Submission to Senate Inquiry into Commonwealth Funding and Administration of Mental Health

I am writing to request 1. increased public access to neuropsychological services, and 2. to support specialist endorsement of neuropsychologists by the Psychology Board of Australia. In particular, my submission addresses the following reference points.

I have worked as a clinical neuropsychologist at public mental health services since 2003, and currently hold a senior position at a Victorian area mental health service. In addition, I see patients through private practice including those with complex substance use and medical backgrounds. My experience to date and research on the issue highlights the limitations of the mental health system in addressing patients with brain injury.

Questioning the limited place of brain injury with the public mental health system and policy
My first concern involves the place of brain injury within the public mental health system and policy. I would like to highlight that the recent National Mental Health Policy does not include brain injury as a term, or make reference to it. Similarly, the recent and current budgets provide no allocation to patients with both acquired brain injury and mental illness. Area mental health services have no clinical service guidelines to screen and manage brain injury patients who present with psychiatric conditions. The staff is often unequipped to screen patients, and when patients are known to have brain injury, staff is unable to devise management strategies, this influencing quality of service and care to this vulnerable disability group with dual-diagnosis. I have recently undertaken research to evaluate screening process in an inpatient psychiatric unit (results will be submitted for publication in November 2011); and the study revealed that the brain injury screening was non-systematic and poor. There is a need to devise clinical guidelines for systematic screening of patients with brain injury when they present at mental health services. Further, funding is needed for training of mental health staff to recognise and manage brain injury patients. Overall, at policy and practice level, the mental health system does not cater for patients with brain injury. There is an urgent need to do so, given the high risk of developing brain injury in patients with psychiatric disorders; and development and emergence of psychiatric symptoms following brain injury itself.

Supporting specialist endorsement of neuropsychology
My next concern involves the specialist title of neuropsychology. Neuropsychologists are equipped with specific skills and training to assess and diagnose patients with suspected brain injury; to devise treatment and management recommendations; and to rehabilitate patients. In additions, they work with families, treating health professionals, schools and workplace. Early diagnosis is crucial for prompt treatment, and appropriate community integration.

In Australia, clinical neuropsychology training involves a three-year undergraduate, one year honors degree, and a minimum two-year postgraduate coursework degree with a focus on neuroanatomy, neuropsychological disorders/assessment/rehabilitation, supervised placements, and research. This training is unique compared to all the other specialities, as it provides specialty on understanding specific brain-behaviour relationships, while taking into account a wide array of factors such as crosscultural background, mental state and so forth.

I strongly support specialist endorsement by the PSYBA with regard neuropsychology. The lack of specialised training in the area places the public at risk, as the ability to make appropriate diagnostic and treatment decisions requires highly developed theoretical knowledge and skills. Neuropsychological assessment does not just rely on testing and test results, but requires sound knowledge of disease profiles such as frontotemporal dementias, the diagnosis of which often requires knowledge of behavioural and psychiatric changes alongside test results. If specialist endorsement did not exist, any registered psychologist could claim to offer neuropsychological assessments without the PSYBA protecting our specialist title

With regard to specialist endorsement, postgraduate training provides unique training and expertise in specific areas such as health, clinical, organisational or neuropsychology, and these need to be recognized under specialist endorsement. Such training comes from a high level analytical ability to evaluate theoretical knowledge, research in this area that provides the basis to continue working to do so, and hands-on practical placements that provide the ability to combine learnt theoretical knowledge through supervised patient work by trained senior clinicians.

The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program; and the adequacy of mental health funding and services for disadvantaged groups

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.

Neuropsychological disorders (e.g., cognitive/behavioural difficulties due to neurological, medical, developmental disorders) are not the same as mental health disorders (as defined by the mental health funding scheme), but neuropsychological disorders have significant mental health ramifications (e.g., adjustment issues, anxiety, depression, postictal psychosis...). 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. Needs of people with brain injury are not met by the focus on only providing psychological assistance to people with mental health disorders. Having a brain injury places patients at risk of developing new psychiatric symptoms post-injury, and these symptoms can be evidence even decares following injury (e.g., injury following motor-vehicle accident). Early assessment of patients for neuropsychological disorders increases the ability to assist patient's return to community, and hence, partly prevent development of psychiatric symptoms such as depression.

In addition, services available in the community to support people with neuropsychological disorders are limited, especially those with noncompensable conditions, or aged under 65. The out-of-pocket cost is high given that an assessment takes approximately eight-hours. As a result, it is difficult to afford for most clients, particularly those who are from disadvantaged backgrounds, e.g., multicultural backgrounds (which also need interpreter fees), regional and remote areas of Australia including indigenous people, and people with existing disability. Neuropsychological assessment is crucial to ascertain problems associated with brain injury and assist person and closed-ones in managing cognitive, behavioural or psychiatric outcomes of injury.

The current focus of providing psychological services to people with confirmed mental health conditions is a form of discrimination against people with neuropsychological conditions, who often present with mental health issues, even these may not meet diagnostic criteria for a psychiatric disorder. Our clients have a significant need for therapeutic psychological interventions, but they are severely underserviced. According to the World Health Organization, neurological disorders and disease account for the largest proportion of medical disability in the developed world, yet Australians with these conditions are neglected by the Mental health funding initiatives of recent years.

On mental health workforce issues

In its current state, there are no Medicare rebates at all for neuropsychological assessment and treatment services, despite an avalanche of letters of support written to Health Minister Roxon in 2007, and again to PM Rudd in 2010.

People with neuropsychological disorders are not able to access Medicare unless they have a mental health disorder, but treatment in such cases is best informed by a neuropsychological assessment as discussed above. Further, the number of neuropsychologists in Australia fails to meet the current need for services, or the projected need with 1400 new cases of dementia each week.

Training for neuropsychologists cannot be considered adequate without postgraduate specialist training. Training for psychologists in general needs to meet international standards, which in the US and England is a doctoral degree. In Australia, there are only six postgraduate training programs (LaTrobe, Macquarie, Melbourne, Monash, UQ, UWA) at present, down from eight a few years ago. The Victoria University course closed due to budgetary pressures on the School of Psychology and lack of support from the faculty. Most neuropsychologists practice where they have been trained, and as a result, the spread of neuropsychologists across states is imbalanced with a higher portion residing in Victoria, and in particular Melbourne. Some states are significantly underserved; and significant incentives are needed to provide access to services in a large portion of Australia.

With regard to training, universities need funding support to offer specialised neuropsychology postgraduate training places, and neuropsychology students should be given the same fee reductions as clinical psychology students. Further, it is difficult for universities to find enough clinical placements, of the right type, for their postgraduate psychology students. Financial assistance for clinical placements (as is available to medical trainees) should be considered to allow public health agencies to train neuropsychologists, because neuropsychologists need to be exposed to the variety of cases and the multidisciplinary team work conducted in the public sector, particularly hospitals and rehabilitation centres. Establishment of funding for clinical educator positions in existing neuropsychology departments could be one way of ensuring enough clinical placements for neuropsychology students.

Finally, the training and experience of psychologists needs to be recognised 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, psychologists in the public sector are often paid the same as undergraduate-trained allied health workers.

I look forward that the Committee takes into account the issue of recognising neuropsychologists within the mental health system, and providing funding for needed services for patients with brain injury, who often present with psychiatric symptoms but may fail to meet diagnostic criteria for a mental health disorder.