27/7/11

Dear Senate Inquiry,

I write in my capacity as a registered psychologist who is a member of the Australian Psychological Society (APS), the APS College of Clinical Neuropsychologists and endorsed with the Psychology Board of Australia as a clinical neuropsychologist. I work in the public health system in Melbourne and wish to provide a submission to the upcoming Senate Inquiry into *Commonwealth Funding and Administration of Mental Health Services*. I will provide some background as to my role specifically and regarding clinical neuropsychology more generally, before addressing some items in the terms of reference for the Inquiry.

Briefly, in my role as a clinical neuropsychologist, I perform a variety of duties. At the outpatient service of a major public hospital in Melbourne, I am involved in the provision of neuropsychological assessments, which involve the assessment of cognitive and behavioural function in the context of acquired brain dysfunction secondary to trauma (e.g., car accident or assault), stroke, neurosurgery and neurodegenerative conditions such as dementia and multiple sclerosis. These assessments serve to both guide the treating team and act as a starting point to provide appropriate supports (be they psychological, functional, behavioural or otherwise) for an individual who has brain dysfunction. This commonly involves the provision of psychological support to maximise the mental health of those with neuropsychological conditions. In my other role, I am employed with a public hospital state-wide community service, where I work to support individuals, their families, support networks and other health providers after they have sustained an acquired brain injury. Our service specialises in working with individuals who have a mental health illness (including, but not limited to, depression, anxiety, psychosis and personality disorders) in the context of the acquired brain injury, and often involves the provision of strategies to assist in managing behaviours of concern such as verbal and physical aggression. In both of my roles, both myself and the other neuropsychologists that I work with aim to provide an evidence-based service that effectively identifies cognitive, behavioural and psychologcial dysfunction and implements appropriate strategies and supports with the goal of providing patient-centered, preventative health care (including the promotion of mental health) to the community.

Clinical neuropsychologists work in a variety of roles across Australia, including paediatrics, mental health, acute and sub-acute, community health, rehabilitation and geriatrics to name but a few. The role is highly specialised and involves intensive training including a minimum of six years of formal tertiary training (Undergraduate, Honours or equivalent and a Masters, Doctorate or PhD). This training focuses on neuroanatomy, neuropsychological disorders and their functional impact, neuropsychological assessment and rehabilitation techniques and interventions. The training is unique in that other psychological specialties do not have a focus on the brain-behaviour relationship that is an integral component of neuropsychological training. The post-graduate component of neuropsychological training requires coursework, supervised placement in a variety of health settings and the completion of research (that is often presented at conferences and in peer-reviewed journals).

Given the intensive and unique nature of the training required to practice clinical neuropsychology and the distinctive role we perform in health settings, I strongly support the recent implementation of the specialist endorsement of 'Clinical Neuropsychologist' by the Psychology Board of Australia. I fear that if this endorsement category were to be removed, any registered psychologist with less intensive training could use the term clinical neuropsychology to describe their practice. My opinion is that this would lower the overall level of service provided to the community and worse still, place the community at risk of incorrect diagnoses being provided and inappropriate neuropsychological/psychological interventions being implemented.

I have seen several examples of registered psychologists without specialist training in neuropsychology providing neuropsychological diagnoses to the determent of the patient. For example, I recently encountered a 35-year-old gentleman who was involved in a motor cycle accident. A registered psychologist with no neuropsychological training provided an opinion that this individual's cognitive functioning was 'normal' based, in my opinion, on an inappropriate and ill-informed pseudo-neuropsychological investigation. This psychological report was passed on to various service providers, who denied him appropriate supports as there was deemed to be no evidence of neuropsychological dysfunction. As a result, he received inadequate support from the hospital (and insurance) system and due to the significant functional impairments that were not identified by the psychologist, he could not return to work, experienced substantial family conflict and developed a major mental illness. It was not until a follow-up neuropsychological assessment was completed later by a clinical neuropsychologist with appropriate training in the area, that the substantial memory deficits the gentleman sustained as a result of the brain injury from the car accident were correctly identified. Following this correct diagnosis, appropriate supports could be applied for and neuropsychological strategies that dealt with his mental illness in the context of cognitive dysfunction could be implemented.

With regard to the terms of reference of the Senate Inquiry, I will address some of them individually:

c) The impact and adequacy of mental health 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**
- **iii) People with disabilities**

I will address both these terms of reference together as they are related in the case of clinical neuropsychology. In my opinion, the Access to Allied Psychological Services Program does not effectively cover the psychological needs of those with disabilities and subsequent neuropsychological disorders. For example, individuals (and their families) with acquired brain injuries secondary to events such as strokes, car accidents or assaults often have significant psychological needs that must be dealt with in the context of

dysfunction in memory, concentration and problem solving. I believe clinical neuropsychologists are often best placed to provide these services because:

- Clinical neuropsychologists are trained to be able to provide a detailed assessment of the person's cognitive and behavioural functioning in the context of brain dysfunction/damage. As I have discussed, many other registered psychologists are not trained to provide these assessments and as such, are at risk of recommending inappropriate and potentially harmful psychological interventions.
- Neuropsychological disorders are not the same as mental health disorders as defined by the mental health funding scheme, but neuropsychological disorders do have significant ramifications for mental health. Individuals with cognitive or behavioural deficits (in the context of acquired brain injury, progressive neurodegenerative condition or developmental disorders) are much more likely to have significant mental health disorders. These individuals are likely to be forced to adjust to major changes in their life, including potential job change/loss and subsequent income loss, change in relationship status and loss of functional independence (i.e., ranging from assistance required to remember appointments through to significant supports such as a full-time carer to support significant cognitive dysfunction). Again, a clinical neuropsychologist is best placed to work with these individuals given their detailed understanding of the behavioural and cognitive implications of the brain dysfunction and the most appropriate mental health supports that can be implemented given the person's cognitive and functional limitations. In many cases, clinical neuropsychologists are making a substantial contribution to the mental health of many people with neuropsychological dysfunction, despite the relatively limited access to the service.

The importance of the role of the neuropsychologist is illustrated by the potential life-long impact of mental health issues post brain injury. Many sources of neuropsychological impairment are more likely to occur in one's younger years. For example, the young male who sustains an acquired brain injury and subsequent cognitive dysfunction in a car accident may not be able to work, have relationship difficulties and require periodic neuropsychological intervention to maintain and support mental health for the next 60 years. This is obviously an example of an extreme case, but in my experience working with these clients, they represent a significant burden to the health system, both in terms of the resources and finances required. This burden only increases if they can not access appropriate neuropsychological support, particularly if this support is unavailable in the early stages post-injury to act as a preventative measure minimise the likelihood of extensive neuropsychological dysfunction and mental health concerns in later life.

In my opinion, the current mental health system lacks appropriate community supports for individuals with significant neuropsychological disorders. To illustrate my point, I will briefly describe a situation I am facing with a 38-year-old client who lives in a rural region of Victoria. He sustained and acquired brain injury with substantial neuropsychological deficits (i.e., poor memory, reduced concentration, poor problem solving) after being assaulted and has subsequently developed a psychotic illness. He currently lives in a supported accommodation as he is not able to care for himself at

home. In the context of his neuropsychological deficits and psychiatric illness, he has threatened co-residents and appears to be at risk of absconding (placing his own safety at significant risk). He is currently wait-listed for services through the public health system that would be entirely appropriate to optimise his mental health and provide him with a safe means by which to access the community. Evidence suggests that this intervention would be highly likely to have beneficial effects. Unfortunately however, we have been informed that while identified as high priority, the client is unlikely to receive any formal support from the public health system as there is no funding available. I feel that this lack of support has significantly reduced the likelihood that this gentleman will ever live independently and that the risk that this vulnerable man with an acquired brain injury, neuropsychological disability and mental health concerns who lives in an isolated, rural region will experience further deterioration in his mental health, which increases the risk that he may hurt others. The current, insufficient supports provided have placed a huge burden on the existing support system, the gentleman's family and the existing accommodation and as he is not yet 40 years of age, it likely to continue to place considerable stress on the system until more effective supports can be funded.

Finally with regard to the terms c) and f), the World Health Organisation has indicated that neurological disorders account for the largest proportion of medical disability in the developed world, yet in Australia, these conditions have been neglected by the lack of allocation of mental health funding in recent years. This is despite the fact that, as I have mentioned, mental health concerns often occur in the context of neurological conditions. In my opinion, neuropsychologists, with their advanced knowledge of appropriate neuropsychological assessment and interventions for these conditions, are very well placed to be more involved in the support of this group. I would fully support a review of mechanisms to increase consumer access to clinical neuropsychology to address what I see as inadequate supply for an increasing demand.

e) Mental Health Workforce Issues, including:

i) The two-tiered Medicare rebate system for psychologists

ii) Workforce qualifications and training of psychologists

iii) Workforce shortages

From the perspective of a clinical neuropsychologist, there are several issues that I wish to raise for the Inquiry to consider:

- There are currently no Medicare rebates available for neuropsychological assessment or treatment, despite the utility of the profession that I have touched on above. This significantly limits the access of the community to neuropsychological support. I understand that numerous letters supporting Medicare rebates have previously been submitted to Health Minister Roxon in 2007.
- Treatment of neuropsychological disorders is best informed by a neuropsychological assessment. In my opinion, the inability of individuals to be able to access such a service limits the utility of psychological interventions aimed at treating mental health disorders in the context of neuropsychological disorders (i.e., depression in the context of acquired brain injury; anxiety in the context of dementia).

    - As such, I strongly support the addition of clinical neuropsychology items to Medicare to increase the access of the community to this important service.
- At present there are only six training courses for neuropsychology in Australia (none in South Australia, Tasmania or Northern Territory). This, combined with the fact that as of May 2011, there were only 384 clinical neuropsychologists endorsed by the Psychology Board of Australia, is likely to lead to an extensive workforce shortage. It is of note that 1400 cases of dementia, a condition with substantial neuropsychological ramifications, are diagnosed each week. There is an insufficient neuropsychological workforce to cope with this patient-load (particularly as it will only increase as the 'baby-boomer' population ages).
    - To address this, I would fully support a call for extra funding to be provided to Universities to support them to increase the size of neuropsychology post-graduate training programs. Furthermore, given the important and unique nature of neuropsychological work, I feel that the profession, and subsequently the community more generally, would benefit if neuropsychology students were provided with the same fee-reduced University places afforded to clinical psychology students.

To summarise, I strongly support the notion of clinical endorsements provided by the Psychology Board of Australia, particularly the endorsement of clinical neuropsychologists. These endorsements allow the community to identify the registered psychologist with the appropriate, intensive and unique training that all endorsed clinical neuropsychologists complete. I feel there is significant risk of ineffective service, or even worse, a risk of harm for the public if registered psychologists without specialist neuropsychological training are permitted to practice the profession. As outlined, I also feel strongly that clinical neuropsychologists are uniquely placed to be able to provide effective service to members of the community that require clinical neuropsychological assessment and intervention (i.e., those with neuropsychological impairment) to improve their mental health in the context of brain dysfunction. At present, clinical neuropsychological assessment and treatment is not included as a Medicare item and I feel this significantly limits the ability of vulnerable individuals to appropriately seek support to manage their mental health needs following a brain injury or in the context of some other neurological condition. In my opinion, the current Inquiry represents an ideal opportunity to advocate for the role of clinical neuropsychologists and review whether clinical neuropsychology items should be added to Medicare.

I thank the Senate Inquiry for the opportunity to provide a submission. I would be happy to be contacted should it be required.

Yours sincerely,

Dr. James Campbell, MAPS
Clinical Neuropsychologist
Melbourne, Victoria