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Commonwealth Funding and Administration of Mental Health Services

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Background

I am writing as a Clinical Psychologist who gained a post-graduate qualification in Clinical Psychology in the UK in 1976. At that time the 'apprenticeship' model through which a graduate psychologist could gain recognition as a clinical psychologist through 3 years supervision but without structured placements, course work and formal examination was just being phased out in the UK. Since 1978 I have worked in Australia as a clinical psychologist, both in government service and private practice, mainly with people with disabilities. For the last few years I have been working with people aged 55+ years, many of whom have a combination of one or more of early memory changes (pre-dementia), depression/anxiety, chronic pain, sleep disturbance and other mental and physical health issues. I have a working knowledge of State funded services, non-government support services and GP based services, including the use of Mental Health Treatment Plans (Better Access) for this part of the Australian community.

(e) Mental Health workforce issues, including:

- (i) The two tiered Medicare rebate system for psychologists,
- (ii) Workforce qualifications and training of psychologists.

Any two tiered rebate system within a profession is likely to be controversial and produce anomalies, particularly when it is based on qualifications. However remuneration tied to qualifications has a long history in health professions such as nursing eg SENs and SRNs. Level of staff training and qualification is also a typical indicator in quality assurance exercises that seek to measure the capacity of organisations to carry out certain tasks.

While there appears to be no question about the ability of endorsed/registered clinical psychologists with appropriate post-graduate qualifications and records of on-going professional development to carry out the tasks required of them by Better Access MHPs (MBS item 2710, 2702), there is debate about what tasks those with a first degree in psychology (plus 2 years supervision) can carry out competently and without undue risk to the public.

I suggest the reasons for doubt include, but are not limited to:

1. The content of undergraduate degrees in psychology. Undergraduate Psychology degrees provide an academic overview of the very extensive body of knowledge of the discipline. This includes Mathematical and statistical psychology, Animal behaviour, Philosophical psychology, Brain behaviour relationships, Social psychology, Experimental psychology, Psycho-linguistics, Research Methods, Developmental psychology, Psychological measurement, Psychology of Ageing, Education and Learning, Perception, Psychology in the Workplace, Criminal/legal Psychology, Computer/Artificial Intelligence, Psychology in business,

Health psychology etc, as well as the Psychology of abnormal behaviour or Clinical psychology. As can be seen the amount of time devoted to assessment and intervention with people in distress in an undergraduate degree is likely to be small and may be an elective, rather part of the core course. My own first degree contained no clinical psychology content at all. It is also the case that an undergraduate degree is not a professional training in the same way as a speech pathology or physiotherapist degree. It is not expected that a physiotherapist would practice after completing a human anatomy degree.

2. The inadequacy of supervision requirements compared to a structured post-graduate degree. Granted that a psychology first degree may have very little clinical content or professional skill building, this places a great onus on post-graduate supervision to provide the content and skills. It is unrealistic to expect this to be completed as well as a structured post-graduate course. As noted above the 'apprenticeship' model was discarded as inadequate in the UK in the mid 1970's.
3. Comparison with international standards. The US and UK both require appropriate post-graduate qualifications for someone to work independently with people with a mental illness.
4. The lack of an evidence base for work carried out by those without post-graduate clinical training. Almost all the work reported in peer reviewed journals that forms the evidence base for the efficacy of clinical psychology interventions has been carried out by clinical psychologists or clinical psychologist trainees under the direction of clinical psychologists. While there is on-going research about what a broad-based clinical training adds to manualised treatment protocols, this question is yet to be resolved.
5. Not to have a two tiered system implies that there is no value added to service provision and outcomes by university-based post-graduate training and that by implication the body of scientific knowledge and clinical skills accumulated over the past 60 years or more that make up the discipline of clinical psychology are worthless in their practical application. This stance contradicts mandatory requirements for professional development which are based on an assumption that keeping up with new developments in knowledge and skills leads to improved service quality.

Given the doubts concerning the capabilities of psychologists with first degrees only to carry out a full range of clinical psychology tasks that may be required in response to an MHP, and the assumption that there are a range of more straightforward tasks (focussed psychological strategies) that can be carried out by this section of the workforce, I suggest the two tier system, for all its faults, is appropriate. If the two tier system is abolished one of the strong incentives to complete post-graduate clinical psychology training will be removed and the undeniable result will be a 'dumbing down' in the quality of services to people in distress.

I would like to see better integration between psychologists and clinical psychologists in both government and private practice. In my mind there is no doubt that an experienced clinical psychologist can work most effectively by acting as a consultant/leader/supervisor with a small team of psychologists who have yet to complete clinical training. I have worked successfully in such a structure in the UK.

(f) the adequacy of mental health funding and services for disadvantaged groups

People aged 55+ with age related changes in memory and thinking

It is widely acknowledged that Australia, like many other Western nations, is facing a 'dementia epidemic' as a greater proportion of the population (baby boomers) start entering their 60's and with an expectation of living well into their 80's. Until around five years ago people with Alzheimer's disease were typically not diagnosed until the disease had progressed to be so severe as to be clearly interfering with their everyday life ie so severe so as to be called a dementia.

Recent research shows that people with Alzheimer's disease (and other neurological diseases that will progress to dementia) can be identified years before there is serious interference with their everyday life. The person and those around them may notice subtle changes in memory and thinking. It is estimated that up to 20% of people aged 70+years have cognitive impairment that is not consistent with ordinary healthy ageing, but is not serious enough to be labelled as a dementia. This degree of change is sometimes called 'Cognitive impairment – no dementia' (CIND) or mild cognitive impairment (MCI). The causes for CIND or MCI can be varied and sometimes reversible eg from sleep disturbance, chronic pain or other health issues. There is a greater risk among these groups of progression to dementia.

Two types of tools can then be used to identify the presence of Alzheimer's disease at this pre-dementia stage: cognitive assessment (ie over the table memory tests and similar) and brain imaging (MRI and other scans). If both tools show positive results then prodromal Alzheimer's disease can be identified. A person with prodromal Alzheimer's may then be advised to make lifestyle changes, engage in stimulation programs and take medication to slow the disease and maintain their quality of life. This has benefits for the person, their family and the wider community.

The cognitive assessment needed differs from the current screening carried out by practice nurses which aims to identify dementia. The tests are more extensive and the statistical interpretation more complex, as the memory changes are more subtle.

Cognitive assessment is more economical than brain imaging. It makes sense to make such assessment more freely available at the primary care level through Better Access. Assessment is best carried out over 2-3 sessions of more than 1 hour. DVA have introduced a rebate item for 4 hours assessment time. Extending this rebate to Medicare for clinical and neuropsychologists for assessment for early changes in memory and thinking for people aged 55+years would greatly assist with the cost-effective early identification of people with CIND or MCI that could lead onto addressing reversible causes where possible and intervention to prevent or slow progression for those identified as likely to have Alzheimer's disease.

I hope the Inquiry will consider extending the DVA cognitive assessment rebate to clinical psychologists and neuropsychologists for people aged 55+ years who are experiencing changes with their memory and thinking.