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

August 4th, 2011

Dear Committee

RE: COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

Thank you for providing the opportunity to submit to this important inquiry. In my submission, I would like to address the following issues from the terms of reference:

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program; &
(f) the adequacy of mental health funding and services for disadvantaged groups, including:
(i) culturally and linguistically diverse communities,
(ii) Indigenous communities, and
(iii) people with disabilities;
I will also be discussing: **(e) mental health workforce issues later on in the submission**

I am a clinical neuropsychologist, and a member of the APS College of Clinical Neuropsychologists (CCN). I am *not* writing on behalf of the CCN, which represents a large proportion of Australian neuropsychologists, but my involvement on the CCN National Committee over the past 5 years has given me the opportunity to survey and communicate with many of the members about issues related to this inquiry. The opinions and recommendations I give in this submission are my own, but they are informed by discussions with many of my colleagues, in both neuropsychology and medicine. As some of the opinions expressed in this email are of a sensitive nature, I would prefer this submission to remain confidential.

Firstly, while I applaud the Better Access Initiative that allowed people with mental health conditions to access publicly funded psychological services, I have felt an ongoing sense of frustration at the neglect of people with brain conditions, who have a great need for access to clinical neuropsychological services. This frustration is shared by the majority of my colleagues, who mostly work in the public sector.

Clinical neuropsychologists specialize in the assessment, diagnosis, and treatment of psychological disorders associated with conditions affecting the brain. We are trained to understand brain conditions like head injury, dementia, multiple sclerosis, brain tumours, stroke, Parkinson's disease, and encephalitis, which can result in changes in cognitive, memory, emotional, motivational, behavioural, and personality functioning. People with brain conditions often experience depression, anxiety, and adjustment disorders as a result of their condition. These complex disorders require high-level integration of knowledge and skills, and membership of the CCN is the foremost tangible recognition of appropriate training and skills in clinical neuropsychology in Australia, in line with international standards.

Neuropsychological assessment and treatment planning is invaluable for people with brain and other medical conditions, and for people with mental health conditions including depression and psychosis. Neuropsychologists are able to provide a unique contribution to the care of these people, and our contribution is highly valued by neurologists, neurosurgeons, psychiatrists, geriatricians, paediatricians, rehabilitation physicians, specialist and general physicians, general practitioners, nursing and allied health professionals. While other professions may be able to screen for cognitive and behavioural impairment, neuropsychologists have the most scientifically validated tools for assessing and understanding the real-life manifestations of brain disorders. While MRI scans can show the structure of the brain, and PET scans can

show areas of changed metabolism, only neuropsychologists can integrate medical, personal, and psychological factors into a comprehensive understanding of a person's functional abilities. A neuropsychologist's assessment is useful for improving diagnostic precision, for establishing a baseline for future comparison, and is very important for helping the patient, their family or carers, and professional support networks to help maximize their functional and emotional adaptation.

The World Health Organization has stated that brain diseases and disorders account for the largest proportion of medical disability in the developed world, yet people with these conditions are still misunderstood and often neglected by large-scale public health initiatives. I often wonder if the cognitive impairments experienced by people with brain conditions mean that they end up suffering in silence, while cognitively intact people with lower-frequency conditions get more attention because they are able to advocate for their own interests.

People with neuropsychological disorders often have disabilities that are life-long, and sometimes progressive, with major ramifications to their psychosocial adjustment, education, careers, and families. Their psychological needs are currently not being met. There are not enough services in the community available to support people with neuropsychological disorders, especially those with noncompensable conditions, or aged under 65. Working in Northern Tasmania, I am very aware of the difficulties with accessing community services for people with acquired brain disorders, the lack of supported and residential care options available, the huge burden of care on families, and how neuropsychological assessment and interventions can have a significant positive impact on the lives on people with complex disorders.

Neuropsychological services in Australia are only affordable to patients who are able to access public hospital neuropsychology departments for free, or who have a compensable injury, or DVA cover. Private health insurance rebates for psychology services are not set up for neuropsychological assessments, with an average total time of 7.5 hours per patient (2007 CCN survey of members). When I was in private practice in Melbourne, patients were baulked at a comparatively cheap $600 flat rate for an assessment that included 4 hours of face to face time, and an additional 4 to 6 hours of scoring, medical records review, informant interview, interpretation of results and report writing. In Sydney in 2007, the going rate for a comprehensive neuropsychological assessment for people with MS was reportedly $2000 (source: MS Society submission to Minister Roxon in 2007). In Melbourne, which has the highest concentration of neuropsychologists in the country thanks to a number of training courses, anecdotal evidence suggested that some neuropsychologists charged less than $100/hour, most of these worked in part-time private practice to supplement part-time public sector employment. In Tasmania, where we only have 8 members of the CCN, many patients cannot afford to pay $600 for an assessment, although the MAIB and other insurers will pay market rates for private assessments.

Neuropsychologists, like many other health professions, have limited data on cost-effectiveness. However, there are some facts that suggest we can have important impacts:

1. In helping to get a diagnosis right, the first time, time and money is saved on further investigations and consultations. An assessment by a public sector neuropsychologist costs less in wages than an MRI scan. Multiple consultations with medical specialists consumes the patient's time and money. Incorrect diagnosis can result in increased pain and suffering, and the possibility that reversible causes of cognitive decline are not detected on time.

2. Early diagnosis of dementia through the use of sensitive neuropsychological assessment can result in the prescription of medications that slow the course of Alzheimer's disease, and can potentially delay nursing home admission by up to 3 years, a saving of nearly $100,000 per patient.

3. There is an inestimable human value of being able to help a person with dementia to be involved in advanced care planning, or in helping provide a brain-injured young man with preventative measures to reduce the high risk of depression, anxiety, and relationship breakdown. The psychoeducation that arises from a neuropsychological assessment can be very powerful in helping patients and families understand

and adjust to their illness or injury, and can help with successful return to work or study after illness or injury. Unfortunately, this is the very difficult to estimate.

The Access to Allied Psychological Services program does not cover the psychological needs of people with neuropsychological disorders, i.e., a neuropsychological assessment and treatment informed by the results of that assessment. Neuropsychology services are not covered by Medicare in any form, despite an avalanche of letters of support written to Health Minister Roxon in 2007, and again to PM Rudd in 2010. The APS wrote a budget submission for neuropsychology assessment and intervention items in 2007, again in 2009, and as part of their pre-budget submission in 2011, but these have not been successful. To reduce the risk of a cost blow-out if neuropsychology services were covered by Medicare, I would recommend that senior representatives of the Australian neuropsychology community be contacted through the CCN to ensure that only appropriately trained neuropsychologists be able to provide those services. Neuropsychologists could be asked to commit to bulk-billing of pensioners and healthcare card holders to improve access, in line with other areas of practice in fee-for-service medicine.

Recommendation: that Medicare items be created for neuropsychological assessments and interventions, in line with the APS submission of 2007 (see attached file). These items could be modeled on the DVA model of short, medium, and long assessment items for neuropsychology, but modification to more effectively address the diversity and complexity of patient needs.

Our small neuropsychology workforce has impacts on culturally and linguistically diverse communities, indigenous communities, and rural and remote Australians - i.e., without enough neuropsychologists, these communities are missing out on important health services.

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

I support the continuation of the current rebate scheme for psychological services under the Better Access to Mental Health. This scheme has made mental health services available to many Australians who previously could not afford to access them, and who could not access private psychiatrists, or who were not suitable for the public mental health system. Taking care of the mental health of Australians is an investment in our wellbeing, and I do not support the proposed cuts to the number of psychological sessions available under Medicare.

The issue of the two-tier Medicare rebate predated, and has nothing to do with, the Psychology Board of Australia's (PSYBA) areas of specialist endorsement. PSYBA endorsement of the specialist areas provides the public with a useful way of determining whether or not a psychologist has engaged in further training in an area of specialization, each of which has its own unique competencies and areas of practice. Further, specialist endorsement is a form of protecting the public from people operating outside their area of professional expertise. In my opinion, this forum (i.e., the Senate inquiry) should not have been used to raise the issue of specialist registration, as specialist registration is a progressive step towards recognizing the skills of psychologists who have engaged in specialist postgraduate training.

(ii) workforce qualifications and training of psychologists, and

(iii) workforce shortages;

We do not have enough neuropsychologists in Australia to meet the current need, let alone the projected need with the ageing of the baby boomer generation and the predicted dramatic increase in dementia, up from the existing 1400 new cases per week. The following table from the Psychology Board of Australia shows the numbers of specialist psychologists in each state, broken down by specialization.

Psychologists: by area of practice endorsement and by state or territory Approved area of practice endorsement (May 2011)
http://www.psychologyboard.gov.au/About-Psychology.aspx

Area of practice endorsement	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Not supplied	Total
Clinical neuropsychology	**2**	**91**	**-**	**57**	**16**	**10**	**183**	**19**	**6**	**384**
Clinical psychology	86	1,439	16	544	343	107	1039	770	31	4,375
Community psychology	-	8	-	3	1	-	24	7	1	44
Counselling psychology	8	177	1	59	6	5	381	102	8	747
Educational and developmental psychology	3	121	-	61	21	16	147	54	4	427
Forensic psychology	6	116	8	46	22	6	92	34	1	331
Health Psychology	4	38	2	29	17	8	68	4	1	171
Organisational psychology	14	105	2	41	26	1	99	37	3	328
Sport and exercise psychology	3	18	-	20	6	1	12	7	1	68
Total	**126**	**2113**	**29**	**860**	**458**	**154**	**2045**	**1034**	**56**	**6875**

The table demonstrates that neuropsychologists are the fourth-largest group with specialist endorsement, but that the greatest numbers are in Victoria and New South Wales. While this may be partly due to population density, it is possibly also because those two states have the longest history and greater number of postgraduate courses for the training of neuropsychologists. The lack of local training in neuropsychology has resulted in many students moving to another state to study, and then staying there permanently. It also makes it difficult for states without training facilities to attract staff.

Australian clinical neuropsychologists have to complete a minimum 2-year postgraduate coursework degree with a focus on neuroanatomy and neuroscience; neuropsychological disorders, assessment, and rehabilitation; and supervised placements in neuropsychology. Our training is unique compared to all the other specialist areas of psychology, although we share common core units in psychopathology and diagnosis with clinical psychology. Clinical neuropsychology is a recognized specialty in the USA and the UK, where neuropsychology qualifications are usually obtained after completion of a doctoral degree in clinical psychology – a total postgraduate training route that can take more than 10 years. In order to increase our neuropsychology workforce, it is important for the government to support our more time-efficient Australian training model.

A Masters level degree is the minimum qualification for neuropsychologists in Australia. The Doctor of Psychology (DPsych) is a professional doctorate with 3 years of coursework and placements, plus a thesis component. This, in my opinion, is the best training model for excellent clinicians, compared to the 5-year Masters/PhD degree offered by some universities. This 5-year option is inferior to the 3-year course if the aim of postgraduate training is to produce an excellent specialist clinician. The Masters/PhD route is preferred by some universities for funding reasons, and by students for the access to scholarships, but it slows down the entry of the students into the workforce by several years. Australian DPsych (neuropsychology) graduates are valued for their specialist knowledge and skills in the UK NHS, where I have heard of recent graduates of mine having other psychologists working under them.

There are currently only 6 postgraduate neuropsychology training programs in Australia (LaTrobe, Macquarie, Melbourne, Monash, University of Queensland, and UWQ), down from 8 a few years ago. I lectured at the excellent Victoria University course from 2003-2009, but it was closed due to budgetary pressures on the School of Psychology and lack of support from the faculty. There have been discussions at the University of Tasmania about starting a course, but without better funding support, this seems unlikely. South Australia would also like to start a course but finding academic staff and sufficient placements is a problem.

Having thought long and hard about the workforce and training issues in neuropsychology, I would like to make the following **recommendations**:

1. Universities need funding support to offer neuropsychology postgraduate training places, or to establish courses in states which do not have them (i.e., Tasmania and South Australia)
2. Neuropsychology students should be given the same fee reductions as clinical psychology students.
2. Universities need support in the difficult task of finding enough clinical placements, of the right type,

for their postgraduate psychology students.

3. Financial assistance for clinical placements should be considered to encourage public health agencies to train neuropsychologists, because neuropsychologists need to be exposed to the variety of cases and the multidisciplinary teamwork conducted in the public sector, particularly hospitals and rehabilitation centres.
4. Establishment of funding for clinical educator positions in existing neuropsychology departments in the public health sector could be one way of ensuring enough clinical placements for neuropsychology students.
5. Recognition of the training and experience of psychologists through increased wages in the public health sector. In Britain, under the NHS, and in Western Australia, psychologists are paid less than physicians, but more than other allied health workers because their work value and professional expertise is recognised. In the rest of Australia, post-graduate trained psychologists in the public sector are often paid the same as undergraduate-trained allied health workers.
6. Consideration should be given to bonded scholarships, such as in the rural GP training programs, to ensure that rural and regional areas of Australia are able to employ neuropsychologists in positions that are often difficult to fill.

Thank you for reading this submission, and please contact me if I can be of further assistance.

Yours sincerely

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Clinical Neuropsychologist