

An Evidenced-Based Report on the Division within the Psychology Profession:
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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 is unlimited.
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 need unlimited consultations, 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. The general public are most likely to be the ones ultimately 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 psychologist 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 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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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 1984, 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		
		Psychologists	Clinical Psychologists	Psychiatrists
10968/ 80000/ 296	Better Access to Mental Health (initial appointment)	\$84.80	\$124.50	\$224.60
80100/ 81355	Allied health / ATSI Allied Health	\$52.95	\$52.95	-
82000/ 82015	Better Access for Children with PDD	\$84.80	\$84.80	\$227.70
81000	Pregnancy Support Counselling	\$62.20	\$62.20	-

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 B¹

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		
2007¹											
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		
2008¹											
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		
2009¹											
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 B¹

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 A¹

		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 measures¹

		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:

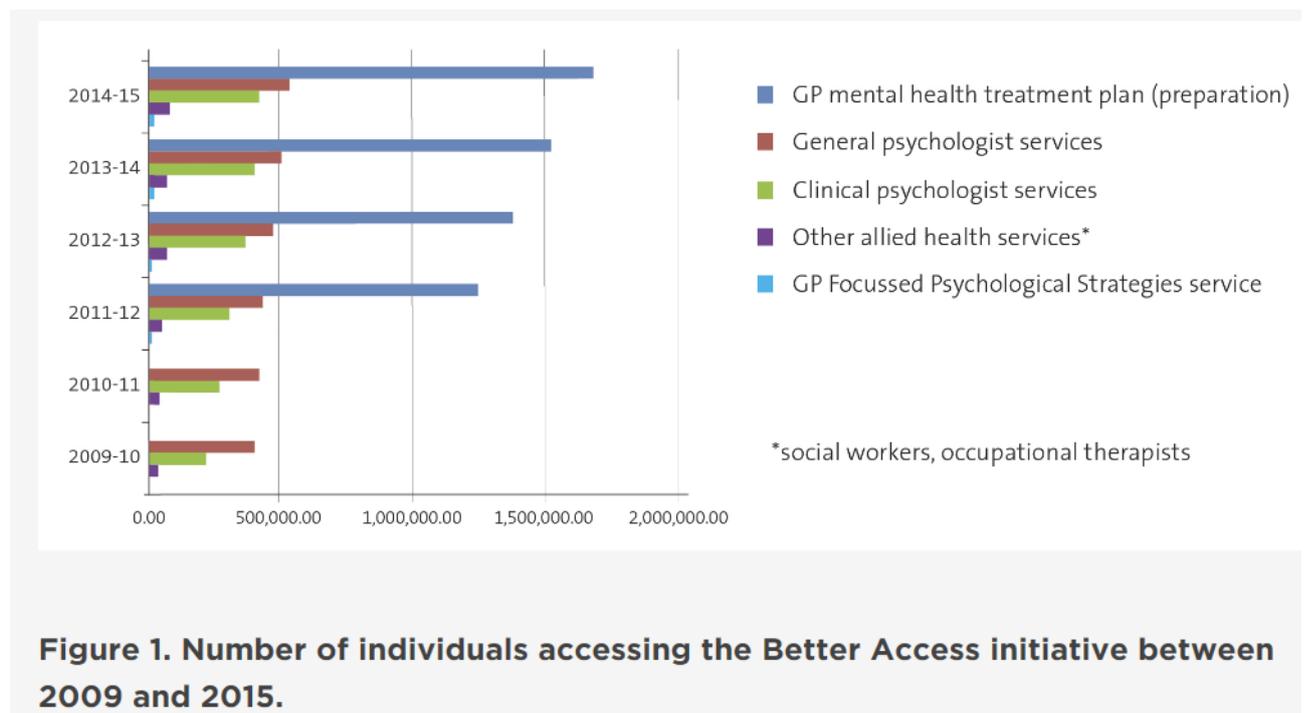
1. “The summative evaluation provides good evidence that Better Access has improved access to mental health care and increased treatment rates for people with common mental disorders” (p.45).

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.



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.

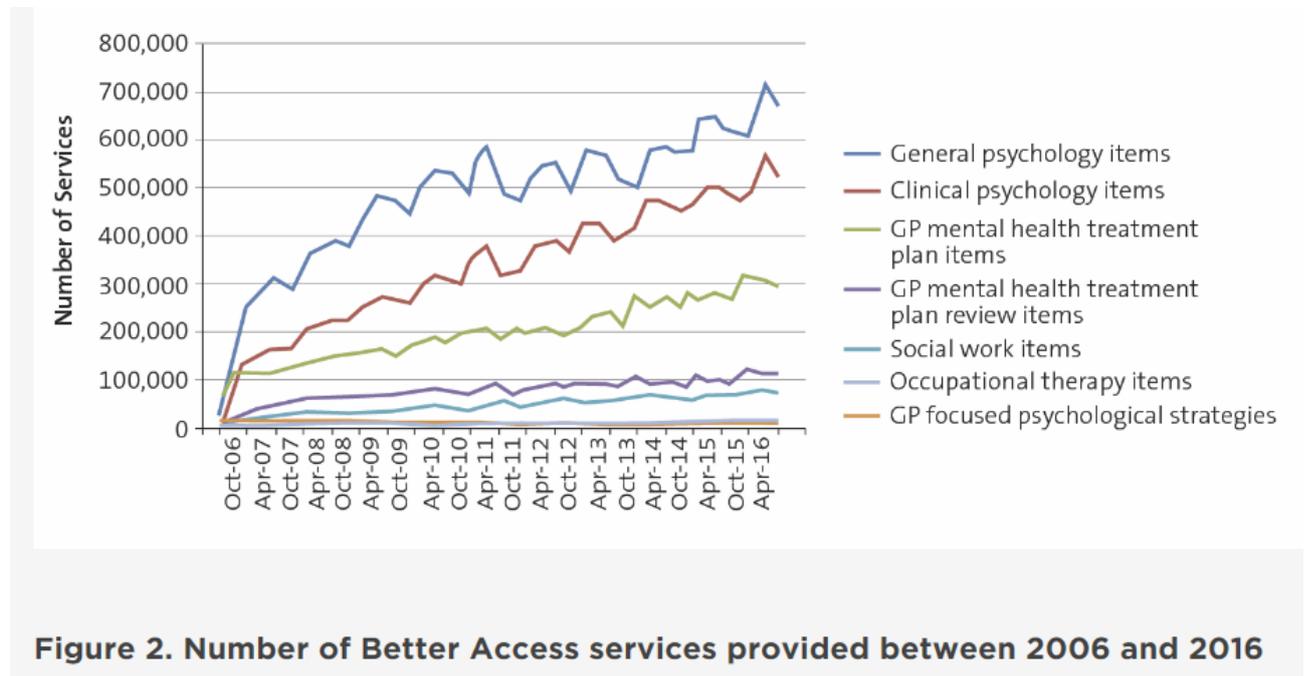


Figure 2. Number of Better Access services provided between 2006 and 2016

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)
Consultant psychiatry	> 20	2713	3 019 386	- 0.08 (- 0.11, - 0.05)
	> 45	291	22 258	- 0.08 (- 0.13, - 0.02)
	30-45	293	963	- 0.18 (- 0.34, - 0.02)
	> 45	296	303 240	0.03 (- 0.01, 0.06)
	> 45	297	14 499	0 (- 0.07, 0.07)
	> 45	299	285	0.34 (0.01, 0.7)
	< 15	300	126 179	- 0.13 (- 0.23, - 0.03)
	15-30	302	944 908	- 0.07 (- 0.14, - 0.002)
	30-45	304	187 116	0.04 (0.002, 0.08)
	45-75	306	2 572 228	0.21 (0.18, 0.25)
	> 75	308	111 875	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	62 523	0.22 (0.15, 0.28)
> 75	318	906	0.08 (- 0.04, 0.20)	
> 45	319	264 437	0.22 (0.15, 0.28)	
Psychological therapy services				
Clinical psychologist	30-50	80000	39 262	- 0.07 (- 0.15, 0.01)
	30-50	80005	1535	- 0.07 [†] (- 0.31, 0.18)
	> 50	80010	3 754 815	0.13 (0.10, 0.17)
	> 50	80015	24 882	- 0.08 (- 0.15, 0)
	> 60	80020	14 436	- 0.07 [†] (- 0.27, 0.13)
Focused psychological strategies				
General psychologist	20-50	80100	108 723	- 0.26 (- 0.33, - 0.18)
	20-50	80105	9027	- 0.26 (- 0.42, - 0.10)
	> 50	80110	6 325 499	- 0.01 (- 0.04, 0.03)
	> 50	80115	194 844	- 0.14 (- 0.20, - 0.08)
	> 60	80120	25 819	- 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	72 607	- 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	472 353	- 0.02 (- 0.06, 0.02)
	> 50	80165	25 211	- 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.

- Ensure that clinical services align with best-practice guidelines.
- Increase access to allied health in primary care.
- Ensure that the list of eligible allied health professionals under the MBS reflects contemporary practice.
- Facilitate group-based allied health therapy where clinically appropriate.
- 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.
- Strengthen evidence base for the provision of allied health care in Australia.
- Improve access to allied health services in rural and remote areas.
- Change the delivery model and focus of allied health in Australian primary care.
- 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 and 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 \$384.80, for an initial consultation \$221.30, 45-minute consultation \$156.15, and 30-minute consultation \$113.15.

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.

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 as required items per year, telephone or in person.

It is recommended that the items be listed as below:

Psychology assessment items	1-90 min	91-120 min
Psychology treatment/therapy items	1-30 min	30-60 min
Telephone consultations items	1-30 min	31-60 min
Group Therapy items		91-120 min
12 items per year	12 numbers per group	
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
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,

GC

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,

JR

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 by 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 through 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 Queensland Corrective Services, who paid for my 3rd year university fees. Once I gained my Provisional Registration, I began my 4 + 2 pathway at Wolston Correctional Centre 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. Corrective Services 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

To: psychologychair@ahpra.gov.au

Sent: Sunday, 14 Apr, 2019 At 12:10 PM

Subject: Your recent Newsletter

Dear Ms Phillips,

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 completed 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.

Appendix D: Curriculum Vitae

D1 Registered Psychologist

EDUCATION, QUALIFICATIONS & MEMBERSHIPS

Doctor of Philosophy (PhD) conferred 2010
 Bachelor of Psychology with First Class Honours
 Griffith University Scholarship
 Griffith Academic Excellence Award 1999-2004
 Member of the Australian Psychological Society
 AHPRA Board Approved Supervisor
 Registered Provider with Medicare, Private Health Insurance, WorkCover, PHN PSP, DVA

EMPLOYMENT HISTORY

Employer: CBT Professionals
Position: Registered Psychologist
Period of Employment: May 2018 – Current

Employer: Griffith University
¹Rehabilitation Innovation Service Evaluation (RISE) team
²Centre of National Research on Disability & Rehabilitation
³School of Applied Psychology

Position: ¹Research Fellow
²Senior Research Fellow
³Senior Research Assistant
³Lecturer
³Tutor for Quantitative Analysis/Business Statistics
³Research Assistant

Period of Employment:

Research Fellow	February 2019 - Current
Senior Research Fellow	October 2014 - December 2015
Senior Research Assistant	April 2010 - September 2012
Senior Research Assistant	February - August 2014
Lecturer	2007 - 2010
Tutor	July 2004 - December 2006
Research Assistant	September 2003 - December 2006

Employer: Gold Coast Integrated Care, Gold Coast Health and Hospital Service
Position: Senior Research Assistant
Period of Employment: March 2016 - May 2018

Employer: Impact Health and Allied Health Performance Medical
Position: Registered Psychologist
Period of Employment: December 2015 - March 2016
Employer: Bond University
 Faculty of Health Sciences and Medicine
¹Centre for Research in Evidence-Based Practice (CREBP)
²Department of Psychology
 Faculty of Society and Design

Position: ¹Senior Research Assistant
²Teaching Fellow

Period of Employment: Senior Research Assistant June 2013 - December 2014
 Teaching Fellow September 2013 - December 2014

Employer: Family Interaction Program, Griffith University
Position: Registered Psychologist
Period of Employment: August 2005 - June 2011

Employer: Emergency Psychiatric Services/Acute Care Team, QLD Health
Position: Registered Psychologist
Period of Employment: October 2005 - December 2009

Employer: Sentient Psychology
Position: Registered Psychologist
Period of Employment: January 2010 - April 2010

Employer: Coomera State School
Position: Registered Psychologist
Period of Employment: April 2008 - December 2008

Employer: Wolston Correctional Centre
Position: Registered Psychologist (Probationary)
Period of Employment: October 2004 - July 2005

Employer: Burleigh Heads Community Corrections
Position: Community Corrections Officer
Period of Employment: April 2002 - October 2004

Employer: Harmony Support Service
Position: Community Mental Health Support Worker
Period of Employment: February 2002 - April 2002
 Voluntary position January 2001 – February 2002

D2 Registered Psychologist

EDUCATION, QUALIFICATIONS & MEMBERSHIPS

Bachelor of Behavioural Sciences (Honours), LaTrobe University
 Master of Educational Psychology, University of Melbourne
 Member of the Australian Psychological Society
 AHPRA Board Approved Supervisor
 Registered as a Psychologist with the Psychologists Board Australia, AHPRA
 Registered Provider with Medicare, Private Health Insurance, TAC, Worksafe, VOCAT, DVA
 Current in CPD requirements and Professional Memberships

EMPLOYMENT HISTORY

<i>Employer:</i>	Self - Employed
<i>Position:</i>	Psychologist
<i>Period of Employment:</i>	1995 to present
<i>Employer:</i>	SMS Consulting Group
<i>Position:</i>	Change Management Consultant
<i>Period of Employment:</i>	April 1995 - January 1996
<i>Employer:</i>	Accenture (then Andersen Consulting)
<i>Position:</i>	Psychologist
<i>Period of Employment:</i>	December 1991 - March 1995
<i>Employer:</i>	Department of Labour
<i>Position:</i>	Statistical Information Officer, Coordinator OHS
<i>Period of Employment:</i>	April 1990 - December 1991
<i>Employer:</i>	Career Wise
<i>Position:</i>	Psychologist, Vocational Testing (4 days/week)
<i>Period of Employment:</i>	January - June 1989
<i>Employer:</i>	La Trobe University
<i>Position:</i>	Tutorial Leader of Psychology Subject (PT)
<i>Period of Employment:</i>	January - December 1988
<i>Employer:</i>	La Trobe University
<i>Position:</i>	Co-ordinator of Mental Health Volunteer (PT)
<i>Period of Employment:</i>	October 1988 - October 1989
<i>Employer:</i>	Lifeline
<i>Position:</i>	Telephone Counsellor (PT)
<i>Period of Employment:</i>	June 1988 - December 1990

EMPLOYMENT HISTORY (cont.)

Provision of Services to Corporate Clients including:

- AMP Insurance Company (Sydney); Ansett Australia; Australian Paper; Australia Post; Bundoora Extended Care Centre; Coles Supermarkets; Email Metals; Esso Petrochemical Company (Malaysia); Gas And Fuel Corporation; Holmesglen TAFE; Interactive Pictures; Kowloon Canton Railway Corporation (Hong Kong); Kraft Food; Macmillan Shakespeare Publishing; Mobil Oil Company; Portfolio Partners; Sustainability Victoria; Telstra Australia; Tesselaars; Village Cinemas; Zurich Insurance Sydney

EXPERIENCE

PSYCHOLOGICAL INTERVENTIONS

- For individuals across the lifespan, families, and large groups
- Work in metro and rural Victoria in private practice
- Founded a preventative mental health program delivered across QLD, NSW & Victoria
- Focus on improving core emotional resilience using evidence-based techniques
- Experienced and trained in range of interventions including Cognitive Behavioural Therapy, Rational Emotional Behavioural Therapy, Acceptance and Commitment Therapy, Behaviour Modification, Mindfulness Based Cognitive Therapy & Stress Reduction, Meditation, Family Therapy, Psychoeducation, Play Therapy, Interpersonal Psychotherapy, Solutions Focussed Therapy and Emotional Focussed therapy models
- Preparation of reports for Department of Immigration, Family Law courts, VOCAT, TAC, WorkSafe, DVA

Children and Adult emotional and behavioural difficulties including:

<ul style="list-style-type: none"> - Social Anxiety Disorder/Social Skills Issues - Adjustment Disorder - Somatoform disorders - ADHD - Depression; Mixed Anxiety & Depression - Bullying - Separation Anxiety - Sibling Rivalry - Sleep Problems - Eating Disorders - Confidence & Emotional Resilience Management - Motivation - Enuresis and Encopresis - Conduct Disorder - Obsessive Compulsive Disorder - Self-Harm - Relationship Issues - Generalised Anxiety Disorder /Panic Disorder 	<ul style="list-style-type: none"> - Parenting Experiences; Separation/Divorce/Court processes - Custody Issues/Grandparents as Carers/Parents incarcerated - Post-natal issues - Drug and Alcohol Use Disorders - Trauma/PTSD - Dissociative Disorder - Chronic/acute Psychotic Disorders; Schizophrenia - Depression, Mood Disorders and Bipolar Disorder - Sexual Disorders - Unexplained Somatic Complaints - Phobic Disorder - Anger Management - Disability Issues - Aged Care/Elder Abuse/Dementia/Later Stages of Life - Grief/Bereavement Disorder
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D3 Registered Psychologist

EDUCATION, QUALIFICATIONS & MEMBERSHIPS

Doctorate of Clinical Psychology, Monash University (Research Scholarship)
 January 2005 - July 2006 (Intermission of Candidature; Regrettably not resumed)
 Bachelor of Arts (Double Major - Psychology and Sociology), Monash University 1999-2001
 First Class Honours (Psychology), Monash University, 2002
 Advanced Certificate in Business Management, Swinburne University of Technology 1989-1992
 Associate Member of the Australian Psychological Society
 Member Society of Australian Sexologists (SAS)
 Secretary and Executive Committee Member, Society of Sexologists (SAS), 2010-2013
 Registered as a Psychologist with the Psychologists Board Australia, AHPRA
 Registered Provider with Medicare, Private Health Insurers, TAC, VOCAT, Victorian Police
 EAP Provider to: Victorian Police Force, Red Cross Australia; Ambulance Victoria; Apple Aust.

EMPLOYMENT HISTORY

Employer: Founder of Ringwood Psychology
Position: Registered Psychologist; Business Owner; (5 employees)
Period of Employment: 2013 - Present

Employer: Richmond Hill Psychology (Private Practice)
Position: Provisional Psychologist
Period of Employment: 2007 - 2016

The above positions entailed the following:

- Providing psychological counseling and interventions to a range of private clients experiencing anxiety and depressive disorders, sexual dysfunctions, compulsions and addictions, relationship difficulties, Complex Trauma.
- Areas of interest: Anxiety; Sexually compulsive behaviours; Childhood abuse/trauma; Domestic Violence; Anger Management issues; Personality Disorders.

Employer: Australian Society of Sex Educators, Researchers & Therapists
Position: Secretary & Executive Committee Member ASSERT (Vic. Branch)
Period of Employment: 2010 - 2013

Employer: Medical Register of Australia
Position: Lecturer
 Relationship Counselling; Grief Counselling; Conflict Resolution
Period of Employment: June 2009 – July 2011

Employer: Monash University
Position: Tutor of 3rd Year Psychology students
Period of Employment: March 2005 - August 2005

Employer: Mental Health Research Institute
Position: Research Assistant
Period of Employment: April 2003 - March 2005

- Assistance implementing and evaluating a 12-week psycho-educational treatment package designed to assist mental health consumers with a diagnosis of Bipolar Affective Disorder in maintaining and managing their mental health.
- Assisted with the production of ethics applications and information files for mental health consumers and General Practitioners
- Editing and maintaining manuals designed for group-based interventions
- Sourcing appropriate psychological assessments for research projects
- Recruiting and consenting research participants
- Conducting psychological assessments of research participants utilizing a detailed battery of tests designed to gather data on variables such as comorbid diagnoses, perceived stress and quality of life, suicide risk, adherence to medication, medical services utilization, drug and alcohol issues, severity of symptoms, and insight to illness. (Specific assessments included: The MINI, BPRS, SANS, MADRS, Young Mania Scale, Perceived Stress Scale, MARS, Locus of Control, WHOQoL, DIP, etc.)
- Received training in facilitating group workshops

D4 Registered Psychologist

EDUCATION, QUALIFICATIONS & MEMBERSHIPS

Bachelor of Psychological Science, Honours (2010 - 2015), University of Queensland St. Lucia
 Associate Member of the Australian Psychological Society
 Registered as a Psychologist with the Psychologists Board Australia, AHPRA
 Registered Provider with Medicare, Private Health Insurance, WorkCover, PHN PSP, DVA

EMPLOYMENT HISTORY

Employer: CBT Professionals
Position: Registered Psychologist; Child and Adolescent Psychologist
Period of Employment: 2018 - Present

Employer: Change Futures Pty Ltd
Position: Provisional Psychologist
Period of Employment: 2016 - 2018

The above positions entailed the following:

- Providing psychological counselling and interventions to a range of both financially disadvantaged (outreach) and private clients experiencing anxiety and depressive disorders, ADHD, ASD, alcohol and substance misuse, relationship difficulties, PTSD and complex trauma. Applying evidence-based interventions and therapies including ACT, MCBT, CFT, strengths-based, solution-focused, and Positive Psychology.
- Areas of interest: Anxiety; Depression; Childhood abuse/trauma; Domestic Violence; Anger Management issues; Personality Disorders; Pervasive Developmental Disorders; Attachment.

Employer: Lives Lived Well
Position: Diversion Counsellor
Period of Employment: 2017 - 2018

- Psychological assessment including alcohol and drug history, family history, mental health history, risk assessments, social supports, legal history, etc. Utilising Motivational Interviewing, and subsequently providing psychoeducation around substances and harm minimisation techniques where motivation to change is low or non-existent. Finally, provide referral information appropriate to clients' cultural, individual and age-appropriate needs.
- Areas of interest: Anxiety; Depression; Childhood abuse/trauma; Domestic Violence; Anger Management issues; Personality Disorders.

Employer: Change Futures (tender for Uniting Church)
Position: Redress Support Worker
Period of Employment: 2016 - 2018

- Conducted phone consults supporting and explaining interim redress process to incoming calls for Uniting Church (UC) applicants. Conduct risk assessment and trauma-informed service delivery for adult survivors of childhood sexual abuse. Supported survivors in meetings and throughout process if required. Liaised with Uniting Church, other organisations and other professionals (i.e. psychologists) where necessary on survivor's behalf.
- Areas of interest: Childhood abuse/trauma

Employer: Lifestyle Triple P (University of Queensland)
Position: Research Assistant
Period of Employment: 2014 - 2015

- Role included data entry, intake assessments; psychoeducation regarding healthy lifestyle behaviours with children and families; behavioural observations of children aged 2 - 10; phone interviews with longitudinal questionnaires and feedback.
- Areas of interest: Anxiety; Pervasive Developmental Disorders; Attachment; Positive Parenting

Professional Development and Additional Skills

- Motivational Interviewing
- Introduction to CBT & ACT
- MCBT (Mindfulness-based CBT)
- Introduction to Psychodynamic Therapy
- Substance Abuse Workshop with Matthew Berry
- WAIS-IV, WISC-V and WMS- IV – theory, administration, report writing
- PAI and NEO-PI-3 – theory, administration, report writing
- Blue Knot's: Trauma-informed Service Delivery
- Outreach Service Delivery training (ethical considerations)
- ThinkUKnow Cyber Safety Workshop
- Child Therapy series (e.g. play and art therapy)
- Compassion Focused Therapy (CFT)
- Conversational in Spanish and Portuguese