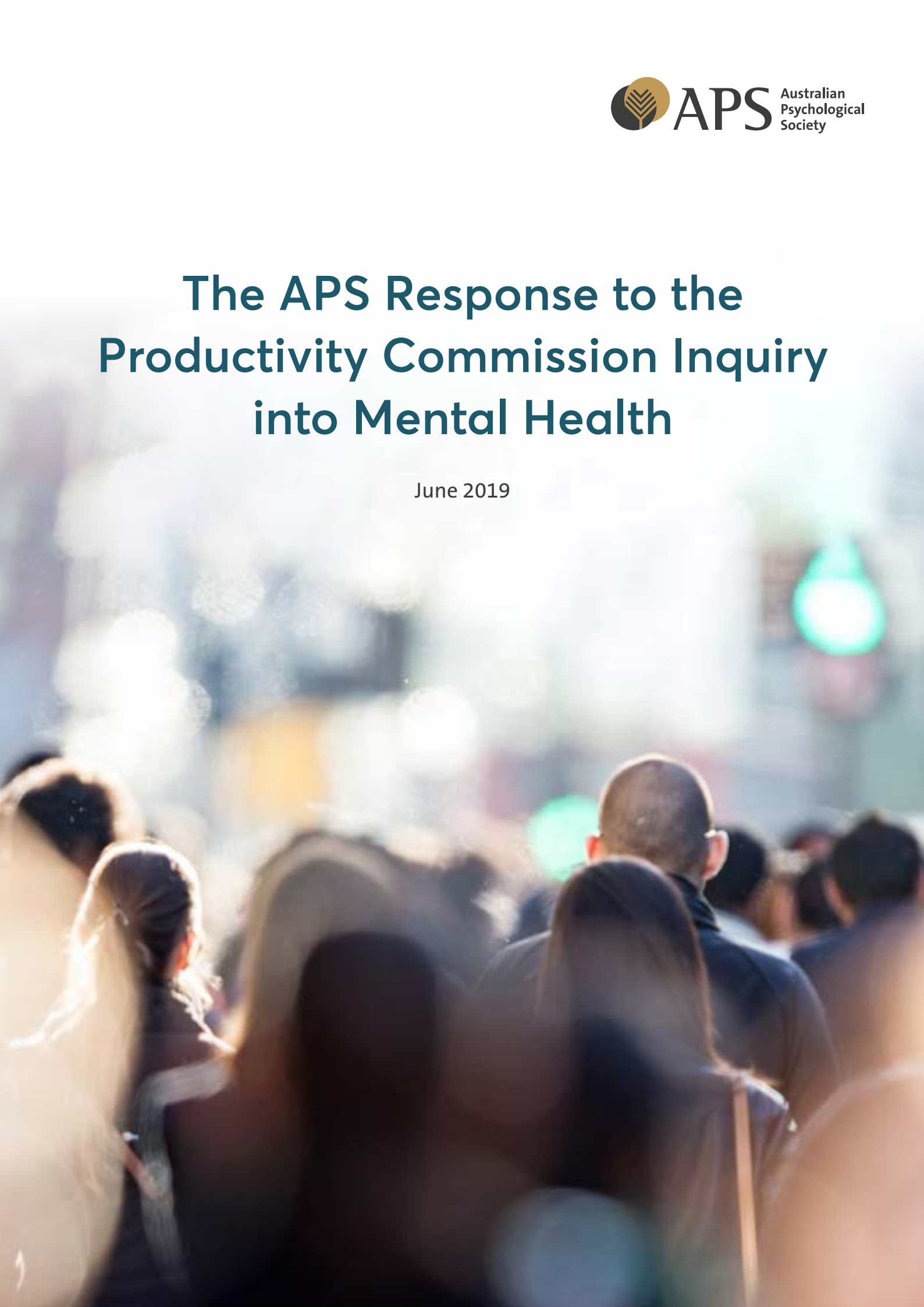
APS Australian Psychological Society

The APS Response to the Productivity Commission Inquiry into Mental Health

June 2019



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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future, for they hold the dreams of Indigenous Australia.

Contents

Executive summary

The Australian Psychological Society (APS) welcomes the opportunity provided by the Productivity Commission Inquiry into Mental Health to make a real difference to the lives of many Australians and to the broader productivity of the nation.

The social and economic burden

Despite significant reform over many years, too many Australians with mental health conditions are experiencing considerable distress, social exclusion, lost productivity and premature death. Forty-five per cent of Australians are estimated to experience a common mental disorder in their lifetime with the major burden across the lifespan on children and young people.

Mental and substance use disorders are the highest cause of disability and third highest cause of burden in Australia after cancer and cardiovascular diseases.

The direct and indirect cost to the economy of mental illness is in excess of 3.5 per cent of GDP. It cost the Australian workplace $12.8 billion in 2015–16, an average of $3,200 per employee with a mental illness, and up to $5,600 for employees with a severe mental health condition.

The economic burden of mental illness does not rest entirely with the mental health service delivery system; indirect costs extend beyond this sector and include welfare payments, costs to employers, homelessness services, and the corrections system.

There is a strong economic and humanitarian argument to address mental illness.

An essential, but not sufficient, strategy will be to invest in the system because despite increases in funding for mental health, the overall expenditure remains substantially below the estimated cost burden. Decades of under investment will take time to repair.

The mental health dividend

Preventing the onset of mental health disorders has the potential to directly reduce treatment needs as well as the indirect burden associated with mental health disorders. The biggest gains from investing in prevention are likely to accrue from focusing on children and young people and the workplace.

It is also vital Australia addresses its lack of affordable public housing both to prevent mental illness and to enable people experiencing mental illness to recover.

The provision of evidence-based treatment to all people experiencing mental health conditions is also essential to enable these individuals to lead a contributing life.

Psychological treatments are considered first line intervention for many mental health disorders, at least equivalent to medication in the short-term and better at preventing relapse and sometimes superior in the long-term. They are overwhelmingly preferred by consumers to medication. We know a lot about what 'works' but the system is not yet fully delivering it.

Psychological treatment needs to be more readily available through the state/territory health systems and to key groups including people in the criminal justice system, individuals with chronic physical disease, and people in residential aged care.

The Medicare Better Access initiative has significantly improved access to evidence-based psychological treatment in the community and could be further enhanced to meet the needs of more vulnerable groups. This submission includes a White Paper outlining the APS vision and blueprint for better mental health outcomes for all Australian through Medicare.

Governance and system issues

The Federal and State/Territory Governments share the responsibility for mental health services in Australia. This had led to inefficiencies in the system including the emergence of new gaps that need to be addressed.

Mental health workforce

Psychologists comprise the largest segment of the mental health workforce in Australia with over 29,000 practitioners. Governments need to make better use of this skilled workforce and ensure they are placed in the right location to deliver evidence-based treatment.

Maldistribution of the mental health workforce, especially between urban and rural Australia, continues to be unresolved. Investment in developing a rural psychology pipeline and incentives for rural practice could address this issue.

Research and evaluation

Addressing the challenge of mental illness requires greater investment in mental health research and evaluation that is focused on the outcomes of service delivery models, programs and individual client care.

Recommendations

The Productivity Commission has the opportunity to set the vision for Australia to become the leader in preventing and addressing mental health conditions and provide a detailed pathway to achieve that vision. Australia has a strong base from which to commence this work.

The APS make the following recommendations to the Productivity Commission. It is recommended that priority be given to prevention efforts, particularly with children and young people, to ensuring all Australians can access evidence based psychological treatment through Medicare and the state/territory mental health systems, to addressing the gaps between services funded by the Federal Government and state/territory governments, and to workforce issues.

Recommendation 1: The Productivity Commission recommend Government build on and develop a robust approach to providing psychology services in Australian schools through:

(i) Developing a national benchmark (number of school-based psychologists to student ratio) that aligns with international best practice to ensure all children and young people in Australia, regardless of where they are schooled, have access to mental health prevention, early intervention, essential assessments and treatment services that are fully integrated within the educational environment

(ii) Developing a set of national standards for school-based psychology services that includes minimum qualifications of providers and expectations of services

(iii) Implementing incentive packages to attract psychologists to rural and remote schools

(iv) Ensuring the collection of appropriate data to assess the effectiveness of school-based mental health prevention and intervention programs.

Recommendation 2: The Productivity Commission recommend Government improve access to evidence-based treatment of young people displaying oppositional and conduct disordered behaviours (including parenting and behaviour management training programs) to prevent young people with mental illness from entering the criminal justice system and improve the wellbeing of families.

Recommendation 3: The Productivity Commission recommend Government implement safe and evidence-based strategies about what fosters good workplace-related mental health by reforming the regulatory approaches to mental health at work so that regulators are sufficiently resourced to engage with industry and monitor and enforce legislative requirements. The regulatory system needs to act as an incentive to drive change in organisational culture.

Recommendation 4: The Productivity Commission recommend Governments overhaul workers' compensation schemes to enhance outcomes for workers with a psychological injury by reviewing workers' compensation legislation and policy to improve the timeliness and quality of the claims management process to align with best practice.

Recommendation 5: The Productivity Commission recommend Government explore opportunities for small to medium businesses to have affordable access to organisational psychologists to develop and oversee the design and implementation of tailored and positive psychological strategies to boost wellbeing, performance and productivity.

Recommendation 6: The Productivity Commission recommend Government increase the delivery of psychological treatments available to people attending public mental health services by:

(i) Implementing policy levers though Commonwealth-State/Territory funding agreements to ensure services are delivering evidence-based psychological interventions

(ii) Supporting service delivery organisations to achieve cultural and structural change though Commonwealth-State/Territory funding agreements.

Recommendation 7: The Productivity Commission recommend Government adequately resource public mental health services by increasing funding to services and ensuring funds are quarantined to prevent cost shifting and revenue siphoning so there is an adequate psychology workforce to deliver evidence-based treatment to clients.

Recommendation 8: The Productivity Commission recommend Government:

(i) Support the psychology profession to identify competencies in relation to e-mental health to be achieved during their training and developing ethico-legal guidance materials

(ii) Ensure the completion of the Digital Mental Health Services Certification process currently being managed by the Australian Commission on Safety and Quality in Health Care

(ii) Consult with the profession and consumer advocates about the roles and contribution of psychologists to the dissemination and uptake of e-mental health tools and appropriate forms of remuneration.

Recommendation 9: The Productivity Commission recommend Government:

(i) Support hospitals to integrate mental health professionals, especially health psychologists, into departments where consumers with chronic physical illness regularly receive care

(ii) Unlink the psychology items from the allocation of five sessions per year under the Chronic Disease Management Medicare items sessions to enable the delivery of an evidence-based psychological intervention for people with chronic illness at risk of mental illness.

Recommendation 10: The Productivity Commission recommend Government rigorously evaluate the various service models identified by Primary Health Networks for the delivery of psychological services to residential aged care facilities (RACFs) to ensure that each Primary Health Network provides an adequate level of service delivery to meet consumer needs across their region. This approach to funding and service delivery may need to be revised depending on the results of the evaluation.

Recommendation 11: The Productivity Commission recommend Governments address the high rate of mental illness among people within the criminal justice system by:

(i) Making regular screening for mental health disorders mandatory for all people involved in any aspect of the criminal justice system

(ii) Making diversionary approaches available to all Australians supported by the provision of access to psychologists

(iii) Providing access to evidence-based psychological treatment for people incarcerated in the criminal justice system delivered by psychologists

(iv) Building the capacity of the forensic psychology workforce by incentivising forensic training and supporting agencies to provide placements.

Recommendation 12: The Productivity Commission recommend that Government reviews the private health insurance legislation to support community-centric evidence-based psychological treatment and remove the incentives for hospitalisation over community-centric treatment.

Recommendation 13: The Productivity Commission recommend Government increase funding to develop postvention support services, including outreach, following an emergency department presentation. These services must be staffed by psychologists.

Recommendation 14: The Productivity Commission recommend to Government that they address the lack of safe and secure housing for people with or at risk of mental illness by:

(i) Increasing the availability of suitable safe, emergency accommodation and secure, affordable public housing

(ii) Funding a national roll out of the Housing First initiative including psychological support as an integral component to assist people to obtain and maintain housing.

Recommendation 15: The Productivity Commission recommend Government review the Medicare legislation and associated compliance mechanisms to prevent cost shifting to Better Access so that it is able to deliver on what it was intended to do.

Recommendation 16: The Productivity Commission recommend Government ensure the security of psychosocial support services for people with mental illness by:

(i) Conducting an independent evaluation of the effectiveness of the National Disability Scheme (NDIS) to ascertain if it is fit-for-purpose in meeting the needs of all people with a psychosocial disability

(ii) Responding to the recommendations in the independent evaluation to ensure there are sufficient and appropriate psychosocial support services to meet the identified need.

Recommendation 17: The Productivity Commission recommend to Government that the gap between state/territory mental health services and primary mental health care be minimised by:

(i) Implementing psychology outpatient clinics in the public sector to support people discharged from specialist public mental health services prior to transitioning to primary mental health care services

(ii) Incentivising public sector-private psychologist partnerships for the treatment of borderline personality disorder.

Recommendation 18: The Productivity Commission recommend Government:

(i) Work with key Australian mental health researchers and the sector to establish priorities for mental health research in Australia and ensure regular ongoing funding rounds

(ii) Implement an easy-to-use, secure online point-of-service data collection system that could support the delivery and evaluation of psychological services under Medicare

(iii) Implement robust outcome data collection and feedback loops to monitor the implementation of stepped care

(iv) Ensure that Commonwealth mental health (and related) program funding includes (and quarantines) at least two per cent of total program costs to enable regular program evaluation that focuses on outcomes

(v) Use funding levers to shift the public mental health sector to an outcome-based approach to evaluation.

Recommendation 19: The Productivity Commission recommend Government make better use of the psychology workforce, the largest and most diverse mental health workforce in Australia by:

(i) Allowing treating psychologists visiting rights to provide treatment to their clients in psychiatric in-patient facilities

(ii) Investigating the value of introducing prescribing rights for psychologists

(iii) Implementing a rural pipeline approach to growing the rural psychology workforce that includes mandated places for rural students in psychology programs, funded rural placements, scholarships, supported rural internships and registrar opportunities

(iv) Implementing Higher Education Contribution Scheme exemptions for rural and remote practice

(v) Implementing financial incentives for rural psychologists who work under Medicare.

Recommendations relating to the APS response to the MBS Review of Better Access

The APS make the following recommendations to the Productivity Commission with regards to the current MBS Review and focus specifically on the vision for psychological services within Medicare (Appendix "A").

Recommendation One: Amend the Better Access Framework.

- Separate the psychology workforce from medical and other allied health professionals who provide mental health services as an adjunct to their profession
- Three levels of mental health interventions are available to clients as follows:
  a. Supportive Therapy provided by medical and other allied health professionals
  b. Psychological Therapy provided by all psychologists
  c. Advanced Psychological Therapy provided by psychologists with an Area of Practice Endorsement and who are working within their area of advanced competency, as determined by the Psychology Board of Australia
- Clients being treated by provisionally registered psychologists are eligible to receive a rebate.

Recommendation Two: Individual psychological services.

- Increase the number of available sessions for clients who require more intensive psychological services to stabilise their mental health, prevent deterioration and relapse and to allow the delivery of evidence-based interventions that support recovery
- Clients are stepped through levels of psychological care according to the: - nature of the mental health disorder - expertise of the psychologist - needs of the client (number of sessions required to achieve effective clinical outcomes; up to 20 sessions for low intensity treatment needs and up to 40 for clients with specific diagnoses and high intensity treatment needs)
- Regularly measure and review outcomes to determine treatment progress and to ensure responsiveness is embedded in the delivery of psychological services within Medicare
- Clients can be referred to a psychologist by any medical practitioner registered with the Australian Health Practitioners Regulation Agency
- Collaborative care is supported by strengthened reporting, enhanced referrals, integrating outcome measurement, and by implementing criteria to clarify clinical care pathways.

Recommendation Three: Family and couples therapy.
Introduce items for family and couple therapy where one or more members of the family/couple are experiencing mental health problems.

Recommendation Four: Amend group therapy items.
Amend group therapy items within Medicare by:

- Reducing the minimum participant numbers and increasing the maximum number of participants
- Enabling group therapy for kinship groups
- Enabling two clinicians to facilitate a group therapy program
- Increasing the range of timed items to allow for flexible group therapy and longer sessions.

Recommendation Five: Evidence-based interventions for parents and carers of children with a mental health disorder.
Introduce an item for the specific purpose of providing evidence-based interventions between health professionals and family, parents, carers and/or support people of children or adolescents with a mental health disorder.

Recommendation Six: Developmental neurocognitive assessments.
Introduce items that enable clients to access comprehensive developmental neurocognitive assessments to accurately delineate the impact of cognitive, behavioural and psychosocial issues that are associated with neurodevelopmental problems and to improve diagnostic accuracy and client outcomes, especially among children.

Recommendation Seven: Standardised evaluation and measurement for the delivery of psychological services.

- Invest in the collection of data, including outcome data, within the Better Access initiative
- Introduce standardised evaluation into the Medicare Benefits Scheme and that the APS be consulted and work with the Government to assist with the development of appropriate tools.

Recommendation Eight: Neuropsychological assessment to differentiate dementia from mental health disorders.
Introduce items to allow a comprehensive neuropsychological assessment for people with potential neurocognitive problems/dementia who are at increased risk of a mental health disorder, or who may have a co-occurring mental health condition.

Recommendation Nine: Consultation with family, parents, carers and support people.
Introduce an item for the specific purpose of enabling consultation between health professionals and family, parents, carers and/or support people.

Recommendation Ten: Mental health case conferencing with other health professionals.
Introduce items to enable psychologists to be included in case conferencing with other health professionals involved in the client's care.

Recommendation Eleven: e-Mental health assessments.
Introduce two items for clients with low intensity treatment needs to assess suitability for and facilitate access to e-mental health programs and to assess the client's response to these intervention programs.

Recommendation Twelve: Initial intake, assessment and report item.
Introduce items to conduct an initial assessment of a client presenting for treatment with a psychologist. This includes preparing a report for the referring practitioner to enhance collaborative care arrangements.

Recommendation Thirteen: Universal access to Interpreters.
Expand access to free interpreter services currently available for medical consultations within Medicare to psychological services delivered under Medicare.

Recommendation Fourteen: Amend telehealth items.
Expand access to telehealth for clients in metropolitan areas who face barriers to attending face-to-face psychological therapy and removing barriers to access for people in regional, rural and remote areas of Australia.

Recommendation Fifteen: Enhance access to psychological services for people in regional, rural and remote Australia.
Introduce financial incentives, such as rural loadings, to improve the financial viability of providing psychological services to people who live in regional, rural and remote areas of Australia.

Recommendation Sixteen: Independent mental health assessment, opinion and reporting.
Introduce items to refer clients for an assessment, expert opinion and report to psychologists with an Area of Practice Endorsement in clinical or counselling psychology.

Recommendation Seventeen: Scheduled fees.

- The Government continue with the current two-level rebate system within Medicare.
- Extend the higher rebate to all psychologists who hold an Area of Practice Endorsement. Increase the scheduled fees for psychological therapy services.
- Increase the scheduled fees for assessment items to 1.5 times the scheduled fee for individual treatment.

About the APS

The APS is the largest national professional organisation for psychologists, with over 24,000 members across Australia. It seeks to help people achieve positive change so they can confidently contribute their best to the community.

Psychologists are experts in human behaviour and use evidence-based psychological interventions to prevent people from becoming unwell, improve human performance and productivity in the workplace, and assist people to overcome mental and physical illness and optimise their health and functioning in the community. Economic evaluations highlight the cost-effectiveness of psychological interventions to prevent people from becoming mentally unwell, and to treat a range of mental health symptoms and disorders when they do occur.

The APS has a long history of working collaboratively with the Australian Government and other agencies to help address major social, emotional and health issues for local communities and ensuring health care is equitable and accessible to all members of the Australian community.

The highly engaged membership of the APS was extensively consulted to develop this response to the Productivity Commission Inquiry into Mental Health. Our Members have a broad range of expertise in human behaviour that enables them to undertake assessments and deliver evidence-based psychological interventions within the mental health service delivery sector but also more broadly in schools, correctional facilities, workplaces, welfare agencies, and sporting organisations. They are familiar with the widespread impact of mental illness on individuals, their families, friends and carers, as well as the broader community and future generations. APS members also understand the range of individual, work, social, community and economic factors that contribute to poor mental health outcomes. They have a passionate commitment to system-level improvements that will help prevent mental illness from developing and also enable people experiencing mental illness to lead a fulfilling and productive life.

1. Introduction

Across Australia, the demand for mental health services and psychosocial support far exceeds supply and the burgeoning economic, social and individual burden of mental illness has been extensively documented. Few people remain untouched by mental illness – most are aware of the devastating impact of mental illness on individuals and their families as they struggle to access appropriate treatment and care.

The Productivity Inquiry into Mental Health represents a critical window of opportunity to address this situation. An essential, but not sufficient, strategy will be to invest in the system because despite increases in funding for mental health, the overall expenditure remains substantially below the estimated cost burden.[1,2] Decades of under investment will take time to repair.

In order to achieve real improvement in mental health and reduce the social and economic burden, financial investment will be insufficient without improving access to treatments that work. The availability of evidence-based treatments does not ensure their translation into practice. We know a lot about what 'works'[3] but the system is not yet fully delivering it. System and organisational barriers prevent consumers accessing services, and gaps in the continuum of care mean that some individuals are not receiving the treatment they require. We need to make better use of the skilled workforce available to deliver mental health care and to ensure the appropriately skilled professionals are placed in the right location to deliver the right care. Doing this will require a whole of government approach predicated on the knowledge that the current burden of mental illness cannot be tackled by the mental health system alone.

The long term impact on productivity of Australia continuing to ignore the upstream causes of much of the burden of mental illness is of great concern. Solutions will require *all governments* to work together to resolve the burden of mental illness on the community.

The Productivity Commission has been granted a real opportunity to make a difference to the lives of Australians both today and into the future. The APS is hopeful the work of the Commission can bring this to fruition.

1.1 Approach to this submission

On 23 November 2018, the Australian Government released the terms of reference for the Productivity Commission's Inquiry into Mental Health. The Commission has extended the date for the APS submission to 3 June 2019.

The APS has been able to undertake extensive consultation in relation to both this response and the review of the MBS Better Access items. Better Access is a key component of the Australian mental health system and the stepped care approach, undertaking this work contemporaneously has ensured that the APS can provide a comprehensive solution.

The APS believes mental health is a crucial issue for Australia and that psychological knowledge and psychologists are vital in reducing the many costly impacts that poor mental health can create. The psychology sector is in a unique position to provide 'inside' views on the current state of Australia's health system in supporting positive mental health outcomes. As such, the APS submission highlights a number of key issues gathered through member consultation.

While there are many areas where the APS could provide comment, this response focuses on the areas that, on the basis of our membership consultation and examination of the literature, we believe are most crucial to improving mental health outcomes. While comment on other mental health areas are included where we can provide informed perspectives, we have predominantly concentrated on the contribution of psychological knowledge and services to improving mental health outcomes and where policy settings can best ensure maximum value.

1.2 Mental health

According to the World Health Organisation,[4] mental health is "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" and is an integral and essential component of health. Many Aboriginal and Torres Strait Islander people prefer the term social and emotional wellbeing as it takes a holistic view of mental health and differs in important ways to Western concepts of mental health. The term social and emotional wellbeing is used by many Aboriginal and Torres Strait Islander people to describe the social, emotional, spiritual, and cultural wellbeing of a person. This term recognises connection to land, culture, spirituality, family, and community are important to people and can impact on their wellbeing. It also recognises that a person's social and emotional wellbeing is influenced by policies and past events.[5]

Mental health disorders comprise a broad range of problems, with different symptoms, severity and duration, with some being episodic in nature. They are generally characterised by the combination of abnormal thoughts, emotions, behaviour and relationships with others, and can have a significant impact on individuals, their families and society as a whole. Common or high prevalence mental health disorders include anxiety, depression and substance use disorders; low prevalence disorders include psychotic illnesses and severe personality disorders.

In 2017-18, 20.1 per cent of Australians had a mental or behavioural disorder.[6] Forty-five per cent of Australians are estimated to experience a common mental disorder in their lifetime, and each year, one in five adults (aged 16-85) are projected to experience a mental disorder.[7] Survey data collected in 2013-14 suggests that one in seven young people aged 4–17

have one or more mental health disorders; the most common being attention deficit/hyperactivity disorder, followed by anxiety disorders, major depressive disorder and conduct disorder.[8]

The severity of mental health disorders varies and can fluctuate over time. The Australian Institute of Health and Welfare (AIHW)[9] states that two to three per cent of the population have severe mental health disorders (based on diagnosis, intensity and duration of symptoms, and degree of disability). An additional four to six percent of Australians have moderate disorders, and a further nine to 12 per cent have a mild disorder.

1.3 The social and economic cost of mental health

Economic costs

The economic cost of serious mental illness in Australia in 2014 was estimated to be $56.7 billion (3.5% of GDP), due at least in part to the higher rates of premature death, physical ill-health, side effects of medication and chronic disease among this group.[10] The economic burden associated with neurological, mental health and substance use disorders combined is in excess of $74 billion.[11] For young men alone, the cost of mental illness in Australia in 2012 was estimated to be $3.27 billion, a burden that included justice system costs.[12] Mental illness cost the Australian workplace $12.8 billion in 2015–16, an average of $3,200 per employee with a mental illness, and up to $5,600 for employees with a severe mental health condition.[13]

Expenditure on mental health service delivery is shared between the Australian Government (approximately 33%), the State and Territory Governments (approximately 62%), and private health insurers (approximately 6%) and these proportions have been relatively stable over time.[14] This expenditure has been slowly increasing.[15] During 2016–17, $9.1 billion ($375 per person) was spent on mental health-related services in Australia, representing 7.4% of the total Government expenditure on health. Between 2012 and 2017, it is estimated that funding from the Australian Government for mental health-related services (adjusted for inflation) increased by an average annual rate of 0.8%, while funding from state and territory Governments increased by an average annual rate of 3.1%. Despite the small increase in funding over and above inflation, the overall investment in mental health service delivery is disproportionate to the estimated cost burden.

The cost of mental illness to the Australian community is considerable but the burden does not rest entirely with the mental health service delivery system. It is the indirect costs associated with the social burden of mental illness that contribute significantly to this burden and have to be met from outside the mental health system. These costs include welfare payments, lost educational opportunities and reduced workforce participation among people with mental illness and the roll on effects on homelessness services, as well as costs associated with physical ill-health, suicide and incarceration.

The social burden of mental health disorders

The burden of mental illness to the Australian community is substantial, particularly for young people.[16] The burden is felt not just by individuals experiencing mental illness but by their families, carers, employers, and the broader community. In 2017, the Australian population lost approximately 670,000 years of healthy life as a result of mental and substance use disorders, making these disorders the highest cause of disability and third highest (12.1%) cause of burden in Australia after cancer and cardiovascular diseases.[17,18] Many issues confronting Australia are likely to increase the future burden of mental illness. These include increasing inequality, the nature of our ageing and growing population, the changing nature of employment, and the increasing incidence of natural disasters.[ii]

The burden from mental and substance use disorders is mostly non-fatal. Between one-quarter to one-half (28–47%) of the non-fatal health loss in people aged one to 49 is accounted for by mental and substance use disorders, with the burden greatest for ages 25–29.[19] Anxiety and depressive disorders are among the leading causes of health loss in both males and females, although anxiety is higher for women. Schizophrenia and drug use disorders ranked within the leading 20 causes in males, whereas bipolar affective disorder and eating disorders ranked in the top 20 for females.

The non-fatal burden of mental health is experienced in multiple ways. Individuals with a mental health disorder experience considerable distress related to their symptoms but many also struggle with feeling they lack choice, a sense of control and belonging, and experience a lack of energy, motivation and hope for the future.[20] Mental illness has wide-reaching effects on people's education, employment, physical health, parenting and relationships. For children and young people, mental illness can seriously disrupt their ability to reach full potential.[21] It can have a ripple effect among friends and families, creating distress and conflict and often dramatically changes lives.

The potentially negative impact of parental mental illness on children and young people is also increasingly being documented. Up to one in five young people live in families in which a parent has a mental illness; many undertake caring responsibilities that interfere with their social functioning, school attendance and academic attainment.[22]

The fatal burden of mental health disorders is often associated with high suicide rates. Suicide is associated with some mental health disorders but is not confined solely to people with poor mental health. The National Survey of Mental Health and

Wellbeing 2007 estimated that over 90 per cent of persons who attempted suicide in the previous 12 months had experienced a mental health disorder in the same time period.[23] The fatal burden associated with mental health and substance use disorders for males is more than twice the rate for females.[24]

Indirect costs of mental illness include loss in economic activity caused by reduced participation in the workforce, and absenteeism and presenteeism by the person with the mental illness and their family or carers. People with mental health disorders are three times more likely to be unemployed than people without mental health problems, are overrepresented in benefit schemes, and when they do hold down a job, struggle with more and longer periods of sickness, absence and underperformance at work.[25]

Mental health disorders are associated with social disadvantage and poverty, with the relationship between poverty and mental illness assumed to be bi-directional. It is estimated that around 20 per cent of people with a moderate mental health disorder and around 36 per cent with a severe or high intensity disorder are living in poverty, raising the potential for intergenerational transmission of both poverty and mental illness.[26] The co-occurrence of mental illness and poverty creates further cost burden to government through the need for homelessness support services and the Disability Support Pension.

1.4 Government response to mental health burden

The Australian Government has responded to the growing burden of mental health with a number of major reforms, particularly the provision of universal access to evidence-based psychological treatment in the community and expanded access to a range of services for young people aged 12-25 years.

Better Access has resulted in a significant increase in the proportion of Australians with mental health disorders who receive treatment.[27] By 2010, the initiative had improved treatment rates for people with mental health disorders from 35 to 46 per cent. The independent evaluation of Better Access showed positive client outcomes.[28] The items are being used by new consumers demonstrating the increased accessibility and affordability offered by the initiative, and Better Access provides cost-effective treatment that is cheaper than expected at an average of $753.00 per person.[29,30]

Better Access is also the major mechanism through which new initiatives such as *headspace* have been able to provide psychological treatment to young people. *headspace* has improved access to services for vulnerable and disadvantaged youth and resulted in modest but positive client outcomes.[31]

Recent claims suggest Better Access is not producing sufficient gains in mental health at a population level.[32,33] However, the claim that Better Access has not reduced rates of psychological distress and suicide has been strongly challenged on methodological and conceptual grounds. Better Access is unlikely to directly influence suicide rates because they are affected by a range of factors in addition to mental illness,[34,45] Moreover, the indices of psychological distress reported by Jorm as not being influenced by Better Access, actually show some evidence of improvement since its introduction.[36] Others have argued that Better Access is not a population level intervention so should not be expected to have population-level outcomes; the effectiveness of Better Access can only be assessed by examining outcomes for the people who use it.[37]

Rather than reflecting on the failure of Better Access, the high levels of mental illness and suicide in the Australian community potentially say more about the lack of investment by governments in the full spectrum of services for people with mental illness, particularly prevention. The prevention of mental illness is not mentioned in the current National Mental Health and Suicide Prevention Plan.[38] The inadequate attention to the prevention of mental illness, despite evidence of its cost effectiveness,[39,40,41,42] is likely to be one of the significant factors contributing to the failure to reduce the rate of mental health disorders in Australia.[43,44,45]

It is vital that the Productivity Commission seeks to build on the gains already made in the primary mental health care sector by landmark initiatives such as Better Access. Large numbers of children, young people and adults are now able to access first line, evidence-based treatment delivered by the provider of their choice in the community – many of whom would never have been able to do so prior to Better Access. As with all programs, Better Access can be enhanced to even more effectively meet individual needs, but the community will not be served by significant disruption to a mental health system that is already confusing to consumers.

2. Mental health dividend

The economic case for mental health reform is built upon the premise that individuals with good mental health are likely to be productively employed to the benefit of the individual, their family and the broader community.[46] Improving mental health can have substantial gains. A one standard deviation improvement in mental health increases the probability of engagement in the workplace by thirty percentage points, and even more so for females and older people.[47] The importance of wellbeing is such that the New Zealand (NZ) Government recently became the first western country to adopt the wellbeing of its people as an indicator of success rather than economic measures. Among the measures in the new NZ *Living Standards* Framework is mental health.[48]

In a fiscally cautious environment, policy makers must prioritise mental health reform that delivers economic gains for government as well as improving the lives of individuals at risk of or already experiencing mental illness. Preventing the onset of mental health disorders has the potential to directly reduce treatment needs as well as the indirect burden associated with mental health disorders.[49] Since failure to identify and provide effective treatment to people with mental health conditions makes it difficult for these individuals to lead a contributing life,[50] it is also vital that the service model be shifted to better identify people with mental health issues and deliver evidence-based interventions, particularly for people who currently 'fall through the gaps'.

This section outlines a number of systemic reforms and opportunities for Government to accrue positive benefits from investing in mental health reform while at the same time improving outcomes for individuals, families and the broader community. Keeping in mind that current funding for mental health is disproportionate to the estimated cost burden, it is likely these reforms will require additional investment in the sector in order to achieve long term economic gain.

The focus of these recommendations is a population level, whole-of-government response that draws on science-based strategies underpinned by a commitment to ongoing program evaluation. The recommendations emphasise children and young people but consider people across the whole of the lifespan and address the intersection of the mental health system with other human service systems including education, health, housing, welfare, criminal justice and aged care as well as the workplace.

2.1 Prevention and early intervention

Children and young people

In Australia, almost 10 per cent of children aged six to seven show signs of social-emotional stress and mental health disorders affect one in seven students.[51,52] Given the long term implications of mental illness for children and young people, prevention, early intervention and treatment offer the best way to reduce individual and family distress and reduce the direct and indirect costs to the community.

The identification of a number of risk factors for mental illness in children and young people means this age cohort is likely to significantly benefit from an enhanced approach to prevention and early intervention. Risk factors for mental illness that emerge in childhood and early adulthood include exposure to trauma, child abuse and neglect, family violence, developmental problems, cognitive impairment, low socioeconomic status and poverty.[53,54,55]

The current Australian Government investment in prevention and early intervention is the school-based *Be You*, a program that seeks to build resilience skills from early childhood to secondary school.[56] Be You is an opt-in program (replacing *KidsMatter* and *MindMatters*) that focuses on capacity building the staff within preschools and schools so they can implement mental health promotion, prevention and early intervention, and suicide prevention. It includes information toolkits and an online platform housing a suite of interactive evidence-based resources for educators supported by professional learning and facilitated support. It does not provide resources that target parents and families nor resources to support the development of partnerships between education settings and mental health professionals. *Be You* is a relatively new initiative and is yet to be evaluated. However, *Be You* acknowledge that the school mental health prevention space is crowded and often overwhelming for educators.[57]

There is a growing evidence base that supports a more comprehensive approach to the prevention of mental illness in children and young people that should be used to build upon *Be You*. The school environment is essential but educators need to be supported to work collaboratively with psychologists within the school environment in order to better identify and target vulnerable young people and drive early intervention with students who have emerging mental health conditions. School-based strategies must be complemented by better support for parents and a focus on reducing the adverse childhood experiences that are strongly related to subsequent mental illness.

Prevention and early intervention in schools

There is much to be gained by improving the mental health of children and young people so that they can achieve their academic and future life potential. For example, the analysis of educational outcomes from the *Young Minds Matter: the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing* highlighted the strength of the relationship between mental health and poor school connectedness, poor academic outcomes and academic trajectories.[58] The findings suggest if effective interventions were implemented to reduce

the prevalence of mental illness among students there would be significant improvements in school attendance, positive attitudes to schooling and academic performance in Australia.

The UK has acknowledged the vital preventive role played by schools. A collaborative effort between the Department of Health (UK) and the Department for Education (UK), has established a new model for supporting the mental health of young people. This collaboration is based on two key pillars: earlier intervention and prevention in the mental health of young people, and investment in the role played by schools in student mental health and wellbeing.[59] The model depends on all children and young people having access to high quality mental health support linked to their school. The reforms involve:

- Incentivising every school to identify a designate senior mental health leader to deliver whole of school approaches to promoting better mental health for students as well as staff
- Funding mental health teams managed by schools to provide extra capacity for early intervention.

The model has been trialed in a pilot program and independently evaluated. The evaluation showed that the model:

- Strengthened communication and joint working arrangements between schools and external mental health services and other experts that may be required (e.g., when neurocognitive or medical problems are contributing)
- Improved understanding of referral routes
- Improved school-level knowledge and understanding of mental health
- Improved the timeliness and appropriateness of referrals.[60]

The report on the *Australian Child and Adolescent Survey of Mental Health and Wellbeing* made recommendations that align with the approach being implemented in the UK in terms of building capacity within schools and enhancing the role of trained mental health professionals such as psychologists employed in schools.[61] The report recommended there be a set of national standards developed for school-based mental health activity in Australia to:

- Specify minimum requirements for the school-based mental health workforce
- Ensure there is an emphasis on preventative measures in school programs
- Emphasise the strengthening of connections between school-based practices and community agencies.

National standards that address the school-based mental health workforce are required in order to improve the currently highly variable skill base of this workforce. For example, Queensland public schools employ 'guidance officers' most of whom are not psychologists and have minimal mental health training.

There is also no national standard or benchmark for the required number of psychologists to students in Australian schools. The APS recommends a ratio of one psychologist to 500 students, in line with the 2010 recommendation of the NSW Coroner in response to a student suicide at school.[62] The US recommends a ratio of no more than 1,000 students per psychologist, in general, and no more than 500 to 700 students per psychologist when more comprehensive and preventive services are being provided, for example, in the most disadvantaged schools.[63]

Identifying the actual student to psychologist ratio in Australia is challenging. However, based on 2011 census data, there were 3,076 psychologists working in school settings[64] and there were 3,541,809 students attending school in Australia (Government, Catholic and Independent schools).[65] On this basis, a considered estimate would be one psychologist to 1,151 students, although this ratio is likely to vary significantly between jurisdictions and types of schools. This estimated figure is more than double the ratio recommended by the NSW Coroner and international best practice.

The poor ratio of psychologists to students in many Australian schools has meant a reduced focus on prevention. The *2012 APS National Survey of Psychologists in School* was the largest survey of psychologists working in schools undertaken in Australia.[66] It found that psychologists mainly provide individual assessments and due to heavy workloads and time constraints their work is often reactive rather than proactive. Similarly, the demand for assessment services within schools (often linked to funding) tends to override the development of systemic and preventative practices.[67]

With limited input from psychologists, it is difficult for a school to maintain a focus on prevention activities. Whole of school programs such as *Be You*, *School Wide Positive Support*, *Positive Psychology* and other social and emotional learning programs are opt-in programs. Programs are often overseen by teaching staff and begun enthusiastically but not maintained with fidelity during the day-to-day activity of schools.[68] Increasing the workforce of psychologists working in schools to best practice level would enable such prevention activities to be prioritised and supported within the school environment and for the missing link in the *Be You* program, connection with the mental health system, to be addressed.

Educational and developmental psychologist working in schools in rural Australia

From 2009 to 2017, I was the only psychologist in our network of 18 small rural schools spread over an area 10,000 square kilometres for a total of 3,000 students. Early last year we recruited a provisional psychologist who now works alongside me. I understand today we are being given another five schools to add to our client base. I am swamped by teachers needing consultation over student behaviour problems and the demand for formal assessment is so great that I don't get a chance to do much treatment these days or run prevention programs.

David, educational and developmental psychologist, 2019

The inadequate employment of psychologists in schools has led schools and governments to turn to external private providers to deliver services to students under Medicare. Access to external mental health providers is important to extend options for treatment, but should not come at the expense of employed school-based services. Better Access is not designed to work as a stand-alone service delivery option for schools. To be eligible for a psychological service through Better Access, a child or young person must have a diagnosis of a mental health disorder. Transient mental health issues, often associated with developmental periods, learning difficulties and life stressors are *not* mental health disorders. Prevention activities for children at risk (for example, of disengaging from school) are also not able to be delivered under Medicare unless the young person has a diagnosed mental illness.

The use of external services has the potential to erode the imperative for education departments and schools to employ psychologists to work at a whole of school level to prevent mental health disorders and work with young people at high risk of mental illness. These services are an important adjunct to school-based services in terms of their capacity to provide additional treatment options. However, they are unlikely to be able to assist a child or young person to re-engage with their education because external providers are not able to work collaboratively with teachers to meet students' holistic needs in relation to their learning. It is vital governments raise the number of psychologists in schools to best practice level.

Psychologist working in a school in Western NSW

Alejandra is a 14 year old girl attending a high school in regional NSW. Over six months, her teachers noticed that her grades were slipping and her best friend said to one of Alejandra's teachers that she was worried about her not eating at school, increasing teariness, and she was saying some "scary things". The teachers came to me to ask me what to do. I asked Alejandra to see me and at first she was very reluctant but eventually over a couple of sessions described to me what had been happening for her. My assessment was that Alejandra was experiencing a Major Depressive Disorder. With Alejandra's permission, I met with her parents who were unaware of what had been happening at school and although they noticed Alejandra had been spending more time in her room and sometimes picking at her food, they had no idea of the extent of her distress.

I was able to provide treatment to Alejandra and with her permission, liaise with her teachers so they could support her in the classroom.

Alejandra's parents were upset they were unaware of Alejandra's declining mental state but extremely grateful for the school to have identified the changes in Alejandra early and to have assisted them to obtain prompt treatment.

Henry, psychologist, 2019

Recommendation 1: The Productivity Commission recommend Government build on and develop a robust approach to providing psychology services in Australian schools through:

(i) Developing a national benchmark (number of school-based psychologists to student ratio) that aligns with international best practice to ensure all children and young people in Australia, regardless of where they are schooled, have access to mental health prevention, early intervention, essential assessments and treatment services that are fully integrated within the educational environment

(ii) Developing a set of national standards for school-based psychology services that includes minimum qualifications of providers and expectations of services

(iii) Implementing incentive packages to attract psychologists to rural and remote schools

(iv) Ensuring the collection of appropriate data to assess the effectiveness of school-based mental health prevention and intervention programs.

Prevention, early intervention and parenting

In addition to schools, parents and families must be included in policy efforts to address mental health concerns in children and young people. Disruptive behaviours typically occur as a result of problems with self-regulation and, in addition to conduct disorder, are often associated with attention deficit hyperactivity disorder and oppositional defiant disorder.[69] An area that should be of particular interest to the Productivity Commission is disruptive, impulsive and conduct problems among children because of the strong link to mental illness and the indirect burden incurred to the community through the juvenile detention and criminal justice systems. There is strong evidence that early intervention with the child and their parents can mitigate much of this burden.

Significant disruptive, impulsive and conduct problems are estimated to occur in 5-10 per cent of children aged 3-17 years.[70,71] The presence of persistent disruptive behaviours in childhood indicates problems with emotional and behavioural regulation and if left untreated and unaddressed are a common precursor to developing a mental health disorder in adulthood.[72] Moreover, disruptive behaviours sufficient to warrant a diagnosis of conduct disorder are estimated to have been present in 50 per cent of prisoners before age 18.[73] Evidence suggests the earlier onset of conduct problems among children is associated with a more severe and chronic course compared with onset during adolescence.[74]

The presentation of these problems among young children is an indication for early intervention with the child and their parents as it has been shown to interrupt the development of more serious behavioural and mental health disorders as the child develops.[75] For example, research has shown interventions for conduct disorder, implemented during early childhood, can produce significant recovery rates where these children no longer meet criteria for conduct disorder.[76] The most effective interventions have been found for children below age 13 years and where the intervention includes parent and/or carer interventions, such as group based behavioural and cognitive-behavioural interventions.[77]

Despite the potential economic gains from psychological interventions, they are not easily accessed by parents in Australia. Recommendations for improving access through the Better Access initiative are included in the White Paper (see Appendix "A"). However, access also needs to be more readily available through a wide range of agencies that are accessible to families, young people, and children particularly those under 13 years of age. This could be achieved by greater employment of psychologists in public sector early parenting centres and community health settings. These interventions will produce cost savings for the government by reducing the number of young people entering the criminal justice system, improving family wellbeing and mental health and increasing academic engagement.

The costs to society for individuals with childhood conduct disorder are ten times higher than for children without these behaviour problems.[78] Compared with their peers, these children are on average:

- Twice as likely to leave school with no qualification
- Four times more likely to become drug dependent
- Six times more likely to die before the age of 30
- 20 times more likely to end up in prison.

The lifetime costs of untreated conduct disorders are approximately $AUD 289,000 per person, and evidence suggests that the appropriate treatment of conduct disorders yields a return on investment of 34.1, when all downstream costs are included.[79]

Recommendation 2: The Productivity Commission recommend Government improve access to evidence-based treatment of young people displaying oppositional and conduct disordered behaviours (including parenting and behaviour management training programs) to prevent young people with mental illness from entering the criminal justice system and improve the wellbeing of families.

Prevention, early intervention and adverse childhood experiences

Certain types of adverse childhood experiences (ACEs), many of which occur within the family context, predict the development of a range of mental health conditions (e.g., depression, anxiety, substance misuse and posttraumatic stress disorder) and suicidality.[80,81] ACEs include child abuse and neglect, parental substance abuse and mental illness, intimate partner violence, parental separation, incarceration or death, and poverty. The negative impact of exposure to ACEs is cumulative and exposure to particular types of ACEs at critical developmental points in childhood and adolescence is predictive of specific mental health diagnoses.[82,83] In Australia, it has been estimated that for females, child maltreatment accounts for 23 per cent of the burden for depressive disorders, 31 per cent for anxiety disorders and 33 per cent for self-harm with similarly high proportions for males.[84] The experience of adverse events in childhood can also trigger mental health diagnoses during pregnancy including depression and posttraumatic stress disorder.[85]

Australia is lagging behind the US and other western countries in relation to responding to the evidence about ACEs. While evidence of the effectiveness of ACE-based approaches to prevention is still developing, there is promising international work seeking to minimise the harm associated with ACEs.

For example:

- An innovative model for low income families in the US utilises a trauma-informed approach to targeting both housing and education. Offering stable affordable rent, free after-school care, and a range of community events, the model has improved the academic performance of children and reduced crime rates.[86]
- A number of paediatric clinics in the US have commenced screening three-year-olds for ACEs and providing additional support to parents and/or carers, where required. The work is helping clinics to become more trauma-informed and has been well accepted by parents.[87]

The experience of adverse events in childhood can also trigger mental health diagnoses during pregnancy. Research in the US shows that pregnant women are happy to be screened for ACEs, particularly within a context of resilience and when psychological treatment can be provided to women who need further support.[88,89]

The link between ACEs and mental illness in adulthood may also have important implications for how Australia develops a stepped care approach to mental health service delivery. There is no robust evidence to help funding bodies and service delivery agencies determine the right mix of treatment and providers at each step or what criteria should be used to allocate consumers to a step.[90] Screening people for ACEs may offer an important tool to guide decision-making in stepped care. For example, someone presenting with depression or anxiety with a high ACEs score should not be offered a low intensity intervention; rather they are likely to do better with an approach that also addresses the childhood trauma.

As research efforts to identify the effectiveness of ACE-based approaches to the prevention of mental illness are in their infancy, the APS congratulates the Australian Government for launching the new Centre of Research Excellence in Childhood Adversity and Mental Health. The Centre will bring together researchers from a number of universities to investigate which adverse childhood experiences and the developmental stages at which they occur are most associated with depression, anxiety and suicidality and which interventions are most likely to be effective.

The workplace

Prevent mental illness at work

Schools and families are appropriate settings for the prevention of mental health for children and young people and the workplace is a key conduit for the prevention of mental illness in adults. On average, employment is associated with better mental health than unemployment.[91,92] However, work can also be associated with a range of mental health disorders. A number of core psychosocial job characteristics are harmful for workers' mental health including high job strain (i.e., a combination of high work demands/intensity concurrent with low autonomy at work), inadequate supervisor support, low job security, non-standard work schedules, long work hours and workplace bullying.[93,94]

Mental health problems are most likely to occur in workplaces and industry groups that are at high risk for exposure to psychosocial hazards. At risk populations include first responders such as teachers, train drivers, emergency department personnel, child protection and mental health workers. Evidence suggests the early signs of, and risks for, psychological injury, are poorly recognised in these (and other) industries and effective prevention and early intervention should be a priority for all employers.[95]

Employers have considerable control over the impact the working environment and organisational culture have on a worker's mental health. Early identification and modification (i.e., primary prevention) of psychosocial hazards is the most effective way to reduce the burden of mental health problems among working populations.[96] This is particularly so when implemented alongside secondary and tertiary level interventions, and when interventions are targeted at both individual employee factors, as well as organisational level factors.[97]

In contrast to the evidence about what works, organisations tend to focus on secondary and tertiary interventions designed to change employee behaviour and reduce stress responses through training, information and counselling (such as through an Employee Assistance Program).[98] There is a clear lack of organisational level interventions. The over-emphasis on stress education and resilience building interventions may reflect erroneous employer beliefs that mental health is an individual issue, and if employees are stressed, they need to be assisted to cope.

One of the major barriers to action is the disconnect between legislation and workplace policy that sets out what is required for a healthy workplace and the coalface operationalisation of such policy. Organisations need to not only develop workplace policies and procedures that promote healthy workplaces, but ensure uptake of them.

Creating an organisational culture that supports a healthy workplace requires:

- The acceptance at all levels of an organisation that stress and mental ill-health are both an individual and organisational problem
- A culture that normalises help seeking
- The acceptance of workplace mental health strategies as core business rather than add-ons
- A commitment to on-going monitoring of prevention and support processes
- Amplified preventive action in high-risk organisations such as first responder agencies, schools, public transport agencies, hospitals, welfare, child protection and mental health organisations
- Longitudinal monitoring of affected individuals and work groups in a way that is built into the culture of the organisation.

The case of Colin, aged 39 years

Colin has been a career prison officer for 19 years. He has been involved in an inordinate amount of incidents including:

- Being involved in the pre, during and aftermath of a deliberately lit prison fire which resulted in multiple inmate deaths by immolation
- Soon after that incident Colin was required to release a young man who had suicided by hanging
- Being assaulted by a group of inmates and only belatedly receiving help from colleagues, and
- Being taunted and having his family threatened by a well-known violent and sadistic sex offender.

Colin received negligible on the job counselling or any interventions surrounding these incidents while employed in the corrections system although his file notes him to have posttraumatic stress disorder.

APS member, Tasmania, 2019

At the policy level, health and safety legislation and labour laws are an important catalyst for organisational action.[99] Finland, Norway, Sweden, Denmark, the Netherlands, Austria and Belgium have all tackled psychosocial workplace risks and job strain through labour legislation. Finland, Lithuania, New Zealand and Japan are examples of countries that require employers to assess and respond to mental stress and strain at work. In Finland, employers must identify and address psychosocial risk factors to employee health. While Australia requires employers to provide and maintain a working environment that is safe and without risk to the mental health of their employees, much more must be done to ensure Australian businesses provide a healthy workplace.

Recommendation 3: The Productivity Commission recommend Government implement safe and evidence-based strategies about what fosters good workplace-related mental health by reforming the regulatory approaches to mental health at work so that regulators are sufficiently resourced to engage with industry and monitor and enforce legislative requirements. The regulatory system needs to act as an incentive to drive change in organisational culture.

Support recovery from workplace-related mental illness

APS members report that much needs to be done to better support workers recovering from work-place related mental illness, particularly in relation to workers' compensation schemes. These observations are supported by evidence that indicates the compensation claims management process can exacerbate the mental health of people making claims.[100] The independent report by the Ombudsman on the WorkSafe system in Victoria found high levels of poor claim management and moreover, disputed cases showed a high rate of overturn indicative of the problems in processing claims:

- 58.5 per cent of decisions disputed at conciliation were changed
- between 64 and 75 per cent of decisions disputed at court were overturned or changed
- 71 per cent of decisions referred to a Medical Panel were overturned.[101]

The Ombudsman noted that poor claims management leading to disputing a decision often had a profound impact on injured workers and their recovery.

One modifiable factor that could improve outcomes for claimants is the quality of the interaction between the person making a claim and the claims management organisation. Research findings and the experience of APS members treating workers under various compensation schemes indicates:

Interactions experienced as stressful

- Slow or delayed decision making.
- Poor communication with claims organisation/insurer.
- Poorly conducted or repeated medical examinations.
- Having multiple points of contact with claims organisation/insurer.
- People making claims for mental health disorders being required to re-live traumatic experiences.

Strategies to overcome the identified deficits in communication

- More appropriate data collection.
- Enhanced risk screening and triage.
- More rapid access to healthcare.
- Enhancing the role of the case manager.
- Better training and support for staff.
- Benchmarking.
- Mechanisms for case conferencing.

It is likely that improving the claims management process, supported by the necessary policy and legislative amendments, could improve the outcomes of workers' compensation claims and reduce the ongoing burden of mental illness currently associated with this process. There is a need for training psychologists treating workers with a compensable injury; such work requires comprehensive understanding of the compensation process as well as up-to-date knowledge of evidence-based approaches to the assessment and treatment of injured workers that supports their return to work. There is currently no such training/continuing professional development in Australia.

Recovery from mental illness, whether workplace-related or not, is further hindered by the response to people with mental illness by insurance companies. A range of insurance providers (including income protection and life insurers) continue to discriminate against people who have had a mental illness diagnosis by requiring them to pay higher premiums or even excluding them from certain products.

Recommendation 4: The Productivity Commission recommend Government overhaul workers' compensation schemes to enhance outcomes for workers with a psychological injury by reviewing workers' compensation legislation and policy to improve the timeliness and quality of the claims management process to align with best practice.

Promote wellbeing at work to drive high performance

ASX listed businesses and corporates have invested—beyond the prevention of mental illness—in the development and promotion of healthy workplaces. They leverage key human resource practices that define and embed organisational culture to help organisations execute strategy successfully. Psychological science and practice have contributed to the design and implementation of many of these practices, such as:

- Talent assessment, which involves job analysis, competency design and the use of work-appropriate, evidenced-based psychometric assessments to improve the selection and appointment of external candidates, and the promotion of employees within organisations
- Talent management, which includes best practice principles in performance appraisal, evaluation and feedback to improve how individuals give and receive feedback
- Leadership and executive team development, which leverages social psychology; strengths-based, positive psychology and neuroscience to inform both the content and process of learning and growth

- Staff engagement, which considers and assesses which key organisational and leadership practices drive increased satisfaction, motivation, retention and loyalty
- Diversity and inclusion, which is underpinned by notions of individual and collective psychological biases that either inadvertently or consciously influence key human resource decisions.

While many other organisations, boards, senior executives, managers and team leaders understand the principles of a healthy workplace, they struggle to implement them effectively. Small to medium businesses, in particular, have limited capacity to translate the evidence and best practices to their own unique organisational context.

Recommendation 5: The Productivity Commission recommend Government explore opportunities for small to medium businesses to have affordable access to organisational psychologists to develop and oversee the design and implementation of tailored and positive psychological strategies to boost wellbeing, performance and productivity.

2.2 Identify and treat mental illness

Despite multiple reviews and considered reform, the burden associated with mental illness remains high. APS members report that outcomes remain disappointing largely because there are sections of the service spectrum that are not delivering evidence-based treatment and many individuals continue to 'fall though the gaps' in accessing the services that they need.

Psychological treatments are considered the first line intervention for many mental health disorders, at least equivalent to medication in the short-term and better at preventing relapse and sometimes superior in the long-term.[103] The evidence of the effectiveness of psychological treatments for a broad range of mental health disorders is summarised in a systematic review of the literature commissioned by the Australian Government Department of Health.[104] There is also evidence that psychological treatments are overwhelmingly preferred by the community to medication.[105] Not only are psychological treatments effective first line treatments acceptable to consumers, there is burgeoning evidence of their cost-effectiveness.[106-123] To summarise the cost-effectiveness literature, psychological interventions can reduce health costs and be more cost effective than optimal drug treatment, especially (but not only) for high prevalence disorders. There is a therefore a strong economic and humanitarian argument for psychological treatment to be readily available to all people with mental health conditions at the right place and time.

Public mental health services

Evidence–based treatment

Public mental health services struggle to deliver what the evidence indicates is required to best assist people affected by a mental health disorder who need specialist services. APS members report that public mental health services increasingly focus on crisis care, and case management supported by pharmaceutical or other medical interventions. However, generic case management is increasingly being critiqued as ineffective and inefficient as it:

- Provides only small to moderate improvements in the effectiveness of mental health services[124]
- Results in a greater proportion of clients being hospitalised[125]
- Displays increasingly limited clinical and cost effectiveness[126]
- Has little evidence that it results in reduced symptoms or higher levels of functioning.[127]

In an attempt to manage high demand and the increased acuity and chronicity of clients seeking services, case management offers the sector a mechanism to manage client load within their limited budget. Psychologists are being replaced in the sector by cheaper generic mental health workers who can deliver case management but do not have the capacity to deliver evidence-based psychological treatment. Many public sector services, particularly outside capital cities, do not deliver any psychological treatment. There is a belief among many APS members working in the sector that the loss of workforce capacity to deliver evidence-based psychological treatment within state/territory mental health services is an unintended consequence of cost shifting to Commonwealth-funded psychological services by health departments who are themselves under financial pressure.

An example of the use of evidence-based psychological interventions in emergency departments

Monash Health, which services a catchment comprising one quarter of Melbourne's population, has developed the Agile Psychological Service. The service aims to provide brief psychological interventions in the community to consumers who have presented to its emergency department (ED) with the aim of increasing client functionality and linking them to primary supports. It has also developed a program where consumers who most frequently present to ED are allocated a senior psychologist to provide therapy and care coordination and ensure a comprehensive management plan is in place. The service has been successful in reducing ED presentations, improving the safety of staff and mental health patients.

M. Casey (2015). Agile psychologists designing and delivering change in adult public mental health, *InPsych*, 37(2). https://www.psychology.org.au/inpsych/2015/april/casey

Cost-effective evidence-based treatments should be available to all individuals with the most severe and persistent mental illness and many of these are best delivered by the public sector because it can:

- Provide strong clinical governance vital to ensuring the safe care of people who are significantly unwell
- Offer an uncapped number of treatment sessions
- Deliver administrative support such as follow-up for clients who miss appointments and the provision of transport support
- Provide free services.

Some public mental health services also provide services that support people with severe and persistent mental health disorders to adopt a healthy lifestyle (e.g., St Vincent's Hospital Mental Health Service in Sydney) to avoid the high rates of premature death, physical ill-health, side effects of medication and chronic disease among this cohort.[128] These physical sequelae are not inevitable for people with severe mental illness but there are many barriers for these individuals to overcome in order to lead a healthy lifestyle.[129] The burden of physical ill-health experienced by many people with severe and persistent mental health disorders could be minimised by the provision of multidisciplinary teams including sport and exercise psychologists and health psychologists to help them overcome the barriers to leading a healthy lifestyle.

Colin, 39 years old, Prison Officer

Colin eventually resigned from his role in the Office of Corrections and went to work on an assembly line of a factory but resigned from the role after two years. At the time of referral to a public mental health service he had been unemployed for two years.

On presentation, Colin met criteria for posttraumatic stress disorder. He also complained of chronic headaches, double incontinence, and difficulty with sexual relationships. He reported being abusive and aggressive if he perceives criticism. He also has frequent arguments with his older brother who is unemployed and living with their parents. These rages lead him to storm out of the house and he has stopped visiting his family.

Following an evidence-based staged model of treatment, the clinical psychologist in the mental health service provided the following interventions:

1. Stabilisation
2. Education
3. Skill development
4. Exposure therapy
5. Coping and resilience training, and
6. Relapse prevention.

The mental health service was able to obtain assistance for Colin to attend his face-to-face appointments and in the first few months of treatment, was also in regular contact with him via home visits and telephone. Within 18 months of commencing treatment, Colin was able to moderate his posttraumatic stress disorder symptoms, successfully address his headaches, personal hygiene and sexual function. He retrained and returned to work in a skilled technical role in the gas industry.

APS member, Melbourne, 2019

Implement levers to increase the delivery of evidence-based psychological interventions in state/territory mental health services

Given that a major component of the mental health service system appears to be delivering only a limited amount of evidence-based practice, this need to be considered a contributor to the ongoing mental health burden that is potentially modifiable. The barriers to the delivery of psychological treatment in the sector are complex but include the organisational culture, the dominance of the medical model in approaches to treatment and staffing mix, and funding issues. Shifting to a service model focused on the delivery of evidence-based interventions requires a proactive approach by policy makers, organisations, and mental health practitioners.[130,131] This includes leadership, cultural change, enhanced communication networks, and the monitoring of the implementation climate as well as a variety of strategies at the coalface to support practitioners.[132,133,134] Lau and colleagues propose a capability framework to guide publicly-funded mental health services to adopt evidence-based practices.[135] The implementation manual identifies priority therapies, capability levels for the workforce and a guide to data collection and analysis.

For the mental health service system to successfully address mental illness, it must deliver treatments that are cost-effective. To that end, the public sector should reduce its reliance on low value case management and expand the delivery of cost-effective psychological treatments.

Recommendation 6: The Productivity Commission recommend Government increase the delivery of psychological treatments available to people attending public mental health services by:

(i) Implementing policy levers though Commonwealth-State/Territory funding agreements to ensure services are delivering evidence-based psychological interventions.

(ii) Supporting service delivery organisations to achieve cultural and structural change though Commonwealth-State/Territory funding agreements.

Funding issues

To meet demand within budget, the public mental health sector has implemented rigid eligibility criteria. APS members report that eligibility decisions are often taken on the basis of geographical location and/or spurious diagnostic distinctions between 'behavioural' and 'mental health' disorders. People with comorbid mental health and substance misuse issues are also frequently excluded from mental health services. For example, one member employed by a public mental health service stated:

> *[They] typically will not see clients they decide are 'behavioural', which usually means a personality disorder or substance abuse, but these clients often have comorbid disorders and are not well-managed in private practice when they make frequent threats of self-harm or harm to others. Where do they go?*

Lack of funding to the public mental health sector is widely acknowledged and APS members working in these services also report mental health funding is frequently used to support a range of activities within the broader local health and hospital service. Funding streams to mental health service delivery are not always used solely to support these services. Mental health funding needs to be quarantined to prevent cost shifting and revenue siphoning. With the appropriate level of funding, the sector would be able to provide a sufficient workforce to meet service demand. An adequately funded public sector should provide:

- A psychology workforce of sufficient capacity to deliver psychological treatment to clients who would benefit
- Psychologists in maternity hospitals, prenatal clinics, early parenting centres and community health settings
- Clinical neuropsychologists and educational and developmental psychologists within paediatric services and child and adolescent mental health services
- Clinical neuropsychologists within aged care inpatient and outpatient services.

Recommendation 7: The Productivity Commission recommend Government adequately resource public mental health services by increasing funding to services and ensuring funds are quarantined to prevent cost shifting and revenue siphoning so there is an adequate psychology workforce to deliver evidence-based treatment to clients.

Strengthening Medicare's Better Access initiative

Access to mental health treatment has substantially increased since the introduction of psychological services within Medicare's Better Access initiative. However, there are opportunities to further improve the initiative. The APS's vision for psychological services delivered by psychologists within Australia's Medicare Benefits Scheme are outlined in the attached White Paper (see Appendix "A").

The intention of the Better Access initiative was to address high prevalence mental health disorders, however the mental health needs of the Australian community have shifted over the past 13 years. While acute services address and care for the most unwell within our community who are experiencing a crisis and preventative services are designed to reduce the incidence of mental health disorders, there is a significant proportion of Australians with a diagnosed mental health disorder who require access to essential psychological services to recover. The mental health needs of this 'missing middle' are not being addressed effectively as the current structure of psychological services within the Better Access initiative requires strengthening so that evidence-based interventions can be delivered.

Reforms to the Better Access initiative are needed to ensure psychological assessment and treatment services are targeted appropriately and effectively. The targeted reforms outlined in the White Paper represent an investment in mental health to ensure psychological services are, and remain to be, fit for purpose within Medicare. The recommendation outlined in the APS's White Paper consider the downstream savings and will deliver economic and productivity gains for governments, businesses and the broader community that far outweigh the required investment.

Treatment delivery using e-mental health

The Australian Government has invested in the use of e-mental health as a service delivery tool that may help people in hard to access groups (e.g., young people and people in rural and remote regions) to access support as well as supporting clinicians to be more efficient in their practice. These tools provide engaging ways of providing assessment and feedback, consolidating learning and incorporating lived experience perspectives in therapy. The use of these tools is also consistent with recovery perspectives, in which the informed client is at the centre of their own care and able to select the right interventions for their particular situation. Many mental health professionals, especially psychologists, already engage with these tools in a range of ways through the clients' treatment journey. Engagement ranges from providing information about helpful resources through practice websites and welcome materials, providing advice to clients and other health practitioners about credible tools through to integrating digital tools into their assessment and therapy.

The competent use of these tools can allow psychologists to achieve more in the available sessions and to help people find high quality self-help tools. Currently however, there is variability in how psychologists engage with digital mental health tools. In order to provide a more coherent framework for practice in this area, a number of steps are required:

- Identification of competencies for psychologists to achieve during their training
- Completion of ethico-legal guidance materials
- Completion of the Digital Mental Health Services Certification process currently being managed by the Australian Commission on Safety and Quality in Health Care
- Consultation with the profession about the roles and contribution of psychologists to the dissemination and uptake of e-mental health tools and appropriate forms of remuneration. This consultation should be led by regulatory and professional bodies along with consumer advocates.

Recommendation 8: The Productivity Commission recommend Government:

(i) Support the psychology profession to identify competencies in relation to e-mental health to be achieved during their training and develop ethico-legal guidance materials

(ii) Ensure the completion of the Digital Mental Health Services Certification process currently being managed by the Australian Commission on Safety and Quality in Health Care

(ii) Consult with the profession and consumer advocates about the roles and contribution of psychologists to the dissemination and uptake of e-mental health tools and appropriate forms of remuneration.

Treatment for people with comorbid mental and physical illness

Despite the high level of need, international and Australian research suggests that there are significant treatment gaps in mental health care for people with chronic disease.[136,137,138] At a population level, there is value in better targeting mental health interventions, for both prevention and treatment, to people with chronic illness who are at risk of/or experiencing mental illness.

Chronic physical disease is common with 50 per cent of Australians reporting they have at least one (of eight) chronic diseases, and 87 per cent of people aged 65 years and over experiencing a chronic disease.[139] The relationship between chronic physical illness (e.g., cancer, cardiovascular disease, diabetes) and mental illness (particularly affective and anxiety disorders) is well documented. For example, a large population study of seven million people in Sweden reported that somatic disorders such as chronic obstructive pulmonary disease, cancer, spinal disorders, asthma and stroke are significant independent risk factors for suicide above what could be predicted by mental health diagnosis.[140] Similarly, 48.7 per cent of Queenslanders who commit suicide suffer from a chronic physical health condition.[141] Moreover, people with chronic illness experience a significantly higher chance of mood and anxiety disorders than people without chronic physical conditions.[142] When a mental illness co-occurs with a chronic physical condition, both disorders become more challenging to treat and treatment outcomes can be poor.[143,144]

Currently, the Australian service system primarily locates mental health personnel within specific mental health service domains. However, key population groups such as people with chronic illness would benefit from the integration of mental health services into the service sector where they already receive their care. For people with chronic disease, this includes the hospital environment (both inpatient and outpatient) but also primary care. In relation to the hospital environment, public health services currently provide limited positions for health psychologists (or any psychologist) outside mental health departments. Health psychologists are particularly well placed to undertake this work because they specialise in understanding the relationships between psychological factors (e.g. behaviours, attitudes, beliefs) and health and illness.

Within primary care, people with a chronic illness and a *diagnosed* mental health condition are able to access psychological treatment for their mental illness under Better Access. However, access to psychological interventions to *avert the development of mental illness* is limited. Individuals at risk of mental illness and individuals whose symptoms do not yet meet formal criteria for a diagnosis, must rely on the Medicare Chronic Disease Management items to access psychological interventions. This initiative allows for five short treatment sessions per year shared among the multidisciplinary allied health team supporting the client. This could be addressed by unlinking the psychology items from the five allowed sessions and enabling sufficient psychology sessions to deliver an evidence-based intervention. Investing in mental health prevention and early intervention in this high-risk cohort has the potential to reduce the burden of mental illness, and physical illness, on the community.

Recommendation 9: The Productivity Commission recommend Government:

(i) Support hospitals to integrate mental health professionals, especially health psychologists, into departments where consumers with chronic physical illness regularly receive care

(ii) Unlink the psychology items from the allocation of five sessions per year under the Chronic Disease Management Medicare items sessions to enable the delivery of an evidence-based psychological intervention for people with chronic illness at risk of mental illness.

Treatment for residents of aged care facilities

The Australian population is ageing and although the prevalence of mental health disorders tends to decrease with age,[145] rates are very high among certain subgroups including people living in residential aged care,[146] people in hospital and/or with physical comorbidities, people in supported accommodation, people with dementia, and older carers.[147] This will place increased burden on mental health services if we maintain a 'business as usual' approach to service delivery. For example, it is projected that dementia will become the leading cause of death in Australia by 2021, costing nearly $15 billion in 2017 and $37 billion dollars in 2056 – a cost of more than $1 trillion dollars over the next 40 years.[148]

Unrecognised and poorly managed mental health conditions and dementia in older Australians contribute to:

- Poorer health outcomes for older Australians
- Greater demands on families and carers
- Higher demands, stress and potential burnout for the aged care workforce
- Physical abuse and vicarious trauma of the workforce
- Higher health care and aged care costs.[149]

People living in residential aged care facilities (RACFs) are currently one of the groups of Australians who struggle to access appropriate assessment and treatment for mental illness. Nearly a quarter million older people live permanently in RACFs, a figure that will rise with the growing number of older adults.[150] Their demand for mental health services is high. The prevalence of depression and anxiety is around 10-15 per cent amongst older people in the community but is higher among older Australians living in RACFs.[151] Of those living in RACFs on 30 June 2016, more than half had dementia and 57 per cent had a mental health or behavioural condition, with 46 per cent having a diagnosis of depression.[152] A recent systematic review found that 3.2–20 per cent of residents were diagnosed with anxiety disorder, while up to 58.4 per cent experienced clinically significant anxiety symptoms.[153]

Access to psychological interventions is particularly important for older people because they avoid the adverse events associated with

pharmacological treatment in the elderly, especially falls. Despite the gains that could be accrued by improving the identification and psychological treatment of mental illness and dementia in older people living in RACFs, residents do not have the same level of access to psychological treatment as older people living in the community. Due to legislative barriers, Better Access services are not able to be delivered to residents in Commonwealth-supported beds in RACFs. In 2018, the Australian Government provided funding to deliver some psychological services to residents through Primary Health Networks. Most Primary Health Networks have limited connection with RACFs in their region and are yet to commence service delivery. Similarly, RACFs have limited understanding or time to engage with Primary Health Networks or commissioned service provider agencies. It is therefore essential that approach is rigorously evaluated to ensure that it provides an adequate level of service delivery to meet consumer need, and that regional variations do not result in some localities continuing to be under or inappropriately serviced.

Recommendation 10: The Productivity Commission recommend Government rigorously evaluate the various service models identified by Primary Health Networks for the delivery of psychological services to RACFs to ensure that each Primary Health Network provides an adequate level of service delivery to meet consumer needs across their region. This approach to funding and service delivery may need to be revised depending on the results of the evaluation.

Treatment within the criminal justice system

A significant proportion of the downstream costs of mental illness are borne by the criminal justice system. Most people with mental illness do not commit crimes and are not violent and most people who commit crimes, including violent crimes, are not mentally ill.[154,155] However, mental health disorders are greatly overrepresented in the criminal justice system. The prevalence of psychiatric disorders among imprisoned offenders is three to four times that found among community populations, which is consistent with international prevalence studies,[156] and about two in five prison entrants (40%) in Australia have a mental health condition.[157]

There is a significant overrepresentation of Aboriginal and/or Torres Strait Islander people within the criminal justice sector and mental illness or cognitive disabilities are highly prevalent within this population.[158,159] For example, the past year rate of mental illness among incarcerated Aboriginal people is approximately 80 per cent (73% of males and 86% of females), with posttraumatic stress disorder being the most commonly reported diagnosis.[160]

The high level of people with mental health disorders within the criminal justice system warrants attention from the Productivity Commission to not only improve the quality of life of affected individuals and their families, but to also reduce the downstream economic impacts of offending, recidivism and lower rates of workforce participation.

Sam, 45 year old man

Sam has a dual diagnosis of mental illness and mild intellectual disability. He has been diagnosed with schizophrenia, posttraumatic stress disorder and borderline personality disorder and has had several psychotic episodes requiring hospitalisation.

He did not come into contact with the criminal justice system until he was 21 when, precipitated by a significant stressor, he engaged in several thefts. Sam was referred to the forensic psychologist employed by the community corrections service and had no recorded hospitalisations or offences during his period of parole. However, on completion of the period of parole and without support, Sam struggled to cope and a cycle of offending and regular readmission to hospital and incarceration commenced. Sam continues to be involved in the criminal justice system and has had four periods of incarceration.

APS member, Perth, 2019

As discussed in the AIHW's feasibility study[161] for collecting national data on the health of justice-involved young people, the screening and treatment for mental illness (and cognitive disability) among youth in contact with the justice system varies widely across Australia. APS members report the intersection between public mental health services and the criminal justice system is poor and state/territory based mental health services do not prioritise this cohort; many exclude young people with a history of violence or substance misuse and there is a lack of adolescent mental health units for young people with higher intensity disorders. Custodial facilities for young people are also ill-equipped to manage young people with a mental health disorder. APS members report when young people are able to access treatment it is frequently a medical or pharmaceutical intervention that fails to address the underlying issues such as trauma, attachment issues and substance misuse.

There are multiple diversionary approaches and treatment models that have a strong evidence-base that have been implemented across Australia. Some jurisdictions (e.g., Western Australia,[iii] South Australia[iv]) have special courts for people with mental health problems. These courts view offending behaviour as reflecting broader mental health, substance abuse, and ecological challenges and attempt to respond holistically by referral to treatment services. There is evidence to support their effectiveness at reducing reoffending behaviour among those who complete the program.[162] These courts offer great potential but with many of these clients not meeting criteria for entry to state/territory mental health services and the ten-session cap on Medicare services being insufficient to manage the needs of this clientele, the approach struggles to deliver on its aims. Prioritised access to psychologists skilled in working with this cohort is urgently required. Moreover, these courts only operate in selected regions of Australia and are accessible to a limited number of people.

Mick, 32 year-old man

Mick has Foetal Alcohol Spectrum Disorder resulting in mild intellectual disability and a history of posttraumatic stress disorder and substance misuse. He has been on methadone for ten years. Mick has spent over 2,000 hours in custody and has had multiple admissions to mental health units for drug-related mental health and self-harm issues.

Mick's engagement with the criminal justice system has been heavily related to his intellectual disability and his vulnerability to being used by other people to commit offenses for them. His substance abuse also precipitates exacerbation of his mental health issues and has led to him being homeless on several occasions.

On Mick's last appearance before court, he was referred to the mental health court to assist him to end the cycle of offending and address Mick's mental health and substance abuse issues. Mick appeared before the mental health court but due to lack of resourcing he was unable to be seen by their psychologist for six weeks after release from prison. Mick was able to attend his weekly drug screens but with no support he became involved with people who sought to use him to procure drugs for them and was again arrested and incarcerated.

APS member, 2019

For people who are incarcerated, mental health treatment is often restricted to medical and pharmaceutical solutions that are unlikely to address the underlying causes of mental illness and offending behaviour. APS members report there is little to no access to evidence-based psychological treatment, despite the high incidence of trauma, mood disorders, personality disorders and drug and substance abuse among this cohort. Many people in this cohort have high intensity mental health disorders that require evidence-based psychological assessment and treatment.[163]

Efforts must be made to expand and embed forensic psychology services within the criminal justice system and more health-justice partnerships are needed. This will need to be accompanied by capacity building in the sector as there are currently only two training programs for forensic psychology in Australia. Government incentives for forensic psychology training and assistance to the sector to provide training placements, as occurs for professions such as pharmacy and medicine, is required.

Education and training should also be provided for police, lawyers, court support workers and magistrates in recognising, understanding and appropriately responding to children, young people and adults with mental health disorders, cognitive impairment and other support needs. There is a particular need for on-going training to support all professionals to work effectively with people with complex trauma presentations. One-off training is insufficient to foster changes in practice thus efforts must be made to develop on-going education and opportunities for mentoring and supervision.

Recommendation 11: The Productivity Commission recommend Government address the high rate of mental illness among people within the criminal justice system by:

(i) Making regular screening for mental health disorders mandatory for all people involved in any aspect of the criminal justice system

(ii) Making diversionary approaches available to all Australians supported by the provision of access to psychologists

(iii) Providing access to evidence-based psychological treatment for people incarcerated in the criminal justice system delivered by psychologists

(iv) Building the capacity of the forensic psychology workforce by incentivising forensic training and supporting agencies to provide placements.

Treatment through private health insurance

The Australian private health insurance system is accessed by only a relatively small number of people compared to other mental health services.[164] It is a complex product currently undergoing significant reform to be financially viable for consumers and fit for purpose in a contemporary health environment. Despite this reform, private health insurance offers little to individuals with mental illness other than hospital-based care. The existing private health insurance legislation encourages hospitalisation and provides very limited access to community-based or step down care. For example, to offer outpatient-based care post-discharge, private hospitals need to ensure the care meets the requirements of a day admission.

Community-based psychological treatment to keep people out of hospital is only available to individuals holding 'extras' cover. Even then, not all 'extras' packages include psychological treatment, and of those that do, the low rebate and annual cap are inadequate to provide sufficient treatment for recovery from most mental health disorders.

The crucial role of diagnostic assessment is also not recognised by private health insurers who structure their rebates around single session 'therapy' rather than recognition of several hours of assessment. Psychological assessments are often lengthy and done over several hours on the same day but the client is only eligible for a rebate on the one session. Scoring and interpreting psychological tests is also a lengthy process that is not remunerated by private health insurers and instead must be fully met by the client.

At present, there are few incentives for individuals with a mental illness to hold private health insurance. It is difficult to estimate the potential economic gains from the provision of appropriate mental health assessment and treatment under private health insurance because of the unknown size of the market. However, private health insurance is an option in the Australian health care landscape that could be made more accessible to people with mental illness.

Recommendation 12: The Productivity Commission recommend that Government reviews the private health insurance legislation to support community-based evidence-based psychological treatment and remove the incentives for hospitalisation over community-based treatment.

2.3 Suicide management

Rates of mental illness are not yet declining and despite the Australian Government's major efforts to reduce the rate of suicide, it remains a significant and unrelenting issue impacting on our community and on productivity. Suicide was the thirteenth leading cause of death in Australia in 2016-17:

- Among males aged 1-14 years, suicide is the eleventh cause of death and fifth among same aged females
- Suicide is the top leading cause of death for youth (both males and females) aged 15-24 years and 14-44 years
- Suicide is the third leading cause of death among males aged 45-64 and ninth for females of the same age range.[165]

Psychologists in private practice often manage clients who are at significant risk of dying by suicide. However, psychologists (and GPs) in private practice cannot provide 24/7 services to clients. It is thus vital that the Government continues to provide strong support to the primary mental health care sector to act as a safety net. To that end, the APS acknowledges and congratulates the Government for recent increases in financial support to crisis national telephony and digital services. These are an essential component of an effective mental health system.

There are several additional actions that would further reduce the burden of suicide on the community. APS members report that people in crisis who present to hospital as an emergency admission are often quickly discharged without ongoing support or outreach. The high rate of early discharge is confirmed by data on emergency department hospital stays. In 2017-18, almost 300,000 Australians presented to an emergency department due to mental health problems.[166] Of these, almost 93 per cent were classed as an emergency, urgent or semi-urgent requiring immediate care within 10-60 minutes of presenting. However, the average length of stay was approximately 3.5 hours. The introduction of postvention support following an emergency admission, including outreach services, has the potential to significantly improve outcomes if staffed by psychologists who are trained to provide evidence-based, safe care to people in high risk situations.

We note, however, that the suicide burden is unlikely to drastically decline without increased upstream prevention to prevent downstream suicidality.

Recommendation 13: The Productivity Commission recommend Government increase funding to develop postvention support services, including outreach, following an emergency department presentation. These services must be staffed by psychologists.

2.4 Housing services

Mental illness can contribute to unstable housing and ultimately homelessness, outcomes that can maintain and exacerbate mental illness.[167] APS members working in the public mental health sector report that discharge to homelessness (or near homelessness) is a common occurrence across Australia. Moreover, among prisoner populations where rates of mental illness are high, more than one in two dischargees expect to be homeless on release from prison.[168]

Available housing options are often short term and not conducive to recovery from serious mental illness. As one member reported their client saying on discharge from a psychiatric inpatient unit:

> *how do they expect me to get better when the only place I have to go to is an emergency hostel with people using drugs in the next room; I can't sleep, I don't feel safe, and I have to get out at the end of the week. Suicide seems a good option. (Psychologist, Country NSW)*

Improving access to housing for people with mental illness is a challenge for governments because it requires policy-making to be far more joined up than is currently the norm. Even with the best systems in place, Australia has a huge shortfall of affordable housing and the needs of people with or at risk of mental illness simply cannot be met.[169] The Productivity Commission is uniquely placed to make recommendations to Government that span several policy sectors and identify mechanisms to enhance the availability of suitable emergency accommodation and affordable public housing to meet the needs of people with or at risk of mental illness. The text box on page 32 provides an example of an international solution to provide housing for people with mental illness.

International exemplar: Housing First

Housing First is an evidence-based, successful and cost-effective model that provides accommodation for people with mental illness in many countries including some states in the United States, Finland, Canada and most recently New Zealand. Intervening to provide housing to those in need has been shown to provide a net cost benefit for the health system in Australia.^

Housing First aims to connect people experiencing homelessness with long-term housing as quickly as possible and without preconditions. Once housing is secured, a multidisciplinary team of mental health workers are available to an individual but engagement with these support services is not required to maintain accommodation. Each individual is assisted in sustaining their housing as they work towards recovery and reintegration with the community at their own pace.

Although there have been successful pilots of Housing First in Australia, broad uptake has not occurred because of the lack of affordable housing stock necessary to quickly house those experiencing homelessness.

^Wood, L., Flatau, P., Zaretzky, K., Foster, S., Vallesi, S. and Miscenko, D. (2016). *What are the health, social and economic benefits of providing public housing and support to formerly homeless people?* AHURI Final Report No. 265, Australian Housing and Urban Research Institute Limited, Melbourne. https://www.ahuri.edu.au/research/final-reports/265, doi:10.18408/ahuri-8202801.Proiroising

Lack of suitable accommodation is a primary barrier to obtaining housing for people with mental illness, but the way in which many homelessness services operate presents an additional barrier. Many people with mental illness are trauma survivors and APS members report that their clients find some housing agencies (and human service agencies like Centrelink) difficult to navigate and requiring the completion of lengthy complex forms and reporting processes, often without advocacy or support through the process. Under stressful situations, people with mental health problems and histories of trauma may behave in ways perceived by these services as indicative of non-compliance, further diminishing their likelihood of a positive outcome. The agencies also fail to understand the fluctuating nature of mental illness and lack the capacity to tailor approaches to suit the individual's needs. APS members report it is not uncommon for their clients to just give up as services are not responsive or it's just "too difficult to navigate".

Outcomes for clients of homelessness agencies (and organisations such as Centrelink) could be improved by organisations shifting to a trauma informed approach to service delivery. Trauma informed care is based on the premise that many behaviours expressed by people with or at risk of mental health disorders are related to and exacerbated by an experience of trauma. It is not a treatment but rather a whole-of-service-system approach whereby all aspects of the organisation (practitioners through to administrative support and the physical setting) are organised on the basis of understanding how trauma affects people's lives and their service needs.[170] A trauma informed human service understands the symptoms and presentation of an individual who has experienced trauma should be viewed as adaptations to trauma rather than as pathologies.

APS members report there are structural barriers to the implementation of trauma informed care within housing organisations, many of whom are non-government organisations. The barriers include the reliance on short term program funding and concomitant organisational instability, crisis levels of staffing and high turnover. Shifting Australia's approach to housing people with mental illness to an appropriately-funded, wrap-around multidisciplinary team approach such as that offered by Housing First, would support the implementation of trauma informed care.

Recommendation 14: The Productivity Commission recommend to Government they address the lack of safe and secure housing for people with or at risk of mental illness by:

(i) Increasing the availability of suitable safe, emergency accommodation and secure, affordable public housing

(ii) Funding a national roll out of the Housing First initiative including psychological support as an integral component to assist people to obtain and keep housing.

3. Governance and system issues

Mental health reform in Australia is particularly challenging because responsibility for mental health sits across two tiers of government: the Federal Government and state and territory Governments, and among several departments within each tier of government. The Australian Government funds:

- Medicare-subsidised mental health services by general practitioners (GPs), psychiatrists, psychologists, approved mental health social workers and occupational therapists
- Subsidised mental health prescription medications under the Pharmaceutical Benefits Scheme (PBS) and Repatriation PBS
- Veterans' mental health services through the Department of Veterans' Affairs
- Primary care services though Primary Health Networks
- Social security payments (e.g., Disability Support Pension, unemployment benefits).

State and Territory Governments:

- Manage and administer public hospitals
- Fund and manage community mental health services.

There is shared responsibility for:

- Funding of public hospitals
- Registration of mental health professionals
- National Disability Insurance Scheme
- National Housing and Homelessness Agreement
- Suicide prevention.[171]

Nationally, expenditure on admitted patient services is the largest component of State and Territory Governments' expenditure on specialised mental health services ($2.4 billion or 44.1 per cent) in 2015-16, followed by expenditure on community-based ambulatory services ($2.0 billion or 37.6 per cent).

The dynamics between the two tiers of government in relation to mental health are noted to impinge on the delivery of effective reform.[172] National reform has been centrally driven by the Federal Government (e.g., Better Access, Primary Health Networks, *headspace*, NDIS) but must then integrate with acute and specialist mental health services operated by states and territories. The two tiers of government come together in relation to mental health via the Council of Australian Governments and the Australian Health Ministers' Advisory Council.

The inefficiencies brought about by the governance and funding arrangements for mental health are responsible for some of the current problems confronting the mental health sector. For example, Federally-funded Primary Health Networks are tasked with implementing stepped care within their respective regions but have no levers to bring this to fruition within state/territory services. Acute and specialist care is delivered within the state/territory system but there are no mechanisms to assist consumers to bridge the gap when they are discharged to primary care services. One of the most significant negative outcomes of the dual approach is cost shifting by state/territory departments to Federally-funded programs that has resulted in shifting the funding for key services from one tier of government to the other with limited overall net gain in the availability of care to consumers.

Cost shifting

The introduction of psychological treatment to the primary care sector through Medicare, *headspace*, and primary care organisations (most recently Primary Health Networks) has provided millions of Australians with treatment many would never have been able to access. However, there have been unintended consequences from these reforms including cost shifting and the development of new gaps in the system.

Prior to the introduction of psychological services to primary care, psychological treatment was largely only available to special cohorts such as veterans or people with compensable injuries, full fee-for-service in the private sector, or through state/territory-funded services. Since the commencement of Better Access, government agencies who are themselves under pressure appear to have identified a means to keep their own spending in check by cost shifting to Medicare. While this can be of benefit to an individual agency, "dumping onto other budgets"[173] reduces the efficiency of the overall system. APS members report cost shifting to Medicare is extensive:

- Investment in school-based psychology services is being challenged by agencies delivering services in schools under Medicare
- Court-mandated clients regularly have to access their psychological treatment through Medicare
- Community/human services departments provide limited access to psychological services and rely on Medicare
- Employee Assistance Programs routinely cap the number of treatment sessions available and then refer to Medicare
- Many community health services no longer employ psychologists as services are available through Medicare
- Compensable bodies increasingly refuse to continue to pay for treatment and refer clients to Medicare.

The significant reduction in positions for psychologists in the public sector is evidence of cost shifting. It is difficult to substantiate the loss of positions in the public sector given the poor quality and availability of data on the national psychology workforce. However, perusal of the APS membership workforce data exemplifies the decline since the introduction of Better Access (see Table 1). It is likely that some psychologists moved

from the public sector to private practice following the introduction of Better Access in 2006; however, this does not explain the on-going decline in the size of the public sector psychology workforce.

Table 1: *Percentage of APS members working in the public sector or engaged in independent practice (data published in the Annual Reports of the APS)*

Year	Independent Practice	Public Sector#
2001	21.2	30.4
2006^	26.0	22.5
2011	33.6	23.8
2016	33.1	17.0

^ Better Access commenced; # Excludes tertiary sector and schools.

The cost shifting has reduced the capacity of the system to meet consumer need by removing key 'steps' that previously offered important levels of care. In providing greater access to psychological treatment in primary care, ironically the gap between services delivered by primary care and state/territory mental health care has widened. The latter contain costs by implementing entry and exclusion criteria that permit only the most acutely unwell people to access their services and discharge clients as soon as they no longer meet criteria. Excluded from specialist mental health services, the only places to obtain assistance is family members, GPs and psychological treatment in primary care.

The next section describes actions that could be taken by the public sector to address this service system gap. The APS White Paper (Appendix "A") makes recommendations to amend Better Access that also address the gap. However, there are some existing policy levers, if supported by adequate compliance mechanisms that could reduce cost shifting to Medicare.

Recommendation 15: The Productivity Commission recommend Government review the Medicare legislation and associated compliance mechanisms to prevent cost shifting to Better Access so that it is able to deliver on what it was intended to do.

New gaps

Between specialist state/territory and primary mental health care

The introduction of psychological services to primary care (Medicare, *headspace*, Primary Health Networks) has greatly increased access to psychological services. However, it has also produced a new gap in the continuum of care as people now move from a state/territory funded service to primary care with no efficient or effective pathways to support their journey. APS members engaged in both sectors report the new gap (or 'very large step') between specialist state/territory and primary mental health care services is seriously impacting on the client journey and the outcome of treatment.

Under high demand conditions, state/territory services are discharging clients early and many are still too unwell to be managed in ten capped sessions in a private practice setting. On discharge from inpatient care, people go from having health professionals available on a 24/7 basis to having to wait for appointments in the community and be sufficiently well to organise to attend appointments. There is no mechanism for case conferencing or collaborative care between the sectors to support comprehensive treatment planning on discharge. The limitations of Better Access in supporting people on discharge are also discussed in the attached White Paper outlining the APS recommendations for Better Access increasing the number of sessions and case conferencing items (see Appendix "A").

The inclusion of another 'step' between the two sectors would also provide a more gradual and appropriate 'step-down' from intensive treatment to primary care. This could be achieved by implementing outpatient clinics in state/territory mental health services. Specialist psychology out-patient clinics, supported by the public sector infrastructure, would enable clients to obtain services at no cost, support to get to appointments, no penalty for no-shows, and a capacity to access support outside scheduled appointments.

Between treatment and psychosocial support

The decision to include psychosocial disability in the NDIS has the potential to significantly destabilise the mental health system, particularly for people with the highest level of need and to create significant gaps in access to psychosocial support. Approximately 700,000 Australians experience a severe mental illness in any one year, but of those, only 64,000 are expected to be eligible for the NDIS.[174] For people with mental illness who do meet NDIS eligibility criteria, the capacity of the NDIS to meet their needs remains unknown. At a basic level, it is difficult to see how the principles of the recovery movement that underpin mental health service delivery will be accommodated by a disability insurance scheme based on functional limitation and the concept of permanence of disability. The notion of permanence is not commonly used in the mental health sector. The NDIS has limited engagement with the mental health sector and is still developing processes and staff competence in identifying the psychosocial support needs of people with serious and persistent mental illness. The risk is that the long period of time required for the NDIS to reach full maturity in relation to mental illness service delivery will mean that for many years, large numbers of Australians with the highest level of need will fail to receive adequate services.

The Productivity Commission confirmed the potential for a new gap to emerge in the mental health system in relation to psychosocial support as funding shifts from the Commonwealth-funded Partners in Recovery and Personal Helpers and Mentors Service to the NDIS.[175] A number of existing clients of these services will not meet NDIS eligibility criteria despite having a clear and ongoing need. Some states/territories are winding down their delivery of psychosocial support as the NDIS rolls out and will not be able to service those who miss out on NDIS services. Some additional funding has been provided to Primary Health Networks to bridge the new gap but it also will not address the service shortfall. The "confusion and uncertainty about what services will continue to be provided and/or funded"[176] cannot continue.

The provision of appropriate psychosocial support to the relatively small percentage of Australians with mental illness who require it, will help reduce the costs associated with relapse and readmission and many of the indirect costs associated with mental illness.

Recommendation 16: The Productivity Commission recommend Government ensure the security of psychosocial support services for people with mental illness by:

(i) Conducting an independent evaluation of the effectiveness of the NDIS to ascertain if it is fit-for-purpose in meeting the needs of all people with a psychosocial disability

(ii) Responding to the recommendations in the independent evaluation to ensure there are sufficient and appropriate psychosocial support services to meet the identified need.

Partnerships

There are opportunities for partnerships between the state/territory services and the primary mental health care sector, particularly psychologists in private practice. One of the client groups that are high users of mental health and emergency department services, are people with borderline personality disorder.[177,178] Dialectical behaviour therapy is an effective treatment for borderline personality disorder[179] but few patients have access to it in the public sector and delivery under Better Access is extremely difficult. Combining the resources of the specialist public mental health services (group component of dialectical behaviour therapy) and the private sector (individual therapy) would make such treatments more readily available. There are at least two examples of such partnerships successfully operating in Melbourne. In addition, there are other treatments shown to be evidenced based for this disorder[180] that have been proven cost effective that need to be further delivered in public outpatient services.

Recommendation 17: The Productivity Commission recommend to Government that the gap between state/territory mental health services and primary mental health care be minimised by:

(i) Implementing psychology outpatient clinics in the public sector to support people discharged from specialist public mental health services prior to transitioning to primary mental health care services

(ii) Incentivising public sector-private psychologist partnerships for the treatment of borderline personality disorder.

4. Mental health research

Investment in mental health research is needed to ensure we build on our current knowledge, find new breakthroughs, and support innovative developments to better treat Australians with mental health problems. However, funding for mental health research in Australia has been poor in relation to medicine. The lack of government investment in mental health research was exemplified by the recent funding round for the Medical Research Future Fund that failed to allocate funds for any mental health research.

While research funding has led to significant improvements in treatments for physical conditions, including for example, safer and more tailored interventions for cancer and cardiovascular disease, there remains a dearth of investment in mental health research, resulting in insufficient progression in the development of more effective treatments.

Research

Research is fundamental to Australia's capacity to address the burden of mental illness and improve productivity and economic outcomes. Innovative solutions to such complex challenges will require investment in both basic and applied research. There has been an on-going lack of attention to basic research in Australia, and although one of the nine current Science and Research Priorities is health, there needs to be more strategic and targeted investment in mental-health research. Some of the priority areas for mental health research should be:

- Prevention
- The implementation gap – how to promote the uptake of what we know works
- Ways to improve mental health for specific populations, in particular for Aboriginal and/or Torres Strait Islander people and people from different cultural backgrounds
- Interventions for individuals with mental health disorders that do not respond to conventional treatment.

Evaluation

The mental health sector lacks an overarching framework to measure the outcomes of mental health policies, service models, programs and services. This reduces the capacity to ascertain accountability for funding investment by both tiers of government. Without high quality evaluation it is impossible to establish what is working and what isn't.

Quality evaluation focuses on the outcomes or impact of service models, programs or services. However, the collection of output data still dominates most mental health service level data, particularly in the public mental health sector. State/territory mental health services and Primary Health Networks have adopted what has been described as an "audit society"[181] that focuses more on the achievement of targets and key performance indicators than the quality of care delivered and clinical outcomes. There is also no requirement for psychiatrists, GPs, psychologists or other allied health professionals to report on outcomes for services delivered under Medicare.

The APS and its members are committed to being accountable for their work under Medicare and accordingly have submitted to the Department of Health a proposal for an easy-to-use, secure online point-of-service data collection system that could support the delivery of psychological services under Medicare. Recognising that ease of use for both clinicians and consumers is critical to national uptake, the system has been designed by practicing psychologists to support them in their clinical decision-making and piloted under real-world conditions to the satisfaction of both the administrator and consumer. The system requires only a moderate investment by the practice in technology. The implementation of this outcome measurement system would enable on-going evaluation of the Better Access initiative but also has the potential to be expanded to evaluate other treatment programs.

Outcome assessment is important for service delivery models, not just individual client care. The adoption of the stepped care approach to the delivery of mental health services in Australia is a significant reform to the way services are delivered and must be evaluated. The Department of Health defines stepped care as a "staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs".[182] Internationally, there is very limited evidence of the effectiveness of stepped care for mental health service delivery.[183] The uptake of stepped care policy in Australia is viewed as both resource efficient and client-centred ("right place, right time")[184] and would appear to have good face validity but the findings from overseas shed doubt on these claims. One author has even suggested that stepped care actually delivers consumers less professional expertise and choice.[185] Stepped care may not deliver on its promises because of the challenges inherent in implementation;[186] that is, there is no robust evidence to help funding bodies and service delivery agencies determine the right mix of treatment and providers at each step or what criteria should be used to allocate consumers to a step.[187] The absence of such evidence to underpin implementation makes it imperative that Government closely monitors the implementation of stepped care. Without adequate monitoring and feedback loops to accompany this policy decision, there is a very real danger that stepped care could actually reduce access to quality mental health services in Australia.

The lack of investment in quality outcome evaluations means the effectiveness of much of the expenditure on mental health remains unclear. There needs to be adequate resourcing of independent, quality evaluation of all Commonwealth-funded mental health initiatives including but not limited to the effectiveness of models of service provision, treatment

approaches and workforce. Such evaluations should be routinely undertaken, including for key mental health programs like *headspace* and Better Access which have been evaluated only once in their long history. Future Commonwealth program funding should include (and quarantine) at least two per cent of total program costs to enable regular program evaluation. A shift to mandated outcome evaluation of programs and services provided by the public mental health sector could also be facilitated through Commonwealth funding agreements.

Routine outcome evaluation of all mental health service models, programs and services will provide transparency and accountability to ensure the best possible investment of Australian dollars towards assisting vulnerable members of the community struggling with mental health problems.

Recommendation 18: The Productivity Commission recommend Government:

(i) Work with key Australian mental health researchers and the sector to establish priorities for mental health research in Australia and ensure regular funding rounds

(ii) Implement an easy-to-use, secure online point-of-service data collection system that could support the delivery and evaluation of psychological services under Medicare

(iii) Implement robust outcome data collection and feedback loops to monitor the implementation of stepped care

(iv) Ensure that Commonwealth mental health (and related) program funding includes (and quarantines) at least two per cent of total program costs to enable regular program evaluation that focuses on outcomes

(v) Use funding levers to shift the public mental health sector to an outcome-based approach to evaluation.

5. The mental health workforce

Investing in the mental health system so it better meets the needs of vulnerable individuals and reduces the significant burden on the broader community will require a mental health workforce that is fit-for-purpose; that is, appropriately trained and able to work to their full scope of practice.

The mental health workforce includes psychiatrists, psychologists, mental health nurses, social workers, occupational therapists, and general practitioners although it is only psychiatrists, psychologists and mental health nurses who work principally in mental health care. Psychologists make up the largest segment of the mental health workforce with over 29,000 practicing in Australia (about 89.3 full-time equivalent (FTE) psychologists per 100,000 population).[188,189] In 2016, there were 3,244 psychiatrists and 21,558 nurses working in mental health in Australia.[190]

Make better use of the psychology workforce

The underuse and poor distribution of psychologists across the mental health system is of concern given the size of their workforce. The need to make better use of the psychology workforce becomes particularly salient when examining the constraints on the psychiatry workforce. There are only 12.6 FTE psychiatrists per 100,000 population in Australia and there is a projected shortage of 74 FTE psychiatrists by 2025 and a shortfall of 124 FTE by 2030.[191] The psychiatry workforce is not going to be able to adequately oversee the mental health sector into the future.

In Australia, psychologists have traditionally worked within the hierarchical medical model that grants superiority to the psychiatry profession. This is not the model adopted in other western nations. For example, in the UK, psychologists within the public sector play a more equal role in the management of mental health service delivery. For the long-term future of mental health service delivery in Australia, this anomaly needs to be addressed to ensure the community has adequate access to well qualified mental health practitioners.

Consideration could be given to the introduction of prescribing rights for psychologists. This is a complex issue but has been implemented with some success in other countries. The APS has not reached a formal position on this matter and would encourage caution in terms of adequate safeguards including the appropriate training and supervision of psychologists wishing to prescribe. However, given the workforce and economic issues involved, we are strongly supportive of the Productivity Commission considering the value of introducing prescribing rights for psychologists.

The Productivity Commission could also consider the provision of visiting rights for treating psychologists attending their clients in psychiatric in-patient facilities. Given the current difficulty in accessing psychological treatment in the public sector, this may be a way to ensure consumers are able to continue their treatment.

Psychologists in private practice could be freed up to undertake more clinical work by review of the current legislation and practices of lawyers in requesting information about the clients of psychologists. APS members report that they receive requests from lawyers for full client records, often on a weekly basis. These requests appear to have escalated since the changes to the Privacy Act. Clients are often unaware of the potential implications of the release of these records and the information could be more efficiently provided through the provision of a report by the treating psychologist.

Rural and remote psychology workforce

Maldistribution of psychologists across Australia impacts on the delivery of psychological services through state/territory and Commonwealth-funded services. There are proportionally many more psychologists than psychiatrists in rural and remote regions,[v] but the distribution of psychologists does decline with increasing remoteness. The AIHW reports that in 2016, 82.7 per cent of psychologists were employed in major cities although only 71.2 per cent of the population resided in these locations.[192] Specifically, per 100,000 population there were:

- 103.8 FTE psychologists in major cities
- 60.6 FTE in inner regional
- 44.8 FTE in outer regional
- 33.9 FTE in remote
- 21.5 FTE in very remote areas.

Maldistribution is the result of both a failure of recruitment and retention. There has been significant under-investment by governments in capacity building in the rural, remote and very remote psychology workforce, particularly compared to the medical and pharmacy workforces. Despite the success of a rural pipeline approach to the rural medical workforce,[193] the same approach has not been applied to psychologists: there has been no implementation of mandated places for rural students in psychology programs, limited funding of rural placements and scholarships, and no supported rural internships or registrar opportunities. There are only a small number of relocation supports, of varying quality, for psychologists in either the public or private sector. There is also a major question mark over the financial viability of rural psychology practices. Moving beyond major cities, population density decreases meaning a smaller client base but with a concomitant demand for greater bulk billing. With the long-standing freeze on Medicare rebates for psychologists and the loss of contracts with Primary Health Networks to larger organisations,[vi] it is increasingly difficult for a psychologist to survive in rural private practice. Despite these pressures, there remains no financial incentive for rural psychologists who work under Medicare as there is for rural GPs.

6. Conclusion

Recommendation 19: The Productivity Commission recommend Government make better use of the psychology workforce, the largest and most diverse mental health workforce in Australia by:

(i) Allowing treating psychologists visiting rights to provide treatment to their clients in psychiatric in-patient facilities

(ii) Investigating the value of introducing prescribing rights for psychologists

(iii) Implementing a rural pipeline approach to growing the rural psychology workforce that includes mandated places for rural students in psychology programs, funded rural placements, scholarships, supported rural internships and registrar opportunities

(iv) Implementing Higher Education Contribution Scheme exemptions for rural and remote practice

(v) Implementing financial incentive for rural psychologists who work under Medicare.

To conclude, the APS is available to discuss and work with the Productivity Commission to ensure the long term future of mental health services in Australia.

Appendices

Appendix A:

APS Australian Psychological Society

The Future of Psychology in Australia

A blueprint for better mental health outcomes for all Australians through Medicare

White Paper, June 2019

Recommended citation

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future, for they hold the dreams of Indigenous Australia.

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The Australian Psychological Society

The Australian Psychological Society (APS) is the peak professional organisation for psychology in Australia, representing more than 24,000 members.

As the peak representative organisation, the APS works to amplify the role of psychological science and psychologists in helping people achieve positive change in order to contribute their best to the community.

This means the APS strives to ensure psychological services are used to benefit individuals, systems and communities with a focus on quality improvement strategies and research on responding to increasingly complex societal issues.

Psychologists represent the largest mental health workforce in Australia. Through their extensive training they are highly skilled to provide evidence-based psychological assessments and interventions for individuals experiencing mental health difficulties.

As the peak representative body, the APS regularly provides advice to stakeholders to inform best practice in mental health services in Australia.

The APS has a long history of working collaboratively with the Australian Government and other agencies to help address major social, emotional and health issues, and to ensure mental health care is equitable and accessible to all members of the Australian community.

The things the APS does as an organisation, the way it does them and the decisions it makes are guided by integrity, influence, professionalism and respect.

Table of Contents

Executive summary

This White Paper has been developed to communicate the APS's vision for psychological services delivered by psychologists within Australia's Medicare Benefits Scheme. This vision is intended to strengthen access to high quality and safe mental health services for the Australian community and to reduce the burden that mental health problems place on the individual, their family, friends and carers, the community, and the Government. This paper will guide our advocacy efforts to advance the importance of psychological assessment and treatment services, so they are and remain to be fit for purpose within the Medicare Benefits Scheme.

Mental ill-health has broad and far-reaching impacts on individuals, the community and the Government, and the Australian Government invests significantly in mental health reforms and programs for the benefit of all Australians. However the burden of mental health remains high and mental illness and suicide rates are not reducing. More strategic long-term and comprehensive reforms are required to ensure the government investment is targeted, cost effective and of high value.

The current system of delivering psychological services within Medicare was introduced in 2006 and requires urgent updating to ensure all members of the community can access the care they need. In response to the Government's review of the Medicare Benefits Schedule, the APS conducted an extensive member consultation to provide a comprehensive model for the delivery of psychological services within Medicare. The APS undertook this process to provide the Government with a targeted and effective solution for addressing the burden of mental health in Australia. The APS's recommendations for change to the delivery of psychological services within Medicare are outlined as follows:

Recommendation One: Amend the Better Access Framework

- Separate the psychology workforce from medical and other allied health professionals who provide mental health services as an adjunct to their profession.
- Three levels of mental health interventions are available to clients as follows:
  a. **Supportive Therapy** provided by medical and other allied health professionals.
  b. **Psychological Therapy** provided by all psychologists.
  c. **Advanced Psychological Therapy** provided by psychologists with an Area of Practice Endorsement and who are working within their area of advanced competency, as determined by the Psychology Board of Australia.
- Clients being treated by provisionally registered psychologists are eligible to receive a rebate.

Recommendation Two: Individual psychological services

- Increase the number of available sessions for clients who require more intensive psychological services to stabilise their mental health, prevent deterioration and relapse and to allow the delivery of evidence-based interventions that support recovery.
- Clients are stepped through levels of psychological care according to the:
  - nature of the mental health disorder
  - expertise of the psychologist
  - needs of the client (number of sessions required to achieve effective clinical outcomes; up to 20 sessions for low intensity treatment needs and up to 40 for clients with specific diagnoses and high intensity treatment needs).
- Regularly measure and review outcomes to determine treatment progress and to ensure responsiveness is embedded in the delivery of psychological services within Medicare.
- Clients can be referred to a psychologist by any medical practitioner registered with the Australian Health Practitioners Regulation Agency.
- Collaborative care is supported by strengthened reporting, enhanced referrals, integrating outcome measurement, and by implementing criteria to clarify clinical care pathways.

Recommendation Three: Family and couples therapy

Introduce items for family and couple therapy where one or more members of the family/couple are experiencing mental health problems.

Recommendation Four: Amend group therapy items

Amend group therapy items within Medicare by:

- reducing the minimum participant numbers and increasing the maximum number of participants
- enabling group therapy for kinship groups
- enabling two clinicians to facilitate a group therapy program
- increasing the range of timed items to allow for flexible group therapy and longer sessions.

Recommendation Five: Evidence-based interventions for parents and carers of children with a mental health disorder

Introduce an item for the specific purpose of providing evidence-based

"The current system of delivering psychological services within Medicare was introduced in 2006 and requires urgent updating to ensure all members of the community can access the care they need."

interventions between health professionals and family, parents, carers and/or support people of children or adolescents with a mental health disorder.

Recommendation Six: Developmental neurocognitive assessments

Introduce items that enable clients to access comprehensive developmental neurocognitive assessments to accurately delineate the impact of cognitive, behavioural and psychosocial issues that are associated with neurodevelopmental problems and to improve diagnostic accuracy and client outcomes, especially among children.

Recommendation Seven: Standardised evaluation and measurement for the delivery of psychological services

- Invest in the collection of data, including outcome data, within the Better Access initiative.
- Introduce standardised evaluation into the Medicare Benefits Scheme and that the APS be consulted and work with the Government to assist with the development of appropriate tools.

Recommendation Eight: Neuropsychological assessment to differentiate dementia from mental health disorders

Introduce items to allow a comprehensive neuropsychological assessment for people with potential neurocognitive problems/dementia who are at increased risk of a mental health disorder, or who may have a co-occurring mental health condition.

Recommendation Nine: Consultation with family, parents, carers and support people

Introduce an item for the specific purpose of enabling consultation between health professionals and family, parents, carers and/or support people.

Recommendation Ten: Mental health case conferencing with other health professionals

Introduce items to enable psychologists to be included in case conferencing with other health professionals involved in the client's care.

Recommendation Eleven: e-Mental health assessments

Introduce two items for clients with low intensity treatment needs to assess suitability for and facilitate access to e-mental health programs and to assess the clients response to these intervention programs.

Recommendation Twelve: Initial intake, assessment and report item

Introduce items to conduct an initial assessment of a client presenting for treatment with a psychologist. This includes preparing a report for the referring practitioner to enhance collaborative care arrangements.

Recommendation Thirteen: Universal access to Interpreters

Expand access to free interpreter services currently available for medical consultations within Medicare to psychological services delivered under Medicare.

Recommendation Fourteen: Amend telehealth items

Expand access to telehealth for clients in metropolitan areas who face barriers to attending face-to-face psychological therapy and removing barriers to access for people in regional, rural and remote areas of Australia.

Recommendation Fifteen: Enhance access to psychological services for people in regional, rural and remote Australia

Introduce financial incentives, such as rural loadings, to improve the financial viability of providing psychological services to people who live in regional, rural and remote areas of Australia.

Recommendation Sixteen: Independent mental health assessment, opinion and report

Introduce items to refer clients for an assessment, expert opinion and report to psychologists with an Area of Practice Endorsement in clinical or counselling psychology.

Recommendation Seventeen: Scheduled fees

- The Government continue with the current two-level rebate system within Medicare.
- Extend the higher rebate to all psychologists who hold an Area of Practice Endorsement.
- Increase the scheduled fees for psychological therapy services.
- Increase the scheduled fees for assessment items to 1.5 times the scheduled fee for individual treatment.

Strengthening the mental health of Australians

Over the past 30 years Australian governments have demonstrated their commitment to the mental health of Australians through their significant, iterative and growing investment in reforms to address the burden of mental health.[1] This investment recognises the broad and far-reaching impact mental health has on individuals, the community and the economy. Over this time, access to mental health services has substantially increased. As access has increased, stigma and discrimination around mental health have reduced in the Australian community and mental health is now a strong focus across sectors such as health, education and employment.[2] With the economic impacts of mental ill-health estimated to be $60 billion per year,[3] and the burden of mental health remaining high,[4] there are further opportunities to implement targeted reforms that produce positive outcomes.[2,5] These targeted reforms represent an investment in our society and the downstream savings will deliver economic and productivity gains for business and the broader community which will far outweigh the initial investment.[5]

The changing mental health landscape

The Australian Government spends $9.1 billion (2016-17) each year to address the burden of mental health, however this burden is not reducing, and significant reform is still required.[1] Mental illness and suicide remain major public health issues with almost half of all Australians experiencing a mental illness in their lifetime.[6,7]

The impact of mental health on the Australian community has been increasingly recognised and the Government has implemented major reforms, particularly in the primary care sector. This includes providing universal access to evidence-based psychological treatment and expanding access to a range of services for young people through *headspace*. Psychological services have also been provided to hard-to-reach groups through a range of primary care organisations (Primary Health Networks). Although these reforms have improved access to services, we are yet to see the impact of these reforms.

Approximately 62% of government spending is for acute and specialised mental health services.[1] Additionally, statistics show that Australians aged 15-64 represent the largest proportion of mental health related presentations to emergency departments.[8] In 2017-18, almost 300,000 Australians presented to an emergency department due to mental health problems.[9] Of these, almost 93% were classed as an emergency, urgent or semi-urgent requiring immediate care within 10-60 minutes of presenting, however the average length of stay was approximately 3.5 hours.

Acute care is designed to contain major and serious symptoms of mental illness, such as psychosis. It is designed to address mental illness among those who are at crisis point where acute care is required. Preventative measures are also not designed for people who have a mental health diagnosis and is instead targeted at preventing the onset of mental health problems. This leaves a majority of Australians with a mental health disorder with reduced options for treatment outside of acute and specialist care and risks a decline in their mental health.

There are further hidden costs to the Government and the community that are distributed across numerous sectors. For example, there is little data collected about the cost of mental illness incurred by clients, employers, emergency departments, carers, and across the housing, aged care, education and justice sectors. There are additional downstream costs of mental illness, such as homelessness, incarceration, welfare dependence and unemployment.[2] The cost of mental health problems is underreported and more can be done to measure and evaluate the true cost of mental health across Australia.

Rates of mental illness are not yet declining and sadly, despite the Australian Government's major efforts to reduce the rate of suicide, it remains a significant and unrelenting issue impacting on our community and the 13th leading cause of death in Australia in 2016-17.[10] For example, Indigenous Australians are twice as likely to die as a result of suicide and alarmingly, in the first quarter of 2019, 24 Indigenous Australians took their own life.[10] Tragically three of these Australians were 12-year-old children. Despite increased investment in suicide prevention, there

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has been no significant reduction in suicide rates in the past decade.[11]

It is clear that major efforts by the Australian Government to address mental illness and suicide require further investment. Reform is needed to address the significant and far reaching impacts of mental illness and suicide in Australia. This was made clear in the Mental Health Commission's 2018 report card where they state that while some investments in mental health are working, others are not.[11] Reform requires more than simply addressing topical issues and acute presentations. It requires a larger and more strategic approach, built on research about what works, for who and when.

Changes to the Medicare Benefits Schedule are needed

The current review of Medicare items provides an opportunity to reform mental health services and improve mental health outcomes in Australia. The APS has been guided by the overarching aim of determining and implementing improvements with meeting the client's need foremost, with expert assessments, accurate referrals and targeted interventions provided in a timely manner to effectively reduce the burden of mental health difficulties for the client and the wider community.

In 2015, the Government established the MBS Review Taskforce to review more than 5,700 health professional services listed in the Medicare Benefits Schedule to ensure the scheme is fit for purpose.[12] The review criteria for the MBS Review was to align services with contemporary evidence and practice methods and identify obsolete, outdated and potentially unsafe items.

The initial intention of the Better Access initiative was to address low intensity mental health disorders. However, 13 years on the mental health needs of the Australian community have shifted. While preventative services are designed to reduce the incidence of mental health disorders and acute services address and care for the most unwell within our community, there is a large proportion of Australians with a mental health disorder who have inadequate access to essential psychological services. The mental health needs of this 'missing middle' section of our community are not being addressed.

The current structure of psychological services is no longer fit for purpose. The one-size-fits-all approach of 10 sessions per annum is incompatible and insufficient to meet the mental health needs of the Australian community.

The Better Access initiative could be strengthened to ensure there are clearer clinical care pathways so that the client is more easily referred to the right mental health provider, at the time they need it. Appropriate and targeted psychological assessment services are needed to enable comprehensive formulation of an individual's mental health to ensure services are targeted appropriately and effectively. More support for collaborative team-based care, multidisciplinary communication, evaluation of outcomes and broader based treatment services for people with particular needs, such as parents or carers of children with mental health disorders, is needed.

White Paper development process

From December 2018 to May 2019 the APS undertook a member consultation process to gather feedback to enhance the delivery of psychological services within Medicare.

The APS Board of Directors established an APS MBS Expert Committee to represent members' views and formulate recommendations for change. The APS Board of Directors developed guiding principles for this consultation process (Table 1). The purpose of these principles was to underpin any model developed.

The MBS Expert Committee considered member submissions and survey results to produce a Green Paper for consultation with members.[13] With the assistance of the APS policy team, the committee incorporated member feedback to develop final recommendations to be considered by the APS Board of Directors. The MBS Expert Committee was able to reach consensus on most of the recommendations in this White Paper. There are some areas where Committee members were unable to reach consensus. The APS Board of Directors took the findings of the Committee and, guided by the principles, produced the recommendations in this White Paper.

Table 1: Guiding principles

The APS Board of Directors developed principles to guide the MBS consultation process. These guiding principles are:

Client and outcome focused

Submissions will be underpinned by the clear view of APS members that client and community needs are the priority, including contemporary and long-term positive health and economic outcomes for Australia. Client wellbeing including practice integrity and optimum practice standards will be promoted at all times.

Client equity and fairness is protected within the system

APS members support an MBS system that is just and equitable for the community. Equity is one of the two key considerations in good policy development (the other being efficiency). Access through affordable and available service provision is a key factor in providing equity across the health system. The MBS system should therefore ensure access for different groups within our society regardless of geography, cultural considerations, and income and education levels.

Cost-effective delivery

Recognising the Medicare system supports a broad range of important areas in Australia's health sector, the APS supports cost-effective provision of services in promoting the long-term financial sustainability of the Medicare system. Cost-effective does not mean providing the cheapest service or model, but the method that will, in the most cost-effective way, maximise beneficial outcomes for clients and the community over the long-term.

Simplicity

The system should be simple to understand, administer and use. The greater the complexity of a system, the higher the transaction and administration costs for those providing services, in turn impacting costs for clients. Complexity can also provide unnecessary barriers for clients to the system benefits.

Best practice

The APS recognises the importance of evidence-based practice and the fundamental role of early intervention in preventing deterioration of mental health. The APS acknowledges that mental health research is continually developing, and ongoing education of practitioners is important.

Stepped care

The APS recognises the Australian Government's Stepped Care approach is central to mental health service delivery in Australia.

Accountability, measurement and evaluation

Data collection and availability within strict privacy rules will assist the sector and Government in providing the best possible services. The APS and its members recognise the importance of program and service evaluation in continuous improvement of the MBS system.

Flow-on and longer-term impacts

All policy models are likely to contain both positive and negative unintended consequences or flow-on impacts. The benefits and costs to the clients, the sector and the economy more broadly will be carefully considered. As part of these considerations, it is important that recommendations are integrated and cannot be segmented by Government.

Investing to save

The government has committed to investing $104 billion towards health expenditure in 2019-20.[14] The most recent data suggest that approximately 7.4 per cent of this total health expenditure will be allocated towards mental health-related services,[8] yet the burden of mental illness on the population is a much greater share, accounting for 12 per cent of the total burden of disease.[4]

The costs and level of disability associated with mental health disorders is rising[15] and psychologists play a core role in helping to moderate and contain the burden, including the economic costs. Mental health disorders can emerge at any time and at any age, and can significantly impact a person's life, their family, workplaces, society and the economy. The significant costs mental health disorders impose on individuals, employers and the community, highlights the need for integrated and strategic reforms that optimise the prevention and treatment of mental health disorders in Australia.[16]

This paper outlines a range of key recommendations to strengthen psychological services within Medicare. These recommendations aim to improve the health and wellbeing outcomes for individuals, and as a result, delivering economic returns to government and the broader society. Currently the Government spends approximately $524 million[i].[1] on psychology services as part of the Medicare Benefits Scheme. The recommendations in this paper will require a minor increase in expenditure to improve the effectiveness of the Better Access initiative. This investment will enhance the clinical outcomes and deliver significant benefits, including:

Reduce and avert the burden of disease in Australia: resulting from improved diagnosis and treatment of mental ill-health. The economic burden of mental illness is estimated to be $43.6 billion, and result in 670,000 lost years of healthy life.[17] However, there is evidence to suggest this economic burden is vastly understated. For example, the economic burden of serious mental illness is estimated to be $98.8 billion per year when all downstream costs are included.[3] Other studies and reports produce different estimates of the burden of mental health problems, highlighting the need to comprehensively and consistently measure the economic impacts.[11] In addition to the economic burden, mental health disorders have a significant impact on the quality and length of life for individuals. For example, the life expectancy of both men and women with serious mental health disorders is up to 30 per cent shorter compared with the general population.[18]

The recommendations in this paper aim to improve the assessment, diagnosis and treatment of individuals, reduce the impact of mental health disorders on quality of life and life expectancy, and reduce the growing cost of the mental health burden in Australia.

Increase access to mental health services for those in need: through increased services and mediums of psychological support. While access to psychological services has increased over the last decade, regional and remote populations, and those in deprived regions, continue to be under-serviced. For example, mental health disorders are more common among children and adolescents who experience socio-economic disadvantage[19] and these young people, along with those living in more remote areas, are less likely to use psychological services compared with their metropolitan counterparts.[20]

The recommendations in this paper will improve access to and engagement and participation, of these populations, with mental health services.

Deliver labour market productivity benefits: given improved employment outcomes and increased productivity. A healthy labour supply is one of the major factors that drive the economy, however mental ill-health can significantly impact the labour market, with a one standard deviation decline in mental health found to reduce employment by 30 percentage points.[21] For those employed, mild and moderate mental health disorders can reduce productivity by 4 per cent and 7 per cent respectively, increasing to over 9 per cent for severe mental health disorders.[22] For example

(i) Expenditure on psychological services in the 2017-18 financial year

absenteeism and reduced productivity (presenteeism) due to mental ill-health are estimated to be $11 billion per year.[23,24] As an example, psychologist-led return-to-work programs have been shown to deliver a return of approximately $4.70 per dollar invested.[5] Further investment in improved psychological services will assist in supporting individuals with mental health disorders to gain and maintain employment, and promote the mental health and wellbeing of the workforce.

Generate health sector savings: resulting from a reduction in health service utilisation including fewer emergency department visits and inpatient hospital stays. Individuals experiencing mental illness can incur a range of avoidable health-related expenses, including emergency department presentations and hospitalisations. In 2017-18, there were 286,985 mental health-related visits to public hospital emergency departments, with almost a third resulting in hospital admissions.[9] With the average cost of an admitted emergency department presentation of $977 (and the average cost of a non-admitted presentation of $517),[25] the costs of emergency department presentations and hospitalisation relating to mental illness are estimated to be over $190 million each year. Investing in mental health and wellbeing provides an opportunity to reduce avoidable costs associated with emergency department presentations and hospitalisations. An early evaluation of the Better Access initiative found that improved access to psychological services within the community helped deliver better outcomes for patients in the long term and prevented unnecessary hospitalisations.[20]

Provide justice sector savings: resulting from a reduction in justice service utilisation. Most people with mental health problems do not commit crimes, however mental health disorders are overrepresented within the justice sector.[26] The prevalence of mental health disorders among prisoners is almost double the 12-month prevalence of mental health disorders within the community.[11,27] The high prevalence of people with mental illness in the criminal justice system is a major indirect contributor to the economic burden of mental illness in Australia. It is estimated that a total of $2.9 billion in government justice service expenditure relates to supporting people with a mental health disorder, representing approximately 15 per cent of the recurrent government justice expenditure.[28] This does not include the economic impacts of offending on the broader community and the justice sector more broadly.

The development of serious antisocial patterns of behaviour that lead to offending are likely to emerge during childhood, with almost 50 per cent of prisoners estimated to have had a conduct disorder before age 18.[29] The recommendations in this paper support interventions to address mental health and behavioural disorders, especially among children. These interventions will produce cost savings for the government by reducing the number of young people entering the criminal justice system.

"The recommendations in this paper aim to... improve the health and wellbeing outcomes for individuals, and as a result, deliver economic returns to government and the broader society."

Recommendations

Recommendation One:

Amend the Better Access Framework

The APS Position

Psychologists are enabled to provide their full scope of services within Medicare for the benefit of the client.

Background and context

Psychologists have advanced expertise and skills to provide psychological therapy and are distinct from other health professionals due to the depth of psychological expertise, training and skills.

In addition to differences between psychologists and other mental health professionals, there are distinct and diverse competencies between the different areas of psychological practice as recognised by the Psychology Board of Australia. Area of Practice Endorsement is a mechanism provided for by Section 98 of the National Law through which additional qualifications and advanced supervised practice are recognised by the Psychology Board of Australia and identified to the public.[30]

Within the current structure of the Better Access initiative, clients of psychologists providing focussed psychological strategy items, can only claim a rebate for a defined range of therapies. This limits the full range of psychological treatment that can be provided to clients within the Better Access initiative and may prevent the client from receiving the right evidence-based care at the right time. For example, under the current model:

- Personality disorders are not an eligible diagnosis
- Eye movement desensitisation and reprocessing is not an eligible intervention for the treatment of post-traumatic stress disorder if delivered by psychologists who do not hold an Area of Practice Endorsement in clinical psychology
- Assessments are not an eligible activity for psychologists who do not hold an Area of Practice Endorsement in clinical psychology
- Evidence-based interventions cannot be provided effectively due to the restriction on the number of sessions.

Further, psychologists with provisional registration work with clients under supervision as part of their training (internship or placements within a postgraduate course). This work is currently undertaken at a cost to the provisional psychologists who are not paid for providing therapy to clients. The APS believes that all provisional psychologists registered with the Australian Health Practitioner Regulation Agency should be remunerated for their work. Such placement/internship option provides additional workforce and ensures they are work-ready for the Medicare environment upon completion of their training.

Mental health clients have diverse treatment needs and stand to benefit from increased recognition of diverse skills within the psychology profession. This will enhance the availability of treatment and simplify the referral pathways. This stratification of mental health interventions, as recommended by the Mental Health Commission,[11] aligns the needs of the client with the skills and training of the treating professional.

In recognition of the advanced skills of psychologists, the APS believes the psychological workforce is separated from the allied health professionals who provide mental health services as an adjunct to their profession. To enhance referral pathways, three levels of mental health interventions should be available to clients. The following therapy approaches are suggested for the delivery of mental health services within Medicare:[31]

a. Supportive Therapy
Therapies that can be provided by other medical and allied health professionals. Supportive therapy includes activities such as establishing, maintaining and supporting relationships with clients and relatives, using techniques, such as counselling and stress management and basic behavioural techniques.

b. Psychological Therapy
Therapies and assessments can be provided by all psychologists as they require a high level of knowledge and skill. This therapy includes undertaking an increased range of psychological interventions to include all Level I evidence-based therapies as described by the NHMRC guidelines.[32]

c. Advanced Psychological Therapy
The psychologists who can provide this type of therapy are those with an Area of Practice Endorsement and who are working within their area of advanced competency, as determined by the Psychology Board of Australia and the Australian Psychology Accreditation Council. These activities require expert psychological intervention, in circumstances where the client has a complex, comorbid or treatment resistant mental health disorder, which requires high level clinical judgement to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

Recommendation One: Amend the Better Access Framework

- Separate the psychology workforce from medical and other allied health professionals who provide mental health services as an adjunct to their profession.
- Three levels of mental health interventions are available to clients as follows:
  - **a. Supportive Therapy** provided by medical and other allied health professionals.
  - **b. Psychological Therapy** provided by all psychologists.
  - **c. Advanced Psychological Therapy** provided by psychologists with an Area of Practice Endorsement and who are working within their area of advanced competency, as determined by the Psychology Board of Australia and the Australian Psychological Accreditation Council.
- Clients being treated by provisionally registered psychologists are eligible to receive a rebate.

Recommendation Two:

Individual psychological services

The APS Position

Strengthening the delivery of individual psychological services within Medicare requires a more targeted approach to addressing the burden of mental health in Australia.

Background and context

The current one-size fits all approach within Medicare needs to evolve to align with the Australian Government's Stepped Care approach to mental health service delivery. There are opportunities to strengthen psychological services within Medicare to ensure clients are receiving the right level of intervention to make significant clinical improvements to their mental health. The current availability of 10 sessions per annum limits the ability of many clients to access evidence-based psychological interventions to meet their mental health needs. For example, people with a psychotic disorder,[33] eating disorder,[34] persistent or recurrent depressive disorders,[35] borderline personality disorder[36] and conduct disorder[37] often require more intensive services to facilitate recovery and prevent transitions to secondary care, such as hospitalisation. Collaborative and team-based care can be strengthened by embedding reporting and communication between health professionals. Broadening the referral process to include all medical practitioners recognises the inextricable link between mental and physical health conditions. Strengthening this collaboration includes ensuring outcomes are measured and responsiveness is inherent in the system.

Proposed solution

Implementing a stepped care approach to the delivery of psychological services within Medicare.

The APS suggests clients are stepped through levels of psychological care according to the:

- nature of the mental health disorder
- expertise of the psychologist
- needs of the client (number of sessions required to achieve effective clinical outcomes; up to 20 sessions for low intensity treatment needs and up to 40 for clients with a specific diagnoses and high intensity treatment needs).

This stepped care approach is enabled through two referral pathways to psychologists (See Figures 1 and 2):

1. Low Intensity Disorder Pathway
(Up to 20 sessions of *Psychological Therapy* provided by any psychologist); and

2. High Intensity Disorder Pathway
(Up to 40 sessions of *Advanced Psychological Therapy* provided by psychologists with an Area of Practice Endorsement and who are working within their area of advanced competency, as determined by the Psychology Board of Australia).

Low Intensity Disorder Pathway

Referral criteria: Client can be referred to the *Low Intensity Disorder Pathway* if they do not meet criteria for the *High Intensity Disorder Pathway*.

Number of sessions (maximum): Clients referred for this pathway can access up to 20 sessions per year, with a review after each 10 sessions.

Eligible Providers: All psychologists can provide *Psychological Therapy* to clients referred through this pathway.

High Intensity Disorder Pathway

Referral criteria: The *High Intensity Disorder Pathway* is limited to clients diagnosed with the following diagnosis:

- Eating Disorders[34]
- Psychotic Disorders[iii] [33]
- Conduct Disorders[29]
- Borderline Personality Disorder[36]
- Recurrent and Persistent Depressive Disorders[35]

Number of sessions (maximum): Clients eligible for this referral pathway can access up to 40 sessions per year, with a review after each 10 sessions.

Eligible Providers: Psychologists with an Area of Practice Endorsement and who are working within their area of advanced competency, as determined by the Psychology Board of Australia, can provide *Advance Psychological Therapy* to clients referred through this pathway.

Clients initially referred through the *Low Intensity Disorder Pathway* can transition to the *High Intensity Disorder Pathway* at any time within the first 20 sessions upon review by a medical practitioner.

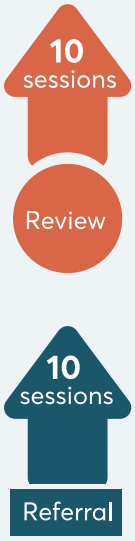


Figure 1. Low Intensity Disorder Pathway

Client can access up to 20 Psychological Therapy sessions delivered by all psychologists.

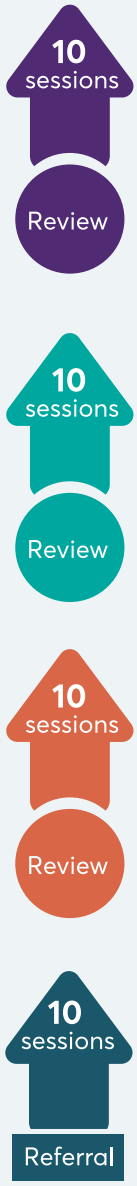


Figure 2. High Intensity Disorder Pathway

Client can access up to 40 Advanced Psychological Therapy sessions delivered by psychologists with an Area of Practice Endorsement and who are working within their area of advanced competency, as determined by the Psychology Board of Australia.[ii]

(ii) Eating Disorders, Psychotic Disorders, Conduct Disorders, Borderline Personality Disorder and Recurrent or Persistent Depressive Disorders.

(iii) excluding substance induced psychosis and schizoid personality disorder

To support this stepped care approach to the delivery of psychological services within Medicare, the APS proposes the following recommendations:

The APS suggests the following amendments to medical practitioner referrals:

- Increase the maximum number of allowable sessions per referral from 6 to 10 sessions.
- Broaden eligible referrers to include all medical practitioners registered with the Australian Health Practitioner Regulation Agency to enhance collaboration, reduce administrative burden on the client and reduce the cost to government.

The APS suggests the following amendments and new criteria for medical practitioner reviews:

- Require reviews after each block of sessions (maximum of 10 sessions)
- Introduce pre- and post- outcome measures for each block of sessions
- Require a psychological report to be provided to the referring practitioner prior to each review
- Introduce review criteria after each course of treatment (up to 10 sessions).

Review Criteria

The criteria to access more than the initial 10 sessions is based on the combination of measured outcomes, the nature of the presenting problem and how they match with the qualifications of the treating psychologist.

This requires amendments to the current triage and referral processes, the embedding of outcome measures and communication (reporting) between health professionals and simplifying the initial triage process.

After each course of Therapy, the client will require a review by the referring medical practitioner to determine the efficacy of treatment and make decisions about the next step of psychological care the client needs.

For clients to access an additional course of treatment (10 sessions) the treating psychologist will need to provide a report that contains evidence of the benefits of therapy preferably in the form of a standardised outcome measure, however in certain circumstances functional measures may be preferable. This brief report must be provided to the referrer prior to the medical review and the psychologist will need to indicate whether the client is either:

i. benefiting from therapy but is not yet symptom free; or
ii. benefiting from therapy but would benefit from continued treatment to prevent relapse; or
iii. has not benefited from therapy, but therapy has prevented inpatient admissions or inappropriate use of other services; or
iv. make recommendations for alternative treatment options.

Where these criteria are met, the referring medical practitioner will either refer the client for additional treatment sessions (up to 10 sessions); or where the client was previously referred through the Low Intensity Disorder Pathway, the medical practitioner can refer the client to the High Intensity Disorder Pathway if they meet the criteria.

Where these criteria are not met, the referring medical practitioner will need to consider whether to:

- refer to an alternate psychologist; or
- refer to a psychiatrist or paediatrician; or
- refer the client to an alternative service.

Economic case for the High Intensity Disorder Pathway

The following section outlines the economic case in support of the recommendation to increase the number of sessions for the serious mental health disorders eligible for the High Intensity Disorder Pathway.

- **Eating Disorders** – Eating disorders are serious mental illnesses that require physical and psychological treatment. In 2014, there were more than 945,000 Australians living with an eating disorder, with less than 30 per cent accessing treatment.[38]

  Applying best practice interventions to all new cases of eating disorders would represent an intervention cost of approximately $2.8 billion. These best practice interventions include a multidisciplinary team approach integrating medical, nutritional and psychological treatments.

  Due to the long lasting and debilitating ways in which eating disorders impact individuals in society, the resultant productivity benefit and other gains to the economy would be approximately $15 million. This represents a return on investment of more than 5 to 1.
- **Psychotic Disorders** – The costs of early psychosis intervention (including increased inpatient and community care) are outweighed by benefits associated with reduced outpatient and inpatients stays. A short-run return on investment of 2.5 has been found to occur, with an Australian study demonstrating a return on investment of 8.6 over the long run.[39-41]
- **Conduct Disorders** – Nearly 6 per cent of children aged 5-16 display behavioural problems associated with conduct disorder. A longitudinal study of children found that by age 28, the

costs to society for individuals with childhood conduct disorder were ten times higher than for children without these behavioural problems. Compared with their peers, these children are on average:

- twice as likely to leave school with no qualification
- four times more likely to become drug dependent
- six times more likely to die before the age of 30
- 20 times more likely to end up in prison.

The lifetime costs of untreated conduct disorders are approximately $AUD 289,000 per person.[42] Evidence suggests that appropriate treatment of conduct disorder in children will result in a 58% recovery rate where these children no longer meet criteria. This early intervention for conduct disorder is estimated to yield a return on investment of 7.89 using conservative clinical measures, and a return on investment of 34.1 when all downstream costs are included.

- **Borderline Personality Disorder** – The provision of evidence-based psychological treatment to clients with borderline personality disorder results in a reduction in costs associated with acute health service use, such as inpatient admissions, emergency department presentations and intensive community-based services. The estimated cost saving for treating borderline personality disorder across studies was $US 2,987 (~$AUD 4,313) per client per year.[43]
- **Recurrent and Persistent Depressive Disorders** – The marginal impact of severe depression on labour productivity is 9.2 per cent through both absenteeism and presenteeism. It has been estimated that providing support to people with severe mental illness could generate a return on investment of 1.9 in the short term and 2.3 in the long term.[22]

Recommendation Two: Individual psychological services

- Increase the number of available sessions for clients who require more intensive psychological services to stabilise their mental health, prevent deterioration and relapse and to allow the delivery of evidence-based interventions that support recovery.
- Clients are stepped through levels of psychological care according to the:
  - nature of the mental health disorder
  - expertise of the psychologist
  - needs of the client (number of sessions required to achieve effective clinical outcomes; up to 20 sessions for low intensity treatment needs and up to 40 for clients with a specific diagnoses and high intensity treatment needs).
- Regularly measure and review outcomes to determine treatment progress and to ensure responsiveness is embedded in the delivery of psychological services within Medicare.
- Clients can be referred to a psychologist by any medical practitioner registered with the Australian Health Practitioners Regulation Agency.
- Collaborative care is supported by strengthened reporting, enhanced referrals and integrating outcome measurement, and by implementing criteria to clarify clinical care pathways.

Recommendation Three:

Family and couples therapy

The APS Position

Psychologists play an integral role to support family groups and couples and enhance the quality of relationships and the emotional, psychological and physical safety of families and couples where mental health problems are involved.

Background and context

The Australian Institute of Family Studies concluded the presence of mental health problems can have a significant impact on family relationships and dynamics, and as such the burden of mental illness is particularly relevant for family relationships.[44] For example, a changed or changing relationship arising from a family member's mental illness, which may involve issues related to living with, or caring for, that person.

Family dynamics and the quality of family and couples relationships can impact on every member of the relationship and have a significant influence on the prevalence and trajectory of mental health problems.[45] Access to appropriately qualified mental health experts for relationship and family therapy can enhance the mental health of the couple and family and greatly enhance the wellbeing of each family member. For example, evidence shows that it can enhance the capacity of families to resolve problems before the relationship breaks down, improve the physical, emotional and psychological safety of all members of the family/couple and reduce the burden of mental health problems in the community.[44]

Recommendation Three:
Family and couples therapy

Introduce items for family and couple therapy where one or more members of the family/couple are experiencing mental health problems.

See Appendix for item description

Recommendation Four:

Amend group therapy items

The APS Position

Current restrictions in the use of group therapy items within Medicare are a barrier to access to these services. Improving access to group therapy will allow for more effective treatment for a range of people and diverse groups.

Background and context

There is a strong evidence base for the effectiveness of group therapy treatment, however the uptake of current items for group therapy could be improved.[32,46] Group therapy provides cost effective and evidence-based interventions for many mental health disorders. However, the flexibility of current group therapy items within Medicare could be enhanced to improve access, minimise the impact (i.e., out of pocket costs) of non-attendance by some participants for small groups, enhance access to culturally appropriate treatment and improve the viability of group treatment in regional, rural and remote areas.

Recommendation Four:
Amend group therapy items

Amend group therapy items within Medicare by:

- reducing the minimum participant numbers and increasing the maximum number of participants
- enabling group therapy for kinship groups
- enabling two clinicians to facilitate a group therapy program
- increasing the range of timed items to allow for flexible group therapy and longer sessions.

See Appendix for item description


22 The Australian Psychological Society

Recommendation Five:

Evidence-based interventions for parents and carers of children with a mental health disorder

The APS Position

The effectiveness of treatment for children experiencing a mental health disorder is significantly enhanced when parents and carers are involved in the treatment process.

Background and context

There is a large body of evidence supporting enhanced outcomes when psychologists can work with parents, carers and the family of children with mental health needs, without the child being present.[47] The literature shows that evidence-based interventions with parents and carers of children with a mental health disorder improve treatment outcomes, shift the long-term trajectory of the child's wellbeing and reduce the wide ranging social, emotional and economic burden on the child and their family.[29] For example, compared to children who receive treatment during childhood, children with an untreated conduct disorder are at a much greater risk of social, emotional and economic disadvantage including an increased risk of offending behaviour and incarceration.[29] The effectiveness of early intervention and parental involvement in treatment is poorly recognised in the current system. Additionally, the child mental health services in Australia that do exist, struggle to bridge the gaps.

Recommendation Five:
Evidence-based interventions for parents and carers of children with a mental health disorder

Introduce an item for the specific purpose of providing evidence-based interventions between health professionals and family, parents, carers and/or support people of children or adolescents with a mental health disorder.

See Appendix for item description

Recommendation Six:

Developmental neurocognitive assessments

The APS Position

Comprehensive developmental neurocognitive assessments are essential to improve diagnostic accuracy of a mental health condition and enable interventions, including the functional impacts of the neurocognitive problems, to be appropriately tailored and targeted.

Background and context

Developmental neurocognitive impairment is an early risk factor for the onset of a mental health disorder; early identification and treatment of neurocognitive impairment may prevent progression towards mental illness.[48]

Although children and adolescents have access to mental health treatments within Medicare, treatment can be less effective or misdirected when the child or youth has an undiagnosed neurodevelopmental disorder (e.g., attention deficit hyperactivity disorder, specific learning disability, schizophrenia/psychosis) or a developmentally acquired neurological condition (e.g., seizure disorders, meningitis, birth trauma, foetal alcohol spectrum disorders), or where the impact of these disorders is not recognised until adulthood.[49-52]

Neurodevelopmental disorders pose an increased challenge to correct diagnosis and effective treatment of mental health disorders[53] and are often undetected or misdiagnosed if not appropriately and expertly assessed.[54] Improving access to sources of reliable and comprehensive assessment (beyond a mental health assessment) reduces the risk of misdiagnosis and inappropriate treatment (e.g., in relation to medication for attention deficit hyperactivity disorder), and has been shown to enhance outcomes in disorders such as learning disabilities.[55-57]

Recommendation Six:
Developmental neurocognitive assessments

Introduce items that enable clients to access comprehensive developmental neurocognitive assessments to accurately delineate the impact of cognitive, behavioural and psychosocial issues that are associated with neurodevelopmental problems and to improve diagnostic accuracy and client outcomes, especially among children.

See Appendix for item description

Recommendation Seven:

Standardised evaluation and measurement for the delivery of psychological services

The APS Position

Evaluation and outcome measurement is an integral component of mental health service systems to monitor and improve services and ensure investment is targeted and outcomes achieved.

Background and context

There is currently little to no data available about the effectiveness of the Better Access initiative. Without the presence of more extensive data there is no evidence about service effectiveness or the ability to evaluate and provide a targeted response to reducing the increasing burden of mental health in Australia.[58] The current population measures used to evaluate the Better Access initiative lack specificity, are not appropriate for evaluating outcomes, and more appropriate and targeted measures are required.[59] The evidence-based delivery of psychological services includes the use of routine outcome measures to provide evidence about baseline symptoms, progress throughout treatment and the extent of treatment effectiveness.[60-62] The use of measures is a well-established principle in the psychology profession and is considered best practice. There are a large number of tools for measuring outcomes and the decision about which tool to use is usually determined by the type of presenting problem(s) including cultural considerations to ensure the tool is validated in the population to which the client belongs. For example, some measurement tools have not been validated for use with Aboriginal and Torres Strait Islander peoples.

There is a strong case for the use of routine and consistent outcome measures within Medicare, not only for tracking individual client progress through treatment but also as a mechanism for providing policymakers and Government with evidence of the effectiveness, quality and safety of the Better Access initiative. Evaluation across a system, particularly a devolved system, is essential for identifying areas for improvement and determining what works, for who and when.

Recommendation Seven:

Standardised evaluation and measurement for the delivery of psychological services

- Invest in the collection of data, including outcome data, within the Better Access initiative.
- Introduce standardised evaluation into the Medicare Benefits Scheme and that the APS be consulted and work with the Government to assist with the development of appropriate tools.

> **"Evaluation... is essential for identifying areas for improvement and determining what works, for who and when."**

Recommendation Eight:

Neuropsychological assessment to differentiate dementia from mental health disorders

The APS Position

Neuropsychological assessment to differentiate dementia from mental health disorders

Background and context

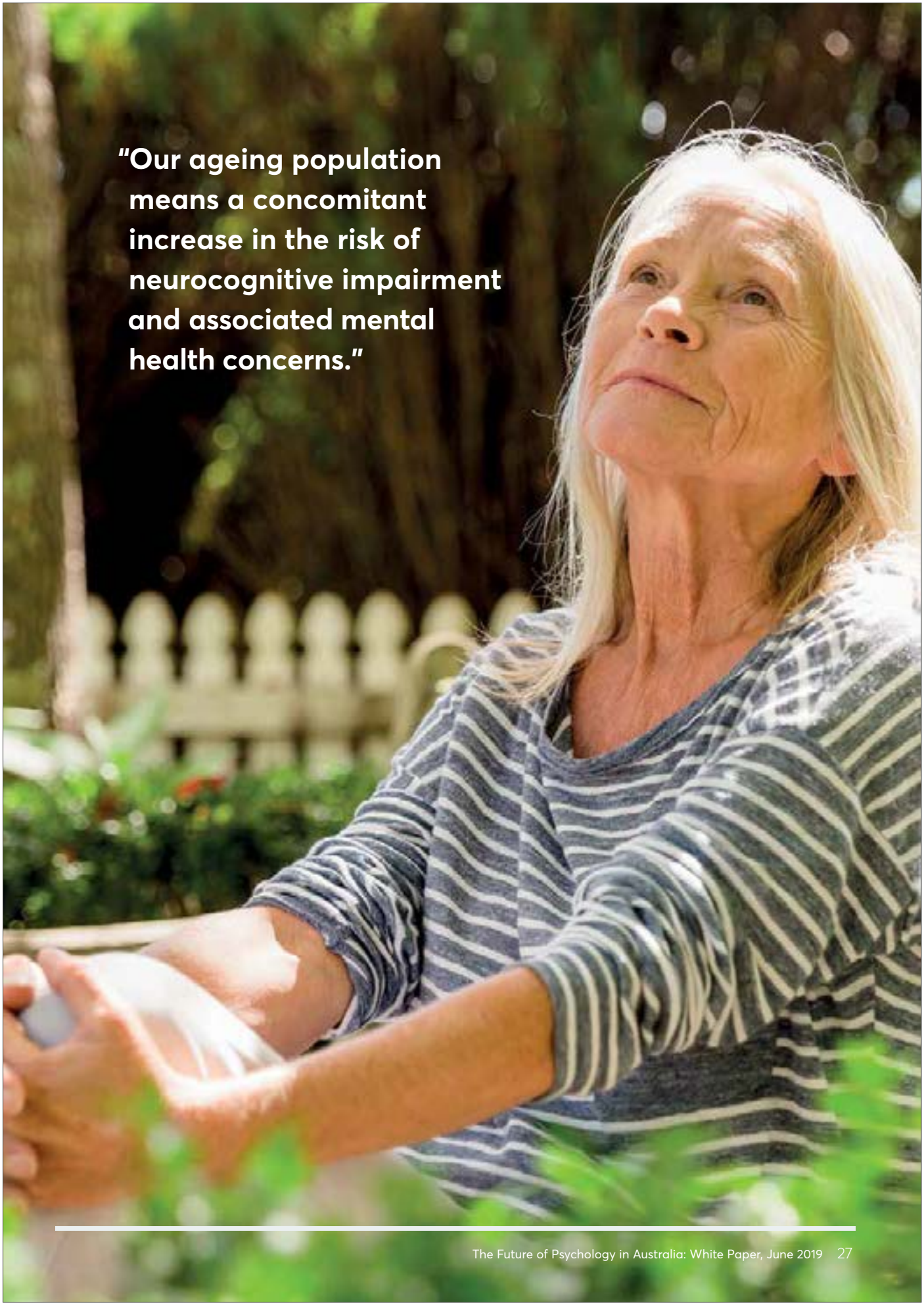
Our ageing population means a concomitant increase in the risk of neurocognitive impairment and associated mental health concerns.[63-66] Improving diagnosis and care can reduce the socioemotional and economic burden of this fast-growing area of need in the community.[67-69]

Differentiating mental health conditions from neurocognitive impairments such as dementia, as well as early/timely diagnosis of dementia by a clinical neuropsychologist, can facilitate the provision of more appropriately targeted treatment and care, at the same time reducing the impact or risk of further mental health concerns. In particular, certain mental health disorder (e.g., depression, anxiety, psychosis) and dementia frequently co-occur or can masquerade as one another, increasing diagnostic complexity.[70,71] Early onset dementias, as well as rare, atypical and comorbid neurological presentations in this domain are also vulnerable to misdiagnosis.[70] Thorough, objective neuropsychological assessment and expert knowledge is critical to the provision of appropriate care for this client group.

Recommendation Eight:
Neuropsychological assessment to differentiate dementia from mental health disorders

Introduce items to allow a comprehensive neuropsychological assessment for people with potential neurocognitive problems/dementia who are at increased risk of a mental health disorder, or who may have a co-occurring mental health condition.

See Appendix for item description



The Future of Psychology in Australia: White Paper, June 2019 27

Recommendation Nine:

Consultation with family, parents, carers and support people

The APS Position

The treatment of specific populations (e.g., children, people with an intellectual disability, older people) and mental health problems (i.e., psychotic disorders) is enhanced when there are sessions with family, parents, carers and other support people.

Background and context

There is strong evidence for enhanced clinical outcomes for people with a mental health disorder when the client's support people can be involved in their care and treatment.[73] Among specific populations (e.g., children, people with an intellectual disability, older people), treatment is enhanced when family, parents, carers and other support people are involved in the clients' care. Involving carers enhances collaboration, increases engagement and recognises the value of support people in assisting clients with a mental health disorder.[74] This is recognised within Medicare for medical practitioners by the availability of sessions with people who form a support team for the client but this is not currently available for psychological services.

Recommendation Nine:
Consultation with family, parents, carers and support people

Introduce an item for the specific purpose of enabling consultation between health professionals and family, parents, carers and/or support people.

See Appendix for item description

Recommendation Ten:

Mental health case conferencing with other health professionals

The APS Position

Case conferencing with other health professionals enhances clinical care; aligns with the evidence-base, and supports multidisciplinary collaboration for the benefit of the client.

Background and context

The value of multidisciplinary collaboration between health professionals is well documented.[75] It enables complex care management, improves communication between the treating team, and enhances clinical outcomes for the client. The inclusion of items for case conferencing between health professionals is well supported throughout the Medicare Benefits Schedule and aligns with both the Mental Health Reference Group[76] and Specialist and Consultant Physician Consultation Clinical Committee's[77] recommendations for including case conferencing items for allied health professionals, including psychologists. However, these items are not yet available to psychologists which has the potential to negatively impact on the safety and quality of mental services for the client.

Recommendation Ten:
Mental health case conferencing with other health professionals

Introduce items to enable psychologists to be included in case conferencing with other health professionals involved in the client's care.

See Appendix for item description

Recommendation Eleven:

e-Mental health assessments

The APS Position

Psychologists play an integral role in facilitating appropriate access to, and measuring the effectiveness of, low intensity e-Mental health services.

Background and context

Research highlights the potential positive client outcomes of e-mental health and clients, especially those with low intensity treatment needs, may benefit from access to high quality, evidence-based and planned online treatment programs.[78] Early access to online treatment programs has been shown to reduce distressing symptoms of mental health disorders, improve the individual's ability to cope and recover and prevent the deterioration of mental health.[79] Individuals benefit the most when they are matched to the right treatment for their presenting mental health problem. This requires an assessment of the problem and any risks, and a facilitated referral to the appropriate treatment program.

The Australian Government has invested in a suite of e-Mental health/online therapy programs and is developing a certification framework and national standards for digital mental health services; however, there is currently low uptake of these programs by the Australian community. Psychologists can play an integral role in facilitating appropriate access to these programs to facilitate uptake during this transitional phase. Psychologists have the expertise to assess the suitability of a client for the e-mental health treatment program and provide a mechanism for appropriate evaluation of program effectiveness.

Recommendation Eleven:
e-Mental health assessments

Introduce two items for clients with low intensity treatment needs to assess suitability for and facilitate access to e-mental health programs and to assess the client's response to these intervention programs.

See Appendix for item description

Recommendation Twelve:

Initial intake, assessment and report item

The APS Position

Assessments and reports are essential to ensuring treatments are targeted; the client has been appropriately referred, and the referring practitioner and treating team have up to date information. This is important to assist in making informed decisions about the client's health, including mental health.

Background and context

Psychologists are experts in the assessment and treatment of mental health disorders and other related problems impacting a client's ability to function in society. They conduct comprehensive assessments of psychological problems impacting on the client's functioning across multiple life areas (e.g., occupational, social, personal). This often includes conducting formal assessments to measure baseline symptoms, mental state examinations, risk assessments and documenting relevant clinical history. This assessment function is necessary for formulating the client's current mental health problems and for making decisions about the most effective treatment.

The current structure of care pathways to psychological treatment include a brief assessment by the referring medical practitioner.[80] This assessment typically involves identifying and treating medical issues that may be causing or contributing to mental health symptoms and preparing a mental health care plan and referral for psychological treatment services.

There is a need to strengthen the collaboration and communication between medical practitioners and psychologists for the benefit of the client.[81] This includes collaboratively assessing the client's mental health needs by respecting the differentiation between the professions and supporting team-based care where the client benefits from a multidisciplinary approach to their treatment. This will also assist medical practitioners and other health professionals to better understand the psychological issues currently impacting on the client.

There are no current items for an initial assessment and report conducted by psychologists to strengthen the multidisciplinary team-based approach to mental health care for the benefit of the client. Additionally, assessments conducted by psychologists are not explicitly available for clients and although integral to treatment, if included they would reduce the number of remaining treatment sessions allowable under the Better Access initiative.

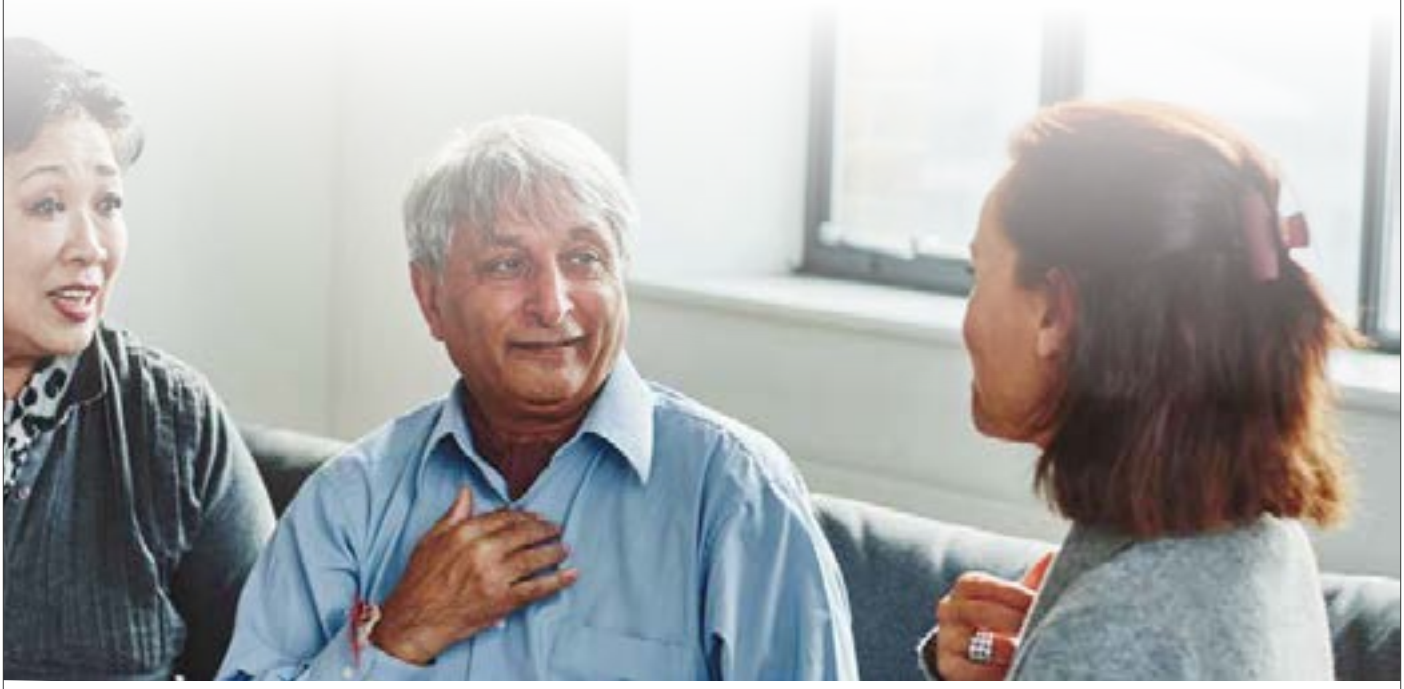
Recommendation Twelve: Initial intake, assessment and report item

Introduce items to conduct an initial assessment of a client presenting for treatment with a psychologist. This includes preparing a report for the referring practitioner to enhance collaborative care arrangements.

See Appendix for item description

Recommendation Thirteen:

Universal access to interpreters



The APS Position

Interpreter services are necessary and important to facilitate universal access to psychologists within Medicare.

Background and context

Australia is a culturally diverse country with over 300 languages spoken across the community and 21% of Australians who speak a non-English language at home.[82] Many sub-groups within this population have experienced adversity across their lifespan, are marginalised in our community and are at an increased risk of developing mental health problems.[83] For example, refugees and asylum seekers are likely to have experienced multiple traumas and are estimated to be 3-4 times more likely to develop a mental health disorder.[84,85]

Access to professional interpreter services is currently devolved across the states and territories and only three Australian states have a state-wide transcultural mental health service. This means 3.5% (819, 925)[82] of the Australian population who do not speak English well or at all are without clear and universal access to psychologists within the Better Access initiative. However, there is strong evidence for the effectiveness of interpreters when delivering psychological therapy, including the benefit of professional interpreters in bridging cultural barriers to access.[86,87]

Access to the Department of Social Services' Free Interpreting Services (the Translating and Interpreting Service) is available for medical practitioners delivering Medicare services in private practice to eligible non-English speakers.[88] However, this professional interpreting service is not available to clients seeking mental health treatment services within Medicare. This leaves an already marginalised section of the Australian population with limited access to psychologists.

Recommendation Thirteen: Universal access to interpreters

Expand access to free interpreter services currently available for medical consultations within Medicare (the Translating and Interpreting Service) to psychological services delivered under Medicare.

Recommendation Fourteen:

Amend telehealth items

The APS Position

Improve the flexibility of telehealth items.

Background and context

Access to psychological services via telehealth has improved with the introduction and recent expansion of items. Minor amendments to telehealth items could further increase access to psychological services, particularly for disadvantaged groups. These amendments are not intended to replace face-to-face services.

Recommendation Fourteen:
Amend telehealth items

Expand access to telehealth for clients in metropolitan areas who face barriers to attending face-to-face psychological therapy and removing barriers to access for people in regional, rural and remote areas of Australia.

See Appendix for item description

Recommendation Fifteen:

Enhance access to psychological services for people in regional, rural and remote Australia

The APS Position

Access to psychologists for people who live in regional, rural and remote areas of Australia requires more targeted reform within Medicare.

Background and context

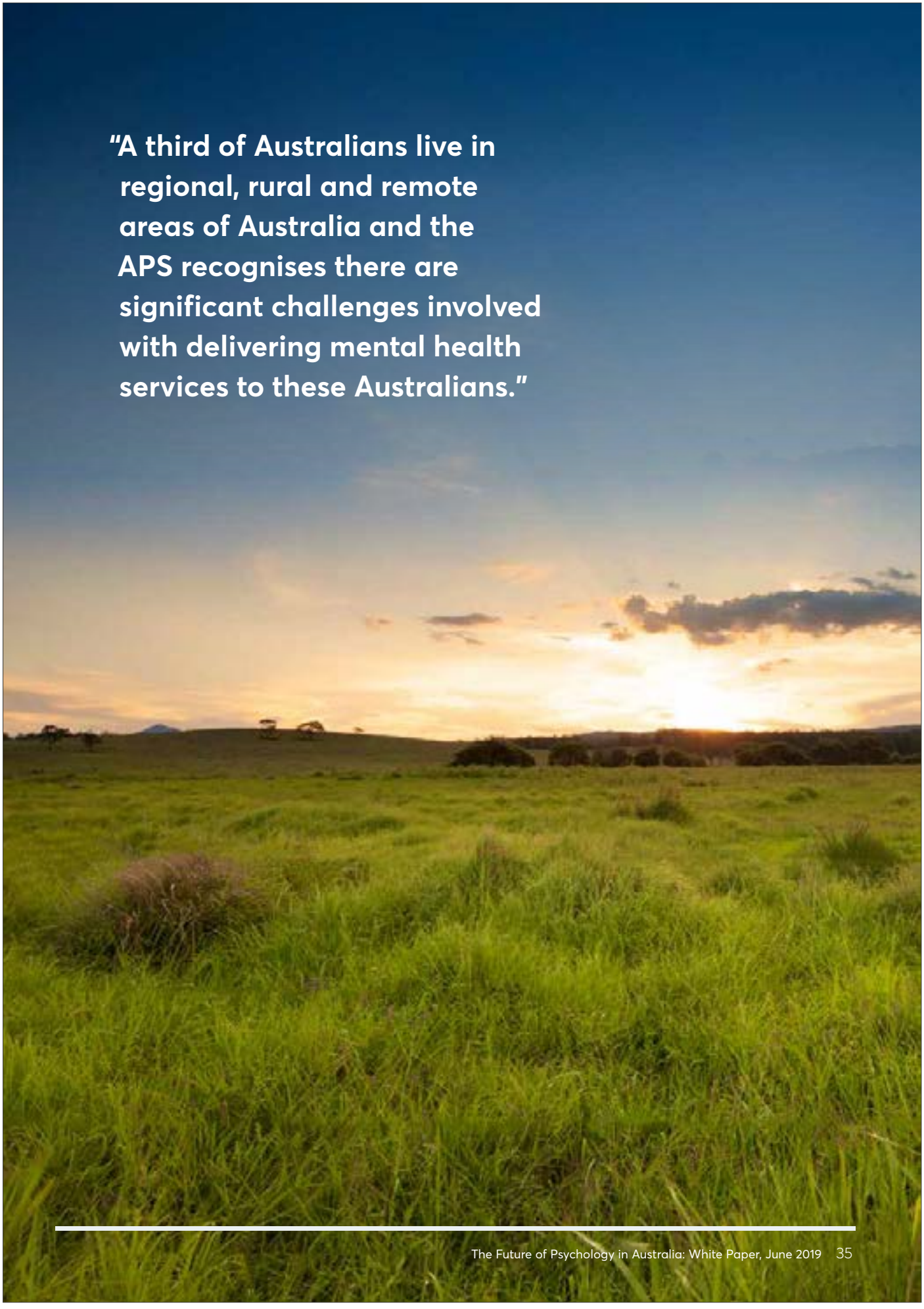
A third of Australians live in regional, rural and remote areas of Australia and the APS recognises there are significant challenges involved with delivering mental health services to these Australians. The nature of the mental health workforce is determined by various factors including health services models, and recruitment and retention strategies.

Efforts to improve the engagement and participation with mental health services is a priority across Australia[89] and this relies on the availability of psychologists in regional, rural and remote areas. The distribution of psychologists declines with remoteness.[1]

Psychology practices in regional, rural and remote areas face greater financial challenges due to a decreased client base, larger distances between psychologists and clients; and the increased demand for bulk billing. These challenges negatively impact on the financial viability of providing psychological services and the availability of psychologists in these areas. While this disproportionate spread of health practitioners is recognised within Medicare for rural GPs, there remains no financial incentive to improve the sustainability of regional, rural and remote psychological practices.

Recommendation Fifteen:
Enhance access to psychological services for people in regional, rural and remote Australia

Introduce financial incentives, such as rural loadings, to improve the financial viability of providing psychological services to people who live in regional, rural and remote areas of Australia.


"A third of Australians live in regional, rural and remote areas of Australia and the APS recognises there are significant challenges involved with delivering mental health services to these Australians."
The Future of Psychology in Australia: White Paper, June 2019 35

Recommendation Sixteen:

Independent mental health assessment, opinion and report

The APS Position

Independent mental health assessments provide practitioners with an opportunity to obtain another opinion about the best course of treatment for the benefit of the client.

Background and context

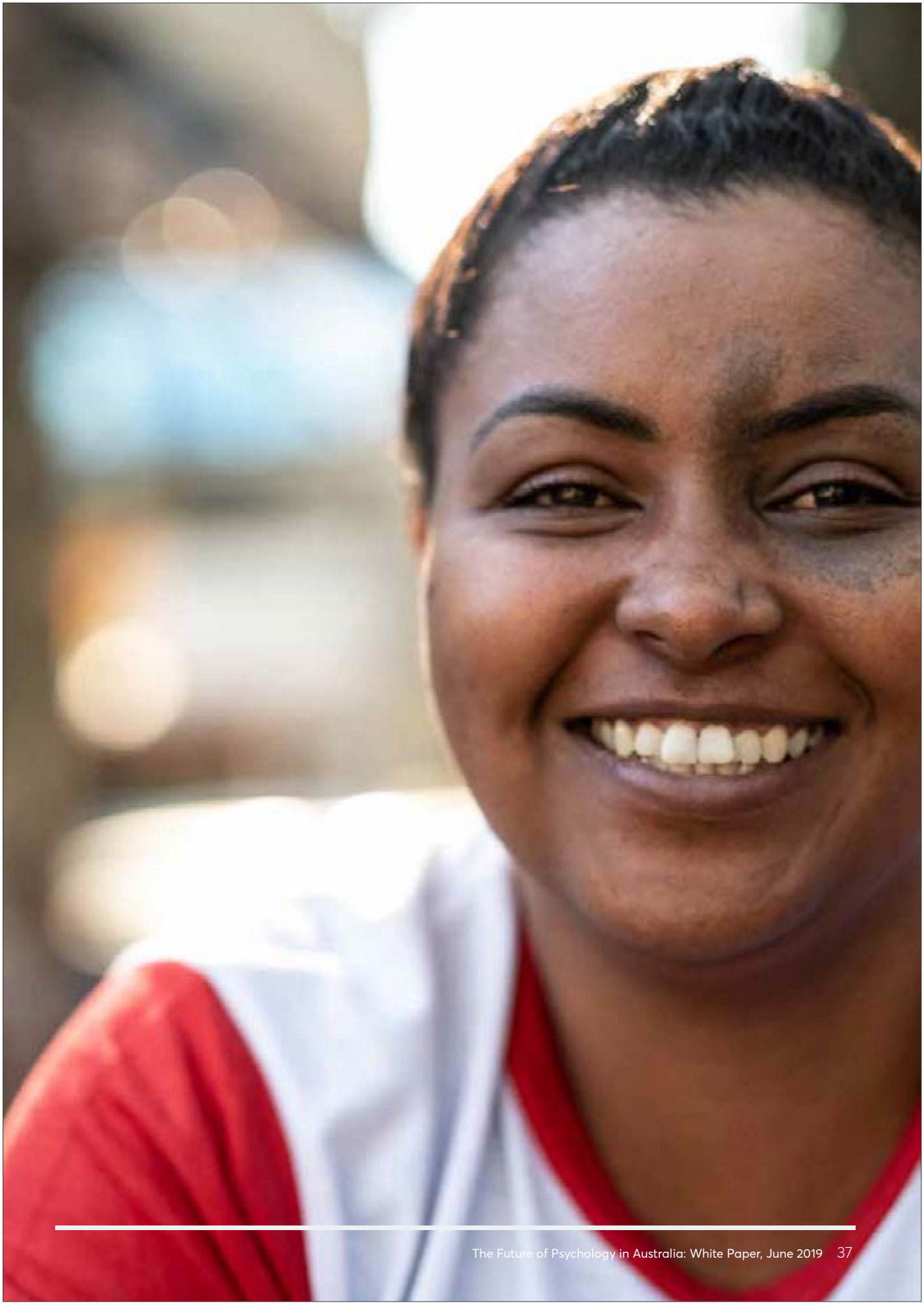
The quality and effectiveness of health services requires a mechanism to gather an independent opinion on the client's mental health diagnosis, treatment needs and progress.[90] While there are mechanisms available to other health professionals within Medicare, there is little choice for clients and referring medical practitioners to obtain an independent opinion about a mental health diagnosis and treatment progress.

Independent and comprehensive assessment of the client's treatment needs are required to enhance the quality and safety of services. The benefit of this assessment is to provide clients with some additional information to support their participation in treatment decisions, clarify diagnostic concerns and assist the treating psychologist to provide early access to more comprehensive and targeted treatments. Independent opinions also enhance decision making about the client's needs, including ongoing management needs.

Recommendation Sixteen: Independent mental health assessment, opinion and report

Introduce items to refer clients for an assessment, expert opinion and report to psychologists with an Area of Practice Endorsement in clinical or counselling psychology.

See Appendix for item description


The Future of Psychology in Australia: White Paper, June 2019 37

Recommendation Seventeen:

Scheduled fees

The APS Position

Diversity of psychological expertise benefits the long-term mental health of Australians. Improvements to the Medicare Benefits Schedule are required to ensure clients are able to access the right care at the right time.

Background and context

In 2010 the Psychology Board of Australia introduced nine areas of endorsement which recognises those with this endorsement have advanced competencies and in-depth expertise in particular areas. The diversity of skills within the psychology profession ensures the full breadth of psychological expertise is available to the society. This recognition of diversity occurs across the world (i.e., United Kingdom,[91] Canada,[92] New Zealand,[93] and U.S.A.[94]).

Over the past 20 years, the diversity within the profession has been declining. The introduction of psychological services into Medicare has played a role in incentivising students to preference clinical psychology training. This means that within the next 10 years services in some areas of psychology that are recognised world-wide will cease in Australia, or only be available to a select few clients.

In addition to this reduced level of psychological expertise, clients are facing increasing cost barriers to access psychological services within Medicare. Medicare data showed the cost to access psychologists has risen. This is due to the increasing cost of providing services that was compounded by the freeze on Medicare fees in 2012. For example, the schedule fee for psychological services within Medicare is well below the APS recommended fee. Further, comprehensive psychological assessments, if implemented, require psychologists to spend a substantial amount of time outside of direct client contact hours to score assessments and tests, gather collateral information and prepare a report.

Cost to access services is a major barrier for clients, particularly those with the highest mental health treatment needs as they are more likely to be financially disadvantaged members of the community.

Recommendation Seventeen: Scheduled fees

- The Government continue with the current two-level rebate system within Medicare.
- Extend the higher rebate to all psychologists who hold an Area of Practice Endorsement.
- Increase the scheduled fees for psychological therapy services.
- Increase the scheduled fees for assessment items to 1.5 times the scheduled fee for individual treatment.

Appendix

Appendix

Item Descriptions for recommendations where indicated

	Item Description
Two. Individual psychological services	• Details are outlined in Recommendation 2 on page 16
Three. Family and couples therapy	• Introduce items to enable couples and family therapy • Not less than 50 minutes per session • Involving a family group of two or more related participants • Referral required for each family member • To claim this item, psychologists must provide a formal intervention with a specific therapeutic outcome, such as improved family function and/or communication
Four. Amend group therapy items	• Reduce the requirement for participant numbers in group treatment to four; and three participants in regional, rural and remote areas MMM 4-7 • Increase the maximum number of participants to 15 • Allow kinship groups to be included in this item • Allow for two clinicians to facilitate a group therapy program • Include items based on times: - 30 minutes or more - 60 minutes or more - 90 minutes or more - 120 minutes or more
Five. Evidence-based interventions for parents and carers of children with a mental health disorder	• Up to 10 sessions in any 12-month period • Allow a psychologist who is treating a child or adolescent to work directly with the parent/s or carer without the child present • Enables evidence-based practice interventions for children with a diagnosed mental health disorder
Six. Developmental neurocognitive assessments	• Up to three developmental neurocognitive assessment sessions in any 12-month period where the complexity of the presentation requires an expert opinion • Conducted by psychologists with an Area of Practice Endorsement in clinical neuropsychology or educational and developmental psychology • Enables a battery of clinically indicated developmental neurocognitive assessments specifically for neurodevelopmental disorders • Each session is for up to 120 minutes • Referral by medical practitioner (GP, paediatrician, psychiatrist, paediatric neurologist) using standard item numbers • More than one session can be completed on the same day to enable flexibility for the client, particularly for people from regional, rural and remote Australia • Provision of a report to referrer • Timed items as follows: - 50-60 minutes - 60-90 minutes - 90-120 minutes

	Item Description
Eight. Neuropsychological assessment to differentiate dementia from mental health disorders	• Up to three neuropsychological assessment sessions in any 12-month period where the complexity of the presentation requires an expert neuropsychological opinion in order to facilitate the characterisation or differential diagnosis of dementia, including (but not limited to) differential diagnosis of dementia from a mental health condition • Assessments to be conducted by a psychologist who holds an Area of Practice Endorsement in clinical neuropsychology • Conduct a battery of clinically indicated neuropsychological assessments to: - enable characterisation of, or differential diagnosis of, dementia from other disorders, including mental health disorders - provide considerations and recommendations to develop appropriately tailored interventions for clients with neurocognitive disorders such as dementia, or dementia and a co-occurring mental health disorder - enables capacity/decision making assessments that are crucial for people with dementia and others with compromised cognitive functioning • Each session is for up to 120 minutes • Referral by a medical practitioner (GP, neurologist, psychiatrist and geriatrician) using standard item numbers • More than one session can be completed on the same day to enable flexibility for the client • Provision of a report to referrer • Timed items as follows: - 50-60 minutes - 60-90 minutes - 90-120 minutes
Nine. Consultation with family, parents, carers and support people	• Up to four sessions in any 12-month period • Corresponds with current items for psychiatry and other consultating physicians • Enables evidence-based practice for people with moderate/severe mental health disorders who require more intensive support (i.e., people with psychosis, people at risk of harming themselves or others, children)
Ten. Mental health case conferencing with other health professionals	• Introduce items to enable psychologists to case conference with other health professionals • Five or more case conferencing sessions stepped across level of need. For example, the more severe, complex or chronic the problem, the more sessions for case conferencing are required. • Timed items as follows: - 6-10 minutes - 10-20 minutes - 20-40 minutes - 40 minutes plus • Base the wording of the case conferencing item on the new item introduced for psychiatrists (AN.0.62 Case Conferences by Consultant Psychiatrists - Items 855 to 866)

	Item Description
Eleven. e-Mental health assessments	**1. Referral and facilitated access to an appropriate e-mental health/online treatment program** • One session in any 12-month period for the purpose of: - assessing client suitability for online treatment - facilitating access to the appropriate online treatment program - measuring baseline symptom levels and - contingency planning with the client in the case symptoms worsen during the treatment program • This item can be conducted via telehealth • Referral by a medical practitioner (GP, paediatrician, psychiatrist) using standard item numbers **2. Review response to e-mental health/online treatment program** • Two sessions in any 12-month period for the purpose of reviewing the client's response to an online treatment program • This includes: - assessing clients symptom levels and comparing with any baseline measures - assessing for further treatment needs where appropriate - developing a relapse plan - provide a report to the GP or medical practitioner regarding the clients response to treatment and recommendations for any further treatment required, including a relapse plan • This item can be conducted via telehealth • Referral by a medical practitioner (GP, paediatrician, psychiatrist) using standard item numbers
Twelve. Initial intake, assessment and report item	• Attendance at consulting rooms for an initial assessment of the client's mental health problem including the preparation of a psychological report. This assessment process and report includes the following: - a baseline outcome assessment using the appropriate clinical tool - a mental state assessment - a mental health diagnosis or provisional diagnosis - a brief outline and history of the presenting problem; and biological, psychological and social issues - recommendations for a course of treatment addressing biological, psychological and social issues, including any requirements for multidisciplinary support - a report provided to the referring practitioner within two weeks of completing the assessment • Timed items as follows: - At least 60 minutes duration - At least 90 minutes duration

	Item Description
Fourteen. Amend telehealth items	• Expand access to telehealth to clients in metropolitan regions where: - the client's physical or mental health condition prevents attendance; or - where the client is experiencing family violence; or - where the client is in the ante- or peri- natal period • Remove the 15 km requirement in regional, rural and remote areas to allow for continuity of care where the client is experiencing problems attending due to transport and other barriers related to social determinants
Sixteen. Independent mental health assessment, opinion and report	• Up to three sessions in any 12 month period • Conducted by psychologists with an Area of Practice Endorsement in clinical or counselling psychology • Independent assessment that cannot be provided by the treating practitioner • Referral by a medical practitioner (GP, psychiatrist, paediatrician) using standard item numbers • This Item is for individuals with a moderate to severe mental health problem involving complexities for which a GP and treating mental health provider would benefit from an expert psychological opinion • An attendance at consulting rooms during which: - an outcome tool is used where clinically appropriate - a mental state examination is conducted - a mental health diagnosis or provisional diagnosis is made - a 12-month treatment plan, appropriate to the diagnosis, is provided to the referring practitioner which must: a) comprehensively evaluate psychological treatment needs including a detailed case formulation of the issues underpinning the disorder b) address diagnostic mental health issues c) make detailed management recommendations addressing psychological treatment needs d) be provided to the referring practitioner within two weeks of completing the assessment of the clients • The diagnosis and treatment plan is communicated in writing to the referring practitioner/treating mental health provider • The diagnosis and treatment plan is explained and provided, unless clinically inappropriate, to the client, treating practitioner and/or the carer (with the client's agreement) • Client must be classified as moderate or severe and where the GP determines progress of treatment falls outside the expected course of treatment • Timed items as follows: - 50-60 minutes - 60-90 minutes - 90 to 120 minutes

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Appendix B: Future pressures on the mental health system

Policy makers planning to manage the future burden of mental illness in Australia will need to consider several changes in the community including:

- **Increasing inequality** – Inequality in Australia is increasing.[194] This is of concern given the robust evidence of a social gradient in health such that the lower a person's socioeconomic position the worse their health including their mental health is likely to be.[195] This social gradient impacts both risk of disorder and access to services.[196] Poverty impacts many areas of life but particularly access to secure housing. Currently, income support and the minimum wage are insufficient to provide rental accommodation in most capital cities of Australia.[197]
- **The nature of our growing population** – Australia's population is currently growing at a rate of 395,100 people per year; of this, 60 per cent is through immigration.[198] Immigration brings many benefits to society but can also bring costs such as social tensions and greater fractionalisation of society. Factors that contribute to increased risk of mental illness are prevalent in culturally and linguistically diverse populations (e.g., exposure to trauma before migration, multiple stressors, lack of social support, limited knowledge of the health system, educational and employment issues).[199] The *Building a New Life in Australia* longitudinal study that is tracking humanitarian migrants who arrived, or received their permanent visa, in Australia between May and December 2013, is reporting high levels of psychological distress among all young people, with 31 per cent of young men and 37 per cent of young women being classified as having moderate/high psychological distress.[200] This is much higher than the proportions of moderate/high psychological distress found in the general population (5% of males and 12% of females aged 16–25 years). Australia is therefore likely to see a significant increase in need for culturally appropriate mental health services in the future.
- **The growth of racism and discrimination** – Racism, prejudice and discrimination are pervasive and persisting challenges for Australian society. There is compelling evidence of a link between ethnic and race-based discrimination and poor mental health and wellbeing via psychological stress, assault, and denial of goods, resources and services.[201,202] Australia is also likely to see discrimination associated with the increasing diversity of family structures and experiences.
- **Increasing family violence** – Violence against women is today widely recognised as a global problem.[203] Women experiencing violence are at risk of stress, anxiety, depression, phobias, eating disorders, sleep disorders, panic disorders, suicidal behaviour, poor self-esteem, traumatic and post-traumatic stress disorders, and self-harming behaviours.[204] Underestimating the current and most importantly future costs of mental illness will lead to an underestimate of the benefits from any proposed reforms. If the base case scenario is incorrect due to underestimating the future costs of mental illness then the cost-benefit analysis will also be incorrect and undervalue the benefits of any proposed mitigating initiatives.
- **The changing nature of employment** – The changing nature of work and the labour-force in Australia is likely to negatively impact on the mental health of the community. These changes include increased casual employment,[205] more sedentary work,[206] polarisation of overwork and underemployment,[207] and more mobility, connectivity and technology in workplaces and workspaces.[208] There is also concerning evidence of age discrimination in the Australian workplace. Around one third of Australians aged over 45 years report they have experienced some form of age-related discrimination while employed, many of whom go on to prematurely give up work.[209,210] Unemployment itself is associated with mental health problems,[211,212,213] though transitioning from unemployment to 'poor' quality work also has poor outcomes, particularly for young people.[214,215] The changing nature of work will increasingly impact on employed parents who struggle to manage work and family/carer commitments.[216] It disrupts parenting and family functioning, increases inter-parental conflict, alcohol and drug use, and health behaviours and has flow-on effects for the mental health of children and young people.[217,218,219]
- **Natural impacts** – The rate of natural disasters such as flood, drought, cyclones and bushfires in Australia is increasing.[220] Assuming this trend continues there will be higher costs to community resilience with potential to impact on the mental health of Australians. For example, a recent report on the sequelae of the 2009 Victorian bushfires indicated that five years after the fires, a proportion of the survivors were still experiencing significant mental illness at a rate higher than that of the general population.[221]
- **Australia's ageing population** – The prevalence of mental health disorders tends to decrease with age,[222] but rates are very high among certain subgroups including people living in residential aged care,[223] people in hospital and/or with physical comorbidities, people in supported accommodation, people with dementia, and older carers.[224] As the Australian population ages this will put more pressure on mental health services. For example, it is projected that dementia will become the leading cause of death in Australia by 2021, costing nearly $15 billion in 2017 and $37 billion dollars in 2056 – a cost of more than $1 trillion dollars over the next 40 years.[225]

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19APS-MBS-PCS-P1