Clinical Psychology is one of nine equal specialisations within Psychology. These areas of specialisation are internationally recognised, enshrined within Australian legislation, and are the basis for all industrial awards. They have been recognised since Western Australia commenced its Specialist Title Registration in 1965, and it is the West Australian model which formed the basis for the 2010 National Registration and Accreditation Scheme recognition of specialised Areas of Endorsement.

All specialisations require a minimum of eight years training including a further ACPAC accredited postgraduate training in the specialisation leading to an advanced body of psychological competency in that field. No specialisation should be referred to in a manner that creates the appearance of the same level of skill and knowledge as the basic APAC accredited four year training of a generalist psychologist. This is counter-intuitive and unrealistic. As is the case with Clinical Psychology currently, each area of specialisation deserves a specialist rebate with its own item number relating to that which is the specialist domain of that area of psychology (e.g. for clinical neuropsychology - neuroanatomy, neuropsychological disorders/assessment/rehabilitation, etc; for health - clinical health psychology, and health promotion; forensic - forensic mental health, etc). I personally chose to undertake the further training in both clinical and health psychology to ensure that I would be qualified beyond the training of a generalist psychologist in order to offer the most specialised services to my clients. Generalist psychologists undoubtedly provide an essential components of the psychology profession within Australia; however when a practical consideration of the stark differences in level of training, specialisation and services offered by specialist psychologists is in comparison to generalist psychologists is undertaken, the differentiation is clear. I deeply respect specialisations within psychology and believe that qualified individuals would seek to undertake further training in those fields should they wish to seek to demonstrate that they have attained those other advanced specialised competencies that are not part of clinical psychology.

Regarding my specialisation, I wish to re-state that 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.

Regarding Better Access,it is abundantly clear that there is an obvious significant gap in mental health service provision for those in the community presenting within the range of the moderate to most complex and severe presentations. Those presenting with only mild presentations are unlikely to be affected by the cuts to session numbers. The treatment of the moderate to severe range is the unique specialised training of the Clinical Psychologist and, to undertake a comprehensive treatment of these individuals, more than thirty sessions per annum are sometimes required. In this way, Clinical Psychologists should be treated as Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices. Furthermore, the decision to cut session numbers for the specialist clinical psychologist Medicare items should be reversed immediately.