



Learning for Life
AUTISM CENTRE INC
Helping children with autism
reach their full potential

National Autism Strategy

Feedback Dated: 29/10/2023

I am an Educational and Developmental Psychologist and the Head of Allied health at an NDIS registered organisation (The Learning for Life Autism Centre). We have a team of psychologists who work with autistic children aged between 6 and 18 years of age. Many of our clients have co-occurring mental health conditions and we constantly navigate addressing these mental health conditions within the context of their autism. The common mental health related symptoms they present with are, self-harm behaviours, suicidal ideation, panic attacks and/or agoraphobia. I agree with the points outlined under the mental health, and access to supports, services and information sections on pages 32 and 33 of the document titled 'What we have heard: moving towards development of a National Autism Strategy'. In particular, I would like to address the final point that 'Government services and information are fragmented...' as I feel that even if more providers were trained to work in this area, they are then going to be significantly constrained by the disagreements about which level of government should be funding the support. As an organisation that does have the training and experience to work with children who have autism and a mental health condition, our work with this group of children is constantly hampered by funding constraints.

I won't delve into what we do differently when working with children who have co-occurring autism and mental health conditions versus if we were working with children with an isolated mental health condition (however I am happy to have a more detailed conversation about it or provide further written feedback if desired). But I do want to highlight that there are differences. Having autism can influence the way a person processes and understands the world around them and engages with their everyday environments. These underlying cognitive processes and experiences do not go away when a young person also has a mental health condition. As providers working with people with autism, we must respect these differing views and processes and take the time to understand them in order to help each particular young person understand how they can use their experience of autism to also address their mental health condition. This means that the autism is always at the forefront of the intervention and supports provided even when the specific symptoms being addressed are related to a mental health condition.



The two funding systems we get stuck between when working with this group of children are Medicare, Mental Health Care Plans (MHCP) and the NDIS. To be eligible for a MHCP a person must have a diagnosed mental health condition and an autism spectrum disorder is not one of those eligible conditions. Additionally, any diagnosis of a mental health condition would require demonstrating that the mental health condition 'symptoms' are occurring separately to the autism 'symptoms'. This can be particularly difficult to do when a person has difficulties with communication, uses alternative communication methods or has an intellectual disability as well as autism. If the diagnosis of the mental health condition is going to be an accurate and ethical one, it requires thorough and detailed assessment to ascertain that the 'symptoms' are in excess of what is considered typical of an autism spectrum disorder. This process rarely informs the clinical work with a young person significantly and rather is often just being done to gain access to funding under a MHCP. Alternatively, under the NDIS pathway, a mental health condition does not meet access criteria. However, if the symptoms can be considered a 'psychosocial disability' the NDIS may fund some psychology support. So, the provider is in a position where they have to think about how they are going to 'define' or 'label' symptoms of mental health conditions based on which funding model the client will be using.

The next complication occurs because the different funding models place different restrictions on how and what the funding can be used for. In terms of a MHCP, the provider is limited to six individual sessions and a possible extra four following re-assessment from a medical practitioner across a 12-month period. The person who is named on the MHCP must be present for those sessions, which means in the case of children, it does not allow the flexibility of working with the guardians for some of those sessions. In contrast, NDIS funding often comes with more than 10 sessions in a year and does not require re-assessment by another professional after the first six sessions. NDIS also has more flexibility about who is present for those psychology sessions. However, the NDIS will only fund psychology sessions that assist the person to manage the impact their disability has on their day-to-day life. They will not fund supports that would be considered 'therapeutic' or 'therapy' for a mental health condition. This presents a conundrum because often a person will require a combination of these supports. The psychologist will likely help them identify strategies they can use in day-to-day situations to manage their difficulties whilst also providing therapeutic supports to help them understand and process their mental health symptoms. But if the client is funded through the NDIS this therapeutic support should not be being provided.

To provide an example, I have had countless clients ask me over the years whether it is 'normal' for people with autism to have suicidal ideation or self-harm. This type of question is not a simple yes/no answer. It requires exploration of why the question is being asked and what that individual person's perspective and experiences are. Not to mention the nuance that is then involved if the child asking that question uses an alternative communication method such as typing or another augmentative communication system. Under NDIS we

can't take the time to explore those types of questions and instead should be focusing only on the strategies the person should be using when they experience suicidal ideation.

The reality is that 'mental health' difficulties do not occur in isolation. When working with people with autism the 'mental health' difficulties are inextricably linked to their autism and cannot be separated from one another. Yet the two funding models try to separate them and there is then also a gap with young people that don't fit into either funding model. Providers are left needing to spend time focusing on which system a client is eligible for, justifying that decision and then making sure their intervention fits within that model. All of this takes time away from direct work with clients and contributes to the long waitlists and limited availability of experienced providers. No doubt it also contributes to the lack of autism specific knowledge among mental health providers because the sector appears so confusing and daunting. So, a streamlining of the government services and associated funding models would likely help to alleviate those limitations and help ensure that the mental health of autistic people can be addressed in an appropriate and timely manner.

