

Senate Inquiry Submission

I respectfully submit that the current two tier arrangements for psychology should be scrapped. My objections are based on scientific, economic and commonsense grounds.

Data from the recent evaluation of Better Access (Department of Health and Aging, 2011) show that clinical and generalist psychologists saw similarly distressed clients with the generalists achieving better results. The finding that “higher” qualifications don’t translate into superior client outcomes is routine within the psychotherapy literature (Atkins & Christensen, 2001; Bickman, 1999; Stein & Lambert, 1995). The reason for this repeated finding is well understood. Wampold (2001) explains that the efficacy of psychotherapy is largely due to contextual factors such as client characteristics, therapist qualities, relationship elements, etc rather than specific techniques. Contextual factors account for 70% of client outcomes while specific techniques account for 8% of the variance. It is the personality of the therapist rather than adherence to any particular technical protocol that drives change. Technique is useful in so far as it provides a structure for therapy. The ability to form a therapeutically useful relationship is not something that seems to be taught in post-graduate psychology training and indeed may not be a teachable skill (O’Donovan, Bain & Dyck, 2005).

So while there is some face validity to clinical psychologists’ claims of superiority by virtue of their training, the evidence flatly contradicts it.

Economically it makes little sense to award higher status and remuneration to clinical psychologists when the evidence is that they don’t offer a superior service. The only consequence is an inflation of the costs of psychological services. This will harm the public and the profession.

Clinical psychology originated in the USA after World War 2. There were not enough psychiatrists available to deal with the number of traumatised veterans who needed treatment. At the time doctoral trained psychologists were seen as potential substitutes for psychiatrists. Since then American psychology has tried to compete with psychiatry, requiring lengthy and expensive training and most recently lobbying for prescription rights (Cummings & O’Donohue, 2008). It seems apparent that Australian psychology is determined to follow the American approach. However, American psychologists don’t seem to be thriving. 40% of psychologists in private practice in the USA were driven out of business in the tight economic times that initiated managed care (Cummings, 2002). American psychologists currently earn much less than psychiatrists and less than occupational therapists, nurses, podiatrists and a range of other health care professionals (Cummings & O’Donohue, 2008). There is a lesson to be learned here – psychology is not going to topple psychiatry and needs to carve out a distinct identity as other health professions have done.

On a personal note I would like to say that I have worked in public mental health services for almost twelve years, providing therapeutic interventions to the most acutely unwell and at-risk clients. Yet if I (and many others like me) were to see

the less unwell clients using Better Access I would be paid at the lower rate.
How does this make sense?

In conclusion there are compelling reasons to end an entirely artificial division in psychology that offers nothing to the public or the profession.

Thank you for your consideration of the above.

Ben Hansen

References:

- Atkins, D., & Christensen, A. (2001). Is Professional Training Worth the Bother? A Review of the Impact of Psychotherapy Training on Client Outcome. *Australian Psychologist*, 36, 122-130.
- Bickman, L. (1999). Practice Makes Perfect and Other Myths about Mental Health Services. *American Psychologist*, 54, 965-978.
- Cummings, N. (2002). Economic and Policy Issues. In M. Hersen & W. Sledge (Eds.), *Encyclopaedia of Psychotherapy*, San Diego: Academic Press.
- Cummings, N., & O'Donohue, W. (2008). *Eleven Blunders that Cripple Psychotherapy in America: A Remedial Unblundering*. New York: Routledge.
- Department of Health and Aging, (2011). *Better Access to Psychiatrists, Psychologists and GPs through the MBS*, viewed 18 July 2011, <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-eval>
- O'Donovan, A., Bain, J. & Dyck, M. (n.d.). Does Clinical Psychology Education Enhance the Clinical Competence of Practitioners? Viewed July 17 2011, <http://www98.griffith.edu.au/dspace/bitstream/10072/4844/1/297271.pdf>
- Stein, D., & Lambert, M. (1995). Graduate Training in Psychotherapy: Are Therapy Outcomes Enhanced? *Journal of Consulting and Clinical Psychology*, 63, 182-196.
- Wampold, B. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings*, Hillsdale NJ: Lawrence Erlbaum.