



THE AUSTRALIAN  
**CLINICAL** PSYCHOLOGY  
ASSOCIATION

**Submission to the Productivity Commission on  
the Social and Economic Benefits of Improving Mental Health**

Contact:

A/Prof Vida Bliokas  
ACPA President  
[President@acpa.org.au](mailto:President@acpa.org.au)

The Australian Clinical Psychology Association (ACPA) thanks the Productivity Commission for the important work being undertaken to review mental health in Australia. ACPA represents those clinical psychologists who hold the minimum qualifications for endorsement as a clinical psychologist in Australia, and have a critical role in the assessment, diagnosis, treatment and management of mental health disorders, particularly at the moderate to severe end of the spectrum.

### **Psychology as a profession**

Psychology as a profession has a critical role to play in mental health services. Psychology is a regulated health profession under the authority of the Australian Health Practitioner Regulation Agency (AHPRA) and the Psychology Board of Australia (PsyBA). Registration with the PsyBA is essential to practice as a psychologist in Australia, and psychologist titles are protected.

For general registration as a psychologist a four-year undergraduate degree in the science of psychology plus either a two-year supervised internship (known as the 4 + 2 pathway), or a further one-year accredited Master Degree and one year of internship (known as the 5 + 1 pathway), is required. Psychologists with higher levels of education and training beyond a one-year Master Degree can be endorsed in nine areas of specialisation following the completion of a registrar program.

### **Clinical Psychology**

Clinical psychology is the area of practice that specialises in the assessment, diagnosis, treatment, and management of serious, chronic, and complex mental health disorders. Services are provided to the most vulnerable members of the Australian public. The ACPA represents those clinical psychologists who hold the minimum education and training for endorsement as a clinical psychologist as determined the PsyBA, namely at least an accredited two-year Master's Degree in clinical psychology, followed by a two-year registrar program. Full ACPA members have therefore completed a minimum of eight years of accredited education and training.

Accreditation of psychology education and training programs occurs via the Australian Psychology Accreditation Council (APAC). APAC accredits higher education psychology programs in 5-year review cycles to ensure compliance with the Accreditation Standards for Psychology Programs (the Standards). The Standards describe the competencies required at each level of psychology training: [https://www.psychologycouncil.org.au/sites/default/files/public/Standards\\_20180912\\_Published\\_Final\\_v1.2.pdf](https://www.psychologycouncil.org.au/sites/default/files/public/Standards_20180912_Published_Final_v1.2.pdf)

## **Questions on structural weaknesses in healthcare**

- ***Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?***

In providing a summary of the challenges and barriers to effective government reform, McGorry (2016) cites a focus on cost containment and acute care as the greatest barriers. McGorry provides the example of an announcement made regarding a measure to develop new responses to young people with serious non-psychotic mental illness, where the funding was pulled from that already committed to interventions for early psychosis. Funding constraints also lead to the rationing and restriction of treatment, especially “expert, specialised care”, and as such, leads to “late presentations, with a duration frequently insufficient for remission and recovery” (p.351). McGorry (2016) recommends, “targeted and weighted (right care, right intensity, right time) and more holistic” (p.351) interventions.

A further barrier to effective healthcare is the split between state and federal funding. This leaves those with complex disorders, who need expert care, falling between the funding gaps of federal and state services. McGorry (2016) recommends a step-up in expertise approach, utilising a team-based approach with input from psychiatrists at the higher levels; Hickie (2019) recommends that properly qualified clinical psychologists lead such teams.

A major structural weakness is the lack of integrated outcome data collection regarding models of service delivery, to ensure appropriate, effective and safe interventions, as well as promoting innovation. McGorry (2016) recommends adequately funded, “Stepwise expanded investment in and structural support (data collection, evaluation, model fidelity, workforce training) for evidence-based care” (p.351) in which new programs are piloted and evaluated, and only those with demonstrable success are provided with new investment. Evidence-based support for governments to undertake informed reform is sorely lacking, particularly in light of the vast expenditure in mental health. There appears to be little political will to subject extensive public funding to appropriately funded evaluations (Allen & Jackson, 2011). For example, while a stepped care model for mental health services would appear to have high face validity, there is need for further high quality research to support its efficacy and cost efficiency.

- ***What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?***

### **Data Collection**

An issue not being targeted by reform is the accountability and quality of mental health care services. For example, there are no routinely collected outcome measures for interventions provided

by social workers, occupational therapists, speech pathologists, psychologists, and clinical psychologists, despite the expenditure on these services increasing annually and costing \$834 million in 2016 – 2017 (Department of Health, 2019). It is essential that services funded by governments are properly evaluated and quality assured, via the routine collection of progress and outcome data for all patients. Outcome data will allow governments to determine the most effective utilisation of funding. Investment in the routine and mandatory collection of data is essential to ensure government funding is targeting the best services, in the best programs, with the best outcomes.

Further, feedback itself has been associated with enhanced treatment outcomes (Shimokawa, Lambert & Smart, 2011). An analysis of 12 studies undertaken by Lambert (2017) found that patient monitoring, when combined with feedback on progress to the patient, substantially reduces deterioration rates, and increases recovery rates, particularly when combined with problem-solving methods. Lambert concluded that, “Such a change in patterns of care can be achieved through minimal modification to routine practice but may require discussions with patients about their clinical progress” (Lambert, 2017).

The “evaluation of symptom reduction, therapeutic outcomes, the therapeutic alliance and client progress throughout therapy” is a core competency in clinical psychology training (Australian Psychology Accreditation Council, 2019) and needs to be a component of all accredited health professional training for those providing services under government funding, to ensure quality outcomes and appropriate implementation of the stepped care model.

### ***Questions on specific health concerns***

- ***Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?***

Mental illness prevention and early intervention are essential for reducing the national burden of mental illness in Australia. However, it is important to deliver evidence-based services within models of delivery that are proven to be cost-effective, or public money is wasted.

The Report from the Mental Health Reference Group (Department of Health, 2018) recommends expansion of the Medicare Benefits Schedule (MBS) to include at-risk patients without a diagnosable mental health disorder. While early intervention is essential to prevent disease in all areas of health, and at-risk populations, such as perinatal patients, are readily identified, management of sub-clinical mental health disorders should not be included directly in the MBS until pilot trials identify this model of delivery as the most cost-effective model of care. Until this can be proven, low intensity and self-help strategies should be delivered outside of the MBS and general practitioners should be encouraged to be “more sparing in referral of patients to face-to-face psychological services” (McGorry, 2016, p.352). McGorry (2016) suggests that e-Health strategies can be an excellent

complement to all steps in the care pathway, and states that, “it would be safer to offer it initially as a choice, rather than as a triage strategy or barrier” (McGorry, 2016, p.352).

It is more likely that group therapies, based on evidence-based principles and incorporating the qualities of support groups (e.g. Pfeiffer, Heisler, Piette, Rogers & Valenstein, 2011), would best serve at-risk populations, while also being more efficient and cost effective. A review of the literature conducted by Worrell and his colleagues in 2018 concluded that, “There is strong, scientifically rigorous evidence which shows the effectiveness of professionally facilitated, family-led support groups, psychoeducation carers support groups, and professionally facilitated, program-based support groups for people living with mental illness.” When delivered through community health services, these services can be evaluated and supervised by expert community health staff.

Online programs with high fidelity to evidence-based treatments, also offer accessible, efficient and effective services (e.g. The MindSpot Clinic, Macquarie University; the Cool Kids Program, Macquarie University). These are cost-effective treatments that reach all populations and have demonstrated positive outcomes. Step-wise expanded investment into such programs, allowing step-up to more intensive services, are essential to curtail the costs of funding early intervention, ensure fidelity to evidence-based treatments, and produce ongoing evaluation of services (McGorry, 2016).

- ***What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?***

People suffering from personality disorders (6 – 6.5% of the population) are amongst the greatest users of mental health services, similar to those suffering psychosis (Lewis, Fanaian, Kotze & Grenyer, 2019). This population is at significant high risk of mortality, suicidal behaviour and self-harm, and “rates of comorbidity of other mental health conditions such as mood, anxiety and substance abuse disorders are also high” (Lewis, Fanaian, Kotze & Grenyer, 2019, p. 1). Personality disorders, particularly borderline personality disorder, is associated with a greater number of hospital admissions and “are more likely than any other disorder group to re-present at or be re-admitted to an in-patient mental health unit” (Lewis, Fanaian, Kotze & Grenyer, 2019, p. 1).

Strategies to intervene in the community setting with rapid follow-up and stepped care treatment have been shown to be effective for those with personality disorders. A randomised controlled trial conducted in Australia has demonstrated that psychological treatment is effective when provided in a stepped care model of clinics. Lewis, Fanaian, Kotze and Grenyer (2019) found that “using existing resources, supported and championed by senior management and clinical leaders, can result in cost savings by reduced demand on inpatient and emergency hospital services” (p. 10). In this study, the total annual saving per patient following implementation of the intervention was USD\$2,720.

Current service delivery in the public and private sectors remains grossly inadequate for this patient group. Due to high caseloads in public health and the limitation imposed by the 10-session Medicare model on clinical psychologists in private practice, clinicians must focus on crisis management, rather than true recovery. This leads to high re-presentation rates, hospital admissions, and impacts significantly on the capacity of these patients to achieve their true potential. While there are

excellent, evidence-based models for working this population, such as Schema Therapy for Personality Disorders and Dialectical Behaviour Therapy, these models are rarely implemented with high fidelity, due to the limitations on clinician time and session time.

- ***What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?***

We refer the Commission to the Black Dog Institute's research and the information within the LifeSpan project and the Centre of Research Excellence in Suicide Prevention:

<https://www.blackdoginstitute.org.au/research/key-research-areas/suicide-prevention>

### ***Questions on health workforce and informal carers***

- ***Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?***

The public requires a clear, recognisable, well-supported system that enables appropriate referral to practitioners trained in the specific area of expertise they require. The profession of psychology is made up of practitioners with varied pathways to registration, which can be confusing to the public. The system of endorsement (Areas of Practice Endorsement) implemented by the PsyBA in 2011, in part addresses this, by enabling the public and referrers to make an informed choice through identification of psychologists who have undertaken accredited professional postgraduate training in clinical psychology, the psychological specialisation in mental health, as opposed to those who have undertaken accredited training in other areas of specialised practice, or general training without an area of specialisation.

Clinical psychology is an internationally recognised specialty that is differentiated and acknowledged as such in all other comparable jurisdictions: United Kingdom (since 1973), Ireland, Canada, the United States of America, New Zealand, Norway, Sweden, Finland, India, Singapore, and South Africa.

“The profession of clinical psychologist is regulated in eight EEA [European Economic Area] countries. Direct professional regulations, i.e. special professional titles, exist in Austria, Portugal, Spain, and in the United Kingdom. Norway does not confer protected titles for this profession, but there are regulations based on a private-law agreement between the health insurance fund and the individual clinical psychologists. Indirect regulations are found in three countries, namely Belgium, Ireland and Italy, where a description of the profession and regulations concerning education and training exist, but no professional titles are awarded.” (Bednar, Eva & Scaffenberger, 2004, p. 1)

For clinical psychology in Australia, the current minimum standard is a two-year Masters Degree, followed by a two-year registrar program of supervised practice and further learning. This is the highest level of education and training in mental health assessment, diagnosis and treatment; similar to that of psychiatrists. In many ways, the extensive expertise of clinical psychologists is underutilised within our mental health systems, which are predominantly driven by a medical model. Better use of this expert workforce in leadership and decision-making levels would address issues of staff shortages, in both psychiatry and also general practice, and has the potential to carry cost savings.

There is an unfortunate history in public health of de-funding clinical psychologist positions and moving to a generalist mental health provider model. This deskills the public mental health system, as clinical psychologists then move across to private practice. In private practice the skills of clinical psychologists remain grossly under-utilised, as the 10-session model of Medicare Better Access service delivery is not consistent with evidence-based clinical psychology practice for clients with moderate and severe presentations. As such, clinical psychologists are not able to use the breadth of their training and implement high fidelity, formulation-based treatments with these patients, unless patients are able to afford additional private sessions. This results in significant inequality in service delivery to patients from different socio-economic backgrounds and is not consistent with the Medicare model of universal health care. While the MBS items are currently under review and the inclusion of additional sessions for patients with moderate-severe presentations have been proposed, we are aware that there is a substantial push from less-trained providers to be included in these higher tiers of a future MBS Better Access stepped care model.

Australia holds the lowest standards of registration or licensure of general psychologists in the world (Psychology Board of Australia, 2018). The majority of general psychologists have trained under a model that has been defunct in the United Kingdom since the 1970s (Helmes & Pachana, 2006), and was labelled as an “an awful training route” by Skilbeck in 2004 (cited in Helmes & Pachana, 2006, p.105). This model is known as the 4 + 2 pathway to registration and comprises four-year accredited education in the science of psychology, followed by an unaccredited two-year period of supervised work. Unaccredited pathways can offer highly variable training experiences and the achievement of specific competencies, until more recently, has not been formally evaluated.

Since 2013, the PsyBA has required registrants via the 4 + 2 pathway to undertake the National Psychology Examination, to ensure they have adequate knowledge required for practice. The PsyBA has further proposed to retire the 4 + 2 pathway to registration (Psychology Board of Australia, 2018). Retirement of this pathway will ensure that new registrants have at least one-year of accredited education and training in professional psychology following their initial four-year psychology degree. This is to be encouraged, as it will increase safeguards for the public and ensure that practising psychologists are better equipped to deliver evidence-based assessments, diagnosis and treatments to patients with mild to moderate mental health disorders.

- ***What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?***

A third of Australians live in regional and remote Australia. The provision of health services including mental health services is therefore, an area of national priority. Unfortunately, difficulties in the delivery of mental health services in regional and remote areas of Australia have been well documented in official reports (e.g., Australian Institute of Health and Welfare, 2015, Mental Health Services in Australia). Such reports have identified multiple challenges, including the recruitment and retention of suitably trained health professionals and the provision of training, clinical supervision, professional development and career development opportunities for health professionals.

Addressing such challenges requires solutions tailored to different locations. Possible solutions include changes in remuneration and funding, travel and technology, such as:

1. Increasing salary packages for mental health professionals in regional and remote locations.
2. Regular travel by metropolitan-based mental health professionals to regional and remote locations.
3. Travel by consumers from regional and remote locations to locations where services are located.
4. Remote training and supervision of mental health professionals in regional and remote locations.
5. Remote service provision including current tele-health arrangements (that is, video-conferencing).
6. Extending tele-health to include telephone and online (e.g., secure email) consultations.

Several factors affect the choice of and deployment of these solutions including:

1. Expense. The provision of services in regional and remote Australia is generally more expensive than delivery in metropolitan regions. However, sending metropolitan-based mental health professionals to regional and remote locations is also expensive, as is sending consumers from regional and remote locations to locations where services are situated. In addition, extension of tele-health to include telephone and secure online consultations will substantially increase access, demand, and therefore costs.
2. Sustainability of Regional and Remote Services. Remote delivery of services can reduce the sustainability of regional and remote services, by reducing demand and therefore, financial viability of such services.
3. Evaluation of Outcomes. Existing data sets often provide information about the number of services provided and the person providing the service. However, the data rarely provides information about the outcomes of such services. Consequently, there is limited data to inform the value and benefit of services, thus limiting the ability to identify and fund optimum models of service provision.

### **Use of technology and tele-Health services, and barriers to uptake**

In locations in which local mental health services are either not available or are over-stretched, existing models of tele-health offer potential solutions. In recognition of this potential, the Australian Government has supported multiple tele-health initiatives, including funding tele-health

services by medical specialists via the Medicare Benefits Schedule (MBS). However, the Australian Government has also supported broader use of technology to reduce barriers to accessing care. These initiatives include developing strategy, and funding the development of, a digital mental health sector and more recently introducing limited funding of tele-health services for allied health professionals via the MBS.

## **Outcomes**

Australian Bureau of Statistics data indicate a moderate uptake of tele-health by psychiatrists and medical specialists, but a relatively low uptake by allied health professionals, although the latter items were only recently introduced. These data provide information about the number of services provided and indicate that they represent a promising way of increasing access to care. Unfortunately, data collected via the MBS does not include the clinical outcomes of such services, thus making it impossible to determine the benefits of such services.

In contrast, there is a strong and well documented evidence-base for some digital mental health services, such as the MindSpot Clinic (Titov et al., 2017; Titov et al., 2018). Since 2013, MindSpot has provided online and telephone assessment and treatment services each year to 20,000 Australian consumers with high prevalence mental conditions, such as anxiety and depression, with many from regional and remote Australia. The results have been benchmarked against results from face-to-face psychological care and have been demonstrated as highly cost-effective and valued by consumers (Yu-Chen Lee et al., 2017).

## **Barriers to uptake**

Barriers to uptake of technology and tele-health services include attitudinal and operational barriers. Examples of attitudinal barriers include:

1. The community's general reluctance to reach out to mental health services either face-to-face or tele-health due to stigma, shame, or preference to self-manage (Mojtabai et al., 2011).
2. Limited knowledge about the existence or effectiveness of this model of care.
3. Concerns by consumers about privacy and security of tele-health services.

Examples of operational barriers include:

1. Mental health professionals having limited, if any, training in delivery of services via tele-health.
2. Limited national guidance about the technology approved for use with tele-health.
3. Limited funding:
  - a. The funding available for tele-health particularly for allied health professionals requires components delivered face-to-face or via video-conferencing, but excludes telephone consultations. The requirement for video-conferencing significantly limits access in areas with poor internet quality, and the requirement for compulsory face to face sessions represents another access barrier. These

could be addressed by allowing telephone consultations, although it is recognised that this will significantly increase demand, and thereby, costs.

- b. Services such as MindSpot are funded through the Australian Department of Health project-funding with fixed budgets. Thus, there is no motivation for such services to increase capacity or awareness, even though services are accountable and highly cost-effective.
4. Limited telephone and internet coverage. Notwithstanding improvements resulting from the national broadband network (NBN), coverage in many parts of regional and remote Australia remains poor, resulting in unreliable connections.

Additionally, we believe that providers offering tele-health services need to be more effectively supported, to allow them to provide these services as part of team-based care where needed. Our members have shared with us the challenges of providing these items across large regions, where they may not have existing relationships with local acute care services. This creates increased risks for these providers in service delivery, that would not be encountered when servicing patients face-to-face within a set geographical area, where the provider is highly familiar with the local acute care services and other supports that these patients may require.

## **Recommendations**

The aforementioned comments indicate that technology and tele-health represent a method for significantly increasing access to mental health services by consumers from regional and remote Australia. We recommend:

1. The Australian Government continue to support initiatives (e.g., eMH Prac) that aim to promote and educate health professionals and consumers about tele-health and digital mental health services.
2. The Australian Government consider a trial of funding services via telephone, without requirement for face to face or video-conferencing.
3. The Australian Government increase funding to evidence-based digital mental health services, such as MindSpot.
4. Notwithstanding the Commission's decisions, we have two additional recommendations:
  1. That increasing the availability of such services is carefully weighed against the priority of supporting existing regional and remote mental health services, which may be undermined.
  2. It is also strongly recommended that the Australian Government mandate the introduction of patient reported outcome measures (PROMS) and patient reported experience measures (PREMS) for publicly funded MBS services. Data from such measures allow evaluation of treatment outcomes, quality, acceptability, and cost-effectiveness. They are essential for responsible planning, but are currently not available to Government. See also: <https://www.safetyandquality.gov.au/our-work/indicators/patient-reported-outcome-measures/> and <https://www.aci.health.nsw.gov.au/make-it-happen/prms>

- ***What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?***

Scopes of practice need to be based upon the accredited education, training and assessed competencies of practitioners. This ensures safe and efficient practice that tailors the needs of the public to the level of education and training best able to meet that need, in a stepped care model of health delivery that minimises public risk. Within the MBS, scopes of practice are different for general psychologists and clinical psychologists, to reflect the training differential (see Australian Psychology Accreditation Council Standards; Psychology Board of Australia). Similarly, many government jurisdictions and industrial awards reflect the distinction between general psychologists and clinical psychologists. We believe that this is warranted.

Clinical psychology training is broad and deep, and clinical psychologists are trained in accredited programs to assess, diagnose, formulate, and treat across the full range of mental health disorders from mild to severe, chronic, intractable, and comorbid disorders. Clinical psychologists are skilled to treat the most at-risk people with serious, chronic, and complex mental health disorders. Research in the field of clinical psychology leads in the development and evaluation of evidence-based therapies, from cognitive-behavioural therapy for high prevalence disorders such as anxiety and depression through to advanced treatment for personality disorders, psychosis, eating disorders, and other complex, chronic, and comorbid disorders etc. This status is evidenced by specialised clinical psychology journals that are published by the American Psychological Association (*Journal of Consulting and Clinical Psychology*), the Australian Psychological Society (*Clinical Psychologist*), the British Psychological Society (*The British Journal of Clinical Psychology*) and other high impact, international journals such as, the *Annual Review of Clinical Psychology*, [Clinical Psychology Review](#), [Journal of Abnormal Psychology](#), [Clinical Child and Family Psychology Review](#), [Clinical Psychology: Science and Practice](#), [Journal of Clinical Child and Adolescent Psychology](#), [Clinical Psychology and Psychotherapy](#), [International Journal of Clinical and Health Psychology](#), [Journal of Clinical and Experimental Neuropsychology](#), [Cognitive Therapy and Research](#). These journals, and those dedicated to more severe and challenging disorders, publish research and reviews that are relevant to the practice of clinical psychologists and attest to the fact that both locally and internationally clinical psychology research is considered to be specialised and advanced.

Patients accessing services from clinical psychologists need to be supported via retention of the current higher MBS rebates as those with moderate to serious mental health disorders are often the most disadvantaged and also require more frequent or intense treatments. Similarly, for practitioners, rebates provide incentives for undertaking advanced education and training in clinical psychology, offset training time and costs, and ensure that those providing advanced specialised services to the public have the competencies required to provide evidence-based treatments at an advanced level for serious mental health problems and those most at risk.

The PsyBA is embarking on a review of general practice and Areas of Practice Endorsement with the view of determining the best way for the psychology profession to meet the needs of the public and increase the transparency of the differentials between general psychology and advanced areas of

specialised practice (personal communication, Ms Rachel Phillips, Chair, Psychology Board of Australia, personal communication, 4<sup>th</sup> December 2018). The structure of the profession will be reviewed to ensure that proper differentiation of competencies is readily discernible, and that advanced training meets the needs of the public. Furthermore, the Mental Health Reference Group of the Medicare Benefits Schedule Review Taskforce (Department of Health, 2019) has recommended that a group or committee be established to review rebates for professional groups under the Better Access to Psychiatrists, Psychologists and General Practitioners initiative (Department of Health, 2018). We wish to stress the importance of ensuring that the membership of this group is such that no significant potential conflict of interests exist – for example, group members should not be current providers under MBS, and must not be seen to be representing the interests of any particular group of professionals. The focus must remain entirely on ensuring that the model developed provides the best fit between provider competency and training and client need.

- ***What could be done to reduce stress and turnover among mental health workers?***

Burnout is a key driver of stress and turnover among mental health workers. A systematic review of the prevalence and efficacy of approaches to reduce burnout among mental health care workers found high rates of burnout that was related to physical and mental health problems in the mental health workforce (Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012). Burnout also affected care delivery (Morse et al., 2012) and one of its key intervention components – empathy (Wilkinson, Whittington, Perry & Eames, 2017).

Researchers have continuously made strong recommendations for organisational interventions to reduce burnout (Morse et al., 2012). The review by Morse and colleagues (2012) examined the support for various approaches for the reduction of burnout amongst this workforce and found two successful elements were training of supervisors in communication and social skills and the delivery of psychological interventions, such as cognitive-behavioural therapy coping strategies, to the workforce. Organisational psychologists are ideally trained to deliver the required training within organisations and individual and group-based coping strategies.

Supervision, including peer supervision, have also been recommended in order to prevent and reduce burnout (Morse et al., 2012). One of the primary difficulties for the bulk of the Australia mental health workforce is that the training received in the delivery of clinical services is generally integrated into other programs, such as occupational therapy, social work, and general psychology. While certain intervention skills or techniques can be taught, the complex task of navigating the therapeutic relationship with patients with complex mental health presentations in the intervention context, such as dealing with transference and countertransference, framing therapy sessions, boundaries and microskills, often requires more lengthy, intensive education, training, observation, reflection and evaluation.

Clinical psychologists have a key role to play in the provision of expert supervision in the assessment, diagnosis, and delivery of evidence-based psychological treatments to the mental health workforce.

- *How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?*

## **Professions**

'Revalidation' of qualifications is progressing in varying forms internationally for health professionals and offers opportunities for health professionals to maintain and enhance their skills throughout their working lives. "The fundamental purpose of revalidation is to ensure public safety in healthcare" (Medical Board of Australia, 2017).

The current regulatory system of identification of poorly performing health practitioners is retroactive and complaints-based, which would be expected to have low identification rates. Notifications were made against 1.6% of psychologists during 2016 – 2017 (Australian Health Practitioner Regulation Agency, 2017).

The Medical Board of Australia is undertaking reform of its continuing professional development (CPD) and introducing practices to proactively identify doctors who are either performing poorly or are at risk of performing poorly. The Medical Board intends to extend the requirement that CPD be strengthened via greater prescriptiveness and the accreditation of all CPD programs and eliminating self-directed CPD undertaken outside accredited programs (Medical Board of Australia, 2017). There is also an intention to be "proactively identifying and assessing 'at-risk' and poorly performing practitioners" (Medical Board of Australia, 2017, p. 4).

In psychology, general psychologists trained prior to 2013 undertook little external validation of their competencies to practice, particularly when trained via a non-accredited pathway of supervision. From 2013, the National Psychology Examination was introduced by the PsyBA in an attempt to provide more reliable outcomes from training for general psychologists. Revalidation is a strategy to ensure the workforce meets current expected levels of competencies. The National Psychology Examination is an ideal tool to assess knowledge and competency in decision-making in psychology and could be applied in a revalidation strategy for the psychology profession.

## **Organisations**

It is incumbent on organisations to ensure employees are provided with the resources to undertake the work required. Burnout is a costly consequence of poor workplace support and supervision. The requirement for training and continuing professional development is recognised and laid out in the National Practice Standards for the Mental Health Workforce (2013) and for non-Government organisations in the Implementation Guidelines for Non-Government Community Services, Standard 8: Governance, Leadership and Management (2010).

All professionals are required to undertake annual continuing professional development. In the public system, medical specialists are likely to be well-funded under workplace awards; however, the mental health workforce outside of medicine also requires targeted group and individual funding to meet workforce needs.

- ***What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?***

Community-based programs utilising an 'Experts by Experience' (EbE) model are being implemented with promising results in the United Kingdom (Bauer, Fernandez, Knapp & Anigbogu, 2010). The EbE model employs those with experience of using mental health services, housing support services and social care services to assist in the assessment of services from the consumer's perspective, enable access to services, and provide input into the interconnectedness of services and their navigability. Prospective cost-benefits analysis (Bauer, Fernandez, Knapp & Anigbogu, 2010) suggest an average net benefit from a government perspective of £1,047 per client, and an average rate of return of 4.44 not including quality of life improvements. Such programs are certainly worth monitoring to determine if the prospective benefits materialise.

Tasmania (Anglicare Tasmania, 2009) and South Australia (South Australia Health, 2010) introduced EbE programs, and the Aboriginal Health Experts by Experience (EbE) Register is the flagship of the Aboriginal Community and Consumer Engagement Strategy (ACCE) in South Australia. However, there has been no evaluation of these programs to determine its suitability and utility on a broader scale.

## ***Questions on justice***

- ***What mental health supports earlier in life are most effective in reducing contact with the justice system?***

There is a significant research literature documenting the links between early/childhood trauma and future mental health and psychosocial problems (Wu, Schairer, Dellor, & Brella, 2010). The relationship between mental disorder and incarceration is also well documented (Greenberg & Rosenheck, 2008).

Psychological disorders during infancy, childhood, and adolescence - the peak developmental periods in an individual's life - can have enduring longitudinal consequences for individuals if left unaddressed (Arseneault et al., 2011). This can include negative self-concept and self-esteem, poor educational and employment outcomes, and increased risk of substance abuse and onset of major mental disorders such as mood and anxiety disorders, personality and interpersonal dysfunction, psychotic disorders, and other mental disorders. Children and young people who engage in offending behaviours exhibit higher rates of mental health issues than the general population (Fergusson & Horwood, 2001). Trauma is pervasive in these populations, with neglect, abuse, and family violence common.

A key principle underlying therapeutic approaches to these populations is that of 'early identification' for 'at risk' children and families who have experienced trauma and adversity, as well

as prevention strategies (Howe, 2005). These interventions aim to reduce the likelihood and impact of adverse outcomes which form part of the causal pathway to mental disorder, and potentially to future offending.

Positive childhood experiences characterised by attachment security and safety are fundamental to a child's development (Greenberg, 1999). Mental health supports and interventions early in life should ideally incorporate initiatives which enhance protective factors for vulnerable child populations, based within principles of systemic security and attachment. Examples of 'early intervention' strategies targeting these causal factors include access to primary care and general health services, child/family clinical psychology services, public mental health services, education, social and emotional wellbeing and support services, housing, and parental employment and support initiatives (Howe, 2005). For Indigenous people, services that are culturally informed and safe, and those which incorporate principles of connectedness to culture and cultural strengthening are important considerations (AIHW, 2018).

Evidence suggests that young people with mental health and child protection histories comprise a significant portion of those who offend and enter the juvenile and adult justice systems (Atkinson, 2018). Children and young people identified as being at risk of offending, such as those displaying conduct disorder and antisocial behaviours, require intensive psychological and ecological support (Burrell, 2013). This support should include parent education and behaviour management education, psychological therapy services, and support and/or respite services for children with severe behavioural problems and disabilities. An evidence-based example of such an approach to supporting vulnerable families and children, and one shown to be effective in reducing offending of children and young people is Multi-Systemic Therapy (MST) (Curtis, Ronan, Heiblum, & Crellin, 2009). MST addresses antisocial behaviours in young people using intensive community and family-focussed psychological interventions to address risk factors that contribute to and maintain problematic behaviours in youth. MST is focused on empowering parents and other important members of the youth's ecology to develop the necessary skills and competencies to help the youth reduce problematic behaviour and function more effectively. Longitudinal research has found that MST participants had significantly lower recidivism rates at follow-up compared to their counterparts who did not receive MST (Porter & Nuntavisit, 2016).

An example of an effective and evidence based early intervention program to address child behaviours and family system risk factors is the Triple P program (see <https://www.tripleparenting.net.au/qld-uken/triple-p/>). This structured parenting and behaviour management training program draws on psychological and system principles to effectively intervene in externalising, oppositional, and conduct disorder behaviours, the presence of which indicate a dramatically increased risk for developing future mental health problems, and increase potential for engaging in antisocial and offending behaviours (Prinz et al., 2009).

'Justice reinvestment' approaches have been suggested, involving reallocation of investment from prison and correctional services to community services, such as community centres and mental health programs, thereby strengthening and empowering communities to assist those at risk of developing mental health issues and thereby reducing offending. Early life approaches to reduce contact with the justice system includes increased investment in early intervention programs for

children, young people and adults involving mental health and psychological services, health services, schools and education resources, youth services, housing, employment, and effective child safety and family intervention programs (such as parent support and attachment based family intervention programs).

Overall, it is recommended that there be investment in prevention and early intervention psychological programs for children and their families through partnerships between mental health services and providers, maternal and child health services, schools and other related organisations, and trials for prevention and early intervention programs.

- ***To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood, and extent, of peoples' future interactions with that system?***

Research clearly shows that those individuals who come into contact with justice and forensic systems have higher rates of mental disorder compared to the general population, with elevated rates of major affective disorders, psychotic disorders, personality disorders and vulnerabilities, and substantial rates of drug abuse (White, Lau, & Aalsma, 2016). These higher rates are seen across populations who have contact with police services, courts, and correctional settings. Given these findings, screening and assessment of mental health concerns of all people across the age spectrum is imperative.

There are multiple opportunities for effective mental health screening and identification of those with mental health needs within the justice system. This includes during initial contact with police and while in police custody, placement in remand settings, court presentations, and in correctional and prison settings.

Currently, jurisdictions in Australia generally have in place forms of mental health screening and diversion for those identified as displaying evidence suggestive of the presence of major mental disorder. These services can be found in courts, prisons, and police watch houses. Those displaying evidence of mental disorder or unmet mental health needs may be diverted to local public mental health clinics or hospitals for further psychiatric assessment and intervention. These assessments are often undertaken by teams comprising nurses, psychologists, and psychiatrists.

The challenge, however, for these services is the twofold – 1) increasing populations of individuals within justice systems without a concordant increase in funding to meet the increasing need, and 2) limited hospital / community mental health service capacity and availability of suitably qualified private psychology / mental health providers.

Those attempting to access public mental health services face significant restrictions, with increasingly higher diagnostic, illness severity, and functional impact thresholds to entry (Atkinson, 2018; AIHM, 2018). Many individuals across the justice system, or who have exited the justice system, fall below these ever-increasing thresholds and require mental health treatment through private providers. However, there is limited funding and limited numbers of professionals with the requisite skills needed to provide effective interventions to this complex population. Ideally forensic

or clinical psychologists would be the providers of treatment for these populations, however the current Medicare Benefits Scheme (MBS), which allows only ten treatment sessions per year, does not allow for the necessary treatment framework; evidence-based treatments for moderate or serious conditions require a greater number of sessions. This client group may seek support through primary care providers such as GPs, however more often than not, a medical intervention involving the prescription of psychiatric medications is provided. This unfortunately does not address the mental health issues or specific factors driving problematic behaviours and offending, or other key issues such as trauma, substance use, and other psycho-social needs. These people then go on to re-offend. Further, issues of limited follow up by primary care providers, poor treatment adherence by patients, and misuse of medications is not uncommon. Ideally, funding would be made available for services or individual providers to provide specialist targeted psychological interventions, delivered by forensic or clinical psychologists, and appropriately funded via the MBS.

Some jurisdictions have introduced so called 'problem solving' courts, these providing specific court services for particular populations, such as those with drug abuse difficulties or those who are homeless (Berman & Feinblatt, 2002). These courts take a therapeutic jurisprudence approach, viewing the offending behaviour as reflecting broader mental health, substance abuse, and ecological challenges, with court interventions often including referral to public or private psychology treatment services. Again, a significant challenge here is that public mental health services are rarely able to provide assistance due to the high thresholds to enter, while there is limited funding available for these individuals to access quality evidence based psychological interventions delivered by appropriately trained specialist psychologists.

- ***Where are the gaps in mental health services for people in the justice system including while incarcerated?***

Currently there exist significant gaps in mental health treatment services for people in the justice system, specifically access to targeted evidence based psychological treatment services. While basic supportive and medical services may be available, in addition to in-house pastoral care, there is little to no access to specialist psychological therapy and rehabilitative services. This includes treatment for trauma (an issue pervasive across populations within justice systems), chronic and severe mood disorders, drug and substance abuse, and a range of other psycho-social issues impacting on wellbeing.

Further, with the significant rates of trauma and mental disorder, trauma informed care services are imperative (Miller & Najavits, 2012). Such services would ideally be delivered by postgraduate trained forensic or clinical psychologists with training in formulation driven evidence based advanced therapies. Further, specialist psychological services are required for those where there is evidence of comorbid mental health and intellectual or cognitive impairments, or developmental disabilities. Those with intellectual impairment have equal mental health needs to the general population, and require specialist assessment and treatment services to not only address mental disorders, but also to effectively address through clinical functional analytic assessment the drivers of offending and problematic behaviours. Forensic psychologists are specially trained in these areas.

Generally, the justice system does not sufficiently address psycho-social issues contributing to crime (Delisi, 2001). By failing to address these, imprisonment is unlikely in most cases to contribute to community safety and reduced offending. Imprisonment without adequate psycho-social rehabilitation and not addressing the social determinants of offending increases risk to the community through recidivism and ongoing disengagement from positive participation in activities, such as employment. It is suggested that greater weight needs to be placed on rehabilitation and the achievement of community safety, via effective psychological treatment services in addition to prevention strategies that sit across agencies and government departments (AIHW, 2018). Prevention strategies should target psychosocial determinants of offending, for example, substance use should be viewed and treated as a health issue, to be addressed by health professionals in preference to the legal system.

- ***What are the main barriers to lowering the over-representation of people living with a mental illness in the justice system and what strategies would best overcome them?***

Australia has high rates of recidivism, with over half of all prisoners having been previously incarcerated (AIHW, 2018). This rate has remained stable over the past decade. While rehabilitative and educational programs are generally offered to prisoners, these are of varying success in reducing recidivism. In the prison context, structured manualised group programs are often delivered around topics of self-regulation and basic life skills, anger management, and offence specific groups (such as for sex offenders with the level of intervention based on the identified risk level). While helpful, these do not specifically target or provide the necessary and sufficient treatment for those with mental health concerns.

Further, prison and justice populations are characterised by significant diagnostic complexity and co-morbidity. These high levels of co-morbidity and complexity impact not only on engagement in group programs, but also require individually tailored and formulation-driven treatment programs, taking into consideration the complex interactions between mental health, personality, and other psycho-social factors. Forensic psychologists are trained in the assessment, diagnosis, and treatment of such populations and would ideally be employed or contracted to provide such services to high need and complex clients. There is currently limited funding available for psychological therapies and targeted problem behaviour psychological intervention.

Private forensic and clinical psychologists offer targeted intervention services, for example, around sexual offending and paraphilias, yet there is limited to no resourcing for these services. Currently, psychological therapy can be accessed via the Medicare system, where 10 sessions may be accessed with a psychologist annually via referral from a GP. This is highly inadequate for the effective treatment of mental health conditions and the complex psycho-social issues and other determinants which often drive offending behaviour, yet this is often the only way in which psychological services (albeit limited) can be accessed. It is suggested that psychological therapy should be funded in the community, specifically forensic psychological therapies. These types of therapies are also indicated to assist intellectually/cognitively impaired offenders and those with developmental and other disorders (such as foetal alcohol spectrum disorders).

Broad psycho-social interventions targeting determinants of offending are necessary (Burrell, 2013). Factors such as employment and training, accommodation, child health and child care support, legal assistance, social and financial supports, and transport all play a significant role in community integration and contribution, and in reducing recidivism. For example, research shows that unemployment is correlated with crime and recidivist offending, while vocational education and training can reduce recidivism. Therefore, employment services and vocational training should form a core component of broad intervention framework.

Recidivism risk factors need to be addressed through a whole of government response. These factors are not addressed via imprisonment, and indeed are increased as a result of imprisonment. Longer term follow-up of those with complex mental health needs is required, with increased comprehensive case management and psychological support.

Research shows that the transition out of custody is a high-risk period for relapse and recidivistic behaviour. Prison transition services targeting those with severe and persistent mental health and other psychosocial needs have been shown to be effective in reducing recidivism risk. These generally non-government services assist with:

- Accessing treatment and mental health services
- Accessing training and employment opportunities
- Supporting access to accommodation services
- Independent living
- Connections to local community services
- Accessing drug and alcohol services

### **Prevention and early intervention**

The placement of children in care should only occur in the context of extreme forms of abuse, exposure to family violence and neglect. However, the cumulative impact of milder forms of maltreatment that do not result in children being placed in care is well documented, with greater numbers of adverse childhood experiences positively associated with greater risk of developing mental health disorders (McLaughlin et al., 2012). These findings highlight the importance of coordinated service systems, spanning physical and mental health, education, police and child protection, to intervene early to reduce the impacts of cumulative harm among at-risk families. In preparing this response, we observed that it is hard to identify services for at-risk families that are sufficiently differentiated from child protection (i.e., feel safe, supportive and are de-stigmatising) in ways that may encourage families to seek help proactively when risk levels are low.

In Victoria, the 2015 Royal Commission into Family Violence has led to some promising innovation in early intervention with family violence. In addition to establishing a new department, Family Safety Victoria, which will oversee a range of family violence services, the Victorian Government has responded to the Royal Commission's recommendations by funding twenty-six Therapeutic Interventions Demonstration Projects (State of Victoria, 2017). Evaluation data for each three-year project will be available when the projects end in June 2018. These diverse projects across different regions of Victoria have been tasked with transforming the way the system responds to family violence, and support family violence services to strengthen and enhance its therapeutic response to

adults and children impacted by family violence. These kinds of initiatives provide an important opportunity to identify effective early intervention programs that have been successfully implemented in localised contexts. The challenge is to ensure that effective projects are sustainably funded in a way that demonstrates ongoing commitment to delivering these services. The pitfalls of short-term, project based government funding in the delivery of community services have been described (Scott, 2003).

### **Out-of-home care**

It is recognised that many areas of policy and practice relating to out-of-home care in Australia are founded on a very limited base of evidence (Cashmore & Ainsworth, 2004), with limited quality research programs examining operation and effects of out-of-home care systems on Australian children (Delfabbro, King, & Barber, 2010). Much of what is known about the effectiveness of care systems is largely derived from international contexts (primarily United Kingdom and United States). However, variability in social and political contexts has made it difficult to translate programs neatly and effectively into the Australian context.

The out-of-home care system in Australia is under enormous strain (Delfabbro et al., 2010). Australian research has highlighted the need to address a number of entrenched problems in out-of-home care including placement instability, a lack of coordination and access to specialist services (including specialist mental health services), and limited or inadequate models of care (Association of Children's Welfare Agencies, 2016; Frederico, Long, McNamara, McPherson, & Rose, 2017). Policy and practice models that address these issues are fundamental to improving the mental health outcomes for children in out-of-home care. Sadly, achieving necessary reform has proven elusive in all but small degrees across Australian jurisdictions (McPherson, Gatwiri, Tucci, Mitchell, & MacNamara, 2018; Mitchell, 2008).

'Therapeutic care', sometimes referred to as 'enhanced care', has been identified as a highly promising practice model that can address the wide range of challenges faced by children who enter out-of-home care (Frederico et al., 2017; McPherson, Gatwiri, Cameron, & Parmenter, February, 2019; McPherson et al., 2018). In these models, the person(s) who provide day-to-day care of the child (both in foster/kinship and residential settings) is conceptualised as the therapeutic agent of change, and through which children are helped to recover from their emotional difficulties and supported to modify any challenging behaviours (Sinclair, 2005; Wilson, 2006). Research suggests that, given the appropriate parenting experiences, children can recover, or at least significantly improve, from even the most severe early adversity and trauma caused by abuse and neglect (Child Protection Development, 2011; Rutter, 2000; Sinclair, 2005). This is a departure from traditional approaches to child and adolescent mental health treatment, where therapy with a professional usually occurs within a clinical setting outside of the family home. Rather, therapeutic care is defined by its integrated, systems-level approach to care, which coordinates the involvement of specialist professionals to support and inform the care environment.

Various forms of therapeutic care have been adopted in a number of jurisdictions (Frederico et al., 2017), with New South Wales most recently undergoing reform to deliver therapeutic care across all residential programs. In 2019, the Centre for Excellence in Therapeutic Care was established as a

partnership between the Australian Childhood Foundation and Southern Cross University, indicating noteworthy optimism about this approach. Two therapeutic foster care programs in Victoria, established in 2002 and 2009, have recently been evaluated, and report improved placement stability, educational stability, greater likelihood of family reunification, and gains in children's capacities to form relationships, regulate their emotions and participate in community activities (Frederico et al., 2017; McPherson et al., 2018). The wide range of positive impacts across various aspects of children's development highlight the value of this integrated and holistic approach. Effective therapeutic care programs that have been successfully implemented in local contexts are highly noteworthy and should receive the full attention of state and federal governments.

### **Leaving care**

There has been increased political support across the country, via the Home Stretch campaign, to extend government support for children in care to 21 years, rather than the current age of 18. Research both nationally and internationally indicates that a high proportion of care leavers end up homeless, in the criminal justice system, unemployed or a new parent within the first year of leaving care (Home Stretch, 2018). We are in full support of all jurisdictions taking this important step to provide the children leaving care with the option to remain in foster, kinship or residential care until 21 years. The termination of care by at 18 years is not consistent with parenting that is seeing most young people remain home well into their third decade. Universally extending the age that children and young adults can access foster, kinship or residential care support is consistent with knowledge that this is a high risk period for the onset of mental health disorders (Merikangas et al., 2010), and young people who have experienced abuse and neglect experience even greater risks for a broad range mental health disorders during early adulthood (McLaughlin et al., 2012).

There are state-based services that provide low or no cost counselling support for survivors of sexual abuse, who can present for help at any age. While this is commended, young adults who have experienced neglect, emotional abuse and physical violence do not necessarily have access to vital services because their abuse is not sexual in nature, despite substantial research showing that the mental health impacts resulting from other forms of adversity are significant (Green et al., 2010). Furthermore, the experience of childhood maltreatment is often interrelated with other forms of abuse or neglect (Dong et al., 2004; Green et al., 2010), such that services that focus on only a single form of adversity may lead to fragmented treatment experiences for clients, or the provision of treatments that focus on issues peripheral to presenting concerns.

- ***What, if any, alternative approaches to child protection would achieve better mental health outcomes?***

### **Prevention and early intervention**

Risk and protective factors for child maltreatment are well documented (Australian Institute of Family Studies, 2017), with many of these risk factors evident in the perinatal period. This period of development requires families to interact with multiple services (i.e., maternal child health, early childhood educators, teachers, emergency departments), creating an ideal opportunity for early intervention with at-risk families. While we acknowledge that existing services would be aware of

their mandatory reporting responsibilities, targeted training for services that routinely interact with expecting parents, infants and children about both risk factors for maltreatment and how to identify early warning signs of maltreatment across different stages of child development will facilitate early detection. We highlight, particularly, the need for professionals to have greater awareness of the psychological and behavioural signs of maltreatment, which may be subtler to detect, particularly in infants and young children. Further, early detection will be enhanced by training professionals in ways to ask about maltreatment in non-stigmatising ways. Routinely administering screening tools for adverse experiences and family stress as part of existing public health programs may also be helpful for early detection.

There also appears to be an opportunity to develop a nation-wide child safety agency that can provide public health messages regarding child safety, connect at-risk families and professionals with information, as well as provide initial triage services via less stigmatised pathways. Critical to the success of such a service would be a highly skilled, trauma-informed workforce, who hold deep knowledge of relevant services in their districts. The Orange Door (State Government of Victoria, 2018) family violence service that also responds to child safety concerns, which is currently being rolled out across Victoria through the newly formed Family Safety Victoria, is a comparable, state-based initiative and one worth monitoring over the next few years.

### **Out-of-home care**

We believe that long term investment and commitment to increasing access to therapeutic care across all jurisdictions is an important step in achieving better mental health outcomes for children involved in child protection. While there are a multiplicity of therapeutic care models, there has been increased interest in identifying the core elements that are associated with effective outcomes (McPherson et al., February, 2019). This research question is relatively new, and while findings to date rely on qualitative and theoretical evidence (due to an insufficient number of empirical studies), they nevertheless provide an evidence-informed framework for policy development in this area. The key features of therapeutic care have recently been described in detail (McPherson et al., February, 2019), with practice guidelines for effective programs also readily available (i.e., Victorian Government Department of Human Services, 2009).

It is worth highlighting here that the difficulties of translating internationally developed programs to the Australian context may also be analogous to translating effective programs across Australian jurisdictions. Therefore, understanding of the *principles* of therapeutic care is critical to developing localised *practices* that meaningfully fit within the social and political contexts of local communities.

We are encouraged to see increased adoption of therapeutic care models across Australia. However, the adoption of these models is far from universal, nor is access to such programs universally available to all children who enter out-of-home care, even in jurisdictions where programs have been long established. The adoption of such programs should be accompanied with adequate resources to undertake research for ongoing service evaluation and quality improvement.

## Leaving care

In addition to providing care leavers with extended access to supported care environments, this population is likely to benefit from being able to access specialist mental health services that have expertise in the impacts of all types of developmental trauma (i.e., physical, emotional and sexual abuse, and neglect). Initiatives like the trauma counselling services provided by the Australian Childhood Foundation (Australian Childhood Foundation, 2018), currently available in Tasmania, Victoria and coming soon in New South Wales may provide examples of the types of cost-free specialist counselling services that can support this young adult population during the leaving care journey.

## Questions on education and training

- *What are the key barriers to children and young people with mental ill-health participating and engaging in education and training, and achieving good education outcomes?*

The timing of onset of illness in children and young people can derail secondary education, the transition to further education and training, and employment. This is exacerbated by generally low levels of mental health literacy amongst teachers, inadequate support for students with mental health issues in school, and poor integration with external mental health providers. There are also high levels of stigma and pervasive myths about the interaction of mental ill health and scholastic achievement. For example, it is known that being around friends and engaged in supported activity such as education is good for people, and yet many young people with mental ill health are separated from education and their friends.

- *Is there adequate support available for children and young people with mental ill-health to re-engage with education and training?*

While it is clear that the recovery and the social inclusion of people with psychotic disorders is facilitated by participation in both mainstream education and employment, there remains clear evidence of lower levels of educational achievement of people with mental ill health (Degney, Hopkins, Hosie, Lim, Rajendren, & Vogl, 2012) and lower employment levels ([Waghorn, Saha, Harvey, Morgan, Waterreus, Bush, Castle, Galletly, Stain, Neil, McGorry, & McGrath, 2012](#)).

As part of the second Australian survey of psychosis, Waghorn et al (2012) assessed labour force activity and participation in formal education among working age adults with psychotic disorders. They found, since the prior national survey in 1997, the proportion of currently employed adults with psychotic disorders had remained stable, at 22%. This suggests a failure of policy and service providers to provide more effective assistance with respect to education and employment. The impact of these outcomes extends well beyond the cost of direct mental health services to disability welfare payments, unemployment benefits, imprisonment costs, and lost productivity and earning potential. (Degney et al., 2012).

- ***Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?***

Gaps to adequate mental health related support and education include the ad hoc nature of links between education and mental health services, and the lack of integration of primary mental health services with specialist mental health services. For example, some headspace centres have well integrated programs with their local schools, while others do not. This seems dependent on the goodwill of individuals in either setting.

Improved linkage of programs such as headspace with Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) would ensure that if there is a need for a greater level of care, this could be provided seamlessly for the individual and their family, without them having to negotiate multiple different systems. At all stages, education needs to be kept in the loop and, to the degree possible, the young person needs to be supported to remain connected to their education and friendship groups.

- ***What overseas practices for supporting mental health in education and training should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?***

There is some activity in the United Kingdom addressing university student mental health with policy and program development (Universities UK, 2015). A similar policy document has been developed in Australia by (Bai, C., Larcombe, W., Brooker, A., Wyn, J. Allen, L., Brett, M., Field, R. & James, R. (2017).

There are several small, promising studies looking at getting students with mental health issues back to school. Education support modelled on the Individual Placement and Support approach to supported employment delivered by occupational therapists (Robson, Waghorn, Sherring, & Morris, 2010); Sherring, Robson, Morris, Frost, Tirupati, 2010) found that 70 – 77% of service users either continued or completed their chosen course of formal study.

An exploratory study utilising Individual Placement and Support (IPS) for education in the early stage of mental illness (Killackey, Allott, Woodhead, Connor, Dragon, & Ring, 2017) found that it is feasible to adapt IPS to focus exclusively on education at the outset of mental illness with success. Clearly, large studies and evaluation of programs as they are applied are necessary to support these interventions.

### ***Questions on government-funded employment support***

- ***How cost effective have the Australian Government's Disability Employment Service (DES) and Personal Helpers and Mentors service (PHaMs) been in enabling people with a mental illness to find and keep a job? Have the DES and PHaMs been targeted at the right populations?***

According to the Government's own report (Department of Education, Employment and Workplace Relations, 2012), Evaluation of Disability Employment Services 2010-2013: Final Report, these services have not been very successful. The report showed that with the highest level of support, very few people with psychiatric and psychological illness accessing disability employment services are able to obtain and retain employment. Dr Geoffrey Waghorn, an expert in this area, gave the following testimony to a House Committee examining employment and mental health in 2011:

At the moment in Australia we have an increasing availability of ineffective services. The availability of services in Australia is no longer a barrier, except in remote locations. Australia now has a multibillion dollar disability employment industry, consisting of disability employment services contracted to DEEWR...the effectiveness has recently crashed. According to DEEWR's own interim evaluation released in July this year, specifically table 3.3 on page 31, only 10.6 percent of clients with a primary psychiatric disability at funding level two – the client group most relevant to our research – achieved 13 weeks of employment or an education pathway outcome in the nine-month period of March to December 2010. How can anybody say, 'wow' about a program that achieves 10.6 percent?

Dr Geoffrey Waghorn, House of Representatives Standing Committee on Education and Employment. *Work Wanted: Mental health and workforce participation*. Commonwealth of Australia, 2012

This evidence suggests that declining DES performance now represents the greatest barrier to employment for Australian residents with severe mental health and psychiatric disability. People with a psychiatric disability make up one of the most populated sub-groups (72% in 2012) of people with disabilities seeking employment, yet this sub-group is the worst performing in the sector with what could be classified as below a net zero effect. A reason for this declining performance appears to be the failure of the majority of DES providers to adopt the evidence-based practices shown over the last 20 years to be the most effective in international trials for people with severe mental illness. Current DES providers do not appear to be providing this, and rather are operating along the lines of a volume-based service; coaching people in the office, giving them a list of things to do, and sending them to seek employment.

- ***How could employment outcomes for people experiencing mental ill-health be further improved?***

The utilisation of highly motivated, skilled, knowledgeable employment specialists applying evidence-based practices in a one-to-one arrangement is imperative. Effective employment specialists build strong relationships with employers, back these up with reliable support, and are individually-focused.

- ***What alternative approaches would better support people with a mental illness (whether episodic or not) to find and keep a job?***

Individual Placement and Support (IPS) is the leading evidence based internationally validated way to support people with a mental illness to find and retain employment. There are around 25

Randomised Controlled Trials (RCTs) demonstrating the effectiveness of IPS, including two in Australia for young people with psychosis (Killackey, Allott, Jackson, et al., 2019; Killackey, Jackson & McGorry, 2008). The Australian Government, through the Department of Social Services, has invested \$34M in trialling IPS through 24 headspace centres for young people, which is ongoing.

- ***What will the transition to the NDIS mean for those receiving employment support?***

There is some emerging potential for the NDIS to have positive outcomes when evidence-based, recovery-oriented approaches to early intervention in psychosocial disability are utilised (Hayes, Brophy, Harvey, Tellez, Herrman, & Killackey, 2018). Such interventions include social skills training, supported employment and supported housing.

- ***How could employment outcomes for people experiencing mental ill-health be further improved?***

It is important that employment is viewed as *part of* recovery, not the end point of recovery. Employment outcomes could be improved by providing evidence based IPS services through AMHS and CAMHS, as well as expanding the IPS trial in headspace to all 110 headspace sites.

### ***Questions on coordination and integration***

- ***To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government?***

#### **PHNs**

The establishment of Primary Health Networks (PHNs) as a lead agency in mental health planning and integration across organisations and providers has been an extremely important initiative. However, the short-term nature of funding for programs across health and mental health impacts significantly on this process of service coordination and the development of ongoing collaborative partnerships. Additionally, engagement of independent providers operating under the MBS remains a challenge, and it is concerning that some providers are still not aware of the essential role of PHNs, and do not make use of the extensive resources and referral networks made available by PHNs. It is essential that registration as a provider under the MBS be contingent upon completing ongoing education regarding the primary health care system as a whole, to ensure that providers remain up-to-date, informed and engaged with this system. Engagement with PHNs and other initiatives such as the Mental Health Professionals Network (MHPN) is essential to breaking down silos in mental health care and increasing communication among professionals.

## NDIS

While the principles underlying the establishment of the NDIS are to be applauded, the implementation has been problematic for many consumers, carers and providers. At this time there remains confusion as to how the NDIS interacts with other systems, and this has at times resulted in fragmentation and poor coordination of support for people with a mental illness. We recognise that it is early days still for the initiative and that all parties acknowledge there is still much to be done to ensure more efficient and coordinated operation of this system.

The psychosocial disability pathway has been particularly confusing for consumers, carers and providers to navigate, and the outcomes of eligibility assessment has been, at times, highly variable. We are aware that NDIA staff report pressure to make case planning decisions in short time frames, and that this is likely a factor in the variability in assessment outcomes that consumers have experienced. People with psychosocial disabilities should not have to deal with such additional barriers to accessing and implementing plans. Such experiences can potentially compound feelings of isolation and hopelessness in this vulnerable group.

- ***What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?***

The Mental Health Commission of NSW (2016) evidence guide on physical health and mental wellbeing sets out an agenda for clinicians and policymakers to prioritise the physical health of mental health consumers. The guide focuses on the "need for a holistic, collaborative and coordinated approach" and "the need to overcome the physical/mental dualism that is typically experienced by consumers" (p. 6). The Commission has outlined the many barriers limiting the contribution of primary health care to physical health outcomes in people living with mental illness. The Commission presents evidence confirming that "people with mental illness are a vulnerable, marginalised, stigmatised and, in many cases, discriminated-against population with extremely poor health outcomes, deserving of a greater level of physical health care".

Despite many reforms, our health care system continues to operate in a siloed manner, and this impacts most significantly on those with comorbid mental health and physical health conditions. As noted above, there are no specific requirements for individual MBS providers to engage with one another, or with the system as a whole. Professor Ian Hickie has argued strongly that our health care system must, as a matter of urgency, adapt to meet the needs of people with complex presentations, which are associated with the greatest losses in productivity. A team-based approach to care is vital for optimal treatment outcomes for these patients. Professor Hickie states that these patients should have access to "a bundled care model, under which a larger sum could be allocated to put together a team of specialists - such as a GP, psychologist, mental health nurse and dietician - to provide a tailored "package of care" to the patient. People need combined interventions - medical, psychological but also social, occupational and educational - to get an outcome." Similarly, the Mental Health Commission of NSW has argued for the development and evaluation of "systems of care in which more people with mental illness are seen regularly by GPs, and better communication exists between mental health services and primary care providers". Case conferencing items that recognise the interdependency of physical and mental health issues

and the more extensive cross-discipline consultation that would be required to provide optimal care for this patient group, are considered a priority. Co-location of providers is one of many possible strategies to increase collaborative, person-centred care.

- ***Is the suite of documents that comprises the National Mental Health Strategy effectively guiding mental health reform? Does it provide government and non-government stakeholders with clear and coherent policy direction? If not, what changes could be made?***

The National Mental Health Strategy must provide more comprehensive guidance regarding the role of different health care providers in the mental health system. Currently there is substantial confusion regarding role differentiation, which risks diluting the specific areas of specialisation and training of different practitioners.

A solid health care system requires all practitioners to value and utilise their specialised skills to provide quality, integrated, accessible services. We are concerned about any funding models that risk diluting specialties and inadvertently impacting on the shape of our psychology and allied health work force into the future. Mental health reform needs to be grounded in solid evidence and a comprehensive understanding of the professional standards and areas of practice of the providers delivering these services.

### ***Questions on funding arrangements***

- ***What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?***

While successive Australian governments have increased their spending on mental health in recent decades, we have not seen corresponding improvements in the rate of mental illness. However, increased spending does not necessarily produce more or better services. There remain significant gaps in our understanding of what is actually being delivered, in terms of the volume and quality of services and the outcomes they achieve.

We would suggest that a significant driver of the growth of mental health expenditure in Australia is inadequate treatment dosage due to inadequacies in existing funding arrangements. While programs such as Better Access and Headspace have opened up access to services to a broader population, concerns have been repeatedly raised regarding adequacy of treatment dosage (e.g. Jorm, 2016). Current service delivery in the both the public and private sectors remains grossly inadequate for patients with moderate-severe presentations. Due to high caseloads in public health and the limitation imposed by the 10-session Medicare model on clinical psychologists in private practice, clinicians must focus on crisis management, rather than true recovery. This leads to high re-presentation rates, hospital admissions, and impacts significantly on the capacity of these patients to achieve their true potential. *(see response to question on MBS for further detail).*

- ***Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?***

The establishment of Primary Health Networks (PHNs) has been an important initiative supporting coordination and integration of services. However, we understand that the commissioning process has had some unintended negative effects, impacting on existing collaborative relationships with local providers. Certainty and adequacy of long-term funding for PHNs is critical. Any lack of certainty in this regard will undermine the commissioning process and the capacity of PHN to perform vital coordination and integration functions.

Ongoing evaluation of the effectiveness of these programs, and preparedness to modify or replace programs in response to these evaluations, is essential.

- ***How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?***

The current Better Access items provide for up to ten psychological therapy services provided by clinical psychologists per calendar year. This is the same number of services provided for under the Focused Psychological Strategy items, which were designed for patients with milder mental health symptoms and less complex presentations. Ten sessions are insufficient for more complex or chronic presentations, and for patients with moderate to severe mental health symptoms. Additionally, the ten-session annual limit is across all clinicians that provide services under the Better Access items, with patients with more complex and/or severe presentations often requiring services by multiple providers. Patient session allocation should be determined based on clinical needs and not on arbitrary session limits that are not in keeping with evidence.

Bergin and Garfield's Handbook of Psychotherapy and Behavior Change Sixth Edition (Lambert, 2013) arguably provides the most important overview of research findings in psychotherapy for professionals, academics, researchers, and students. In reviewing the evidence for the efficacy and effectiveness of psychotherapy in this text, Lambert (2013) concludes that therapy "is highly efficient for a large minority of patients, perhaps 30% of whom attain a lasting benefit after only three sessions." and when monitoring for "reliable improvement ... it appears 50% of patients respond by the 8th session and 75% are predicted to need at least 14 sessions to experience this degree of relief" (p.204). 'Reliable improvement' is a formal way of measuring 'appreciable benefit'; it is not, however, 'recovery'.

Ideally, interventions for many mental health conditions should have a goal of full recovery rather than just 'reliable improvement'. Lambert concludes, "For patients who begin therapy in the dysfunctional range, 50% can be expected to achieve ... recovery after about 20 sessions of psychotherapy. More than 50 sessions are needed for 75% of patients to meet this criterion." Lambert also states, "Outcome by therapist showed considerable variability, with the most effective therapist's patients showing rapid and substantial treatment response, while the least effective therapist's patients showed an average worsening in functioning" (p.197).

Lambert (2015) summarises typical numbers of treatment sessions for various mental health disorders in the literature, all of which are above the 10 sessions provided for under MBS psychological therapy services:

- Generalised Anxiety Disorder (GAD) – 16-20 sessions of Cognitive Behaviour Therapy (CBT)
- Panic Disorder – 12-16 sessions of CBT
- Posttraumatic Stress Disorder – 10-16 sessions Prolonged Exposure (PE)
- Depression – 12-20 sessions, with treatments including Behavioural Therapy (BT), Cognitive Therapy (CT), Mindfulness-Based Cognitive Therapy (MBCT), Interpersonal Psychotherapy for Depression (IPT), Emotion-Focused Therapy (EFT), CBT
- Anorexia Nervosa – 20 sessions in the third phase of Family-Based Treatment (FBT), after the first phase (reversal of acute starvation) and second phases of treatment (returning control of eating to the patient) have been completed
- Bulimia Nervosa – 20 sessions of CBT, IPT or FBT
- Binge Eating Disorder - 20 sessions of CBT or IPT

With increased complexity and chronicity of presentation, increased sessions are typically required. Bamelis and colleagues (2014) reported that successful treatment of those suffering with diverse personality disorders involved 40 sessions in the first year of treatment and ten in the second year (i.e. 50 in total). The current annual session limit under the current MBS provisions means that clinical psychologists are often utilising a heavily diluted form of quality evidence based therapies, such as schema therapy. We do not have research to assist us in understanding whether this is ultimately still helpful, or whether the effects are diluted to such an extent that the treatment is no longer valid.

As Layard and Clark (2014) have so effectively argued in their book "Thrive: the power of evidence based psychological therapies", there is a compelling case, in terms of both relief of suffering and economic saving, for more major investment in the treatment and prevention of psychological disorders. Research strongly suggests that, in general, patients are more often under-treated than over-treated. Unfortunately, the current structure of the MBS psychological services items means that many Australians experiencing mental health issues are under-treated.

Treatment within a ten session per calendar year model may have unintended iatrogenic consequences, such as treatment being interrupted or ceased prematurely. Such treatment interference may result in symptom exacerbation or relapse, treatment aversion, and/or reinforcement of long-standing patterns of abandonment and neglect, particularly for individuals with trauma or personality disorder presentations. Such outcomes ultimately add to the community's disease burden. At best, a ten-session model may only be sufficient to contain a patient's symptoms but provide insufficient opportunity for recovery. It is arguably the most vulnerable and unwell patients who are most affected by these limitations.

An alternate model is available for psychiatrists under Medicare. Patients of psychiatrists can access up to 50 MBS psychiatry sessions per annum under MBS item 306. Once the patient has exhausted their 50 sessions (item 306), they are able to access further sessions under item 316. Patients have access to up to 160 sessions with a psychiatrist in a calendar year if they (a) have been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (b) for persons 18 years and over, have been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale. Psychiatrists are therefore able to provide treatment under the MBS at a frequency that is clinically indicated, rather than limited to an arbitrary number that is not consistent with evidence-based practice.

As a result of the limit on session numbers, clinical psychologists often need to refer patients, who may be well engaged in effective psychological treatment, to psychiatrists for ongoing care after completion of the available ten MBS psychology sessions. This is an inefficient process that is not cost effective, particularly once the safety net has been reached and patients are rebated at 80% of the gap. Such referrals are also highly disruptive for patients and place unnecessary demands on private practice psychiatrists, who are often already over-stretched and have long waiting lists.

The current model does not provide the option for additional sessions with a clinical psychologist, should an exceptional circumstance arise, following the patient's completion of the ten sessions in that calendar year. Therefore, a patient who experiences a significant loss, trauma or other stressor precipitating a new mental health episode, or substantially exacerbating ongoing mental health symptoms, would be unable to access MBS-funded psychological services until the next calendar year. While it is recognised that alternate services may be available to a patient in these circumstances, treatment efficiency is likely to be greater when a patient is able to access a practitioner with whom they have formed a solid therapeutic relationship, and who is familiar with their history and previous treatment response. Unfortunately, patients will often choose to wait to see their preferred practitioner in the new year, leading to an increased duration of untreated mental illness and a cascade of negative psychosocial effects that add to the public health burden.

We support the National Mental Health Commission's (2014) recommendation for the provision of up to six additional sessions of psychological treatment per calendar year for those with moderate-severe, chronic, comorbid, acute, and/or complex presentations. However, we note that the research on best practice, referred to above, identifies 20-40 sessions as the appropriate figure.

The Commission additionally recommended that, "For people with more severe conditions, where the GP assesses they are likely to require more than the initial six sessions with an allied health professional, GPs should be encouraged by the guidelines and supported in practice to initially refer to an endorsed clinical psychologist (for example, by provision of easily accessible information about the different qualifications of psychologists available for referral within their local area)" (National Mental Health Commission, 2014 p.95). It is appropriate that provision of additional sessions of treatment for mental disorders be restricted to clinical psychologists, given

their training and expertise in treatment of more serious, complex, chronic, acute, and comorbid mental health disorders. However, we note that some five years on, this recommendation is still yet to be implemented.

### ***Questions on monitoring and reporting outcomes***

- *Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions?*
- *Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?*
- *Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?*
- *Which agency or agencies are best placed to administer measurement and reporting of outcomes?*
- *What approaches to monitoring and reporting are implemented internationally? What can Australia learn from developments in other countries?*

The Australian Government funds multiple bodies and organisations to deliver a broad range of services to a broad cross-section of the community. Each generate data about activities, such as number of services, while some also deliver data on outcomes. The following submission is concerned with the collection, availability, and use of data from services provided by clinical psychologists, psychologists, and allied health professionals funded under the Medicare Benefits Schedule (MBS).

### **Challenges**

In order to make informed decisions about the nature, structure, and funding of any health services, it is reasonable to expect that decision makers require access to data about:

1. Consumers (demographics, presenting symptoms, history)
2. Their presenting problems
3. The service they are seeking (e.g., information, referral, assessment, treatment)
4. Immediate and long-term clinical outcomes
5. The acceptability of services to consumers
6. Impact of the service on other health and social services
7. Impact of the service on the consumer's engagement in vocational activities

Unfortunately, due to the limited administrative requirements for receiving funding for services from the MBS, data is only collected about activity rather than outcomes (Jorm, 2018). As a consequence, decision-makers and funders are unable to make high quality, strategic decisions and, consequently, may be funding inefficient and ineffective services.

The impact of these weaknesses is non-trivial; in 2016-2017 the Australian Government spent \$1.2 billion on benefits for Medicare-subsidised mental health-specific services (AIHW).

The reasons for the lack of this essential data are complex, but include:

1. Data are not mandated by funders; for example, such data is not required under current MBS requirements and, therefore, rarely collected.
2. Clinical practice: Despite using outcome measures when training, after graduating health professionals in Australia rarely measure outcomes in routine care and consequently, there is debate about which measures should be used. In addition, collection of outcome data requires systems for administration and collection, which are not part of the usual work flows for many health professionals.
3. Concern about misinterpretation: Due to the nature of their condition or circumstances, not all patients improve during treatment, and interventions are sometimes aimed at reducing further harm, rather than recovery. These factors make it less likely that some health professionals will want to measure and report outcomes. In addition, data may be used inappropriately to only fund services that result in symptom reductions, even though this is not always possible.
4. Data collection, linkage and analytics: If health professionals collected data, the Australian Government would require mechanisms to collect, store and analyse the data. A system for this is currently lacking. Furthermore, data about longer term outcomes and impact on vocational activity are not readily available without data linkage arrangements and commitment to ongoing analytics.

### **Solutions and examples**

There are several examples of successful administration and analysis of outcome measures in routine clinical care in publicly funded services. One of the best examples is the Improving Access to Psychological Therapies (IAPT) service model in the UK NHS (IAPT). This high-volume model now serves more than one million people each year, with compulsory routine outcome monitoring that occurs on a session by session basis. Specifically, measures of anxiety and depression are administered during each session to guide treatment planning for individual patients, to benchmark services against each other, and to track progress against national goals for the mental health system. These activities are not currently possible here in Australia.

A local example of successful administration of outcome measures in routine clinical care and use of this data for planning of services is the national MindSpot Clinic (Titov et al., 2017; Titov et al., 2018). As noted earlier, MindSpot provides online and telephone assessment and treatment services each year to 20,000 Australian consumers with high prevalence mental conditions such as anxiety and depression. MindSpot also administers clinical outcome measures at each session, thus allowing treatment planning and benchmarking against other services. Unfortunately, it is difficult to compare MindSpot outcomes against psychology services funded by the MBS, primarily because there is no data available from the MBS.

## Recommendations

As noted, currently the only data to inform planning of MBS funded psychology services relate to activities, not outcomes. Consequently, decision makers are severely limited in their ability to make well-informed decisions about funding.

Our main recommendation is, therefore, that mental health services funded under MBS should require reporting of outcomes. We propose that these outcome measures should be brief, validated, administered at each funded session, and should enquire about the symptoms as well as experience; that is, both patient reported outcome measures (PROMS) and patient reported experience measures (PREMS) should be administered. See also: <https://www.safetyandquality.gov.au/our-work/indicators/patient-reported-outcome-measures/> and <https://www.aci.health.nsw.gov.au/make-it-happen/prms>

We acknowledge that this is not a light undertaking and will require both system and cultural change. However, we contend that doing nothing is also unacceptable; it is not only unconscionable that the Australian taxpayer is spending at least \$1.2 billion each year without knowing the clinical benefits, but patients may be receiving services which are possibly ineffective or even damaging.

- ***To what extent is currently collected information used to improve service efficiency and effectiveness?***

There are significant concerns that, when service evaluation raises issues regarding the efficacy of that service, this has not necessarily resulted in changes in funding or changes in the service model to ensure high quality, high value service delivery. The headspace evaluation is an often-cited example: the comprehensive evaluation undertaken by UNSW in 2015 found that only 13.3% of headspace clients experienced a clinically significant reduction in psychological distress while 9.4% experienced a significant increase in distress (Hilferty et al, 2015). It has been argued that one reason for this is the programs “failure to engage young people sufficiently to give evidence-based psychological therapy” (Jorm, 2016). Additionally, it has been argued that the funding model has not facilitated development of partnerships, and there has been poor client retention and outcomes because of a lack of experienced, senior staff and very little multidisciplinary input. However, funding for Headspace has continued, without substantial changes to the service model. Another \$263.3 million in additional funding has been proposed in the 2019 Federal Budget, and while this is considered essential to dealing with problems of long waiting lists, this program is yet to demonstrate that it offers the integrated, high quality mental health service that young people need.

The ACPA Board extends our sincere thanks to the Productivity Commission for the opportunity to input into this important process. ACPA looks forward to reading the draft report of the Commission, and the opportunity for further comment regarding the draft report in the future.

## References

- Arseneault, L., Cannon, M., Fisher, H.L., Polanczyk, G., Moffitt, T.E., & Caspi, A. (2011). Childhood trauma and children's emerging psychotic symptoms: A genetically sensitive longitudinal cohort study. *The American Journal of Psychiatry*, 168, 1, 65-72.
- Association of Children's Welfare Agencies. (2016). *Enhanced Foster Care Literature Review and Australian Program Description*. Brisbane.
- Atkinson, B. (2018). *Report on youth justice*. Brisbane: Queensland Government.
- Australian Childhood Foundation (2018). <https://www.childhood.org.au/our-work/helping-children-heal/sydney-trauma-centre/>
- Australian Institute of Health and Welfare. (2018). *Youth justice in Australia 2016-17*. Canberra: The Australian Institute of Health and Welfare.
- Australian Institute of Family Studies. (2017). *Risk and protective factors for child abuse and neglect* Australian Government.
- Australian Institute of Health and Welfare (2019). <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services/downloaded-05/03/2019>.
- Allen, N. B. & Jackson, H.J. (2011). What kind of evidence do we need for evidence-based mental health policy? The case of the Better Access initiative. *Australian and New Zealand Journal of Psychiatry*, 45, 696-699.
- Anglicare Tasmania (2009). *Experts by Experience: Strengthening the mental health consumer voice in Tasmania*  
<https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=6&ved=2ahUKEwjKkdPqtengAhXBdnOKHcqxAWOQFjAFegQIBhAC&url=https%3A%2F%2Fwww.socialactionresearchcentre.org.au%2Fwp-content%2Fuploads%2FExperts-by-Experience-Report.pdf&usq=AOvVaw16P1kwfqxPBmmaeWNVvvhZ>  
downloaded 05/03/2019.
- Australian Health Practitioner Regulation Agency (2017). *Annual Report 2016 – 2017*.  
<http://www.ahpra.gov.au/annualreport/2017/downloads.htm> downloaded 03/03/2019.
- Australian Psychology Accreditation Council (2019). *Accreditation Standards for Psychology Programs*.  
[https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=16&ved=2ahUKEwjK8Ycm1efgAhXJfXOKHYfwBy4QFjAPegQIAhAC&url=https%3A%2F%2Fwww.psychologycouncil.org.au%2Fsites%2Fdefault%2Ffiles%2Fpublic%2FStandards\\_20180731\\_Published\\_Final\\_0.pdf&usq=AOvVaw0mXkm1YiTCPk5LQDHPkQ](https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=16&ved=2ahUKEwjK8Ycm1efgAhXJfXOKHYfwBy4QFjAPegQIAhAC&url=https%3A%2F%2Fwww.psychologycouncil.org.au%2Fsites%2Fdefault%2Ffiles%2Fpublic%2FStandards_20180731_Published_Final_0.pdf&usq=AOvVaw0mXkm1YiTCPk5LQDHPkQ)  
downloaded 05/03/2019.
- Bai, C., Larcombe, W., Brooker, A., Wyn, J. Allen, L., Brett, M., Field, R. & James, R. (2017). *Enhancing Student Wellbeing: A Framework for Promoting Student Mental Wellbeing in Universities*.  
[unistudentwellbeing.edu.au/wp.../MCSHE-Student-Wellbeing-Framework\\_FINAL.pdf](http://unistudentwellbeing.edu.au/wp.../MCSHE-Student-Wellbeing-Framework_FINAL.pdf) downloaded 18/02/2019.

Bamelis, L., Evers, S., Spinhoven, P. & Arntz, A. (2014). Results of a Multicenter Randomized Controlled Trial of the Clinical Effectiveness of Schema Therapy for Personality Disorders. *American Journal of Psychiatry*, 171, 305-322.

Bauer, A., Fernandez, J., Knapp M. & Anigbogu, B., 2010. Economic evaluation of an 'Experts by experience' model in Basildon district. *Personal Social Service Research Unit (PSSRU) LSE Health and Social Care*. London School of Economics and Political Science.  
[https://www.researchgate.net/publication/220026412\\_Economic\\_evaluation\\_of\\_an\\_expert\\_by\\_experience\\_model\\_in\\_the\\_Basildon\\_district](https://www.researchgate.net/publication/220026412_Economic_evaluation_of_an_expert_by_experience_model_in_the_Basildon_district) downloaded 03/03/2019.

Berman, G., & Feinblatt, J. (2002). Problem-solving courts: A brief primer. *Law & Policy*, 23, 2, 125-140.

Burrell, S. (2013). *Trauma and the environment of care in juvenile institutions*. Los Angeles: National Centre for Child Traumatic Stress.

Cashmore, J., & Ainsworth, F. (2004). *Audit of Australian out-of-home care research*. Sydney.

Child Protection Development. (2011). *Specialist Foster Care Review: Consultation Report*. Retrieved from Brisbane.

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy*, 52, 337-345.

Curtis, N., Ronan, K., Heiblum, J., & Crellin, K. (2009). Dissemination and effectiveness of multisystemic treatment in New Zealand: A benchmarking study. *Journal of Family Psychology*, 23, 2, 19-129.

Degney, J., Hopkins, B., Hosie, A., Lim, S., Rajendren, A. V., & Vogl, G. (2012). *Counting the Cost – The Impact of Young Men's Mental Health on the Australian Economy*. Young and Well Cooperative Research Centre.

Delfabbro, P., King, D., & Barber, J. (2010). Children in foster care – Five years on. *Children Australia*, 35(1), 22-30. Retrieved from <https://www.cambridge.org/core/article/children-in-foster-care-five-years-on/EB9C5D5011A56C62DA0C0E3A3BF380DB>. doi:10.1017/S1035077200000936

Delisi, M. (2001). Designed to fail: Self-control and involvement in the criminal justice system. *American Journal of Criminal Justice*, 26, 1, 131-148.

Department of Education, Employment and Workplace Relations (DEEWR) (2013). *Evaluation of Disability Employment Services 2010-2013 Final Report*  
[https://d3n8a8pro7vnmx.cloudfront.net/wecanwork/pages/38/.../DES\\_Evaluation.pdf?](https://d3n8a8pro7vnmx.cloudfront.net/wecanwork/pages/38/.../DES_Evaluation.pdf?) downloaded 01/03/2019.

Department of Health (2019). *Report from the Mental Health Reference Group*.  
<http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-pcrq-consult> downloaded 18/02/2019.

Department of Health (2013). National Practice Standards for the Mental Health Workforce (2013)  
<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-wkstd13> downloaded 27/02/2019.

Department of Health (2010). Implementation guidelines for non-government community services. <http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-nongov-toc~mental-pubs-i-nongov-st8#86> downloaded 27/02/2019.

Department of Health (2018). *Report from the Mental Health Reference Group*. <http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-pcrq-consult> downloaded 03/03/2019.

Department of Health (2018). *Better Access to Psychiatrists, Psychologists and General Practitioners*. <http://www.health.gov.au/mentalhealth-betteraccess> downloaded 18/02/2019.

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., Thompson, T. J., . . . Giles, W. H. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse and Neglect*, 28(7), 771-784. doi:10.1016/j.chiabu.2004.01.008

eMH Prac. [www.emhprac.org.au](http://www.emhprac.org.au)

Fergusson, D., & Horwood, J.L. (2001). The Christchurch Health and Development Study: review of findings on child and adolescent mental health. *Australian and New Zealand Journal of Psychiatry*, 35, 3, 287-296.

Frederico, M., Long, M., McNamara, P., McPherson, L., & Rose, R. (2017). Improving outcomes for children in out-of-home care: the role of therapeutic foster care. *Child & Family Social Work*, 22(2), 1064-1074. Retrieved from <https://onlinelibrary.wiley.com/doi/abs/10.1111/cfs.12326>. doi:10.1111/cfs.12326

Green, J. G., McLaughlin, K. A., Berglund, P. A., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2010). Childhood adversities and adult psychopathology in the National Comorbidity Survey Replication (NCS-R) I: Associations with first onset of DSM-IV disorders. *Archives of General Psychiatry*, 67(2), 113. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2822662/>.

Greenberg, M. T. (1999). Attachment and psychopathology in childhood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 469-496). New York, NY, US: The Guilford Press.

Greenberg, G.A., & Rosenheck, R.A. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, 59, 2, 170-177.

Hayes, L., Brophy, L., Harvey, C., Tellez, J. J., Herrman, H., & Killackey, E. (2018). Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the National Disability Insurance Scheme. *Australasian Psychiatry*, 26, 578-585.

Helmes E. & Pachana N. A. (2006). Issues in training in clinical psychology in Australia: inter-play between training goals and legal standards of practice. *Australian Psychologist*, 41, 104–111.

Hickie, I (2019). Critics lash proposed mental health changes. *Radio National: Health Report*. <https://www.abc.net.au/radionational/programs/healthreport/mental-health-services-proposed-changes/10820896> downloaded 03/03/2019.

Hilferty, F., Cassells, R., Muir, K., Duncan, A., Christensen, D., Mitrou, F., Gao, G., Mavisakalyan, A., Hafekost, K., Tarverdi, Y., Nguyen, H., Wingrove, C. and Katz, I. (2015). Is headspace making a difference to young people's

lives? Final Report of the independent evaluation of the headspace program. (SPRC Report 08/2015). Sydney: Social Policy Research Centre, UNSW Australia.

Home Stretch (2018). <http://thehomestretch.org.au/learnmore/>

Howe, D. (2005). *Child abuse and neglect: Attachment, development, and intervention*. Gordonsville: Palgrave Macmillan.

IAPT (Improving Access to Psychological Therapies). <https://www.england.nhs.uk/mental-health/adults/iapt/>

Jorm, AF (2016). Should we be protecting headspace youth mental health service? *Online Opinion – Australia's e-journal of social and political debate*.

Jorm AF. (2018). Australia's 'Better Access' scheme: Has it had an impact on population mental health? *Australian and New Zealand Journal of Psychiatry*, 52(11), 1057-1062.

Killackey, E., Allott, K., Jackson, H. J., [Scutella, R.](#), [Tseng, Y. P.](#), [Borland, J.](#), [Proffitt, T. M.](#), [Hunt, S.](#), [Kay-Lambkin, F.](#), [Chinnery, G.](#), [Baksheev, G.](#), [Alvarez-Jimenez, M.](#), [McGorry, P. D.](#), & [Cotton, S.M.](#) (2019). Individual Placement and Support for Vocational Recovery in First Episode Psychosis: A randomized controlled trial. *British Journal of Psychiatry*, 214, 76-82.

Killackey, E., Allott, K., Woodhead, G., Connor, S., Dragon, S., & Ring, J. (2017). Individual Placement and Support Supported Education in Early Stage Mental Illness: An Exploratory Study. *Early Intervention in Psychiatry*, 11, 526-531).

Killackey E, Jackson HJ, McGorry PD. (2008). Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual. *British Journal of Psychiatry*, 193, 114-120.

Lambert, M.J. (2013). Bergin and Garfield's Handbook of Psychotherapy and Behavior Change, Sixth Edition. US: John Wiley & Sons.

Lambert, M.J. (2015). Effectiveness of Psychological Treatment. *Resonanzen. E-Journal für biopsychosoziale Dialoge in Psychotherapie, Supervision und Beratung*, 3(2), 87-100.

Lambert, M.J. (2017). Maximizing psychotherapy outcome beyond evidence-based medicine. *Psychotherapy and Psychosomatics*, 86, 80-89.

Layard, R & Clarke, D (2014). *Thrive: the power of evidence-based psychological therapies*. London: Penguin.

Lewis, Fanaian, Kotze, B. & Grenyer, B.S. (2019). Mental health presentations to acute psychiatric services: 3-year study of prevalence and readmission risk for personality disorders compared with psychotic, affective, substance or other disorders. *British Journal of Psychiatry*, 5, 1-7.

McGorry, P. (2016). Stepwise expansion of evidence-based care is needed for mental health reform. *Medical Journal of Australia*, 9, 351–353.

McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2012). Childhood adversities and first onset of psychiatric disorders in a national sample of US

adolescents. *Archives of General Psychiatry*, 69(11), 1151-1160. doi:10.1001/archgenpsychiatry.2011.2277

McPherson, L., Gatwiri, K., Cameron, N., & Parmenter, N. (February, 2019). *Research Briefing: What is Effective Therapeutic Care*. Centre for Excellence in Therapeutic Care: Australian Childhood Foundation.

McPherson, L., Gatwiri, K., Tucci, J., Mitchell, J., & MacNamara, N. (2018). A paradigm shift in responding to children who have experienced trauma: The Australian treatment and care for kids program. *Children and Youth Services Review*, 94, 525-534. Retrieved from <http://www.sciencedirect.com/science/article/pii/S0190740918302834>. doi:<https://doi.org/10.1016/j.chilyouth.2018.08.031>

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., . . . Swendsen, J. (2010). Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(10), 980-989. Retrieved from <http://www.sciencedirect.com/science/article/B987N-50NH68N-2/2/925f58aa33dfab12a52e446fc6cfa8bc>.

Miller, N.A., & Najavits, L.M. (2012). Creating trauma-informed correctional care: a balance of goals and environment. *European Journal of Psychotraumatology*, 3, s1, 1-7.

Mitchell, J. (2008). *A Case Study in Attempted Reform in Out of Home Care: A Preliminary Examination of the Introduction of the Circle Therapeutic Foster Care Program in Victoria*. . Monash University,

Medicare Benefit Schedule. [www.mbsonline.gov.au](http://www.mbsonline.gov.au).

Medical Board of Australia (2017). *Expert Advisory Group on revalidation: Final Report*. <https://www.medicalboard.gov.au/registration/revalidation.aspx> downloaded 03/03/2019.

Mental Health Commission of NSW (2016). Physical health and mental wellbeing: evidence guide.

Mental Health Commission of NSW, Sydney.

Mojtabai R, Olfson M, Sampson NA, et al. (2011) Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. *Psychological Medicine* 41: 1751–1761.

Morse, G., Salyers, M. P., Rollins, A.L., Monroe-DeVita M. & Pfahler, C. (2012). Burnout of mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health*, 341 -352.

National Mental Health Commission (2014). *The National Review of Mental Health Programmes and Services*. National Mental Health Commission, Sydney.

Pfeiffer, P.N., Heisler, M., Piette, J.D., Rogers, M.A. & Valenstein, M. (2011). Efficacy of peer support interventions for depression: a meta-analysis. *General Hospital Psychiatry*, 33, 29–36.

Porter, M. & Nuntavisit, L. (2016). An evaluation of multisystemic therapy with Australian families. *Australian and New Zealand Journal of Family Therapy*, 37, 443-462.

Prinz, P., Sanders, M., Shapiro, C., Whitaker, D., & Lutzer, J. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*, 10, 1, 1-12.

Psychology Board of Australia (2018). *Public Consultation paper on the proposal to retire the 4+2 internship pathway to general registration*. <https://www.psychologyboard.gov.au/News/Past-Consultations.aspx> downloaded 18/02/2019.

Psychology Board of Australia (2011). *Guidelines on area of practice endorsements*. <https://www.psychologyboard.gov.au/Standards-and-Guidelines/Codes-Guidelines-Policies.aspx> downloaded 19/02/2019.

Robson, E., Waghorn, G., Sherring, J. & Morris, A. (2010). Preliminary Outcomes from an Individualised Supported Education Programme Delivered by a Community Mental Health Service. *The British Journal of Occupational Therapy*, 73, 481-486.

Rutter, M. (2000). Children in substitute care: Some conceptual considerations and research implications. *Children and Youth Services Review*, 22(9), 685-703. Retrieved from <http://www.sciencedirect.com/science/article/pii/S019074090000116X>. doi:[https://doi.org/10.1016/S0190-7409\(00\)00116-X](https://doi.org/10.1016/S0190-7409(00)00116-X)

Scott, K. (2003). *Funding Matters: The Impact of Canada's New Funding Regime on Nonprofit and Voluntary Organizations*.

Sherring, J., Robson, E., Morris, A., Frost, B. & Tirupati, S. (2010). A working reality: evaluating enhanced intersectoral links in supported employment for people with psychiatric disabilities. *Australian Occupational Therapy Journal*, 57, 261-267.

Shimokawa, K., Lambert, M.J. & Smart, D.W. 2010. Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology* © 2010 American Psychological Association, 78, 298–311.

Sinclair, I. (2005). *Fostering Now: Messages from Research*. London: Jessica Kingsley Publishers.

South Australia Health (2010). Experts by Experience – Mental Health. <https://www.sahealth.sa.gov.au/wps/wcm/connect/public/content/sa+health+internet/about+us/our+local+health+networks/country+health+sa+local+health+network/engaging+with+chsa/experts+by+experience+initiative++mental+health++country+health+sa> downloaded 05/03/2019.

State Government of Victoria (2018). The orange door. <https://orangedoor.vic.gov.au/what-is-the-orange-door#heading4>

State of Victoria, Department of Health and Human Services (2017). Therapeutic Interventions: Demonstration Projects. <https://providers.dhhs.vic.gov.au/therapeutic-interventions-demonstration-projects-word> downloaded 02/05/2019

Titov, N., Dear, B.F., Nielssen, O., Staples, L., Hadjistavropoulos, H., Nugent, M., Adlam, K., Nordgreen, T., Hogstad Bruvik, K., Hovland, A., Repål, A., Mathiasen, M., Kraepelien, M., Blom, K., Svanborg, C., Lindefors, N., Kaldo, V. (2018). ICBT in routine care: A descriptive analysis of successful clinics in five countries. *Internet Interventions*; 13, 108-115.

Titov N, Dear B, Staples L, Bennett-Levy J, Klein B, Rapee R, Andersson G, Purtell C, Bezuidenhout G, Nielssen O (2017) The first 30 months of the MindSpot Clinic: Evaluation of a national e-mental health service against project objectives. *Australian and New Zealand Journal of Psychiatry* 51, 12, pp. 1227-1239.

Universities UK (2015). *Student Mental Wellbeing in Higher Education: Good practice guide*. <https://www.universitiesuk.ac.uk/policy-and-.../student-mental-wellbeing-in-he.pdf> downloaded 28/02/2019.

Victorian Government Department of Human Services. (2009). *The Circle Program – a therapeutic approach to foster care: Program Guidelines*. Melbourne, Victoria

[Waghorn, G.](#), [Saha, S.](#), [Harvey, C.](#), [Morgan, V. A.](#), [Waterreus, A.](#), [Bush, R.](#), [Castle, D.](#), [Galletly, C.](#), [Stain, H. J.](#), [Neil, A. L.](#), [McGorry, P.](#), [McGrath, J. J.](#) (2012). 'Earning and Learning' in those with psychotic disorders: The second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry*, 46, 774-785.

White, L.M., Lau, K.S.L., & Aalsma, M.C. (2016). Detained adolescents: Mental health needs, Treatment use, and recidivism. *The Journal of the American Academy of Psychiatry and the Law*, 44, 200-212.

Wilkinson, H., Whittington, R., Perry, L., & Eames, C. (2017). Examining the relationship between burnout and empathy in healthcare professionals: A systematic review. *Burnout Research*, 18 – 29.

Wilson, K. (2006). Can Foster Carers Help Children Resolve Their Emotional and Behavioural Difficulties? *Clinical Child Psychology and Psychiatry*, 11(4), 495-511. Retrieved from <https://journals.sagepub.com/doi/abs/10.1177/1359104506067873>. doi:10.1177/1359104506067873

Worrall, H., Schweizer, R., Marks, E., Yuan, L., Lloyd, C. & Ramjan, R. (2018). The effectiveness of support groups: a literature review. *Mental Health and Social Inclusion*, 22, 85-93.

Wu, N., Schairer, L.C., Dellor, E., & Grella, C. (2010). Childhood trauma and health outcomes in adults with comorbid substance abuse and mental health disorders *Addictive Behaviors*, 35, 1, 68-71.

Yu-Chen Lee, Y.C., Gao, L., Dear, B.F., Titov, N., Mihalopoulos, C. (2017). The cost-effectiveness of the online MindSpot clinic for the treatment of depression and anxiety in Australia. *Journal of Mental Health Policy and Economics*, 2017, vol. 20, issue 4, p. 155-166. PMID: 29300702.