Dear Senate Standing Committee,

I am writing to declare myself a supporter of Clinical Psychology as a distinct mental health specialisation in Australia. I am the Director of Monash University's Clinical Psychology Centre, primarily a training clinic for Clinical Psychologists. Our interns are extensively trained in all aspects of assessing, managing and treating mental illnesses such as Major Depressive Disorder, Bipolar Disorder, Schizophrenia and Posttraumatic stress Disorder. Their training is comprehensive in an effort to bring about advanced competency in their clinical approach to care.

Lately, I have been inundated with spam email from a group of psychologists who are intent in arguing that Clinical Psychology is the same as other specialisations (forensic, counselling, educational, etc). Besides feeling somewhat intimidated by their threats to name and shame anyone who disagrees with their agenda, I am confused by their approach which fails to acknowledge that the reason why they cannot gain Medicare rebates in the same way as Clinical Psychologists is that they obviously do not meet the requirements for acceptance into that College. Their claim, of course, is that they ought to be awarded the same recognition on the basis that they 'do the same thing'. I could not disagree more. Training in forensic, counselling and education psychology is distinct to training in clinical psychology by the mere fact that their focus is on forensics, vocational, supportive and educational counselling. If individuals have then gone onto practice outside their chosen speciality then this is a question of ensuring their individual competence to do so, rather than bring down the Clinical Psychology training standards and profession as a whole. Indeed, it should be an alarming situation that if these psychologists are as competent as they claim, why is it that they continuously fail to meet the standards of inclusion into the Clinical College?

The second point, I want to mention is to do with the proposed decrease of Better Access under the Mental Health Plan Medicare funded sessions. To offer one session a month per year to a person suffering from a mental illness is the very least a responsible government should offer its citizens to ensure a healthier society. According to our government's own research in this area, under the mental health scheme, most people only access around 6-7 sessions per calendar year, so why penalise those with severe mental illnesses who require more consistent attendances and who are by default a minority of the economic burden? By targeting this most vulnerable group the Australian government is at risk of disadvantaging those most in need of this scheme.

It is my hope that common sense prevails in these deliberations by recognising that Clinical Psychology is the specialisation that has been extensively trained to assess, manage and treat mental conditions that meet international agreed diagnostic criteria using extensively researched approaches. Perhaps the solution is for the government to develop other Medicare items for different specialisations. Specialist items for the other specialisations of psychology may mean that clinical

psychologists might not qualify for any those second tier items pertaining to other specialisations. Indeed, this letter is not a call to establish the 'superiority' of Clinical Psychology, but rather, assert our uniqueness in the profession. To re-iterate, Clinical Psychology requires a minimum of eight years' training and is the only profession, apart from Psychiatry, whose entire accredited and integrated postgraduate training is specifically in the field of lifespan and advanced evidence-based and scientifically-informed psychopathology, assessment, diagnosis, case formulation, psychotherapy, psychopharmacology, clinical evaluation and research across the full range of severity and complexity. We are well represented in high proportion amongst the innovators of evidence-based therapies, NH&MRC Panels, other mental health research bodies and within mental health clinical leadership positions.

Clinical Psychologists should ideally be treated as psychiatrists are under Medicare as both independently to diagnose and treat client cohorts within the core business of their professional practices. Psychiatrists do not require elaborate Mental Health Plans but simply the recognition from a Medical General Practitioner that a patient is in need of specialised mental health services, so a simple referral suffices. To extend the same courtesy of confidence in professional practice to a Clinical Psychologist would indeed be a step forward in the right direction. I strongly believe that the outcome of your deliberations will significantly impact, not only the provision of mental health services in Australia but also the future of our profession.

With kind regards,

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