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TO: Senate Standing Committees on Community Affairs
The Senate
Parliament of Australia

Email: community.affairs@aph.gov.au

RE: "The Government's funding and administration of mental health services in Australia"

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SUMMARY OF SUBMISSION FROM

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This submission focuses particularly on the following items to be considered by the Inquiry:

(b) - (i), (iii) and (iv)

(c)

(d) – (i), (ii) and (iii)

1. The *detrimental/negative* impact on patient care of reducing Medicare supported sessions for psychological therapy from the existing 6+6 (+another 6 in exceptional circumstances) to the proposed 4+4.

Reason: The patients who use more than 6 or 12 therapy sessions actually need the extra therapy.

2. *An explanation of the* different levels of clinical expertise between Psychology Board of Australia “registered” psychologists and those registered as “Approved Clinical Psychologists”, normally with doctoral level training as clinicians. *An argument is made in support of recognizing these different levels of expertise and that this should be reflected in the Medicare rebates.*

Reason: For a significant number of patients high-level clinical psychological expertise is required to effectively help them with their problems, through sophisticated assessment, analysis and interventions, tailored to patient need.

More detailed information and argument is provided in my main submission.

Submission to Senate Community Affairs Committees’ inquiry regarding “The Government’s funding and administration of mental health services in Australia”.

In my submission to this inquiry I wish to offer some reflections and observations based upon my experience of over 45 years of work as a clinical psychologist in the fields of mental health pertaining to both psychiatric mental health disorders and to mental health concerns associated with suffering serious physical injury and illness. In both Australia and the United Kingdom (UK), I have worked in senior positions in both mental health and consultation-liaison settings in medicine and surgery at university teaching hospitals (The Royal Melbourne Hospital and The Queen Elizabeth Hospital, Birmingham, UK). I have also been responsible for convening and teaching psychology courses as applied to health care, to both clinical psychology trainees undertaking Doctoral level studies, and to medical students as an integral part of their syllabus at the University of Melbourne (for over 30 years). I have always maintained an active clinical practice as well as my teaching and research activities.

I have internationally recognized specialist knowledge and skills in the treatment of both physical and emotional trauma associated with injury (eg motor vehicle and other accidents), and of serious illnesses (especially cancer).

Against this background, I will provide comments that are particularly pertinent to the following items to be considered by the Inquiry:

(b), (i), (iii) and (iv)

(c)

(e), (i), (ii) and (iii)

1. This concerns the impact of reducing the number of medicare funded psychology treatments from the current 6+6 (+6 more in exceptional circumstances) to only 6+4. I would emphasise that, as far as specialist clinical psychology interventions are concerned, the evidence indicates that the people who use the current approved funding arrangement are generally those who really do need more intensive treatment because they have moderate to severe, and often chronic mental health problems; such as Post-Traumatic Stress Disorder, longstanding depression and comorbid illnesses such as cancer. Also, these referrals actually come from independent assessments of patients' needs from authorized medical practitioners (namely General Medical Practitioners, Psychiatrists and Paediatricians). Also, once the initial six therapies have been provided further Medicare fund treatment can only occur when authorized, after review, by the referring medical practitioner. Thus, presumably these competent medical practitioners are making the request for further psychological therapy for a patient on their expert clinical assessment of what is best for their patients. It is not the clinical (or other) psychologist who makes the decision for further treatment. Certainly, it is my experience

that when extended psychological therapy is recommended, it is in the patients' best interest, and to arbitrarily terminate therapy when a person is beginning to obtain benefit is likely to make them dependent upon more frequent visits to medical practitioners (who generally do not have the necessary sophisticated knowledge and skills in psychological assessment and therapies) and to increase their reliance upon expensive psychotropic medication.

2. I would also like to address the question of the difference in psychological expertise and skills between registered psychologists taking the 4+2 route to registration (4 year Honours degree plus a 2 year Masters or 2 years supervised experience) and those psychologists registered as "Approved Clinical Psychologists" by the Psychology Board of Australia.

Clinical Psychology is a well established Post-graduate University based Doctoral level of training for Psychologists, who having completed an undergraduate honours degree at a high level, wish to learn the skills and competencies to be specialist experts in the psychology of complex mental health problems. For example, training in the UK in clinical Psychology at the Doctoral level is recognized by the State as essential to providing effective skills to those psychologists working in both mental health and physical health. In the UK the State funds their clinical training over the three year doctoral program; much as medical doctors are paid a salary whilst working as junior doctors.

It is also true that in Australia this higher level of specialist expertise is recognized by the recently formed Federal Psychology Board of Australia, through the title of "approved clinical psychologist".

Thus, in the UK, and also in the United States of America (USA) and currently in Australia, it is recognized that post graduate Doctoral level trained clinical psychologists are health professions on a par with medical specialists such as Psychiatrists, Neurologists, etc, and not equivalent to general practitioners. This does not mean that General Practitioners, medical or psychological, do not have a key role to play in healthcare; they quite clearly do. What it does mean is that for people with more complex psychological health problems, be they associated with specific mental illnesses or as reactions to major traumatic life events, such as serious injury or illnesses (such as cancer), specialist clinical psychological expertise is often required. It, therefore, seems inappropriate to not financially recognize and reward those psychologists who have undertaken advanced academic, research and clinical training at the post graduate Doctoral level and who can provide people with severe health problems (both mental and

physical) with expert investigation, assessment and therapy that undergraduate degree level psychologists normally cannot due to lack of knowledge and skills.

I was convenor of the psychology course for medical, dental and physiotherapy students at the University of Melbourne for 31 years (1969-2001) and I also established a clinical psychology service at the Royal Melbourne Hospital during that time. From 2001 until my return to Melbourne in December 2008, I was Honorary Professor of Clinical Psychology at the University of Birmingham, UK, where I ran a clinical psychology service and was responsible for a staff of 60 clinical psychologists in a large Mental Health Trust, and also established a clinical psychology service in the cancer service across Birmingham, UK.

In both these services psychology graduates (with an Honours degree) were employed as Assistant Psychologists. They did excellent work with their clients/patients but needed to be supervised at all times by a qualified clinical psychologist. In the UK two years as an Assistant Psychologist working in a health care service, is mandatory before being able to embark upon training as a clinical Psychologist.

An analogy I often use in my work with medical practitioners, to explain how clinical psychology skills differ from those of graduate psychologists with some level of supervised training (hopefully but not always in healthcare in Australia) is that of a patient who presents with severe, unremitting headaches. As a General Medical Practitioner, I would be entitled to diagnose the cause, and if a brain tumour was present, carry out brain surgery. But would I do this? Only in exceptional emergency circumstances if no other specialist care was available. I would normally refer to my specialist medical colleagues, such as neurologist, radiologist and neurosurgeon, for assessment and treatment of the patient who initially presented to me. Referrals to clinical psychologists can usefully be seen in the same way.

In my career I have worked clinically and in a research capacity in psychiatry but also in surgery, anaesthetics and oncology where patients have presented with extremely complex, and often life threatening illness (Horne and Watson, 2011; Strain and Horne, 2001; Horne et al. 1994). Sometimes, intense, specialized psychological intervention has actually been life saving; for example, treating a patient for severe medical phobias that prevents them having potentially life saving treatments for cancer. (Horne et al. 1986).

I do hope that what I have provided to this Select Committee is of help and I am more than happy to be called upon to provide further information.

I provide examples of relevant illustrative references concerning some of these areas of specialist clinical psychology expertise, from my own experience:

Horne, D. and Watson, M. Cognitive-Behavioural Therapies in Cancer Care in: Maggie Watson and David Kissane (eds.) Handbook of Psychotherapy in Cancer Care. Chapter 2, pp. 15-26, Wiley-Blackwell, 2011.

Horne, D., Vatmanidis, P. and Careri, A. (1994). Preparing patients for invasive and medical procedures. Behavioral Medicine; 20 (1), 5-22.

Strain, J. & Horne, D. Consultation-Liaison Psychiatry and Psychology. In: J. Milgrom & G. Burrows (eds.) Psychology and Psychiatry: Integrating Medical Practice. Chapter 4, pp. 93-125. John Wiley, 2001.

Horne, D. et al. (1986). Psychological treatment for phobic anxiety associated with adjuvant chemotherapy: a case study. Medical Journal of Australia, 145: 346-348.