# NATIONAL COLLEGE OF CLINICAL PSYCHOLOGISTS

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05 August 2011

Dear Committee:

## *Re: COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES*

The Australian Psychological Society (APS) National College of Clinical Psychologists wishes to thank the Senate on initiating an inquiry into the Commonwealth funding and administration of mental health services and for inviting comment for all interested parties. The National Clinical College respectfully submits the following comments and suggestions as detailed below.

## ***Disclosure Statement – Who are we?***

### 1. Who is the APS College of Clinical Psychologists?

- The **Clinical College** is a Constituent Unit of the Australian Psychological Society (APS) with approximately four and a half thousand members as at July 2011. It is estimated that there are 29,000 registered psychologists in Australia.
- The Constitution of the APS allows for it to make General Rules for its Constituent Units, including Generic and Specific Rules for APS Colleges. The Clinical College was established pursuant to the APS Generic Rules for Colleges (sections 3, 4 and 5), and is concerned with the specialist area of Clinical Psychology;
- Under the APS Generic Rules, the Clinical College has **four (4) primary objectives**:

- *to implement the mission statement of the APS as it applies to the Clinical College;*
- *to focus on and promote the specialist content area of Clinical Psychological practice;*
- *to maintain practice standards and quality assurance in the specialist field of Clinical Psychology;*
- *to encourage and support the education and continuing professional development of specialist practitioners within the Clinical College's area of Clinical Psychological practice.*

## .2. What is a Clinical Psychologist?

### *2.1 Overview -*

- Clinical Psychology is an internationally recognised specialisation within psychology in its body of knowledge and practice. Clinical psychologists specialise in the assessment, diagnosis, case formulation, evidence-based and scientifically-informed psychological treatment, and treatment outcome evaluation of mental health disorders across the lifespan at all levels of complexity and severity. Apart from Psychiatry, Clinical Psychology is the only mental health profession whose entire APAC and PsyBA accredited and integrated postgraduate professional 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.
- The data from **evidence based interventions** which informs efficacious best practice for the management of mental illnesses and psychological disorders comes from international and national trials that are designed and conducted by clinical psychologists. There is little evidence that generic counselling improves adjustment to these conditions. The interventions published in **JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY** (our first tier international journal for the field internationally) are the ones that drive or underpin best practice, policies and training. In the majority of cases therapists characteristics for the most effective interventions are reported as trained clinically psychologists
- Clinical Psychology requires a minimum of eight years' training. There are approximately 40 APAC-accredited and PsyBA-approved professional Doctoral and Masters Clinical Psychology training programmes in Australia, most of them long-standing and the first opened in the mid 1960s in Perth and Sydney.
- Clinical Psychology is one of nine diverse specialisations within Psychology. These areas of specialisation are internationally recognised as separate specialist bodies of knowledge and skill. Many are referred to within Australian legislation, for example the Medicare Legislation refers to Specialist Clinical Psychology Rebates, and many are referred to in industrial awards. The Psychology Board of Australia advises that the specialist fields of psychology, Areas of Endorsement, will further inform the nature and structure of future Industrial Awards.

- Like all specialist psychologists, Clinical Psychologists possess unique expertise and skills. While some other psychologists and health professionals have made claims to have the same skills, they do not in fact have the same training. If they did, then their training would satisfy the criteria for APAC accredited postgraduate professional training in Clinical Psychology. If one college truly was "the same" as another college, then that college would no longer satisfy the criteria for existence as a separate specialised body of knowledge and skill, and would have ceased to be known as a separate specialisation and college both within Australia and internationally. This has not occurred. When these other psychologists have been provided the opportunity to test their claims through the legislated Medicare Assessment process, only a small percentage of the claimants who felt strongly enough to apply were actually able to demonstrate equivalence. This highlights that is easy to make such claims but that the assertion of such claims does not mean they are true, and there is no evidence for their substantiation.
- As summarised in the table below, Clinical Psychology was the first specialisation to have been recognised internationally in 1896, and within Australia ever since Western Australia commenced its Specialist Title Registration in 1968, 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 professional training in the specialisation, beyond the initial undergraduate academic four year generalist Psychology degree, leading to an advanced body of psychological competency in that field.

### *2.2 Significant Dates in the Early History of Clinical Psychology in Australia and Internationally*

**1896** First psychological clinic and course in **Clinical Psychology** at University of Pennsylvania.

**1901** British Psychological Society founded and included a division/section of '**Medical (later Clinical) Psychology**'.

**1917** American Association of **Clinical Psychology** separated from the American Psychological Association, re-joined as a Division in 1919.

**1920s** First government appointments of psychologists in New South Wales, South Australia, Tasmania and Western Australia.

**1929** First Australian Professor of Psychology appointed at University of Sydney.

**1930** First Australian BA in Psychology established at University of Western Australia.

**1944** Foundation of the Australian Branch of the British Psychological Society (44 members)

**1949** In the United States of America, the Boulder Conference defined 'Scientist-Practitioner' model of training, and established PhD as necessary for the practice of **Clinical Psychology** in North America.

**1956** University of Western Australia introduced an Australian first two year Graduate Diploma in **Clinical Psychology**.

**1959** Two year Graduate Diploma in **Clinical Psychology** established at University of Sydney.

**1965** Victoria enacted Psychological Practices Act.

**1965** **Division of Clinical Psychology** established in the Australian Branch of British

Psychological Society in 1965 with 41 members, and continued as the first Division of a specialisation of Psychology within the APS.

**1966** Foundation of the Australian Psychological Society (941 original members)

**1966** University of Western Australia commences the first Australian two year professional **Masters in Clinical Psychology** Programme

**1968** First **Specialist Title Registration for Clinical Psychologists** commenced in Western Australia's Psychologists Registration Act.

**1967** Division of Education Psychologists commenced

**1972** Division of Occupational Psychology commenced

**1977** Division of Counselling Psychology commenced

**1983** **Board of Clinical Psychologists** formed

**1993** **College of Clinical Psychologists** formed

**1990s** First professional Doctorates in Psychology introduced in Western Australia

**2010** National Registration and **Endorsed Area of Practice in Clinical Psychology** commenced. Transitional arrangements allow for **Specialist Title Clinical Psychologists** (and other specialists), registered with the Psychologists Board of Western Australia, to maintain their title of **Specialist Clinical Psychologist** ( other specialist psychologist) until the end of the transitional period of 01 July 2013, and promises of a review of provisions to enable an ongoing Specialist Title to exist.

**2010** **College of Clinical Psychologists** represents over 50 percent of all APS college memberships and around 20 percent of APS membership.

***2.3 Specialist Title Registration and Higher levels in Awards in Australia since 1968 –***

- Since the mid 1960s, Western Australia, which developed in a more attuned manner to that of the United Kingdom than did the Eastern seaboard states, had a Psychologists Registration Act which included a number of specialist titles (e.g. Clinical Psychologist, Forensic Psychologist, Clinical Neuropsychologist, etc).

- These titles reflect the qualifications, the level of training and the area of work undertaken by the specialist psychologist. Specialist Title Registration arose in the early 1960's from the identified need for additional qualification and training (at that time initially in the area of Clinical Psychology) which substantially exceeded that which was capable of being provided by the four year Bachelor of Psychology Degree.

- Government Departments, including the then Mental Health Services, offered remunerated cadetships to enable four year trained psychologist to complete this additional training and this strongly demonstrates the acceptance of specialist registration within Australia more than 35 years ago.

- In the early 1980's the Health Department of Western Australia determined that clinical psychologists and neuropsychologists, with a minimum of six years accredited professional university training and a further two years' supervised practice, represented the minimum acceptable training of a workforce expected for working in mental health.

- In a very recent Industrial Relations case in WA, heard by a FULL BENCH of the IRC (submitted in 1997 and resolved in 2002) it was demonstrated and accepted that clinical

psychology specialisation was both cost saving and resulted in improved patient care to the Health Dept of WA. In the private sector, prior to the introduction of Better Access, the primary Health insurers had determined that qualifications in clinical psychology were an essential component for the allocation of rebates to private psychological treatments.

- The recognition of specialist title for clinical psychology in Western Australia was predicated by the need to assist the public and referrer to easily identify which psychologist had received accredited specialised training in working with mental health disorder. The minimum training and supervision requirements follows the pathway set by other major western countries such as the UK, USA, Canada and South Africa, where 6 year of training is required to work as a psychologist in mental health. No other major western country, including New Zealand, enables four year trained psychologists to treat mental health disorder and would not enable a situation to exist where the most vulnerable and disadvantaged in our community could be sufficiently confused so as to present to an untrained psychologist for expert mental health treatments.

- It is very widely acknowledged Better Access (Medicare) acknowledges and utilises the title of Specialist Clinical Psychologist to denote the higher tier of psychology rebates, in acknowledgement of the long held international and Australian tradition of accredited postgraduate professional training in clinical psychology that is an internationally recognised specialisation of psychology. It is only within the Specialist Clinical Psychology item that the public receives Medicare-rebated Psychological Therapy for psychiatric disorder. The Focused Psychological Therapy item, the lower tier of Medicare, is currently made available to the vast majority of the psychology workforce who do not work with the public within their four year academic undergraduate training programme.

- The Psychology Board of Australia (PsyBA) has established the standard for endorsement of clinical psychologists as a post-graduate APAC-accredited and college approved degree of Masters in Clinical Psychology (2 year EFT) or Doctoral in Clinical Psychology (3 year EFT), plus a period of two and one year (respectively) supervised training to bring the total amount of post-graduate training to four years minimum. In March, 2010, AHMAC granted endorsement for psychology specialities with the concept that it relates to specialisation within an advanced application of psychology with its own unique body of knowledge and skills.

- Western Australian trained clinical psychologists working throughout all of Australia, along with other specialist psychologists, held specialist title for over almost 45 years prior to Western Australia joining the National Health Practitioners Registration Scheme in October, 2010. At this time, specialist title was revoked under the Health Practitioner Regulation National Law Act of 2009. Specialist psychologists in Western Australia were permitted to use the title until 2013, and a notation to that effect is placed on the register for those who gained specialist title in a psychology speciality in Western Australia prior to October, 2010. Specialist psychologists in Western Australia were assured their entitlement to use specialist titles would be reviewed prior to 01 July of 2013, and consideration would be given to extending this status to specialists in psychology with accredited post-graduate training nationally.

- In the best interests of the public, who cannot be reasonably expected en-masse to have the required knowledge-set to easily differentiate who has received accredited specialist training in the provision of evidence-based and scientifically-informed psychological interventions with psychiatric disorder across the entire lifespan and all levels of complexity and severity, I urge you to urgently he committee to strongly endorse the two tier system of rebate as this will enable the public to make a clear and properly founded choice of specialist psychologist for their mental health care needs.

### *2.3 United Kingdom's National Health Service Review of Psychological Services*

In 1989, the Management Advisory Service to the NHS differentiated the health care professions according to skill levels. Skills in this sense referred to knowledge, attitudes and values, as well as discrete activities in performing tasks. The group defined three levels of skills as follows:

**Level 1**- "Basic" Psychology – activities such as establishing, maintaining and supporting relationships; use of simple techniques (relaxation, counselling, and stress management)

**Level 2** – undertaking circumscribed psychological activities (e.g. behavioural modification). These activities may be described by protocol

**Level 3** – Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complex 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 group suggested that almost all health care professionals use level 1 and 2 skills and some have well developed specialist training in level 2 activities. The group went on to argue that *clinical psychologists are the only professionals who operated at all three levels and (I quote) "it is the skills required for level 3 activities, entailing flexible and generic knowledge and application of psychology, which distinguishes clinical psychologists..."*

This is consistent with other reviews which suggest that what is unique about clinical psychologists is his or her ability to use theories and concepts from the discipline of psychology in a creative way to solve problems in clinical settings.

### 2.4 APA Division of Clinical Psychology and BPS Division of Clinical Psychology definitions of Clinical Psychology –

Please note that it is viewed as very significant that clinical psychology is recognised as one of several specialisations within psychology within the United States and Britain. The links to APA and BPS are as follows –

- **http://www.apa.org/ed/graduate/specialize/clinical.aspx and Britain -**
- **http://www.clinicalpsychology.org.uk/** a website for the public.

**Further information regarding Clinical Psychology may be viewed within the following Australian and international websites –**

- **http://www.isdscotland.org/wf_psychology/clinicalpsychologywfp.pdf**
- **http://www.apa.org/ed/graduate/specialize/clinical.aspx**

- http://www.clinicalpsychology.org.uk/
- http://www.psychologyboard.gov.au/

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## *New Initiatives and expanded programmes –*

- The Clinical College applauds the commonwealth for its innovative initiatives for primary mental health services across the lifespan, including the expansion of existing programmes. We will provide no further comment regarding this apart from the Tier 3 funding in following sections.

- We further congratulate the commonwealth for establishing a peak body, the National Mental Commission within the Prime Minister's portfolio. As the unique specialisation within Psychology whose entire postgraduate eight year training is specifically within the assessment, diagnosis, formulation and evidence-based treatments of Psychiatric Disorder, the APS College of Clinical Psychologists will support the operations of the Commission in any manner appropriate and remains available to feed into the Commission as a major stakeholder.

## *Rationalisation of Session Numbers under the Better Access Programme –*

We are deeply troubled by the cuts to Better Access items for Clinical Psychologists and remain concerned that people with serious mental health disorders will potentially be left without appropriate mental health care under recent Budget cuts to the Better Access to Mental Health Care program and wish to highlight the following –

- the number of sessions of psychological treatment a person with a mental health disorder can receive each year will be cut from a maximum of 18 down to 10 (not from 12 to 10 as was widely reported)

- the Government has stated that people with serious mental health disorders who need more than 10 sessions of treatment should receive services through the specialised public mental health system, private psychiatrists or the expanded Access to Allied Psychological Services (ATAPS) program

- there are concerns that people with severe depression and anxiety related disorders will not be able to get into public mental health services, be able to get timely or affordable access to a psychiatrist or into ATAPS which we understand cannot accommodate all these people.

- We appreciate the government imperative to demonstrate overall cost savings within Better Access; however, it is abundantly clear that the obvious and significant gap in mental health service provision is 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 eighteen sessions per annum are sometimes required. The evidence-based literature within Psychiatry and Clinical Psychology demonstrates that there is no evidence that ten or fewer sessions of treatment for the moderate to severe range leads to a resolution of distress and dysfunction.

- The evidence base demonstrates that rates of relapse increase with incomplete treatments, thus creating a "revolving door" situation of repeated presentations over successive years and a costly blow-out in economic liability, as well as morbidity and mortality rates.

- Because the competencies of Clinical Psychologists are specifically specialised to provide effective treatments for the moderate to severe range, clinical psychological treatments should be treated as per Psychiatrists are under Medicare as both independently diagnose and treat these client cohorts within the core business of their professional practices. At a minimum, we would assert that the decision to cut session numbers and extraordinary circumstances provisions for the Specialist Clinical Psychologist Medicare items should be reversed immediately.

- The Clinical College believes that the government has misunderstood evidence-based treatments for high complexity and severity presentations, equated it 'en masse' to team-based care involving multiple services (e.g. personal carers), compromised consumer choice of provider and access times, and unintentionally introduced inequality to the provision of standard evidence-based therapy wherein only the most disadvantaged and vulnerable are unable to afford to complete their course of clinical psychological treatment.

- Given that clinical psychology is the only mental health discipline, apart from psychiatrists, whose ENTIRE accredited training is specifically focused in the field of evidence-based assessment, case formulation, diagnosis and treatment of the full spectrum of lifespan mental health disorders across the full spectrum of complexity and severity, the cuts directly minimise the distinct contribution of the clinical psychologist to specialist mental health care in Australia.

- Due to their unique accredited and integrated specialised training and competencies, the Clinical Psychologist is frequently referred the most complex and severe mental health presentations. Any cut to the present maximum of 18 permissible annual Medicare subsidised consultations directly undermines the most unique contribution of the Clinical Psychologist to evidence-based and scientifically-informed mental health treatment. The most vulnerable population cohort will be those who cannot afford to fully pay for their remaining mental health treatment, and it is very disappointing that the government is introducing inequality into the provision of mental health care in Australia.

- APS accessed Medicare data on all sessions provided by psychologists for the period 2007 – 2008 (with the numbers virtually identical for Psychology providers and Specialist Clinical Psychology providers) showing that 21 percent received 7 – 12 sessions and 5 percent received 13 – 18 sessions. In December 2010, PsyBA released workforce data

on psychologists in Australia indicating that 13.5 percent had an endorsement and/or specialisation in Clinical Psychology. **These data suggest that a possible maximum of 1.6 percent of all Medicare rebated sessions beyond 10 were delivered by Specialist Clinical Psychologists – hardly a massive saving to the government, and yet a high impact to morbidity and mortality rates** amongst our most disadvantaged patient cohorts, their families, employers, communities and loved ones.

## *A precautionary note on the Better Access Evaluation –*

- The Clinical College wishes to respectfully draw the Senate Committee's attention to significant research methodological flaws within the Better Access study, which cautions us as to the credibility of the study and to any unintended simplistic equating of its findings to "proof" or "fact" to a level of evidence that would inform thinking around service planning and workforce issues. The level of evidence attributable to a single study with such a research design is not sufficient for such purposes.
- In particular, we note that the following –
    - the study did not meet fundamental standards of research design (it did not identify the nature, diagnosis or complexity of the clients seen by psychologists by type of psychologist;
    - it did not identify the nature or type of psychological intervention actually provided;
    - it did not factor in or out medication use by the client; it did not factor in or out therapy adherence indicators;
    - it did not have a valid criterion measure actually related to a range of diagnoses or complexity in order to assess pre and post intervention condition of clients;
    - it did not undertake follow-up assessment of clients, which is often the point at which the relative strength of any competent treatment becomes manifest;
    - it did not determine relapse rates by type of psychologist;
    - it was a self-selected sample of psychologists who self-selected their clients and clinically administered the research questions in session;
    - it was not subjected to peer review), and
    - what is needed is a well-designed prospective study aimed clearly at answering specific questions in accordance with principles of psychological research.

- The Senate Affairs committee with notice that there are comments from some psychologists that this Better Access (Medicare) Evaluation is convincing proof that general psychology is the same as clinical psychology and that there should be no recognition of the specialisation. However many of the same psychologists have communicated to the clinical college that, in another related study overseas in the United Kingdom known as the IAPT study, because there were no demonstrated differences in therapeutic outcomes between registered psychologists and untrained counsellors, the profession of psychology should also be de-registered and treated the same as untrained counsellors. The logical extension is that all professions are deregistered and

naturally gifted untrained members of the public provide services currently performed by the professions. This is an unacceptable and unsafe principle upon which to guarantee an accredited standard of competencies in the delivery of any professional service and we would advocate that the issue is a red herring.

- A further comment which is hijacking the issue of the two tier rebates is a confusion between minimum internationally accepted accredited standards of training, and individual differences between psychologists. Clinical Psychologists have been subject to intolerable bullying and intimidation when they publically speak to defend standards of training in clinical psychology. Our generalist colleagues, and some other specialist psychologists, are confusing the concept of specialisation with superior/inferior or better/worse. We wish to advise the Senate Affairs Committee that the Clinical College is accurately portraying internationally accepted understandings of specialisation within psychology, and that some of our colleagues are unfortunately misinformed about such matters.

## *Concerns regarding ATAPS administration and funding –*

- The Clinical College is concerned that much of the declared new mental health program money for ATAPS will not arrive until years three and four, leaving a serious question as to how the gap in service provision will be filled in the initial years.

- We understand that the current entity, a Division of General Practice, will cease to upon creation of that area's Medicare Local (ML), with all expected by the end of 2012, although it will continue to deliver mental health services for up to one year under a transitional role. The ML will cover approximately two to three current Division catchment areas, and occasionally in a rural area it will be one existing area.

- Unlike Divisions, ML's will not deliver services; they will contract for any of the area's Primary Care sector agencies to provide program specific services such as ATAPS. Some Divisions, who have formed incorporated Company structures, may place a tender for the provision of ATAPS services. Indeed, this has already been the case in several instances.

- It is noteworthy that many Divisions have now adopted the direct employment method, a shift from the initially commonplace contracts with privately practicing clinical psychologists and other providers. Our members advise us that many Divisions, both metro and rural, now frequently employ general psychologists at uncompetitive salary levels that deters involvement from experienced clinical psychologists. Members have been recently advised by their local Division that they are not accepting any further providers on their books and/or have changed to any employment model.

- Much of the new ATAPS funding is for the Tier 3 funding ("severe and persistent" mental illness) and we are of the understanding that, once programme-related overhead and administrative costs are deducted, this leaves provisions for as low as an approximately mere 0.8 EFT salaried clinical position dedicated to the Tier 3 program per current division of general practice area.

- One of our members explained how she was unable to provide her specialist clinical psychology services within the ATAPS structure, and we are deeply concerned that the public may not have sufficient access to specialist mental health care under such administrative arrangements of the ATAPS program -

  *"I have contacted one GP division in X (Y division) and was told that because my practice location falls just outside (my a km or so) of their boundaries they would not accept my application to become a provider under their program. I have since contacted the division my practice falls within (Z division) and they have not responded to my application at all. I was told by both divisions that I would have to agree to see clients at the bulk bill rate of $119.80 (so less than the scheduled fee). I could not continue to run my practice if this was the fee I was paid for all clients. However, I decided to see if I could register as I have a number of clients with chronic mental health conditions such as OCD and severe social phobia who will not be able to afford to pay for additional sessions after the 10 sessions end and would be happy to see them under this program. These clients have been refused services by government mental health services (adult and child). It is my opinion that these clients would experience significant set-backs if they had to change therapists as trust is a big issue for them.*

  *I am also concerned that despite the fact that I have 11 years experience, in government mental health services and in the private sector, and I specialise in areas of child and adolescent mental health and OCD in all ages (which many psychs and clinical psychs struggle to work with) that ATAPS would not consider contracting me to provide services. The other issue is that despite falling outside the boundary for the X division the majority of my clients and most of the GP's I have established good working relationships with fall within this boundary. I have asked them to explain the criteria for selection but they have not responded. So I am assuming that the only clinical psychologists they will contract to are those that fall within their boundary. This may mean that if they do not have skilled and experienced psychologists in their boundary they will still only contract work to people within their boundary. So people in the outer suburbs and rural areas maybe disadvantaged by receiving mental health care that might not be of the highest standard because of work force issues. I also wonder if my lack of success is because I am a clinical psychologist rather than a psychologist and would cost the division more money to provide services"*

## *In Conclusion –*

- The Australian Psychological Society (APS) National College of Clinical Psychologists applauds the commonwealth for its innovative initiatives for primary mental health services across the lifespan, including the expansion of existing programmes. We have highlighted our reservations, however regarding the funding and administration of ATAPS and its new Tier 3 funding arrangements.

- We further congratulate the commonwealth for establishing a peak body, the National Mental Commission within the Prime Minister's portfolio. As the unique specialisation

within Psychology whose entire postgraduate eight year training is specifically within the assessment, diagnosis, formulation and evidence-based treatments of Psychiatric Disorder, the APS College of Clinical Psychologists will support the operations of the Commission in any manner appropriate and remains available to feed into the Commission as a major stakeholder.

- We are gravely troubled by the cuts to Better Access, strongly challenge the validity of utilising the methodologically compromised Better Access Evaluation study to rationalise services and draw workforce conclusions, and earnestly advocate for an immediate reinstatement of the eighteen sessions per annum and provisions for exceptional circumstances under the 'Specialist Clinical Psychologist' Medicare item.

Once again, the APS College of Clinical Psychologists wishes to thank the Senate on initiating an inquiry into the Commonwealth funding and administration of mental health services and for inviting comment for all interested parties.

The National Clinical College respectfully submits the above comments and suggestions on this fourth day of August, 2011.

Please do not hesitate to contact me for any further information.

Yours Sincerely,

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