

Commonwealth Funding and Administration of Mental Health Services

Submission

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This submission has been prepared by Cinzia R Gagliardi, Clinical and Forensic Psychologist.

I wish to put forward a brief submission in relation to the current enquiry into the funding and administration of mental health services.

As a Clinical and Forensic Psychologist with over 16 years experience working with people with serious mental illness in both public and private sectors, the provision of Psychological Services to mentally ill people under Medicare was welcomed. I had witnessed many individuals fall through the cracks of the over-stretched State-based mental health services, and saw people whose illnesses were not deemed "severe enough" unable to access any service at all.

The services set up under Better Access Program was, in my opinion, well thought through and considered. The two tiers (although misunderstood by many) related to an appreciation that not all professionals had the knowledge and skills necessary to treat people with diagnosable mental illness, and some safeguards were necessary to ensure that the community were well informed about the skills their practitioner would possess. I saw this as akin to a person seeking assistance from a general practitioner for most common illnesses, but needing to seek specialist opinion and treatment from professionals who have the endorsement to practice in a particular area, for a specific diagnosable illness.

Under the two-tiered system, GPs would assess a patient to determine whether they had a diagnosable mental illness and thus required the specialist skills of a Clinical Psychologist, who are specifically trained in the assessment and treatment of mental illness across the life span. NB: I do not wish to propose that there are not other Psychologist who have developed the skills to treat this client group, as it is evident that there are, however, it is important for the Community that specialist qualifications and experience are used as a benchmark to determine specialist status, as there is too much variability in training and experience for other areas of Psychology. Once a GP undertook a thorough assessment (whether they were actually skilled enough to do this is another question, or whether this should have rested upon a referral to a Clinical Psychologist for assessment should be considered), the GP would then decide whether the patient's psychological problem should be handled by a Clinical Psychologist or a non-Clinical psychologists / social worker / nurse, etc, for focused Psychological Strategies.

My experience of the system is that the program collapsed at this initial assessment and referral stage. GPs appeared to lack the skills and knowledge to properly assess mental illness and determine which professional would best be suited to treat the patient. In fact, I was privy to many discussion with GPs who would call me not knowing how to assess a patient, and what the distinction was between a Clinical Psychologist and other non-Clinical Psychologists. The upshot was that ALL patients (regardless of symptomatology, presentation, or diagnosis) were sent to ALL Psychologists for treatment. Anyone who put

their hands up reporting they had the skills, were referred patients, even if they had never seen a mentally ill client before.

Doctors were unaware that the requirements for specialisation in Clinical Psychology involved a 6-7 year post graduate training program, with a 1-2 year supervision period as part of an internship. They were all exposed to all main areas of mental illness across the life span, and specific targeted evidence-based intervention strategies. Consequently, doctors referred mentally ill people to psychologists with a range of variable skills, including those with a limited scope of training (4 years + 2 years of variable practice in all sorts of areas), to those with highly specialised skills in other areas, such as Health, Neuropsychology, Forensic etc.

It is my opinion that the massive blow out in spending was a direct result of this gross error in implementation. If a patient presents to a doctor with a neuropsychological condition, it would be appropriate for a referral to a Neuropsychologist. Similarly, if a patient has psychological issues around chronic health problems, then a referral to a Health psychologist is relevant. As a Clinical and Forensic Psychologist I keep my scope of practice around what my qualifications and skills provide me. I do not venture into Neuropsychology, Health Psychology, etc. My belief is that Medicare should be expanded to incorporate these specialities, outside of Mental Health.

If, as initially developed, GPs referred people with general psychological complaints (such as anger management, sleep disturbance, stress management etc, who do not meet the criteria for a major mental illness) only to those professionals qualified to provide focused psychological strategies, and left mental illness only to Clinical Psychologists (or Clinical Psychology trainees) then this problem would have been averted.

It is thus my proposal that rather than cut sessions, or reduce the rate of payment to Clinical psychologists (which will mean that none of us will either work under this scheme or bulk-bill as most of us do now); that a savings will be made if appropriate assessment and referral takes place.

Action:

1. Ensure that GPs have the skills to properly assess mental illness or psychological dysfunction, and determine the appropriate treatment strategy required (either specialist Clinical intervention, or focused psychological strategy);
2. If above cannot be effectively achieved, a referral to a Clinical Psychologist for an initial assessment of diagnosis and need to assist the GP should be made. This Psychologist does not then undertake the treatment;
3. referrals for Focused Psychological Strategies in areas such as anger management, stress management, pain management etc, be referred to those clinicians delivering those services;
4. referrals for specialist treatment of mental illness be referred only to those practitioners with the specialist endorsement, or undergoing a recognised post-graduate specialist Clinical Psychology training program.

My only concern is the access to Clinical Psychologists in rural and remote areas, as the need for people in these areas is great. As a Clinical Psychologist I deliver a bulk bill service to those in need, and would travel to remote areas if the costs associated with that were considered. Cutting my fees, as rumoured to be proposed, will mean that I and all my colleagues will leave the program or no longer bulk-bill, thus making our services unaffordable and inaccessible. Mentally ill people will then be seen by other professionals who may or may not have the skills, and certainly under ATAPS will definitely not have the skills at all.

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