

## **Senate Community Affairs Reference Committee inquiry into Commonwealth Funding and Administration of Mental Health Services -**

To the Honourable Members of the Senate Committee Inquiry into **Commonwealth Funding and Administration of Mental Health Services**, I respectfully submit the following information in responding to identified sections of the Committee's Terms of Reference:

### **(b) Changes to the Better Access Initiative, including:**

#### **(ii) The rationalisation of allied health treatment sessions:**

As a clinical, counselling and educational psychologist working privately predominately with child and adolescent clients in a rural area of South Australia (3 ½ hrs north of Adelaide) I have genuine concerns regarding the impact of reducing the number of session available for clients requiring psychological therapy.

It has been my experience that the child and adolescent clients referred, usually by General Practitioners, Paediatricians and Psychiatrists, to the Better Access program are frequently presenting with moderate, severe and /or complex mental health issues.

Within our rural community the options for support of children and adolescents with mental health needs are limited to the State government CAMHS service, visiting Psychiatry services (monthly/bimonthly services) and private psychology services. Of these services CAMHS, whilst having experienced social workers, do not have any psychologists working locally with them. The visiting Psychiatry service involves monthly visits by the Psychiatrist attached to the CAMHS service and bimonthly visits by the only private specialist child/adolescent Psychiatrist. Psychology services for children are also limited, with my clinic providing specialist services to child and adolescent clients and one other experienced Clinical Psychologist providing services to adults and children. Other visiting Psychologists to this area do not currently provide services to children and adolescents.

The reality of working in this specialist area in my clinic, is that due to the lack of alternative therapist options that clients do present with a range of issues, many of which do require significant psychological intervention. Many of the clients do access the visiting Psychiatrist services for specialist opinions however these clients are generally referred back to myself (or psychology services) to provide the regular face to face psychology therapy, that these clients often need.

For clients with chronic conditions that require specialist services, the children or adolescents generally will be admitted to metropolitan facilities, but once discharged they tend to access local services, often requiring significant psychological support. Where in metropolitan areas, clients can remain outpatients of specialist units and have regular access to these services with some top up service from private clinicians those in the country areas tend to have a high dependency on services provided locally when they return home. Restricting sessions will reduce the flexibility in offering those with needs, such as in the conditions of eating disorders, complex mood disorders and trauma related conditions, access to psychology services in our region. This will add a further burden to the families, who are often already struggling to cope with their child's condition.

In supervision and peer discussion with many of my colleagues who are metropolitan based, it is clear that the nature of many of the rural clients needs are relatively complex. Although funding is available for rural clients through ATAPS and specific funding for child and adolescent services is found in the Head Space and Kids Matter programs, our area does not have access to a Head Space program, our schools currently aren't involved in Kids Matter and a majority of ATAPS focus in our region has been on adult clients. This means that

parents can only access psychological therapy for their child in our area through the Better Access system or privately.

**(iv) The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule:**

As previously indicated many referrals are quite complex, but of those that are considered to be in the mild- moderate range, I have experienced on more than one occasion where despite treatment progressing well in relation to the anxiety or depressive symptoms, that part the way through the course of therapy unexpected life events occur, such as the death of a family member, parents separate, child is involved in a significant traumatic event such as an accident, someone known to the young person commits suicide or young person is involved in family disruption resulting in becoming homeless. Whilst these incidents are not part of the initial referral they certainly impact on the young person's mood and require psychological support – particularly with the therapist that they have already established a rapport and relationship with. For a young person to have to start again with another therapist mid way through some of the situations described above would be quite challenging, particularly for adolescent clients – who often are quite challenging to engage in therapy at the best of times.

The 18 session options permits the flexibility to manage these complex situations as they arise, thus enabling a better overall outcome for the person and society. The 10 session plan appears to me to make the assumption that the initial diagnosis is independent and static in the person's life. It does not allow for any complex factors to arise in the persons life during the course of therapy.

For us working in relative isolation in the rural areas, it will leave the clinician in a challenging situation – as currently if I have a case that appears to be mild-moderate but throughout therapy it becomes obvious that a client's situation is significantly more complex, I can develop a therapy plan with the referring Doctor, the child and the family using the additional sessions. The additional sessions can either permit time to complete the therapy or enable the transition of the client over to the state based services (CAMHS) for long term therapy to occur– with me continuing to work with the young person until a therapist becomes available to work with the young person in government system. This process enables the smooth transition between clinicians, which is important for the client, and also enables mental health care to continue rather than the young person having a lengthy gap in therapy whilst on therapy wait lists.

**(e) Mental health workforce issues, including:**

**(i) the two-tiered Medicare rebate system for psychologists:**

As a clinical psychologist recognised by Medicare to provide Individual 'Psychological Therapy' I hold the greatest concerns for the future of this specialisation within my profession if the two-tiered Medicare rebate system should not continue. This in turn will, I believe, have significant and aversive effects for the clients requiring and seeking expert, specialist clinical services in Australia.

Having completed a Counselling Master's degree in Psychology and worked under the generalist "Focused Interventions" under Medicare prior to deciding to up-skill through enrolling in a Clinical Doctorate I am aware of the differences in skills that the post-graduate advanced courses offer.

Being rurally based, I have personally observed metropolitan based psychologists, with minimal academic qualifications, setting up part-time visiting practices in rural areas. Whilst these appear to be of benefit to the rural community –who certainly need access to services, the professionalism and skills of some of these minimally trained psychologist have been

quite varied, particularly around neuropsychological, developmental, syndromal and ethical areas of psychological practice. This becomes a significant issue, when considering the highly complex presentations that rural clients often present with. The current separation of those with expert qualifications from those with generalist qualifications assists clients in making informed decisions about therapists. It also validates the therapists decision to spend considerable time and money in participating in advanced University Courses.

The costs to myself and my family to up grade my skills through participating in a Clinical Doctorate Course include -

- \$30,000 course fees (as rurally based I study externally, so full up front fees apply)
- \$12,000 costs for travel to and from Uni for residential schools (compulsory)
- \$5,000 printing, postage, books
- \$45,000 loss of income over the 4 years whilst attending residential schools and taking time off work to complete assignments and thesis research.

TOTAL \$92,000 over 4 years.

The loss of the two- tiered system would really make a clinician question the benefit of such costs (I am actually horrified – I have not sat down and worked this out before!).

I am currently aware that some clinicians charge a significant gap between their fee and the Medicare fee – the reality of work in the rural area is that most families are struggling and so the majority of my clients are bulk billed. The current clinical rate permits the bulk billing option within my clinic, thus enabling a service to be provided to children and youths in our region with minimal financial impact on the families.

#### (ii) workforce qualifications and training of psychologists:

As indicated above I consider the higher qualifications do reflect an increase in expertise and skills. The importance of having a high level of skills in working with those with issues around mental health should not be undervalued, particularly when working with children and adolescent clients – where it is not just a matter of knowing how to implement CBT strategies, but having knowledge of developmental levels, learning styles, personality types, attachment issues and family dynamics.

A concern would be that without the incentive and motivation to work towards clinical status, that a lot of people would seek the easiest way to earn an income and thus enrolment and participation in post graduate clinical studies would reduce – thus lowering our professional standard.

#### (iii) workforce shortages;

Whilst shortages in psychologists exist in rural areas, the aim should be to support the development of highly skilled practitioners to work in these areas, rather than lower standards or accept less qualified people. The complexity of many of the issues in rural areas really does place minimally trained and clients at risk – as the higher level University study does provide the theoretical framework to address the complex issues.

### **h. The impact on online services for people with mental illness**

In working with children and adolescents in the rural areas I am aware of some parents who have attempted to have their children engage in on-line/ telephone therapy programs, with parents and children reporting significant challenges with engagement. I have also seen quite disengaged adolescents in tele-conference situations with specialist services. For a majority of the young people I work with programs need to be individualised in relation to the young persons literacy skills, developmental level and learning styles – (visual/language based).