Submission to the inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)

I am a registered unendorsed generalist Psychologist, working for the past 23 years with an NGO providing rehabilitation for clients with psychiatric disabilities. Approximately 80% of my clients within this NGO have schizophrenia, 10% are biopolar or suffer major depression, and 10% have other conditions.

I completed my non-clinical Masters degree in Psychology at Sydney University in 1995. When the Medicare rebate was introduced in 2006 I changed my employment to part time (3 days per week) with my NGO and began taking private clients. The majority of my new Medicare bulk billed clients (approximately 80%) are clients referred to me by the [redacted] Court facing charges, and Stream 3 and 4 Centrelink clients. These are vulnerable clients with multiple issues and significant barriers to employment. Approximately 70% of these new clients have a chronic mental illness including psychotic disorders, bipolar disorder, major depression, anxiety disorders, drug abuse, alcoholism, domestic violence abuse. The remaining 30% of my private clients are referred by GP's and have a range of problems and disorders, but mostly have much lesser needs than my bulk billing clients. I charge them up to $40 above the Medicare rebate (ie $120 per hour).

I draw on my wide range of training, which includes Cognitive Therapy, Brief intervention, Mindfulness, Psychodynamic, ACT, Narrative and Hypnotherapy. In 2006 I considered studying for a clinical masters degree in psychology. However my research revealed that, at that time, I would be given very little advanced standing for my 17 years of mental health experience and that the majority of clinical masters degrees focused only on Cognitive Behaviour Therapy (CBT). Along with most other psychologists, including the majority of endorsed Clinical Psychologists I have met, I believe that the teaching of only one modality in a psychology clinical masters degree is irresponsible and arguably unethical.

I use CBT in my practice and recognize it is a very useful and efficacious tool. It is such a practical and logical treatment modality that even psychologists and counselors without formal training in CBT are using it without knowing they are doing so. However it cannot be applied as a 'one size fits all' to every client in every situation for every issue and disorder. By teaching CBT exclusively, clinical masters degrees are doing a major disservice to clients who need practitioners with a much wider range of experience with modalities.

A significant number of my full fee paying clients complain about the limited approaches they have previously experienced with the endorsed clinical psychologists they have seen in dealing with their disorders and issues. Clients have observed that these endorsed psychologists simply do not appear to have a wide enough range of tools to draw on.

The wider acceptance of psychological interventions in the broader community is still relatively in its infancy, reflected by only 5 years of Medicare rebates. Research on the comparative efficacy of differing modalities is inconclusive at best. The current debate raging that endorsed clinical

psychologists are better equipped at interventions than unendorsed generalist psychologists is spurious. I am 53 years old with 23 years continuous mental health experience. I sit on a number of Mental Health Sector boards and committees, have made major contributions to capacity building in the sector, have supervised placements for over 30 students and interns over 23 years and was a major contributor to the curriculum development for the Certificate 4 and the Diploma in Mental Health developed by the Mental Health Coordinating Council. The current claim by inference that a 24 year old endorsed clinical masters student is better equipped and should therefore be paid at a significantly higher Medicare rebate than me is insulting.

Unlike other approaches to health, psychotherapeutic interventions are primarily about relationships. Psychology is only 100 years old. Its clinical application is not an exact science, yet to its detriment I have observed over my career, academic institutions and elite professional bodies exacting increasing power and control over its dissemination, while suppressing broader or dissenting dialogue amongst the majority of its practitioners. Psychotherapeutic intervention is my passion. I have a dream that in the future its most efficacious application will depend on attributes other than whether you have solely studied cognitive therapy for 2 years at university level for all of your intervention skills.

The introduction of the Medicare rebate for allied health professions was a significant step towards addressing a major mental health deficit in the community. There are a majority of unendorsed generalist psychologists like me who bulk bill those clients with greatest need. The majority of these clients are on Centrelink benefits and simply cannot afford payment beyond the Medicare rebate.

Most endorsed clinical psychologists do not bulk bill clients. If you pay the medicare rebate only to them, then those clients of greatest need will lose any access to treatment, as they will have no competition from the unendorsed psychologist, so they wont even bother with the poorer clients. The medicare rebate will then become the sole privilege for the worried well wealthier middle class.

I recommend in fairness, the Medicare rebate should be available only on a bulk-billing basis, at an equal rate for all psychologists, so the clients of greatest need will continue to receive the best possible treatment from psychologists with the broadest possible skills base.

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