29 July 2011

TO THE SENATE COMMUNITY AFFAIRS REFERENCE COMMITTEE INQUIRY INTO COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES.

Introduction

I provide the following submission in support of maintenance of the current funding for the Better Access Scheme by providing specific concrete details about work within a clinical psychology practice and the implications for this of cuts to funding.

1) Details of A Regional Clinical Psychology Practice in the Current Scheme.

1.1 Background

I am a Clinical Psychologist of 25 years experience. I spent about 10 years at University, studying postgraduate clinical psychology and obtaining 2 Masters degrees in Clinical Psychology and Child/Adolescent Clinical Psychology. I have worked in public adult mental health services and child/adolescent mental health services for 20 years. This has included work with children, adolescents and adults with severe mental illness, combat veterans, refugees, trauma victims and in drug and alcohol services. I have now been in private practice for 5 years in a semi rural, regional area. I also undertook my own personal therapy for many years, a prerequisite during postgraduate study, and which has enabled me to maintain a good ability to monitor and reflect on my own clinical practice, particularly with challenging clinical issues. For most of my training years I was on a very limited income and dependent on scholarships, part time work and student loans.

Since commencing private practice 5 years ago, I have treated approximately **500** clients many of whom are children, adolescents and their families. I receive referrals from the local paediatricians, GPs and psychiatrists. I work in an area, which, although only just over an hour to a capital city, is poorly serviced by public services as indicated below:

1.2 Current limitations in local mental health services

- The local Child and Adolescent Mental Health Service (CAMHS) is severely under resourced; it is **very** difficult to get clients into that service and treatment is often short term (e.g. If the case is accepted onto the general waiting list there may be up to a 6 month wait, if the client is acutely unwell they are unlikely to be seen urgently unless they have had an **actual** suicide attempt. Suicidal ideation is usually insufficient for acceptance for urgent assessment). The service is difficult to access by public transport for many families.

- The Adult Mental Health Service also has marked limitations on whom they can see and for how long.

- There are NO local child psychiatrists in the region. The nearest are about one hour's drive away, have lengthy waiting lists and significant out of pocket costs. There are few local adult psychiatrists, they often have closed waiting lists and rarely bulk bill.

- Local welfare organizations are overwhelmed, often with closed waiting lists or restricted number of sessions to clients. (often no more than 6).

- The local 'Headspace' service is some distance from many clients, is limited to clients over 12 years of age, and has restrictions in what it is able to provide.

1.3 My current clinical practice

The vast majority of my clients are from low to moderate income families with moderate to severe levels of psychological impairment and multiple problems. For many of my child/adolescent clients, they have either previously had no psychological or psychiatric treatment or have been managed solely by the paediatrician or GP, which, whilst well intentioned, is far from sufficient. Some say they have had previous counseling but this has not been sufficient and has left the clients feeling they are 'untreatable' or that 'no one can help'. Many of these clients' difficulties have persisted over many years if not most of their life. My fees are such that clients are either bulk billed or out of pocket up to $40 per session, depending on income. Examples of common referrals are the following:

- Adolescent depression, self harm and suicidality
- Adolescent eating disorders, usually where weight loss is severe
- Adolescent acting out behaviours, including aggression in the home, running away, drug use, dropping out from school
- Adolescent psychosis
- Post natal depression
- Severe anxiety or obsessive compulsive disorder
- Significant disturbance in the perinatal period and/or marked difficulties in the mother-child relationship, arising from post natal depression, post traumatic stress disorder, drug use, abuse etc.
- Severe child behavior disorders including aggression, ADHD.
- Autistic spectrum disorders
- Multi problem disadvantaged families with prominent parenting problems, abuse, domestic violence, drug use, alcoholism
- Complex post traumatic stress disorder/personality disorder arising form abuse history.

- Severe paediatric health conditions associated with depression, anxiety and family disruption.

Most of my cases have required an extensive knowledge of psychopathology and it's assessment and treatment, knowledge of child and adolescent development and the ability to utilize various treatment modalities such as family therapy, crisis work, case management, long term individual child and adult psychotherapy.

1.4 Costs of a clinical practice

- I require a practice which has reception staff, administrative support and a waiting room. This is because I am often seeing clients who are acutely distressed, require telephone access in crises, assistance with bills. I need messages to be taken, referrers contacted, reports faxed, information given. Security is also relevant.
  The cost of this is $30 per hour and does not include typing.

- I earn approximately on average $140 per hour and can see about 6 clients per day, with up to several hours per day spent on unpaid phonecalls, reports and administration. My income per hour is therefore $110 per hour. This is before tax, and does not include other professional expenses which are mandatory.

2) The Advantages and Limitations of the Current Scheme.

From my experience, it is certainly the case that this current scheme has provided help for many individuals and families who would otherwise be unlikely to receive any assistance and has contributed enormously to early intervention, particularly in the area of perinatal, child and adolescent mental health. My experience also suggests that it is likely to save significant costs in relation to a decreased use of public health and welfare resources. However, the following points are made:

- *The current scheme still does not formally allow for parents of a child/adolescent client to be seen without the child present in the room during the assessment or treatment. This is not feasible for most child/adolescent cases and contraindicated for appropriate child psychological intervention. It is often inappropriate for a young person to be witness to their parents' own difficulties and concerns which are often central to the presenting problems.*

- *It should be also noted that the current number of rebated sessions is still minimal and below recommended guidelines for treatment of many severe and complex disorders.*

- *Most children and adolescents with significant and complex difficulties cannot be assessed and treated within 10 sessions. They require more extensive assessments and multifocused treatments.*

3) Implications of the Proposed Cuts to the Better Access Scheme To Clinical Practice

3.1 Reduction of sessions to 10 sessions per year:
Clients with severe mental health difficulties usually cannot be appropriately treated in 10 sessions per year, e.g. once every 6 weeks. In some instances even this should not be provided as it 'opens up' issues that cannot be resolved within this time frame. Other options for treatment are limited or nonexistent.

3.2 *Removal of Specialist Clinical Psychology rebates*:
I cannot afford to lower my fees further in order to provide treatment to individuals/families who cannot afford any or minimal out of pocket expenses. If I charge approximately $80 per hour, I will earn $50 per hour, after rent, and not counting other expenses. This is not sustainable. I could not work at this profession in a private capacity unless I only see those who can afford significant out of pocket expenses and manage without intensive input. i.e. those who are financially well off and without significant or complex psychological disturbance.

4) CONCLUSIONS

4.1) *The current scheme enables those who are most in need and can least afford it to access some treatment for mental health problems. It enables early intervention for at risk children and adolescents and families and may decrease frequent, expensive use of community/welfare/protective services.*

4.2) Those clients with moderate to severe and complex mental health issues require treatment from a psychologist with specialized and extensive training and experience in psychopathology and various treatment modalities. It is the usual work of a clinical psychologist.

4.3) If the proposed cuts are implemented those clients most in need are unlikely to get the treatment they require.

Therefore:
I strongly recommend that due consideration be given to the continued provision of adequate treatment to the most vulnerable members of our community.
Thank you for your time and consideration of the above matters.

A Clinical Psychologist.