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Wednesday 27th July 2011

Committee Secretary
Senate Standing Committees on Community Affairs
PO BOX 6100
Parliament House
Canberra ACT 2600

Dear Sir/Madam

Re: Submission for Senate Community Affairs Committee into Commonwealth Funding and Administration of Mental Health Services.

This Submission has been prepared by Bob Duncan (Clinical Psychologist).

Summary

I want to express my concern about the impact on some of my most vulnerable clients of the changes the government has made to the Better Access to Mental Health program.

This submission relates to two of the committee's terms of reference, namely:

Section b) part (iv) – Changes to the number of allied mental health treatment services for patients under the Medicare Benefits Schedule

And

Section e) part (i) – mental health workforce issues, including the two- tiered medicare rebate system for psychologists

The effect on those with severe mental illness of the change to a maximum of 10 sessions per calendar year.

I practise as a clinical psychologist in Annandale in Sydney's inner west. Until 2007 I was employed for almost 30 years in the public mental health sector. As such most of my clinical experience has been with the seriously mentally ill who require long-term care including in-patient treatment from time to time.

In my private practice a substantial **minority** of my clients are seriously mentally ill. I have bulk billed these people and seen them at intervals of about three weeks. Under the existing provisions this allows me to see them indefinitely. This provides them with assurance that they do not have to get better in a limited period of time or be abandoned to their own resources. That is important for people who are vulnerable and cope less well than others with uncertainty and change.

May I illustrate with a case example. This 44 year old man on disability support pension was diagnosed with schizophrenia many years ago and had a number of hospitalisations before I first saw him four years ago. He has a private psychiatrist who he sees about four times a year to review medication. I saw him 13 times in the first year and 17 more times over the last three years.

The effect on those with severe mental illness of the change to a maximum of 10 sessions per calendar year continued.

During this time he has: not needed any inpatient care; made and sustained a partnership; maintained casual work at the rate of a few hours most weeks and successfully completed three semesters of a university degree which when he finishes will extend his employability in his present work sector. None of this has come easily to him and he has told me that the help I have given has made the difference between success and failure several times.

Under the new arrangements of fewer rebates I will be unable to provide an adequate level of care for someone like this. I believe this is tax payers' money well spent. The cost being more than offset by just one week in hospital which may well have been otherwise necessary. It is, also, consistent with the value the community puts on compassion for those who through no fault of their own and despite profound disability are having a go.

It is unlikely that any other existing service would fill the breach for these people. The Better Outcomes in Mental Health Care program is specifically for socially disadvantage people with mild to moderate mental illness and presently provides for a maximum 12 sessions per year. As an Access to Allied Psychological Services provider I was advised by my local GP network that funds were fully committed by January in the last financial year. This year funding is allocated on a monthly basis. That is, once the monthly budget is spent those referred will have to join a waiting list which will no doubt grow over the year until people will wait long periods.

From my years in public mental health practice and through the network I have with colleagues still working in the public sector I know just how acute patients have to be before they receive the care they need. People with **major diagnoses** I have seen privately have been turned away from community mental health centres because they are not **presently actively suicidal**.

Private psychiatrists are in short supply and few of them bulk bill. While many of them have good psychological skills they do not have the time to do this kind of work and are rightly engaged providing the specialist medical care for which they are the best trained.

My concerns are not about my income. I receive more referrals than I can accept. Indeed those with the most serious problems are those I bulk bill and that reduces my average hourly rate.

Removing the two-tiered Medicare rebate for clinical psychologists versus psychologists.

Australia lags the rest of the developed world in the standard set for registration as a psychologist. The academic standard required for entry to a postgraduate clinical program is higher than that required to qualify as a psychologist. It follows that clinical psychologists have demonstrated that they are better students than most psychology graduates. Post graduate clinical training covers a clinical curriculum that barely gets a mention at undergraduate level. It is not just academic work but includes skill development and typically 1000 hours of field placements with experienced clinical psychologists who provide supervision.

To do away with differential rebates will discourage clinical training and keep standards of practice in Australia below those in comparable countries.