Introduction

I am a Psychologist registered to practice the profession of psychology. I hold a BA Dip Ed (Sydney University, 1968) MEd (School Counselling) (Canberra University, 1988), 17 years in schools in Education and Development, 18 years in private practice, trained in EMDR therapy in order to expand practice to adults suffering from PTSD, EMDRAA accredited EMDR consultant from 2012, ACT #15 when registration was first introduced in 1995 in ACT, author of 'Body Blame', developer of emotional eating EMDR group protocol and obesity and emotional eating workshops, presenter at international and national conferences on addiction, obesity, domestic violence, EMDR advanced training nationally and in NZ. I have been a member of Australian Psychological Society (APS), my professional membership body, for16 years. I was very proud when I was invited to become a full member, believing that the APS was representing me. I am an APS member of the APS DGPP working party who wrote a submission for the DGPP representatives (non endorsed psychologist members of the APS), for the recent white paper written by the APS MBS expert committee. However, the main tenet of the DGPP paper written on behalf of 50% of the membership was ignored, it being that there should be no discrimination between psychologists.

I am a member of EMDRAA, was a member of the EMDRAA Board of Directors from 2008-2014, and am a member of the APS EMDR and Psychology Interest group, running peer groups in Canberra and Kallangur, Qld. The APS advocacy and representation to government has unfairly restricted my trade and those of my colleagues of practising psychology which has resulted in competition within the profession and further restricted access to postgraduate training in the profession of psychology.

Of particular distress to me is the manner in which the dual qualifications of school counsellors in education as teachers and education and developmental psychology have been denigrated and regulation has resulted in the demise of MEd in school counselling so that only two courses exist in the nation, with the result that departments of education are not able to recruit suitably trained teacher/psychologists but have been forced to employ psychologists only, or even worse those with an AoPE of clinical psychology.

I had considered registration as a school psychologist very important. I was among the very first psychologists in the ACT to apply for registration when it was introduced in 1995, obtaining the ACT registration number 15. Part of the documentation I provided was the supervision by a

clinical psychologist Dr Chandra, PhD while I worked for the Catholic Education Office in Canberra from 1987 to 1990.

School Counsellors were not required in 1995 to be registered as we worked for a government department. This probably didn't change until 2010 with the introduction of national registration. When a school counsellor colleague had her application for registration rejected in 1996 I advocated on her behalf, urging the ACT Board of Psychology to recognise that meeting with a school counsellor was often the first interaction people would have with a psychologist. I urged them to bring them under the umbrella of registration. My arguments were successful and school counsellors were readily accepted for registration afterwards even when they had not completed their thesis for their masters degree. I do not know if this would now be described as a 4+2 pathway or a 5+2, given the three years plus Dip Ed and then the masters of 2 years, or one without the thesis. I rather regret my enthusiasm now as it seems to me that regulation has not done any favours for the profession of school counsellors.

I am not sure I understand whether my qualifications and supervision would have enabled me to obtain an AoPE in Educational and Developmental psychology prior to 2011 if I had been a member of the interest group which somehow became a college but that 'door' has been closed. I don't know when the APS College of Educational and Developmental psychologists was inaugurated. The APS website gives no historical information on this. However it was never a requirement for my work, nor was membership of the APS, which is a voluntary professional association. I did not join the Australian Psychological Society until 2004. I had tried to connect with the APS during the 1990s but their reception of me at the local branch was dismissive as I was 'only' a school counsellor so I did not pursue it. This is reflective of the initial reaction of the Board of Psychology at that time. I would suppose this would place me on a 5+ 2 track, or maybe it should be 6+2 with my Dip Ed?

In order to be eligible to study for the MEd and obtain a position with the ACT Department of Education as a school counsellor I had to be a qualified graduate teacher with a minimum of three years experience. Teaching experience does not appear to be the requirement everywhere now as far as I can tell from eligibility to enrol, though there appear to be Masters in Teaching in School Counselling where it is, and teaching has in itself become something where registration has been introduced.

The ACT Department of Education's School Guidance and Counselling Section discouraged the use of the nomenclature of 'school psychologist' as elitist, distancing and off-putting to school staff, students and parents. I don't believe school communities would feel any greater rapport now with that title and even less with "clinical psychologist". Parents are distressed to be confronted with that title, as it implies their child has a mental illness, an implication reinforced by the advertising by clinical psychologists that they are the people most qualified to assess,

https://acpa.org.au/what-is-a-clinical-psychologist/

clinical psychology is focused on the assessment and evidence-based treatment of mental illness
A clinical psychologist is able to assess your symptoms of psychological distress
An extensive knowledge of mental illness and how to diagnose and treat it.
one of the highest levels of education of all health care professionals,
Clinical psychologists are experts in mental health

This was in contrast to when I worked as an Educational Consultant with the Catholic Education Office, in my position from outside the school communities throughout the diocese where there appeared a desire to elevate the standing of the external educational consultant.

As a school counsellor, I was a familiar and approachable person within the school. I organised, managed and conducted many classroom and school-wide programs which involved the general student body. For instance I promoted playground programs where all year six students were matched with a kindergarten child as their playground buddy for the first semester. Along with teachers I trained the buddies and was part of the team to support them. This also occurred with year 9 in high school with the year 7 intake. It made remarkable differences in playground cooperation and harmony which were documented. Other peer programs involved reading with students from younger grades being paired with older students to enhance their literacy. When assigned to a number of schools, I was able to encourage other schools to replicate successful programs.

I organised a Rainbows program across my primary schools in cooperation with the local catholic primary school to help children cope with the grief and distress when their family had changed because of death, separation or divorce. I conducted this after hours for several years,

training other interested adults, often teachers, to facilitate the small groups of five children as they progressed through the program workbooks.

A huge program I undertook in [redacted] which involved 44% (of 800) students over several years was my relaxation classes. Rather than have individual students see me first thing in the morning to help them relax and desensitise so they could enter their classrooms, I conducted sessions with up to thirty students during first period three times a week. The logistics was important with signed permission notes from teachers each lesson a requirement.The students came in and laid down on the floor after handing me their signed permission slips without speaking as I began with a simple breathing instruction. This was followed by progressive muscle relaxation, a self-hypnosis countdown and guided visualisation, then using the relaxed state, visualising something that disturbed them, desensitised on that, with affirmations at the end. I reported to the school community on the success of the program, using pre and post measurements. A former student approached me recently in a chemist shop, to let me know how important it had been, and still was. Now I would suppose this would be called CBT in a group.

I know not everyone worked as I did, and many were sceptical that even students notorious for misbehaviour and disruption would be capable of doing this. I never had any difficulty and teachers would give me great feedback about how much more settled a student became. Some teachers in primary and high schools also asked me to introduce their classes to relaxation which they eventually took over. However, other school counsellors developed other programs that suited their school communities.

Prevention is a hard thing to measure, but I can assert quite confidently that there were no suicidal attempts in my five years at the high school and suspension rates were low. The latter contrasted with a young higher duties welfare teacher who boasted how many more students were suspended or on detention once he took over from a colleague whose rapport with students was enviable..

Providing a mentor lunch discussion program in response to social isolation in the playground; a reading program for high school students because so many children (usually boys) who were in conflict within the school had literacy problems, utilising adult community volunteers; specifically identify students in year 8 for an Anxiety prevention program which was developed in

Queensland; and collaborating with providing play therapy groups in each other's schools with a colleague; running parenting programs in primary schools such as Systematic Training for Parents; a week long wilderness camping with students in danger of expulsion with Project Saul; leadership training camp with year 5 students who were facing the challenge of one of their schools closing and amalgamating the following year with the other, in opposition to parental attitudes that hit the newspaper headlines because of the antagonism between them: these were a few of the programs I designed or collaborated on and were all possible because I was a teacher and a psychologist.

Staff also were very important, as I understood their concerns should students not attend a class especially when they were introducing a concept. It was important that my work with students did not disregard theirs. I made myself a part of the welfare teams and forged connections with members of the staff and front office, even volunteering as the tea lady for a period of time as stress levels in the high school became elevated through extra administrative demands and no-one felt they could turn on the water to boil in time for morning tea. I raised the task to an art and was pleased to see those that followed added the extra touches I had initiated to make the teachers feel appreciated. I took part in the playground roster too. Australian teachers resent unnecessary elitism.

This contrasts markedly with the advice the APS gives to psychologists, assuming they are setting up a quasi private practice within a school setting.

It is pertinent that (1/11/18) the APS has published a paper

Starting out: Working in schools Information for Early Career Psychologists

https://www.psychology.org.au/getmedia/a8fc9582-d5ae-4e11-9b91-55936bbb756f/IS-Early-Career-School-Psych.pdf

Challenges

• *Professional isolation*

• *Conflict between professional Code of Ethics and organisational obligations*

• *Principals and teachers can have poor understanding of the skills, training and professional ethics of psychologists*

Things to consider before you start

• *Personal indemnity insurance*

• *Employment contracts*

• *Management of clients files*

• *Confidentiality and working in a multidisciplinary team*
• *Supervision and peer consultation*
• *Models of practice*

How unhelpful that new psychologists are primed to be in opposition to the school staff with the challenge: *Principals and teachers can have poor understanding of the skills, training and professional ethics of psychologists.*

Of course schools come in many different sizes, independent, systemic, private, government, but without experience as a teacher, in my opinion, a psychologist brings less to the position than the school community deserves. The medical model is not appropriate in an educational setting. I realise my experience is NSW and ACT based and may be different from other states. In the ACT the ratio of school counsellors to students was such that my high school could purchase extra two days over their allocation to make me full-time with a student body of 800.

The role of the school counsellor does not fit in neatly with the boundaries of a private practice and should not be judged nor regulated by academics and psychologists who see themselves as clinical psychologists. Imposing inappropriate distance and confidentiality clauses for instance does not serve the school community well. However there are many nuances and discussions that do take place. I found in the main a great deal of respect from staff about the needs for confidentiality though there were differences of opinion. The discussion should be about what is in the best interests of the student and a school psychologist should be able to discuss this without resorting to some “but the rules say”.

When students were referred to me by staff rather than through self-referral, the level of trust I had with the student body usually effected rapid development of rapport even with those who initially may have been reluctant. Being able to invite them into a relaxation class was non threatening and did not expose them to queries about why they were seeing the school counsellor. I don’t believe academics and members of Boards understand the lack of confidentiality inherent in calling out a student from class to attend a counselling session, the stigma or embarrassment. I was more than happy to allow their avoidance of maths as an excuse to attend relaxation sessions and to bring along a friend, a very important need for a teenager, as a precursor to seeing me individually.

When four very large year nine boys were sent to me for anger management, they arrived with their newly testosterone infused bodies, and challenged me with , “Aren’t you scared to be here alone with us?” With the door closed for privacy and with them positioned between me and said door, I looked at them. “Well, actually,” I said, “I have four sons and this just feels like home.” They visibly relaxed. We had some great sessions. They were able to relate how they were just friends but that when they walked through a mall together, the reaction of other shoppers was as if they were a gang. One of them had been on detention for assaulting a teacher. He had slid down the bannister from the second storey and the senior English teacher had been startled. He had not in any way touched her or intended to do so. I had useful discussions around this scenario with the teacher and student.

Familiarity of the normal development of large cohorts of normal children in their normal school setting might mitigate the medicalisation and pathologizing of normal behaviour but not if the psychologist remains in the office with a closed door. Some psychologists who have an AoPE in clinical psychology are renowned for diagnosing ADHD in everyone they see. I have never met a true ADHD student without a trauma background. I so wish I had known EMDR therapy when I was in schools and that it would have been a possible approved intervention. Sandtray therapy was useful but it took a long time to effect change. EMDR therapy with children works so rapidly and effectively.

Each of the aforementioned challenges reflects a lack of understanding of the profession of school counsellor and sets a non-teacher psychologist off on the wrong track. I found school counsellors were a wonderful group of colleagues. Working within a school was far from isolating. Conflicts exist everywhere but the APS setting up an expectation of a code of ethics conflicting with organisational demands is counter-productive and reflective it seems to me yet again of a lack of knowledge on the part of the APS and the Board of Psychology.

The current regime restricts competition by the more qualified professionals against the least qualified for the position of school counsellors because it inappropriately favours academic psychology qualifications over the necessary dual qualifications and experience of a school counsellor, imposes huge financial burdens on teachers wanting to pursue school counselling, forcing departments of education to select from a diminishing pool of properly qualified school

counsellors, forcing them to employ those with psychology only qualifications and experience, and outsourcing much of the work that was in-house and tailored to their school community needs.

I have grave fears that the [redacted] decisions are contributing to destroying school counselling as a profession. I hardly see the increased cost has benefited anyone beyond people setting up private consultancies and academia, ensuring that their courses or institutions continue to be able to charge exorbitant fees, students accrue expensive HECS debt, and they certainly do not benefit school communities, parents, teachers or indeed students who once accessed school counsellors for free. So instead of a free service necessitated by the needs of their child in a government public school, parents are referred to external expensive psychologists with an AoPE. Suicide, bullying, and depression and anxiety have all markedly increased with these decisions.

This problem has arisen from the APS having a non-representative board, which doesn't reflect the diversity in the profession, and through its lobbying to the Psychology Board of Australia, alongside academic and medical professionals, and has resulted in a mis-representation of the skills of registered psychologists. This further compounds the restriction of the practice of psychology in the private sector. The result is mis-representation of psychologists who are not endorsed[1], as inadequately skilled or experienced to practice psychology. In effect this is mis-leading the public with regard to the status and competence of psychologists. The APS lack of advocacy for the entire population of their membership, has resulted in a two tier Medicare system for mental health items, with higher rebates for clients under Medicare if the psychologist has a postgraduate degree the APS has deemed sufficient for membership of one of its APS college, resulting in higher payment for services for clinically endorsed psychologists over all other psychologists. The competitive advantage created by this tiered system has informed policy and direction for other organisations and government departments. When the two tier Medicare system was introduced, I accepted it was a government decision and expected the APS to advocate on having it remedied, as this was what I heard they were doing. I was shocked last year to find out the APS had actually instituted it, by recommending only rebates to clients of clinical psychologists should be made, and the government was the instigator of actually including all psychologists.

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[1] An '**endorsement**' indicates that a registered **psychologist** has qualifications in a particular area of practice (such as clinical **psychology**, health **psychology** or sport and exercise **psychology**) and an additional two years or more of supervised experience in that area (https://www.psychology.org.au/for-the-public/about-psychology/types-of-psychologists/Psychologists-with-an-Area-of-Practice-Endorsement, accessed March 24, 2019)

More recently the APS propose to change this to include other endorsements, excluding psychologists with general registration from assessment and treatment of clients in the community unnecessarily. The proposals advocated by the APS have the flow on effect of damaging my professional reputation through implying that general registration is no longer adequate protection to ensure compliance with all ethical and practice guidelines that structure the practice of psychology. The APS in fact, propagated that by restricting practice of registered psychologists, they are 'protecting the public' (APS, 2013).

Whether or not a school counsellor chooses to seek an AoPE, does not determine their fitness or otherwise to continue doing the work they may have successfully done for thirty years. Nor can the APS and Board assert that such endorsement "ensures consumers can be confident about the education and training of psychologists who have endorsements" while it implies that those who haven't applied are inferior. Consumers are being mislead to believe that their school counsellors are under-qualified or worse, inappropriately trained, when the truth of the matter is that other psychologists who have taken positions in schools are the ones who should not be there. Indeed, the AoPE in Educational and Developmental psychology that is awarded to someone without substantial teaching experience may result in the public being mislead that that person has better qualifications than the dually qualified and experienced school counsellor. This is against the APS Code of Ethics that was endorsed by the Board of Psychology.

Some prominent psychiatrists have compounded the false narrative and division by stating that small private practices are ineffective, and that larger multidisciplinary "hubs" are needed (Rosenberg & Hickie, 2019). The Federal Government's budget has just announced it is allocating $400 million to 30 adult headspace centres, diverting funds away from private practice. Statements by Ian Hickie in the media such as these centres needing to be staffed "by properly trained clinical psychologists" (ABC, 2018) is not only a sleight on registered psychologists without endorsement, but an inaccurate reflection of the profession of psychology.

When I worked in Catholic schools staff, executive and parents were very appreciative of the fact that I understood from experience the way classes and schools worked, how the needs of an individual impacted on a classroom, school community, their or parents, parents of other children both in class and on the playground, on individual teachers and staff and executives. They were not familiar with this because at that time their catholic school counsellors did not have my qualifications but were social workers.

They were very much subjected to a view in the late 1980's that a child with needs outside of the normal range should be identified and transferred to a government school that could cater for their needs. I believe this was inculcated in their communities by a tick the box mentality of diagnosis with a universal prescription of treatment by transfer. This was despite the 'hygiene' principle being counter to the whole philosophy of catholic education.

I always undertook at least three days of assessment and observation and my reports were very detailed in how the school community could cater for the child. I never treated by transfer. When recalled to a school for further assessment of a child with selective mutism after two years, I requested details on what strategies they had implemented from my first report. While in the office with the principal, the staff were mortified to find that report unread in his file in the office immediately adjacent to where we were meeting, with the filing cabinet in my line of sight. I coached this new team of educators as to their role in meeting the child's needs. I refused to reassess him until they had implemented my prior report. They did this and on review they did not seek further assessment as he was making marked progress. The inability to do what I saw as the necessary follow-up in the Catholic Education Office led me to return to school counselling with the education departments of NSW and the ACT. I think this is a clear example of the difference in an external consultant model contrasting to an in-situ school counsellor.

Integration of children with special needs was a priority for me. I undertook the pilot study of integrating 44 students in three special needs classes in Giralang Primary School in 1993,4. I made the submission to the school and department, designed and managed its implementation and documented and reported on the outcomes. Having conducted the annual panel meetings with all the stakeholders for all of the special needs students, part of which was to keep up to date diagnosis, assessments of behaviour, academic, intellectual and social indicators and tests I was ideally placed to advocate for change and report on the success or otherwise of implementing such a radical re-organisation.

Students were allocated to be part of every classroom and were no longer taught in separate learning modules hidden from the rest of the student body. I organised the timetables for the support staff and teachers' aides and special needs teachers so that each classroom teacher had staff to

support her or him in those activities where it was needed to maximise the learning benefit for the whole class.

Teachers' aides were no longer seen as velcroed to the hip of a particular student so that the most qualified and experienced teacher was now able to implement an individual educational plan themselves rather than have a minimally trained non educator teach the student with the greatest need. The teacher aide became what she was titled, and could free up the real educator by monitoring or undertaking other tasks with other students needing minimal assistance. I trained the staff in this new model and managed their timetables, ensuring all students received their mandated assistance but it was often with the most educated specialist as opposed to the least.

I documented and complied the extensive report and the school was given an award for the implementation of the program.

All students bar one had improved outcomes on all indicators for social, academic and behavioural markers. Only one student with a diagnosis of fetal alcohol spectrum disorder who had been in the segregated special needs classrooms for the previous five years failed to make academic progress but socially and behaviourally he had improved.

The outcomes for the main student body were also positive. Playground and classroom interactions with students who were previously isolated and segregated became much more positive.

Twenty years later it would seem that the APS and the Board of Psychology seek to deem that I am not supposed to have diagnosed anything but I am supposed to have referred my students to a non existent psychologist in private practice who had a non existent AoPE for clinical psychology as they are now opined to be the only people who could do so. Further, the Board would infer I was working outside my scope of practice despite the fact that was what I was trained and employed to do.

In my employment as a School Counsellor with the ACT Department of Education I was required to undertake assessment for students with behavioural and psychological difficulties. I was renowned for achieving successful placements of my students in the few available places in the

behavioural units at Dairy Flat or the Adolescent Day Unit because my reports were so good. To now have implied that I was not capable of diagnosis is ridiculous and reflects more on the ignorance of those making that pronouncement than on me.

EMDR therapy

There is no evidence to suggest that EMDR therapy provided by psychologists without an AoPE is any different from that provided by a psychologist with an AoPE. This is the null hypothesis. In fact, Ad de Jonge's[2] research in the Netherlands demonstrates a lack of therapist effect in his study where different therapists provided EMDR therapy for each of 8 sessions over a two week period.

The use of AoPEs unfairly discriminates amongst EMDR therapists and fails to protect the public. The client of a psychologist with a AoPE as a clinical psychologist, newly introduced to EMDR therapy without even completing basic training, receives a rebate of $124.80 compared to the rebate of $84.60 she would receive from someone like myself with 12 years of experience and who is also an EMDRAA accredited consultant. The ludicrous situation is highlighted when that psychologist with a AoPE as a clinical psychologist seeks help from me through supervision as an EMDRAA accredited consultant to devise the treatment plan and overcome any difficulties. The public is badly misled into believing that the psychologist with a AoPE as a clinical psychologist is better equipped, trained and experienced than experienced EMDR therapists simply because of their AoPE. It would appear that I and other EMDRAA accredited consultants, not endorsed as psychologists with an AoPE as a clinical psychologist (more than 50% of consultants, including two EMDR Institute trainers) could be incorrectly viewed by the public as less able to provide the Level 1 evidenced based therapy to the public. This is despite being the only people accredited to supervise a psychologist with an AoPE as a clinical psychologist wishing to learn and upgrade their own practice in EMDR therapy. It also effectively demonises all the other allied mental health professionals trained in EMDR therapy, implying they are less qualified to provide EMDR therapy.

To say this is ludicrous is putting it mildly. I was appalled to discover that my professional organisation APS has no understanding and no scientific evidence to support this view but made a damning submission to MBRC stating that I am not capable, qualified or experienced enough to do

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[2] https://psycho-trauma.nl/wp-content/uploads/2015/07/Phase-based-treatment-versus-immediate-trauma-fcused-treatment-Van-Vliet-et-al.2c-2018.pdf

what I have been doing successfully with my clients for twelve years. This is a serious breach of ethics and a profound betrayal. This is relevant as the APS is accredited to provide training for the National Examination and has maligned EMDR therapy in one of its courses. See Appendix 1. I have had no response to my complaint about this. I would make a complaint to AHPRA if I knew who the author was.

Facts about Registered Psychologists

- Psychology in Australia is one single nationally registered and regulated health profession. Currently (and historically) in Australia, once a psychologist is generally registered without conditions and/or restrictions, they can practice within the limits of their competence across the spectrum of mental health disorders, and within all steps of a model of severity, that is, mild, moderate and severe mental health disorders.
- Psychologists are under ethical and legal obligation to practice within the scope of their capabilities. The scope of a psychologist's practice capabilities changes over the course of their professional careers within the context of ongoing professional development, work opportunities/experiences, reflective practice, peer supervision and all other applications of the lifelong learning process.
- All psychologists are registered and regulated through the Australian Health Practitioner Regulation Agency (AHPRA) because all psychologists are considered Health Practitioners.
- The specific area of health that all psychologists are registered to practice is Mental Health. Thus, all psychologists gain registration to practice in the specialised field of mental health through AHPRA. In this context, all psychologists are mental health specialists deemed so by their registration to practice as a psychologist through AHPRA.
- Once registered through AHPRA, psychologists apply their knowledge and skills across a range of areas and contexts. For example; through organisations, sports teams, community groups, schools, the forensic setting, NGO's.
- Many registered psychologists hold Masters and PhD's in their chosen field (Counselling, forensic, education etc.). In fact, a recent study of 755 psychologists in private practice not endorsed as "clinical" hold postgraduate degrees found that 76% had post graduate degrees (Knott, 2018). Like many I could have sought an Area of Practice Endorsement in 2010 but

I did not know anyone in the college and it was a requirement to be referred by two college members. I did not comprehend that this choice at that late stage of my career would eventually see my right to practice restricted, with subsequent advice that my degrees being more than ten years old make me ineligible to do anything besides completely retrain, and that I would have to do another bachelor degree to even start.

Ensuing difficulties

A. After the Department of Human Services (Centrelink) put in a policy that my Psychologists reports which provided mental health diagnosis were no longer acceptable and only endorsed Clinical Psychologists diagnostic reports would be accepted, I had to refuse to complete any Centrelink forms for clients as a result and they have left my practice, prematurely terminating therapy.. Furthermore, I had to inform potential new clients that I could not see them if they requested this support.

B. The National Disability Insurance Agency has instituted a policy of not accepting an Autism Spectrum Disorder (ASD) diagnosis from psychologists other than clinical psychologists in line with other government departments and insurers. This despite the fact that I have undertaken autism specific training and have identified adults on the Autism Spectrum when previous clinical psychologists have missed this diagnosis causing great harm to them, for instance inappropriately treating them for eating disorders.

C. The National Disability Insurance Agency attempting to introduce a Two-Tiered pricing model, similar to the MBS Better Access 2-tier model co-designed with the APS persuaded me not to apply to be an NDIS provider, though I took on some NDIS clients privately.

D. Fewer referrals from General Practitioners because they have been falsely informed that only clinical psychologists can assess and diagnose mental disorders.

E. The decrease in availability of University programs for areas of specialisation other than clinical psychology. See comments earlier re school counselling, ineligibility to do a bridging course which doesn't yet exist because of decision that degrees have to be less than ten years old.

F. Clients choosing to see a Clinical Psychologist over me because they receive lower rebates

from me for the same service with the same outcomes without evidence to support the decision. This is particularly galling when that same clinical psychologist is newly trained in EMDR and using me for EMDR supervision without which they can not complete their basic training in EMDR therapy.

G. The public slander of registered psychologists by specialty interest groups with no consequence as AHPRA does not accept notifications about groups, only individuals. This is despite the fact that individuals are identifiable. (Refer to ACPA statement and Chair of AHPRA endorsement. Indeed, in 2015, the ACT Regional Board Chair of the PsychBA at a public forum proudly declared how successful they had been in increasing the number of clinical psychologists from 5000 to 10000 over five years. This was an exaggeration as subsequent investigation showed less than 8000 were recorded in the AHPRA annual report. For all those in the room, there was no doubt about this being their goal for all psychologists with subsequent belittling of those not endorsed.

H. Misinformation provided to government department review boards: *";Endorsed Psychologists have better outcomes with any client group compared to unendorsed Psychologists" or that" unendorsed Psychologists are not competent to provide Level 2 and Level 3 services" (*APS, 2018*)*

I. Erosion in public perception of the competence of psychologists. I hear and read my reputation being damaged in print (e.g. APS, 2018, APS 2019). This is reinforced by relatives informing me they were referred to clinical psychologists because they were better trained, despite knowing I was not endorsed. The loss of status within my family has been sorely felt.

J. Pushes to move WorkCover to a two- tier model- I will receive lower rebate. Also potentially if the APS 3-tier proposal is accepted I will no longer be able to treat Workcover clients with complex conditions such as Post Traumatic Stress Disorder (PTSD), despite my specific training and expertise as well as documented success in treating such clients.

Recent developments in further restrictions

The APS released a "Green Paper" (APS, 2019) consisting of a qualitative analysis of 500 submissions (of which 46% were clinical psychologists, which only represent 26% of the total APS membership. Not only is the sample biased in this regard, but thousands of psychologists who

already left the APS due to the poor behaviour of the APS discussed already, were prevented from submitting their views of the APS model of the MBS for mental health. The entire process has been a sham, with the model being presented as a result of this submission clearly designed to functionally de-register non endorsed psychologists. The release of the white paper sent to government was even more appalling.

The total rejection of the paper written for the expert committee by the DGPP representing more than 50% of the APS membership as evidenced by the contrasting submissions.

DGPP Submission

Principle 1*: Facilitate effective service delivery by removing restrictions on scope of practice:*

1. *That the Australian Government and the APS recognise that general registration as a psychologist with AHPRA is based on equivalency of pathways to registration. General registration as a psychologist qualifies an individual to work in any area of psychology that is within their scope of competence and use the title Psychologist therefore there should be no arbitrarily imposed restrictions on practice and treatments that can be delivered.*

2. *As psychologists are legally bound to practice within their competence, the DGPP calls on the Australian government and APS to affirm, assent and advocate there should be no arbitrary practice restrictions placed on psychologists based on AoPE. All appropriate evidence-based interventions a psychologist is competent to deliver should be available to their clients. Psychologists currently develop, maintain and expand their competencies to provide these services by undertaking additional education, training and experience throughout their career*. [3]

Instead the APS wrote a white paper[4] to Medicare Benefits Review describing a very distinct division based on endorsement not competence.Additionally the APS created a new term of Advanced Psychological Therapies without defining it but limiting it to psychologists with an area of practice endorsement. This is actually a fallacious circular argument.

Psychological Therapy Therapies and assessments can be provided by all psychologists as they require a high level of knowledge and skill. This therapy includes undertaking an increased range of psychological interventions to include all Level I evidence-based therapies as described by the NHMRC guidelines.32

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[3] http://admin.psychology.org.au/Assets/Files/DGPP%20Submission_Final%20Version_February%202019.pdf

[4] https://www.psychology.org.au/getmedia/a1c6fc1f-8356-471c-9247-36832da61299/APS-White-Paper-The-Future-of-Psychology-in-Australia-June-2019-FINAL.pdf

c. Advanced Psychological Therapy. The psychologists who can provide this type of therapy are those with an Area of Practice Endorsement and who are working within their area of advanced competency, as determined by the Psychology Board of Australia and the Australian Psychology Accreditation Council. These activities require expert psychological intervention, in circumstances where the client has a complex, co-morbid or treatment resistant mental health disorder, which requires high level clinical judgement to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

The following demonstrates how these three aspects have or will affect me via APS conduct.

The Medicare two-tier rebate system established in 2006 (rebate $124.50 for consultations with a clinical psychologist versus $84.80 for consultations with all other psychologists, (despite equivalent quality of service) was established based on advice rather than evidence to the Government by the APS. This imposed a division within the profession of psychology based on competitive behaviour between psychologists due to clients having financial incentive to see an endorsed psychologist with no evidence of better outcomes as a result of increased expenditure. I have been disadvantaged competitively because of this division, as explained above.

In addition to lower rebates, it is inferred that I am not permitted to provide services other than the "Focussed Psychological Strategies". This is in spite of my being trained in EMDR therapy which is the evidenced based therapy recommended for PTSD and have additionally done more than 50 days of advanced EMDR training for CPD, which have been offered through the APS which provides certificates for all psychologists. Indeed, GPs, mental health nurses, Mental Health social Workers also attend these trainings. Thus, the APS by providing this training certification are then stating competence to treat clients using therapy, at the same time also restricting me to practice "Focussed Psychological Therapies" which contradicts the acknowledgment I am adequately trained to provide EMDR therapy. Meanwhile other professions have no such restriction placed on them.

We are now beginning to see mental health services as well as private practices recruiting clinical psychologists over other, possibly more experienced and qualified psychologists, simply because they attract a greater Medicare rebate and therefore proportionally higher fees can be charged. As discussed above, once a psychologist is registered to practise, they may do so without

restrictions; Proposals such as put forward by the APS (2018, 2019) to the Medical Benefits Scheme (MBS) Review to limit me to treat "mild to moderate disorders" will restrict my trade to provide psychology services to clients. The severe or chronic cases will be referred on to Clinical Psychologists, in spite of my qualifications and expertise to competently do so, due to the following argument which was never supported by evidence, only opinion from the APS:

*"Within psychology, one endorsement area (Clinical Psychology) was identified by the Government when the Better Access Medicare items were first introduced to meet the standard required to provide treatment services to individuals affected by the more severe, complex and chronic mental health disorders."(*APS, 2018)

The Green Paper that was supposed to be more representative of APS membership views is a completely biased, and further underscores the many trade restrictions that will result. I attempted to counter the bias on 3/1/2019 by suggesting options to increase proportional representation on the proposed expert committee but it was The APS states in this paper that psychologists who are not listed in this as providers of services to consumers with a severe level of need are not prevented from providing psychological services to these consumers privately. However, consumers of these services will not be eligible for rebate from Medicare. Medicare rebates for consumers assessed with a severe level of need are available only to psychologists who hold endorsements. The APS acknowledges psychologists have competency to provide psychological services but restricts Medicare rebate thus reducing who will engage their services. It also states that in regional areas psychologists without endorsement will be able to continue to treat severe/complex cases (who have certificate demonstrating 40+ hours of training and supervision). The APS cannot have it both ways: either a psychologist is either competent to treat clients or not- clients in regional/rural areas are no different to those in urban areas.

In the APS green paper it is stated that 20% presentations are severe, 40% are mild and 40% moderate. Thus it was stated it is therefore impossible for all psychologists to be seeing severe presentations.

However, a recent review estimated that 2–3% of Australians (about 730,000 people based on the estimated 2016 population) have a severe mental disorder, as judged by diagnosis, intensity and duration of symptoms, and degree of disability caused (DoHA 2013). This group is not confined to those with psychotic disorders and it also includes people with severe and disabling forms of depression and anxiety. Another 4–6% of the population (about 1.5 million people) are

estimated to have a moderate disorder and a further 9–12% (about 2.9 million people) a mild disorder.

So 730000 Australians have a severe mental illness and from my calculations only 304000 Australians actually see a psychologist. It isn't hard for me to see that most psychologists just might be seeing mostly severe presentations.

"Data from the National Profile of Mental Health and Well-being study indicates that approximately 20% of the Australian population will meet the criteria for a mental health problem or disorder (ABS, 1997). Yet, only 38% of these people will seek professional help. Of those who do seek professional help, 75% do so from their GP." (Primary Mental Health Care, AGPN)

So approximately 25% of 38% of 20% of Australian population over 15 (16 million) seek help from psychologists. That is 3.2 million have a mental illness, so 38% or 1.216 million seek help then 25% or 304 000 see a psychologist or other allied health.

I would suggest that looking at a 40:40:20 breakdown overlooks the fact that the majority of people with a 'mental illness' do not see a psychologist in the first place and to then decide that most psychologists could not see severe presentations must be an erroneous conclusion. In fact severe presentations includes the 75% of homeless with severe mental illness and 40% of prisoners.

These broad restrictions did not negatively impact my role in school counselling in ACT, NSW and Catholic Education Departments between 1985 and 2001, but would now because of the demise of many MEd where dual qualifications of experienced teaching and psychology, education departments are now recruiting clinical psychologists. A clinical psychologist is now erroneously seen to represent a psychologist with more expertise than I have. I am now restricted from providing assessments and reports in this system, despite years of experience and appropriate expertise. I have lost clients as a result. In contrast, newly qualified psychologists with a clinical endorsement, despite their limited experience, can write and sign the report. Many clinical psychologists and psychiatrists acknowledge they are prepared to sign off a diagnosis based on the referring psychologists' assessment and report. This is duplication, a waste of time and government money.

There are an increased number of employment agencies and organisations advertising for clinical psychologists only, despite other psychologists being more adequately qualified with the skills and experience required for the position. This is particularly the case in schools.

Further, repeated reference to a **WA work value case** often shuts down discussion. In his submission to the Psychology Board, Anthony Cichello, an APS president, College Chair, wrote

In 2001 the Full Bench of the Industrial Relations Commission of Western Australia determined that there was a higher "Work Value" of the "Calling" of Clinical Psychology over that of general non-specialist Psychology. I quote the following section on Pages 23 – 24 of this document, which differentially defines the Clinical Psychology profession from Psychology and allied health, with acknowledgement and gratitude to all listed authors and co-editors involved in compiling this document -

"...Clinical Psychologists are often grouped with "allied health" for administrative purposes and this has led to a mistaken belief that there is sufficient commonality between this profession and other allied health professions to treat all groups similarly. Clinical Psychologists differ markedly from other allied health professions.

This quote is the first paragraph of page 23 from their own submission Application No P39 of 1997 made by HSOA Clinical Psychology Negotiating Committee in support of Application No P39 of 1997 HSOA v Royal Perth Hospital & Others. Work Value Doc - W A Clinical Psychology Health Sector 1998.pdf. There is no reference to higher work value of clinical psychology over that of a general non-specialist psychology. In these pages 23,24 to which Cichello refers at the bottom of page 25 from their own submission they assert that the Burdekin Commission on p178 to 182 'F*ound that Clinical Psychologists have distinctive skills which differ from those of other types of psychologists and differ from those of other allied health professions." Is this really what the Burdekin Commission found?*

Looking at those pages, there are two quotes from the APS Tasmanian branch that state

'Psychologists' and 'clinical psychologists' should be distinctly defined... Clinical psychologists 46 have distinctive skills.

'Clinical psychologists' possess diagnostic and treatment skills on the same footing as psychiatrists, except that psychologists cannot prescribe [medication]... Clinical psychologists can often more accurately measure function, point to origins and set about assessment and treatment with patient participation... As such, clinical psychologists should take key roles in 47 clinical and administrative structure and policy-making. [5]

So once again Cichello , the APS President is actually quoting from one of their own APS submissions **NOT** from findings by either the WA Industrial Relations Commission or the Burdekin Commission.

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[5] See Work Value Doc - W A Clinical Psychology Health Sector 1998.pdf application no P39.

(http://www.aph.gov.au/DocumentStore.ashx?id=495f9838-801e-46e4-a257-110d33228770)

This is a contexomy, an informal fallacy and a type of false attribution in which a passage is removed from its surrounding matter in such a way as to distort its intended meaning. Contextomies may be either intentional or accidental if someone misunderstands the meaning and omits something essential to clarifying it, thinking it to be non-essential.

Arguments based on this fallacy typically take two forms:

1. As a straw man argument, it involves quoting an opponent out of context in order to misrepresent their position (typically to make it seem more simplistic or extreme) in order to make it easier to refute. It is common in politics.
2. As an appeal to authority, it involves quoting an authority on the subject out of context, in order to misrepresent that authority as supporting some position.[2]

It is analogous to saying I wrote this, you stated I wrote this, therefore you agree with what I wrote.

Cichello's quotation effectively misrepresented the case. The work value case from twenty years ago relates to 135 clinical psychologists in WA Public health asking to increase their award at levels 6 and 7 / 8 in comparison to social workers, OTs and mental health nurses etc but not in comparison to psychologists as none were employed. The Mental Health Reforms in Western Australian – the Report of the Government Reform Programme, October 2000 recognised that "the major difficulty in this field is the retention of senior clinicians". The report also noted that "current awards restrict salary and many experienced practitioners find private practice more attractive".

Also of note was there was no expected flow on to private sector. The work value was increased because of the development of evidenced based therapies like DBT, CBT, EMDR, Schematic therapies, being used where they weren't used in 1985. It is important to note that this is the same case all psychologists in 2019 who have done extensive training in these modalities after registration can make. Thus it really enhances the current situation for private sector registered psychologists to demonstrate they have the same added value.

Thus a case from 20 years ago, specifically for 135 clinical psychologists in WA employed in public health asking for an award increase to retain senior staff by comparing what they did in 1985 to 1998 is used to assert that the work in 2019 by clinical psychologists in the rest of Australia is superior to all registered psychologists. I don't know what psychologists did in WA in 1985. I know I did intelligence and behavioural assessments, wrote reports, made referrals, diagnosed, provided individual therapy, devised programmes, ran groups, without the supervision of

psychiatrists and that in 2019 with the development of evidence based therapies like EMDR, CBT, DBT I still do. The WA clinical psychologists only accepted national registration in 2010 IF they could retain their title. Despite the Ministers of Health deciding not to have specialist titles within psychology gradually there is whittling away of that decision.

*The applicant (*the union for the clinical psychologists*) says that there is no history of linkage or flow-on of wage increases from clinical psychologists in the public sector to private sector awards …. In the main, those in the private sector operate in independent private practice. On this basis, the applicant says there is little prospect of flow-on. The applicant also says that if the claim is granted, it would not create any precedent on the basis that it is the particular circumstances, educational requirements, registration procedures and classifications which sets this group of professionals apart.*

Hence there was no intention at the time to effect any economic repercussions on the private sector, but it has been used to do this and misquoted frequently.

The utilisation of clinical psychology services are said to have resulted in a reduction in the utilisation of costly medical services, medications and reduced in-patient bed days. Interventions that have been developed or implemented by clinical psychologists can have a major impact on the physical and psychiatric health of individuals. Such psychological treatments as Cognitive Behaviour Therapy ("CBT"), interpersonal psychotherapy, family systems interventions, and brief and long term psychodynamic interventions are said to have proven efficacy. Disorders such as clinically severe anxiety disorders (including obsessive – compulsive disorder and post-traumatic stress disorder), depressive illness, chronic pain syndromes, eating disorders, chronic personality disorders, substance misuse, and the management of symptoms associated with schizophrenia are all able to be treated by psychological treatments. **These are the same treatments provided by the registered psychologists resulting in the same cost savings.**

28 The Work Value Document claims that the responsibilities of clinical psychologists have increased considerably since the mid to late 1980s, with the profession becoming "more fully established", and providing "highly specialised and autonomous mental health services to individuals across all developmental stages". It says that "the profession provides amongst other things, specialist diagnostic and complete psychobiosocial assessments, treatment services in areas as complex and diverse as psychotic illness, severe personality disorders, and co morbid disorders". In addition to providing treatment to patients, clinical psychologists have been increasingly called on by psychiatrists to provide additional diagnostic information, to assist with diagnosis of complex cases. Clinical psychologists are said to be "especially trained and skilled in the use of specialist psychological and neuropsychological tests that can only be validly interpreted by psychologists and no other mental health profession. These tests are being continually revised." One such test is the Wechsler Adult Intelligence Scale ("WAIS") which was said to have been revised again in 1997. The Work Value Document asserts that "Clinical Psychologists are the only mental health profession which has the depth of psychometric and empirical training, and consequently, the responsibility of reliably and validly applying and interpreting tests essential to the effective and ethical mental health practice". **These are the same services and the same tests interpreted by registered psychologists**.

*Dr Anthony Mander is a Director of the Division of Clinical Neurosciences based at Royal Perth Hospital. He was a member of the (*WA*) Psychologists Registration Board between 1996 and 1999. He says that although clinical psychologists are not trained in clinical diagnosis as understood by medical practitioners, they are trained to produce a detailed formulation of an individual's problems which is sufficient to enable the practitioner to instigate an effective individualised treatment package using psychological principles. Hence, although it is different to the "medical model" approach, it could be said to be a complementary diagnostic and treatment procedure. Clinical psychologists are involved in the "development of effective, rigorously evaluated, focused psychological treatments" and "operate with a degree of independence far in excess of other "allied health professions"". Dr Mander noted that clinical psychologists are in short supply and are easily able to successfully establish private practices. This creates difficulties in the retention of top quality clinical psychologists in the mental health delivery system.*

However, in 2019, when all psychologists are registered under National Law and national registration, using the term 'clinical psychologist' from this WA 1998 work value case may mislead to the belief that they, and only they, have these skills.

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

…… He believes that that responsibility has now shifted because of the kinds of treatment ……. due to the new techniques …… developed, including assessment tools such as CBT, which have been refined and applied to a broader range of clients problems. He says that there has been a real shift in the kind of techniques that have been developed, which is innovative, not merely evolutionary change.

It should be noted that none of the clinical psychologists in WA are able to claim credit for developing any of these treatments. e.g. EMDR was developed by Francine Shapiro, 1987 in USA.

Increases in drug induced psychosis amongst young people are now being increasingly treated ……. utilising their evidence-based treatments for first episode and early psychosis. They did not have this role 10 years ago. In addition, a disorder which typically manifests itself during adolescence is borderline personality disorder, and the treatment approaches known as Dialectical Behaviour Therapy and Schema-focus Therapy have been developed for this purpose. These treatments are said to be "specifically and primarily the domain of Clinical Psychology".

135 public health therapists aiming to distinguish their contribution to their workplace in order to gain a salary increase continually refer to themselves as by their job title of clinical psychologists as distinct from OT, social workers, nurses. This does not equate to clinical versus some other nomenclature in psychology, as is often implied.

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

As do all psychologists and certainly since 2010 when national registration was introduced.

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

This may have been the case in 1998 in WA but it is not the case in 2019 anywhere in Australia, nor has it been since 2010 when national registration was introduced.

So rather than continuing quoting from the APS's own submission, looking at the actual judgements of the WA IRC shows the following (2002 WAIRC 07218. pages 69 onwards)

Conclusions
Following the conclusion to the hearing in this matter, by letter dated 24 January 2002 the Commission in Court Session sought .... job description and duty statements .... for the period 1985 to today. .... indicate(ing)... there has been a core of requirements of the positions which has not changed. The essential aspects of the positions remain the same:
- *to undertake psychological assessments and interventions with clients and systems in accordance with psychological principles;*
- *to provide advice to colleagues in multi-disciplinary teams (or in inter-disciplinary relationships);*
- *to undertake or participate in research and evaluation;*
- *to contribute to disciplinary or multi-disciplinary teams; and*
- *to provide training and education regarding psychological processes to more junior colleagues and to other professions.*

However, the job descriptions .... do not reflect .... the following changes which we find have occurred in the application of those general terms, including:
- *the complexity added to the assessment and diagnosis by increasing co-morbidity, substance abuse, the aging (sic) of the population, ADDH, the effect of HIV/AIDS, chronic disease, etc.*
- *a substantially increased body of knowledge and more sophisticated psychological assessment brought about by research undertaken or participated in by clinical psychologists, amongst others, beyond the normal expectations of progress within a profession in a multitude of existing and new areas including:*
- *adults`*
- *children and adolescents*
- *Aboriginal people*
- *elderly*

- *medical/surgical fields such as gynaecology, obstetrics, pain management.*
- *the significant improvements and developments in treatments, resulting in more cost effective and efficient treatments, also beyond the normal expectations of progress.*
- *the increased use of psychological treatments, in addition to, or in substitution for, pharmacological based treatments, which is another factor to be counted towards the cost effective and efficient treatment of patients.*
- *the increased role of clinical psychologists (*as opposed to OTs, Social workers, nurses in the public health system *) having overall responsibility and accountability for assessment, diagnosis and treatment of the patient, whereas this responsibility and accountability was previously in the hands of medical professionals such as psychiatrists.*
- *an increased supervision load at mid to higher levels of the profession, due both to the requirement for a longer and more complex supervised period for junior staff, and a depletion of numbers at senior levels.*
- *an increased training period for registrars to reflect the increased demands and complexity of the role, and increased body of knowledge.*
- *increased specialisation.*

....

*As to the claim that changes to the work environment of community-based work rather than the previous hospital based focus, and the use of multi-disciplinary teams, t**hese are common across the mental health sector. The clinical psychologist operating within that system is no different from the mental health nurse, occupational therapist, psychiatrist, or medical practitioner in that respect.** (bold added by author) The clinical psychologist may head the multi-disciplinary team, but so might other professionals. .... We conclude that the change to the community based approach has lead to increased efficiency and cost effectiveness of treatment, by the significant reduction of in-patient bed days and by the use of the multi-disciplinary approach. Other professions may contribute to this and any such contribution would need to be weighed with any other changes to the professions should they make a similar claim.*

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

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

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

Central to the applicant union's case has been the skill and expertise of clinical psychologists in the development and application of more sophisticated tests and assessments. From this has developed a greater involvement in direct referral of patients, and the management of cases. Evidence was forthcoming from a number of witnesses on the use of tests and assessments and the application of cognitive behavioural treatments. In this respect Dr Merryweather informed the Commission that such tools as CBT have been refined and can now be applied to a broader range of clinical problems. Indeed, Ms Griffiths (Unit Manager, Youth Link Inner City Mental Health Service) points out that CBT has received recognition under the NHMRC guidelines for use in cases of youth depression, replacing total dependence on medication and electroconvulsive therapy. We accept this and the use of Dialetic(al, sic) Behaviour Therapy in the treatment of borderline personality disorders as factors contributing to the change in work value of clinical psychologists. It is noted from the evidence of Professor Lipton (former Chief Psychiatrist and General Manager, Mental Health Division, Dept. of Health) that CBT and other neuro-linguistic programmes are not the exclusive domain of clinical psychologists and were developed by psychiatrists. It was acknowledged, however, that psychologists have developed the treatment further. Ms Jones (Senior Clinical Psychologist and Co-ordinator at Warwick Clinic) attested to the use of new assessment techniques in the early 1990s for measuring clinical levels of dysfunction in cases such as ADD/ ADHD. The development of clinical psychology in the field of neuro-psychology is evident from the role that these professionals now have in the diagnosis, management and rehabilitation of patients with brain injury. This involves the use of CAT and MRI scans. Again in this respect we accept the uncontroverted evidence of Dr Conner (Senior Clinical Psychologist, Neuroscience Unit) that this has contributed to the change in work value of clinical psychologists.

In our view it is implicit in changes which we have identified that the worth of clinical psychologists within the health care environment has been re-assessed. Their roles have changed and whilst degrees of specialisation and patient care responsibility have always been features of the profession, ***the evidence presented to us on issues of co-morbidity, the developing role of psychology in complementing and/or replacing medication as the standard form of treatment and the development of new diagnostic skills have contributed to an increase in levels of skill and responsibility.*** *(*all within the domain of all registered psychologists since 2010*)*

As to any prospect of flow-on, we note that clinical psychologists have demonstrated a package of changes, including in skill or expertise, responsibility, training, supervision, environment and in the nature of their patients' conditions. ***Some or all of those changes may be able to be demonstrated by other groups either within or outside the public health sector.*** *They would need to prove such changes, and the degree of change, and whether taken as a whole they constitute an increase in work value. However, the prospect of flow-on should not deny to one group the benefit of increases in remuneration due to the increased work value they have demonstrated.*

There is no real suggestion that the cost of this claim being granted, even if granted at its highest level, would have any real detrimental effect on the state of the national or the Western Australian economies. The claim will have a direct impact on, at most 135 positions, and a cost estimated at between $540,000 and $924,000. There is some potential for limited flow-on, subject to those seeking flow-on being able to demonstrate the merits of their case. In a total health budget for the

state of $1.8 billion, this does not constitute a real impediment to the claim being granted, whether in full or in part.

We conclude that there has been demonstrated a net increase in work value for clinical psychologists in the public health sector at current levels 6 and 7/8 which is sufficient in the terms of the Work Value Principle, "to warrant the creation of a new classification or upgrading to a higher classification".

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

Thus the changes WAIRC accepted that made a case for senior clinical psychologists to a salary increase in the WA public health system are the same that can be made for private registered psychologists in 2019 and would also have been the case in 2006.

The artificial division of the psychology profession created by the APS does not benefit the Australian public. There is a continuing narrative analogous to testing oranges for Vitamin C content, comparing oranges to apples and pears, then stating that oranges have higher Vitamin C content than mandarins, without ever testing a mandarin.

Additionally there is the manner of **APS advertising** of training courses.

I was wondering how much income the APS makes from advertising psychological therapies, compared to Focussed Psychological Strategies without even looking at any income they might gain through co-sponsoring through APS interest groups. I was considering the ethics of this. So I looked for definitions.

It really distressed me to read the circular definitions on PsychBA website

if you provide psychological therapy services you also need to maintain a clinical psychology area of practice endorsement. [6] This is contradicted by other statements. *Psychologists with general registration have unrestricted rights to use the title Psychologist or Registered Psychologist, and may undertake any work using that title*. [7] And that Regulated health service[8]
Means a service provided by, or usually provided by, a health practitioner (as defined in the National Law).

A health service includes the following services, whether provided as public or private services:
1. services provided by registered health practitioners
2. hospital services
3. mental health services

A health practitioner means an individual who practises a health profession.

So the PsychBA have contradictory definitions or circular definitions. To

further confuse, the PsychBA state

Professional development is an ongoing process which continues over the course of a career, adapting to changes in practice environments, professional domains, new information and consumer needs. Carefully tailored professional development can assist competency and relevance in practice, which in turn assists members of the public who seek psychology services.[9]

I could not find a definition of psychology services, or psychological therapies

on PsychBA website. However, on the APS Website, repeating Medicare definitions,

1Mental disorder is a term used to describe a range of clinically diagnosable

disorders that significantly interfere with an individual's cognitive, emotional or

social abilities. This includes people with mental disorders arising from:

Chronic psychotic disorders Acute psychotic disorders Schizophrenia Bipolar disorder Phobic disorder Generalised anxiety disorder Adjustment disorder Unexplained somatic complaints Depression Sexual disorders Conduct disorder

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[6] Since 1 November 2014 there are no longer separate CPD requirements for registered psychologists who provide services under Medicare's Better Access to Psychiatrists, Psychologists and General Practitioners Scheme (Better Access). This applies to both psychological therapy services provided by clinical psychologists, and focussed psychological strategies (FSP) services provided by psychologists. Instead you are required to meet the Board's CPD requirements to maintain general registration, and if you provide psychological therapy services you also need to maintain a clinical psychology area of practice endorsement.

[7] https://www.psychologyboard.gov.au/Standards-and-Guidelines/FAQ/Psychology-FAQ.aspx

[8] https://www.psychologyboard.gov.au/Standards-and-Guidelines/Codes-Guidelines-Policies/Guidelines-for-advertising-regulated-health-services.aspx

[9] https://www.psychologyboard.gov.au/Standards-and-Guidelines/FAQ/CPD-resources.aspx

Bereavement disorder Post-traumatic stress disorder Eating disorders Panic disorder Alcohol use disorders Drug use disorders Mixed anxiety and depression Dissociative (conversion) disorder Neurasthenia Sleep problems Hyperkinetic (attention deficit) disorder Enuresis (non-organic) Obsessive Compulsive Disorder Mental disorder, not otherwise specified

'Focussed Psychological Strategies' items (Items 80100 to 80120) which can be provided by all fully registered psychologists who are competently skilled in this area; and 'Psychological Therapy' items (Items 80000 to 80020) which can only be provided by clinical psychologists who hold area of practice endorsement in clinical psychology with the Psychology Board of Australia.

Both categories of psychology Medicare items can only be provided to people with 'an assessed mental disorder'. So we are expected to be registered to provide **any** mental health services, keep up to date, but not provide psychological therapies that are not defined anywhere unless we have a clinical psychology area of practice endorsement.

Re the APS advertising:

Looking at the December 2018 InPsych issue, there are nine advertisements

for training workshops, all of which are psychotherapies and not Focussed Psychological

Strategies. The APS would benefit by approximately $20,000 for these nine advertisements for this

one issue.

Advertisements summary

Acceptance and Commitment Therapy
It is a mindfulness-based, values-oriented behavioural therapy,for everything from full-blown psychiatric illness to enhancing athletic or business performance.

Schema Therapy
Schema Therapy is an innovative psychotherapy developed by Dr. Jeffrey Young for personality disorders and other so called "treatment resistent" psychological disorders.

Radically Open Dialectical Behaviour Therapy
The target population for RO-DBT are individuals with over control issues such as chronic depression, obsessive compulsive disorder, avoidant personality disorder, or anorexia nervosa.

Trauma Therapy
Uses ACT, Schema, DBT, CBT, Metacognitive therapy, Emotion Focussed therapy for survivors of child abuse and neglect.

Clinical Hypnosis
Pain relief, For burn patients, to reduce inflammation and promote healing, therapy with victims of crimes such as incest, rape and physical abuse, allergies; anxiety and stress management; asthma; bed-wetting; depression; sports and athletic performance; smoking cessation; obesity and weight control; sleep disorders; Raynaud's disease; high blood pressure; sexual dysfunctions; concentration, test anxiety and learning disorders

EMDR
Eye Movement Desensitization and Reprocessing (EMDR) therapy is an interactive psychotherapy used to relieve psychological stress. It is an effective treatment for trauma and post-traumatic stress disorder (PTSD). EMDR has been found to effectively treat other mood and anxiety disorders, including depression, phobias, and panic disorder.

Compassion Focussed Therapy
to work with people with severe and enduring mental health problems: depression, anxiety disorders, eating disorders, personality disorders, PTSD

Flash and EMDR
Reduces distress prior to using EMDR

Mind Only
Attachment Pathology in adults, acute and complicated grief.

... all advertising[10] in APS publications and at APS events must comply with
- *the APS Code of Ethics and any relevant requirements stipulated by the Psychology Board of Australia (PsyBA) or the Australian Health Practitioner Regulation Agency (AHPRA)*

The promotional material must NOT contain:
- *The word 'specialist' (or words to that effect, such as 'specialises in') used in relation to describing a registered health practitioner or regulated health service*
- *Claims that cannot be substantiated by a body of reputable research*
- *Inaccurate or misleading representation of a product/service or an individual's details or qualifications*
- *Claims implying* ***superiority of a psychologist over other psychologists***
- *Claims that could induce fears in clients if they did not obtain a particular service, product or publication*
- *Information or images that are vulgar, sensational, in poor taste or that will reflect poorly on the APS or the profession of psychology*
- *Sweeping statements that are not able to be substantiated (e.g., 'the best in the world')*
- *The use of testimonials in advertising of regulated health services, as per the Guidelines for advertising regulated health services developed by the National Boards and published by the Australian Health Practitioner Regulation Agency (AHPRA).*

Nowhere does the APS warn the 16000 members that they can pay to go to the training BUT should not use it! However, we know this is not what is done. Nor does the PsychBA ever query psychologists about their use of a psychological therapy without having a clinical endorsement. They query records, advertising, telephone calls, publications, but not psychological therapy. NEVER.

Another case of contextomy

Misrepresenting Tribunal cases by the APS and Psych Board. In an APS news, 13 March 2019, the President of the APS Roz Knight and the Chair of the Psychology Board Rachel Phillips made an announcement that there was a Supreme Court finding that qualifications overrode experience. However some time later they had to retract that as there was no such decision.

[10] https://www.psychology.org.au/About-Us/news-and-media/advertise-with-us

They stated that the Chair of the Psychology Board had met with the APS Medicare Expert Committee and that she had made this statement, which may be construed to have effectively shut down discussion.

"an important precedent contained in a Supreme Court judgment *(Pereira v Psychology Board of Australia [2014] VSC 417)* has prioritised formal qualifications over professional experience including continuing professional development for the purpose of determining competency

https://www.psychologyboard.gov.au/news/2017-06-22-endorsement-rejected.aspx?fbclid=IwAR2Lhshf_W8f3ZXjMoxbvL9hRDIOodJIIS8_wL022SYQW-8HD7wcEGCTPy4

The problem was this was not true. However the White paper submitted to government was completed before the apology was made.

The link was to the Supreme Court that disallowed AHPRA's application to award costs against Ms P and the Supreme Court sent the matter back to the Tribunal. The Tribunal rejected the Board's justification of refusal to process the application deeming that two months late was not significantly late, and given the Board had set the deadline, the Board had the authority to vary it. They also noted the need to be consistent with applicants which they hadn't been.

The tribunal noted *Ms P ... is already registered as a psychologist. ..... It is also not our task to approve, or alternatively throw doubt on, her overall ability or qualifications to practise as a psychologist.*

However, it would appear that the APS President could be interpreted as throwing doubt when she referred to *the purpose of determining competency* rather than for determining clinical endorsement. This of course has brought an individual psychologist into disrepute without the possibility of reparation.

The psychologist Ms P was not able to provide contemporaneous notes to validate her claim to have practised as a **clinical** psychologist **under supervision by a clinical** psychologist. The rules had changed. Her attempt to provide documentation in the required format was deemed deliberately misleading. It did not say she did not have clinical experience. It did say they were not able to be satisfied that she had clinical experience that was supervised by a clinical psychologist.

The expert clinical psychology witnesses who had been/were assessors agreed there was a minimum standard, but they could not say what it was, but it was important. Further, the Tribunal did not have enough information about any of the cases presented ... to be able to formulate any minimum required standard that they could apply.

Furthermore they noted that

the criteria for eligibility for clinical College membership as set out in the guidelines for applicants.... Reflect advice received from the clinical College and from the APS executive. Many ... applications ... do not fit easily into the various pathways to eligibility offered by the APS. Thus, the following are guidelines only and each application is to be assessed on a case-by-case basis.

1. Firstly the words"guidelines only"are underscored...to emphasise that point. ... and that the pathways are not rigid.

One wonders why there is not a balanced view. This case, in which the Tribunal states that any psychologist can undertake the work of a clinical psychologist with or without endorsement. In their judgment they note that they are applying the rules as they are, **but suggest these can be changed when the relevant section is reviewed.**

Draper v The Psychology Board of Australia [2013] NSWPST 3 (24 October 2013)
Last Updated: 25 October 2013

1. Ms Draper impressed the Tribunal as an intelligent, competent, caring and dedicated psychologist. The Tribunal was informed that any psychologist can undertake the work of a clinical psychologist with or without endorsement. Ms Draper was frank in indicating that she sought endorsement as both an acknowledgement of her standing in the profession and also as a means by which her remuneration could be increased.

1. The Tribunal's decision in this appeal is not based on any concern for the protection of public or any reluctance to acknowledge the contribution Ms Draper does and will make to the psychology profession. The Tribunal's decision is based on section 98 and related provisions of the National Law. It may well be appropriate, when a statutory review is undertaken, that consideration be given to the operation and effect of section 98, given some of the practical dilemmas Ms Draper's application has highlighted.

Failing to deliver consumer protections, particularly through false and misleading conduct or failing to obtain informed consent before a transaction.

It is not only unethical, but I allege unlawful to claim without evidence that some psychologists are more competent than others.

The Health Practitioner legislation differentiates between an endorsement and a speciality. This means that any practitioner who advertises a "specialist" service is potentially deceiving the consumer into believing that another service provider cannot provide the same service at a competitive rate. The Australian Clinical Psychologists website https://acpa.org.au/ has numerous documents and submissions claiming clinical psychology is a speciality. The APS has been asked numerous times to demonstrate evidence for the superiority in outcomes of Clinical Psychologists of non-endorsed psychologists, and they have never been able to provide such evidence. Conversely, a rigorous study comparing both groups demonstrated no differences in clinical outcomes or client satisfaction (Pirkis et al., 2011). This study has been persistently ignored or dismissed, without alternative evidence being produced.

Further deception is demonstrated in the Frequently Asked Questions component of the Green Paper: Question: What if the members don't agree with the proposed model? Answer: Ultimately it is for the APS Board to make a decision. They have a responsibility as Directors to guide the Company and they will make the final call." What was the point then of the membership consultation? I have paid my yearly fees for 16 years and my interests have not been looked after. In fact, it seems I have been paying for an organisation to feather the nests of an elite group at my expense.

It is a timely reminder of Professor Alan Fels' (1997) ACCC view:

"*Members of the professions often present the view that rules prohibiting anti-competitive conduct should not apply to them as the conduct complained of has the purpose of protecting the public. … But if there is something that is anti-competitive and it really is for the patient's benefit or client's benefit that is, for the public's benefit (as distinct from being a private benefit for the doctors/lawyers etc) - then Parliament has set up a mechanism whereby that conduct can continue with immunity from Court action - seek authorisation. That is, demonstrate that the public benefit of that conduct outweighs its anti-competitive detriment and obtain immunity from Court action for that conduct*."

Yours sincerely

References

Australian Psychological Society (2109). APS Member Consultation paper. The delivery of psychological services under Medicare's Better Health Access initiative. March 25th, 2019.

Australian Psychological Society (2018) APS Submission to the MBS Review: Better Access to Psychiatrists, Psychologists and General Practitioners, August 11th

https://www.psychology.org.au/getmedia/5ee546ee-7a78-4807-a404-45d0d12adca7/2018-APS-submission-Better-Access-following-presentation-aug.pdf

Australian Psychological Society. (2013). Submission by the Australian Psychological Society to the Psychology Board of Australia Public Consultation Paper 26 Review of Area of Practice Endorsements

Cahill, L (2018) Reactions to the APS Medicare MBS Submission. Reform Australian Psychological Science –'RAPS'. https://reformaps.org/reactions-to-the-aps-medicare-mbs-submission/

Fels, A. (1997). Can the Professions Survive under a National Competition Policy?" - The ACCC's view . Joint Conference Competition Law and the Professions. https://www.accc.gov.au/system/files/Can%20the%20Professions%20Survive%20under%20a%20National%20Competition%20Policy.pdf

Knott, J (2018). Report on the Impact of the Two-Tiered Medicare Rebate on Registered Psychologists in Private Practice

Pirkis, J., Harris, M., Hall, W., & Ftanou, M. (2011). Evaluation of the Better Access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule initiative. Summative evaluation. Melbourne: Centre for Health Policy, Programs and Economics.

Reform Australian Psychological Science (RAPS, 2019). https://reformaps.org/resources/foi/).

To Frances Mirabelli, CEO APS
Formation of APS MBS Expert Committee

Summary

There is no prima facie case of legitimacy for the proposed representation.

Rationale

I urge that you realise that the numbers you have suggested will never satisfy face validity of a fair representation. If indeed you wish to hear those that believe the Australian Psychological Society has not listened and to truly heal the divisions, the committee numbers need to be more representative.

Any solution that has the majority represented by a minority will not address the fundamental issues of trust and lack of transparency that have been eroded since 2003 when unbeknown to the majority of members, people employed by the APS were advocating to government that they were inferior in their ability to work with their clients.

I have not included provisional psychologists. Psychologists from the Division of General Psychology Practice should not be enrolled in a program to obtain an Area of Practice Endorsement or intend to be enrolled. Representatives should be known and transparent about their values, qualifications, experience and workplaces. There should be a majority of psychologists who work where the Medicare rebate is utilised by their clients

Option 1

Psychologists with any Area of Practice Endorsement, number 10684, or 37.6% of all registered psychologists have 10 representatives. Thus one committee member can be seen as representing 1068 psychologists with an Area of Practice Endorsement. This would mean the majority of 17758 or 62.4% should generate 16.6 not 3 from the Division of General Psychology Practice.

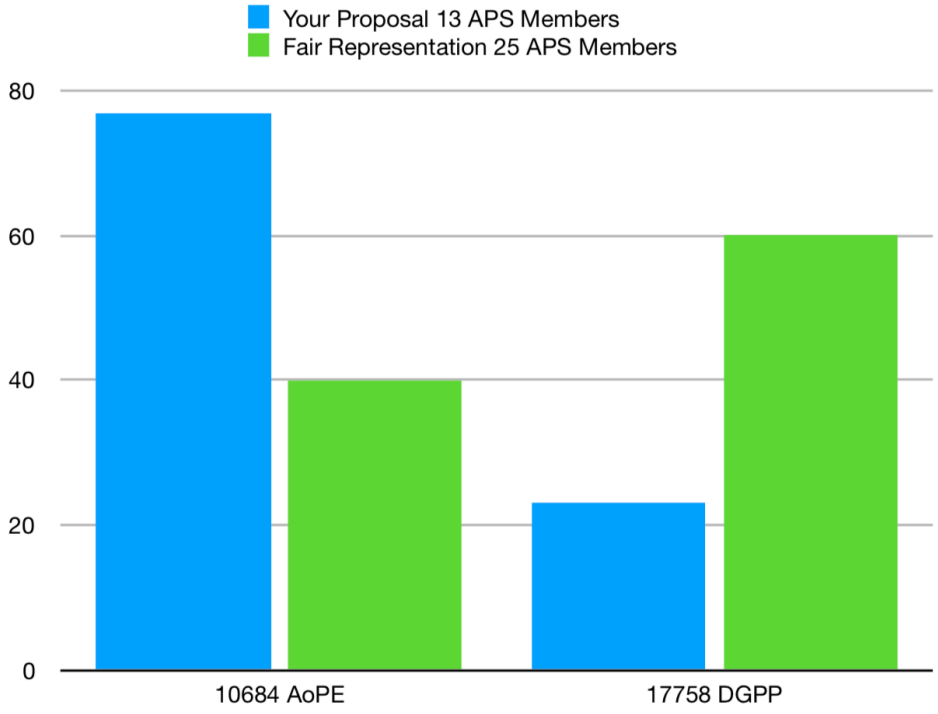
Some Area of Practice Endorsements with registration numbers of less than 1000 or less than 100 as community health with 55 or sports with 92 have been given representation completely out of proportion in comparison to the 24000 who work with mental health but have chosen not to pursue an Area of Practice Endorsement for the myriad legitimate reasons they have.

Option 2

Area of Practice Endorsement	Number	Percentage of psychologists	Proposed Representation on committee	Percentage of Representation on committee	Better Proportional Representation	Percentage of more Proportional Representation
Clinical neuropsychology	630	2.2%	1	7.7%	1	4.0%
Clinical Psychology	7931	27.9%	2	15.4%	2	8.0%
Community Psychology	55	0.2%	1	7.7%	1	4.0%
Counselling Psychology	947	3.3%	1	7.7%	1	4.0%

Educational and Developmental Psychology	647	2.3%	1	7.7%	1	4.0%
Forensic Psychology	565	2.0%	1	7.7%	1	4.0%
Health Psychology	324	1.1%	1	7.7%	1	4.0%
Organisational Psychology	508	1.8%	1	7.7%	1	4.0%
Sports and Exercise Psychology	95	0.3%	1	7.7%	1	4.0%
Total Psychologists with an AoPE	10684	37.6%	10	76.9%	10	40.0%
Psychologists	17758	62.4%	3	23.1%	15	60.0%
Others Not included in %			5		5	
Total Committee			18		30	

From another point of view, if the smallest college has proportional representation, 3/1000, you would need a committee of 1000 people! Closer would be 100 people, with larger factions surrendering an entitlement to allow the smaller ones to be represented. Even 50 people is too large, so looking at a base of 20, dividing by 5, but rounding up to a whole person, we arrive at a committee of 25 psychologists plus 5 other members. This gives a committee of 30 people which is still rather large. Representation of psychologists who have chosen not to pursue an Area of Practice Endorsement, must be represented more in line with their numbers as registered practitioners. Ideally there should be even more given their numbers as members of the APS.



Carolyn Milner BA Dip.Ed MEd (School

committee as Proposed with 13 psychology APS members

Counselling)

EMDRAA Accredited Consultant MAPS 25310

Reply On 1 Feb 2019, at 4:02 pm, MBSconsult <MBSconsult@psychology.org.au> wrote:

Hi Carolyn

Thanks for your message and the amount of effort that you have put into working out what you believe the composition of the committee should be.

I don't believe that because we have not followed your formula (which was considered) that the committee will have no legitimacy.

We are being transparent and consulting with members and I hope that as we go through the process we will rebuild the trust that has been lost over the years.

Kind regards

Frances Mirabelli
Chief Executive Officer
The Australian Psychological Society Limited
a: L13, 257 Collins Street I Melbourne I VIC 3000
p: 03 8662 3318

Appendix 1

It was brought to my attention that the following scenario is used in the APS Institute Ethics course that is preparatory to the National Exam. I was appalled by the tenor of the scenario. I feel it is detrimental to EMDR therapy and perhaps defamatory. It would certainly disturb new practitioners and put them on their guard. Of course, the intern's application of EMDR seems to imply a rapid jump in and wave the fingers approach rather than a comprehensive assessment for traumatic events, but I think this misrepresentation is appalling.

The scenario inaccurately implies attendance at a two day course on EMDR for PTSD, when that is not what is done or how it is advertised. It reduces EMDR therapy to a technique indicating a lack of knowledge of EMDR therapy. Reference to a small restricted outdated body of research is also ludicrous.

If it stated she had attended a two days of a six day blah blah blah course, without reference to EMDR in particular, the whole ethics involved would be the sole focus. However I feel that this misrepresents EMDR therapy, maligns the excellent work our trainers do in having participants be very careful about selecting their first clients, and always having them give consent. I think having every new registrar mandated to sit the national exam in the future will severely affect the acceptance of EMDR by them.

The irony of denigrating the work of other psychologists within this ethics course is hard to ignore.

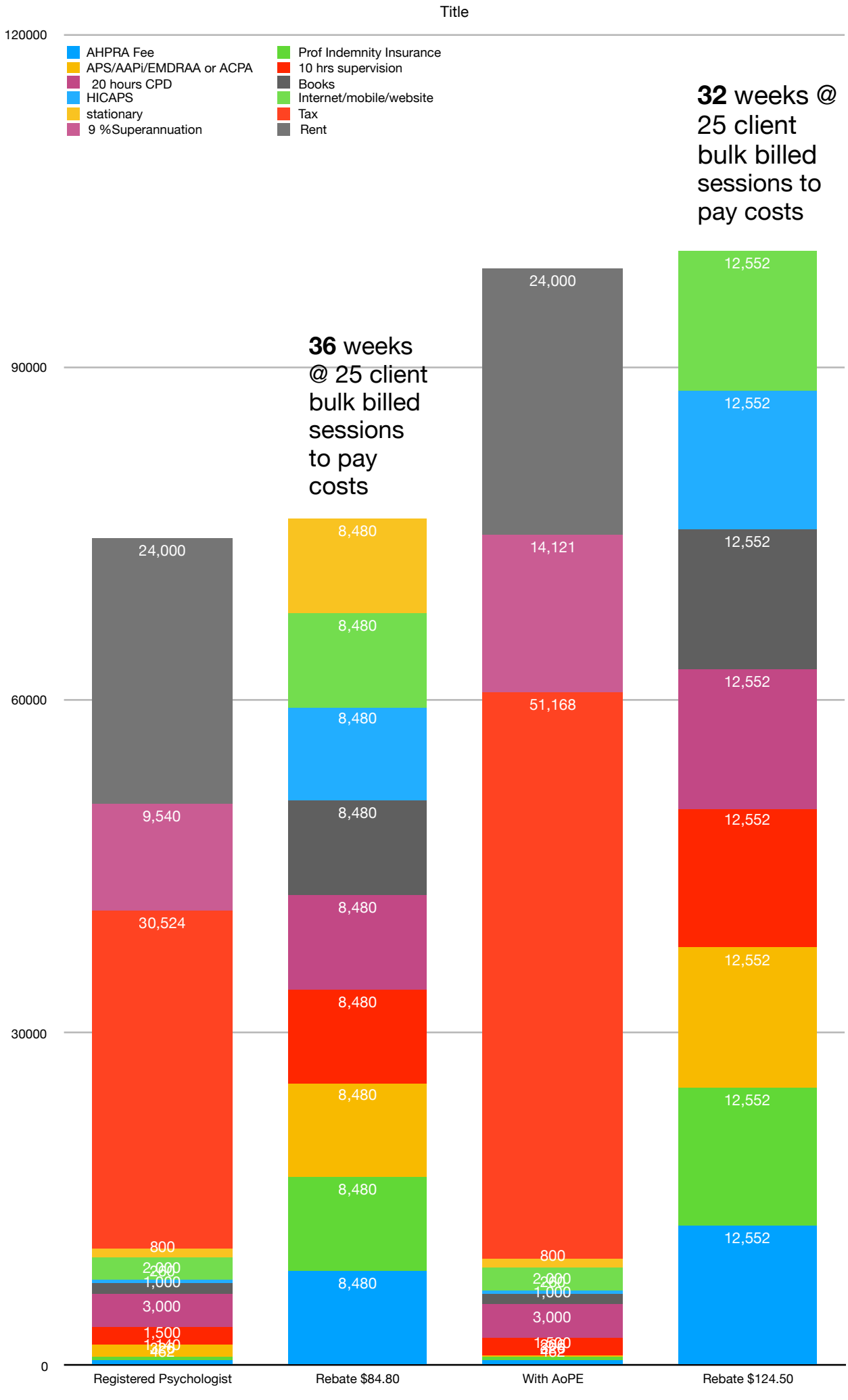
Scenario from Ethics course.
Kelli is a 32 year old health worker who has been diagnosed with social anxiety. She has been referred by her GP under Medicare for CBT for social anxiety. Kelli is reluctant to see a psychologist. Your assessment and formulation is comprehensive and your supervisor and you agree on a diagnosis of social anxiety and agree that you will use CBT - an evidence-informed approach for social anxiety based on a published treatment manual which is freely available from the Clinical Research Unit for Anxiety and Depression report link(CRUfAD)
You explain to Kelli what CBT entails and give Kelli a handout explaining CBT.After 5 sessions of CBT Kelli is not improving - avoiding meetings at work, she is feeling increasingly anxious ("panicky"), and has taken 3 days off work. You have just attended a 2-day workshop on EMDR for PTSD and were so impressed with the quick effects this approach seems to have, that you decide to use the Eye Movement technique in session 6. You have not discussed this change of plan with your supervisor.
What happens next is that Kelli gets very upset with what she called a "whacky approach". Kelli interrupts the session and leaves the room very angrily. As she walks out she shouts at you that this therapy is not CBT and that she had not agreed to this approach. She says she will not be coming back and that you had made her worse rather than better and that she was going to tell her GP that you had "experimented" on her and not provided the "correct therapy" (she understood Medicare was funding you to provide). She was also going to complain to the Psychology Board about you. Kelli refuses to return to the consulting room, and leaves the building.
What should you do now? What will you do now?
Using the 5 step process, imagine you are the psychologist, then Kelli. Examine this ethical problem, work through each step, and identify what actions you will take.

Please review the APS Code of Ethics report link - in particular Sections A.3.1. to A.3.3., B.1.2., and B.3..
Please review Psychology Board Guidelines for developing core capabilities and supervised practice in the 4+2 report link or 5+1 internships report link.Three important legal requirements for consent to be fully informed:

1. *Clients must understand*
2. *Consent must be freely given*
3. *Client must be competent to give consent*

Did you also identify additional ethical issues?
There are clearly additional ethical issues that relate to the competence to deliver EMDR, and the lack of appropriate discussion with the supervisor. If you had not identified these as possible ethical issues, reflect on these and work through each using the 5-step process to ascertain what would be the most ethical actions to take with respect to these two issues.

According to the EMDR Institute report link, although there are many anecdotal reports of successful EMDR treatments of social phobia, to date no studies have investigated the treatment of this disorder.
Several studies have treated persons with complaints associated with social anxiety disorder, such as performance and test anxiety, but participants were not assessed for social phobia. There is a small body of research investigating the application of EMDR to specific phobias. Unfortunately, the findings are limited by methodological flaws, such as failure to use the full EMDR treatment protocol, and confounding of effects, with the exposure treatment protocol used as the outcome assessment.
So given this information, can the provisionally registered psychologist defend her decision to implement a new approach without discussing this with her supervisor?


Title
120000
90000
60000
30000
0
AHPRA Fee
APS/AAPi/EMDRAA or ACPA
20 hours CPD
HICAPS
stationary
9 %Superannuation
Prof Indemnity Insurance
10 hrs supervision
Books
Internet/mobile/website
Tax
Rent
32 weeks @ 25 client bulk billed sessions to pay costs
36 weeks @ 25 client bulk billed sessions to pay costs
24,000
9,540
30,524
800
2,000
1,000
3,000
1,500
8,480
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8,480
8,480
24,000
14,121
51,168
800
2,000
1,000
3,000
12,552
12,552
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12,552
Registered Psychologist
Rebate $84.80
With AoPE
Rebate $124.50

Analysis

A Registered Psychologist needs to work 36 weeks, bulk billing 25 clients every week @ $84.80 to pay basic costs. Of course, if clients don't come then superannuation and tax is reduced. Tax also is on gross income not on net and there would be a rebate for costs. Then taking 4 weeks leave, the Registered Psychologist will work for 12 weeks for themselves earning the grand total of $25, 440, and will be sweating on their tax rebate!!! Oh, and don't get sick!

A Registered Psychologist with an Area of Practice Endorsement in clinical psychology needs to work 32 weeks, bulk billing 25 clients every week @ 125.50 to pay basic costs. Of course, if clients don't come then superannuation and tax is reduced. Tax also is on gross income not on net and there would be a rebate for costs. Then taking 4 weeks leave, the Registered Psychologist with an Area of Practice Endorsement in clinical psychology will work for 16 weeks for themselves earning the grand total of $ 50,208 , and they won't be sweating on their tax rebate quite as much as their colleagues as they have earned twice as much.

Costs of rent varies a lot, so this is a very significant cost. Many home based solo practices ignore the cost of providing their own office that is essentially off-limits for personal use but this is probably the only way small part-time practices can survive.

Every dollar above the bulk billing rate fora Registered Psychologist will contribute to you actually earning a decent pay for a very hard job. You work out how much you want to earn. If it is $100,000, then

$100,000 - $25,000 = $75, 000
Divide that by the 25 clients per week, which is 1200 per year. Divide the amount you want by the number of client sessions, $75, 000 / 1200 equals a gap fee of $62.50.

For Registered Psychologist with an Area of Practice Endorsement in clinical psychology, if you want to earn $100,000, then

$100,000 - $50,000 = $50,000
Divide that by the 25 clients per week, which is 1200 per year. Divide the amount you want by the number of client sessions, $50,000 / 1200 equals a gap fee of $ 41.66.

Same costs: same income: gap fee has to be 50% dearer for the clients of registered psychologists.