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

27th July 2011

To Whom It May Concern,

Re: Commonwealth Funding and Administration of Mental Health Services

I am a Clinical Neuropsychologist who practices in both the public and private healthcare sectors of Victoria. I have prepared this submission to the Senate Inquiry to address three of the terms of reference, i.e. (c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program, (e) mental health workforce issues, and (f) the adequacy of mental health funding and services for disadvantaged groups. This submission specifically relates to the practice of Clinical Neuropsychology within Australia, and the discriminatory way in which people living with neuropsychological disabilities are treated as a consequence of successive governments failing to approve Medicare rebates for neuropsychological services.

Clinical Neuropsychology is a specialist branch of Psychology, which focuses on the assessment and treatment of people suffering from brain disorders, e.g. stroke, Alzheimer's disease, Parkinson's disease, epilepsy, multiple sclerosis, head injury, developmental disorders, alcohol and substance abuse disorders, etc. Assessment by a Clinical Neuropsychologist can often take several hours, comprising the administration of psychometric tests, and the interview of patients and relevant others. Neuropsychologists routinely complete detailed reports of their findings that inform the treatment and diagnosis of neurological conditions, and are involved in the provision of education and/or therapy to patients and caregivers. In Australia, training to become a Clinical Neuropsychologist involves completion of a four-year undergraduate degree in Psychology (including an honours year), plus a two-year postgraduate degree (Masters of Clinical Neuropsychology) as a minimum, with many practitioners having undertaken longer postgraduate coursework degrees (Doctorate of Clinical Neuropsychology), or additional postgraduate research degrees (Doctorate of Philosophy). Postgraduate training focuses on neuroanatomy, psychometric assessment, diagnosis of neuropsychological disorders, and rehabilitation of neuropsychological disorders, through a combination of coursework and supervised placements. There is no other medical or allied health discipline that receives this type of training, making the skill set of the Clinical Neuropsychologist unique. It is widely accepted that best practice in the treatment and management of neuropsychological disorders necessarily requires the involvement of a Clinical Neuropsychologist.

The importance of neuropsychological assessment and treatment is well recognised by specialist medical disciplines, particularly Psychiatrists, Neurologists, Geriatricians, Paediatricians, and Rehabilitation Physicians. In a study recently published by researchers at the Orygen Youth Health Research Centre[1], referrers frequently reported clinically meaningful outcomes associated with neuropsychological assessment, including changes to diagnosis, changes to treatment approach, and increased or appropriate access to services, education or work. There is some variable access to neuropsychological services within the public health service, however, failure by the Federal Government to create Medicare items to rebate neuropsychological services within the private

[1] Allott, K., Brewer, W., McGorry, P. D. and Proffitt, T. (2011), Referrers' perceived utility and outcomes of clinical neuropsychological assessment in an adolescent and young adult public mental health service, *Australian Psychologist*, 46(1), 15-24.

system has resulted in thousands of people suffering from brain disorders being unable to access neuropsychological assessment, either because of prohibitive personal cost (due to the several hours of assessment and report writing time required) or because of there being too few qualified Clinical Neuropsychologists to provide the service. Previous letter writing campaigns to bring this issue to the attention of the Government in 2007 and 2010 were widely supported by practitioners within both Psychology and Medicine, however, no changes were made to the rebate of neuropsychological services under Medicare.

Much of my own practice focuses on the assessment and treatment of both younger and older adults with a combination of neurological and psychiatric conditions. My specialist assessment is vital in the early diagnosis of neurodegenerative conditions and dementias, such as Alzheimer's disease, frontotemporal dementia, Lewy body disease, vascular dementia, etc. Patients with such conditions may often present with symptoms that are very difficult to attribute to either or both psychiatric or neurological disorders, and neuropsychological assessment is frequently the most accurate way in which to make a diagnosis. Medical specialists generally do not have the tools or the training to undertake such cognitive assessments, and neuroimaging technologies, such as CT, MRI, SPECT and FDG-PET (all of which attract Medicare rebate), whilst important in diagnostic workup, are generally viewed as less sensitive and specific for differential diagnosis than neuropsychological assessment. I can think of a vast number of cases in which my neuropsychological assessment has allowed an accurate characterisation of a person's cognitive strengths and weaknesses, informed diagnosis, and been used to direct subsequent management. Knowing the cognitive profile of a person allows specific recommendations to be made regarding what services a person may need to access to remain at home, better education for caregivers, resulting in more precisely directed care and reduced carer stress, and tailored recommendations for activities to improve quality of life. Such intervention strongly accords with a person-centred model of care, reduces disability and dependence within the community, and in the case of dementia, can deliver savings to the Government by delaying the entry into residential care through better targeted community care. This issue will only increase in importance with the aging of Australia's population and the associated upsurge in dementia.

The Senate Inquiry seeks to investigate, (c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program, and (f) the adequacy of mental health funding and services for disadvantaged groups. At present, the Access to Allied Psychological Services program does not cover the psychological needs of people with neuropsychological disorders, which in my opinion, represents a form of discrimination against those with a disability. The World Health Organisation has stated that neurological disorders and disease account for the largest proportion of medical disability in the developed world. Such disorders frequently require neuropsychological input to best inform diagnosis and management, however, in Australia, people suffering from these conditions are discriminated against by the absence of Medicare rebates for neuropsychological services. This lack of Medicare funding seems inexplicable given that other governmentally run bodies, such as the Department of Veterans Affairs and the Transport Accident Commission, do fund neuropsychological services, thus acknowledging the importance of these services. That the general public is unable to access the same services for the identification and treatment of known or suspected neuropsychological disorders, is another strong argument that the present system discriminates against this large section of the community.

It should also be noted that there is a very high prevalence of mental health disorders that occur concurrently in people with neuropsychological disabilities. Rates of depression, anxiety, grief and loss, adjustment disorders, etc. are significantly higher in people experiencing neuropsychological disorders, and the treatment of these mental health problems in this population is significantly more effective with input from a Clinical Neuropsychologist. By way of example, recently I have been working with a young man who had suffered a devastating stroke, which was associated with the development of a range of cognitive problems, plus severe depression and anxiety. He was initially receiving only Clinical Psychological intervention for these mental health problems, however, his progress has notably improved following the concurrent implementation of neuropsychological

treatment and intervention, with a resultant lessening of anxiety, greater subjective sense of wellbeing, and increased engagement with a wider range of activities in the community. Such intervention is frequently unavailable to non-compensable clients, so their needs go unmet.

There are myriad more reasons that could be given as to why it is necessary for the Federal Government to grant rebates for neuropsychological services under Medicare. In the treatment of neuropsychological disorders, the provision of neuropsychological services represents best practice, and people with neuropsychological disabilities are currently being excluded from having their cognitive and psychological needs addressed by the most appropriate clinicians. Furthermore, the provision of neuropsychological services under Medicare will deliver a number of major cost offsets or savings to the Government because of positive outcomes, such as delayed entry into residential care placement, improved functioning in younger people looking to return to work with neuropsychological disorders, and a reduction in long-term psychosocial dysfunction due to better education about, and treatment of, underlying neuropsychological problems.

Another important issue being investigated by the Senate Inquiry is (e) mental health workforce issues, including (ii) workforce qualifications and training of psychologists. I am strongly opposed to the removal of specialist endorsement with the Psychology Board of Australia, particularly regarding the practice of Clinical Neuropsychology. There is no question that it would be unacceptable to allow psychologists who have undergone training by the “4 plus 2” route (i.e. a four-year undergraduate degree plus two years of supervised practice) to practice as Clinical Neuropsychologists. The removal of specialist endorsement would create this opportunity and I hope that the content of this submission demonstrates that the work undertaken by Clinical Neuropsychologists is highly specialised, technical, and unable to be taught at a generic undergraduate level.

In sum, I sincerely hope that the Senate Inquiry is an opportune time for politicians to reflect on the inequity and discrimination engendered by the present circumstances whereby neuropsychological services are not rebated through Medicare. Forward thinking and sensible decision making in relation to this issue will have an enormous benefit to the community, both immediately and in years to come. Additionally, the Senate Inquiry must acknowledge that there are specific areas within the profession of Psychology, of which Clinical Neuropsychology is one, that require a high degree of training and expertise, and should be protected through specialist endorsement.

Yours sincerely,

Dr Ben Harris
Clinical Neuropsychologist