The Collective Conscious: Response to the White Paper

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The Collective Conscious

Response to the White Paper

Background

We, ***the treating clinicians in the psychological and mental health field, who have been left out of discussions*** – regarding mental health and the Australian population's wellbeing – are coming together to put forward our perspective on the future of mental health in our great country to treatment, wellbeing and the future of humanity.

Our VOICE and NARRATIVE has been removed by the APS and the Clinical Psychologists within the APS. We do 'the good work' for the whole of the Australian community. It is our belief that there is now an 'ethnocentrism' of Clinical Psychology in Australia, that has resulted in the Australian public being hoodwinked into believing that psychology is the best method in treatment for counselling and mental health treatment in Australia. Professional, clinical counsellors, generalist psychologists and clinical psychotherapists have been therefore removed from this narrative and out of the national debate of mental health.

For the mental health field we argue that it is compassion that we need to show to each other – in treating our clients and each other – not just merely 'treatment'.

We NEED TO THINK BIG PICTURE for everyone's sake.

It is our firm belief that the current system needs RADICAL change, if we are to embrace change, technological change, the future and the future directions of our nation. Instead, radical change needs to include compassion, empathy and connection – which are the cornerstones of human attachment, bonding and love. We would like to extend this theory into the way that the clinicians in the field work – in not that dissimilar way to the way in which New Zealand has taken on a wellbeing budget. If we are to do this, we cannot remove the voices further afield, like those who work in wellbeing and prevention – the counsellors, psychotherapists and coaches in the broader mental health field.

The current mental health debates often miss out on the whole mental health clinician debate. Our group, the Collective Conscious, is concerned about the future of treatment, due to only a small proportion of professionals, the Clinical Psychologists.

We are suggesting that we as a nation need to 'wake up' to ourselves.

The issue over the years in Australia has been that Clinical Psychologists have taken over the narrative of the broader mental health field. This is extremely problematic for properly and degree-trained counsellors, psychotherapists, social workers, psychiatrists and other mental health specialists.

Clinical Psychologists do not own the mental health field. Clinical Psychologists have become increasingly divisive, money-focused and not focused enough on the wellbeing of their clientele. Instead, the focus on evidence-based practice has meant the client-focus – that

is required – is not being the number one concern.

Regularly, the rest of the mental health field picks up the pieces from poor treatment from Clinical Psychologists. Anecdotal stories from many in the field suggest that a large proportion of clients will initial seek treatment with a Clinical Psychologist, only to find themselves not obtaining the treatment they need – and these clients end up in other mental health clinicians' offices.

If we are to be even-handed in our approach towards Mental Health Care, it's essential to consider all mental health clinicians, not just Clinical Psychologists in the broader mental health narrative.

First though, it's important to set the scene – in the form of some history of psychology and how we found ourselves in this place right now.

Below you will find a brief history of psychology, and our group proposal of what is required to engender care of clientele of the mental health field, now and into the future.

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Historical Overview and Context of Psychology

1. ***Tabula Rasa***

"Tabula rasa is a Latin phrase often translated as *clean slate* in English and originates from the Roman tabula used for notes, which was blanked by heating the wax and then smoothing it"(https://en.wikipedia.org/wiki/Tabula_rasa).

1.1 Psychology and neurobiology - nature versus nurture

"Psychologists and neurobiologists have shown evidence that initially, the entire cerebral cortex is programmed and organized to process sensory input, control motor actions, regulate emotion, and respond reflexively (under predetermined conditions).[8] These programmed mechanisms in the brain subsequently act to learn and refine the ability of the organism.[9][10] For example, psychologist Steven Pinker showed that—in contrast to written language—the brain is "programmed" to pick up spoken language spontaneously.[11]

There have been claims by a minority in psychology and neurobiology, however, that the brain is tabula rasa only for certain behaviours. For instance, with respect to one's ability to acquire both general and special types of knowledge or skills, Michael Howe argued against the existence of innate talent.[12] There also have been neurological investigations into specific learning and memory functions, such as Karl Lashley's study on mass action and serial interaction mechanisms.

Important evidence against the tabula rasa model of the mind comes from behavioural genetics, especially twin and adoption studies (see below). These indicate strong genetic influences on personal characteristics such as IQ, alcoholism, gender identity, and other traits.[11] Critically, multivariate studies show that the distinct faculties of the mind, such as memory and reason, fractionate along genetic boundaries. Cultural universals such as emotion and the relative resilience of psychological adaptation to accidental biological changes (for instance the David Reimer case of gender reassignment following an accident) also support basic biological mechanisms in the mind.[13]"
(https://en.wikipedia.org/wiki/Tabula_rasa)

1.1.1 Social pre-wiring

"Twin studies have resulted in important evidence against the tabula rasa model of the mind, specifically, of social behaviour.

The social pre-wiring hypothesis refers to the ontogeny of social interaction. Also informally referred to as, "wired to be social." The theory questions whether there is a propensity to socially oriented action already present before birth. Research in the theory concludes that newborns are born into the world with a unique genetic wiring to be social[14].

Circumstantial evidence supporting the social pre-wiring hypothesis can be revealed when examining newborns' behaviour. Newborns, not even hours after birth, have been found to display a preparedness for social interaction. This preparedness is expressed in ways such as

their imitation of facial gestures. This observed behaviour cannot be attributed to any current form of socialization or social construction. Rather, newborns most likely inherit to some extent social behaviour and identity through genetics[14].

Principal evidence of this theory is uncovered by examining twin pregnancies. The main argument is, if there are social behaviours that are inherited and developed before birth, then one should expect twin fetuses to engage in some form of social interaction before they are born. Thus, ten fetuses were analyzed over a period of time using ultrasound techniques. Using kinematic analysis, the results of the experiment were that the twin fetuses would interact with each other for longer periods and more often as the pregnancies went on. Researchers were able to conclude that the performance of movements between the co-twins were not accidental but specifically aimed[14].

The social pre-wiring hypothesis was proved correct, "*The central advance of this study is the demonstration that 'social actions' are already performed in the second trimester of gestation. Starting from the 14th week of gestation twin fetuses plan and execute movements specifically aimed at the co-twin. These findings force us to predate the emergence of social behaviour: when the context enables it, as in the case of twin fetuses, other-directed actions are not only possible but predominant over self-directed actions*."[14]
(https://en.wikipedia.org/wiki/Tabula_rasa)

1.2 Computer science

"In computer science, tabula rasa refers to the development of autonomous agents with a mechanism to reason and plan toward their goal, but no "built-in" knowledge-base of their environment. Thus they truly are a blank slate.

In reality autonomous agents possess an initial data-set or knowledge-base, but this cannot be immutable or it would hamper autonomy and heuristic ability.[citation needed] Even if the data-set is empty, it usually may be argued that there is a built-in bias in the reasoning and planning mechanisms.[citation needed] Either intentionally or unintentionally placed there by the human designer, it thus negates the true spirit of tabula rasa.[15]

A synthetic (programming) language parser (LR(1), LALR(1) or SLR(1), for example) could be considered a special case of a tabula rasa, as it is designed to accept any of a possibly infinite set of source language programs, within a single programming language, and to output either a good parse of the program, or a good machine language translation of the program, either of which represents a success, or, alternately, a failure, and nothing else. The "initial data-set" is a set of tables which are generally produced mechanically by a parser table generator, usually from a BNF representation of the source language, and represents a "table representation" of that single programming language"
(https://en.wikipedia.org/wiki/Tabula_rasa)

2. *Innatism*

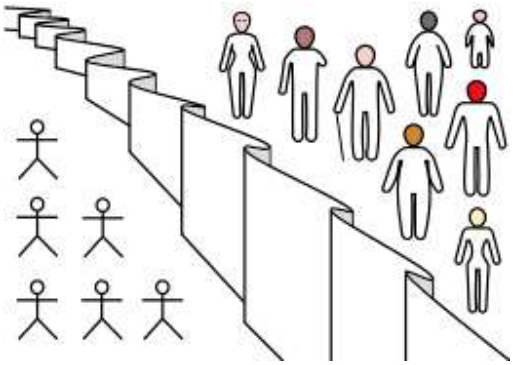
"Innatism is a philosophical and epistemological doctrine that holds that the mind is born with ideas/knowledge, and that therefore the mind is not a "blank slate" at birth, as early

empiricists such as John Locke claimed. It asserts that not all knowledge is gained from experience and the senses. Plato and Descartes are prominent philosophers in the development of innatism and the notion that the mind is already born with ideas, knowledge and beliefs.[1] Both philosophers emphasize that experiences are the key to unlocking this knowledge but not the source of the knowledge itself. Essentially, no knowledge is derived exclusively from one's experiences as empiricists like John Locke suggested.[2]" https://en.wikipedia.org/wiki/Innatism

3. *Pu*

"Pu is a Chinese word meaning "unworked wood; inherent quality; simple" that was an early Daoist metaphor for the natural state of humanity, and relates with the Daoist keyword ziran (literally "self so") "natural; spontaneous". The scholar Ge Hong (283-343 CE) immortalized pu in his pen name Baopuzi "Master who Embraces Simplicity" and eponymous book Baopuzi" (https://en.wikipedia.org/wiki/Pu_(Taoism))

4. *Veil of ignorance*



"Symbolic depiction of Rawls's veil of ignorance. The citizens making the choices about their society make them from an "original position" of equality and ignorance (left), without knowing what gender, race, abilities, tastes, wealth, or position in society they will have (right). Rawls claims this ensures they will choose a just society" https://en.wikipedia.org/wiki/Pu_(Taoism)

5. *Psychological nativism*

"In the field of psychology, nativism is the view that certain skills or abilities are "native" or hard-wired into the brain at birth. This is in contrast to empiricism, the "blank slate" or tabula rasa view, which states that the brain has inborn capabilities for learning from the environment but does not contain content such as innate beliefs. This factor contributes to the ongoing nature versus nurture dispute, one borne from the current difficulty of reverse engineering the subconscious operations of the brain, especially the human brain.

Some nativists believe that specific beliefs or preferences are "hard wired". For example, one might argue that some moral intuitions are innate or that color preferences are innate. A less established argument is that nature supplies the human mind with specialized learning devices. This latter view differs from empiricism only to the extent that the algorithms that

translate experience into information may be more complex and specialized in nativist theories than in empiricist theories. However, empiricists largely remain open to the nature of learning algorithms and are by no means restricted to the historical associationist mechanisms of behaviorism" https://en.wikipedia.org/wiki/Psychological_nativism

6. Major paradigm shifts within psychology

I am going to start where it all began....

6.1 Psychoanaltyic Theory: two of the most prolific theorists of this paradigm

6.1.1 Sigmund Freud was the "grandfather" of psychology. Take what you will from his theory, but there is no disputing that parts of his theories have withstood the test of time.

6.1.1.2 The conscious, subconscious, unconscious.

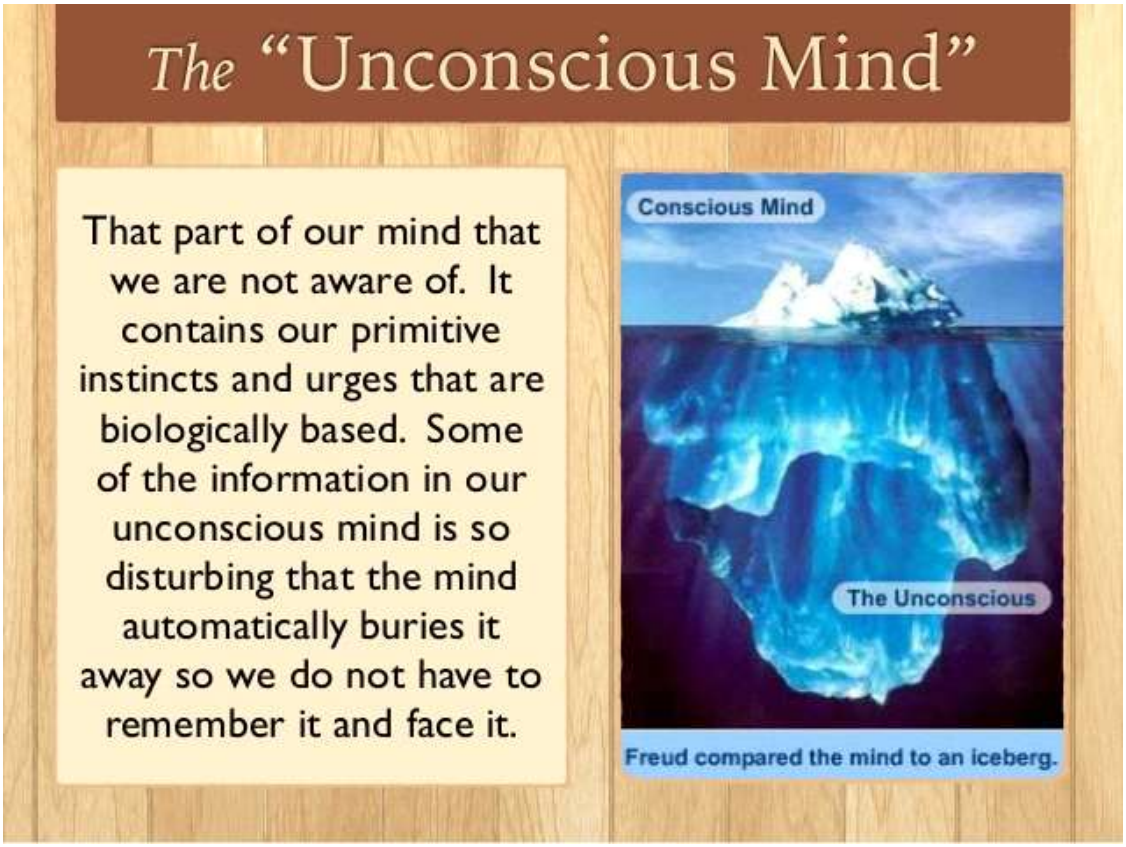


Figure 2 . The Unconscious Mind
https://www.bing.com/images/search?view=detailV2&ccid=oDxZAyV6&id=D4638B5AB2673197A20387F4731190A207401BE2&thid=OIP.oDxZAyV6DtozGzbyjhJf0wHaFj&mediaurl=http%3a%2f%2fimage.slidesharecdn.com%2fsigmundfreud-150412070746-conversion-gate01%2f95%2fsigmund-freud-motivation-3-638.jpg%3fcb%3d1428840534&exph=479&expw=638&q=Sigmund+Freud+Theory+Unconscious+Mind&simid=607994439718405914&selectedIndex=5&ajaxhist=0

Freud believed that it was the first seven years of a person's life that shaped their personality as an adult. He discussed anxiety and how he believed that it originated from traumatic experiences in our younger years. He believed that these experiences lie in the murky depths of the unconscious and could lead to issues in our conscious mind as adults.

6.1.2 Carl Jung was a student of Freud's who didn't agree with components of Freud's theory.

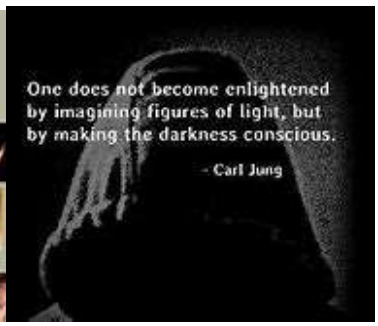
6.1.2.1 The collective unconscious.

The "collective unconscious" (German: kollektives Unbewusstes), is a term coined by Carl Jung, refers to structures of the unconscious mind which are shared among beings of the same species. According to Jung, the human collective unconscious is populated by instincts and by archetypes: universal symbols such as The Great Mother, the Wise Old Man, the Shadow, the Tower, Water, the Tree of Life, and many more.[1]

Jung considered the collective unconscious to underpin and surround the unconscious mind, distinguishing it from the personal unconscious of Freudian psychoanalysis. He argued that the collective unconscious had profound influence on the lives of individuals, who lived out its symbols and clothed them in meaning through their experiences. The psychotherapeutic practice of analytical psychology revolves around examining the patient's relationship to the collective unconscious.

Psychiatrist and Jungian analyst Lionel Corbett argues that the contemporary terms "autonomous psyche" or "objective psyche" are more commonly used today in the practice of depth psychology rather than the traditional term of the "collective unconscious."[2]

Critics of the collective unconscious concept have called it unscientific and fatalistic, or otherwise very difficult to test scientifically (due to the mythical aspect of the collective unconscious).[3] Proponents suggest that it is borne out by findings of psychology, neuroscience, and anthropology" https://en.wikipedia.org/wiki/Collective_unconscious



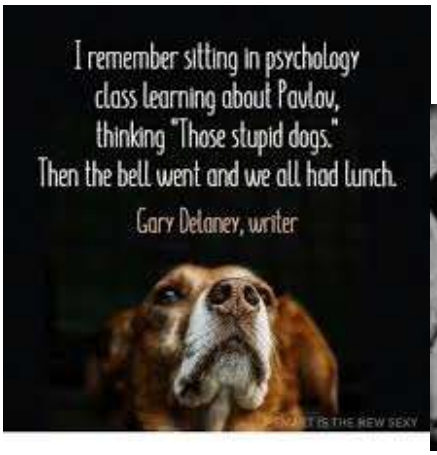
6.2 The Behavioural Perspective

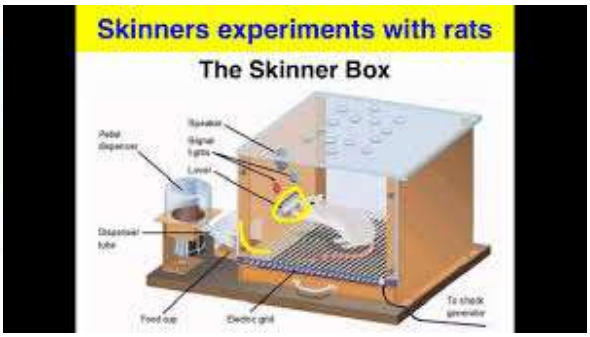
6.2.1 "Behaviorism is an approach to psychology that emerged in the early 20th century as a reaction to the psychoanalytic theory of the time. Psychoanalytic theory often had difficulty making predictions that could be tested using rigorous experimental methods. The behaviorist school of thought maintains that behaviors can be described scientifically without recourse either to internal physiological events or to hypothetical constructs such as thoughts and beliefs. Rather than focusing on underlying conflicts, behaviorism focuses on observable, overt behaviors that are learned from the environment.

Its application to the treatment of mental problems is known as behavior modification.

Learning is seen as behavior change molded by experience; it is accomplished largely through either classical or operant conditioning (described below).

The primary developments in behaviorism came from the work of Ivan Pavlov, John B. Watson, Edward Lee Thorndike, and B. F. Skinner" https://courses.lumenlearning.com/wsu-sandbox/chapter/psychological-perspectives/





6.3 The Cognitive Perspective

The cognitive approach examines internal processes (i.e., problem solving, memory, language). Cognitive theory focuses on the scientific method, rejecting introspection and psychoanalytic themes. Paradoxically, it does accept the existence of internal mental states.

Piaget's Theory

Stage	Age Range	Description
Sensorimotor	0-2 years	Coordination of senses with motor response, sensory curiosity about the world. Language used for demands and cataloguing. Object permanence developed
Preoperational	2-7 years	Symbolic thinking, use of proper syntax and grammar to express full concepts. Imagination and intuition are strong, but complex abstract thought still difficult. Conservation developed.
Concrete Operational	7-11 years	Concepts attached to concrete situations. Time, space, and quantity are understood and can be applied, but not as independent concepts
Formal Operations	11+	Theoretical, hypothetical, and counterfactual thinking. Abstract logic and reasoning. Strategy and planning become possible. Concepts learned in one context can be applied to another.

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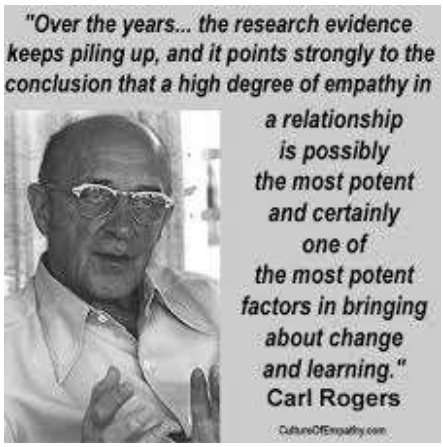
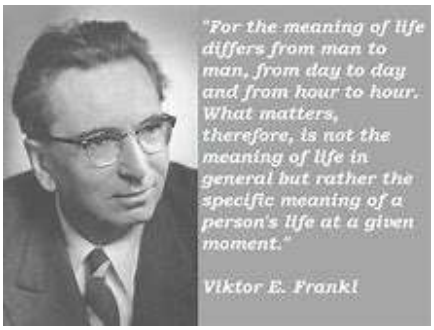
6.4 The Humanistic Paradigm

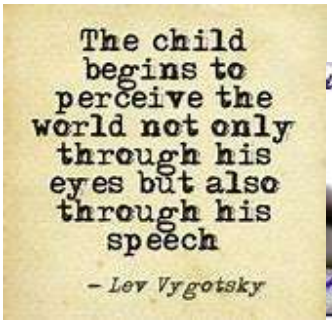
6.4.1 The Humanistic approach broke away from these more measurable constructs and drew on Eastern philosophies such as existentialism. This set of theories is seen as a more holistic approach in that it recognises free will and an innate drive for self-actualisation. Critisised due to its subjectivity and lack of evidence base.

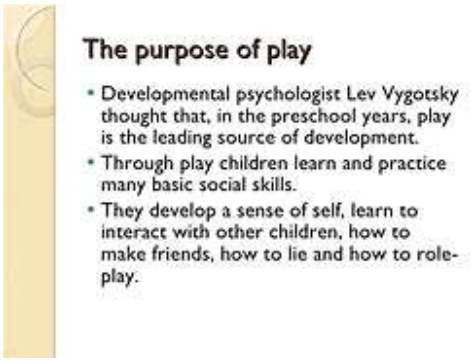




6.5 The Sociocultural Perspective

6.5.1 With concepts similar to that of the collective unconscious, this perspective focuses on how our behaviour is effected by our surroundings, social and cultural factors. This paradigm is often used to focus on the mental health of immigrants. This includes such issues as racial, gender, sexual orientation amongst other marginalised minority areas.



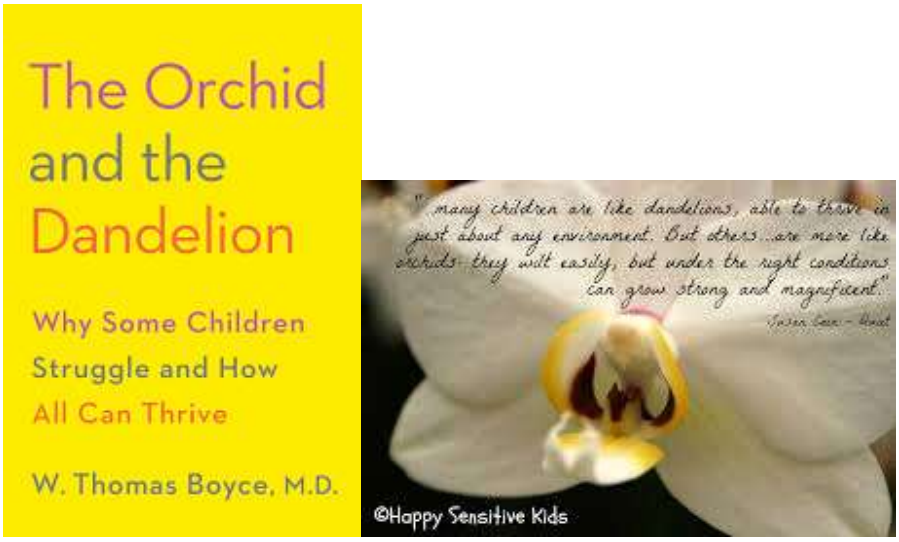


6.6 Social Psychology perspective

6.6.1 Social psychology is the essential component to this perspective is that it studies individuals within their social context and how this impacts on their behaviour.

6.7 The Biological Perspective

6.7.1 Working biologically - As the name suggests, this looks at the biological, physiological and genetic factors and how this can explain human behaviour.



6.8 Evolutionary Theory perspective

6.8.1 Evolutionary theory suggests that evolution is the basis of all wars throughout civilisation.

6.9 Positive Psychology perspective

6.9.1 Positive psychology – Martin Seligman the "father of positive psychology". His theory of learned helplessness shifted to his theory of learned optimism. This was based on an interaction with his daughter. He tells the story of how his daughter, told him "if I can stop whining you can stop being a grouch".

6.10 Attachment theory

In multiple theories, the family system has been proposed as correlates of children's way of thinking about their current and future relationships. For example, this has been proposed within attachment theory (Bowlby, 1969, 1973, 1980), motivational theories that describe people's need to belong (Baumeister & Leary, 1995), the need to relate to others (Skinner & Wellborn, 1994) and the fear of abandonment (Wolchik et al., 2002).

There are two theories that have been very influential among researchers interested in the family as associated with children's development of their conceptions and expectations of interpersonal relationships. First, attachment theorists have attempted to explain the importance of early relationships with primary caregivers as being focal for the development of conceptions of relationships and relationships with others outside the family (Antonucci, 1991; Hazan & Shaver, 1987; Simpson & Rholes, 1998). A second theory, social cognitive theory, has also been influential because of its emphasis on the processes involved in the development of social cognitions and the content of relationship perceptions and cognitions (Berscheid, 1994; Whitaker, Beach, Etherton, Wakefield, & Anderson, 1999).

Attachment Theory

Attachment theory is based on the premise that, in order for young infants to survive, their basic needs must be met and this is facilitated by forming attachments with caregivers (Hazan & Shaver, 1994).

Attachment theory uses the terms mental representations or internal working models to describe children's development of internal representations of themselves and others that follow from early relationships with caregivers (Collins, 1996). Infants are expected to begin the process of developing mental representations of the self, others and the social world, and come to think about themselves and others as either more or less worthy and lovable (Bowlby, 1973). It is thought that these representations are initially developed through repeated interactions with a caregiver in early infancy and toddlerhood. These processes, in turn, structure how the infant forms expectations for whether her/his needs will be met and she/he will subsequently behave according to these expectations in this relationship and in later relationships (Bowlby, 1969, 1973, 1980).

The quality of children's relationships with caregivers is expected to influence their internal working model of relationships. These models, in turn, are expected to have implications for the formation and maintenance of relationships across the lifespan. Although individuals' mental models of interpersonal relationships have the potential to be influenced or revised by new experiences, attachment theory nevertheless emphasises that these mental representations begin in early childhood and are fairly stable into adolescence and adulthood (Hazan & Shaver, 1994). Thus, attachment theory implies that early experiences with acceptance and rejection by caregivers would form the foundation of internal working models for future relationships.

Even more specifically, attachment theorists propose that, in early infancy, children learn to adjust their behaviour according to how their primary caregiver responds to their distress. If the caregiver is consistently available, responsive and meets the infant's needs then they are expected to develop a secure internal working model whereby they expect that others are safe, will meet their needs and will accept and support them (Bowlby, 1973).

When a caregiver is inconsistent with their availability and responsiveness to the child's needs, the child will develop an insecure internal working model where they learn to doubt that others will meet their needs and begin to anticipate and expect rejection. These early working models have a strong influence on the young child's thoughts, feelings and behaviours and form the basis for representations of self and others in future relationships (Bowlby, 1973).

Relationship expectations and related cognitions have been described as one component of the internal working model within attachment perspectives. However, the broader conceptualisation of an internal working model not only includes these relationship expectations, but also includes how people more generally view themselves, others and their relationships with others.

Attachment theorists commonly suggest that internal working models of relationships come from interactions with important and close others, and these working models can affect children's attributions and behaviours in current and future relationships (Bowlby, 1973). One likely set of mechanisms accounting for these linkages are expectations of acceptance and rejection that people have when interacting with others (Downey, Lebolt, et al., 1998). Downey, Lebolt, et al. have described how the growing concentration on theoretical aspects of internal working models has resulted in a more prominent focus on children's relationship expectations of either rejection or acceptance.

Recent attachment research has focused on the continuity and discontinuity of attachment in close relationships from infancy to early adulthood. One proposed mechanism of this continuity over time and across relationships is the relatively stable expectation of acceptance and avoidance of rejection that evolves from close relationships and relational experiences in infancy, toddlerhood and childhood (Bergevin, 2003). Researchers have assessed attachment patterns over time and demonstrated that attachment representations/internal working models of relationships remain relatively stable with age if there is an absence of significant negative attachment related experiences (Albanese, 1996; Bergevin, 2003; Hamilton, 2000; Lewis et al., 2000; Waters, Merrick et al., 2000; Waters, Weinfield et al., 2000).

Five life events, namely parental divorce, parental loss, life threatening illness to either parent or child, parental mental health problems and physical or sexual abuse by a family member have generally been classified as negative attachment related experiences that can prompt changes in internal working models (Hamilton; Waters, Merrick et al.; Waters, Weinfield et al.). In one 20-year longitudinal study following 50 participants from age 12 months to 21-22 years, it was found that change in attachment classification was more likely to occur after a significant change in the caregiver environment as compared to those who did not experience a significant change in the caregiver environment (Waters, Merrick et al.).

The environmental changes most strongly associated with changes in attachment patterns were the five life events previously discussed. These stressful life events were significantly more likely to be related to secure infants being classified as insecure in adulthood. It was reported that if no significant environmental change occurred, 85% of those classified as secure in infancy were also classified as secure in adulthood. When a significant environmental change did occur, only 33% of those classified as secure in infancy were also classified as secure in adulthood**.**

There are two other recent longitudinal studies of attachment patterns that have shown that divorce and family problems are associated with relationship expectations. First, in a study of 84 children measured at one year of age, 13 years and 18 years, it was reported that 17% of the sample had experienced parental divorce over the 18-year time period (Lewis et al., 2000). These researchers found that those whose parents had divorced were more likely to be classified as insecure at 18 years regardless of their attachment at one year of age, whereas those from an intact family were more likely to be classified as secure. It was found that divorce, rather than attachment classification at one year of age, predicted adjustment problems in adolescence.

Second, another study assessed 30 participants at 1, 3, 6 and 17 to 19 years of age (Hamilton, 2000). This study found that parental divorce was the most frequently occurring negative life event, with half of the sample reporting a history of parental divorce. Negative life events, namely parental divorce, parental loss, life threatening illness to either parent or child, parental mental health problems and physical or sexual abuse by a family member, were found to be associated with the maintenance of insecure attachment, and a high degree of marital conflict was also associated with an insecure attachment classification.

Cognitive Relational Schemas

In recent years, Downey and her colleagues (e.g., Downey & Feldman, 1996) have drawn from both attachment theory and social cognitive theory to conceptualise individuals' expectations of relationships and anticipated responses from others. Whereas attachment theory refers to internal working models of relationships to provide an understanding of how

expectations in relationships develop, other theorists use other terms, such as "cognitive relationship schema" to refer to individuals' representations and expectations of the social world based on past experiences (Baldwin, 1992).

In general, relationship schemas are cognitive representations of how the self and others tend to behave in relationships (Baldwin). This has led to investigation of the processes involved in the formation and maintenance of cognitive relationship schemas based on how individuals perceive, interpret, store and recall information (Bless, Fiedler, & Strack, 2004).

Schemas are expected to be triggered relatively automatically and become more salient as they are repeatedly activated. When activated, these schemas have a predictable impact on an individual's behaviours and cognitions. Based on their relationship schemas, individuals are likely to perceive information according to past experiences, interpret ambiguous information consistent with their expectations and filter only the information that is highly relevant to that schema (Baldwin). Schemas often represent expectations about an individual's own behaviour, others' behaviours and the interaction of the two, which often leads to the confirmation of prior expectations even when the interaction is ambiguous (Berscheid, 1994).

Researchers investigating children's social cognitions have predominantly focused on social-information processing and children's aggressive behaviour as an index of children's social adjustment. Much of this research has been based on Crick and Dodge's (1994) reformulated social-information processing model of children's adjustment. Of significance, the majority of these studies have focused on children aged 9 to 12 years. According to this model (Crick & Dodge), the way children mentally perceive and process social cues during interactions with others impacts on their behaviour in these situations. They proposed that a mental representation of past events is stored in long-term memory. This memory is incorporated with other memories into a general mental structure, known as schemas, which facilitate the understanding of future social cues. Children rely on schemas to help interpret situations or internal cues experienced in social situations.

Theoretical Foundations of the Collective Conscious

Researchers with an attachment perspective view the early interpersonal relationship between caregiver and infant as focal whilst theorists interested in cognitive relational schemas place less emphasis on the origins of schemas, concentrating instead on the more proximal processes. Despite these differences, both theoretical perspectives generally provide a sound basis for making hypotheses about how expectations come from experiences in close and important interpersonal relationships. The theories are similar in identifying the self and others, and the interaction of the two, as being important. Moreover, in each perspective, there is a recognition of how an individual's view of the social world is based on past experience and there is a description of how repeated activation of models or schemas result in their increasing relevance and salience (i.e., they become stronger and less resistant to change over time). This becomes clearer by understanding the processes involved in the interpretation of early relationships, the value placed on these interactions, the expectancies of interpersonal relationships and the strategies used to cope with behaviours of significant others.

6.11 Family Factors and Children's Mental Health and Well-Being

There are a number of bodies of research that support a focus on divorce, children's parenting experiences (e.g., hostile or neglectful parenting), and parent conflict/dyadic adjustment as

correlates of children's relationship expectations. Most of this research has focused on children's functioning in the areas of internalising and externalising problems (Fauber, Forehand, McCombs-Thomas, & Wierson, 1990; Jekielek, 1998; Lutzke, Wolchik, & Braver, 1996). In general, divorce, problem parent-child relationships or parenting, and interparental conflict have negative implications for children. Of most relevance to the current studies, all have been shown to be important to how children come to view their relationships with others, whether they expect others to be accepting or rejecting, and whether they are worthy of positive regard from others.

Divorce

Although there is a large body of research investigating the impact of divorce on children's adjustment (e.g., see Amato, 2001; Amato & Keith, 1991 for a review), there is a much more limited literature on divorce and children's relationship expectations. Most of the research that has been conducted included university or adult samples, rather than children, and relied upon retrospective reports of divorce in the family of origin during childhood or adolescence.

Some researchers have reported that adult children of divorce have more negative beliefs regarding relationships than those from intact families (Boyer-Pennington, Pennington, & Spink, 2001; Gabardi & Rosen, 1991; Jennings, Salts, & Smith, 1991; Long, 1987; Wallerstein, 1987). Studies conducted with young adults have also found that those from divorced families have lower expectations and less positive attitudes towards relationships than young adults who grew up in intact families (Boyer-Pennington et al., 2001; Gabardi & Rosen; Jennings et al., 1991; Long; Wallerstein). However, these findings pertain only to expectations of marriage; that is, respondents were asked questions only in regard to their attitude towards marriage. Attitudes toward marriage included such aspects as expected age for marriage, expectations about whether they would marry, whether their future marriage would be good/bad, successful/unsuccessful, wise/foolish, interesting/dull, honest/dishonest and valuable/worthless (Long), whether they held fears for betrayal in relationships, being abandoned, that their future marriage would not last (Wallerstein), of forming intimate relationships (Gabardi & Rosen). Also whether they held expectations of marital success (Jennings et al.), doubts as to whether they would enjoy living exclusively with one person in marriage, how happy they would be in marriage, whether they worry that their partner would not live up to their expectations, likelihood that their marriage would end in divorce, and how much control they perceived they would have over the success of their future marriage (Boyer-Pennington et al.).

Children of divorce are at risk of developing negative general models of relationships. In one study of university students (mean age 19.7 years) who were currently involved in a serious relationship, it was found that females from divorced families had a relatively more negative view of themselves in terms of relationships compared to females from intact families, but there was no group difference in other domains such as social skills, academic achievement, physical appearance and general self worth (Henry & Homes, 1998). Specifically, females from divorced families had more negative expectations about relationships, felt more helpless about interpersonal difficulties, were higher in fear of abandonment, had less optimism in their ability to resolve relationship problems, and were more likely to interpret, and react to, ambivalent behaviours from their partner as a sign of rejection compared to females from intact families. It was argued that differences in cognitions about relationships and associated behaviours between females who experienced divorce as children and those who came from intact families may be due to both the divorce and, since most lived with their mothers, the change in the father-daughter relationship following divorce (i.e., the impact of the father leaving the home and the potential for a deteriorating relationship with the father following

divorce). Although sensitivity to rejection was not measured in this study, the authors did speculate that females who experienced divorce in the family of origin might be more sensitive to rejection due to the experience of their father leaving the home.

In contrast to the findings for females in this study, no group differences were found when male university students who experienced divorce were compared to males from intact families (Henry & Holmes, 1998). Males had more positive expectations towards relationships than females and the authors argued this may be because the relationship with the opposite sex parent was critical. Therefore, since most children remain with their mother, boys' relationships with their mother may have protected them from the disruption in the family environment that is expected to be most salient for the development of negative expectations of relationships.

In summary, research focusing on divorce and relationship expectations has predominantly focused on adults' retrospective account of their childhood experiences of divorce and expectations about marriage, rather than relationship expectations in general. Although the study described focused on young adults and their romantic relationships, it provided some evidence to suggest that divorce may be associated with children's relationship expectations. The preceding study also suggested there may be gender differences in these expectations. However as this previous study was based on adults' retrospective accounts and there are no studies specifically measuring children, no specific gender differences were hypothesised in the current study.

Parent-Child Relationships and Parenting

Typically, parents are the primary attachment and care-giving figures during childhood and adolescence (Furman & Simon, 1999). This makes the parent-child relationship critical for many aspects of development. This belief has resulted in literally thousands of studies on parenting and parent-child relationships. It is impossible to summarise them all, but drawing from the literature investigating divorce, interparental conflict and the parent-child relationship in combination, the parent-child relationship has been investigated by measuring parental warmth (Fauber & Long, 1991; Hetherington, Cox, & Cox, 1982; Tschann, Johnston, Kline, & Wallerstein, 1989), parental acceptance/rejection (Fauber et al., 1990; Fauber & Long; Lutzke et al., 1996; Tschann et al., 1989), psychological control/psychological autonomy (Fauber et al.; Fauber & Long), harsh/lax discipline (Fauber et al.; Fauber & Long; Hetherington et al., 1982), communication (Hetherington et al.; Lutzke et al.), and emotional security (Black, 1994; Tschann et al.). Although there are many terms used interchangeably to describe the parent child relationship, for example, parenting styles, dimensions, qualities and behaviours, children's perceptions of parenting qualities were assessed in the current studies and these are referred to as *parenting*.

Researchers do tend to agree that particular qualities of the parent-child relationship are better predictors of child socio-emotional and behavioural outcomes than is the composition of the family (Hines, 1997; Langley, 1997). Although only measuring child variables retrospectively, Hazan and Shaver (1987) found parental divorce was unrelated to the parent-child attachment relationship after accounting for the associations between attachment and parent-child relationship factors. In their study, using a convenience sample of adults (mean age 36 years, range 14 to 82), they found parental divorce during childhood did not predict whether they were classified as secure, anxious/ambivalent or avoidant in adult attachment styles in relation to their most important romantic relationship. Perceptions of the quality of the relationship with their parents and their parents' relationships with each other were the

best predictors of adult attachment type. Others also have posited that the parent-child relationship may be more important than the act of divorce (e.g., Hines).

The rejection sensitivity model implies that parenting has an impact on relationship expectations. This model proposes that rejection sensitivity develops as a consequence of parental rejection (Downey et al., 1997). Although no studies could be located that measured childhood accounts of parenting and rejection sensitivity, rejection sensitivity has been linked to parenting through adults' retrospective accounts of their parents during their childhood. When sampling university students, rejection sensitivity has been associated with their reports of experiences of parental violence (Feldman & Downey, 1994), parental emotional neglect (Downey et al.), and parental psychological control (Zimmer-Gembeck & Wright, 2007). Interpersonal sensitivity has also been linked to adults' retrospective accounts of parenting experienced in childhood. Perceptions of parental care and overprotection have been found to be associated with one of the subscales of interpersonal sensitivity (fragile inner self) using the Interpersonal Sensitivity Measure (Wilhelm, Boyce, & Brownhill, 2004). Whilst not directly related to children's relationship expectations per se, parenting has also been linked with different aspects of the peer relationships. Parenting has been associated with social expectations of peer support (Liu, 2006), involvement with peers, quality of peer relationships (Dekovic & Meeus, 1997), attachment relationship with friends (Markiewicz, Doyle, & Brendgen, 2001; Wilkinson, 2004) and views of friendships (Furman, Simon, Shaffer, & Bouchey, 2002).

Of direct relevance to the current research, another study examined family structure, parent-child relationships and expectations of relationships (Langley, 1997). In this study with university students aged 18 to 35 years, those who had a parental death prior to 14 years of age (n = 29) were compared to those who had experienced parental divorce prior to 14 years of age (n = 59) and those raised in an intact family (n = 41). The expectation was that adults who had experienced parental loss through either death or divorce as children would have poorer socio-emotional functioning, including relationship expectations, compared to those from intact families. This particular study reported no difference between adults who had experienced loss of a parent through divorce or death as children compared to those from intact families on social anxiety, depression proneness, sociotropy, autonomy and attachment styles. When including perceived quality of parental care (i.e., affection, emotional warmth, empathy and closeness, emotional coldness, indifference and neglect), it was found that warm parenting, regardless of family structure, was important in maintaining social optimism. Overall, the retrospective perception of the parent-child relationship was more strongly associated with the relationship expectations of loss or rejection than family structure.

The intervention literature provides further support for the importance of the quality of parent-child relationships rather than the experience of divorce when studying children's cognitions, emotions and behaviours. For example, one widely studied program, The New Beginnings Program, has the aim of optimising children's outcomes following divorce by focusing on improving the quality of the parent-child relationship (Dawson-McClure et al., 2004; Hipke et al., 2002; Tein et al., 2004; Wolchik et al., 2002; Wolchik et al., 2000). Whereas this program does not examine children's relationship expectations, there is evidence that high quality parent-child relationships can protect children against the possible negative effects of divorce.

Although there have been no studies of *children's* relationship expectations, parent-child relationships and family structure among children, there is evidence that parenting qualities

are associated with children's mental health, behavioural problems and other aspects of socio-emotional functioning. Baumrind (1991) is one widely cited researcher who identified a style of parenting characterised by parental warmth, democratic parent-child interaction and parental limit setting as consistently associated with positive developmental outcomes in young and older children. More recent empirical research also supports these findings in adolescents. For example, in a sample of 175 adolescents aged 13 years, it was found that parental warmth significantly predicted decreases in externalising problems and increases in self-esteem, whilst greater parental psychological control was associated with more internalising problems (Doyle & Markiewicz, 2005). In another study of 272 children in grades 9 to 11, parenting characterised by warmth, non-punitive discipline and consistency was related to higher self-esteem and life satisfaction and lower depression in children compared with indulgent parenting, described as low in levels of demandingness and high in levels of responsiveness, and neglectful parenting, depicted as low in levels of demandingness and low in levels of responsiveness (Milevsky, Schlechter, Netter, & Keehn, 2007).

Generally, it is clear from the literature that multiple dimensions of parenting are associated with children's socio-emotional functioning and behaviour. Parental control is one widely researched parenting dimension that has been defined in multiple ways, known as a multi-forms approach, although it has been suggested that this approach needs refining (Grolnick & Pomerantz, 2009). Grolnick and Pomerantz suggested distinctions be made between parental control and other terms such as autonomy support, structure and chaos to reduce the ambiguity and inconsistent findings yielded by taking a multi-forms approach to studying parental control. These authors also recommended empirical research on parenting needed to be linked to broader theories of child development to gain a better understanding of how parents shape children's development and how children contribute to this process.

In a recent study that attempted to organise the many dimensions of parenting, Skinner, Johnson, and Snyder (2005) employed a framework that conceptualised parenting styles using a motivational model. Although parenting strategies are multifaceted, these authors identified six dimensions of parenting that were considered crucial to understanding the diverse ways that parenting can impact on children's development. The first dimension, involving love and affection, was labelled parental warmth. The second was structure and consistency, whereby the parent provided consistent limits and guidelines for the child. Last, autonomy support was described as important, and defined as a democratic style of parenting where children are encouraged to be independent in their way of thinking.
The three other dimensions of the framework identified negative parenting behaviours. These were rejection, chaos and coercion. Rejection included overt criticism and displays of signs of disapproval toward the child. Chaos included erratic, inconsistent and unpredictable parenting behaviours. Coercion included behavioural and/or psychological control where parenting is restrictive and over-controlling.

There is evidence that these six dimensions are associated, but that they form six separate factors and are differentially associated with a range of child and adolescent outcomes (Johnson, 2004). However, no previous research has examined whether these parenting dimensions are associated with children's relationship expectations. Using these six dimensions will assist in highlighting the importance of distinguishing between the different components of parenting to gain a greater understanding of the parent's role in children's socialisation processes. The current study also will test the validity of using these six dimensions as a framework for measuring parenting.

When discussing the effect of divorce and parent-child relationships on children, there has been an almost exclusive focus on whether divorce and negative parenting processes contribute to children's maladjustment, with very little attention on what parents can do to promote optimum relationship expectations in their children. The current research studies were designed to assess children's positive *and* negative views of relationships. It was expected that not only would negative parenting measures be associated with children's pessimistic views of relationships, but positive parenting measures would be linked to optimistic views. Three positive factors and three negative dimensions of parenting were measured. These have been linked to positive versus negative outcomes, respectively, in past research (Johnson, 2004). In the current research, it was expected that children who had parents high in warmth, structure and autonomy support would have more optimistic expectations of relationships. Conversely, children who perceived their parents to be relatively more rejecting, chaotic, and coercive were expected to have more pessimistic expectations of relationships. In the context of these hypotheses, children from separated/divorced families and children living with two biological parents were compared, and the unique contributions of family structure and the six parenting dimensions to relationship expectations were tested.

Interparental Conflict

Divorce often covaries with interparental conflict (Emery, 1982; Grych & Fincham, 1990). Hence, an important extension of research on divorce and children's adjustment has been the inclusion of a measure of interparental conflict. Research on interparental conflict and children's adjustment shows that negative associations exist within both intact and divorced families, and the differences in children's adjustment found between those from intact and divorced families may be accounted for by interparental conflict. For example, among intact families, interparental conflict has been linked to children's depressed/withdrawn behaviour, antisocial behaviour, impulsive/hyperactive behaviour and behaviour discipline problems at school including suspension or expulsion (see Peterson & Zill, 1986; Turner & Barrett, 1998). Within the divorce literature, considerable research has examined the impact of interparental conflict on children's adjustment. In one meta-analysis (Amato & Keith, 1991), interparental conflict was found to have a more powerful direct effect on children's well-being than divorce per se.

In cases of very high interparental conflict, divorce may even improve children's well-being. In a review of research conducted predominantly in the 1960s and 1970s, Emery (1982) found evidence to support the view that interparental conflict, rather than the separation or divorce of parents, may be the main influence on children's adjustment problems following divorce. Emery suggested that in high conflict homes, divorce may lead to a less damaging environment for the children's psychosocial development, as it will reduce this conflict. To support this view, Emery discussed how research has found more behavioural problems in children following divorce as opposed to the death of a parent. More behavioural problems were also found in children from high conflict intact families compared to children from low conflict divorced homes, and in children from divorced families whose parents were engaged in conflict following the divorce compared to those children from divorced families where there was no conflict. In addition, many of children's problems were prominent well before the experience of divorce. Although there were many limitations in the research reviewed (e.g., an over-reliance on clinical populations), even as early as the 1960s and 1970s there was emerging evidence to suggest that interparental conflict may be more important to understanding children's adjustment than divorce, and that a good parent-child relationship

with at least one parent may buffer against the negative effects found for parental discord on children's adjustment problems.

In a review investigating interparental conflict and children's adjustment conducted nearly a decade later, Grych and Fincham (1990) critiqued Emery's (1982) review, stating earlier research did not use specific or reliable and valid measures to assess interparental conflict and did not focus on factors that may explain the association between interparental conflict and children's adjustment problems. Of the 19 studies examined in this later review, eight investigated the effects of interparental conflict on divorce; four included intact families as a comparison group. Eleven papers investigated intact families, three of which used clinical as opposed to non-clinical samples. Grych and Fincham found, of the 19 studies, 15 provided evidence for the association between interparental conflict and children's adjustment problems, and found that the more frequent, overt and intense the conflict the worse these problems were. In addition, they stated the content and resolution of the conflict was also important. Similar to the suggestion in Emery's review, Grych and Fincham hypothesised that the parent-child relationship may mediate and/or moderate the relationship between the conflict and children's adjustment problems.

More recently, research designs and measurement techniques have improved and researchers have continued to report that more interparental conflict comes with poorer child psychosocial functioning (Burns & Dunlop, 2002; Jekielek, 1998; Richardson & McCabe, 2001; Riggio, 2004). In one longitudinal study of adolescents aged 6 to 14 years, it was found that those whose mothers had self-reported high levels of conflict within the intact family when first measured, and had subsequently experienced divorce over the next four years, reported lower levels of anxiety and depression/withdrawal than those who reported similar levels of interparental conflict and remained in the intact family environment (Jekielek).

These results were found regardless of whether the children had experienced divorce within the last two years or the divorce had occurred two or more years earlier. The lowest level of anxiety and depression was found for those who had low conflict in the intact environment and no family disruption over the four years.
In a longitudinal study of adolescents between the ages of 13 and 16 years, it was found that degree of conflict, but not family structure, predicted adolescents' emotional adjustment and self concept (Burns & Dunlop, 2002). The authors of this study found that interparental conflict also had long term effects and that these effects were similar for children from intact families and those from divorced families. Yet, there was no support for the hypothesis that children from high conflict intact families had worse psychosocial functioning than children from high conflict divorced families. They also found no support for the proposition that children from low conflict divorced families had lower psychosocial functioning than those from low conflict intact families.

Interparental conflict and parent-child relationships. The studies on interparental conflict and family structure have shown how these two factors are important to consider when studying children's adjustment. Other studies have shown the importance of considering both of these factors along with the parent-child relationship as a third important correlate of children's adjustment and well-being. Researchers including family structure, interparental conflict and the parent-child relationship in their studies have generally found (a) a unique main effect for the parent-child relationship on children's adjustment, (b) that the parent-child relationship mediates the association between interparental conflict and children's adjustment, or (c) that the parent-child relationship moderates (i.e., changes) the association between interparental

conflict and children's adjustment (Amato, 1986; Hetherington et al., 1982; Fauber et al., 1990; Fauber & Long, 1991; Lutzke et al.,1996; Tschann et al., 1989). A mediating role of the parent-child relationship may be most likely, as it is often the case that when the parent-child relationship is included in analyses, interparental conflict has only indirect effects on children by adversely affecting the parent-child relationship (Fauber et al.; Fauber & Long). Quality of parenting also has been found to have a greater impact on children's adjustment than interparental conflict (Lutzke et al.).

One study of particular relevance to the current research, due to the age of the sample used, was conducted with sixth grade students (mean age 11 years), and found that when considering interparental conflict and the parent-child relationship, family structure did not predict sixth graders' psychosocial functioning (Black, 1994). This study did not find a mediating relationship for this sample, instead finding that even when controlling for the parent-child relationship, interparental conflict significantly predicted children's rating of their psychosocial functioning. The lack of a mediating relationship may be explained by methodological issues. This sample appeared to be well-functioning and had low rates of interparental conflict which may have contributed to the non-significant mediation effect of the parent-child relationship. It may be that low levels of interparental conflict do not threaten the parent-child relationship.

Relationship Expectations, Family Structure, Parent-Child Relationships, and Interparental Conflict

In the current thesis, associations were examined between children's relationship expectations, family structure, interparental conflict and parenting qualities. Research conducted to date has generally investigated these factors in relation to children's internalising and externalising symptoms. Only two studies were found that included outcome variables that shared some conceptual overlap with relationship expectations. However, both of these studies focused on later adolescence/young adults rather than younger children.

The first of these two studies is a previously reviewed study conducted by Burns and Dunlop (2002). The primary outcome in this research was described as wariness about long term relationships, marriage and family life, which was assessed ten years later (ages 23 to 26 years). Overall, compared to those who grew up in intact families, those who experienced divorce as adolescents were more wary about relationships when in their mid-20s, regardless of the level of interparental conflict self-reported when they were adolescents. However, among participants who had not experienced divorce, greater involvements in their parents' conflicts when they were adolescents was associated with greater wariness about relationships when they were in their mid-20s.

In a second study of divorce, conflict and relationship expectations, participants were between the ages of 18 and 32 years (Riggio, 2004). Of these participants, 401 had grown up within intact families and 165 had experienced parental divorce when they were an average age of 9.4 years. It was anticipated and found that those from divorced families would experience lower anxiety in close relationships. The author suggested that this may be because they had less fear of having to terminate an unsuccessful relationship, due to witnessing their parents' divorce. In addition, the results showed that young adults from high conflict families compared to low conflict families had greater anxiety in personal relationships. The parent-child relationship, especially the relationship with the father, also covaried with relationship anxiety. For young adults from intact families and divorced

families, a positive relationship with their father was associated with less anxiety in personal relationships, whilst their relationship with their mother was not significantly associated with anxiety.

In summary, these two studies of older adolescents and emerging adults indicated that family structure, parent-child relationships and interparental conflict are interrelated. They also suggest that parent-child relationships and interparental conflict may mediate and/or moderate associations between family structure and relationship schemas in the form of expectations of social rejection or acceptance.

Summary and Study Aims

Although theoretical foundations exist, and there are multiple studies of relationship expectations that have included university students or adults, the potential for research with children has been limited by a lack of instruments designed to measure a range of both positive and negative relationship expectations. Whether in studies of adults or in the few studies of children, research on relationship expectations has primarily focused on negative expectations with little examination of whether a low level of negative expectations is a good indicator of positive expectations or whether negative and positive expectations should be assessed separately and considered as different, but related constructs. One aim of the current studies was to develop measures of negative (rejection, pessimism) and positive (acceptance, optimism) relationship expectations of children. Based on the optimism and pessimism literature within personality theory (Scheier & Carver, 1985), the current research contributes to our understanding about whether optimistic views and pessimistic views are two empirically separable constructs or a single bipolar construct. After the measure of children's optimistic and pessimistic expectations of relationships (COPER) was developed and validated, it was used to determine whether children's relationship expectations were associated with their experiences within the family. Associations between relationship expectations, family structure, interparental conflict and multiple dimensions of parenting qualities were investigated.

Three studies were conducted with children between the ages of 9 and 12 years. Study 1 consisted of two phases and focused on measurement development. The new measure tapped optimistic and pessimistic relationship expectations, and the measure was expected to have two subscales with one reflecting optimistic and the other reflecting pessimistic relationship expectations. Phase 1 of Study 1 focused on generating items based on interviews with children. In Phase 2 of Study 1, a large pilot study was conducted to test all items and the measure was finalised for Study 2.

The objective of Study 2 was to validate the new measure using a range of constructs to determine convergent and discriminate validity. A moderate correlation between subscale scores for optimistic and pessimistic views was expected. In addition, scores on each subscale were expected to show differential associations with a range of other scales.

In the third and final study, a large community sample of children participated. Children completed questionnaires that gathered information on their demographics, and included questions pertaining to family structure, interparental conflict, parenting qualities, and the new measure of optimistic and pessimistic relationship expectations. The purpose of this study was to compare the relationship expectations of children from intact and divorced families and determine whether this difference and relationship expectations were better explained by considering interparental conflict and parenting.

6.12 New wave theories, mindfulness overview

Mindfulness-integrated Cognitive Behavioural Therapy's name changed from Mindfulness-based Cognitive Behaviour Therapy (MCBT) and Mindfulness-based Cognitive Therapy recently due to the confusion between the two different acronyms and the fact that therapists found the use of these acronyms interchangeably (Mindful Works, 2008). So, for the purpose of this paper, the acronym MiCBT will be used for all mindfulness therapies used within a cognitive behavior therapy approach framework.

Mindfulness therapies appear to have commenced with Kabat-Zinn's work of Mindfulness-based Stress Reduction (MBSR), (Lau & McMain, 2005). It was William James who suggested that in the 20th Century Buddism and Eastern traditions would become a large influence on Western psychology (Lau & McMain, 2005). As far as Lau and McMain (2005) believe, the musings of James have been realised, in relation to the cognitive behavioural therapies, that Eastern philosophies have been readily accepted with the integration of mindfulness techniques across the therapeutic divide.

Mindful Works (2008) describes mindfulness training as "generalised metacognitive and interoceptive exposure and response prevention" (Mindful Works website). In other words, mindfulness looks at the small, subtle sensations of learnt experiences, especially relating to automatic thoughts, and endeavours to develop awareness and acceptance of thoughts as they are, instead of as truth.

6.13 Somatic psychotherapy

Although situated in the broad family of psychotherapeutic treatments, *Somatic Psychotherapy* is a unique discipline. *Soma* is a Greek word meaning "the living body" therefore Somatic Psychotherapy adds a significant dimension to verbal psychotherapy by including bodily experience as correlative, causative and caused by psychological experience. It is grounded in the belief that not only are thought, emotion and bodily experience inextricably linked (creating a *bodymind*), but also that change can be brought about in one domain of experience by mindfully accessing another.

Like other contemporary psychotherapies, emphasis is placed on the uniqueness of the individual, and the qualities present in the particular therapeutic relationship formed by each therapist-client dyad. The work of somatics is guided by several philosophies and more recently by research in Infant Development, Neurobiology, and Attachment theories. All of which converge in several areas, most notably in their agreement that:

- Mind and Body are not separate entities but mutually influencing aspects of the overall organism, and
- there is an innate capacity of the human '*bodymind*' to move towards healing and growth given the appropriate therapeutic environment.
- That interpersonal interaction in the form of respectful, safe and appropriate relationships positively and directly influence and mediate/regulate the '*bodymind'*.

Retrieved from http://somaticpsychotherapy.asn.au/about-us/what-is-somatic-psychotherapy/

6.13 Trauma informed care

The Five Guiding Principles are; safety, **choice**, collaboration, trustworthiness and **empowerment**. Ensuring that the physical and emotional safety of an individual is addressed is the first important step to providing Trauma-Informed Care. Retrieved from http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

6.14 Future-focused care

Future-focused care needs to incorporate the somatic, the trauma-informed, and consider the latest in mindfulness practice, which includes a multitude of studies regarding how the brain can be re-wired through meditation. It is essential that we consider technology in future-focused care. Ethics and accountability are also essential to be thought through if we are to be really considering where humanity is going. Old paradigms will not work in the future, if we are to take on technology and future inventions in the way that we have in the past.

So, it is our proposal – within the Collective Conscious group – that we need more integrative practitioners, that combine the holistic elements of health – which could include, diet, psychology, health, affects of trauma and the knowledge that trauma is stored in the body (as is suggested by Van der Kolk).

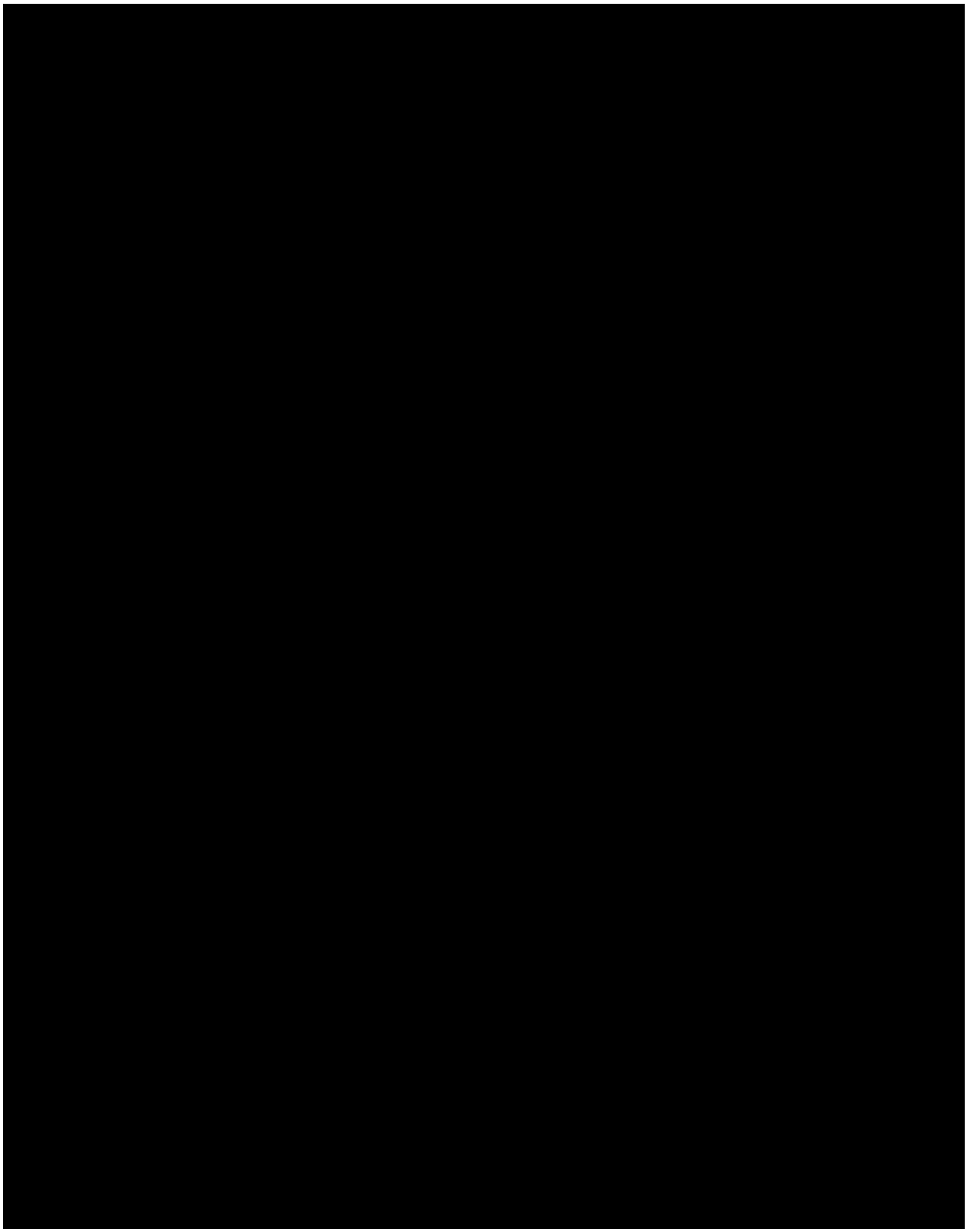
7. Ethics

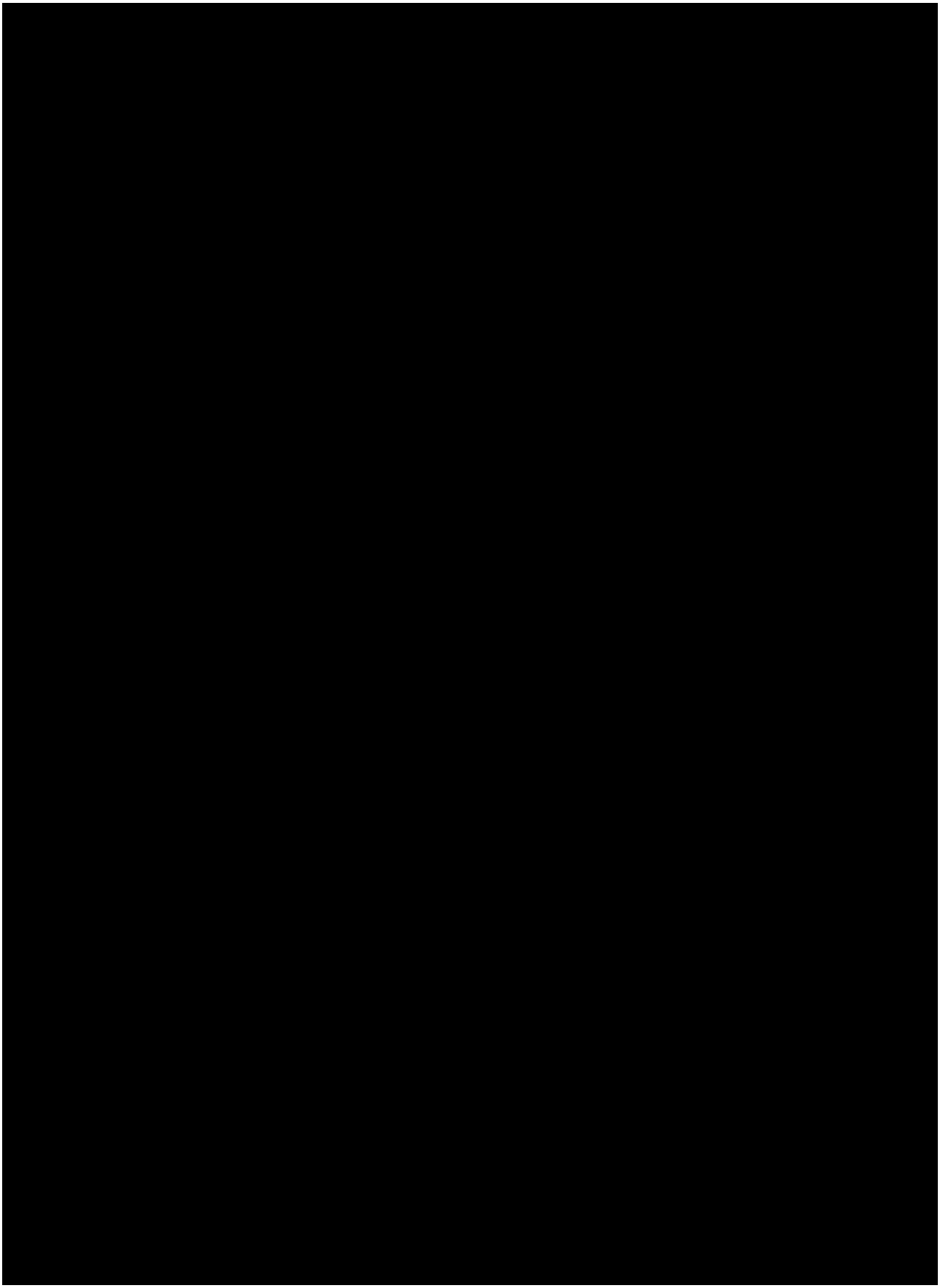
The current system of Medicare Benefits and the subsequent rebates is not working. Suicide rates are up and clinicians are burnt out in the field.

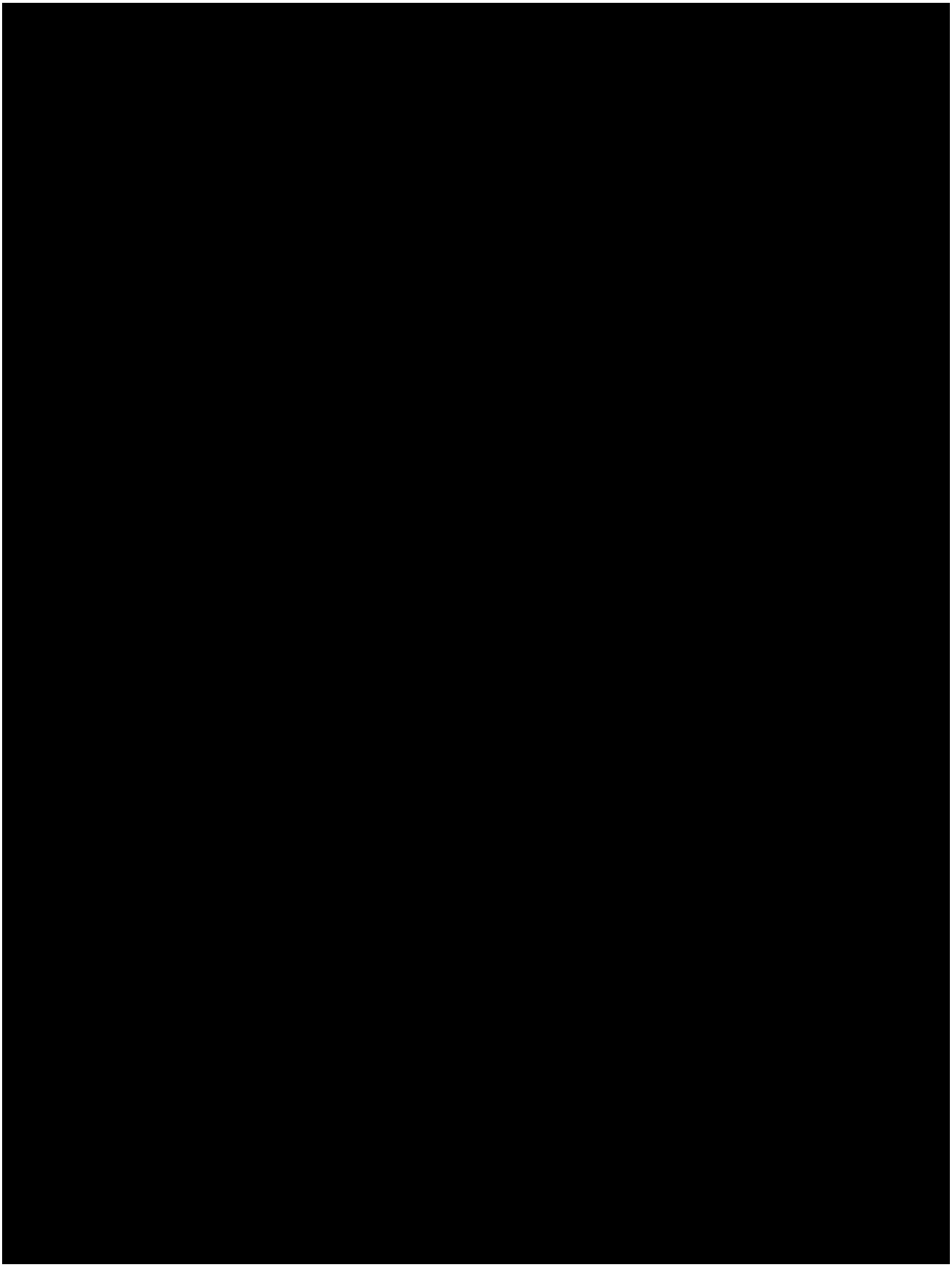
Ethically, it's a problematic minefield where there are 'the haves' and 'the have nots' in the mental health clinician field. On the ground, elitism has proliferated the helping professions and broader mental health field. It has been unfortunate, though an ensuing arrogance now comes along with the position and title of Clinical Psychologist. It greatly disempowers the rest of the profession if there is only one particular group with a direct line of communication with the government – and all other clinicians in the field have been shut out of such discussions.

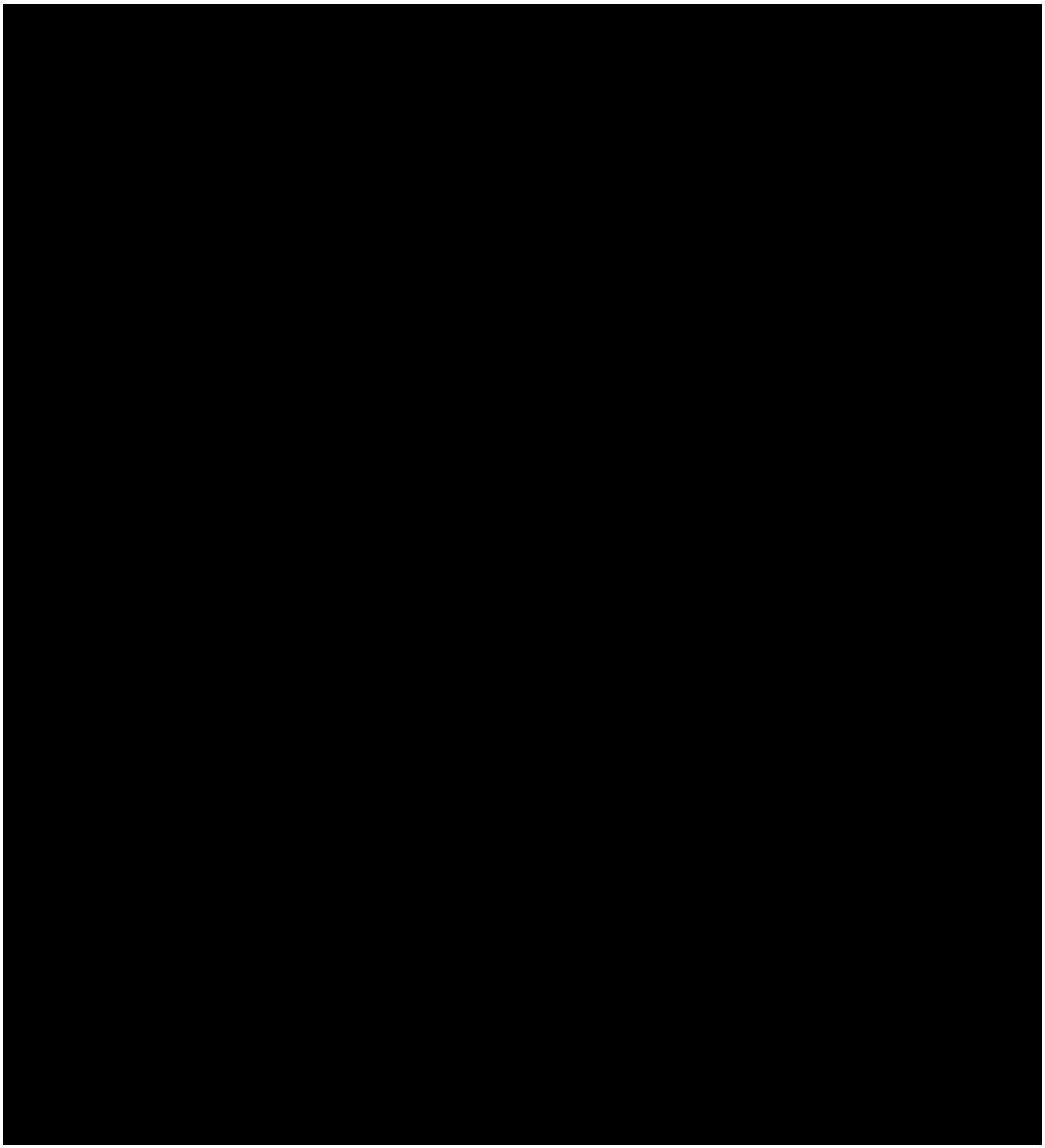
This is problematic ethically and professionally. For example – there are anecdotal examples of psychologists in the field claiming for couples and relationship therapy, when they are not trained in such therapeutic process. Relational approaches are often left off of the psychology courses. The focus on evidence-based practice has meant that the client is being forgotten about in the general and overall outcomes of mental health practice.

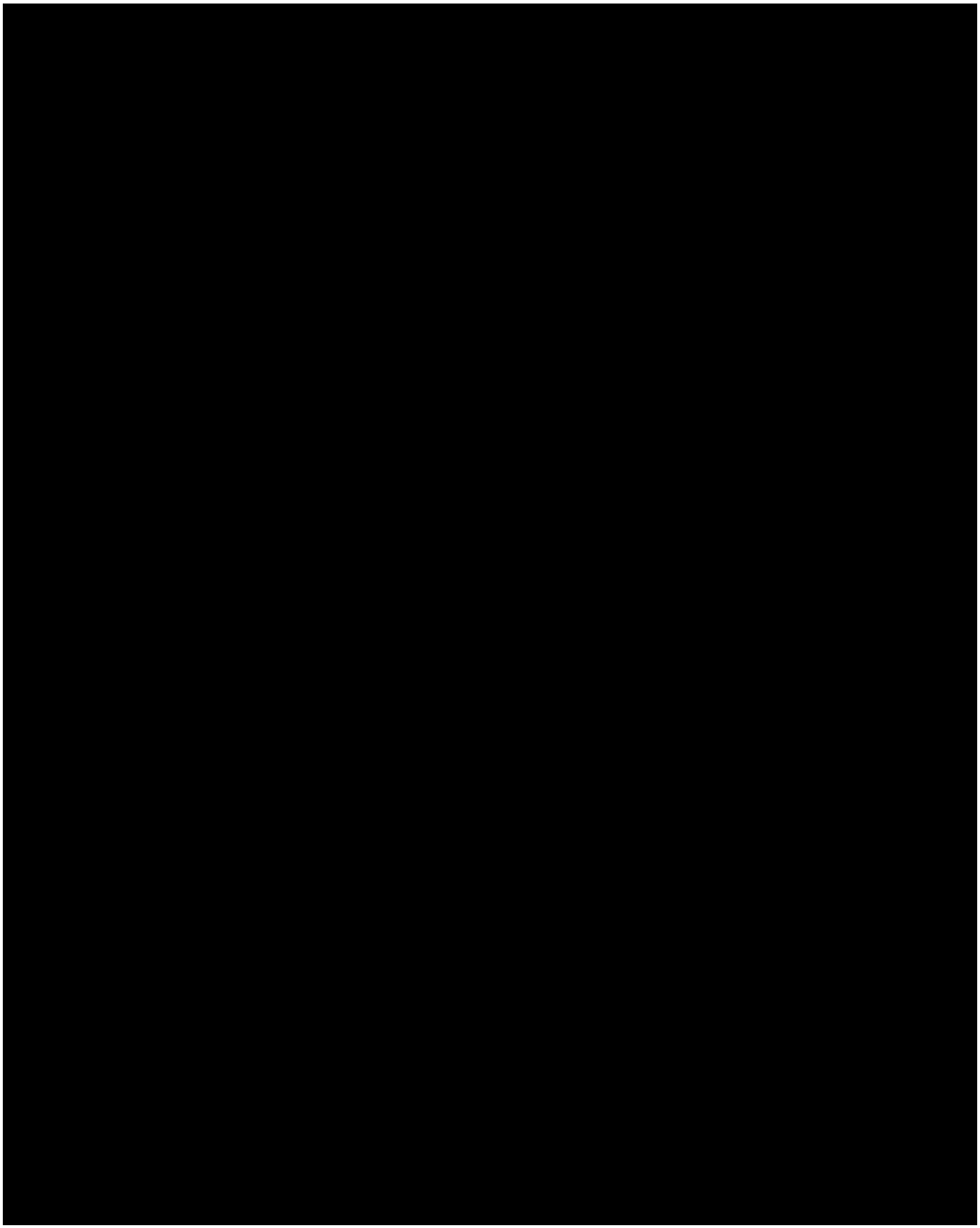
Please see below for examples of the fractured nature of our field.

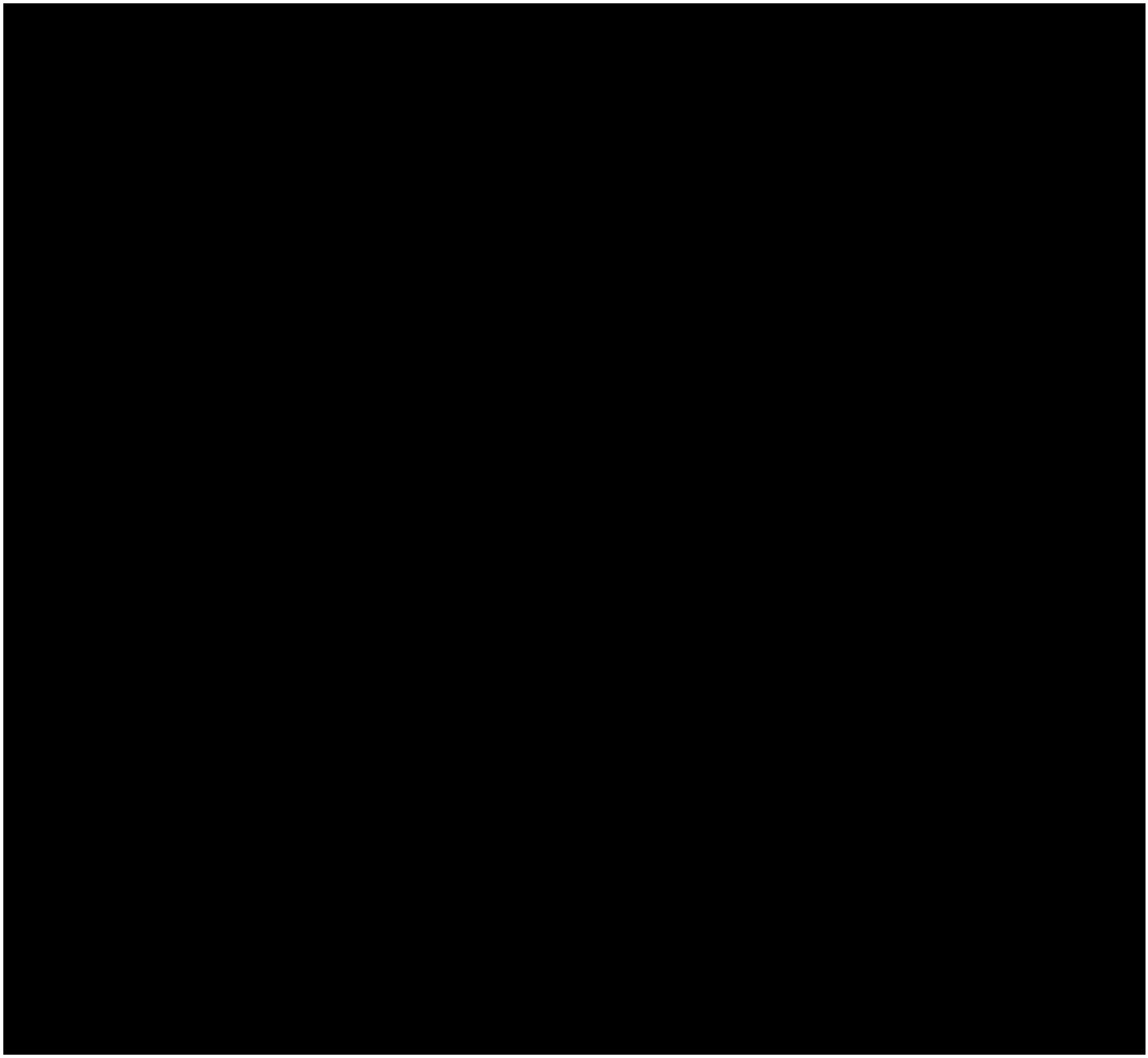


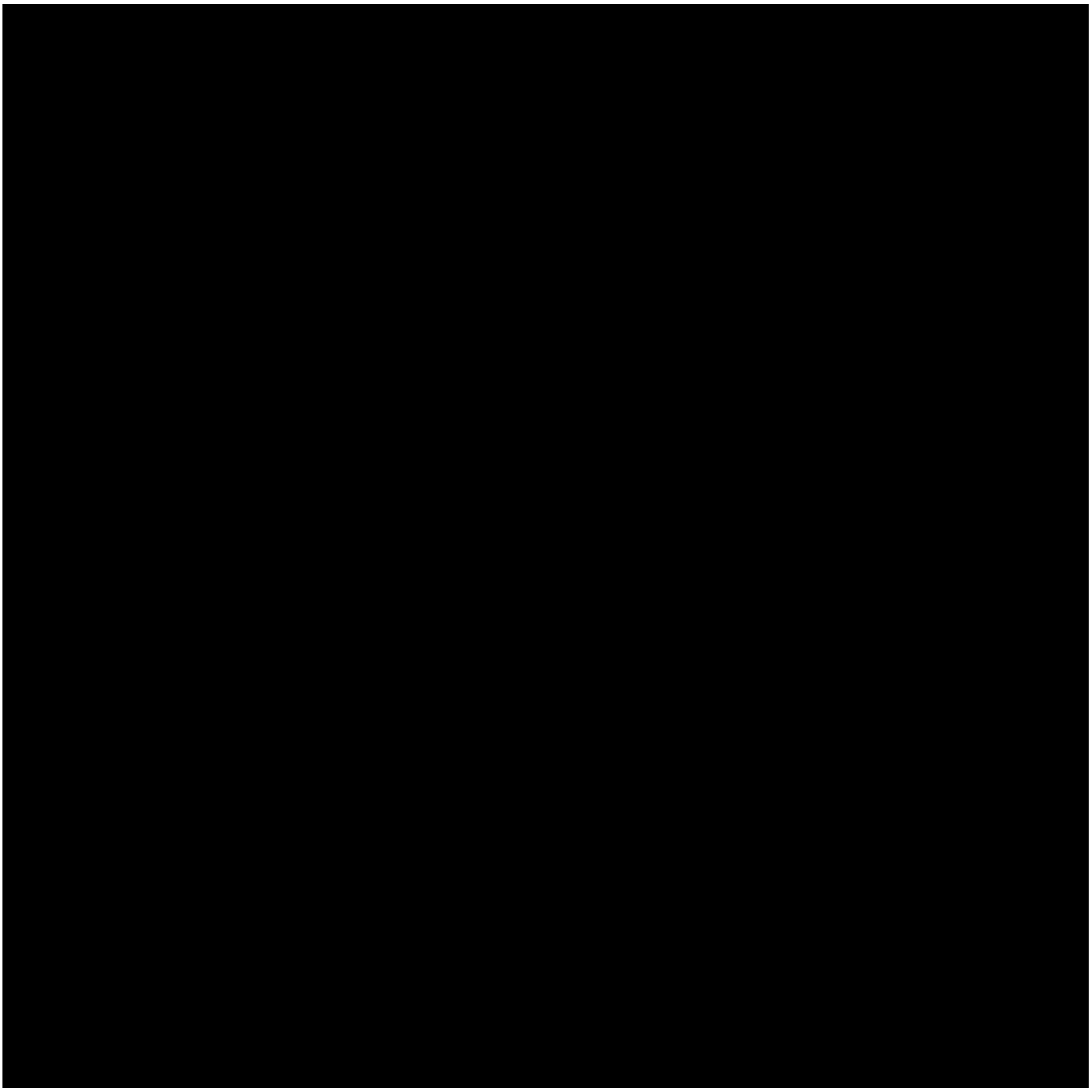


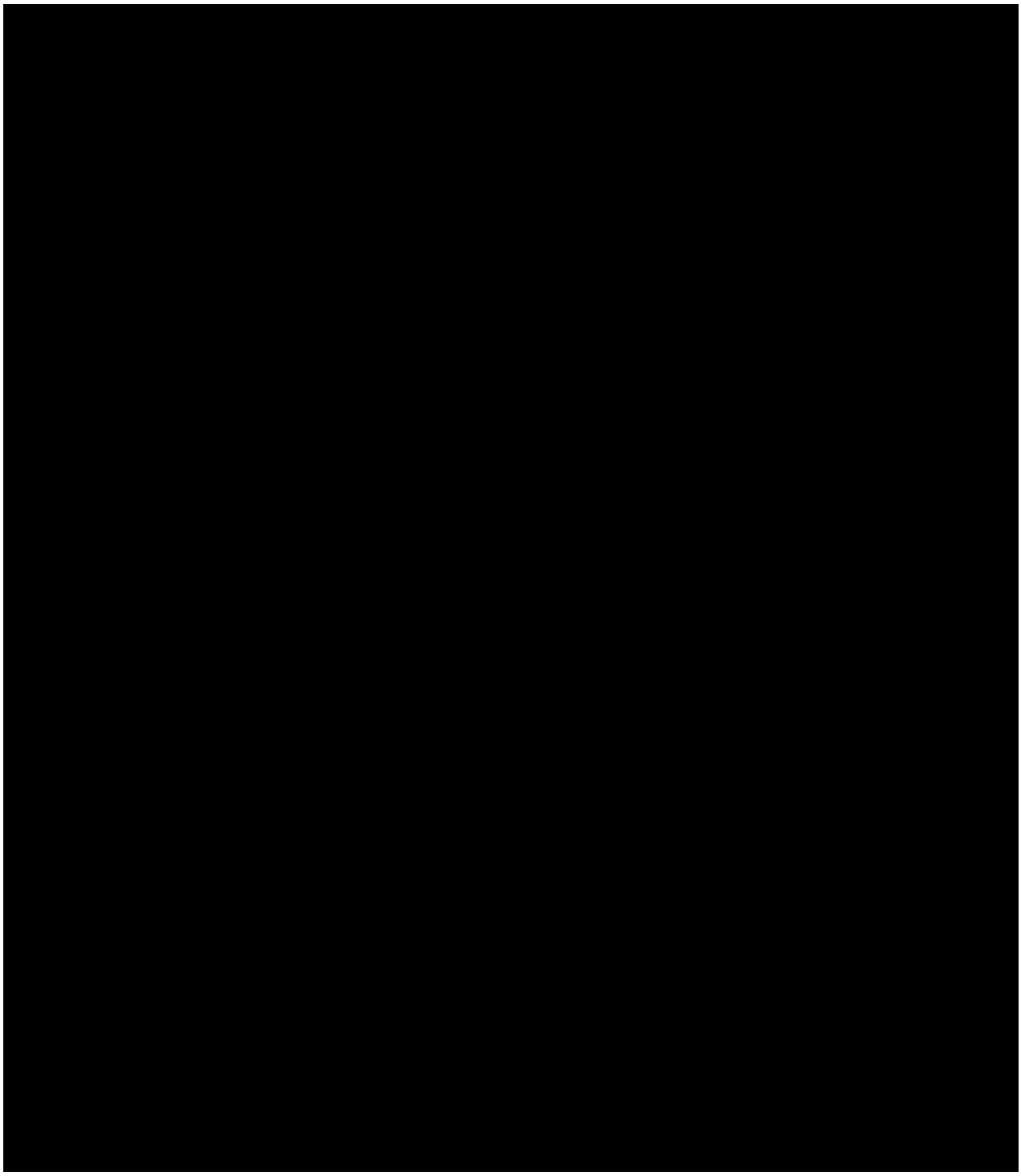


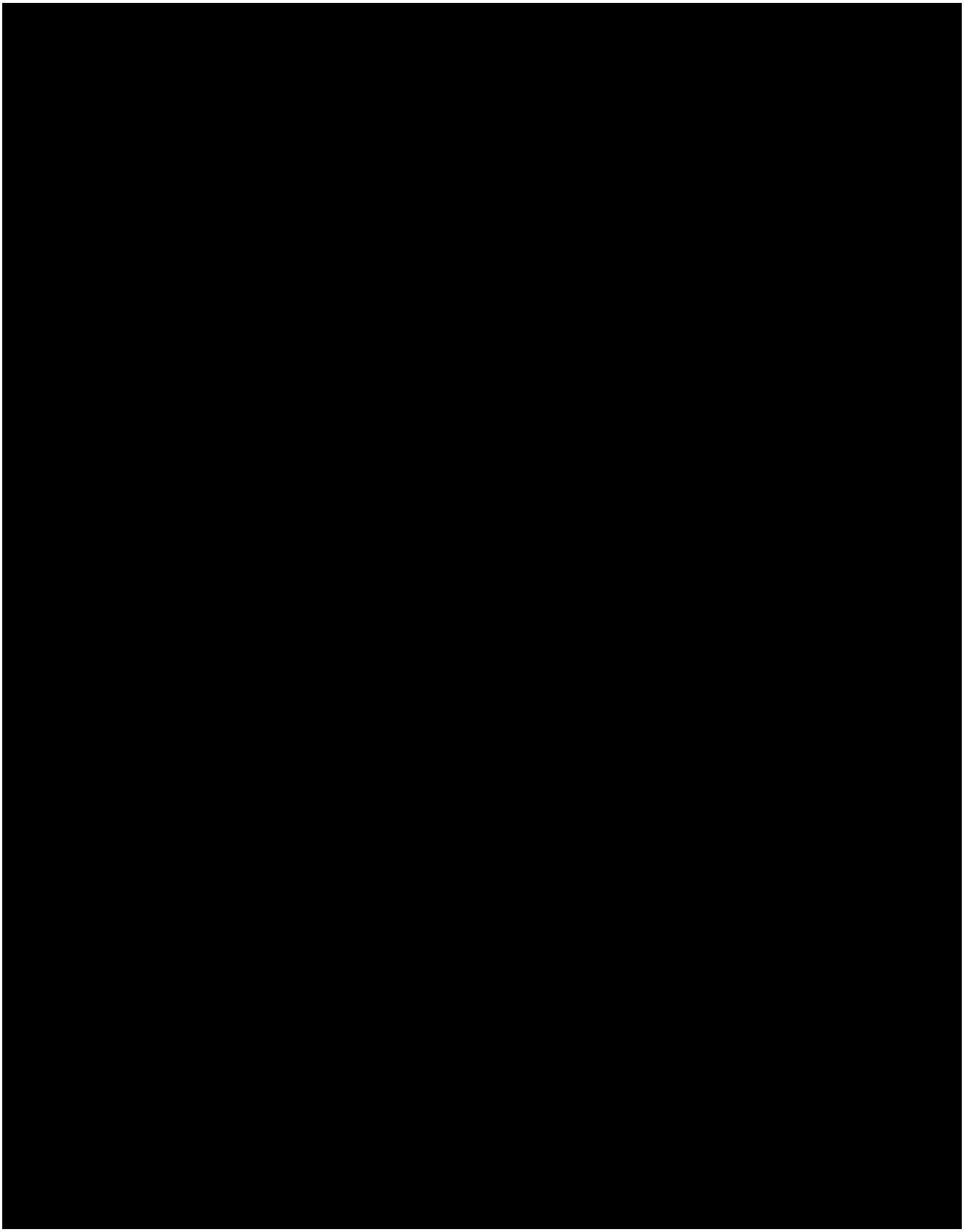


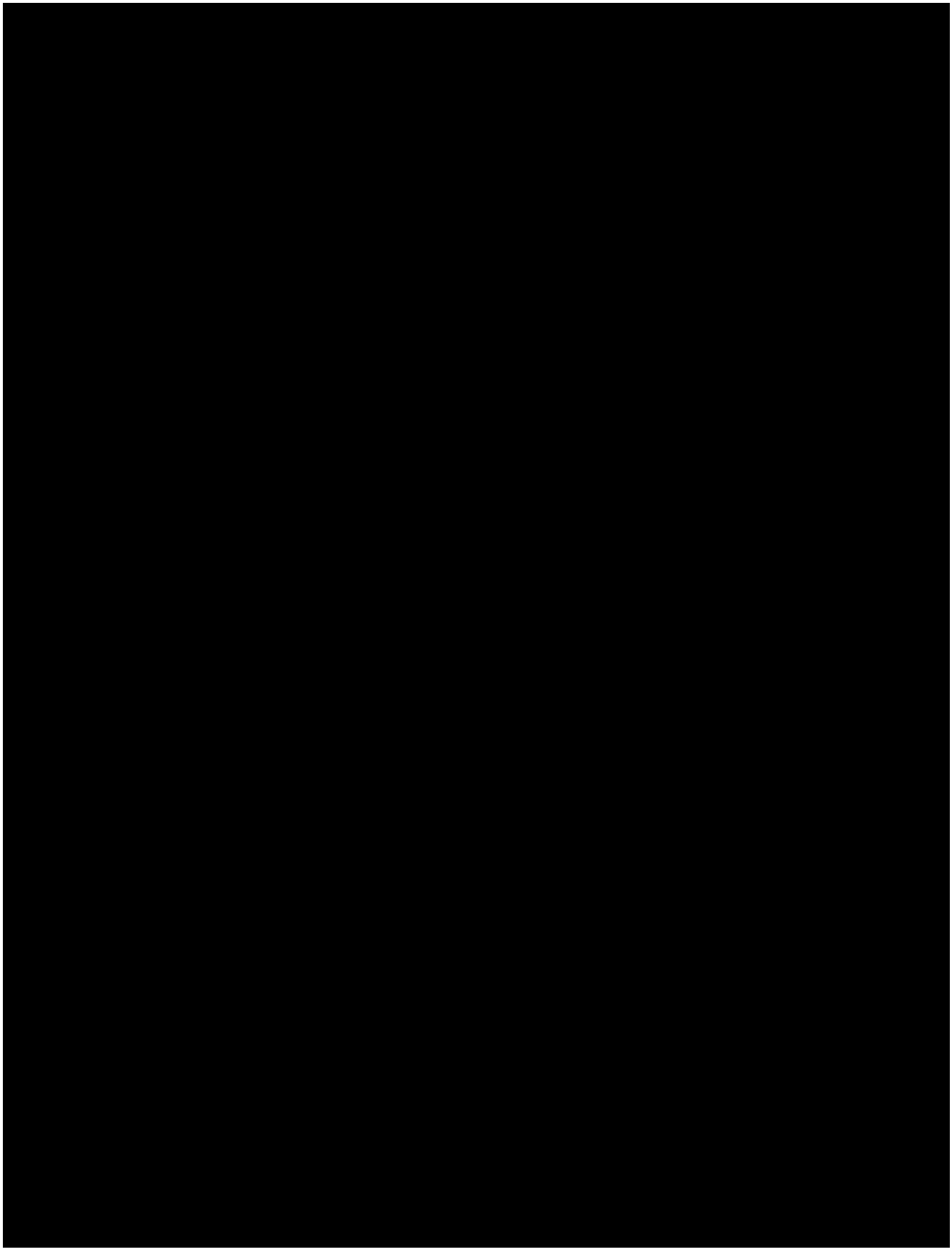


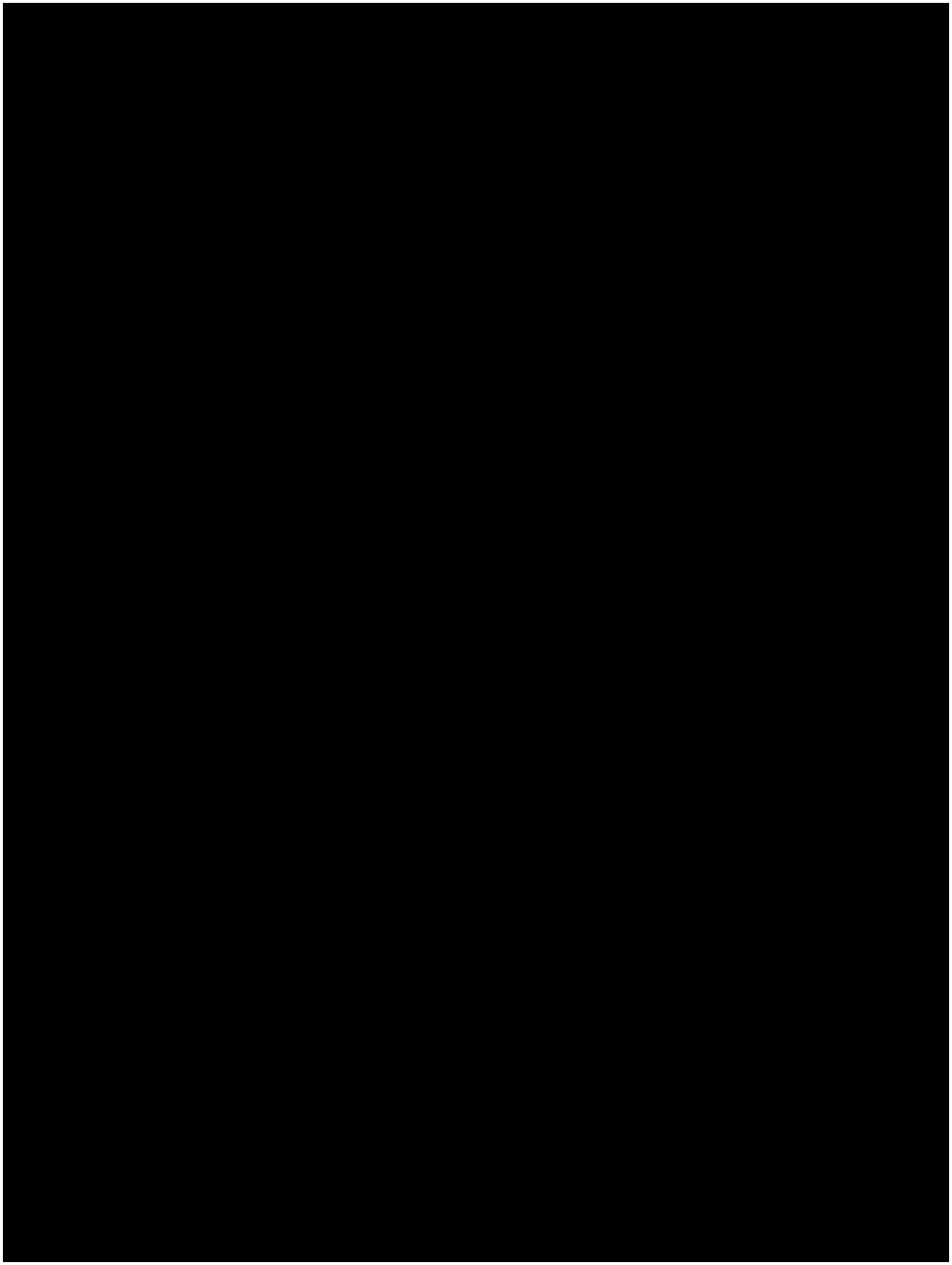


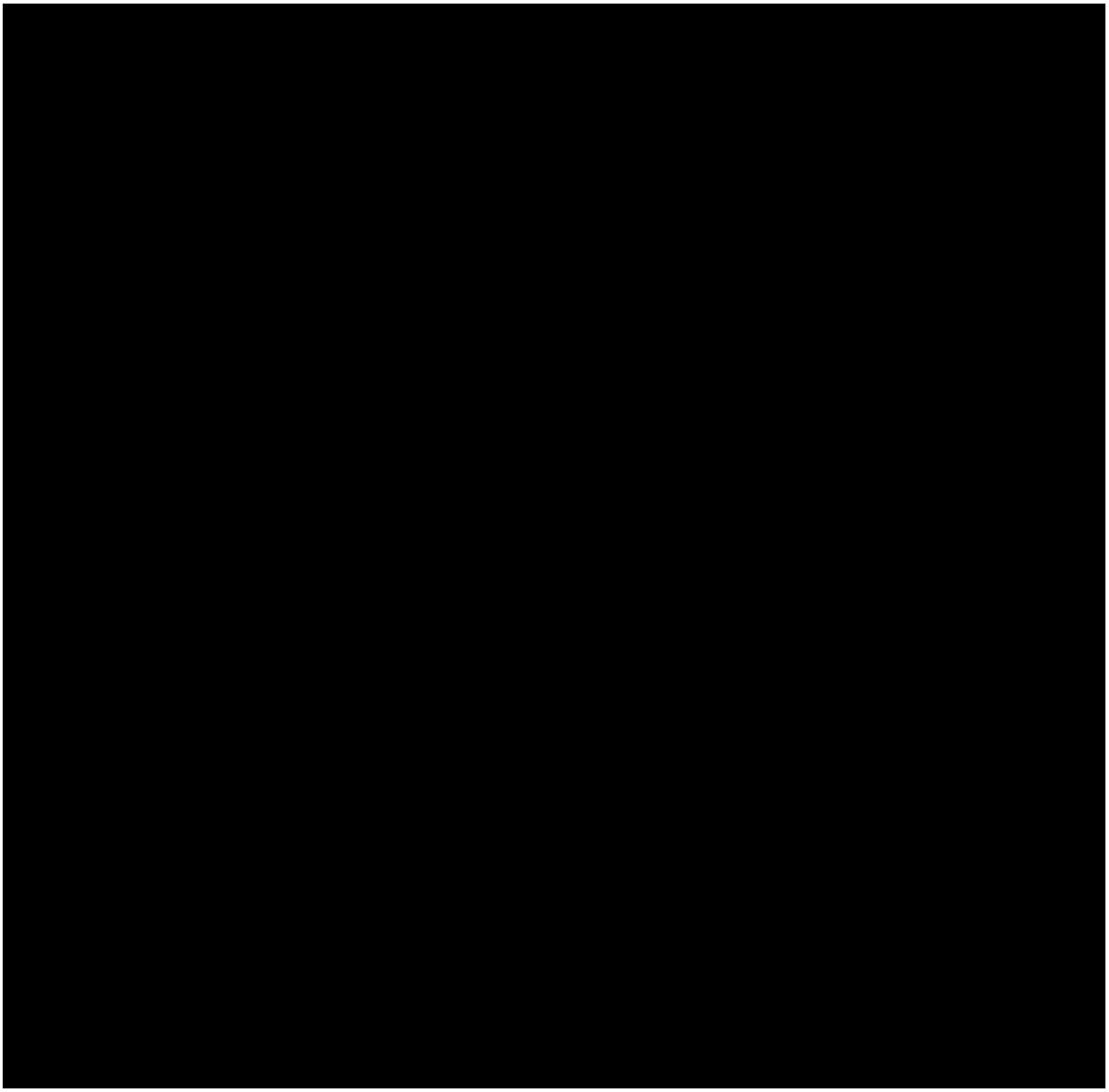












8. The Start

Where to start.... at the beginning....this all started as a result of the MBS Review.

Recently, one of our members, in the last 4-6 weeks, has researched and put together "the pink paper" for the MBS Review.

Whilst that was finished, we weren’t satisfied.

So here we are....

Today, we read the APS "white paper". Some things we agree with, some things are great. Others are not so good and continue to contribute to the segregation within our already fractured profession.

The APS have been held accountable by a grassroots group who do not have a "clinical" area of practice endorsement (AoPE). This group does not form part of an organisation or society. They/we came together through social media because we were angry with the state of the profession. Since the inception of Better Access, the profession has been turned upside down and not in a good way. Working within the field of mental health is not easy.

As a community of like-minded individuals we expect egalitarianism. Not only do we expect it, we are outraged when our collective righteousness is threatened. Hence the current state of the profession. We are outraged by the current political climate. It feels like a David vs Goliath battle. And effectively -- it is....

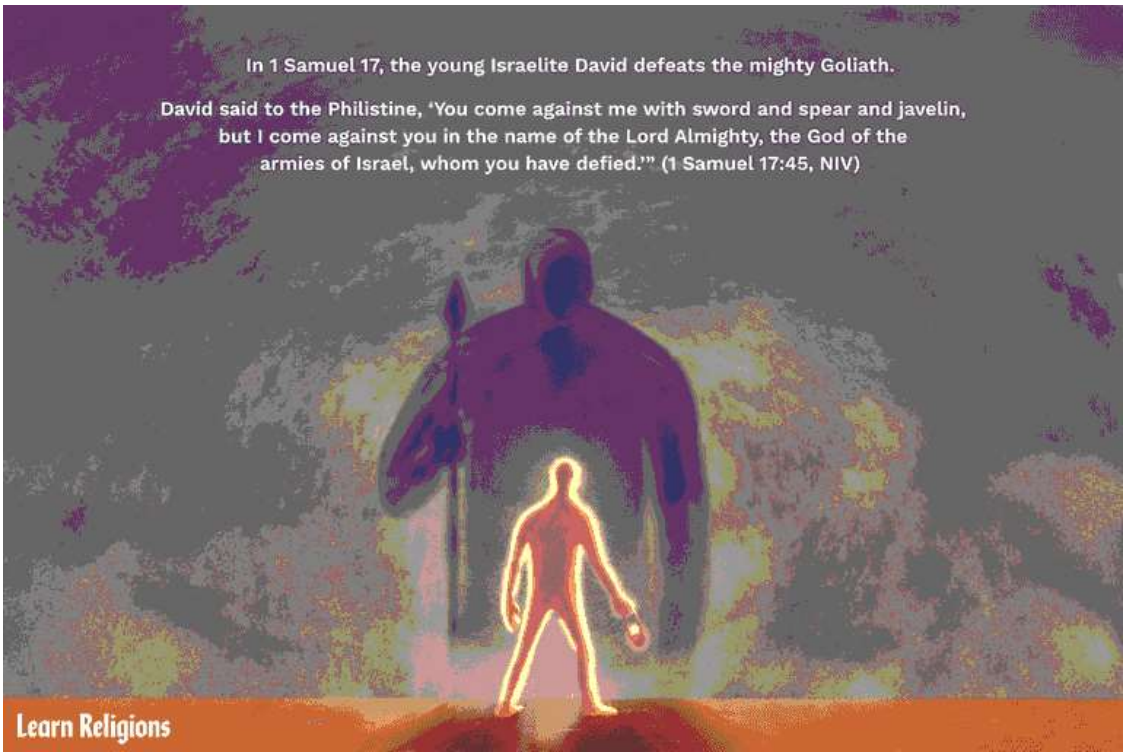


Figure 1. Learn to face your giants with the story of David and Goliath
https://www.learnreligions.com/david-and-goliath-700211

We have found our collective voice and we will not go down without a fight.

9. Tying it all together

Essentially, what we have just delivered is a condensed version of a second -year psychology course and incorporated some of the new and emerging fields. Beyond this paper, we need to incorporate more holistic ways of working across the professions and ensure that we are inclusive of all practitioners out in the field – which in turn includes all clientele and patients seeking treatment. A way forward could be something similar to the New Zealand wellbeing measures. It's essential not to just look through one lens in answer to the mental health crisis – and instead ask all of the professions that work in mental health to work together towards a

new future for the Australian people. We need to consider the mind, body and spirit when it comes to the future of mental health in our country. There are a great many professionals and professions beyond the standard psychological approach that could work together towards the collective goal of better wellbeing and a more positive future and hopeful future for the Australian public.

10. The future – where we are all heading.… whether we like it or not…

The future, whether we like it or not – will include technology. Though, we need to consider the broader health and wellbeing at the same time as this. New and emerging technology is coming, and some of the Collective Conscious members are aware of massive and sweeping changes that will be happening, whether the Australian public would like them or not – and these changes could disrupt society. Ethics, accountability and responsibility need to be included in the measures of using technology – as privacy, security and encryption need to be considered, for the client and patient wellbeing and safety.

The Collective Conscious is here to assist clinicians and government pave a new way forward in order to hold compassion and empathy at the forefront in order to have the best outcome for humanity, whilst using the latest research and not old, antiquated methods of old-school psychology.

It is our firm belief, based on the latest research, that the old ways of CBT are not applicable in our current environment of human change – and therefore, we need to use the latest new methods of technology, practice and human services – in order to help broader society adapt to the changes coming. If elitism is allowed to continue, by way of the Clinical Psychologists receiving the rebates, and other clinicians not, then we risk further societal issues – as Collective Conscious members predict the further breakdown of mental health of our society if the [redacted] is allowed to continue unmonitored.

We, at the Collective Conscious movement, call for government to include professional counsellors, psychotherapists, life coaches, psychologists, social workers and all others working in the broad section of wellness, wellbeing and mental health – in order to work towards preventative aims for our collective communities.

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THE COLLECTIVE CONSCIOUS

This paper was prepared in response to the publication of the APS White Paper. The authors are anonymous and not aligned with any association.

This paper has been produced to highlight the segregation within the mental health field. Psychologists without an Area of Professional Endorsement are being segregated and left out of important conversations.

WHY?

The Collective conscious has come together and we will not go away!

An Evidenced-Based Report on the Division within the Psychology Profession: The Pink Paper 2019

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Executive Summary

The current report is an evidenced-based report on the division within the psychology profession. The report is also contributing to the discussion raised in point 4 of the Mental Health Reference Group's recommendation for the Medicare Benefits Schedule Review Taskforce. The recommendation was to "Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups."

The focus of this report is to propose three models to be reviewed in relation to Better Access sessions delivered by registered psychologists and clinical psychologists. The three proposed models are:

1. Proposed Model 1 is a one-tier model where there is one Medicare rebate for ALL psychological services offered by registered psychologists regardless of endorsements. It is recommended that the Medicare rebate is increased to an amount of $150 for all psychologists and that Mental Health Care Plan sessions increase from 10 sessions to 20 sessions plus an additional 10 sessions able to be accessed.
2. Proposed Model 2 recommends that the Medicare rebate for ALL psychologists follows the same model as the psychiatric Medicare rebate. As with the psychiatric model, a general practitioner referral is required once a year. The amount of consultations ranges from 50 a year to unlimited per year.
3. Proposed Model 3 suggests that psychological service delivery align with the Australian Government's stepped care model of mental health according to the consumers' level of need (mild, moderate or severe), through increased sessions (up to 40) and intensity of services. These psychological services can be delivered by ALL registered psychologists and the Medicare rebate be increased to an amount of $150.

The current report recommends Proposed Model 2. Working collaboratively with psychiatrists is imperative. It is often the case that a psychiatrist may review a patient every couple of months, with the view that the psychologist will see the patient more regularly. This is thought to promote better service of care. To enable this to happen, psychologists needs unlimited sessions a year, with a referral from a GP once a year. This is in the consumers' best interest for good holistic care.

Further, it is recommended that the Medicare rebate for psychology should be ONE-TIER as are all other allied health professions. Ultimately, the general public is disadvantaged by a two-tiered system. In an industry intended to protect mental health, the division via a tiered Medicare rebate system between registered psychologists, has created discrimination against a vast sector of

registered psychologists. This is not ideal for the mental health of the practitioners promoting mental health in others. There is **no scientific nor anecdotal evidence of differences in treatment outcomes between clinical psychologists and non-endorsed psychologists.** Nonetheless, since the inception of Medicare's Better Access initiative in 2006 there have been different rebates used. This is quite ironic given that psychology is taught as an evidence-based science.

Further, to propose a model where only clinical psychologists can see 'severe' consumers would require a solid rationale as the impacts on public health are predicted to be negative. It would lead to burnout for the clinical psychologist and would mean that the consumer cannot see the clinician of their choice. It would ultimately lead to a break in continuity of care as a consumer moves between the levels of care, in that 'severe' consumers could see a clinical psychologist only. It would also lead to the removal of customer choice as the consumer would no longer be able to choose a psychologist who they felt was a good fit for them. This is an inadvisable approach, and predictive of decreasing mental health, increasing anxiety, and reducing customer uptake of psychological services versus improving the mental health of consumers.

To summarise, one of the key issues raised in the current report is the removal of different rebates for consumers to see a psychologist. It is recommended that ALL psychologists have the same Medicare rebate. The Medicare rebate should also be unfrozen and increased accordingly. The final issue is an increase in the number of sessions a consumer can access with any psychologist. It is recommended that ALL consumers have unlimited sessions per year with ALL psychologists, just as they can with psychiatrists.

This report will discuss the evidence in relation to these issues.

Preamble

Firstly, the authors of this report would like to acknowledge the Australian Psychologist Facebook Group (APFG) which has over 2,700 members. This report would not be possible without their passion for psychology as a profession.

We shouldn't have to fight for equality but we have unfortunately found ourselves in this position.

A number of sources and documents were reviewed in this paper. These include:

- 223 submissions to the Australian Productivity Commission (APC) which were published on their website as at 12 April 2019.
- Submission files and discussions from APFG.
- The Australian Psychological Society (APS) Member Consultation Paper: The delivery of psychological services under Medicare's Better Access Initiative.
- Australian Government: Department of Health and Aging: Better Access to Mental Health Care.
- MBS Review Mental Health Reference Group Report.
- MBS Review Allied Health Reference Group Report.
- Australian Government Department of Health Medicare Benefits Schedule Book Category 8, Operating from 1 May 2019.
- Evidence-based peer reviewed journal articles (see references/bibliography)
- 2009 Submission for psychological consultation – Paper 1 – Psychology-Private-Australia-Inc. (PPAi)

The use of the terms 'patient', 'client' and 'consumer' are used interchangeably throughout this report. The word 'patient' tends to reflect Government literature related to Medicare. The term 'client' has been used to reflect the increasing use of this term in treatment paradigms and facilities to engender a sense of empowerment in the people who seek out psychology services. Finally, the term 'consumer' is used to reflect the reciprocal nature of the relationship between those who use the services and those who provide the services. This term was coined to empower the individuals using mental health services, highlighting that they have a *choice* in their treatment, for without the consumer, mental health services could not exist.

We would also like to acknowledge the brave and wonderful stories that make up some of the Appendices. For these stories, we are eternally grateful.

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[redacted]

1. Overview of Mental Health in Australia

The Productivity Commission's Mental Health Issues Paper has a succinct, but telling overview of mental health in Australia. This report quotes the following:

> "In 2014-15, four million Australians reported having experienced a common mental disorder. Mental health is a key driver of economic participation and productivity in Australia, and hence has the potential to impact incomes and living standards and social engagement and connectedness. Improved population mental health could also help to reduce costs to the economy over the long term. Australian Governments devote significant resources to promoting the best possible mental health and wellbeing outcomes. This includes the delivery of acute, recovery and rehabilitation health services, trauma informed care, preventative and early intervention programs, funding non-Government organisations and privately delivered services, and providing income support, education, employment, housing and justice. It is important that policy settings are sustainable, efficient and effective in achieving their goals. Employers, not-for-profit organisations and carers also play key roles in the mental health of Australians. Many businesses are developing initiatives to support and maintain positive mental health outcomes for their employees as well as helping employees with mental ill-health continue to participate in, or return to, work." (p. iii).

> "Many Australians experience difficulties with their mental health. Mental illness is the single largest contributor to years lived in ill-health and is the third largest contributor (after cancer and cardiovascular conditions) to a reduction in the total years of healthy life for Australians (AIHW, 2016). Almost half of all Australian adults have met the diagnostic criteria for an anxiety, mood or substance use disorder at some point in their lives, and around 20% will meet the criteria in a given year (ABS, 2008). This is similar to the average experience of developed countries (OECD, 2012; 2014). Despite a plethora of past reviews and inquiries into mental health in Australia, and positive reforms in services and their delivery, many people are still not getting the support they need to maintain good mental health or recover from episodes of mental ill-health.

Mental health in Australia is characterised by:

- More than 3,100 deaths from suicide in 2017, an average of almost 9 deaths per day, and a suicide rate for Indigenous Australians that is much higher than for other Australians (ABS, 2018)
- For those living with a mental illness, lower average life expectancy than the general population with significant comorbidity issues — most early deaths of psychiatric patients are due to physical health conditions
- Gaps in services and supports for particular demographic groups, such as youth, elderly people in aged care facilities, Indigenous Australians, individuals from culturally diverse backgrounds, and carers of people with a mental illness
- A lack of continuity in care across services and for those with episodic conditions who may need services and supports on an irregular or non-continuous basis
- A variety of programs and supports that have been successfully trialled or undertaken for small populations but have been discontinued or proved difficult to scale up for broader benefits
- Significant stigma and discrimination around mental ill-health, particularly compared with physical illness." (p.1)

The two excerpts above outline some ways mental health significantly impacts individuals, their families, the workforce, the economy, and communities as a whole. Mental health difficulties do not discriminate who is affected, but sadly Indigenous Australians are disproportionately affected by suicide. Most Australians will experience mental health issues at some point in their lives, yet many do not get the support they need. Despite mental health being one of the primary reasons people spend significant periods unwell, and is considered one of the top causes of shortened lifespan, the financial resources are not sufficient for the need. Many programs become discontinued or are limited and not sufficient for the complexity of a person's presentation, e.g. Post-Traumatic Stress Disorder (PTSD). Whilst the stigma of mental health issues is still present for many, there have been positive strides forward in today's society such as increased awareness of mental health issues.

This excerpt is only a small glimpse into some of the primary concerns with regards to mental health and an individual's wellbeing. Continuing to encourage individuals' autonomy and increasing the supports and referral pathways available can go a long way to supporting their mental health and wellbeing, and lower the economic toll mental health issues have in Australia.

2. Summary of Literature on the Effectiveness of Therapists

When Medicare developed Better Access in 2006, it was designed to increase access for consumers to receive care for mental health illness, and to improve treatment outcomes. It appears that it has been successful in achieving positive outcomes, and making care more available to some disadvantaged groups, and for new consumers (Pirkis, Harris, Hall & Ftanou, 2011). In Better Access, a two-tiered system differentiating between clinically and generally registered psychologists was created. Practically, this means clients receive different rebates for their choice of psychologist depending on an endorsement, or lack thereof. A logical conclusion, therefore, might be a different rebate means different therapist expertise. Yet, there is an abundance of literature supporting the *nonexistence* of differences between the efficacy of clinical versus generalist psychologists in their treatment outcomes. Pirkis and colleagues (2011) conducted an extensive evaluation of this very question and found that most people were accessing general psychologists through Better Access and that there appeared to be equally good outcomes for consumers.

Pirkis et al. (2011) also examined the economic cost of Better Access and determined it was a good investment for the Government. Jorm (2011) conducted a post-hoc effect size comparison of Pirkis' work and determined from the data available "that general psychologists produce equivalent outcomes to clinical psychologists and perhaps better average outcomes than general practitioners (GPs)". Jones (2018) also reviewed the evaluation by Pirkis regarding the two tiers in Medicare's Better Access and concluded that when groups were compared: GPs, general psychologists and clinical psychologists all produced symptom reduction at the end of their treatment; however, psychologists **combined** did significantly better than GPs, and there were **no statistical differences** between general and clinical psychologists.

As there is **no** research data indicating differences in treatment outcomes for different psychologist groups, how can one examine who should treat 'moderate to severe presentations' and, addition, why might psychologists' rebate entitlements be different? Hill, Spiegel, Hoffman, Kivlighan, & Gelso (2017) proposed several ways to identify 'expertise' in practitioners and suggested the components at play might include: *performance*, (e.g., therapeutic alliance, using appropriate interventions, multicultural competence, etc.); *cognitive functioning; client outcomes*, (e.g., client engagement, dropout rates, clinically significant change using measures of symptomatology, interpersonal functioning, quality of life/well-being, self-awareness/understanding/acceptance, satisfaction with work); *behavioural assessments* (e.g., fewer missed days of work, fewer doctor visits); *experience* (e.g., years of experience, number and variety of client, amount of training and supervision, qualities

of the therapist, credentials); *reputation*; and lastly, *therapist self-assessment*. Interestingly, many consider a psychologist to have 'expertise' just by their title, e.g., 'Clinical Psychologist', and this fails to incorporate the many variables contributing to best practice, best client outcomes, and improved use of economic resources.

In one particular study, researchers compared first year postgraduate clinical psychology students with provisional psychologists undergoing their first year of supervised practice in order to assess whether graduate programs in clinical psychology made any difference to the abilities of practitioners (O'Donovan, Bain & Dyck, 2005) Whilst the researchers noted modest differences in some areas, (which might be argued reflected recency effects and the testing of specific knowledge attainment and retention), they concluded that "Clinical training increases clinical knowledge, but not clinical practice skills, in some, but not all trainees [students]" (O'Donovan et al., p.17). They went on to report that "after one year of postgraduate training, the competence of some trainees is substantially less than that of peers who have pursued a professional apprenticeship [i.e. supervision as a Provisional Psychologist]." (p.17)

This study identified two clear weaknesses in clinical training programs throughout Australia (O'Donovan et al., 2005). First, was the inability of postgraduate training to enhance the skills of *all* students, and second was their inability to enhance the practice skills of students. The authors suggested a possible reason for the ineffectiveness of clinical programs to provide for the needs of psychology students may be related to the *therapeutic relationship* which research literature indicates plays a key role in determining treatment outcomes. The researchers commented that clinical program "training does not affect performance in this area" (O'Donovan et al., p.18).

Training research acknowledges the frequent failure to observe improvement in relationship skills. Hollon (1996) went further and suggested that the content of training courses could not be expected to enhance the ability of students to bond with their client. O'Donovan and colleagues therefore suggested the possible need for educators to re-examine their course structure. This follows the work of previous researchers (e.g. Nixon, 1994; O'Gorman, 1994) who suggested that university courses place excessive focus on basic science and not enough on developing students' relationship skills. Stricker (2000) reported that the better training schools in the USA seemed to be those where educators were also practicing clinicians as they were more able to demonstrate the competencies in which they provide training. This finding lends weight to the effectiveness of the supervision or probationary pathway.

Whilst the therapeutic relationship is accepted as vital for positive and effective treatment outcomes, it has often been noted that the characteristics needed to establish an effective bond may not be something able to be taught. This assertion was summarised well by Safinofsky (1979) who said of students "Training may mature and refine the experience of his concern and empathy, but it cannot supply what does not exist in the first place" (p.195). This may have been reflected in the research of O'Donovan and colleagues who found that some clinical students were found to be less effective than those under supervised practice and summarised by stating that "Training does not guarantee superior post-training ability" (p.15).

The rift and debate currently occurring between many clinical and generally registered psychologists might be said to be reflective of the rivalry that existed (and some might argue still exists) between psychiatrists and psychologists throughout the latter part of the 20th century. Buchanan (2003) reflected on psychiatry's attempts to monopolise psychotherapy and the polarisation created out of attempts to determine and place boundaries on a science-based profession. Buchanan (2003) wrote "psychologists pressed for a share on the basis of their qualifications and competence, but struggled to overcome the limitations imposed by medical envy" (p.225). It might be suggested that the rivalry and self-imposed superiority of medical models has shifted and now also exists between clinical psychologists and generally registered psychologists. However, there can be no turning back now from the provision of treatment alternatives to the more traditional models based on psychiatric diagnosis and classification. The Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) provides a strong example for this need and has been quickly taken up and promoted throughout Britain and in influential Australian organisations, such as the National Centre of Excellence for Complex Trauma (Blue Knot Foundation).

The PTMF moves away from defining responses to threat in terms of 'symptoms' and looks instead at the role power and its misuse plays in people's lives and how we learn to respond and give meaning to that threat. It is a model that is as applicable to those in the mental health system as it is to all people. The developers of the PTMF wrote that they examined:

> "the problems of medicalisation and psychiatric diagnosis, using comparisons with medical diagnosis to show why a very different approach is needed. It is argued that medical diagnosis is fundamentally an attempt to make sense of problems by drawing on research into patterns/regularities in bodily structure, function and dysfunction, and that while this is appropriate and productive for many bodily problems, psychiatric diagnosis is inherently limited in its capacity to make sense of emotional/psychological distress. This is because it

> largely draws on theoretical models designed for understanding bodies rather than people's thoughts, feelings and behaviour" (Johnson & Boyle, 2018, p.5).

The main aspects of the PTMF are summarised into questions, as detailed below:

- What has happened to you? (How is **Power** operating in your life?)
- How did it affect you? (What kind of **Threats** does this pose?)
- What sense did you make of it? (What is the **Meaning** of these situations and experiences to you?)
- What did you have to do to survive? (What kinds of **Threat Responses** are you using?

The PTMF also encourages consideration of the skills and resources a person has and how all of this information is pulled together into a personal narrative:

- What are your strengths? (What access to **Power resources** do you have?)
- What is your story? (How does this all fit together?)

The PTMF offers an alternative to traditional models based on psychiatric diagnosis which define threat responses in terms of 'symptoms'. The PTMF authors emphasise that this is a model that was co-produced by service users and carers, and from many examples of good practice that is not based on diagnosis (Johnson & Boyle, 2018). The rapid uptake of this framework by influential organisations and psychologists whose work focuses on the treatment of trauma and abuse, may reflect the points made earlier in this summary of the literature, that empathy and an ability to build a strong therapeutic relationship is key in effective treatment outcomes, and relies on far more than the attainment of diagnostic knowledge taught under a medical model in clinical education programs.

As noted by Buchanan (2003), it became clear in the 1950s that medical claims to the exclusive use of psychotherapy were not going to hold. Buchanan asserts that American medicine adopted a strategy of eliminating and subordinating their competitors, which involved making exclusive claims over work which could actually be broadly defined. Buchanan wrote "American medical personnel have been able to outlaw or control a significant proportion of those individuals and groups they deemed unworthy to practice medicine, as well as driving out heterodoxy…" (p.225). It is generally accepted that the Australian Psychological Society (APS) based most of their structure, policy development and legislative recommendation on the American psychiatric model. The division and inferred hierarchy of clinical over non-clinical psychologists that currently exists in Australia is unnervingly similar to rifts and rivalries that existed between the medical/academic/psychiatric

fraternities of the 1950s and their psychologist colleagues. It could be argued that the medical/psychiatric contingent still hold the ear of those in control of legislative policy.

Ideally, all the variables above would be considered when evaluating expertise in a practitioner, and determining financial benefits to consumers on the basis of this so-called expertise. The reality is, however, that there currently exists little data evaluating all of these proposed components, particularly as in the past it has not been easily measured or given much weight. What *is* continually measured, however, and kept foremost in therapists', consumers' and policy makers' interests, is a client's improvement in therapy and overall wellbeing. Yet, if we consider 'expertise' to be solely based on treatment outcomes, there is **no evidence** highlighting differences between the two groups of psychologists (Pirkis et al., 2011; Jorum, 2011; Jones, 2018). Therefore, we propose that the two tiers in Medicare's Better Access is misinformed. Further, given there may be an opportunity to rectify this model in the near future, it would be remiss of the policy makers to ignore the current evidence. Failure to consider the clear lack of evidence in an evidence-based profession, not only divides a professional group unfairly, it also breaks the basics of the profession's Code of Ethics, but most importantly, it impacts a consumer's choice and ability to see whom they wish, impacts the rebates available to them, and possibly impacts the number of sessions they may be limited to.

We argue that it is unacceptable for consumers to be receiving unequal rebates for what has been shown to be comparable treatment outcomes when they may be financially disadvantaged. Further, if the increased treatment sessions available to consumers with moderate to severe presentations were only accessible from seeing a clinical psychologist, the waiting times for consumers will be astronomically increased, as they are relying on the service provision from a much smaller percentage of the psychology workforce. Allowing consumers with severe mental health issues to be left for significant periods of time without support is dangerously unethical, especially if such a crisis can be foreseen.

3. Some Historical Dates in Australian Psychology

The below information is a direct quote taken from Milliken and Wilkie (2018).

3.1 Since 2000

"In 2004, Psychology Private Australia Inc (PPAI) which had taken over the Medicare Rebates Pressure Action surveyed in Brisbane and Darwin, a substantial number of GPs, psychiatrists, psychologists, members of the general public, persons known to have or to have had mental health problems, and came up with a strong recommendation to press for Medicare benefits to be extended to persons experiencing mental health problems.

The survey results were included in a submission to the Australian Government senate enquiry into mental health. This enquiry recommended to the Government that there should be Medicare rebates for psychological services.

In April 2006, the then Prime Minister (PM) released news of a new Australian Government initiative: Better Access via Medicare to psychologists and psychiatrists, for persons experiencing mental health issues. Referral had to be by a GP, the GP maintaining overall responsibility for the patient's well-being. The PM stated that psychologist referrals were only to be made to those practising psychologists who were experienced in working with clients who were "Mental Health Problems" patients.

About June/July 2006, PPAI and APS (and perhaps some other bodies also) were asked for a device for discriminating between the category of psychologists eligible to receive the mental health GP referrals for clients with access to Medicare rebates, and other psychologists.

As the criteria, the APS proposed a higher clinical Masters' Degree and/or membership of its Clinical College. The PPAI proposed four years' experience in clinical practice following the four-year relevant university training plus the two-year supervised practice (4 plus 2 pathway).

About August 2006, the PPAI had sent a delegation to the Minister of Health who referred them to his Parliamentary Secretary for Mental Health, Mr Christopher Pyne. The delegation's proposal arguments appeared to have been favourably received. However, the Australian Department of Health settled for the APS proposal. In September/October 2006, details of the Better Access Initiative operating procedures were officially announced including the two-tier system for psychologists. It was to commence in November 2006".

3.2 November 2006 to mid-2009

"In 2008, the PPAI surveyed a substantial number of psychologists from all jurisdictions to ascertain whether 'focussed' psychologists had followed the Better Access direction to use, in therapy, only one or two 'Better-Access-prescribed' treatment approaches. The responses were clear and firm: the vast majority, true to their training, experience and Code of Ethics, were using whatever treatment techniques were needed for clients' well-being, and were continuing to assess and diagnose. To do otherwise would constitute unprofessional conduct.

Over the period, November 2006 to mid-2009, the PPAI made strenuous attempts to have a changed Government revise the two-tier psychologist system, but to no avail. Indeed, in due course, the changed Government reduced the annual number of psychologist consults per patient/client under the Initiative from 18 to ten.

In 2009/2010, all States and Territories legislated the registration of psychologists to become a Commonwealth function. Western Australia (WA), the only jurisdiction whose registration legislation allowed for 'endorsements', refused adamantly to be a part of, or to be included in, the process unless the rules for psychologist registration

(i) allowed for endorsements in specific areas of psychological knowledge and practice; and

(ii) all existing WA-endorsed psychologists provided automatically an identical endorsement.

In 2009 or 2010, in response to an invitation from the Australian Health Practitioner Regulation Agency (AHPRA), the PPAI forcefully opposed the introduction to Australian use of endorsements based solely on APS college membership or a Masters' degree without any grandfathering of psychologists who were then currently practising in the clinical field. (The colleges of the APS could not have been expected to be of the same mind as the PPAI).

On 1 July 2010, the Australian Psychology Board (APB), as part of the Australian Health Practitioner Regulation Agency (AHPRA), came into force. The top Health Ministerial Council in Australia had ruled that the APB include endorsements in its Rules for Registration.

Since 1 July 2010, supported by many endorsed psychologists but officially not by the APS as an organisation, the public has been under the misapprehension that in endorsement specified areas of psychology, a service will be superior if supplied by an endorsed rather than by a non-endorsed psychologist" (pp.4-7).

The APS has strongly denied that they originally proposed the two-tier system and have claimed that documents obtained under Freedom of Information were "perused out of context and many erroneous claims have been made about the APS position to create division and unrest" as quoted in Littlefield (2011).

3.3 From 2010 to the present time

In 2010, evaluations of the Better Access initiative were conducted. The Government budget for Better Access was approximately $500 million, of which $360 million was for allied health for evidence-based services (Littlefield, 2017). The Government were, however, wanting to reduce Better Access costs. According to the APS, the Government were wanting to get rid of the Focussed Psychological Strategies (FPS) and general psychologists (Littlefield, 2017). In 2011-2012, the Federal Budget reduced the number of Medicare sessions from 18 to 10 sessions per year under Better Access.

In 2015, a report was released from the National Mental Health Commission which had nine strategic directions and 25 recommendations for mental health services. According to the APS, this report wanted to have the FPS funded by Primary Health Networks (PHNs) and only clinical psychologists could provide services through Medicare to consumers living in any area of Australia (Littlefield, 2017). General psychologists could provide services to those who lived in rural areas with populations under 50,000.

In 2015, the Government continued with all psychological services being funded by Medicare but wanted a three-year plan where PHNs would be more important for mental health services. The Government also wanted a 'stepped care' service where consumers would be categorised as low, moderate and severe. It was proposed that Better Access services would be focused on those with moderate mental health disorders (Littlefield, 2017).

The Government is currently conducting an MBS review. Consequently, many psychologists including the current authors, are making submissions about their thoughts on the current climate. Many psychologists do not feel they are being accurately represented by the APS so are making individual submissions. The APS continually deny that they proposed/supported the two-tier system whereby clinical psychologists received a higher rebate than general psychologists. However, the APS is still supporting this system by now proposing a three-tier system where only clinical psychologists can see 'severe' clients. Generally registered psychologists are up-in-arms about this as it would not be in the best interest of the consumer for this to happen. For decades, ALL

psychologists have been providing services to ALL consumers. It would be a disservice for both the consumer and the profession for this not to continue.

Firstly, the APS proposed three-tier model would lead to major disruptions to client progress and mental stability (e.g., psychologists would have to refer consumers who moved into the 'severe' category back to their GP who would then need to refer them onto a clinical psychologist). Second, there would be insufficient clinical psychologists to provide these services. Third, this would create an unrealistic burden of responsibility and expertise on the GP to classify levels of severity. Fourth, a pathway that has, for decades, been considered acceptable to treat all consumers would become obsolete. Lastly, the psychology profession is already fractured enough by the current situation. This would completely undermine the profession as a whole and would lead to the general community losing confidence in the profession.

4. Current Medicare Benefits Schedule Items for Psychologist, Clinical Psychologists and Psychiatrists

4.1 What is Medicare?

Introduced in 1984, Medicare has three components:

1. Free public hospital services for public patients.
2. Subsidised drugs covered by the Pharmaceutical Benefits Scheme (PBS).
3. Subsidised health professional services listed on the Medicare Benefits Schedule (MBS).

The below information is taken directly from the Australian Government Department of Health Medicare Benefits Schedule Book Category 8, Operating from 1 May 2019 (HMBSB).

> "The Medicare Program (Medicare) provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. The Department of Human Services administers Medicare and the payment of Medicare benefits. The major elements of Medicare are contained in the Health Insurance Act 1973, as amended, and include the following:
>
> a) Free treatment for public patients in public hospitals.
> b) The payment of 'benefits', or rebates, for professional services listed in the MBS. In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are:
> i. 100% of the Schedule fee for services provided by a GP to non-referred, non-admitted patients;
> ii. 100% of the Schedule fee for services provided on behalf of a GP by a practice nurse or Aboriginal and Torres Strait Islander health practitioner;
> iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
> iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.
When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.

Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, medical practitioners must ensure that the medicines and medical devices they use have been supplied to them in strict accordance with the provisions of the Therapeutic Goods Act 1989.

Where a Medicare benefit has been inappropriately paid, the Department of Human Services may request its return from the practitioner concerned".

4.2 What is the MBS?

The MBS is a listing of the health professional services subsidised by the Australian Government. There are more than 5,700 MBS items that provide benefits to patients for a comprehensive range of services, including consultations, diagnostic tests and operations.

4.3 What is the Better Access Initiative?

The Better Access to Psychiatrists, Psychologists and GPs through the MBS was introduced due to low treatment rates for mental disorders. It was introduced to encourage GPs to participate and provide access to psychological care; encourage psychiatrists to see more patients; and provide referral pathways to psychiatrists, GPs, clinical psychologists, registered psychologists and other allied mental health professionals (Pirkis et al., 2011). A freeze on the annual CPI indexation of fees and rebates for services provided by psychologists was first brought in from 1 November 2012. This freeze has continued. Consequently, psychologists have not had an increase in pay for seven years. This freeze inevitably leads to psychologists needing to raise their fees which then means the consumer having to pay a larger gap (Littlefield, 2015). Table 1 displays MBS rate comparisons between clinical psychologists, registered psychologists and psychiatrists.

Table 1. Comparison of clinical psychologists, psychologists and psychiatrists MBS rates in place since 1 November 2012

Item no	Description	MBS Rate		
		FPS (AMH) Psychologist[1,7]	**PTS Clinical Psychologist[2,7]**	**Consultant Psychiatrist[3-6]**
291[3]	Assessment and Management >45 minutes, one per year	Letter to GP Free	Letter to GP Free	$390.55
293[3]	Review Management Plan 30-45 minutes, one per year	Letter to GP Free	Letter to GP Free	$244.15
296/297[3]	Initial consult, one every two years >45 minutes[3] Attendance at hospital;[3] Outside of consulting rooms[3]	-	-	 $224.60 $268.60
348[6] 350[6]	Interview without patient for initial diagnostic evaluation 20-45 minutes >45 minutes	-	-	$109.40 $151.00
352[3]	Interview without patient for continual management, four times per year >20 mins	-	-	$109.40
855/861[6] 857/864[6] 858/866[6]	Multidisciplinary case conference 15-30 minutes 30-45 minutes >45 minutes	-	-	$120.05 $180.10 $240.00
80100/80101[1] 80000/80001[2] 304[3]/314[4]/324[6]	Professional attendance and video conferencing 20-50 minutes[1-2] 30-45 minutes	$60.10	$84.80	$114.85[3,6] $57.55[4]
80110/80111[1] 80010/80011[2] 306[3]/316[4]/326[6] 319[5]	Professional attendance and video conferencing >50 minutes;[1-2] 45-75 minutes[3,4,6] >45 minutes[5]	$84.80	$124.50	$158.45[3,5,6] $79.35[4]
80105[1]/80005[2] 80115[1]/80015[2] 336[6]	Professional attendance outside of consulting rooms 20-50 minutes[1-2] >50 minutes;[1-2] 45-75 minutes[3]	$81.75 $106.55	$106.00 $145.65	$189.60
80120/80121[1] 80020/80021[2] 342[6] 344[6] 346[6]	Group therapy and video conferencing[1-2] >60 minutes[1-2,6] 6-10 patients;[1,2] 2-9 unrelated patients or family group of >3 patients; Family group of 3 patients; Family group of 2 patients	$21.65	$31.65	 $42.55 $56.50 $83.55
10968[7]/81355[8]	Professional attendance Chronic condition[7]/ATSI[8]	$52.95	$52.95	-
82000[9]/82015[10] 289[3]	Psychological Health Service, child Assessment, diagnosis, plan	$84.80	$84.80	$227.70
81000[11]	Pregnancy Support Counselling	$62.20	$62.20	-

[Note] Not all Consultant Psychiatric Attendances MBS items are shown in table
[1]FPS (AMH), M7 - Focussed Psychological Strategies (Allied Mental Health), up to 10 sessions per calendar year
[2]PTS, M6 - Psychological Therapy Sessions, up to 10 sessions per calendar year
[3]A8 - Consultant Psychiatrist Attendances, up to 50 sessions per calendar year
[4]A8 - Consultant Psychiatrist Attendances, exceeds 50 sessions per calendar year
[5]A8 - Consultant Psychiatrist Attendances, up to 160 sessions per year – 'severe'
[6]A8 - Consultant Psychiatrist Attendances, no limit
[7]M3 - Allied Health Services, Psychology, chronic condition, five per calendar year
[8]ATSI, M11 - Aboriginal or Torres Strait Islander descent, Allied Health Services for Indigenous Australians who have had a health check, Psychology, five per calendar year
[9]M10 – Autism, Pervasive Developmental Disorder and Disability Services, under 13 years, Psychology, four services per patient (see MBS for more detail)
[10]M10 – Autism, Pervasive Developmental Disorder and Disability Services, under 15 years,
Psychology, 20 services per patient (see MBS for more detail)
[11]M8 – Pregnancy Support Counselling, Psychology, three per patient, per pregnancy

In Pirkis et al., (2011) it was reported that:

> In each year, the vast majority of Better Access consumers (more than 85%) received at least one Better Access service from a GP. This is consistent with the functions of the GP mental health treatment plan and review item numbers (2710[b] and 2713, respectively) as gateways to further Better Access services. Focussed Psychological Strategies services provided by general psychologists had the next highest uptake rate; just under one third of Better Access consumers received one or more of these services in each year. These were followed by uptake rates for Psychological Therapies services provided by clinical psychologists, then Consultant Psychiatrist services (see Table 4).

Table 4: Persons receiving Medicare Benefits Schedule-subsidised Better Access services by provider type, 2007, 2008 and 2009, Component B[1]

Provider type	2007[2]			2008[2]			2009[2]		
	N persons	% of persons	Rate (per 1,000)[3]	N persons	% of persons	Rate (per 1,000)[3]	N persons	% of persons	Rate (per 1,000)[3]
General Practitioner	618,867	87.1	29.5	817,738	85.9	38.3	971,836	86.0	45.4
Consultant psychiatrist	87,947	12.4	4.2	93,736	9.9	4.4	100,434	8.9	4.7
Clinical psychologist	98,612	13.9	4.7	151,587	15.9	7.1	189,418	16.8	8.9
General psychologist	213,963	30.1	10.2	289,785	30.5	13.6	348,417	30.8	16.4
Occupational therapist	2,011	0.3	0.1	3,701	0.4	0.2	5,103	0.5	0.2
Social worker	10,918	1.5	0.5	20,157	2.1	1.0	28,276	2.5	1.3

1. The sum of persons receiving services under each item group will be greater than for all Better Access items because a person may receive services from more than one type of provider.
2. 2007 and 2008 figures have regard to all claims processed up to and including 30 April 2009; 2009 figures have regard to all claims processed up to and including 30 April 2010.

[b] And, from 1 January 2010, MBS item 2702.

Table 4 indicates the highest percentage of persons who received MBS Better Access services for the years 2007, 2008 and 2009 (excluding the GP who makes the referral) were general psychologists (30%, 31%, 31% respectively), followed by clinical psychologists (14%, 16%, 17%) and lastly consultant psychiatrists (12%, 10%, 9%). Although no statistical analyses were completed, it is evident that general psychologists have the highest uptake of persons. This indicates that more consumers see general psychologists than either clinical psychologists or consultant psychiatrists.

Table 5 in Pirkis et al. (2011) indicated that more patients used FPS (provided registered psychologists) than any other item. Consultant psychiatrists had the highest average co-payment.

Table 5: MBS-subsidised Better Access services received, bulk-billing rate, fees charges, benefits paid and average co-payment, by Better Access item group, 2007-2009, Component B

	Total services	Bulk-billed services		Fees charged[2]	Benefits paid[2]	Services with co-payments			Total patients
	N	N	%	$	$	N	%	Average co-payment ($)[4]	N
2007[1]									
GP items[3]	1,012,497	925,910	91.4	119,225,281	117,636,222	86,587	8.6	18.35	618,867
CP items[3]	94,590	30,231	32.0	25,901,960	21,222,543	64,359	68.0	72.71	87,947
PTS items[3]	507,367	136,073	26.8	71,707,903	60,739,728	371,294	73.2	29.54	98,612
FPS items[3]	1,078,995	351,413	32.6	114,779,148	89,272,270	727,582	67.4	35.06	226,169
Total	2,693,449	1,443,627	53.6	331,614,292	288,870,763	1,249,822	46.4	34.20	710,840
2008[1]									
GP items[3]	1,375,025	1,269,689	92.3	152,526,591	150,519,438	105,336	7.7	19.05	817,738
CP items[3]	101,678	34,437	33.9	27,812,365	22,676,030	67,241	66.1	76.39	93,736
PTS items[3]	785,174	250,397	31.9	108,649,361	92,264,952	534,777	68.1	30.64	151,587
FPS items[3]	1,524,723	584,050	38.3	157,551,394	123,987,143	940,673	61.7	35.68	312,035
Total	3,786,600	2,138,573	56.5	446,539,711	389,447,563	1,648,027	43.5	34.64	951,454
2009[1]									
GP items[3]	1,659,534	1,538,270	92.7	182,427,744	179,971,434	121,264	7.3	20.26	971,836
CP items[3]	109,734	39,846	36.3	30,529,663	24,816,904	69,888	63.7	81.74	100,434
PTS items[3]	1,000,129	345,693	34.6	139,410,904	118,370,909	654,436	65.4	32.15	189,418
FPS items[3]	1,894,584	807,337	42.6	194,849,261	154,976,465	1,087,247	57.4	36.67	379,284
Total	4,663,981	2,731,146	58.6	547,217,572	478,135,712	1,932,835	41.4	35.74	1,130,384

1. 2007 and 2008 figures have regard to all claims processed up to and including 30 April 2009; 2009 figures have regard to all claims processed up to and including 30 April 2010.
2. Fees charged, benefits paid, and average copayments are expressed in 2009 dollars.
3. GP, General practitioner; CP, Consultant Psychiatry; PTS Psychological Therapy Services; FPS, Focussed Psychological Strategies.
4. [a] Only services for which the consumer contributed a co-payment are included in the calculation of the average co-payment.

The Pirkis et al. (2011) report, Table 11, showed that registered psychologists had more patients who received services in 2008 and 2009 and also had a higher uptake of patients who received services for the first time than clinical psychologists.

Table 11: Number and percentage of first-time Better Access consumers in 2008 and 2009 derived from Medicare claims data, Component B[1]

Item group	Received services in 2008			Received services in 2009		
	Total N	N received services for the first time in 2008	% received services for the first time in 2008	Total N	N received services for the first time in 2009	% received services for the first time in 2009
Any Better Access item	953,161	648,465	68.0%	1,130,384	644,295	57.0%
GP	818,434	597,996	73.1%	971,713	604,319	62.2%
GP item 2710	555,479	484,272	87.2%	638,756	492,339	77.1%
Consultant psychiatrist	94,398	86,977	92.1%	100,390	87,288	86.9%
Allied Health Professional	452,600	322,985	71.4%	550,354	346,108	62.9%
Psychologists	430,928	307,822	71.4%	520,588	328,750	63.1%
Clinical Psychologist	152,721	113,376	74.2%	189,418	126,778	66.9%
Registered psychologist	292,129	215,259	73.7%	348,417	233,247	66.9%
Social Workers	20,319	16,164	79.6%	28,276	21,078	74.5%
Occupational Therapists	3,719	2,918	78.5%	5,103	3,671	71.9%

1. Data had regard to claims processed up to and including 30 April 2010.

Table 12 in Pirkis et al. (2011) showed the clinical profiles of consumers. They summarised that the findings suggested that most people accessing Better Access had very high psychological distress. As can be seen, GPs had the highest percentage of consumers (58%), followed by registered psychologists (53%), and lastly by clinical psychologists (47%).

Table 12: Clinical profiles of consumers who participated in Component A[1]

		Consumers recruited by clinical psychologists (n=289)[2]		Consumers recruited by registered psychologists (n=317)[2]		Consumers recruited by GPs (n=277)[2,3]	
		Freq	%	Freq	%	Freq	%
Diagnosis	Depression and anxiety[4]	99	34%	121	38%	113	41%
	Depression without anxiety[4]	105	36%	117	37%	102	37%
	Anxiety without depression[4]	66	23%	60	19%	38	14%
	Other[5]	19	7%	19	6%	24	9%
Pre-treatment K-10 score	10-15 (Low psychological distress)	13	5%	8	3%	8	3%
	16-21 (Moderate psychological distress)	37	13%	43	14%	26	10%
	22-29 (High psychological distress)	103	36%	93	31%	81	30%
	≥30 (Very high psychological distress)	133	47%	159	53%	158	58%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Consumers recruited by GPs may have received treatment from the GP in isolation or may have been referred to an allied health professional for further care.
3. Cells do not always sum to the total n due to some missing data.
4. With or without alcohol and drug use disorders, psychotic disorders, and/or unexplained somatic disorders.
5. Alcohol and drug use disorders, psychotic disorders, unexplained somatic disorders, and/or unknown or missing diagnoses.

Furthermore, Table 13 in Pirkis et al. (2011) showed that pre- and post- measures of consumers recruited by clinical psychologists and registered psychologists were similar and both had significant mean differences. Additional post hoc analysis of this data, looked at pre- and post- measures and mean group differences from the K-10 and the DASS; comparisons between mild, moderate and severe pre-treatment consumers; and comparisons between clinical psychologist, registered psychologists and GPs (Anderson, 2016). The results showed that all three groups showed a reduction from pre- to post- measures. Clinical psychologists and registered psychologists together showed a reduction from pre- to post- measures compared to the GPs. There were no differences in post- treatment measures between clinical psychologists and registered psychologists. Conclusion: There is no difference in treatment outcomes between clinical psychologists and registered psychologists (Anderson, 2016).

Table 13: Outcome data for consumers who participated in Component A and had "matched pairs" of pre- and post-treatment scores on standardised measures[1]

		Pre-treatment mean (s.d.)	Post-treatment mean (s.d.)	Mean difference (s.d.)	P-value
Consumers recruited by clinical psychologists	K-10[4] (n=193)	28.63 (7.57)	19.09 (6.96)	9.53 (7.84)	0.000
	DASS_Depression[5] (n=205)	21.02 (11.00)	9.66 (9.63)	11.37 (10.92)	0.000
	DASS_Anxiety[6] (n=205)	14.75 (9.44)	7.58 (7.32)	7.17 (8.73)	0.000
	DASS_Stress[7] (n=205)	22.85 (8.58)	12.93 (8.48)	9.93 (9.50)	0.000
Consumers recruited by registered psychologists	K-10[4] (n=192)	29.44 (7.33)	18.86 (7.13)	10.58 (8.83)	0.000
	DASS_Depression[5] (n=204)	20.41 (10.58)	8.96 (8.99)	11.46 (11.43)	0.000
	DASS_Anxiety[6] (n=204)	15.34 (9.59)	6.55 (7.01)	8.78 (10.09)	0.000
	DASS_Stress[7] (n=204)	23.91 (9.41)	12.22 (9.28)	11.69 (11.01)	0.000
Consumers recruited by GPs[2,3]	K-10[4] (n=177)	30.89 (7.94)	22.88 (8.54)	8.01 (8.72)	0.000

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Consumers recruited by GPs may have received treatment from the GP in isolation or may have been referred to an allied health professional for further care.
3. The DASS-21 was only collected for consumers recruited by clinical and registered psychologists, and not by consumers recruited by GPs.
4. Standard cut-off scores for levels of psychological distress are as follows: 10-15 (Low); 16-21 (Moderate); 22-29 (High); ≥30 (Very high)
5. Recommended cut-off scores for conventional severity labels are as follows: 0-9 (Normal); 10-13 (Mild); 14-20 (Moderate); 21-27 (Severe); ≥28 (Extremely severe)
6. Recommended cut-off scores for conventional severity levels are as follows: 0-7 (Normal); 8-9 (Mild); 10-14 (Moderate); 15-19 (Severe); ≥20 (Extremely severe)
7. Recommended cut-off scores for conventional severity levels are as follows: 0-14 (Normal); 15-18 (Mild); 19-25 (Moderate); 26-33 (Severe); ≥34 (Extremely severe)

Pirkis et al, (2011) also surmised that Better Access care provided by psychologists appeared to be good value for money for Government. Key findings were:

1. "The summative evaluation provides good evidence that Better Access has improved access to mental health care and increased treatment rates for people with common mental disorders" (p.45).

2. "Consumers are generally positive about Better Access as a model of service delivery, and appreciate the clinical care they have received" (p.45).
3. "The above achievements do not seem to be occurring at the expense of other parts of the health system" (p.46)

Finally, adding to the debate regarding clinical and registered psychologists about who should be able to offer different services, Pirkis et al. (2011) concluded:

> Finally, different groups of allied health professionals have expressed disparate views about the services that should be offered through Better Access and the providers who should be eligible to offer them.[46 52-57] Registered psychologists have contended that they are essentially providing the same services as clinical psychologists and should be reimbursed commensurately; clinical psychologists have maintained that registered psychologists are providing the bulk of services and may not be achieving optimal outcomes for clients. Social workers and occupational therapists have stressed the importance of retaining their services. Various other groups of service providers have argued that their services should be eligible for a Medicare Benefits Schedule rebate. The summative evaluation can only inform these debates in a limited way. Component A provided evidence that registered psychologists are achieving positive outcomes for consumers, and Component A.2 showed that consumers were satisfied with the care they received from social workers and occupational therapists.

Littlefield (2017) looked at MBS data from 2009 to 2015. Figure 1 below, again, shows that more consumers accessed general psychologists' services than clinical psychologists' services. Numbers are in 500,000 increments so although the differences may look small in this figure, they are quite substantial.

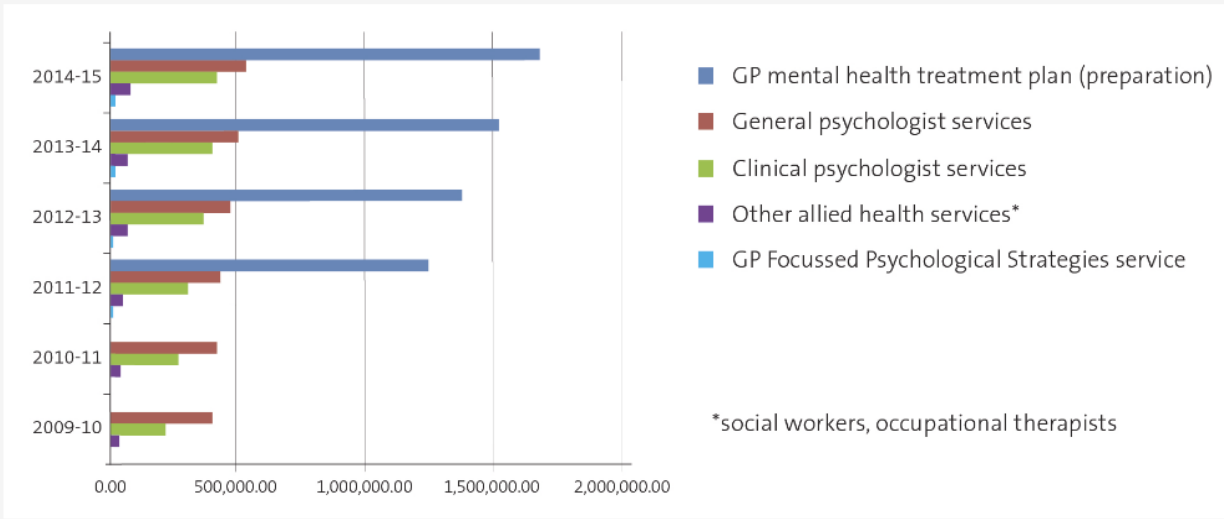

Figure 1. Number of individuals accessing the Better Access initiative between 2009 and 2015.

Further, Figure 2 shows that general psychology items also have had higher number of services compared to clinical psychology items from October 2006 to April 2016 (Littlefield, 2017). Number of services are in 100,000 increments.

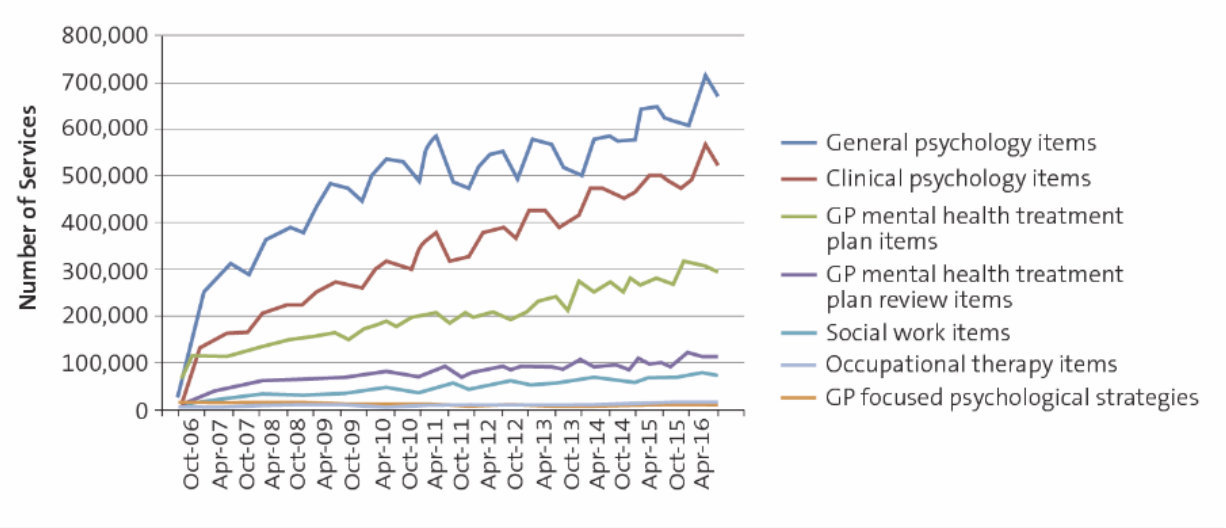

Figure 2. Number of Better Access services provided between 2006 and 2016

Another study conducted by Meadows, Enticott, Inder, Russell and Gurr (2015) showed that in the period 1 July 2007 to 30 June 2011, general psychologists using MBS item 80110 saw 6,325,499 consumers, compared to clinical psychologists using the comparable MBS item 80010 who saw 3,754,815 consumers. Psychiatrists using comparable MBS item 306 saw 2,572,228 consumers over the same period. See Box 1 below.

1 Concentration index calculated using Index of Relative Socio-Economic Advantage and Disadvantage ranking for areas and national Medicare data, 1 July 2007 to 30 June 2011

Provider group	Consultation time (min)	Item no.	No. of patients	Concentration index* (95% CI)
General practitioner	Not timed	2702	317117	− 0.05 (− 0.08, − 0.02)
	Not timed	2710	2181945	− 0.04 (− 0.07, − 0.01)
	Not timed	2712	930248	− 0.03 (− 0.06, − 0.001)
	>20	2713	3019386	− 0.08 (− 0.11, − 0.05)
Consultant psychiatry	>45	291	22258	− 0.08 (− 0.13, − 0.02)
	30–45	293	963	− 0.18 (− 0.34, − 0.02)
	>45	296	303240	0.03 (− 0.01, 0.06)
	>45	297	14499	0 (− 0.07, 0.07)
	>45	299	285	0.34 (0.01, 0.7)
	<15	300	126179	− 0.13 (− 0.23, − 0.03)
	15–30	302	944908	− 0.07 (− 0.14, − 0.002)
	30–45	304	1871116	0.04 (0.002, 0.08)
	45–75	306	2572228	0.21 (0.18, 0.25)
	>75	308	111875	0.05 (− 0.01, 0.10)
	<15	310	0	na
	15–30	312	210	− 0.20 (− 0.29, − 0.12)
	30–45	314	1430	0.10† (− 0.07, 0.26)
	45–75	316	62523	0.22 (0.15, 0.28)
	>75	318	906	0.08 (− 0.04, 0.20)
	>45	319	264437	0.22 (0.15, 0.28)
Psychological therapy services				
Clinical psychologist	30–50	80000	39262	− 0.07 (− 0.15, 0.01)
	30–50	80005	1535	− 0.07† (− 0.31, 0.18)
	>50	80010	3754815	0.13 (0.10, 0.17)
	>50	80015	24882	− 0.08 (− 0.15, 0)
	>60	80020	14436	− 0.07† (− 0.27, 0.13)
Focused psychological strategies				
General psychologist	20–50	80100	108723	− 0.26 (− 0.33, − 0.18)
	20–50	80105	9027	− 0.26 (− 0.42, − 0.10)
	>50	80110	6325499	− 0.01 (− 0.04, 0.03)
	>50	80115	194844	− 0.14 (− 0.20, − 0.08)
	>60	80120	25819	− 0.02 (− 0.08, 0.04)
Occupational therapist	20–50	80125	4236	− 0.20 (− 0.33, − 0.08)
	20–50	80130	849	− 0.08 (− 0.22, 0.06)
	>50	80135	72607	− 0.05 (− 0.14, 0.05)
	>50	80140	7326	− 0.06 (− 0.16, 0.04)
	>60	80145	422	− 0.11 (− 0.24, 0.03)
Social worker	20–50	80150	3850	− 0.04† (− 0.19, 0.12)
	20–50	80155	2228	− 0.14 (− 0.43, 0.15)
	>50	80160	472353	− 0.02 (− 0.06, 0.02)
	>50	80165	25211	− 0.15 (− 0.23, − 0.07)
	>60	80170	331	− 0.25 (− 0.44, − 0.07)

*A positive concentration index indicates inequality of service use in favour of advantaged regions. †Concentration curve with significant areas on either side of equity line. ◆

5. Example of Private Practice for Psychologists Fee Structure

Table 2 is an example of a private practice's fee structure. As can be seen, third party insurance, private patients, Queensland (QLD) WorkCover and the PHN PSP program all charge the same regardless of whether the service is offered by a clinical psychologist or registered psychologist. It is only the Medicare rebate and Department of Veterans Affairs (DVA) that charge differently.

Table 2. Comparisons of all psychologists, clinical psychologists and registered psychologists fee structure in a private practice

Item Number	**Description**	**Fees**
All psychologists		
21110	Third Party Insurance	$251
1003NP	Private patient (not Medicare)	$205
40095	QLD WorkCover	$180
300088	Standard report	$167.20
	PHN PSP program	$143
Clinical Psychologists		
80010	Full fee Medicare rebated	$205
1002NP	Reduced fee Medicare rebated	$165
	DVA	$151.95
Registered Psychologists		
80110	Full fee Medicare rebated	$165
1004RF	Reduced fee Medicare rebated	$130
US14	DVA	$102.95

6. The MBS Review Taskforce

The MBS set up a Review Taskforce to look at the 5,700 items on the MBS. Below are the recommendations made by the Mental Health Reference Group and the Allied Health Reference Group. The current report provides evidence to aid the discussion of point 4 in the Mental Health Reference Group's recommendation.

6.1 Mental Health Reference Group's Recommendations

The Mental Health Reference Group's recommendations are summarised below:

GP Mental Health Treatment Plans (MHTP)

1. Expand the Better Access program to at-risk patients
2. Increase the maximum number of sessions per referral

Better Access items

3. Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness
4. Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups
5. Reduce the minimum number of participants in group sessions
6. Add a new group item for therapy in larger groups

Recommendations that are longer term are listed below:

7. Enable family and carers to access therapy
8. Measure Better Access outcomes
9. Update treatment options
10. Unlink GP Focused Psychological Strategy items from M6 and M7 items
11. Encourage coordinated support for patients with chronic illness and patients with mental illness
12. Promote the use of digital mental health and other low-intensity treatment options
13. Support access to mental health services in residential aged care
14. Increase access to telehealth services

6.2 Allied Health Reference Group's Recommendations

The Allied Health Reference Group's recommendations aimed to address nine broad themes.

1. Ensure that clinical services align with best-practice guidelines.
2. Increase access to allied health in primary care.
3. Ensure that the list of eligible allied health professionals under the MBS reflects contemporary practice.
4. Facilitate group-based allied health therapy where clinically appropriate.
5. Ensure that patients with an Autism Spectrum Disorder (ASD), Pervasive Developmental Disorder (PDD), Complex Neurodevelopmental Disorder (CND) or disabilities have adequate access to high-quality allied health services.
6. Strengthen evidence base for the provision of allied health care in Australia.
7. Improve access to allied health services in rural and remote areas.
8. Change the delivery model and focus of allied health in Australian primary care.
9. Improve communication between allied health professionals and other health care professionals.

7. Psychologists in Australia

7.1 Psychology Workforce

The PBA (2018) figures indicate that in December 2018:

- There were 29,982 registered psychologists in Australia.
- The vast majority of Australian psychologists were female (23,870, 80%).
- The majority of Australian psychologists held general registration without any of the nine 'Area of Practice Endorsement' (AoPE, 18,377, 61%).
- Over a third (11,605, 39%) of registered psychologists had one or more AoPE on top of their general registration.
- Although less than a third (8,725, 29%) of all registered psychologists had clinical endorsement, over two thirds of all (12,644) endorsements were clinical (8,725, 69%).
- Less than a quarter (7,809, 21%) of registered psychologists were approved by AHPRA as principal supervisors and just over half of these (3,542, 12%) were clinical psychologists.

The above data raises and informs two important questions: If Australia's 18,377 registered psychologists decided to pursue the 6 plus 2 pathway to clinical endorsement:

1. Would there be 18,377 or so places available in clinical postgraduate programs, and
2. Could 3,542 AHPRA-approved clinical psychologists adequately supervise them at the current ratio of more than 5:1?

8. Legislation

The PBA Guidelines stipulate the following:

> "Registered general psychologists have unrestricted rights to use the title 'psychologist' and may undertake any work using that title as long as they maintain general registration and practise within the limits of their competence. file:///C:/Users/Clinic/Downloads/Guidelines-onPsychology-area-of-practice-endorsements.PDF
>
> "In Australia, all psychologists are registered on a single register which includes notation of area of practice endorsements. The notation of an endorsement is not a separate specialist register. Nor is it based on experience derived during the course of a professional career." https://www.psychologyboard.gov.au/endorsement.aspx
>
> "Psychologists should avoid using the word endorsed in their titles (that is, should not use a title such as 'endorsed clinical psychologist'). Psychologists should not use the word 'specialist' in their titles as s.118 of the National Law prohibits the use of the title 'specialist' by any practitioner who is not included on an approved specialist register. There is no approved specialist register for psychology, therefore this section of the National Law prohibits psychologists in Australia from using the title 'specialist' which may constitute behaviour for which health, conduct or performance action may be taken (maximum penalty $30,000)." https://www.psychologyboard.gov.au/endorsement.aspx

Back in 2014 the APS also argued for differential treatment by the PBA of 'novices' and experienced psychologists:

> "The APS recognises that there are inherent differences between a novice practitioner (less than five years of experience) and individuals with extensive experience but who have not practised as a registered psychologist for a period of time. ... A one-size-fits-all approach that focuses on re-training of psychological skills and supervision is not helpful to the latter group. The APS recommends that the Board adequately recognise psychological practice through the development of recency of practice guidelines based on assessing applicants' gaps in skills and knowledge and directing applicants to appropriate CPD programs" (APS, 2014. p.4).

9. APS Consultation Process

There are 29,982 registered psychologists in Australia, of which it is claimed approximately 24,000 are members of the APS. Of this 29,982, 8,725 (29%) have clinical endorsement. The APS state that they represent all psychologists, however, a rapidly growing number of psychologists feel they are not being fairly represented.

The APS formed a Terms of Reference for the consultation process. They then developed guiding principles for the delivery of psychological services. They also established the APS MBS Expert Committee. They sought input from APS members and submissions to the APS MBS consultation. They then developed their Green Paper: APS Member Consultation Paper: The delivery of psychological services under Medicare's Better Access Initiative,

The APS asked members to provide feedback on the 'Green Paper' via an online survey which allowed for written feedback. Many members of the APS were appalled by one particular section, recommendation eight of the 'Green Paper'. It was thought that this recommendation would continually contribute to the segregation of those with clinical endorsement and those without clinical endorsement. It also became evident that many members believed the feedback process was not a fair and due process. This was particularly evident in the large volume of information provided via direct email to each and every member of the clinical college. However, the same volume of information was not provided to members without an AoPE.

The APS survey was a measure that lacked validity and instead was full of response bias. There were no items with response options with statements asking about the three-tier system and in particular about the suitability for the appropriate clinician. Instead, written feedback was required. This, of course, would not be given as much weight as the invalid and unreliable items in the survey. This was particularly surprising, as validity and reliability of a scale is taught in undergraduate statistics courses. Many of the APS members felt despondent about the whole process and the lack of regard given to their clinical skills and experience.

10. What is AusPsy?

Below is a summary of AusPsy (2018)'s submission to the PBA:

AusPsy is a community group of psychologists who represent the interests of all registered psychologists and the right of all Australians to access quality care. They acknowledge the individual's right to choose their treatment team in line with their needs and availability.

10.1 Concerns about AoPE

AoPE standards that the PBA are proposing do not recognise the value of experience and prior learning in psychology. Instead, the PBA promotion of alternate pathways to AoPE and the superficial changes made to the AoPE standard, suggests that they support the faulty premise that non-endorsed psychologists are not competent to practice.

The PBA is continuing with an AoPE system that is not evidence based and creates division within the speciality of psychology. This division has already been witnessed, along with the adverse impacts upon university course offerings, job advertisements, restrictions of practice for non-endorsed psychologists and employment pathways for psychologists.

10.2 Unfair Discrimination and Restriction of Trade

The national registration with PBA provides all psychologists with the right to practice. The current and proposed PBA endorsement of divisions within psychology in Australia, and the subsequent training and accreditation pathways to these AoPE, unfairly discriminates, and restricts, psychologists from practicing their profession.

10.3 AoPE Does Not Reflect Best Practice at International Standard

To support, train and retain a strong psychology workforce to serve Australians, the pathways and access to training and accreditation in advanced levels of study in psychology must be reformed beyond a revised AoPE standard.

The Council of Australian Governments (COAG, 2007) directive on international standards and practices states that:

> "Wherever possible, regulatory measures or standards should be compatible with relevant international or internationally accepted standards or practices in order to minimise the impediments to trade" (p.17).

11. A New Way Forward: EuroPsy

11.1 What is EuroPsy (or European Certificate in Psychology)

EuroPsy (or European Certificate in Psychology) is a European standard of education, professional training and competence in psychology set by the European Federation of Psychologists' Associations (EFPA).

11.2 EuroPsy Project Has Significantly Strengthened the Profession of Psychology in Europe

The Basic EuroPsy Certificate presents a benchmark for independent practice as a psychologist that can be issued to a psychologist who has demonstrated that they have met these standards. It requires three-year undergraduate degree and a two-year Masters degree (or equivalent training that is approved by certified supervisor) followed by a year of supervised practice. The type of courses you can do in the higher degree learning phase are flexible. They believe that competence as a psychologist is actually gained during supervised practice. If you want to move to a different area than you have studied or practiced in you need to undergo supervision in order to gain competence in that area. This ensures competence and protection of the public.

The EuroPsy Specialist Certificate in Psychotherapy, or a EuroPsy Specialist Certificate in Work and Organisational Psychology can be issued to a psychologist with more advanced education, training, and experience in these specialist areas of psychology. This is to encourage psychologists to participate in research to further the profession.

There is a Register of EuroPsy psychologists with national listings of certificate holders that can be consulted by any person or organisation seeking the services of a qualified psychologist. Through the EuroPsy, EFPA encourages and promotes psychologists to obtain continuing and specialized education throughout Europe.

EuroPsy is not a license to practice in a particular country, but a European qualification that complements national standards.

Professor Poortinga has been a member of the EuroPsy European Awarding Committee since 2010 and was involved in the development of EuroPsy within the two projects from the Leonardo da Vinci programme of the European Union. (2000). In an interview with Professor Poortinga (full interview here https://efpa.magzmaker.com/december_2018/news_from_europsy/interview_europsy_2) he made the following points that are used here to promote further discussion with Government:

- If psychology as a profession is societally meaningful, it is important that professionals rendering services are competent. In my mind there is no doubt that EuroPsy has contributed to strengthening of the profession in Europe.
- Requirements for continuous professional development (CPD) and the qualifications of training supervisors were not easily met in some countries where there were few traditions of building and maintaining professional competence.
- The shadow side of hope is fear…One may hope that psychologists in Europe will remind themselves that 'united we stand, divided we fall'.
- During the past eight years, the interpersonal relationships on the EAC were collegial and warm, and that has made my membership a pleasant task.

11.3 Support of EuroPsy by AusPsy

AusPsy supports the International benchmark demonstrated by EuroPsy pathways to registration, as it more accurately reflects the needs of, and requirements for, Australian mental health, the psychology profession, and the COAG directive.

This will enable any person or organisation to obtain psychological services from qualified and competent professionals, as supported by AHPRA. It will ensure that there is a diverse workforce to cover the needs of our population.

11.4 Evidence-Based EuroPsy Qualification

AusPsy argues that the evidence-based EuroPsy qualification standard aligns more closely with the needs of Australia than the Americanised approach that is currently being promoted by our health practitioner regulatory body. AusPsy proposes that the EuroPsy qualification pathway is adopted, with the 3 -year undergraduate degree in psychology plus 2-year postgraduate degree in professional psychology plus 1-year supervised placement leading to an area of practice endorsement based upon competencies assessed in the field e.g. Health/Clinical, Educational/School, Work/Organisational and Other. We believe there may be more areas of endorsement due to our particular needs such as Disability and Aboriginal and Torres Strait Islander area of practice. These require further analysis.

In adopting the EuroPsy model all currently registered psychologists in Australia would be eligible to apply for an AoPE by providing documentation as to their experience and supervision in their field of practice. AusPsy has completed a comparison of the EuroPsy system to the Australian system and believes the transition would be cost effective and improve the quality and consistency of degree content across universities and placements.

12. Consumer Choice

AusPsy also values EuroPsy's approach from a consumer choice perspective as it is a clearer and effective method of assessing experience and competence.

12.1 Address Current Misleading Information

Pirkis et al. (2011)'s evaluation of Better Access included an analysis of the outcomes achieved by clinical psychologists and general psychologists. The study also included GPs but this data is omitted for the purposes of simplicity.

The mean improvement in K-10 scores of the sample groups who consulted clinical psychologists versus registered psychologists was not significant.

AusPsy recommended that AHPRA address the current misinformation about competency of psychologists with different registration titles. AusPsy request a correction in line with the evidence that all registered psychologists are competent to assess and treat mental health conditions across the lifespan.

13. Proposed Model

In consultation with the APFG page, and taking into account all the information provided in this report, the authors propose three models for consideration.

13.1 Proposed Model 1

One-Tier Model

One Medicare rebate for all psychological services offered by registered psychologists regardless of endorsements.

The Medicare rebate has remained the same since November 2012. The 2018-2019 APS Recommended Schedule of Fee for a standard 45 to 60-minute consultation fee by all psychologists is $251. It is recommended that the Medicare rebate is increased to $150 for all psychologists.

It is further recommended that MHCP sessions increase from 10 sessions to 20 sessions plus an additional 10 sessions able to be accessed.

13.2 Proposed Model 2

The Psychiatric Model

One Medicare rebate for all psychological services offered by registered psychologists regardless of endorsements.

According to the 2014-2015 Australian Department of Health data, the average psychiatrist fee for a 45-75-minute consultation was $267. The Medicare rebate for psychiatrists for a management plan is $390.55, for an initial consultation $224.60, 45-75 minute consultation $158.45, and 30-45 minute consultation $114.85.

It is recommended that the Medicare rebate for psychologists follows the same model as the abovementioned psychiatric Medicare rebate. As with the psychiatric model, a GP referral is required once a year. The amount of consultations is unlimited per year.

13.3 Proposed Model 3

Three-Tier Model

One Medicare rebate for all psychological services offered by registered psychologists regardless of endorsements.

The Medicare rebate has remained frozen since 2012. The 2018-2019 APS Recommended Schedule of Fee for a standard 45 to 60-minute consultation fee by all psychologists is $251. It is recommended that the Medicare rebate is increased to $150 for all psychologists.

It is further recommended that psychological service delivery align with the Australian Government's stepped care model of mental health according to the consumers' level of need (mild, moderate or severe), through increased sessions (up to 40) and intensity of services. These psychological services can be delivered by ALL registered psychologists.

13.4 Recommended Model

The Psychiatric Model

It is recommended that psychology items mimic the psychiatry items. A referral is required once a year and can come from a GP, psychiatrist or paediatrician. Based on the psychiatry MBS items, it is recommended that psychology items be unlimited sessions per year, telephone or in person. It is recommended that the items be listed as below:

Psychology assessment items	1-90 minutes	91-120 minutes
Psychology treatment/therapy items	1-30 minutes	30-60 minutes
Telephone consultations items	1-30 minutes	31-60 minutes
Group Therapy items		> 60 minutes
Group of 2 to 9 unrelated patients or a family Group of more than 3 patients;		
Family group of 3 patients;		
Family group of 2 patients		
Case conferencing items	1-30 min	31-60 min

14. Glossary of Terms

ATSI	Aboriginal and Torres Strait Islander
CND	Complex Neurodevelopmental Disorder
CPD	Continuing Professional Development
DVA	Department of Veterans Affairs
FPS	Focussed Psychological Strategies
GPs	General Practitioners
HODSPA	Heads of Departments and Schools of Psychology Australia
MBS	Medicare Benefits Schedule
MHCP	Mental Health Care Plan
MHTP	Mental Health Treatment Plan
PBA	Psychology Board of Australia
PBS	Pharmaceuticals Benefits Scheme
PDD	Pervasive Developmental Disorder
PHNs	Primary Health Networks
PM	Prime Minister
PPAI	Psychology Private Australia Inc
PTMF	Power Threat Meaning Framework
PTS	Psychological Therapy Sessions
PTSD	Post-Traumatic Stress Disorder

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Appendix A: Client Experiences with a Psychologist

A1

Dear Sir/Madam,

I have seen my psychologist on referral from a doctor since June 2016 and for approx. 35 sessions.

At the start of our sessions, I was feeling depressed and anxious. I learned how to identify my emotions instead of running away from them, ignoring them, suppressing them, or using alcohol to avoid my emotions and associated feelings. I learned how to take care of my emotions and how to make proactive choices for my wellbeing.

Now I am able to recognise my emotions and feelings and connect with my family albeit in a new way of connection which I still heavily rely on my psychologist for help and understanding. I no longer need to suppress my emotions but can now recognise them and the associated feelings that arise. I can now do what is necessary to make myself feel whole and embark on the action necessary in the circumstance.

What I found really helpful was the way my psychologist was caring, insightful, and informative. I am grateful for the variety of effective interventions she has made available in between sessions via text message, emails and phone calls, etc.

I would wish that I could see my psychologist more per year under the Medicare system.

I would wish that I could receive a higher rebate to see my psychologist under the Medicare system.

In the beginning, I saw my psychologist fortnightly and I felt stressed when the 10 rebated sessions ended for the year. I am still stressed and struggling to deal with this situation.

I had previous experience with several other psychologists who were not a good fit for me because they used interventions that were inappropriate to my situation, mostly only letting me talk the whole session and not saying anything back.

My psychologist does NOT have a clinical endorsement. I want my Government to allow me to choose to continue to see my psychologist. We have come a long way together, she has helped me in the initial phases of my recovery but now I need to learn how to relate to my family and others, processes that I never learned as a child. If you force me to pay out of pocket in full I would feel extremely victimised and would no doubt have to consider terminating therapy; and if you forced me to see a psychologist who is clinical, even though their rebates are significantly higher than what my psychologist can offer me, I would feel my only lifeline has been cut and I have been denied access to the one person who has an intimate knowledge of my case and who has successfully intervened in my life to help produce a state of wellbeing that I have not known before.

Yours sincerely,

A2

To whom it may concern,

I have seen my psychologist on referral from my GP since 2010 and for approx. 45 sessions. At the start of our sessions I was feeling anxious, depressed, and hopeless.

I learned all about how to identify my emotions instead of suppressing them. I learned how to take care of my emotions. I learned how to manage my feelings of overwhelm and panic. Now I am able to engage in social activities, reconnect with my friends, return to study and feel happy. Most importantly, I have richer relationships with my husband and children.

I no longer need to suppress my emotions because I have some tools to manage them.
What I found really helpful was the way my psychologist was insightful, understanding and caring. Although initially unsure how anyone could possibly help, my psychologist has been effective with interventions and has given me hope. I find my psychologist's availability and flexibility really helpful.

I wished, particularly when I first starting seeing my psychologist, that I could see them more times per year under the Medicare system. I felt stressed when the rebated sessions ran out. Now I don't need to see them as often, but still need to when my emotions become overwhelming (maybe 5 times per year on average but some years more than others).

I wish that I could receive a higher rebate to see my psychologist under the Medicare system. The out of pocket cost is sometimes a deterrent in booking an appointment.

I had seen at least 5 other psychologists previously, who were not a good fit for me because they were predictable in their advice. I did not feel they could help me as they didn't seem to really understand what I was experiencing and didn't give me tools over and above what I was already trying. I felt more hopeless after seeing these previous psychologists as I didn't know what would help if they couldn't.

My psychologist is not a 'clinical' psychologist. I want my Government to allow me to choose to continue to see my psychologist because they are important for my well-being and I need to know they are there when I need them. If you force me to pay out of pocket in full, I would feel distressed, and if you forced me to see a psychologist who is 'clinical', I would feel hopeless again.

Kind regards,

[redacted]

Appendix B: Case Studies of Psychologists Who Have Also Been Consumers

B1: Psychosis and the System

I am a registered psychologist and also have a research PhD. I fell pregnant at 40 years of age. I had an unsupportive partner and had a difficult pregnancy where I had "morning sickness" throughout the entirety of my pregnancy. My labour was uneventful. After the labour, I became very anxious and worried that my baby was going to die. Without going into too much detail, I was recommended to demand feed my baby. I had little sleep over the next five days. When I look back, I probably had seven hours sleep over five days. I started to develop psychotic symptoms. I thought I was a median to the midwives. My partner thought I was going crazy, but the midwives were supporting my "delusions" stating some women had very spiritual experiences after child birth.

To cut a long story short, I was discharged from the maternity ward and assessed by the Acute Care Team who I used to work for. I was then taken involuntarily on an Emergency Examination Order by police to the local hospital where I used to work in the Emergency Department. Even the police were questioning why they were taking, to which I explained the circumstances. I was assessed by a registrar psychiatrist who I used to work with. She then contacted the psychiatric consultant who I also used to work with. A decision was made, against my family and my own wishes, to place me on an Intensive Treatment Order. I was then transferred to an out of area public hospital and my baby removed. My baby was five days old. My family were left to fend for themselves with my newborn. When they asked how my breastfeed baby was going to be fed, there were advised by nursing staff that it wasn't their problem.

When I woke the next day, I thought I had dreamt having my baby. I was in a locked ward and thought I had lost my mind. Luckily, I had a consultant psychiatrist who knew about attachment theory and stated that the most important thing was about getting my baby back. My child was away from me for 12 hours. I was transferred by ambulance, without my baby, to a private mother baby unit and went from there. My recovery was slow. I was hospitalised three times over the first six months of my child's life. I had a psychiatrist who tried to diagnose me with bipolar which I resisted. I got my life back together as my child got older and went back to work. I was mistreated by my psychiatrist and remained unwell for seven years. During this time, I saw a psychologist who was my saving grace. Eventually I got another psychiatrist and between the psychiatrist and the psychologist, my child and I are healthy and moving forward. Whilst I was going through this, I lost all faith in my profession.

I now have regained my faith in psychology. I believe it is not about who has what training, that is irrelevant. It's about the therapeutic relationship between therapist and client. Not all therapists and clients are good fits. However, it is not for the client to keep going back to a clinician who they are having trouble building a therapeutic alliance with. Instead, it's finding someone they do. If a mechanic doesn't fix our car the way we want it, we don't go back to him and we also don't never go to a mechanic again. We source out a mechanic that will fix our car the way we like it. It might take seeing ten mechanics to do this, but eventually we will find the one we want.

B2: Lived Experience of Multiple Diagnoses

I am a registered psychologist. I hold a Masters in Education and Developmental Psychology, with an Education/Development area of practice endorsement. I have been in private practice for eight years, treating individuals with Autism Spectrum Disorders (ASD) across the lifespan. I am qualified to supervise four plus 2, 5 plus 1, Education/Development Masters' students and Education/Development registrars. I also currently provide the one third of supervision hours allowed by clinical psychologist registrars for five psychologists.
Additionally, I have 2 children, one with ASD/ADHD, GAD, Panic Disorder, OCD, MDD, PTSD and Tourette's, the other with ADHD, GAD and Tourette's. I also have diagnoses of GAD, Panic Disorder, MDD, OCD and PTSD myself. All three of us have accessed psychological services at various times.

When my eldest son was first diagnosed, we accessed the services of a clinical psychologist and a specialist clinic for ASD. She was our first interaction with mental health services and provided a manualised program titled "Exploring Feelings" by Tony Attwood. While this seemed to have no effect at the time, a year or so after, my son started showing signs of using the strategies, especially the externalisation of anger. He loved to go to sessions with her. Subsequently, he has accessed a number of psychologists, with almost no gains. The only negative experience was with a clinical psychologist, who did not identify his significant ASD, until he told her. We also had a conflict over fees, as she had a complicated fee system, and I ended up being overcharged by around $400.

My youngest son accessed a registered psychologist for anxiety with little effect, and gained more benefit from a group program, the "Brave Program" run buy provisional psychologists at a local university.

I have accessed four psychologists and one mental health social worker during my treatment of my challenges. Two psychologists were clinically registered. One of those told me "you are intelligent, why are you anxious?" I disengaged after that. The second clinical psychologist, the most recent contact with allied health, was helpful in sorting out some relationship issues.

However, my most successful interaction with allied health was the mental health social worker. I visited her weekly for approximately ten months. She practiced from a psychodynamic framework, and was instrumental in breaking down most of my barriers and unhelpful narratives, then supporting me in building more helpful narratives.

In my professional life, I work in a clinic that has 15 psychologists, approximately two thirds are either clinically registered or undergoing the clinical registrar program. Of those, most are gaining professional supervision through myself, some regularly and some occasionally. The practice takes data on client retention and client satisfaction. There are no differences between the clinical psychologists and registered psychologists. I have both the best retention rates and satisfaction rates of the practice.

B3: Postnatal Depression

I am a registered psychologist with a Masters in Population Health. I am also the founder of my private practice.

Basically in 2010 after years of infertility I fell pregnant via IVF and had an early miscarriage. Then in 2011 I gave birth to twins who were conceived via IVF. They were separated from me at birth for a number of hours then my little girl was put into special care as she had low birth weight and could not feed or maintain her body temperature. I think this was the start of what ended up as postnatal depression and anxiety.

When she came home, I was well aware of the risk of SIDS in a low birth weight baby. I spent the nights up and down checking that she was still breathing. Due to her low weight we were told to wake her every three hours night and day for feeding. Feeding would take 45 minutes to an hour as she was a sleepy baby. So, I would get maximum two hours of sleep at a time, night and day unless she or her brother were restless and then much, much less. They had so many feeding problems and allergy to cow's milk so I had to keep breastfeeding. We went to feeding clinics, day clinics, weekly weight checks and every day I felt deficient. It was my fault she wasn't putting on weight. Child health reinforces this in a way. Pushing me to pump and boost my supply. I ended up getting not much sleep at all. Most days I was trapped in their room. Unable to move. Terrified they were going to wake up and I'd have to manage on my own until my husband got home at 4. I would sit and watch the clock every day. Feeling more and more anxious. Feeling overwhelmed by the responsibility of looking after two fussy babies who had colic and reflux.

After nine months we ended up going to a feeding clinic because my daughter still wasn't putting on enough weight. It was only then that someone noticed the state I was in and that this was not normal. I did not even realise I was depressed and anxious and needed help. They arranged for perinatal mental health to start doing home visits to help me regain my mental health. At this point I was also diagnosed as iron deficient and vitamin d deficient due to the demands in my body and isolation inside my home. I was very fortunate that treatment was able to come to me. I would not have been able to leave the house. That was how bad of a state I was in. I was lucky to have the energy to have a shower or change out of my pyjamas. I think doctors don't often ask people how they are doing emotionally. I have no idea why it took nine months for someone to notice what was happening. I was often in tears in appointments, especially weigh-ins with child health and the GP. Yet no one asked me how I was doing emotionally. Even my close friends and family had no idea.

I am absolutely fine now. I had about six sessions with a mental health nurse and my symptoms resolved. I had another baby (complete surprise) and had no signs of PND.

I think this traumatic birth and early life experience also predisposed my twins to anxiety disorder. They have also had treatment with a psychologist last year after issues arose at school. We did this without a mental health care plan as I did not want arbitrary diagnosis that would follow them for their whole lives and did not want mental health on their health file. At $180 a session with a non-endorsed psychologist it was expensive but well worth it.

B4: Consumer inspired to re-commence work as a psychologist

I am a registered psychologist with a Masters in Education and Developmental Psychology. I am midway through gaining an Education/Development area of practice endorsement. I have worked in private practice for 20 years treating individuals of all ages. I am an AHPRA Board Approved supervisor. I have supervised Masters of Counselling students and fourth year placement students.

I sought help from several psychologists throughout my marriage to assist with a lack of connection. This was an overall disappointing experience as I felt our goals, feelings and what we needed to reconnect were unheard. We completed tests which were expensive, time-wasting and ineffective. We were asked to hug each other which we thought was idiotic. One psychologist said he would be able to make me [the woman] happy which made me cringe - it was demoralising. Another therapist did make a connection and helped me to feel validated but he was too direct for my husband who then ended treatment. The therapist had triggered my husband's past, leaving him feeling in the wrong, a mistake, rejected, and not good enough. We separated.

I took my son to see a psychologist at 4 years of age after showing signs of regression following a home burglary. I found the psychologist's manner quite cold. She excluded me from sessions and offered no insights into what was happening for my son. The psychologist requested that we continue to attend and I felt at the time that it was purely for financial gain. However, I kept an open mind and attended about 4 sessions. I felt that the part my son found most beneficial was the extra time I spent with him in the car taking him to the sessions. When I look back now as an experienced psychologist, I wonder how much pressure was put on this young psychologist to 'keep billing' because as the consumer, I experienced little value or satisfaction from the sessions.

Two years ago, my son was assaulted which required him being taken to hospital. He was not offered counselling by the hospital, the police or the court system He experienced Post Traumatic Stress Disorder. I believe that counselling should have been offered to him in an accessible manner as the PTSD severely impacted his day to day living.

During my marriage, my three children were subjected to emotional distress. After separating, on the advice of a Court appointed psychologist, we were ordered to a 50% care plan that was based on no evidence, was contrary to the child's best interests and severely impacted their connections with me, and their sense of security and trust. It took all my focus to keep the children at school and continue their social and recreational interests in order to protect them against the abuse whilst they were young and out of my care. I consulted the courts, lawyers and the appointed psychologist to understand how to implement his unworkable recommendations but he, the courts and the lawyers all advised me to "give it time". My children subsequently endured further anxiety and trauma.

In attempting to get my children therapy I found that many counsellors seemed reluctant to work with such a vexatious case. The one therapist we did see was unable to connect with my children and school counsellors seemed unable to deal with the enormity of the issues. I have had to undergo my own counselling to deal with my children's distress and the impact of their father's behaviour. My counsellor was very helpful because she was non-judgemental, she did not offer superficial practical solutions, she listened, she was empathic, she showed me unconditional acceptance, and she did not rush me through the therapy process. It was such a relief to have somebody on my side, who understood me, and was able to help me at the pace I was mentally and emotionally able to handle.

She helped me to identify what my emotions were, how to take care of myself, and how to use my feelings as a guide to what was good or not for me. She taught me how to respect myself in ways I had not experienced previously in my life. I am a better version of what was already a pretty good person, and much more who I want to be in my life, instead of feeling stressed, nervous and confused about life and its events.

As a psychologist, I knew I could connect with people, hear what they wanted, and help them identify their underlying needs and feelings. I do this in my work now, using a mix of scientific background and the art of knowing when and how to intervene. I wish I had seen someone like me when I was struggling in my marriage to help me perhaps prevent having become separated.

As a consumer, I value the work of psychologists. I believe that experience in the field, and in life, bolsters the efficacy of the psychologist in combination with the evidence-based models and therapies studied at University. Continuing Professional Education and supervision with peers and mentors are also important aspects to keep the psychologist current and innovative, plus refreshed and enriched to continue working in a rigorous and sensitive manner. Psychologists change lives and that ripple effect will create wonderful opportunities and gains for all Australians.

B5: Experience as a Provisional Psychologist and consumer

I am a Registered Psychologist with a Bachelor of Psychological Science with Honours, and completed the 4+2 pathway to registration. My experiences during my internship were incredibly challenging, exciting, thought-provoking, and generally an immensely growth defined period in my life. Compared to friends completing the postgraduate pathways, I felt there were many more hurdles to jump, that my work was held to a higher standard at times, and that I was 'thrown into the deep end' with seeing clients much sooner and with more complex and severe presentations than those at university. I do not regret my choice of pursuing this pathway, and feel well equipped, confident and knowledgeable given I am in my early career.

I was fortunate enough to be guided through the 4+2 pathway by two exceptionally knowledgeable and supportive supervisors. One was clinically registered and one was generally registered, both with decades of experience. My clinical supervisor was wonderful with regards to explaining theories and linking concepts, exploring self-reflection practices, and expanding my skills across several therapies. My other supervisor was more focused on trans- and countertransference, being trauma-focused, reflecting on the therapeutic relationship, and self-exploration. Both excelled in their critical thinking skills, and in their respective knowledge bases, EMDR and EFT. Both strongly believed understanding myself was critical to ensure my biases, prejudices, values, and life experiences were compatible with my chosen career specialisation, my goals and aspirations, and that I was working with the most suitable presentations for my interests. Because of them, I feel suitably confident and competent to practise and maintain high levels of self-care, self-awareness, and self-reflection, and am open to feedback, supervision, and peer consultation which I was less comfortable with prior to my internship. I cannot thank them enough for their expertise, support and belief in me.

There is a particular impetus for why I decided to become a psychologist. I am the eldest of two, and my sister is considered to be severe on the Autism Spectrum. She was mute until five, and still struggles with significant behaviour difficulties, epilepsy, and has an intellectual disability to boot. Due to her developmental difficulties, I was exposed to many Allied Health professionals from a young age, and was inspired to be a part of such an integral group of people who helped my sister become vocal and improve her fine and gross motor skills. She had speech therapists, occupational therapists, dieticians, neurologists, special aid teachers, but never a psychologist. My mother struggled significantly with her diagnosis and having little support from my father at times, felt quite burdened and overwhelmed with the high level of care my sister required. I may have also benefited from such support feeling as though my sister's needs always came before my own, and that I had to be the untroublesome daughter because my parents had enough troubles with her. I noticed this gap with regards to our mental health support as I became a teenager, and my mother got cancer. When she passed away, the caregiving duties fell to me, and it was quite a burden. In high school, I took an elective in Psychology, and the rest is history!

I have had significant losses in my life, including the death of parents when I was still a teenager, and becoming estranged from my family. I have been a consumer of psychological services during that time due to grief and loss, and when I experienced birth trauma after my twin pregnancy. My experiences have been wholly positive with the psychological profession, regardless of one's title, and I have never noticed a difference in their effectiveness. Across those separate experiences, I have been encouraged to develop a more compassionate self, to focus my attention on the present moment, to challenge unhelpful thoughts, to learn how to detach from painful thoughts, to feel strong emotions, and to engage in activities that bring me joy, and set boundaries around people and activities that are not healthy. Each practitioner had their own style, their own way of explaining concepts and way of relating to me, and none were better than the other. I think it would be a detriment to the profession and to clients to limit general psychologists to mild presentations, and clinical psychologists to moderate and severe ones. To have a variety of choice and therapist-client fit was of utmost importance to me, and I carefully selected my psychologist each time. I believe it would be ignoring client's autonomy and freedom to choose by limiting the pool of available psychologists to them.

B6: Lived experience of a student turned consumer turned practitioner

After 15 years working in corporate marketing, I felt completely unsatisfied and decided to follow a long-standing dream into something more meaningful to me. Somewhat concerned, as I hadn't been without an income for over a decade, I submitted, and a few months later accepted, an application to study Psychology as a mature age student at Monash University. It was the best decision I ever made. After my first year of an undergraduate Arts Degree, I was offered a scholarship for academic excellence. I remained on scholarships throughout my degree, including a competitive fourth year, which I completed with First Class Honours.

After study I returned to work as a Research Assistant at a prominent mental health research facility, who had generously accommodated my coming and going over the previous 5 years to fit with my study. I was part of a team researching a psychosocial treatment program for those with psychotic disorders and drug or alcohol dependence (i.e., a dual diagnosis).
Over the years, many attempts to start a family had been unsuccessful. In desperation I threw all my cards in the air and started an IVF program and simultaneously applied to Monash University's Doctorate in Psychology (Clinical). I was accepted and received a Monash Graduate Scholarship. As fate would have it, halfway through the first year of the course, we had a successful IVF round. I reluctantly took leave and ultimately withdrew from my Doctoral candidature.

As my dreams were being realised, my husband's mental illness escalated - perhaps with the pressure of marriage and impending parenthood. He became increasingly controlling, emotionally and verbally abusive, and then physically violent. In an attempt to understand this, I consulted three psychologists and one relationship institute (Court ordered). Of these encounters I recall the following: A social worker said "It will take many years of intense psychotherapy to change your husband"; a Registered Psychologist said "It sounds like he has Narcissistic Personality Disorder"; and a Clinical Psychologist spent much of the hour talking about herself. I have not forgotten how frustrated I felt as an unemployed single parent having spent $200 plus dollars to hear this. Each of these experiences have paved and informed how I operate as a Registered Psychologist.

As a suddenly single parent of a 17-month-old child, I needed to earn a living but had not completed the study required to gain registration as a psychologist. The ideal option was to pursue the 4 + 2 pathway and complete two years of supervision. This way I could begin to earn money as a Provisional Psychologist and become registered in the process. I did all the research to ensure that this pathway to registration allowed me to work as psychologist focussing my interest on anxiety, addictions, childhood abuse and the impact of trauma on individuals and their loved ones.

After completing my supervision requirements, I proudly became a Registered Psychologist. For the next 7 years I work at the private practice where I completed my Supervision. After 5 years, I secured an office lease closer to home and slowly began building my own private practice. The business thrived and for the past 7 years, our staff numbers have increased as our relationships with medical practitioners and word of mouth referrals have flourished. This has been possible because I have a 'bedside manner' that cannot be taught with any amount of study. I understand people and have an innate ability to hear their pain and assist them to work though it and create better futures for themselves.

It is now suggested that the pathway I chose, under the advice of the profession's governing and regulatory bodies, is inadequate for me to practice in my areas of interest. My effectiveness in these areas has produced a thriving business with a wonderful reputation. The suggestion that I must complete two further years of study at an estimated $40,000 is ludicrous, unfair and unreasonable. Worse, the parties suggesting this provide no evidence to support this apparent need.

Reason must prevail to maintain the integrity and unity of this profession.

B7: Pathway to becoming a psychologist

I am a registered psychologist with a research PhD.

My career started as a support worker for people with mental health issues. This was in my second year of an undergraduate degree in psychology. I then started a role as a probation and parole officer at [redacted] who paid for my 3rd year university fees. Once I gained my Provisional Registration, I began my 4 + 2 pathway at [redacted] as a provisional psychologist. The 4 + 2 pathway competencies were exactly the same as my colleagues completing the Masters program. However, I had to source a way to meet my competencies rather than be given assignments that matched each competency. All of my competencies were read and signed off by my supervisors.

Around this time the two-tier system was being debated. I was strongly encouraged to enrol in the Clinical Masters program by a clinical academic, who was also an assessor for the APS for the "grandfathering" of clinical psychologists. I enrolled in the Masters and Corrective Services again covered the fees. However, neither the Clinical Masters program nor my work were flexible with time arrangements. The clinical program expected me to study full-time and seemed to prioritise this over me making a living. [redacted] wouldn't allow me to use the work I was doing with the prisoners to fulfil course work. I was working full-time and didn't see how I could juggle the workload. I applied for a scholarship for the PhD program thinking I had nothing to lose. I received my university's three-year scholarship and embarked on a research PhD.

Whilst completing my PhD I worked for the acute care team at our local hospital, and also for a parenting program at the university. I was still working full-time but now with the flexibility of working nights and weekends.

I finished my PhD and again, I was strongly encouraged to enrol in the Clinical Masters program. There was debate about whether I would need to complete another thesis. I was also advised that I wouldn't be credited for the subjects I had completed earlier as the program had been restructured. Under great duress I re-enrolled but then became pregnant and had to withdraw.

I went on and have attained a lot of experience in lecturing, researching and clinical roles. In my current clinical role in private practice, my clients are charged $165 whilst clinical psychologists' clients are charged $205. Some of these clinical psychologists have only recently graduated from university. I also previously worked for a bulk-billing practice so that we could reach those who were not fortunate enough to be able to pay the 'gap'. Unfortunately, I was not able to sustain working in this practice as I was a single mum on one income. My hourly rate was less than someone working in an unskilled profession, particularly when you consider 'no shows' who are predominantly evident in bulk-billed practices.

It is a complete disservice to the profession and experienced psychologists to have this segregation within our ranks. We should all be getting equal pay and should not be having to fight for this recognition. In what other profession, is experience on the job not recognised.

Appendix C: Letter to the Psychology Board of Australia

[redacted]
Sent: Sunday, 14 Apr, 2019 At 12:10 PM
Subject: Your recent Newsletter

Dear [redacted],

Thank you for your input into the difficulties that the psychology profession is currently facing. It is very unnerving for many people. It also feels highly orchestrated, secretive and blatantly unfair that rules seem to be changing without due consideration for a large portion of the workforce to which you refer. Proposed changes are negatively impacting a highly committed and dedicated workforce of the past 15 years plus.

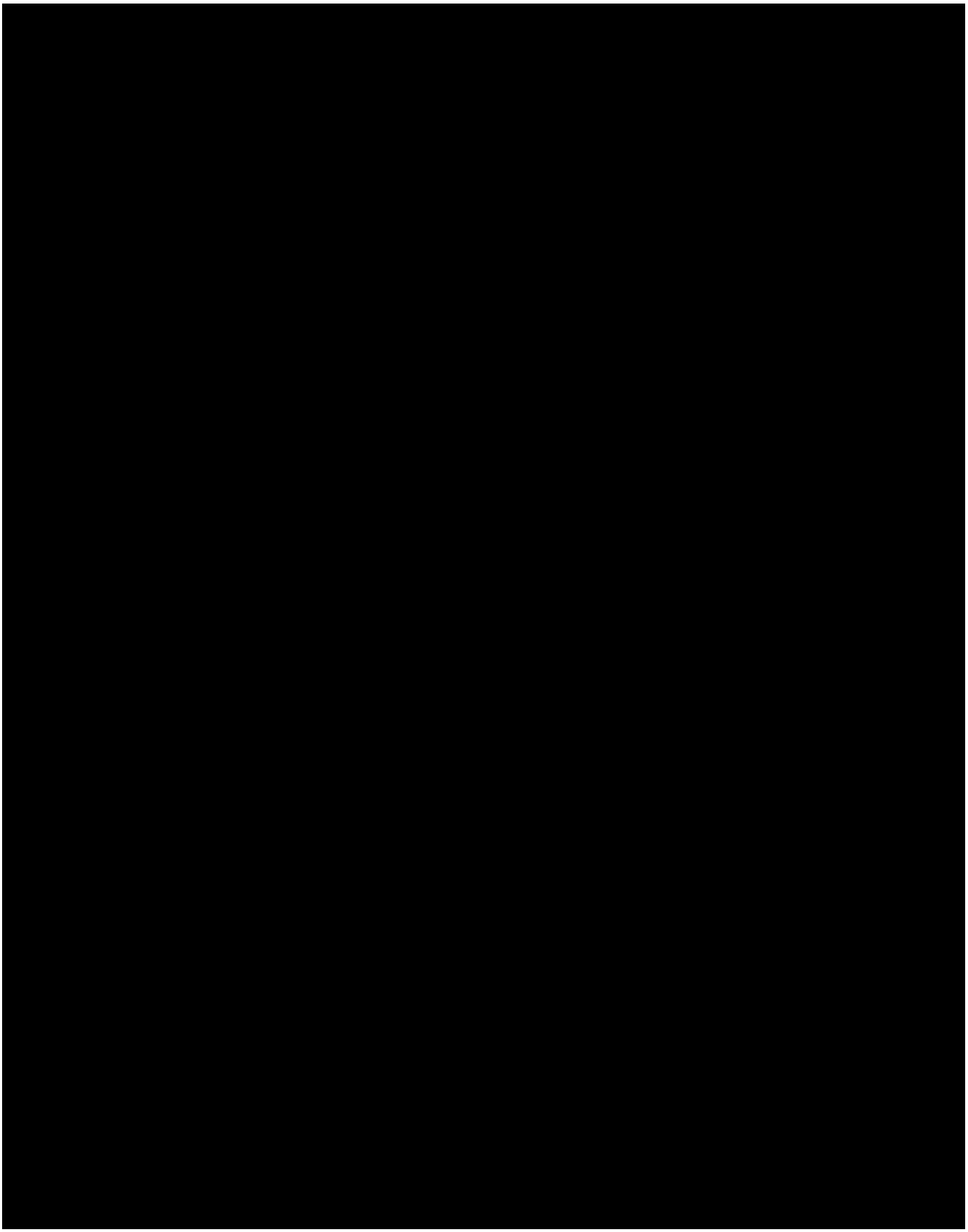
You are no doubt aware of the fractures that are being experienced and the considerable exodus of members from the APS. This may be the reason for your sudden and unexpected email. I am replying because I would like my view and feelings to be known.

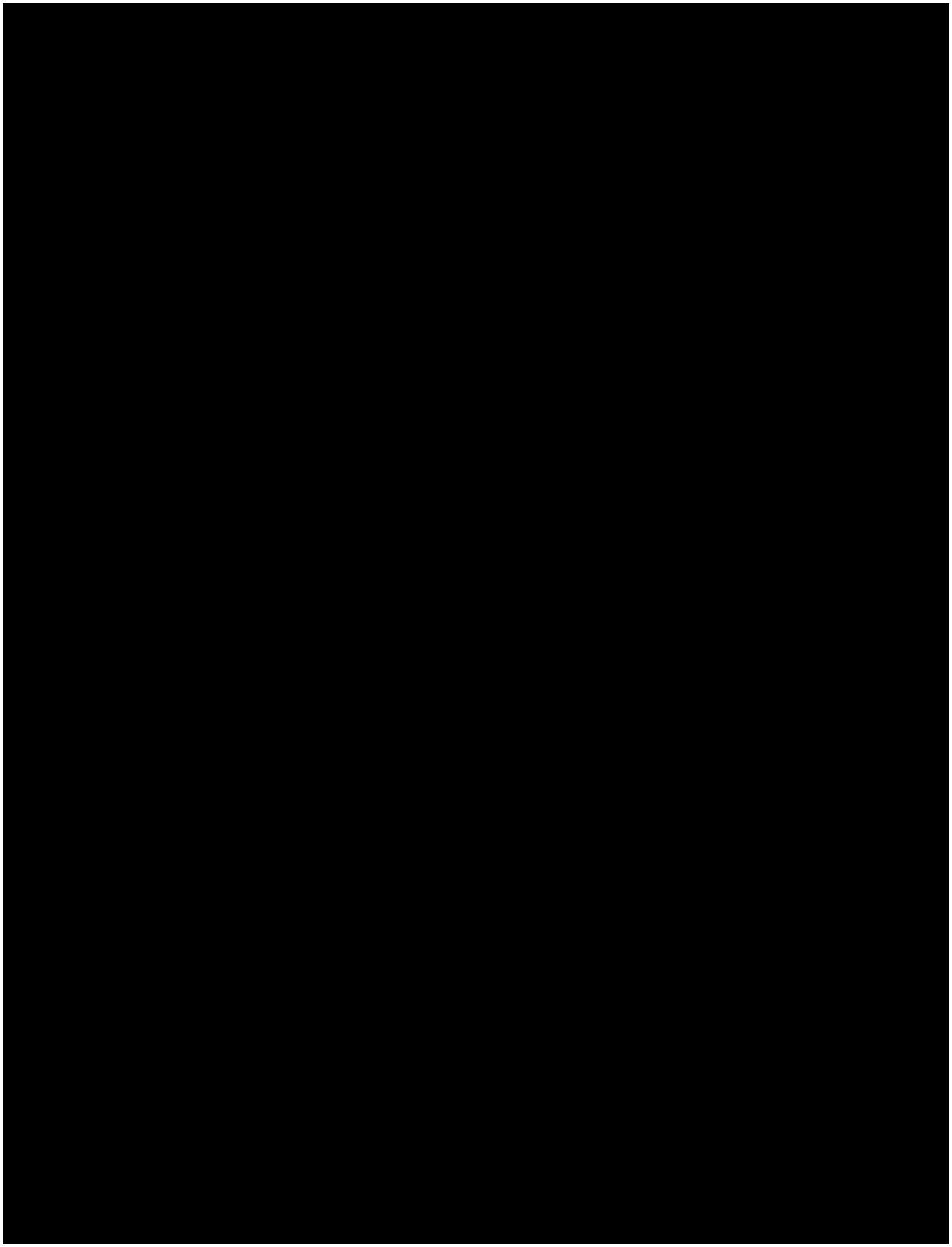
I have no issue with altering the structure of qualifications to practice as a psychologist to reflect current times and needs. What I am absolutely opposed to is for these changes to go ahead without recognition that a large portion of the current psychology workforce competed a registration path that ALL relevant bodies determined to be of the highest standard and satisfactory to work with any client group. To all of a sudden decide that this decision was incorrect means that many psychologists have pursued their training requirements based on incorrect information and guidance from those who are meant to be informing us.

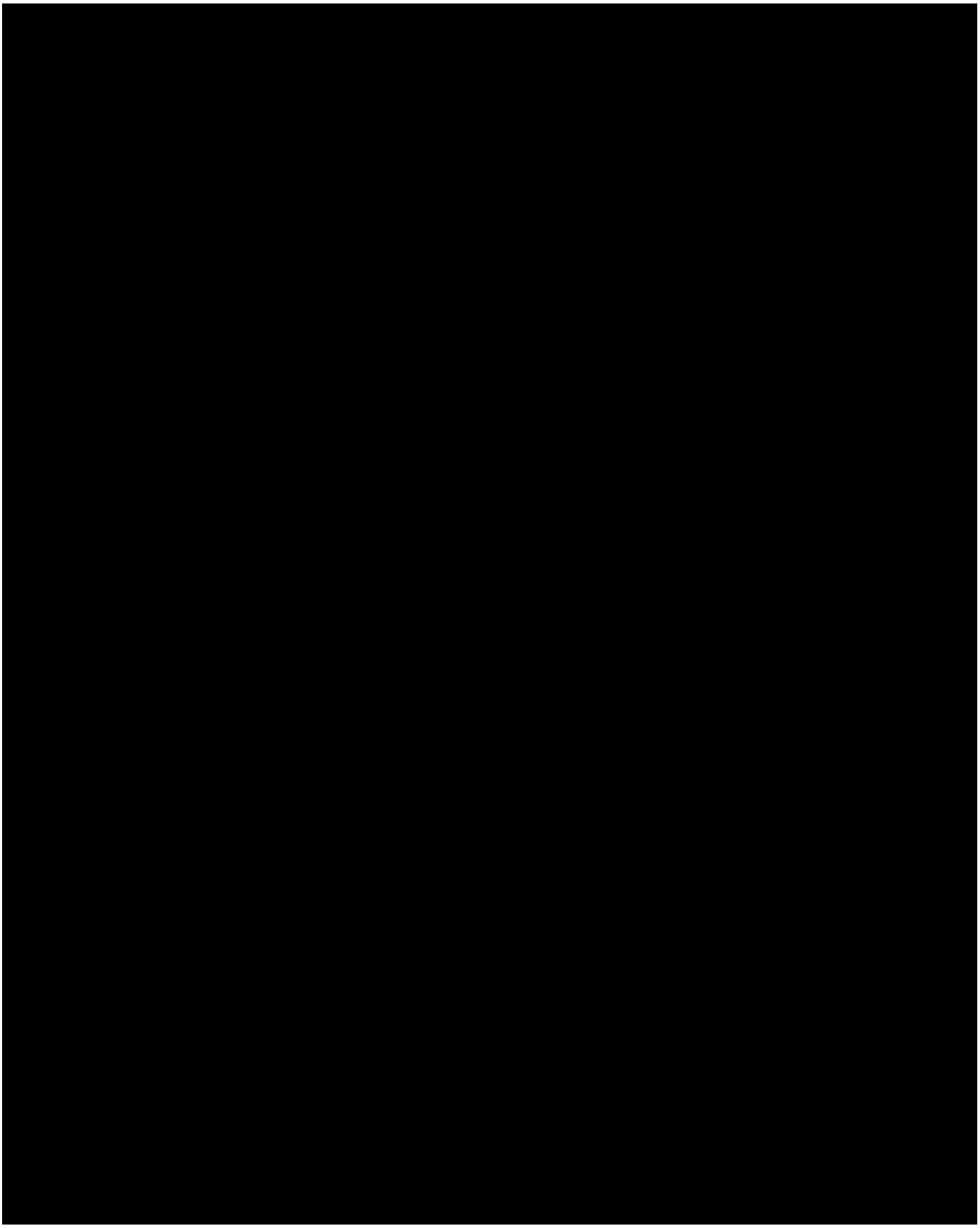
Whilst there are many issues in the industry that I am currently concerned about, I will restrict this email to just this point: I was told by all regulatory bodies that the pathway I chose (i.e., 4 + 2) in order to work in the field of psychology was sufficient and to the highest standard. I was accepted by AHPRA as a Registered Psychologist. For anyone or any organisation to now suggest that their advice was incorrect, to me, requires further investigation.

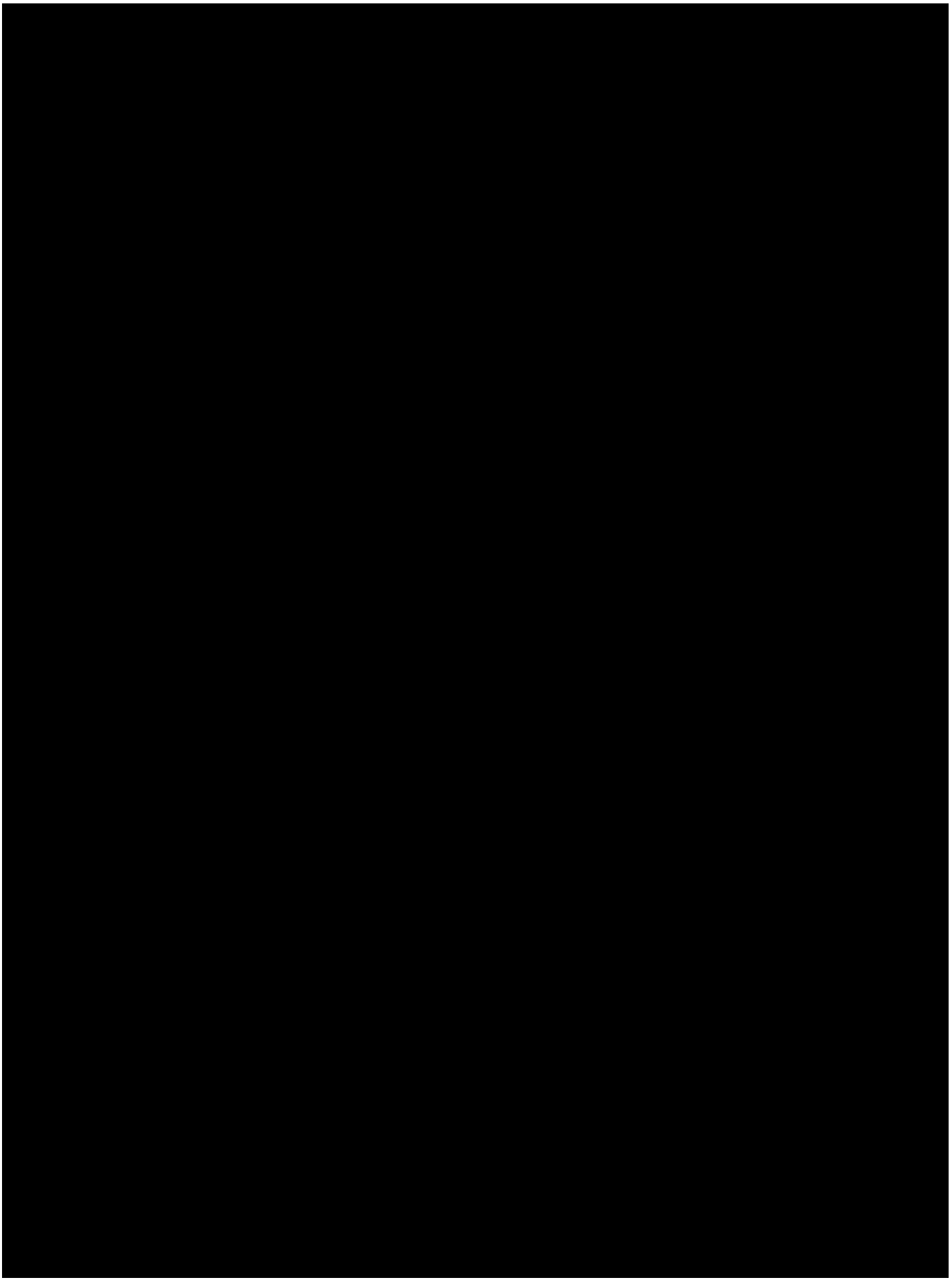
Whilst I acknowledge that the political and financial needs in such a large industry are complex, as an offering of a possible solution, may I suggest the following. At the very least, might there be consideration for any changes to the required qualifications to work as a registered psychologist capable and accepted to treat any area of psychology in which they maintain required professional development (as has always been advised) be put into effect from a given future date. This seems only fair and reasonable. To discriminate against those who took the past advice of governing bodies is only going to cause more damage to an already significantly fractured psychology workforce. The ramifications of which are being felt among colleagues more than you might imagine. Just to highlight, there are clinics and workplaces who currently have a range of psychologists and the tension and 'lunchroom' communication has actually at best become needing to be 'managed' and at worst is becoming unpleasant.

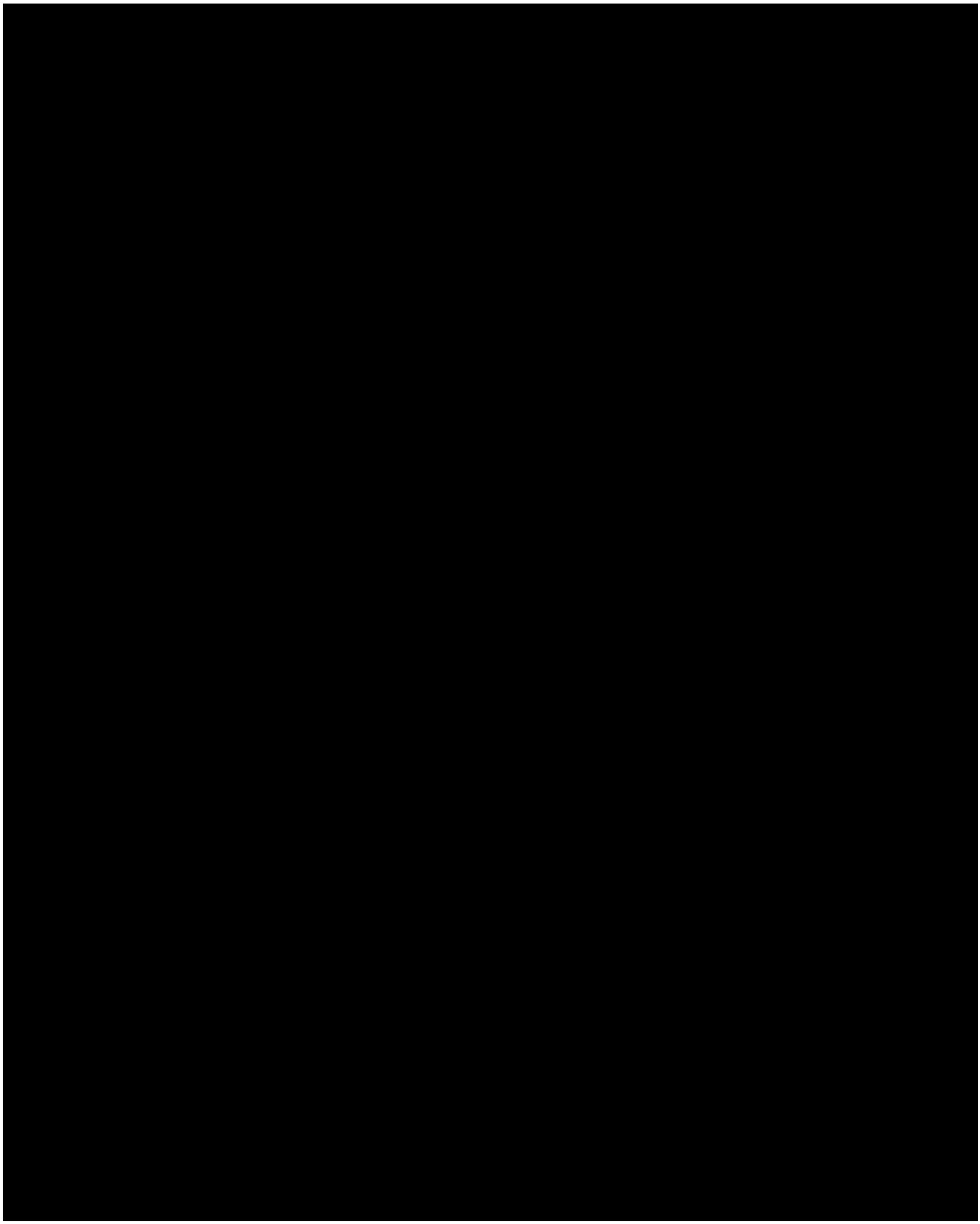
Please consider this input. An industry that I love is hurting badly.

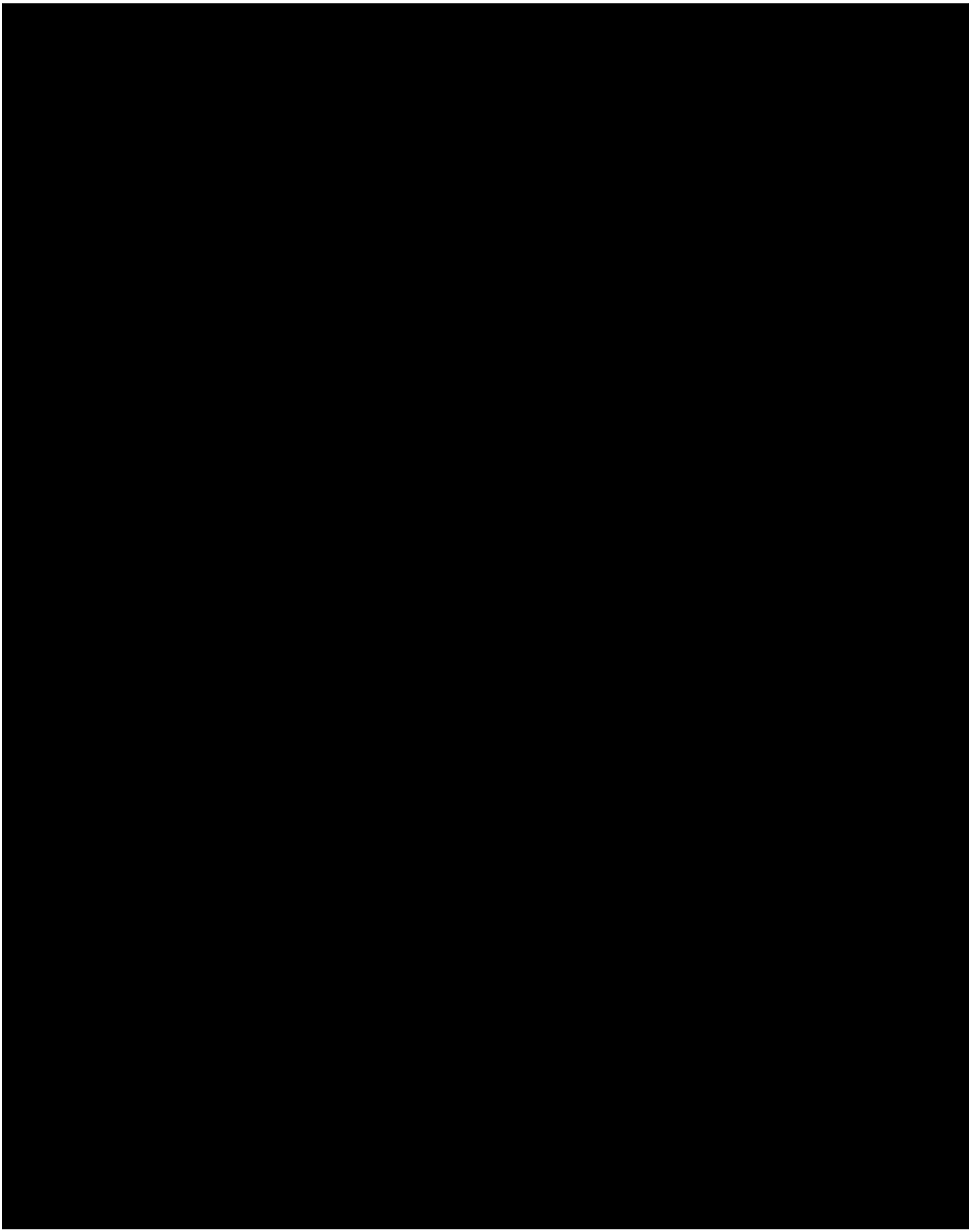


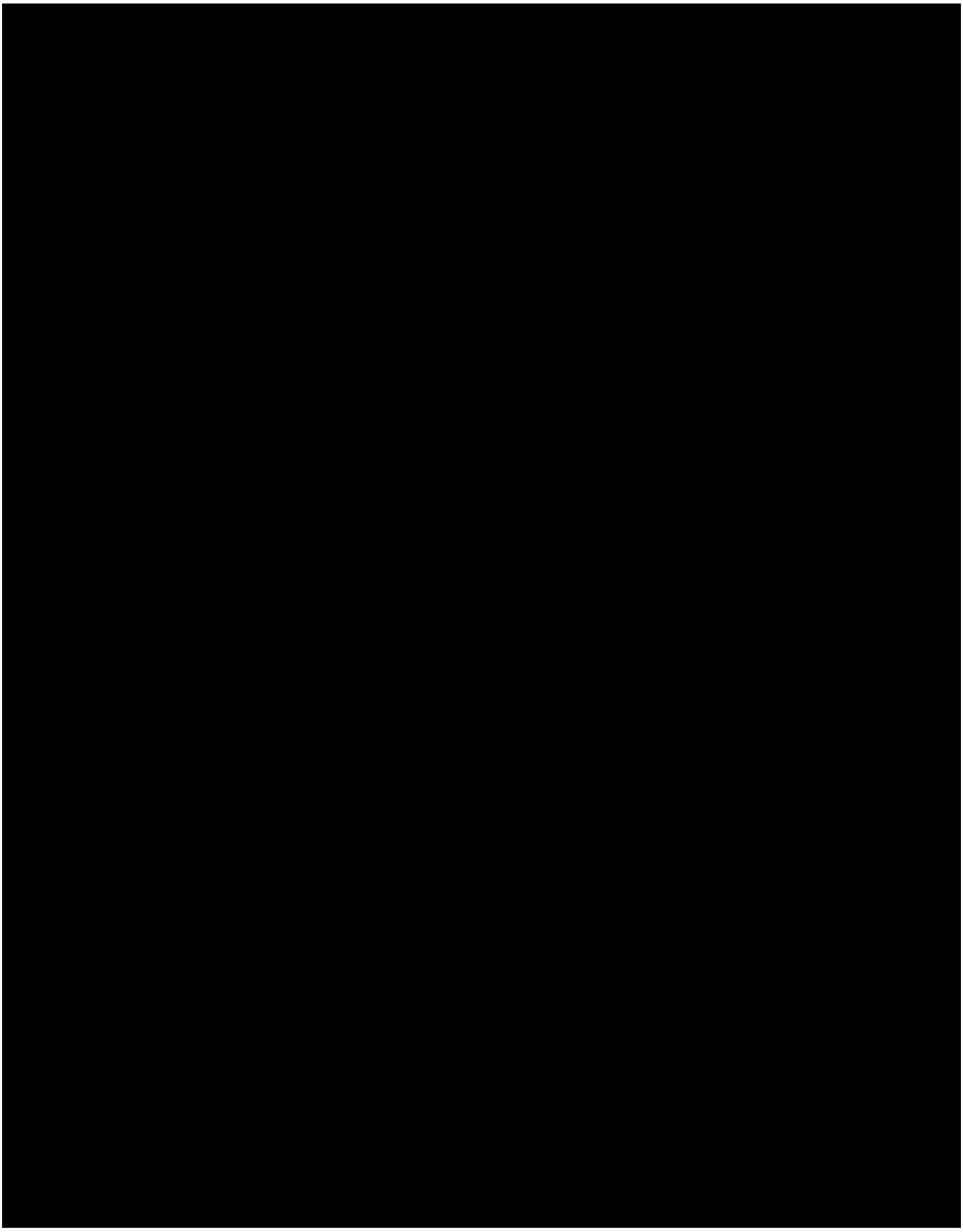


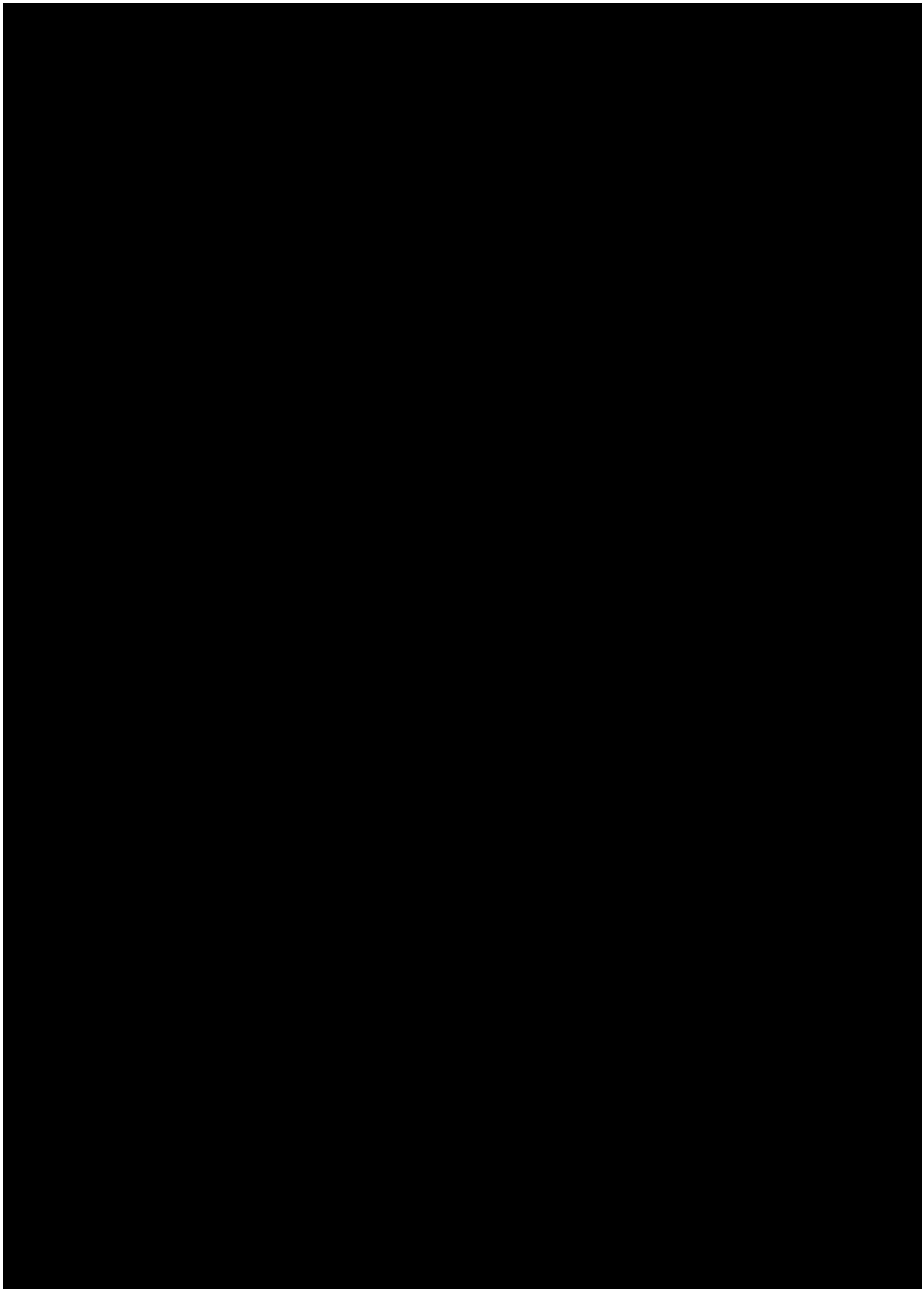












2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
DR Leanne McGregor

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
N/A

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
N/A

What is already working well and what can be done better to prevent suicide?
N/A

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
N/A

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
N/A

What are the needs of family members and carers and what can be done better to support them?
N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
N/A

What can be done now to prepare for changes to Victorias mental health system and

support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
N/A