all able to be treated by psychological treatments. Not only is there cost effectiveness in treatment by clinical psychology but the 1989 review of "The Efficacy of Clinical Applications of Psychology: An Overview of the Research", an English report, also supported the "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 the adolescent age group. A 1997 report regarding YouthLink emphasised the cost effectiveness of community based clinical psychology services for youth in dealing with "such problems as suicidal behaviour, chronic self harming behaviour, substance abuse, depression, offending and sexual abuse issues". Many of the psychological therapies developed for a range of conditions in the adolescent group are said to have been adapted for the elderly population.

28 The Work Value Document claims that the responsibilities of clinical psychologists have increased considerably since the mid to late 1980s, with the profession becoming "more fully established", and providing "highly specialised and autonomous mental health services to

individuals across all developmental stages". It says that "the profession provides amongst other things, specialist diagnostic and complete psychobiosocial assessments, treatment services in areas as complex and diverse as psychotic illness, severe personality disorders, and co morbid disorders". In addition to providing treatment to patients, clinical psychologists have been increasingly called on by psychiatrists to provide additional diagnostic information, to assist with diagnosis of complex cases. Clinical psychologists are said to be "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 tests are being continually revised." One such test is the Wechsler Adult Intelligence Scale ("WAIS") which was said to have been revised again in 1997. The Work Value Document asserts that "Clinical Psychologists are the only mental health profession which has the depth of psychometric and empirical training, and consequently, the responsibility of reliably and validly applying and interpreting tests essential to the effective and ethical mental health practice".

29 Clinical psychologists are also said to have an increased role by taking direct primary responsibility for interventions with patients.

30 There is a continual expansion of psychological knowledge providing data for the efficiency and effectiveness of discrete focus psychological interventions and long term psychotherapy.

31 The Western Australian Institute of Psychotherapy Research ("WAIPR") established a programme in late 1997 to provide the community with a "clinically oriented and practical (research) resource". Its main aim is "to provide excellence in the clinical management of adult psychiatric disorders within the public mental health service". It conducts research in conjunction with other institutions such as the Departments of Psychology and of Psychiatry at the University of Western Australia with other public sector mental health programmes.

32 According to the Work Value Document, clinical psychology also has an increased role "in teaching and informing other professions of evidence-based developments in treatment for mental health disorders". These professions include medical officers, psychiatric registrars, mental health nurses and social workers, in areas such as those relating to "suicidal and chronically self harming individuals, and psychological treatment of depression, anxiety, social phobia, obsessive – compulsive disorder, eating disorders and substance abuse disorders".

33 The applicant claims that there is evidence of the profession of clinical psychology "taking the greatest role and responsibility in the development of a number of new and innovative services and approaches to service delivery", such as in areas of youth mental health and neuropsychological predictive testing. The development of YouthLink was cited as an example of "service delivery being targeted to improve access to services to the most marginalised and at-risk young people".

34 There is reference to developments in improving treatments and service delivery in Aboriginal mental health.

35 Clinical psychologists are said to engage in continual improvement activities associated with knowledge of clinical assessments and interventions, understanding research methodology and analysis.

36 There is also reference to the legal accountability of clinical psychologists in respect of civil action regarding claims of professional incompetence. The Psychologists' Board of Western Australia considers that effective supervision of Clinical Psychologist Registrars includes acceptance of legal responsibility by the supervisor where a "provisionally registered (clinical) psychologist is not yet competent or responsible".

37 The Work Value Document claims that whilst clinical psychologists are often grouped with "allied health" professionals for administrative purposes they differ markedly from those

others. They have "extensive training in the theoretical and conceptual understanding of mental health problems, the correct diagnosis and clinical evaluation of these problems and of effective management and treatment". It is said, though, that the training of allied health professionals is geared towards general medical, general health or general community problems, with short electives in mental health. On this basis, clinical psychologists are said to be the only mental health profession, other than psychiatry, with complete post-graduate training in the area of mental health.

38 Clinical psychologists have a minimum of six years' full time university training, requiring a Masters degree, plus two years' mandatory professional supervision under the auspices of the Psychologists' Board of Western Australia, the state registration authority. This two years supervision period has increased from one year. The additional year was said to have been required due to the increasing complexity of the work, and the substantially increased body of knowledge in the profession. It is said that, increasingly, more students are completing a Doctorate of Psychology, which involves an additional year of training at university, or a PhD in Clinical Psychology, which adds a further two years to their formal university training. The applicant sees this as providing a very high level of specialist competence which it says is acknowledged by private health insurance companies. Post-graduate training programmes are established and accredited by the Australian Psychological Association. It is also 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.

39 The Work Value Document has listed and described a range of innovations in specific areas of increased work value, being in:

- child adolescence and youth;

- neuropsychology;
- adults;
- mental health problems in medical conditions.

The Applicant's Evidence

40 The applicant called a number of witnesses who gave evidence of various aspects of the increased work value claimed within the Work Value Document. These witnesses described what they saw as the changes in the work performed by clinical psychologists and the context and environment in which it is performed in the Western Australian public health system. The Commission had the benefit of receiving evidence from senior clinical psychology practitioners, psychiatrists, and academics. The evidence that they provided was of the following issues and changes to the practice of clinical psychology in the public health sector in the last 10 to 15 years:

- The increasing prevalence of mental health problems in the community including co-morbidity;
- the demand for clinical psychologists' skills, including or resulting in increasing departures from the Health Department into private practice;
- significant developments in assessment and diagnostic tools and treatments in a range of areas including adults, children and adolescents, Aboriginal people, the elderly, and into general medical/surgical fields e.g. gynaecology, obstetrics, pain management.
- Developments in the working environment include:
    - Working within multi-disciplinary teams, sometimes with clinical psychologists heading those teams or the services;

- Working in hospitals, nursing homes, and community services and in the homes of patients;
- Increasing substance abuse, increased longevity of the population, HIV/Aids, chronic disease brought about by behavioural factors etc.
- Cost effectiveness and efficacy of treatment, having a benefit to the community and often supplementing or replacing the need for medical interventions.

- • Clinical psychologists being trained in empirical methods, in undertaking research, understanding research methodologies and analysis, making great developments beyond that expected of normal progress within a profession;
- • Senior clinical psychologists moving to private practice therefore placing a greater load of supervision on students and junior professionals;
- • Increased training requirements imposed for registration, including an extra year of supervision for registration as a clinical psychologist thereby recognising the increased demands and complexity of the role;
- • Increasing specialisation into areas of gerontology, child and adolescent, neuropsychology etc.;

41 In addition to the evidence in respect of these matters which a number of witnesses referred to, the witnesses also made useful comments in respect of other matters.

42 Professor Paul Martin, Professor of Psychology at the University of New England, Armidale, New South Wales and Head of the School of Psychology, and President of the Australian Psychological Society since October 2000, noted that clinical psychology and psychiatry are the only professions which have mandatory post-graduate studies and training at university

degree level, being the basic minimum level of qualifications. The clinical psychologist's post graduate qualifications are higher than those of medical practitioners. Another significant change for typical clinical psychologists was that they have overall responsibility for assessment, diagnosis and treatment of the patients they see. Prior to the 1990s, those responsibilities were usually with the medical persons such as a psychiatrist.

Under cross examination Professor Martin acknowledged that there had been changes in respect of other professional specialities but that his comments were related particularly to clinical psychology. Professor Martin said that training and supervising of students and of other allied health professionals had always been a role of clinical psychologists. However, there has been an increase in this work because the balance of the workforce has changed with there being more junior and less senior people. The supervision involved is across a broader range of skills and domains than previously. This is particularly difficult because the senior people who went through their training before clinical psychology was involved in those domains, are required to re-learn their job rather than refer back to their training in respect of those matters. The trend for clinical psychologists to become involved in assessment and treatment commenced prior to 1989 but has continued and increased. Preventative health enhancement involvement had largely arisen from the 1990s.

43 Dr Anthony Mander is a Director of the Division of Clinical Neurosciences based at Royal Perth Hospital. He was a member of the Psychologists Registration Board between 1996 and 1999. He says that although clinical psychologists are not trained in clinical diagnosis as understood by medical practitioners, they are trained to produce a detailed formulation of an individual's problems which is sufficient to enable the practitioner to instigate an effective individualised treatment package using psychological principles. Hence, although it is different to the "medical model" approach, it could be said to be a complementary diagnostic and treatment procedure. Clinical psychologists are involved in the "development of effective,

rigorously evaluated, focused psychological treatments" and "operate with a degree of independence far in excess of other "allied health professions"". Dr Mander noted that clinical psychologists are in short supply and are easily able to successfully establish private practices. This creates difficulties in the retention of top quality clinical psychologists in the mental health delivery system.

44 Dr Peter Cotton, a clinical psychologist in independent practice for the past eight years and the Director of Communications on the Board of Directors on the Australian Psychological Society, said that there has been a rapid expansion in clinical treatment outcomes research particularly over the last ten years. This has established that specialised psychological treatments are at least as efficacious as medications in treating most types of depression and anxiety disorders; are more cost effective over the longer term due to lower relapse rates; and that severe depressive and anxiety disorders are probably most optimally treated through a combination of both psychological and pharmacological treatments. This upsurge in clinical outcome research has progressively filtered through and influenced training programmes in clinical psychology. He noted that clinical psychologists in independent practice earn average incomes that are substantially higher than the public sector counterparts. Dr Cotton was not cross examined.

45 Dr Andrew Page, Senior Lecturer and Director of Clinical Psychology Training and Deputy Head of the Department of Psychology at the University of Western Australia, dealt with the changes to the period of training, and the options for clinical psychologists with no corresponding change in salary levels. He referred to the restructure of the training programme conducted by the Department of Psychology at the University of WA, so that there was an integrated four year course of study under the combined degree of Master of Psychology Clinical/Doctor of Philosophy. He says that there is pressure from the profession of Clinical Psychology to enhance the training levels, commencing at the increased skill level required of

newly graduated and senior clinical psychologists. There have also been increased levels of responsibility and skills exercised by clinical psychologists. This is evidenced by the increase in restrictions placed on students who have been supervised during their training by clinical psychologists. There has been a marked increase in refusals to accept placements of junior students over the last five years, due to the level of experience required of those students and the level of responsibility expected of clinical psychologists being greater than the previous years.

He says that the requirement for versatility and adaptability has increased in the last 10 years, as have specialisations and the growth and training programmes for these specialisations. In Dr Page's opinion, the skill-based level of responsibility, extent of versatility and adaptability, and cost effectiveness of the work of clinical psychologists have increased qualitatively, and these changes are not reflected in the salary structure. Dr Page was not cross examined.

46 Dr Bill Douglas, senior clinical psychologist employed at Fremantle Hospital gave evidence that there has been a paradigm shift in the assessment and treatment skills of psychologists and he cites as examples chronic pain and disability management. He says that this represents a substantial new development in providing psychological treatment for patients with physical health diagnosis rather than mental health diagnosis. He says that as a result of these developments, clinical psychologists working in areas such as pain management are now expected to be familiar with a range of scientific literature largely of a medical nature and to be familiar with the psychological characteristics of all forms of pain disorder. He says the area of chronic pain is relatively new, and up to 30 years ago, had no medical specialisation. Dr Douglas says that the level of responsibility for clinical psychologists working the area of pain management has been increased substantially in the last decade, as they are working more independently in a hospital environment, often receiving referrals direct from medical specialists and general practitioners rather than through pain specialist colleagues.

Historically, psychologists had been viewed as technicians supplying services under the supervision and directorship of doctors, but this is not currently the case with clinical psychologists working in pain clinics in Western Australia. Dr Douglas was not cross examined.

47 Dr Deborah Wilmoth, Manager of the State Forensic Health Service, says that the expectations of clinical psychological services in Western Australia have changed significantly over a short period of time. She refers to clinical psychologists in North America having parity status with psychiatry in all areas of practice in most states. She says some of the change which has occurred in North America and the UK has not had time to develop in Western Australia and that psychologists have had to increase their range of knowledge of expertise without changes in their training here. She says that in Western Australia and the rest of Australia, training programmes are changing to reflect the actual practice of clinical psychologists. Those changes in the nature of the work include a wide range of interventions in physical, behavioural and cognitive change. Literature has acknowledged the relationship between psychological stress and physical illness, thus requiring more from clinical psychologists. Dr Wilmoth was not cross examined.

48 Sheryl Pope, Associate Professor of Psychology and Co-ordinator of the Post-Graduate Clinical Psychology programme at the Edith Cowan University, was previously employed as chief clinical psychologist at King Edward Memorial Hospital. Associate Professor Pope gave evidence of significant changes in the roles and responsibility of clinical psychologists, especially in the perinatal mental health. She says that the assessment and treatment skills provided by clinical psychologists are being increasingly sought and relied upon by other health practitioners for conditions/disorders that were once considered to be within the domain of medical practitioner and/or psychiatrist. In the past 10 to 15 years many women and their

partners have been referred for psychological assessment, treatment and preventative strategies in respect of perinatal mental health relating to reproductive and obstetric medicine.

49 Dr David Merryweather, senior clinical psychologist with the North Metropolitan Health Authority, gave evidence that since the early 1990s there has been increased emphasis on maintaining mental health clients in the community with less intensive medical interventions. He gave evidence as to a number of other conditions such as personality disorders, especially borderline personality disorders, being dealt with in community based services as opposed to in-patient treatments. There were cost savings associated with clinical psychologists providing their expertise in this area. Clinical psychologists take on the primary therapist role in dealing with a range of circumstances including identifying high risk individuals and managing their risk behaviours. Due to funding difficulties, community mental health clinics have significantly narrowed their intake criteria so that only clients with severe and/or acute psychiatric disorders (often dual diagnosis) are accepted for treatment. Therefore, clinical psychologists' case loads can be defined as "difficult, complex cases requiring highly specialised and intensive intervention". He referred to a landmark case in the Northern Territory in 1998 where the ability of clinical psychologists to assess, diagnose and provide expert opinions on post-traumatic stress disorder was recognised.

Dr Merryweather gave evidence of significant increase in the incidence of dual diagnosis disorders arising in the last 10 years with the increase in availability and diversity of illegal drugs. He also gave evidence that another area of expertise developed with the last 10 to 12 years was Eye Movement Desensitisation and Reprocessing.

There also have been changes in the cultural context of the work of clinical psychologists with the influx of refugees from regions including Baltic States and the Middle East where, because

of the circumstances and experiences of those people, particular approaches have had to be adopted.

Dr Merryweather gave evidence that there had been several examples in the North Metropolitan Health Service where the policy had been to not approve criteria progression for clinical psychologists in the levels 6 and 7/8.

Dr Merryweather said that other health professionals had also been impacted upon by the process of maintaining mental health clients in the community, with less intensive medical interventions, but that clinical psychologists have probably been impacted upon more because of the particular clients that are now being dealt with in the community.

Dr Merryweather works as part of a multi-disciplinary team generally overseen by psychiatrists but in quite a number of cases there is joint management with a psychiatrist.

Dr Merryweather says that in 1992 he took the primary therapist role with some clients, and that these related more to anxiety disorders.

He also said that there are a lot more of borderline personality disorder cases which are part of his responsibility these days. Also in 1992, he had responsibility to deal with personality disorder cases but in a limited way and that it would probably be the psychiatrist who has primary responsibility. He believes that that responsibility has now shifted because of the kinds of treatment clinical psychologist are able to offer due to the new techniques they have developed, including assessment tools such as CBT, which have been refined and applied to a broader range of clients problems. He says that there has been a real shift in the kind of techniques that have been developed, which is innovative, not merely evolutionary change.

Dr Merryweather gave evidence that for example the Wechsler Memory Scale had been revised in the last 4 years to say that it now incorporated subtests and measures some additional functions. He was able to use his pre-existing skills in respect of the Wechsler Memory Scale

without being retrained because of his pre-existing skills but he did have to receive some supervision from a fellow clinical psychologist with someone more familiar with the test to be able to use it effectively.

50 Dr Christine Lawson-Smith, a psychiatrist employed within the health system and Clinic Head at Avro Clinic, gave evidence that during her time as a psychiatric registrar and a consultant over 13 years, she has noticed a change in the work of clinical psychologists including a considerable increase in the volume of the work. Part of this is due to a reduction in in-patient treatments and because patients have more complex problems complicating their psychiatric disorders. Dr Lawson-Smith says that this has meant that diagnostic issues have been clouded, and she has had to ask a clinical psychologist to undertake more psychological testing. Clinical psychologists have had a much more difficult case load to deal with because of the complexity of cases often associated with illicit substances, alcohol abuse and related problems. She also identified that in-patient bed times in places like Graylands have been cut and the clinical psychologists have less time at their disposal to deal with multiple and difficult problems. Dr Lawson-Smith was not cross examined.

51 Dr Gary Groth-Marnat, Senior Lecturer in the M.Psych/Ph.D. Clinical Health Psychology programme at Curtin University, has undertaken private practice focussing on behavioural and medicine interventions, general psychotherapy, and clinical neuropsychology. Dr Groth-Marnat provided an unsigned witness statement. However, before he could sign the statement, he moved to the United States of America. Accordingly, he was unable to sign his statement, nor was he available for cross examination.

He referred to the increase in formal and informal qualifications of clinical psychologists since 1989 and the tightening of requirements for the M.Psych and the increase to two years of supervised experience. He also noted the increased responsibilities of clinical psychologists,

the increase in the quality of work undertaken by them, the versatility and multiplicity of skills utilised by clinical psychologists.

Dr Groth-Marnat commented on an area of expertise for many clinical psychologists, being the ability to perform neuropsychological assessment which is particularly crucial for clinical psychologists working in rehabilitation, substance abuse, neurological, and psychiatric settings. He discussed the changes collectively in the quality and quantity of work as constituting “a quantum leap”.

52 Lynette Clayton is a clinical psychologist in private practice, who left the Health Department Psychiatric Service in 1987, and has conducted her own business since. In addition to evidence of developments including in assessment and treatment, Ms Clayton gave evidence of an increase in report writing for legal cases where clinical psychologists are regularly used as expert witnesses, that this role has more and more been outsourced to people in the private sector with special expertise. This area of work is not only relevant to the Health Department clinical psychologists but to other public service clinical psychologists such as those in Family and Children’s Services and the Sexual Assault Referral Centre.

Ms Clayton says that since 1987, the Australian Psychology Society and the Psychologists’ Board have set supervision and practice standards, and have differentiated specialities within the profession.

Ms Clayton also gave evidence that previously the Health Department clinical psychologists section dealt mainly with “neurotic clients, it now had increasing cases of multi-morbidity, involving more people with multi-problem families”. Ms Clayton gave evidence of where she had been dealing with one untrained counsellor who made a referral to another agency where the client had already been referred to four public agencies dealing with the same family. She

also referred to other agencies like Kinway, Anglicare, and Relationships Australia that are trying to provide similar services.

Ms Clayton also referred to clinical psychologists being in charge of youth services areas where they not only administrate but also supervise those services.

53 Jennifer Griffiths is the Unit Manager of YouthLink Inner City Mental Health Service at Royal Perth Hospital and she has held that position since 1995. YouthLink was formerly known as Troubled Youth Support Service in which Ms Griffiths worked as a clinical psychologist until 1995 when she was appointed co-ordinator.

Ms Griffiths gave evidence of advances in clinical psychological treatments to address mental health disorders and conditions which were previously considered to be treatable only by medication or otherwise untreatable. CBT has received significant recognition through the National Health and Medical Research Council Clinical Practice Guidelines for the treatment of depression in young people as opposed to previously being treated by medication and, in some cases, by electroconvulsive therapy. There have also been developments in treatment approaches to highly complex disorders such as psychosis and borderline personality disorder. Increases in drug induced psychosis amongst young people are now being increasingly treated by clinical psychologists utilising their evidence-based treatments for first episode and early psychosis. They did not have this role 10 years ago. In addition, a disorder which typically manifests itself during adolescence is borderline personality disorder, and the treatment approaches known as Dialectical Behaviour Therapy and Schema-focus Therapy have been developed for this purpose. These treatments are said to be “specifically and primarily the domain of Clinical Psychology”.

Ms Griffiths also gave evidence of the development of the clinical psychologist’s role in addressing needs of special risk populations, such a marginalised youth and Aboriginal people,

in the last 10 years. This has required the adoption of new and culturally appropriate strategies. The clinical psychologists have had to work with a number of agencies and at different levels including schools, the juvenile justice system and families.

This requires increased training and a research role for clinical psychologists in this area. Issues dealt with in government and non-government youth oriented organisations include suicide and self harming, depression, anger management and stress, as they apply to young people.

In response to the evidence to be given by Professor George Lipton, that management positions in the Mental Health Unit of YouthLink having only been held by clinical psychologists, Ms Griffiths referred to a reclassification of the position of Co-ordinator level 7 to Manager level 9 in 1998. Ms Griffiths said that a central criterion in the job description of the position is to be a clinical psychologist. Ms Griffiths says that this reclassification acknowledges the increased work value which has occurred in the profession.

Further, Ms Griffiths says that the nature and status of the advances in mental health treatment within the profession of clinical psychology "are of a qualitative nature far beyond the degree of advancement to be expected, or which could be predicted within a ten year span." She refers to the notable areas of change such as Dialectic Behaviour Therapy in dealing with Borderline Personality Disorder, and the use of CBT for young people with depression. Ms Griffiths was not cross examined.

54 Margaret Jones, senior clinical psychologist and Co-ordinator at Warwick Clinic, gave evidence of a paradigm shift in the knowledge and treatment in respect of childhood psychological problems in the past 10 years. She says that little was known prior to the early 1990s about childhood psychological disorders including the carry-over of such disorders into adulthood, however a number of long term studies emerged in the last 10 years. In addition,

there have been new assessment tools developed in the late 1980s and early 1990s in measuring clinical levels of dysfunction and she referred to internalising disorders and externalising disorders (such as conduct disorder and ADD/ADHD). These measurement systems have allowed assessment of changes in the severity of disorders, outcomes and effectiveness of intervention programmes. This has resulted in "choosing, monitoring and delivering assessments" now being a highly skilled practice.

Ms Jones also noted that since the late 1980s, there have been new evidence-based therapies which require clinical psychologists to continue with their education to learn new treatment approaches reported in the literature as being effective with children and adolescents. She says that this has resulted in clinical psychologists taking on a greater role in prevention initiatives and programmes, and treatment approaches.

There has also been change in the responsibilities of clinical psychologists, involving a greater degree of independence and autonomy than existed 10 years ago. She refers to senior clinical psychologists often working without direct clinical supervision and without reference to a psychiatrist. Ms Jones was not cross examined.

55 Dr Clare Roberts is a clinical psychologist employed as a Senior Lecturer at the School of Psychology at Curtin University of Technology. She teaches in a number of areas particularly associated with clinical psychology. Dr Roberts gave evidence as to the developments in psychological interventions in particular disorders relating to children and adolescents which have been developed in the 1990s. She also gave evidence that there have been "changes in the incidence and prevalence of childhood and adolescent mental health problems, recognition of the burden and impairment suffered by children and adolescents and their families of mental health problems and better identification of such problems", leading to an increased work load

and the increased need for clinical psychology services in the child and adolescence mental health. Dr Roberts was not cross examined.

56 Professor Alison Garton is Professor of Psychology at Edith Cowan University, Joondalup Campus. Professor Garton was employed by the Health Department as a senior clinical psychologist between 1986 and 1994 and acted in high level positions including Assistant Principal (Clinical Psychologist) and Senior Policy Officer (Mental Health). She was a member of the Psychology Registration Board of WA between 1990 and 1994 and was Chair from 1992.

Professor Garton gave evidence of changes in training periods and options for prospective clinical psychologists having increased and being upgraded in the last 10 years. She gave evidence of changes in the educational requirements in Australia and for the growth of knowledge of clinical psychology, with the Masters of Psychology Degree being extended, there being a substantial increase in the knowledge base in respect of treatment and intervention techniques.

Professor Garton says that the evolution of, and the increase in, the introduction of qualitatively new approaches but also in the skills base for clinical psychologists, increases in levels of responsibility and skills exercised, and of the versatility and adaptability of clinical psychologists having increased with specialisation.

She referred to “the explosion of knowledge regarding efficacious and effective psychological treatments”. These have resulted in an increased level of responsibility to patients, managers and the profession generally. Professor Garton was not cross examined.

57 Dr Carmela Connor, the Manager and senior clinical psychologist at the Neurosciences Unit dealt with changes within psychology within the last decade involving increases in “the scope and nature of the expected duties of clinical neuropsychologists and clinical psychologists

working in the area of neuropsychology." She says that neuropsychological practice in Western Australia is virtually unrecognisable compared to what it was in 1989, with neuropsychologists now having a leading role in diagnosis, management and rehabilitation of individuals with suspected brain impairment. She referred to the requirement to "adopt new approaches which are theoretically sound and indicates solid outcome data". She referred to a procedure for candidates for brain surgery to treat epilepsy. Techniques involving CAT and MRI scans means that the role of the clinical psychologist/neuropsychologist moved away from a primarily diagnostic one to include case management, interventions and rehabilitations. Neuropsychological tests are said by her to be "amongst the best predicter of everyday function following brain injury and illness."

Dr Connor also referred to clinical psychologists/neuropsychologists being involved in medico-legal assessments to determine the fitness of an individual to plead. There was also an increase in the role of clinical psychologists/neuropsychologists providing education to health care and medical professionals in affiliation with major tertiary institutions. Dr Connor referred to examples within the past two years of research initiated by clinical psychologists/neuropsychologists at the Neurosciences Unit including predictive testing in Huntington's disease, dementia in young adults and other such studies.

It is Dr Connor's opinion that in respect of "the development of roles, treatments and services for assessment and remediation of neurological and/or psychiatric problems, clinical psychologists and neuropsychologists clearly defines ways in which the degree of scope, skill, autonomy and responsibility has increased over the past decade." Dr O'Connor was not cross examined.

58 Dr Peter Panagyres is a Neurologist at the Neurosciences Unit where his responsibilities include providing neurological assessment and clinical management of individuals and families

affected by Huntington's disease, Alzheimer, Neurodegenerative disorders amongst other things. Dr Panagyres says that the substantive work value increase for clinical psychologists went beyond the normal development of the profession which would have been expected in the last 10 years. Dr Panagyres, like others, referred to what he described as significant developments in the area of neuropsychology resulting from extensive scientific advances in neurosciences and brain behaviour relationships. He referred to work done in respect of dementia, due to the growth in the number of people over the age of 50. Dr Panagyres believes that neuropsychologists now have an important role in the diagnosis, management and rehabilitation of patients affected by neurological conditions, and gave examples of the work that they perform, including an increasing role in areas of epilepsy.

Dr Panagyres also made reference to economic changes in the delivery of health services in Western Australia and the impact upon the requirements of clinical psychologists and neuropsychologists. He said, for example, that in the 1990/91 financial year clinical psychologists and neuropsychologists at the Neurosciences Unit performed 803 occasions of service, whereas in 1999/2000 this had increased to 5,513 occasions of service with the same number of staff. Dr Panagyres was not cross examined.

59 Dr Jonathon K Foster is Senior Lecturer at the University of Western Australia and Co-ordinator (with two others) of the new post graduate programme in Clinical Neuropsychology at that university. Dr Foster says that based on his international experience in the past 15 years, there has been a substantive work value increase in clinical neuropsychology in Western Australia in excess of the normal professional development one would expect. He referred to "huge scientific advances in the area of neurosciences and brain behaviour relationships". This has resulted in clinical neuropsychologists in Western Australia having to increase their knowledge and expertise in a very short time frame. Dr Foster was not cross examined.

60 Allison Fox, a Clinical Psychologist, is a Senior Lecturer in the Department of Psychology in the University of Western Australia. She has a Doctor of Philosophy degree and a Master of Clinical Psychology. Dr Fox gave evidence as to the qualifications necessary for the job of clinical psychologist and the supervision involved in that qualification, as well as the training period required. Dr Fox gave evidence as to the training period required for the Master of Clinical Neuropsychology degree, and made reference to the requirements for continual peer review of clinical and research skills and the ability to provide supervision to others. She says that there are currently no graduates who have completed the Master of Clinical Neuropsychology degree programme, therefore there is no data to evaluate the impact and contribution to patient care and clinical outcomes that the introduction of the post graduate training in Clinical Neuropsychology has made to this point.

Dr Fox has worked in Western Australia only since 1999, and prior to that held senior lecturing positions and undertook private psychological practice. Dr Fox was not cross examined.

61 Susan Lowe, senior clinical psychologist at the Adult Mental Health Service within the Health Department, has 18 years' experience in Clinical Psychology and has worked, in particular, in areas associated with psychological practice with older people. She made reference to the increase in specialisation within geropsychology over the past decade and she said that this has lead to an increase in the breadth and depth of specific knowledge in the assessment and treatment of mental health problems in older people. She referred to changes in post-graduate education in respect of the area of geropsychology, which has developed into a specialisation. Ms Lowe was not cross examined.

62 Joan Klinger is a clinical psychologist at Bentley Lodge (Psychogeriatric Unit), and an employee of Bentley Health Service and holds a Master of Clinical Psychology degree from Edith Cowan University. She has specialised in psychology in older people. Ms Klinger gave

evidence that this has recently become a specialised area and there is a dearth of clinical psychologists with experience in this area. She gave evidence as to the issues confronting clinical psychologists in dealing with the older population, including dementia, and made reference to the role of clinical psychologists in determining the older clients' cognitive status using cognitive and neuropsychological testing, in implementing and assisting with behaviour modification programmes for older people in more advanced stages of a dementing condition. She gave evidence of there being a growing body of evidence in the international literature of the positive outcomes of the intervention of clinical psychologists. Ms Klinger also attached to her statement a case study addendum in which she set out the types of conditions and situations faced by clinical psychologists in respect of patients by reference to a particular client.

Ms Klinger was cross examined. She stated that she was engaged at level 6.3, she completed the two year supervised practice as a registrar and expects to progress to level 7/8 in accordance with the policy of classification criteria progression. She says, however, that the Bentley Health Service policy regarding classification criteria progression is that there have been various "stoppages on employing new people and progressing in recent years". It is her intention to apply in due course by criteria progression for a high level.

Ms Klinger also gave evidence that she works with other allied professionals in a multi-disciplinary team which includes a consultant psychiatrist, occupational therapist, nurses, community mental health nurses and social workers. The nominal head of the multi-disciplinary teams is a consultant psychiatrist, although none of the members really heads the team. She says that she works in a consulting capacity with other team members as required. She says, though, that most clinical psychologists who work with older patients function as sole practitioners, as there are no other clinical psychologists in that team.

She says that the change in clinical practice for clinical psychologists in dealing with older people in their homes in the community is a situation which is restricted to clinical psychologists and psychiatrists, in that other disciplines such as social workers and occupational therapists have a different role and have previously visited the clients in their homes. The changing clinical practice of clinical psychologists is that they have worked more at a clinic or a mental health facility and the client came into the clinic for an appointment.

63 Dr Sudarshan Chawla, consultant in Geriatric Psychiatry at Fremantle Hospital and Health Services for the past 5 years, gave evidence which confirmed other evidence of the impact of the aging of the population, along with the increased specialisation within the field of geropsychology over the past decade.

Dr Chawla says that he is unable to answer questions as to what occurred prior to 1989 in respect of assessment treatment in Australia, as he was in the UK at that time. However, his experience was that in the late 1980s in the UK, psychologists were used only for two purposes; limited memory test assessments and for running memory clinics. Tools for the assessment of elderly patients were developed in the late 1980s, early 1990s.

Dr Chawla says that research is an integral part of the role of clinical psychologists and says that in a health system, 60 – 70 per cent of the time is spent in clinical service, 10 – 15 per cent in teaching activities and 10 – 15 per cent in research activities except in the case of those engaged 100 per cent in research.

Dr Chawla described the distinction between psychologists and a clinical psychologist is that the former is a university graduate who has not performed the supervised clinical element. The latter has undertaken the supervised clinical work.

64 Sandy Williams is a senior lecturer in the School of Psychology at Murdoch University and her qualifications include Masters in Applied Psychology. Her role in the School of Psychology

has been in the post graduate clinical psychology programme and she is Co-ordinator of the Murdoch Applied Psychology Clinic. She also co-ordinates all external field placements for trainees in the schools programme. She runs seminars in the school's clinical psychology health unit and co-ordinates and teaches in all of the practicum units as well as the companion Professional Issues unit.

Ms Williams says that during the period since 1995, the requirements stipulated by external supervisors include that trainees be skilled and knowledgeable at a more complex level to meet the demands of the placements. Supervisors have indicated that the demands made on them to provide the time and attention necessary for supervision has been made difficult by the nature and volume of work in the agencies where they are engaged. This has resulted in supervisors limiting offers of placement to second and third year trainees as the work is considered too complex for first year trainees to undertake. The availability of experienced supervisors has decreased because many appear to have gone into private practice partly due to increased demands from the agencies, without commensurate increases in their remuneration. In addition, private practices appear to be recognising the value of Clinical Psychology in the service provision.

There is increased pressure on universities to offer Doctor of Psychology (three years full time) and combined Ph.D./Masters (a minimum of four years full time) programmes in Clinical Psychology, the inference being that the Masters degree is no longer adequate in preparing students for the increased demands of the position. There has been increased pressure on universities to cover areas of specialisation in the preparation of students. The requirements upon clinical psychologists to keep abreast of evidence based programmes has proliferated in recent years, placing extra demands on the time and energy of clinical psychologists in the field. Ms Williams was not cross examined.

Respondents' Submission

65 The respondents say that in July 1999 a working party was established by the Government health industry to assess the claim from a management and operational prospective. The working party had representation from all areas of the Government health industry, and was to produce a collective view following discussions with interest groups such as the clinical psychologists, the managers, and others. The working party formed the view that an external consultant ought be engaged to review the Work Value Document and analyse the claim. The working party was also concerned about the potential for flow-on.

66 Accordingly, John Holland, a private consultant with "significant experience in classification and work value matters, particularly within the WA Public Sector", was engaged to assess the claim from a work value perspective. Mr Holland undertook an assessment of the work of clinical psychologists based on an examination of past and present job description forms, and the Work Value Document. He produced an interim report on 25 March 1999, then met with groups of clinical psychologists generally and in areas of particular work, consulted the head of the Mental Health Division of the Health Department and produced a final report in October 1999. This report:

1. acknowledged that there had been ongoing developmental expansions of the clinical psychologist's role but found that this is a feature of all professions and, on balance, there was not a significant increase in responsibilities justifying a higher classification for both level 6 and level 7/8 groups. There had "always been an expectation of the positions performing specialist's assessments, individual or group interventions, teaching other professions including medical and nursing staff, and participating in research". This has not changed. There were no significant new responsibilities, and the existing responsibilities were within the expected range;

2. noted that over time there had been an increasing number of clinical psychologist positions functioning at a senior level and "that the ratio of Registrar to senior positions should be reviewed to ensure an adequate number of senior positions". Classification criteria progression would assist in recognising this;

3. recommended the number of level 7/8 positions be examined according to the ongoing complexity of cases;

4. recommended the establishment of a number of level 9 Co-ordinator positions to oversee the more senior work.

67 Mr Holland's report was adopted and forms the basis of the respondents' position before the Commission in Court Session.

68 The respondents say that the time frame for the consideration of work value change is from the second structural efficiency adjustment under the 1989 State Wage Decision, and that there are a number of examples within the applicant's case of changes which occurred prior to 1989. In accordance with paragraph (d) of the Work Value Principle, those matters ought not be taken into account as they have already been assumed to have been considered as part of the structural efficiency exercise.

69 The respondents say that through criteria progression, established for level 7 positions to become level 7/8 in October 1990, and for level 6 position occupants to progress to level 7/8 in 1992, there is recognition of the development of professional knowledge and expertise for clinical psychologists. This allows for progression from the bottom of level 6 through to the top of level 8 without the need for promotion (see Exhibit A2, Vol 1, B 12). All such positions revert to level 6 when they become vacant. The Operating Instruction dealing with classification criteria progression provided that budgetary considerations could not be used as grounds for rejecting an application by an officer who otherwise would meet the criteria for

progression. If a claim was rejected on that basis, then the normal grievance procedures would apply.

70 The respondents also refer to the decision of Fielding C in respect of broad banding, *Hospital Salaried Officers Association of Western Australia (Union of Workers) v Royal Perth Hospital and Others* (69 WAIG 3290 at 3291) in which he noted that those in positions which had been the subject of broad banding would be expected to take on additional responsibilities due to additional increments applying because of the conversion to the new broad banded structure. The respondents say that this applies to clinical psychologists being given access to level 7/8.

71 The respondents also referred to the commitment to the creation of a number of senior specialists clinical psychologist positions in line with the 1996 policy document "Making a Commitment".

72 Taken together, the changes for criteria progression allowing progress from level 6 to the top of level 7/8, plus the creation of a number of senior specialist positions at level 9, recognise and account for any changes in work value. Where there have been other changes in particular areas such as neuropsychology, the respondents say that these ought be dealt with on an individual basis.

73 The respondents say that there is a significant prospect of flow-on which is acknowledged in some of the evidence called by the applicant due to links with the work of the Department of Community Development, the Department of Justice and other public sector agencies, and to other members of the multi-disciplinary teams.

74 As to the proposed classification structure, the respondents read the provision that progression to grades 3, 4 and 5 would be in accordance with terms agreed between the applicant and the employer, that there is potential for clinical psychologists currently at level 6.1 to move all the

way through to level 12.3 without having to apply for promotion, because the claim does not make clear that there would be promotional positions within that structure.

75 As to there being a lack of career structure for the clinical psychology profession, the respondents note that most other allied health profession classification structures end at level 6 for senior positions, with very few level 7 - co-ordinator positions and a limited number of Chief's and Deputies positions in teaching hospitals.

76 The respondents argue that a number of level 9 positions already exist for clinical psychologists, including Associate Head of Department at King Edward Memorial Hospital and Princess Margaret Hospital which has responsibility for a number of clinical psychologists but also has responsibility in areas of management, education, training and supervision and also has research responsibilities. There are a number of level 9 positions which have management responsibilities. The proposed level 9 positions would have a greater focus on clinical work, but with some management responsibilities.

77 The respondents oppose the creation of a Class 1 position within the Award, even though there is provision for classes 1 to 4 in the enterprise bargaining agreement PSA AG 1 of 2002, saying this is considered to be within the senior executive service and within a third tier management level within a total organisational structure. For such a position to have no management responsibilities would be unique within the HSOA structure or any of the public service structures.

78 As to the cost of the applicant's claim, the respondents say that this is particularly difficult to estimate because it requires assumptions to be made as to the placement of existing clinical psychologists on the new scale and as to progression from grade 2 to grade 4. There would also be on-going costs. On the basis of estimates given to the respondents by the applicant as to the numbers which the applicant believed would be the consequence of the granting of the

claim, the respondent produced Exhibit R3 - Cost of Union's Claim Based on Union's Suggested FTE profile". This resulted in a first year cost of $924,670 based on a range of assumptions. The potential flow-on cost to the broader public service area is an additional $400,000. However, the respondents described this as a simplistic approach in an attempt to have some kind of estimate. The respondents also expect a flow-on to Graylands Selby-Lemnos Special Health Care Service.

79 The respondents also say that there would be pressure for flow-on to other allied health professionals partly due to the multi-disciplinary team approach and to the community based service. A number of the grounds for change in work value claimed for clinical psychologists equally apply to mental health nurses, occupational therapists, and even psychiatrists who are part of the multi-disciplinary teams and who work in a similar manner. Although the respondents acknowledge that there may be a need for a review of career structures for clinical psychologists, to do so in isolation of other allied health professionals would be unhelpful. The respondents say that a better approach would be to examine the situation by the use of a Classification Review Committee in each of the particular health services. This would allow the particular localised issues, the individual interests, as well as the overall health service and the team approach to be considered.

80 As to issues of attraction and retention, the respondents say that there has been a 40 per cent increase in the number of clinical psychologists employed since 1996 and that the number leaving the profession is lower than a lot of other allied health professions. The creation of at least half a dozen senior clinical psychologist positions in addition to the existing two level 9 positions, in a workforce totalling 134 would assist in overcoming any excessive senior level departures.

81 The respondents say the decision of the Full Bench of the New South Wales Industrial Relations Commission of 29 November 2001 (in Health and Community Employees Psychologists (State) Award, [2001 NSWIRC 302]) must be looked at in the context of the historical situation in New South Wales as opposed to that applying in Western Australia. The matter before the New South Wales Full Bench related to all psychologists, not just clinical psychologists. Further, the classification scale there had not changed for more than 30 years and during that time there had been significant changes in the work performed and the conditions under which it was performed. On the other hand, in Western Australia, the situation was reviewed as part of the 1985 broad banding determination, which provided an opportunity for an appeal as to the determination of classification for clinical psychologists under the Award and employers agreed in 1992 to provide criteria progression for clinical psychologists to level 7/8. Accordingly, the respondent says that the situation in Western Australia has been subject of review at least as recently as 1992. At that point, it expected that the role of clinical psychologists would include liaising, providing advice, education and training and participating in multidisciplinary teams. The respondents also note that the New South Wales decision established a classification structure which had the effect of adding to salary levels for senior psychology positions, and a general salary increase for all clinical psychologists. The respondent says that as part of the recommendations arising from Mr Holland's report, there would be similar outcomes to that proposed by the New South Wales decision. Further, there was reference to the New South Wales Principal Clinical Psychologist having responsibility for over 100 Psychologists. Bearing in mind that there are only 134 clinical psychologists within the whole of the public health system of Western Australia, it was considered that this was an inappropriate comparison, and in a totally different context, looking at the administrative responsibilities attached to that position.

82 The respondents also say that the changes which have occurred in clinical psychology practice have been evolutionary rather than revolutionary, and any work value change must be offset against additional responsibilities which arose by virtue of access being granted to level 8 as part of the 1992 review.

83 As to the creation of the more senior positions, the respondent advised that a business case had been put to the classification review committee for its endorsement for the creation of those positions and further the developments in that regard are dependent upon the resolution of this matter.

The Respondents' Evidence

84 The respondent called evidence from John Phillip Holland, who was the external consultant engaged at the request of the working party to whom the respondent had referred the Work Value Document for comment.

85 Mr Holland says that he undertook a "desktop review" of the job descriptions for clinical psychologists' positions from 1988/89, compared them with the current work requirements of that group, and also examined them by reference to the senior allied health professional positions. He then referred to other documentation and the Work Value Document. He also took account of the environment in which the work is currently performed, and the community based approach. He made an initial report to the respondents in March 1999, then he met with groups of clinical psychologists from various areas of specialisation to gain a better appreciation of their work. He also consulted with Professor Lipton, the then General Manager of the Mental Health Division of the Health Department. Mr Holland's final report was provided in October 1999.

86 Mr Holland gave evidence that the 1988/89 positions he examined were pubic service clinical psychologist positions, as well as those covered by the HSOA, and he found them to be of

equivalent classification levels, and to contain essentially the same responsibilities at the comparable levels. In the conversion to the broad banded structure, some senior positions within the public service structure gained some financial advantage by having slightly higher classification level increments available to them. The conversion gave them access to another increment in level 8. Accordingly, they were also expected to take on additional responsibilities, however, the nature of some of these "top end" responsibilities was not identified and was not clear. Some were reflected in amended duty statements, others were not. Some duty statements were simply changed from Level 7 to Level 7/8, by the handwritten addition of "/8".

87 Mr Holland accepted that there may an element of unreliability in an assessment based on duty statements in that there would be instances where the nature of the work, the level of skill and responsibility and the conditions under which the work was performed could all change but the duty statement not be changed to reflect this. However, any diligent human resources manager would ensure that the job descriptions were being updated to accurately reflect the requirements of the job.

88 Mr Holland said he reached conclusions that in most cases, the issues referred to in the Work Value Document as constituting changes justifying an increase in work value were included in former job descriptions or had always been an expectation of the positions and the profession of clinical psychology. Other matters relating to a change in the emphasis or broadening of the knowledge base of the profession, by the development of new tests and assessments, the increased activity which have occurred, the emphasis placed on the clinical psychologist's role in the multi-disciplinary setting, and the community based service arrangements were normal requirements of a senior professional.

89 Mr Holland says that newly appointed graduates are "now under supervision for a longer period than previously. The fairly autonomous nature of these positions is much the same as it has always been, and the expectations of these positions at this classification within a few years of graduating are considered to be within the range expected of level 6 allied health positions, many of which have supervisory responsibility." The senior professional responsibilities at level 7/8 demonstrate the "ongoing development and expansion within the profession" however, he says that this was recognised by Negus C in PSA CR 57 of 1990 (the *Board of Management, Royal Perth Hospital and Others v Hospital Salaried Officers Association of Western Australia (Union of Workers)* 72 WAIG 614), as being a "feature of every profession".

90 On the basis of this analysis, Mr Holland concluded that there had not been a "significant increase in the responsibilities across the board for both level 6 and level 7/8 positions sufficient to meet the requirements of the Work Value Principle in justifying a higher classification for both groups of positions."

91 Mr Holland made recommendations as to the proportions of registrar verses senior positions within the Health Department, the use of classification criteria as opposed to the creation or the establishment of substantive level 7/8 positions, and the establishment of a number of level 9 co-ordinator positions "to oversee the more senior work in certain fields of the profession".

92 Mr Holland gave evidence of positions at levels 8 and 9 within the health industry. The distinction between level 8 managers/co-ordinators of Mental Health Services and level 9 directors of Mental Health is that level 9s will manage some in-patient beds in addition to all of the community services provided across the range of mental health services, and he says this adds complexity to the management function.

93 There are a number of positions at level 8 of co-ordinators of Mental Health activities at a regional level. The Associate Head of Department of Psychiatric Medicine at Princess

Margaret/King Edward Hospital is at level 9. Outside the Mental Health Service there are programme managers in a variety of programmes in health services, consistently classified at level 9. Also within the range of salary spanned by HSOA level 9, there are roles of directors of nursing in health services. There is a level 9 position at King Edward and Princess Margaret Hospitals of associate head of the Department of Psychological Medicine in which 40 per cent of the duties of the position are clinical.

94 At level 10 within health services, there are more senior ranges of the directors of nursing, most of which are titled director of nursing/health service manager, being responsible not only for nursing but also for the other services provided at the site, including patient support, Allied Health Services, Clinical Sterile Services Department etc. Also at level 10 are more highly classified directors of nursing including general managers and rural general managers.

95 Mr Holland also set out the history of the industrial coverage and classification of clinical psychologists since 1988. He noted that in 1988, prior to all clinical psychologist positions in the public health system being allocated to the Hospital Salaried Officers Award, the great bulk were covered by the Public Service Award. At that point, there were perhaps 10 or 12 Hospital Salaried Officer Award positions of clinical psychologists within the public health industry. There is now a total of approximately 135. The clinical psychologists in the public service were, in the main, classified at PSA levels 5 and 6 the classifications stayed as they were with the conversion to broad banding and there was an opportunity for each individual to lodge an appeal against the allocation to the new classifications at the time of broad banding. Some 2,500 public service officers exercised that right of appeal.

96 In respect of whether there had been evolutionary or revolutionary change in the work of clinical psychologists, Mr Holland says there would need to be something “clearly and absolutely different” from what had existed previously.

97 In assessing the claimed changes in the nature of duties, skill and responsibilities of clinical psychologists, Mr Holland spoke with Professor Lipton. He says he did so not having been satisfied that there were some clear additional responsibilities, and for him to understand the context of the claimed changed situation, with a view to ascertaining whether he had missed something in his assessment. He relied upon Professor Lipton's advice in respect to the nature of the changes evidenced. In trying to evaluate the degree of change with respect to matters not encompassed in job descriptions, and what degree of change could be expected in a profession over a period of time, he had to be guided by the Mental Health Division.

98 In addition to his discussions with Professor Lipton, Mr Holland had discussions with other senior officers in the Mental Health Division whose roles relate to policy, planning and implementation of national initiatives. He says that following his discussions with the various groups, he was left with the impression that there have been changes but not changes of the magnitude which would result in significant increases in complexity that one would normally expect to justify an increase in work value. Mr Holland says that he recognised within his assessment that there are more people presenting with more serious problems and that is the basis upon which he recommended the establishment of more senior positions. The issue of complex cases had always been the province of clinical psychologists and, in particular, senior clinical psychologists.

99 When asked about the responsibility of clinical psychologists for the development of psychological treatment and service initiatives, and with the new initiatives such as the WA Institute for Psychotherapy Research, work done by YouthLink and others, Mr Holland said that his analysis recognised that there had been initiatives and developments in treatments. However, the expectation of the positions at both levels 6 and 7/8 was that this would occur. He says that he did indeed take this into account in his assessment.

100 Mr Holland's assessment was that there had been enhancements or improvements on pre existing processes. While there have been some new processes a lot of them appear to have replaced pre existing processes and mechanisms, as occurs in a lot of professions.

101 Mr Holland acknowledges that there have been changes in the education, training and supervision requirements, but he had focused on the actual requirements of the position, which included membership of the Australian Psychological Association. This pre requisite, entry requirement, had basically remained unchanged. He says that the addition of higher qualifications has been occurring across a wide range of professions, including the allied health professions, nursing or other groups within the health industry. What he took account of were the essential requirements of the position. He says that professions pursue higher knowledge generally, and this is common across the health industry where there are more highly educated professions, and this is not an issue isolated to clinical psychologists. Other allied health professionals who are required to have post graduate qualifications on appointment include dietitians and audiologists, who are appointed at level 3.5. It was suggested, but not clarified, that to be called a dietitian, a person must have a post-graduate qualification, which could include a graduate diploma.

102 As to the requirements of senior professionals performing extended roles, Mr Holland said that this was not isolated to clinical psychologists but relates to senior allied health professionals generally, where there are requirements to co-ordinate specific programmes and, at level 6, being part of specialised multi-disciplinary teams. The requirement for community involvement and working in that environment applies equally to those other health professionals, as does participation in research.

103 Mr Holland says that by the time professionals reach the maximum of their base classification, they should be operating at a senior level and functioning relatively autonomously. In support

of this contention, he referred to the decision of Negus C in the Health Chiefs and Deputies case (the *Board of Management, Royal Perth Hospital and Others v Hospital Salaried Officers Association of Western Australia (Union of Workers)* 72 WAIG 614). However, he acknowledged the need for the creation of more senior clinical psychologists positions and this was one of the recommendations contained within his report. Mr Holland indicated that he had recommended the creation of additional level 7/8 positions as being a first step to addressing some of the difficulties associated with the supervision of the registrar positions and other higher order responsibilities and he recognised that there were not enough senior positions available.

104 It was also Mr Holland's understanding that criteria progression was available only within the health industry to social workers and clinical psychologists. The whole basis of criteria progression is to recognise the expectation of and make provision for, people to move into a higher classification because of their particular experience and their contribution to the industry. Such positions could be available for a clinical work load, for specialists or for senior professionals. To expand the criteria to include a management role as an absolute requirement would not be particularly helpful.

105 Mr Holland is of the view that the availability of more senior positions would take account of the additional requirements for sole responsibility which have developed.

106 Professor George Lipton gave evidence. Until he retired on 21 December 2001, he was Chief Psychiatrist and General Manager of the Mental Health Division of the Department of Health. He is currently a consultant child and adolescent psychiatrist in private practice. Professor Lipton noted that increased resources are being provided to mental health services. He referred to the essential principles of the policies to establish community based services closer to home, which targeted specific groups of in-patients and communities, including focusing on rural and

remote services, developing a strong health promotion and prevention philosophy, and which would lead to more efficient patient services, increased community accommodation and rehabilitation for people with psychiatric illness and disability. He says that there has been a considerable increase in community based services with a concomitant decrease in the length of treatment in in-patient facilities. There had been a substantial increase in the number of patients seen, from 15,500 in 1995 to 20,500 in 1999, a twofold increase in rural services, development of rehabilitation and disability services, a considerable increase in staff, better opportunities to work in varied settings and improved opportunities to experience job satisfaction, amongst other benefits.

107 Professor Lipton denies that there is any particular difficulty in the recruitment of junior clinical psychologists. However, there is a problem with the retention of senior clinical psychologists due to the narrow range of promotional positions. As a consequence, the Mental Health Division has been developing the concept of senior positions at level 9, having a more specialised role, an increased administrative, teaching and research component, and providing better career options. It would also address the issue of supervision of the lower levels. This initiative was referred to the classification review committee in late August 2001. However, this does not represent a work value issue "but is for the purpose of developing new forms of activity by senior psychologists in a competitive way to contribute to the overall service management and development." The level 9 positions should be promotional positions with competitive application rather than by automatic progression. These would be specialists, co-ordinators, having administrative responsibility and specialist expertise.

108 Professor Lipton referred to the essence of the multi-disciplinary team as being the joint and co-operative activity within the team where each discipline can contribute its discipline-specific skills to the task at hand. The capacity to lead such a team may fall to any person within it who has leadership skills and this is not confined to any particular discipline. As to

the multi disciplinary teams creating any increase in work value, he says that the leadership and associated skills do not constitute any change in work value and are not confined to any particular discipline.

109 Professor Lipton says that "it may be that psychologists (are) seeing a higher proportion of patients (with personality disorders and those prescribed medication by psychiatrists) … but if so they are pursuing activity that has always been within the province of clinical psychologists and which has become more contemporary over the years."

110 In respect of the claim that there is increased work value on account of increased specialisation, he notes that "clinical psychologists have always had individuals within the profession who have undertaken specialised roles" and there is now an increase in recognition of such specialities and the practitioners of those specialities. He says that "this phenomenon is one that has occurred in all mental health professionals and is a desirable one". However, he does not see this as increased work value for all psychologists, whether specialised or not.

111 As to new approaches claimed within the Work Value Document he says that "contemporary practice requires the adoption of new approaches as a routine element of professional development … if a profession did not adopt new approaches as they developed it would lead to a reduction in the value of the work." As to empirically supported treatments, he says that this is in keeping with "modern requirements for all health professionals to practice in evidence – based models of care".

112 As to the claimed increased cost effectiveness, he says that that is expected of all health professionals and health employees.

113 As to the claim of clinical psychologists receiving direct referrals, he says that this applies to any member of the team, or the team as a whole. It may have increased "as the work that all mental health professionals have become increasingly recognised."

114 Professor Lipton acknowledges the increase in demand from more patients with complex problems but says that the evolution of the team approach and the professional development in all health professionals has occurred as part of this process.

115 As to the diagnosis of major mental health disorders, he acknowledges that this "has always been a claim made by clinical psychologists and has been endorsed legally … and that clinical psychologists have the capacity and training to make diagnosis but this has not changed over the years."

116 Professor Lipton gave evidence that psychiatrists undertake 6 years of medicine, 1 year of internship, and then undertake a programme as a trainee psychiatrist including a five year course, undertaken as a paid position, within a hospital, with a salary range of $63,301 to $80,789 according to the AMA Agreement. Social workers in some places have post graduate degrees in mental health, and nurses have post graduate diplomas in psychology.

117 As to the particular specialist treatments offered by clinical psychologists over the last 10 years, Professor Lipton says that groups of professionals developed these treatments, psychologists do not own them but they perform them. He says that CBT was developed by psychiatrists and was being developed further by psychologists, though other health professionals also use CBT treatments. He says that psychologists have also been involved in health promotion, as have other health professionals.

118 Professor Lipton says that clinical psychologists have played a significant role in the development of treatments for depression but "so have everybody else." Pharmacological issues are dealt with as part of the mental health team approach.

119 Professor Lipton agrees that health services now deal with more complex cases, treatments have become more evidence-based, and the team has become much more important. He says that the capacity to work with the community has probably affected nurses more than clinical

psychologists because nurses previously predominately worked in hospitals but have now become independent practitioners in the community. He described these changes as "huge changes". He says that all the mental health professionals have core competencies in common and each profession has its own competencies, and that change has lead to a lot more pressure on everybody including the senior administrators.

120 Professor Lipton says that there are individuals who have developed research skills and specialities. They are mostly employed by universities.

121 Professor Lipton says all mental health workers; psychiatrists, psychologists, nurses, social workers etc. are encouraged to work with general practitioners in "shared care" so that each does not spend his or her time doing things that a general practitioner can do.

122 Professor Lipton does not see the changes in the last 10 years of clinical psychologists having sole patient responsibility or taking on direct referrals as constituting a comparable change to prescribing habits or authority. He says that in late 1960s and 1970s, psychologists took referrals and they related to general practitioners. Nurses have also taken direct referrals, particularly in rural areas. Social workers work independently and that is not new although it may be increasing.

123 Melissa Kay Watson, at the time of her written statement, was an industrial officer of the Department of Health. She submitted a statement as to comparative rates of pay and associated structural matters for clinical psychologists throughout Australian. She noted though, that by the time she gave evidence on 17 January 2002, the rates in the Western Australian public sector may have increased on account of some enterprise agreements. It was not the intention of the respondent to revise the schedule to take account of those changes.

124 Ms Watson was unable to clarify whether the Education Department personnel to whom she had referred in Appendix B of her statement were clinical psychologists with a Master's degree or not.

125 David John Naughton, the Director of the South West Mental Health Service ("SWMHS"), classified at HSO level 9, gave evidence. His responsibilities are for the management of the SWMHS in all its aspects including planning and implementation of departmental policy; the management of multi disciplinary teams; line management of three programme managers and one clinical director (who is the medical clinical director of the Service) budgeting, human resources; policy planning; trouble shooting etc.

126 Mr Naughton has worked in a variety of public sector roles including as a student nurse, registered and charge nurse of in-patients wards, a community mental health nurse, project and service development roles, and since 1993, in leadership and management roles. He was a member of the Ministerial Task Force on Mental Health formed on 1994 and participated in a number of other groups and is currently the chairman of the centre for mental health services research.

127 Mr Naughton gave evidence as to the role of the clinical psychology working party which was to provide input and advice to the government health industry on the applicant's claim from a management perspective. The working party included members from teaching hospitals and rural health services and the health department. It reviewed the Work Value Document and some members provided written comments. The Working Party had concerns as to the potential flow-on effects across the health sector and across government departments. Due to the difficulties the members of the working party were having, it was decided to engage an external consultant to independently review the Work Value Document and to advise as to the

appropriate course of action. Accordingly, the working party requested that the Health Department engage such a consultant, and Mr Holland was accordingly appointed.

128 Mr Naughton says that "whilst clinical psychologists bring important and very relevant skills to the team", the Work Value Document did not demonstrate why clinical psychologists should be given different treatment from other mental health professions. Changes that have occurred in the mental health setting had affected all disciplines.

129 He referred to changes in developments within the SWMHS over the last six years which has "grown from a Bunbury based "outreach" service to a multi sited, multi programmed, multi disciplinary structure providing a range of in-patient and community programmes." The SWMHS has developed generic job descriptions for senior and mid range clinical positions plus it has created some specific profession-based roles where required. Two of the 65 FTEs are new positions for clinical psychologists, being part of a Child and Adolescent Community Team. He says that there is a total of three FTEs devoted to clinical psychology, one at level 6 and two at levels 7/8, the level 6 position being vacant due to budgetary reasons. There is a need for more clinical psychologist positions, as there is for all the positions, but in order of priority, the SWMHS requires additional medical staff, nurses and social workers/counselling staff across the board.

130 The SWMHS has a series of functional programmes including acute in-patient/day therapy, early intervention, psychiatric triage, continuing care, rehabilitation and child and adolescent services. The services are delivered in a multi-disciplinary way with specific teams made up of representatives of each major health profession who work together. All new or referred clients must go through the established community-based triage system where there is screening, prioritisation and, depending on urgency, clinical needs and clinical availability, a response is co-ordinated. A group programme is developed or an individual within the team is then

responsible for further assessment and intervention. Team members work together with more complex clients, often using each others' expertise in the collaborative way. Mr Naughton used examples of community nurses needing assistance with accommodation or financial issues and seeking support/advice from a social worker. A treating doctor may request a range of psychometric testing from a clinical psychologist, a home visit from a community nurse, a family assessment from social worker. Consultant psychiatrists assume medico-legal responsibility and clinical team leadership for clients of their team. All team members consult with and take advice and direction from the clinical psychiatrist. Psychiatric registrars are trainee psychiatrists completing specialised accredited post-graduate training in psychiatry to become consultants. They are less senior members of the multi-disciplinary team but maintain medico-responsibility for the clients they see.

131 Registered mental health nurses and enrolled mental health nurses make up the bulk of numbers of any multi-disciplinary team (plus 50 per cent). Nurses provide assessment, intervention of therapy from a nursing perspective including mental state examinations, social health assessments, counselling and crisis intervention. Clinical psychologists provide assessments and counselling services, seeing clients individually and in groups, and assisting with the development of specific behavioural strategies etc. Social workers provide assessments, intervention and counselling in a social work prospective. Occupational therapists provide assessment, intervention and counselling from the occupational therapist perspective.

132 Mr Naughton says that "the clinical psychologists provide an important role within the team, often being able to consult on specific issues such as a behavioural management plan, without having to take on ownership of the patient. They work along side their colleagues in all aspects of daily operation. They provide specific skills such as psychometric testing."

133 Generic mental health professional positions provide a similar range of interventions which tend to depend on the professional background and the area they are working in.

134 Mr Naughton says that he has had the opportunity to work in several multi-discipline teams and has visited 3 different rural and regional mental health services in Victoria and one in New South Wales. He said that all work along similar lines. He says that it would be difficult to maintain a rural and regional mental health service if the makeup of the teams was dictated along professional lines. He says that the teams need to be determined by skill levels with a good professional mix. Mr Naughton referred to a generic mental health position, which means that those positions are open to anyone from the health professions who meets the essential criteria of the role, and they bring to that position skills specific to their professional background but they have common skills of mental health professionals such as assessment, counselling, understanding the various theories, medication knowledge, understanding of psychiatric illness, suicide prevention, which are all common within all of the professions. All of the positions of senior allied health professional are at level 6, except for one which is a level 3/5 in Child and Adolescent Health.

135 Mr Naughton says that there have been difficulties in recruiting across the board, but in particular with medical staff, and increasingly with mental health nurses because they are not being trained in that specific role anymore. Nurses are now trained comprehensively and a lot more choose not to work in mental health.

136 As to the relativities of rates of pay, the clinical psychologists enter at level 6 as opposed to the other allied health professionals who enter at level 3/5 due to the recognition of the post-graduate qualification of the clinical psychologist, and they have criteria progression for the level 7/8 positions.

137 As to the changes in responsibilities for clinical psychologists, Mr Naughton acknowledges that there have been huge changes in societal pressures but he says there is an increase in co-morbidity which means that the members of the multi-disciplinary teams need to be flexible and able to respond to the needs of the clients. He says that it is a normal expectation of professions to keep up with new theories, new approaches, and he says that in his involvement since 1983, he is constantly reading to keep up with all of the new developments.

138 Mr Naughton distinguished between the Western Australian and New South Wales situations. He believes that Western Australia was quite protected and does not have the major problems with people presenting with triple diagnosis such as HIV, brain induced disorders, schizophrenia and drug and alcohol related problems as well as homelessness. He described the South-West as relatively benign in comparison, providing a relatively safe environment. Although the problems experienced there continue to compound, he sees that a good health professional is always able to adapt to the new developments. He says that the salary structures for each of the health professionals in the team adequately reflect the relative value and worth. He says the present structures recognise that worth.

139 Mr Naughton says that the major difference between the various members of the multi-disciplinary team is that medical staff ultimately bear the medical-legal responsibility for the client and if they were engaged in discussions with the client and are actively involved in the case then they have some overseeing responsibility for the team. In the SWMHS, the medical person is the clinical leader of the team, having extensive qualifications both in medical and post-graduate qualifications. That person is covered by a different award and is paid differently. Clinical psychologists are paid differently to social workers and occupational therapists on account of recognition of their post-graduate qualifications which bring additional and different skills.

140 He also noted that other groups of professionals within the multi disciplinary teams have the opportunity to move towards post-graduate qualifications and several of the staff at the SWMHS have such post graduate qualifications. However, they do not receive recognition for that in their salary, unlike the clinical psychologists whose salary range is based upon their training and qualifications at that higher level.

141 Mr Naughton recognised that there has been some excellent research work undertaken by individuals in areas such as Neurosciences.

Work Value – The Test

142 The Statement of Principles – June 2001 arising from the State Wage Case Decision in 752 of 2001 (81 WAIG 1722) sets out the Work Value Changes Principle as follows:

> **"6. Work Value Changes**
>
> (a) Changes in work value may arise from changes in the nature of the work, skill and responsibility required or the conditions under which work is performed. Changes in work by themselves may not lead to a change in wage rates. The strict test for an alteration in wage rates is that the change in the nature of the work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification or upgrading to a higher classification.
>
> In addition to meeting this test a party making a work value application will need to justify any change to wage relativities that might result not only within the relevant internal award classifications structure but also against external classifications to which that structure is related. There must be no likelihood of wage "leapfrogging" arising out of changes in relative position.
>
> These are the only circumstances in which rates may be altered on the ground of work value and the altered rates may be applied only to employees whose work has changed in accordance with this provision.
>
> In applying the Work Value Changes Principle, the Commission will have regard to the need for any alterations to wage relativities between awards to be based on skill, responsibility and the conditions under which work is performed.
>
> (b) Where new or changed work justifying a higher rate is performed only from time to time by persons covered by a particular classification or where it is performed only by some of the persons covered by the classification, such new or changed work should be compensated by a special allowance which is payable only when the new or changed work is performed by a particular employee and not by increasing the rate for the classification as a whole.
>
> (c) The time from which work value changes in an award should be measured is the date of operation of the second structural efficiency adjustment allowable under the September 1989 State Wage Decision [69 WAIG 2917].

(d) Care should be exercised to ensure that changes which were or should have been taken into account in any previous work value adjustments or in a structural efficiency exercise are not included in any work evaluation under this provision.

(e) Where the tests specified in (1) are met, an assessment will have to be made as to how that alteration should be measured in money terms. Such assessment should normally be based on the previous work and the nature and extent of the change in work.

(f) The expression "the conditions under which the work is performed" relates to the environment in which the work is done.

(g) The Commission should guard against contrived classifications and over-classification of jobs.

(h) Any changes in the nature of the work, skill and responsibility required or the conditions under which the work is performed, taken into account in assessing an increase under any other provision of this Statement of Principles, shall not be taken into account in any claim under this provision."

143 The applicant says that it is able to meet the tests set out in Principle 10 being:

" • why the matter has not been progressed and/or finalised pursuant to s.41 of the Act;
• why the matter has not been pursued under any other Principle set out in this Statement; and
• how in the discharge of its statutory function to consider varying above or below the safety net the Commission should take into account, to the extent that it is relevant, each of the matters identified in section 26 of the Act.

Provided that where parties to a single enterprise specific award apply to vary the award by consent or consent to a replacement award to give effect to structural efficiency initiatives or productivity based arrangements the Chief Commissioner may allocate the matter to a single Commissioner."

144 From time to time, the Commission has noted that particular matters can or cannot be considered as part of a Work Value assessment. Those changes which are evolutionary and apply to the workforce generally, such as changes from the manual to automated or computerised systems are not indicative of an increase in work value (*The Australian Liquor, Hospitality and Miscellaneous Workers Union, Miscellaneous Workers Division, Western Australian Branch v The Honourable Minister for Education* CR 49 of 1997 (79 WAIG 648)). "Mere changes in volume of work or mere changes in technology will not always be sufficient to warrant a new rate of pay … it is a plain fact of life that technology changes and employees

must expect to adapt to meet those changes as and when necessary". (*Hamersley Iron Pty Limited v The Construction, Mining, Energy, Timberyards, Sawmills and Woodworkers Union of Australia – Western Australian Branch and Others* (1994) 74 WAIG 926).

145 As to the degree of change required for there to be an increase in work value, it matters not whether changes have been evolutionary or revolutionary. Evolutionary change can be just as substantial and significant as revolutionary change. (*Hospital Salaried Officers Association of Western Australia (Union of Workers) v Royal Perth Hospital and Others* (1987) 76 WAIG 554 at 557). Incremental or cumulative change, when taken as a whole, may constitute such a level of change that developments have exceeded those which would reasonably be expected.

146 In dealing with the ongoing requirements placed on professional persons to keep up to date with developments in professional practice and knowledge, in his reasons for decision in *Western Australian Branch of the Australian Medical Association Incorporated v The Boards of Management Royal Perth Hospital and Others and the Hon Minister for Health*, No. P 79 of 1988 on 26 May 1989 (69 WAIG 2361 at 2363), Fielding C. dealt with the conditions of employment for Interns, Registered Medical Officers, Registrars and Senior Registrars. He noted:

> "so far as the changes to work value are concerned I adhere to the view … that it has been recognised that the difference between a professional person and a non professional person is that professional persons must expect to make adjustments in the way in which they go about their work and in their working practices without being able to pray in aid an increase in work value. It is, as I said on that occasion the part of professional person's working lot that he keeps up with changes in technology and the changes in professional practice. That person ceases to be a professional person if he practices in ignorance of contemporary standards and knowledge. Nevertheless the authorities are such, as I indicated on that occasion, that the requirement of professional people to adjust with technology and the changes in professional technique is not an absolute bar to obtaining adjustments to salary levels as a result to work value changes where it can be shown that there have truly been work value changes."

147 Fielding C. also dealt with the expectations of professions in dealing with a claim for increased salaries on account of increased work value for hospital pharmacists. He noted:

> "Pharmacists are trained for and remunerated as members of a profession. They must be expected to grow with that profession as with any other professional person. It is not beyond the normal expectations that a member of a profession will keep up to date with developments in it as a matter of course. Indeed even in the case of tradesmen it is to be expected that they should adjust to changing technology without involving any significant additions to their work value [see: Federated Engine Drivers' and Firemen's Union of Workers of WA v. Mt Newman Mining Co Pty Ltd (1981) 61 WAIG 1770, 1772]. In this respect I endorse and gratefully acknowledge the following remarks of Leckie D.C.J. of the Victorian Industrial Appeals Court made in the course of delivering judgement of that Court in the 1980 Victorian Hospital Pharmacists' case:-
>
>> The undertaking of a professional career, whether it be in the law, in medicine or in engineering, entails the self imposed obligation to keep abreast of current developments. The pace in almost all areas seems to be increasing. But, being part of the professional commitment, it is not a matter which in itself can be claimed as an addition to work values. However, the increased knowledge does have its place in the consideration of those new areas of activity which have already been examined.
>
> Similar views are to be found in *re* Medical Officers – Hospital Specialists (State) Award 1978 AR 321; in *re* Hospital Employees – Technical (Metropolitan) Award and another (*supra*) and most recently, in *re* Professional and Technical Employees Award – Public Hospitals Queensland and Queensland Radium Institute, 123 QdGIG 935. It is a well established proposition. Nonetheless, as Kelleher J. noted in *re* Medical Officers – Hospital Specialists (State) Award (*supra*), there can be changes in skills and responsibilities of members of the professions within the meaning of the wage fixing principles. As was indicated by Kelleher J. in that case at page 327, "the question as to whether there have been changes in skills and responsibilities constituting a significant nett addition to work requirements since the salaries were last assessed is entirely one of fact" to be answered on the basis of the available material."
>
> (1987 67 WAIG 554 at 556))

The Changes

148 Importantly the Work Value Changes Principle stipulates that the time from which work value changes in an award should be measured is the date of operation of the second structural efficiency adjustment allowable under the September 1989 State Wage Decision (1989) 69 WAIG 2917. Under that State Wage Decision the structural efficiency principle enabled parties to undertake a "fundamental review of the award with a view to implementing measures to improve efficiency of industry and to provide employees with access to more varied,

fulfilling and better paid positions" (op. cit. at 2917). The wage system comprehends classifications based on skill acquisition and training within the framework of a career structure.

149 With the second structural efficiency increase to this Award, in October 1989, (69 WAIG 3290) the classification structure was changed. The classifications were broad banded to create the structure as it applies today. Subsequently, the HSOA obtained industrial and award coverage of clinical psychologists in the public health sector, the vast majority of whom had previously been covered by the Public Service Award 1992 (No. PSAA 4 of 1989). The new amalgamated clinical psychologists group then had access to classification criteria progression, which enabled movement from level 6 through to level 7 and level 8 upon satisfying the appropriate professional progress criteria.

150 The questions to be determined are:

1. What changes have occurred in the requirements of clinical psychologists in the public health sector since the structural efficiency adjustment?
2. Do the changes apply across the sector?
3. Do those changes constitute a net addition to the work value?

Conclusions

151 Following the conclusion to the hearing in this matter, by letter dated 24 January 2002 the Commission in Court Session sought that the parties address certain matters. One of those matters related to information as to the positions held within the Award and the Public Service areas prior and subsequent to broad banding in both of those areas. The parties submitted a number of duty statements in that regard. They included HSO and Public Service positions at various levels and at various teaching and non-teaching hospitals and within the Health Department. They also provided duty statements and job description forms for positions

within the Disability Services Commission and the Ministry of Justice. An examination of those job description and duty statements indicate the duties, responsibilities and skill levels of the positions for the period 1985 to today. Although the terminology and focus of those documents has changed over time, they exhibit a consistency as to the expectations of the positions. They indicate that throughout this period there has been a core of requirements of the positions which has not changed. The essential aspects of the positions remain the same:

- to undertake psychological assessments and interventions with clients and systems in accordance with psychological principles;
- to provide advice to colleagues in multi-disciplinary teams (or in inter-disciplinary relationships);
- to undertake or participate in research and evaluation;
- to contribute to disciplinary or multi-disciplinary teams; and
- to provide training and education regarding psychological processes to more junior colleagues and to other professions.

152 Level 6 encompasses those who are junior and less experienced, who work under more direct supervision.

153 At Level 7/8, there is less supervision, and a high level of expertise, including specialisation; there may be the co-ordination of staff, and contributions to policy development.

154 However, the job descriptions alone do not reveal the whole picture, and do not reflect qualitative changes and developments in the requirements of the job, nor in the environment in which the work is performed. They do not reflect the changed requirements of a clinical psychologist in the contemporary setting, by recognising the following changes which we find have occurred in the application of those general terms, including:

- the complexity added to the assessment and diagnosis by increasing co-morbidity, substance abuse, the aging of the population, ADDH, the effect of HIV/AIDS, chronic disease, etc.
- a substantially increased body of knowledge and more sophisticated psychological assessment brought about by research undertaken or participated in by clinical psychologists, amongst others, beyond the normal expectations of progress within a profession in a multitude of existing and new areas including:
  - adults`
  - children and adolescents
  - Aboriginal people
  - elderly
  - medical/surgical fields such as gynaecology, obstetrics, pain management.
- the significant improvements and developments in treatments, resulting in more cost effective and efficient treatments, also beyond the normal expectations of progress.
- the increased use of psychological treatments, in addition to, or in substitution for, pharmacological based treatments, which is another factor to be counted towards the cost effective and efficient treatment of patients.
- the increased role of clinical psychologists having overall responsibility and accountability for assessment, diagnosis and treatment of the patient, whereas this responsibility and accountability was previously in the hands of medical professionals such as psychiatrists.

- an increased supervision load at mid to higher levels of the profession, due both to the requirement for a longer and more complex supervised period for junior staff, and a depletion of numbers at senior levels.
- an increased training period for registrars to reflect the increased demands and complexity of the role, and increased body of knowledge.
- increased specialisation.

155 It is true that not all of these developments apply equally to each area of work, or at each level. For example, level 6 Registrars are required to spend an additional year in supervised training on account of the increased demands, complexity and body of knowledge, but would not be involved in specialisation. The more senior levels have increased supervision responsibilities. However, there is sufficient change across the board, and in the various sectors, such as in regional services, in youth services, in gerontology, surgical areas, and all others, to enable a conclusion that there is a high level of change across all of the public health sector clinical psychologist positions before the Commission. It is a matter of how those changes ought be reflected at the various levels.

156 As to the claim that changes to the work environment of community-based work rather than the previous hospital based focus, and the use of multi-disciplinary teams, these are common across the mental health sector. The clinical psychologist operating within that system is no different from the mental health nurse, occupational therapist, psychiatrist, or medical practitioner in that respect. The clinical psychologist may head the multi-disciplinary team, but so might other professionals. That does not mean that there is no increase in work value. We conclude that the change to the community based approach has lead to increased efficiency and cost effectiveness of treatment, by the significant reduction of in-patient bed days and by the use of the multi-disciplinary approach. Other professions may contribute to this and any such

contribution would need to be weighed with any other changes to the professions should they make a similar claim.

157 Increases in workload, lower benefits than in private practice, and attraction and retention of senior practitioners are not directly relevant to work value considerations. The issue of the reduced numbers at senior levels, and the causes of that, may have an indirect impact on the increased requirements for supervision but of themselves, are not work value factors. We are not satisfied that the requirement to train other professions involves any increased work value than applied previously. This has always been a requirement, and while it may have increased, that increase is not of any real substance.

158 The applicant union must discharge the onus of proving in terms expressed in the Statement of Principles (op.cit.) that there has been a significant change in work value. Through documentary evidence and witnesses the Commission was presented with extensive information on the development of the profession over the last ten years. This extended from changes to academic training, the extension of the period of supervision under a registrarship through to the specialised areas of Clinical Psychological practices. Within this framework the Commission was informed of the changing environment within which the profession has to operate.

159 As a community we are now more aware than ever of the complications, both mental and physical, associated with the incidence of perinatal issues, behavioural problems in early childhood, adolescence, and in aging. The prevalence of co-morbidity, brain injury, drugs, suicide and dementia are incidences of our complex society. The impact that cultural and family relationships have on these issues and the long term effect of personality disorders, depression, anxiety and behavioural problems are but a few of the issues which confront health

care professionals generally and in the context of this matter before the Commission, clinical psychologists in particular.

160 The evidence presented to us particularised the evidence-based model of diagnosis and treatment and the psychological and neuro-psychological tools and techniques deployed by clinical psychologists in direct patient intervention in case management and in the multi-disciplinary approach to patient care. As to the conditions under which the services of clinical psychologists are provided, the Commission is informed of the demands for more cost effective delivery of care, the policy initiatives to establish community based services closer to homes to target specific groups including remote and rural communities. There is a focus on rehabilitation of people with psychiatric illness and disabilities.

161 For the applicant union, the convergence of these factors, the development of professional skills, the application of these skills in an environment which demands more cost efficient and effective treatment and which requires the practice of the profession of clinical psychology in circumstances where the problems and illnesses are more complex, amounts to a significant change in work value. This should be recognised with increases in salary and the provision of a career structure for clinical psychologists.

162 While the respondents recognise that there has been a change in work value for the profession of clinical psychology that has been accommodated in classification restructuring that took place in the early 1990s, they submit that pressures now being experienced by senior clinical psychologists can be overcome by the creation of more positions at the level 7/8 classification and at level 9 with the latter being filled on a “competitive basis”. The development of professional skills evidenced by the use of more sophisticated tests and assessments and an involvement in direct patient referrals reflects normal development within a profession. The multi-disciplinary approach to patient care and the treatment of patients with serious

personality disorders and co-morbidity problems is consistent with their training and the role that clinical psychologists have always undertaken. Furthermore, it is submitted that particular areas of early childhood care, adolescence and youth clinical psychological practice, neuro-psychology, pain management, etc., while being evidence of an increase in specialisation do not amount to a change in work value. There have always been individuals within the profession who have undertaken specialised roles.

163 The Commission is faced with evidence of the particularisation of change from the clinical psychologists' point of view and the generalisation of professional development over time from the respondents' perspective.

164 We have already set out in this decision changes and developments in contemporary clinical psychological practice which the job descriptions or duty statements do not reflect. We accept the evidence of Professors Martin and Garton as to changes in academic programmes which involve an extension in the Master of Psychology degrees to more adequately prepare graduates for demands placed on them in clinical practice. This, together with the extended period of supervision for registration by the Psychologists' Board of Western Australia represents a qualitative change in the education and training requirements reflecting the growth of knowledge of clinical psychology. We reject any inference that these changes amount to no more than normal professional development.

165 Central to the applicant union's case has been the skill and expertise of clinical psychologists in the development and application of more sophisticated tests and assessments. From this has developed a greater involvement in direct referral of patients, and the management of cases. Evidence was forthcoming from a number of witnesses on the use of tests and assessments and the application of cognitive behavioural treatments. In this respect Dr Merryweather informed the Commission that such tools as CBT have been refined and can now be applied to a broader

range of clinical problems. Indeed, Ms Griffiths (Unit Manager, Youth Link Inner City Mental Health Service) points out that CBT has received recognition under the NHMRC guidelines for use in cases of youth depression, replacing total dependence on medication and electroconvulsive therapy. We accept this and the use of Dialetic Behaviour Therapy in the treatment of borderline personality disorders as factors contributing to the change in work value of clinical psychologists. It is noted from the evidence of Professor Lipton (former Chief Psychiatrist and General Manager, Mental Health Division, Dept. of Health) that CBT and other neuro-linguistic programmes are not the exclusive domain of clinical psychologists and were developed by psychiatrists. It was acknowledged, however, that psychologists have developed the treatment further. Ms Jones (Senior Clinical Psychologist and Co-ordinator at Warwick Clinic) attested to the use of new assessment techniques in the early 1990s for measuring clinical levels of dysfunction in cases such as ADD/ADHD. The development of clinical psychology in the field of neuro-psychology is evident from the role that these professionals now have in the diagnosis, management and rehabilitation of patients with brain injury. This involves the use of CAT and MRI scans. Again in this respect we accept the uncontroverted evidence of Dr Conner (Senior Clinical Psychologist, Neuroscience Unit) that this has contributed to the change in work value of clinical psychologists.

166 Much of the thrust of the applicant union's case goes to changes in service demands, skills required, evidence based treatment, community emphasis and outcomes and service and evaluation.

167 We accept the evidence of Professor Lipton that the development of community based services and evidence based practices are requirements achieved over a 5 year programme under the State's Mental Health Policy. In this respect quality assurance standards have been imposed upon all health professionals in their adherence to evidence based care. It is also an accepted fact that all health care professionals with whom clinical psychologists work are

required to deal with more complex cases. However, from the evidence presented to us from the range of witnesses we are satisfied that with respect to developments in clinical psychology the degree of specialisation, case management involvement and accountability for patient care go beyond the scope of what could be explained as normal professional development. We recognise that this is not the view of Prof. Lipton and Mr Holland.

168 In our view it is implicit in changes which we have identified that the worth of clinical psychologists within the health care environment has been re-assessed. Their roles have changed and whilst degrees of specialisation and patient care responsibility have always been features of the profession, the evidence presented to us on issues of co-morbidity, the developing role of psychology in complementing and/or replacing medication as the standard form of treatment and the development of new diagnostic skills have contributed to an increase in levels of skill and responsibility.

169 We conclude that the changes in the work of clinical psychologists engaged in the public health sector taken together constitute a significant net increase in their work value since 1990. Changes which occurred within the classification structure for clinical psychologists in the early 1990s do not detract from this conclusion. The broad banding exercise does not reflect a particular examination of the skills and responsibilities of clinical psychologists at that time nor any enquiry into the conditions under which their duties were performed. Indeed as the respondent's witness, Mr Holland testified, there was little or no variation to duty statements save and except that some of the level 7 forms were amended in handwriting to "7/8".

170 As to any prospect of flow-on, we note that clinical psychologists have demonstrated a package of changes, including in skill or expertise, responsibility, training, supervision, environment and in the nature of their patients' conditions. Some or all of those changes may be able to be demonstrated by other groups either within or outside the public health sector. They would

need to prove such changes, and the degree of change, and whether taken as a whole they constitute an increase in work value. However, the prospect of flow-on should not deny to one group the benefit of increases in remuneration due to the increased work value they have demonstrated.

171 How then should that increase in work value be reflected? Do the solutions suggested by the respondents of the proper pursuit of criteria progression and the creation of a number of level 9 positions provide appropriate recognition of that increase in skill, responsibility and expertise and the changed work environment? In light of the inconsistent approach taken by employers to the issue of criteria progression and the general lack of action in respect of the creation of higher level positions since they were suggested a number of times over a number of years, it is difficult to countenance these as being the solution to the problem. They may be part of the solution, but they are not the complete answer. If budgetary considerations have been an issue, then that is contrary to the basis of criteria progression, and actively mitigates against it. If there has been some misconception at local levels about the availability of criteria progression, or a lack of pursuit by clinical psychologists in those circumstances, then the parties have had a responsibility to resolve those matters. We do not see those matters, which ought be addressed in any event, as being the answer to the claim. However, it is clear that more senior positions ought be created and filled, and done so expeditiously.

Principle 10 Issues

172 It is clear that this issue has been the subject of lengthy consideration by the parties. It is recognised in the most recent enterprise bargaining agreement (PSA AG 1 of 2002) as being an issue which has not been resolved and would be the subject of consideration by the Commission. It has not been a lack of attempts to resolve the matter at enterprise level which has resulted in the claim coming before the Commission. Further, given the nature and breadth

of the changes it is not unreasonable that they be dealt with in the manner sought – that is, by Award amendment.

173 There is no real suggestion that the cost of this claim being granted, even if granted at its highest level, would have any real detrimental effect on the state of the national or the Western Australian economies. The claim will have a direct impact on, at most 135 positions, and a cost estimated at between $540,000 and $924,000. There is some potential for limited flow-on, subject to those seeking flow-on being able to demonstrate the merits of their case. In a total health budget for the state of $1.8 billion, this does not constitute a real impediment to the claim being granted, whether in full or in part.

174 We conclude that there has been demonstrated a net increase in work value for clinical psychologists in the public health sector at current levels 6 and 7/8 which is sufficient in the terms of the Work Value Principle, "to warrant the creation of a new classification or upgrading to a higher classification". How, then, should that be reflected in the Award, given the range of levels affected, and the claimed structure?

175 We have reservations about the claim in its current form. If the claim were granted in that form, then clinical psychologists will establish a unique group within the Award. The level of prescription of the grades, entry levels, progression, and definitions is not consistent with the remainder of the Award, and is more consistent with those matters normally prescribed in Job Descriptions forms. The applicant has noted that "at its core, this application is for the reclassification of all Clinical Psychologists positions covered by the Award …" In the normal course, reclassifications are based on an assessment of work value change, and if granted, only the classification, and occasionally, the job title, change. The successful application for a reclassification would not normally result in the particulars of the job being set out in an award provision.

176 Further, the granting of the application is but one step in the resolution of the actual classification to be applied to each position, particularly higher level positions, and the likely review of job descriptions which the parties say will follow.

177 It is also noted, that even if the Commission amended the Award in the manner sought at the higher levels, the actual creation and filling of positions is generally a matter for managerial determination. The application provides for the parties to resolve between them the issue of progression through the higher levels. We are of the view that discussion between the parties on those matters is an important step and ought to be taken in the final resolution of this matter.

178 In the circumstances, we are of the view that the following ought be prescribed by the Award:

1. the Clinical Psychologist Registrar shall enter the existing scale at the existing level 6.1, but have level 6.3 as the second increment to reflect the changed work value associated with the additional requirements reflected in the registration criteria;

2. the existing Senior Clinical Psychologist shall commence at level 7.3 and progress through levels 8.1, 8.2, 9.1 and 9.2. This will provide access to an additional classification level, ie to the top of level 9. We are not satisfied that entry into level 10 is appropriate or justified at this level of work value.

3. progression from level 6 to the top of level 9 to be via criteria progression, and the relevant positions shall revert to level 6 when vacant.

4. the existing senior clinical psychologist shall mean a clinical psychologist who:

    (a) is eligible for registration with the Psychologists' Board of Western Australia;

    (b) has a thorough knowledge of the methods, principles and practices of the profession;

(c) works under general to limited direction; and

(d) has an ability to practice psychology with a high degree of initiative and experience.

179 In addition, the respondents ought move expeditiously to create and fill those more senior positions previously contemplated as being created at level 9, bearing in mind that the positions previously at level 7/8 will move to higher increments and levels. Therefore those new positions will necessarily be higher than level 9.

180 As to the claim for the creation of new grades, definitions, and for higher level grades to be established, it is difficult to come to any conclusions regarding those matters based on the evidence before the Commission. There is not sufficient to allow a conclusion that, for example, a new grade 3 as defined, ought be created, and that one of the differences between grades 3, 4 and 5 respectively might include whether the clinical psychologist is “an expert in a major area of professional practice”, “an authority in a major field of clinical psychology practice in Western Australia”, or “a leading authority in a specialist area of clinical psychology practice in Western Australia”, respectively, and what those differences might mean. Further, based on what is before the Commission, we are unable to be satisfied as to the meaning in the distinction between “an expert consultant at advanced level” (grade 4), and “at a highly specialised level” (grade 5).

181 Therefore, the parties are to discuss between them the establishment of new positions above level 9, and the creation of any higher level positions contemplated in the claim for grades 3 to 5 now that the major issue of dispute as to the recognition of increased work value has been addressed. They should also discuss how to best reflect those positions, i.e. whether it is appropriate for them to be described in full in the Award, by an exchange of letters, in the Job Description forms, or in some other manner.

182 We do not accept the respondents' argument that the granting of the claim will mean that there will be automatic progression all the way from level 6.1 through to the top of the scale. It may be that some positions require particular clinical or other specialisations or skills, such as research, supervision or management. One would anticipate that such positions might be filled by a selection process, consistent with promotion. However, that is appropriately a matter for parties to attempt to resolve between them.

183 The parties are to enter into discussions with a view to resolving the issues of:

(a) The creation and filling of those positions previously agreed to above level 9; and

(b) The creation of new grades and definitions, and for the establishment of higher level grades 3 to 5, and how those grades and definitions are to be reflected.

This should not be taken to mean that the Commission has concluded that a particular structure beyond that resulting from paragraph (a) above should be established. There is insufficient before us to draw any conclusion in that regard. The parties ought to attempt to resolve the issue of establishing positions, for the purpose of creating a career structure which also recognises the level of specialisation within the profession. The parties are to report to the Commission.

184 The parties are to report to the Commission on those issues (a) and (b) in not more than 3 months. In approaching this task the parties are reminded that consideration must be given "to any change to wage relativities that might result not only within the relevant internal award classifications structure but also against classifications to which the structure is related." ('The Statement of Principles – June 2001', Work Value Changes Principle (op.cit. at p.1722).

185 The application is to be divided into two parts. The first part is for the purpose of bringing to a conclusion those matters set out in points 1 to 4 inclusive of paragraph 178. The second part is for the purpose of dealing with points at paragraph 183.

Date of Operation

186 The applicant union seeks retrospective operation of any re-classification arising from the determination of this matter to the 18th July 1997, the date on which the claim in its initial terms was lodged. The application was amended to its present terms on the 28th June 2001.

187 The matter was not progressed in the Commission by either party until October 2000 when the applicant union sought a conference pursuant to Section 32 of the Act. The Commission was advised that despite protracted examination of the claim, the parties had not been able to reach agreement.

188 Hearing dates in April 2001 had to be vacated due to illness and a subsequent listing for July 2001 was cancelled on the respondent's application. At that time public hospitals were the subject of industrial action by members of the applicant union amongst others.

189 The Health Department of Western Australia, on behalf of all respondents, expressed the wish to adjourn the hearing before the Commission in order to "consider a counter proposal with a view to settling P39/97 by agreement." Other correspondence forwarded to the Commission by the respondents indicated their intention to formulate an agreement which would encompass "an award application on an agreed translation process." This, it is assumed, related to a proposed new classification structure. As it turned out, nothing came of this proposed initiative. The matter was the subject of further conferences in July 2001 and November 2001 before the Commission, and directions issued for the presentation of submissions for the hearing. The applicant union was granted an extension of time to comply with particular directions with respect to witness statements.

190 The matter was heard by the Commission from the 14th to 17th January 2001 and final submissions and documentation requested by the Commission were received on the 8th May 2002.

191 In support of the claim for retrospective operation of any re-classification the applicant union cites the history of negotiations from August 1997 through to December 2000 when the matter was the subject of conference before the Commission. The applicant's "Principle 10 Statement" – Attachment 5 - sets out the chronology of meetings, delays, undertaking, understandings and commitments from the applicant's perspective. Although not the subject of evidence there was no objection to that document being submitted.

192 In further support of this claim, the applicant union referred the Commission to the statement submitted when the application to amend the award was made in August 1997. It states:

> "Following the report in March 1996 of the Ministerial Taskforce on Mental Health, the State Government adopted the State Mental Health Plan. At page 54 of the Plan a "Development Programme for the Clinical Psychologists Workforce" is outlined as follows:
>
> > Strategies need to be urgently implemented to attract and retain experienced clinical psychologists. These strategies must include development of:
> >
> > - A career structure which provides a senior focus for the profession and which recognises advanced 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 for some or 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 a joint university/mental health service appointment."

193 It is, in the applicant union's view, the failure of the Health Department, Health Services and the Government to act to address the issues raised in their own reports which justifies the extent of retrospectivity now being sought.

194 Finally, the applicant union claims that it participated in a process of negotiations and co-operation with the respondents in an attempt to bring this matter to an agreed conclusion but ultimately it was forced to a point where arbitration was the only recourse.

195 The power to grant a retrospective date of operation is found in Section 39. The basis upon which s.39 operates is set out by the Full Bench in *HSOA v Association for the Blind of Western Australia (Inc) and others* (1982) 62 WAIG 2080. It requires consideration whether there are special circumstances which make such an order fair and right.

196 In the ordinary and normal case the Commission would not be confronted with circumstances which would compel it to the view that an award should be given retrospective effect. On this basis the existence of circumstances which, in the Commission's opinion, "make it fair and right" to make a retrospective order, might well be seen as special" (op. cit. at 2081).

197 The Full Bench noted that it is "clear enough that the conduct of parties may well be a factor proper to be considered in determining the date from which an order should take effect. It by no means follows, however, that conduct which the tribunal disapproves is a necessary condition of a retrospective grant … Of course, the conduct of the parties may be a matter of major importance in deciding whether, and if so to what extent, an order should be given retrospective effect." (op. cit. at 2082).

198 It is in the circumstances of this matter that the conduct of both parties is squarely the issue. The history of negotiations in the three years prior to being progressed before the Commission late in 2000 is marked by false expectations, delays and the appointment of different officers to re-commence negotiations with the union. However, notwithstanding these issues the union was successful in negotiating an enterprise bargaining agreement for clinical psychologists. Indeed, it may reasonably be inferred that that was the focus of its attention for a considerable period of time rather than the award amendment.

199 There is, however, the issue of the State Mental Health Plan and the specific commitment made with respect to clinical psychologists. The success of that plan in all other respects was attested to by Prof. Lipton. Significant resources were deployed in re-focussing services and implementing strategies to improve service delivery. The evaluation of the standards of care was an integral part of its success. However, what initiatives and recommendations were made about the creation of positions to support senior clinical psychologists and to provide additional opportunities were either ignored, thwarted by budget constraints or bogged down in a mechanism of classification review.

200 On balance, we consider that within the terms of s.39 of the Act, there are special circumstances which make it fair and right to grant some degree of retrospectivity in the operation of any re-classification for clinical psychologists currently employed with the respondents, who are re-classified as a result of this decision.

201 In this respect an operative date of 1st September 2001 is fair and equitable and we decide accordingly.

APPLICATION NO. P 39 OF 1997

Clinical Psychologists Rates of Pay							
Award			Claim			Minutes of Proposed Order	
Current Titles	Levels	$ 1/8/02t	Title	Levels	$ 1/8/02	Levels	$
Registrar	6.1	44,086	Registrar	6.1	44,086	6.1	44,086
	6.2	45,550	Grade 1	6.3	47,630	6.3	47,630
	6.3	47,630					
Senior	7.1	48,743	Clinical	7.3	51,614	7.3	51,614
Clinical	7.2	50,153	Psychologist	8.1	53,749	8.1	53,749
Psychologist	7.3	51,614	Grade 2	9.1	58,147	8.2	55,499
				10.1	62,006	9.1	58,147
	8.1	53,749				9.2	59,989
	8.2	55,499	Senior Clinical	10.2	65,250		
			Psychologist	11.1	67,841		
	9.1	58,147	Grade 3	11.2	70,476		
	9.2	59,989					
			Senior Clinical	12.1	74,089		
			Psychologist	12.2	76,530		
			Grade 4	12.3	79,314		
			Consultant	Class 1	N/A		
			Clinical				
			Psychologist				
			Grade 5				