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Medical Psychology in Australia

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Medical psychology in Australia is heavily influenced by British and American thought. The dominant model for clinical training and practice is the scientist–practitioner model, yet a gulf exists between academic and practice settings. Membership of the professional society requires 6 years of university study in psychology. However, registration requires only 4 years training in psychology. Medical psychologists provide a broad range of services in hospital and community settings, often within multidisciplinary teams. Challenges for the future include bridging the divide between university and health settings, increasing qualifications required for registration, making psychology culturally relevant, and demonstrating to funding managers that psychological interventions are both clinically effective and cost effective.

KEY WORDS: health psychology; psychology; medical schools.

GEOGRAPHICAL AND HISTORICAL OVERVIEW

Australia is a land of extremes. It is the world's flattest continent, the second driest, and the most sparsely populated. It is similar in size to the USA, yet has a population of only 19 million people, with the majority of the population living in state capital cities or within 20 km of the coast. European settlement occurred just over 200 years ago, when a British fleet landed in Botany Bay, New South Wales (NSW). Settlement had horrific consequences for Australia's native inhabitants, the Aborigines, who continue to live in much poorer circumstances than do Australia's more recent inhabitants, with significantly worse morbidity and mortality.

During the last 200 years Australia has been dominated by British and, more recently, American cultures and ways of life. Since World War II, migration from the United Kingdom, Europe, the Middle East, and Asia has been encouraged, making Australia a multicultural nation, with people from different cultures living largely in harmony. The health service has responded to this cultural diversity by providing positions for Ethnic Health Workers who provide direct and consultative services.

The interests of psychologists are represented by the Australian Psychological Society (APS). The APS was established in 1945 as the Australian Branch of the British Psychological Society, later gaining independence and a new name, the APS. The APS currently has over 13,000 members. Until recently, membership of the APS required 4 years of university training in psychology and 2 years of supervised experience. This requirement has now been increased to 6 years of university education in psychology (normally an honors degree plus a professional masters) and 2 years of supervised experience (Cumming & Hyslop, 1998). There are nine colleges of the APS, including those of clinical and health psychology. As of February 1999, the College of Clinical Psychologists had 1,044 members (Ballinger, 1999), though this only represents a small proportion of the total number of clinical psychologists. Two years ago the APS colleges introduced requirements for continuing education, and it is anticipated that general APS membership will follow the same course in the future.

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EDUCATION, TRAINING, AND REGISTRATION

Currently, 38 universities offer a total of 107 courses accredited by the APS for the purpose of full APS membership. Of these courses, 74 are coursework masters degrees, 22 are professional doctorates, and 11 are PhDs. Associate membership of the APS may be achieved through completion of a range of courses in psychology at the same universities. Cumming and Hyslop (1998) have outlined a number of reasons for strong growth in professional training: the profession of psychology continues to be attractive to students, the APS requirement of 6 years of university education, the expansion of professional doctorates, and a forecast expansion in the employment opportunities for psychologists. Cumming and Hyslop note, however, that growth in professional training may be slowed by a reduction in demand following the imposition of full fees for coursework masters degrees.

States have different specific requirements for registration as a psychologist, but all require at least 4 years university training followed by 2 years supervised experience. There are no requirements for continuing education to maintain registration.

Qualifications required for registration as a psychologist in each state are likely to increase to those required by the APS (Cumming & Hyslop, 1998). The current level of qualification required for registration has been criticized widely (e.g., Lovibond, 1994; Touyz, 1995). It is possible to complete an undergraduate degree in psychology with very little exposure to "therapy"—in either a practical or theoretical sense—and then after 2 years supervision begin unsupervised work with patients. Registration can therefore occur without clinical training and without even an examination by one's peers that one has the necessary knowledge and competence to practice. Touyz (1995) strongly argues that the future of clinical psychology lies within medicine, through national 4-year postgraduate clinical PhD programs with 1–2-year postdoctoral internship programs integrated into the hospital environment. He believes that this should be followed by state and national examinations to determine one's competency to practice.

The dominant philosophical stance in Australian clinical training (masters or doctoral) is the scientist–practitioner model, with a research dissertation in all training programs. There is a strong push toward evidence-based medicine and considerable reference to Cochrane reviews. (Cochrane reviews evaluate the effectiveness of treatment programs by systematically reviewing existing treatment literature in specific areas, for example, treatment programs for people with both severe mental illness and substance abuse). Despite this, empirically supported psychological interventions and the scientist–practitioner model have been the subject of debate within the discipline of psychology in Australia. Although there have been calls for psychologists to use empirically supported interventions (e.g., King & Ollendick, 1998, 2000a), and the promulgation of the scientist–practitioner model among all health professionals (James, 1994), others have argued against this (e.g., Andrews, 2000). King and Ollendick (2000b) state that many clinical psychologists prefer to use empirically based treatments when they are indicated, although research is needed on the extent to which they are being used, reasons for their use or rejection, and the most effective means of dissemination.

Thus, the discipline of psychology in Australia has developed along traditional Western lines. Although there is some debate about the utility of the scientist–practitioner model, it remains the dominant model employed in clinical training and practice.

HEALTH CARE FINANCING

A universal, government funded health care scheme, now called Medicare, was launched in 1975. Wage earners contribute around 1.5% of their income to Medicare. It was designed to provide free treatment in public hospitals and a significant rebate or free treatment in outpatient general medical practices. Total health care expenditure is around 8.2% of gross domestic product, compared with 12.4% in the USA (Brooks, 1999). All services provided by psychologists in public health settings are covered by the Medicare system and are free to consumers. There is also a substantial system of private health funds. Membership of private health funds has declined significantly over recent years to the extent that the Australian government recently implemented punitive and reward schemes to maintain membership. Currently around 50% of the population has some private health insurance. The psychology profession has been struggling for many years to obtain fees for services from private health funds. However, many funds still do not cover psychological services, yet they do cover fringe services such as nutritionists and remedial masseurs.

PLACE OF EMPLOYMENT

The health care industry in Australia employs approximately half-a-million people, 7% of the total

population in employment (Grant & Lapsley, 1990, cited in James, 1994). Nurses are the biggest category of health care industry employees (63% of the total), followed by medical practitioners (11.3%). Psychologists represent 1.3% of the total (Australian Bureau of Statistics, 1986, cited in James, 1994). Grant and Lapsley (1990, cited in James, 1994) obtained information on the frequency with which practitioners representing different nonmedical professions were consulted by the general public during the 2 months prior to interview. Psychology had the lowest level of direct contact with the public. James attributed this low demand for psychological services to ignorance of the potential benefits of consulting a psychologist, and to other health professionals offering such services.

Historically, psychologists were often based in large psychiatric hospitals. However, in the last 20 years there has been a very strong trend toward community services, with funding provided through the closure of large psychiatric hospitals. In many areas, attempts are now being made to integrate hospital and community services to improve the continuum of care.

It is difficult to estimate the number of psychologists working in medical psychology. Some surveys (e.g., Carlson & Sheppard, 1992) suggest that around 10% of psychologists have an ongoing interest or activity in health psychology or behavioural medicine, although this may not hold true within a medical setting. Groth-Marnat (1988) states that although many roles for psychologists exist in hospitals, these have not been clearly delineated, most having been restricted to the areas of neurology, psychosomatic medicine, bereavement, pediatrics, and addictive disorders.

Touyz, Blaszczynski, Digiusto, and Byrne (1992) reported that most clinical psychology departments in Australian general hospitals are neither large nor active in medical research. Our experience suggests that the situation has changed little, and relatively few psychologists are directly employed in medical settings, with large idiosyncratic variations. For example, one large teaching hospital in Sydney boasts a medical psychology department of more than 20, whereas a comparable teaching hospital in the same city has only four psychologists. Often these disparities reflect history and politics rather than need. Clinical psychologists have a relative lack of power within hospital structures, and the extent to which clinical psychology services are developed often depends on the perceptions of policy implementers. There has also been considerable competition from other allied health disciplines to fill positions traditionally occupied by psychologists. This has reached the extent (in some settings) that generic mental health worker positions are offered.

Of those psychologists employed within medical settings, the vast majority of appointments are clinical rather than academic, though many may hold honorary academic titles. Conversely, most academics involved in postgraduate clinical training have only marginal affiliations with teaching hospitals. The university clinics, where much supervision and training occurs, bear little resemblance to the real world. Clinical placements, including those in medical settings, are often quite brief and are not fully integrated into academic training. There are a few notable exceptions to this, but in general clinical psychology has remained a university-based rather than a hospital- or clinic-based training.

Franklin, Gibson, Merkel-Stoll, Neufelt, and Vergara-Yiu (1996) conducted a survey to evaluate changes in the employment prospects for psychology graduates in the state of NSW during the 6-year period from 1984–90. As NSW is the most populous state with the largest number of registered psychologists, it was hoped that any trends detected would be representative of similar trends throughout the rest of Australia. A representative sample of 3,816 positions for which psychology graduates were eligible was selected from a major Sydney newspaper for detailed analysis. A number of findings emerged from this survey. Over the period of the survey, the total number of advertisements for psychology graduates and all other professionals grew, except for psychologist positions requiring 4 years of education, indicating that the employment market found 4-year graduates unattractive. There were few differences in the advertised duties for 4-year trained psychologists and 6-year trained clinical psychologists. Hospital advertisements declined from 28.8% to 11.75%, and this decline was much greater than that for social workers and occupational therapists, indicating that other professions may be taking over roles previously assigned to psychologists. Franklin and colleagues concluded that 6-year graduates seem to be increasingly preferred by employers, and that psychologists should capitalize on natural strengths in research, assessment, and testing to develop in the area of program evaluation at the individual, group, organizational, and community level.

Although the influence of psychology as a profession is small, the influence of psychological knowledge through the health care system has been pervasive. Medical and nonmedical health practitioners

are employing psychological theory and practices in a wide range of clinical, counseling, and rehabilitation settings. James (1994) argues that psychologists should consider becoming more directly involved in the education of nonpsychologist professionals in order to exercise influence over the application of psychology in health care, and to facilitate the dissemination of knowledge.

James' stance on educating nonpsychologists in the delivery of psychological services has stimulated debate among Australian academics. Richards (1994) has argued that although James (1994) is basically correct in his overall recommendation that psychologists transfer knowledge to health professionals, an appropriate model is required so as to prevent psychology from falling into obscurity. Richards suggests that psychologists should occupy consultant roles within the health care system, transferring basic and circumscribed-level psychological procedures, and retaining more complex skills. Lee (1994) strongly disagreed with James, questioning the notion that psychologists should be involved in teaching sets of techniques to other health professionals. Lee argued that psychology would do better to continue to develop theories and techniques that can be used to produce a social environment more conducive to good health.

PSYCHOLOGICAL SERVICES

Psychologists working in medical settings provide a broad range of services. They do not have admitting rights to hospitals, and cannot sign involuntary admission forms. They are, however, frequently involved in guardianship applications and competency issues, pain management, neuropsychological assessment, child protection, treatment of eating disorders, and psychoeducational interventions for chronic illness and trauma. The record of psychologists working in the HIV/AIDS area had been impressive, with their influence assisting in the widespread application of a harm minimization approach to substance abuse. As of 30 September 1999, there had been 19,931 new diagnoses of HIV infection in Australia, with injecting-drug use only accounting for 4.5% of this total (National Centre in HIV Epidemiology and Clinical Research, 2000).

The unique population distribution of Australia has encouraged the development of telemedicine, though there are major barriers to its widespread adoption (Mitchell, 1999). Telemedicine has evolved to become an integral part of the South Australian Rural and Remote Mental Health Service. The resulting telemedicine service is one of only a few telepsychiatry services around the world that is firmly embedded in normal clinical practice and can be regarded as sustainable. The telepsychiatry service has been operational in Adelaide since January 1994, and more than 2,000 clinical consultations have been performed since that time (Hawker, Kavanagh, Yellowlees, & Kalucy, 1998).

Touyz (1995) has discussed the issue of mutual coexistence between clinical psychologists and psychiatrists. He states that although relationships of trust and respect are a feature in the domain of research, both professions are becoming increasingly competitive against a background of dwindling resources.

The right to prescribe some psychoactive drugs by licensed clinical psychologists has also been supported by Touyz (1995), who argues that continuity of patient care would be enhanced by such a move. He notes that training would need to include instruction in psychopharmacology and related disciplines and stringent examinations. This is a contentious issue and one that is unlikely to be resolved in the near future.

CULTURAL CONSIDERATIONS

At the 30th Annual Conference of the APS, Sheehan (1995) examined the discipline of psychology in Australia within a cultural context. He maintained that social commentaries criticizing Australians' lack of interest in native originality is also true of the profession. He also noted that the geographical isolation of Australia has meant that psychology has been left almost untouched by theorists from very different cultures and is heavily empirical and functional in its orientation, reflecting British and American thought in particular. According to Sheehan, a weakness in national identity is reflected in the discipline of psychology. He states that if psychologists in Australia can meet the challenges of the information explosion and the growth in multidisciplinary perspectives, with greater cultural awareness and communication of results to practitioners, then psychology in Australia can be different enough from other disciplines to make a difference.

FUTURE CHALLENGES AND PROSPECTS

The amount and standard of training provided to psychologists needs improvement. Parity between

membership of the professional body, the APS, and state registration boards needs to be addressed. Bridging the divide between universities and hospitals is a major challenge for the future. A number of health authorities appear to be rising to this challenge with the creation of jointly funded positions (health/university) and the establishment of university clinics within health settings. The development of professional doctorates also presents an opportunity to further narrow the divide, with the potential establishment of a system of education and internship similar to the USA.

Other challenges facing psychologists in Australia involve making psychology relevant to Aboriginal people and people from non–English-speaking backgrounds. One step in this direction has already been made in NSW through the establishment of the Transcultural Mental Health Centre, which provides assistance to health professionals on cultural matters. Psychologists have also developed culture specific interventions: for example, Rossiter (1994) developed an education program to promote breast feeding among Vietnamese women in Sydney, and Kahn and Fua (1992) described a program to train Australian Aborigines as counselors for people with drinking problems in their communities. However, Aboriginal health remains a source of national shame, and much work remains to be done to reduce Aboriginal morbidity. There is a clear role for behavioral medicine in the design and delivery of services with full consultation with the relevant communities.

Numerous changes are occurring in the Australian health care system. Managed care type arrangements and casemix funding will all have an impact on how psychological services are both funded and provided. Psychologists need to ensure that they do not become sidelined in this process; they can achieve this by demonstrating that their interventions are both clinically effective and cost effective.

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