

Productivity Commission Inquiry into Mental Health

APS Response to the Draft Report

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

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The Australian Psychological Society

The Australian Psychological Society (APS) is the peak professional organisation for psychologists in Australia representing approximately 24,000 members. Psychologists are experts in human behaviour including the processes determining how people think, feel, behave and react, and they apply their expertise using reliable and scientifically supported methods. The APS is proud to represent its members and works collaboratively with governments and other stakeholders to enhance the health and wellbeing of the Australian community. The APS has a long history of advocating for change to the mental health system, particularly for mental health to be considered as important as physical health. We welcome the call to action articulated in the Productivity Commission's Draft Report and the opportunity to contribute to the refinement of its findings and recommendations.

Introduction

The APS welcomes the inquiry into the social and economic benefits of improving the mental health system in Australia and commends the Productivity Commission (PC) for the extensive body of work that it has undertaken, including its synthesis of a large volume of stakeholder submissions. The APS supports many of the proposals formulated by the PC and outlined in the [Mental Health - Draft Report](#).

As highlighted in its response to the PC's [Issues Paper *The Social and Economic Benefits of Improving Mental Health*](#) (see [APS response](#)), the APS strongly supports reform designed to craft a mental health system that provides Australians with inclusive, affordable and timely access to safe and high quality mental health services. The mental health system in Australia should offer a range of services along the spectrum of mental health and wellbeing, from those seeking to maintain or improve their mental health, to those who require more intense services such as individuals with complex, co-morbid or acute mental health issues.

The APS is pleased that the PC has recognised the need to strengthen system responsiveness by bridging gaps in critical services, ensuring continuity of care, implementing prevention measures and making recommendations to ensure Australia has the opportunity to become a world leader in addressing the burden of mental health. The APS is encouraged by the inclusion of psychological science, knowledge and expertise to enhance outcomes for individuals, families and carers, the community and Australia's mental health system.

The APS is aware that the inquiry process led by the PC is occurring at the same time that the Government is forging ahead with changes to the mental health system in Australia, through a range of measures announced in recent Budget processes. In addition, there is significant other review activity occurring that is relevant to the Australian mental health system, including the Royal Commission into Victoria's Mental Health system, several inquiries into the National Insurance Disability Scheme (NDIS), the review of the Medicare Benefits Schedule (MBS) and the Royal Commission into Aged Care Quality and Safety. It is important that the overall approach to the reforms is driven by a coherent strategy and vision to achieve the desired improvements for individuals, families and professionals within the mental health system.

The PC's Draft Report (October 2019) contains an analysis of a wide range of complex issues. The APS response is targeted at selected aspects of the proposed reforms that can be informed by psychological science and where psychologists can assist with crafting a mental health system that is responsive to the needs of all Australians. We provide suggestions about priorities for a reform agenda within a devolved system that provide system flexibility, continual improvement, coordinated translational research to inform best practice and a clearer structure for increasing Australia's knowledge and practice of what works for whom and when. The system needs to be flexible and responsive to changing needs across the long term and this requires significant and continuous investment and commitment by governments that are not undermined by political changes. We also do not see the mental health system as a separate consideration to physical health problems and the system needs to address complexity and comorbidity in a flexible, collaborative and evidence driven manner. The APS looks forward to the PC's final report and opportunities to work with Government to build a fit for purpose system.

Summary comment on proposed reforms

The APS supports the PC's proposals with respect to reorienting services to consumers and broadening access to services within and outside of the mental health system, including improved availability of in-patient services for people who require high intensity care.

The APS supports many of the recommendations to improve education, awareness and information for users, simplify care pathways, and enhance services and transitions across the stepped care model. The APS particularly supports the PC's vision for preventing the onset and deterioration in mental health problems as essential for reducing the incidence and prevalence of mental health illness across the long term.

The APS supports recommendations that prioritise consumer choice and increased services as these will improve access to evidence-based care. In particular, the APS endorses the PC's recommendations to enhance access to psychological services delivered within the MBS. These recommendations align with the APS's White Paper¹ for the delivery of psychological services within Medicare such as the reforms to group therapy, extended referrals, increased sessions, items for families and carers and increased flexibility of referrals and broadening access to videoconferencing for psychological treatment services.

The PC's focus on valuing the role of carers and their families and recognising the role of housing, social inclusiveness, justice services and workplace practices on psychological wellbeing, has the potential to bridge substantial gaps in the current system of mental health care. These areas have typically been considered separate to the larger mental health system and therefore their role in mental health and wellbeing has gone largely unrecognised. Improving services, both in terms of access and effectiveness, is essential not only for prevention of mental health problems but also for facilitating recovery from mental illness. Additionally, co-designing services with consumers will improve clinical care, enhance the care experience and promote recovery for vulnerable people in need of health, mental health and other services.

The APS welcomes the PC's recommendations to implement reforms that enhance services for children and young people. The detection and management of mental health issues among this cohort can have the greatest long-term impact in reducing the burden (both economic and suffering) of mental health in Australia (see the APS response regarding the economic savings associated with detecting and intervening early with children to prevent disruptive behaviours²).

The APS has identified a number of issues that it considers require further attention by the PC and these are set out in the pages that follow. Detailed responses to specific recommendations are contained in Appendix.

In summary the APS response addresses:

1. Strengthening the evidence-base for the delivery of mental health services to ensure the Australia's mental health system is effective and efficacious in reducing the burden of mental health
2. The critical importance of neuropsychological assessments to help provide more targeted care and therapeutic interventions for people with mental illness who also have cognitive impairments
3. The need to address the structure and function of the mental health workforce across the stepped care model to strengthen care pathways and ensure individuals access the right care at the right time
4. The training needs and roles of professionals within the mental health system
5. Enhancing the funding and structural reform of Australia's mental health system to facilitate long-term sustainability

1. Strengthening the evidence-base

The Draft Report outlines ways in which the Government can strengthen monitoring, evaluation and research efforts in Australia. The APS supports many of the proposed recommendations outlined in the Draft Report that act to strengthen evidence-based decision-making to improve the mental health of Australians, including a National Evaluation Framework (recommendation 22.5), the development of a National Research Strategy, and the establishment of a Clinical Trials Network for mental health (recommendation 25.9).

The PC makes it clear that substantial improvements are required to bridge gaps and to improve the accessibility and meaningfulness of the evidence that informs a diverse range of mental health stakeholders, including professionals, consumers, governments, policy makers and researchers. While the evidence is being established, decisions to advance mental health reforms, policy and spending still need to be made in a manner that allows for continual improvement as emerging evidence further clarifies what works for whom and when.

The APS believes that implementing major reforms that are not grounded in synthesised evidence risks undermining the intention of the reform agenda and this will negatively impact on consumers. For example, while there are currently trials related to determining effective triage and care pathways, these trials are in their infancy, often relate only to low intensity service needs and have limited utility across the system (For example PORTS³ and Link-me⁴). To date, there is little evidence demonstrating the effectiveness or efficacy of service delivery models currently being implemented through PHNs. Establishing a robust evidence-base across the multiple domains of mental health requires a cohesive and integrated strategy.

The APS is strongly committed to working with government to improve consumer access to appropriate mental health care. As a profession, psychology is firmly grounded in synthesising evidence for the benefit of individuals, communities and the mental health system. For the benefit of Australia's mental health system, the APS provides the following information to enhance the recommended reforms and ensure the evidence base is well-established and also widely distributed in a usable manner for all stakeholders, especially for the practitioners on the ground responsible for assessing and treating individuals with mental health problems and diverse psychosocial needs.

Evaluation methods

The APS seeks to take an active and constructive role in the evaluation of the various programs, including in the identification and definition of suitable evaluation parameters and outcome measures, as discussed in chapter 25 of the Draft Report. For evaluation results to credibly inform continuous system improvements, systematic and consistent evaluation methods are required to ensure evaluations are planned appropriately

and measure what they are supposed to measure. The research activities required to improve the evidence-base will take a considerable length of time before substantial benefits are recognised in the form of mental health outcomes. These outcomes can only be achieved when strong evaluation and continuous improvement strategies are implemented.

The APS supports rigorous research and evaluation of mental health activities and programs including recommendation 5.4 regarding the evaluation of MBS Better Access. However, to establish a strong evidence base there needs to be evaluation of programs, service delivery and activities across the mental health system in a consistent manner. Employing systematic methodologies for planning and evaluation is required across the full range of activities that contribute to reducing the burden of mental health in Australia. Ensuring that appropriate evaluation research is conducted in a rigorous manner and that appropriate measures are used, is a problem that requires careful attention, especially if research independence is not prioritised and where the interpretation of research may be skewed. For example, while both the PORTS³ and Link-me⁴ trials are encouraging for clarifying care pathways, there are weaknesses with both trials and both tend to clarify pathways and assess effectiveness for consumers with low intensity needs. Research findings published by the receivers of funding and developers of the program is valuable but requires independent analysis of its effectiveness and efficacy. Only when this research is replicated and stratified (for example across providers, stepped care, consumer groups and regions) will the efficacy of these strategies become apparent.

The process of continual improvement requires an evaluation and feedback loop to ensure a strong evidence-base is established that informs policy decisions about the effectiveness and efficacy of services. Globally, many organisations and governments are planning programs and evaluations using the Program Logic Model to ensure evaluation methods identify improvements before they are implemented more broadly.⁵ Program logic ensures that program inputs, goals, activities, resources use, and practice logically link to the expected outcomes.⁶ It ensures that both the design and evaluation of programs and services do not become ineffective but are instead clearly understood and able to be deconstructed so that what works is clear within the context of the program. Employing this method will illuminate the logical link between why certain activities are conducted and how these contribute to the desired outcomes for consumers. Currently, one of the problems with how programs and services are evaluated is that often inputs are misconstrued as outputs. For example, time spent with a consumer (i.e. contact time) is an input whereas the outcome should be how effective the professional was during this time as demonstrated by relevant, reliable and valid clinical measures.

The Draft Report contains many recommendations to strengthen the culture of evaluations and continual improvement. However to ensure evaluation is embedded within Australia's mental

health system the APS calls on the PC to reinforce to government the importance of embedding rigorous, consistent and independent evaluations in all programs to ensure a strong and reliable body of evidence is established about what works for whom and when.

APS Recommendation 1

The APS supports rigorous independent evaluations that inform the continual improvement of Australia's mental health system and recommends that:

- Program logic is employed for the program planning and evaluations using outcome-based results, not activity based inputs
- Evaluation is strengthened in all government funded mental health programs, services and activities, including Orygen, MBS mental health services, PHNs and headspace
- Evaluation includes assessing how well programs, services and activities align with the evidence base
- Evaluation is conducted by independent researchers.

Evaluating the Better Access initiative

The APS commends the Australian Government for the introduction of the Better Access (BA) initiative as one of the most cost-effective and successful ways to improve universal access for Australians to psychological therapy. The system appears to be the sole driver of improved treatment rates for people with mental health disorders and has effectively reduced psychological symptoms among those who accessed treatment. Internationally, BA is well-known to be enormously successful in providing accessible, effective, and relatively low cost services to meet public need. There is however some confusion about the impact and effectiveness of the BA initiative on the mental health of Australians that the APS would like to clarify for the PC.

BA is an example of where the failure to embed appropriate evaluation methods can detract from the effectiveness of the program in improving the mental health of a large number of Australians. While the APS welcomes an evaluation of BA, it cautions that until the structure of BA aligns with the evidence-base for effective psychological service delivery using the appropriate clinical measures, the evaluation is unlikely to provide accurate information about what works for whom and when.

As discussed in the APS White Paper, the current structure of MBS services is poorly aligned with the evidence demonstrating the effectiveness of psychological services for various mental health disorders. For example, not all mental health disorders are eligible for treatment within BA (such as Borderline Personality Disorder), a number of evidence-based treatments are not allowable^a, and many evidence-based interventions cannot be provided effectively due to the restriction on the number of sessions. The number of sessions is insufficient for consumers with particularly severe conditions and the absence of assessment services undermines treatment efforts, especially for young people (this is discussed further in section 2: Cognitive impairments and mental health).

Although the APS supports the recommendation to expand BA sessions from 10 to 20, it is concerned that this will remain insufficient for individuals with complex and comorbid mental health problems. As discussed within the Draft Report and the APS White Paper, there are many disorders and more complex presentations “such as psychotic disorders,⁷ eating disorders,⁸ persistent or recurrent depressive disorders,⁹ borderline personality disorder¹⁰ and conduct disorder¹¹ that often require more than 20 sessions per annum to facilitate recovery and prevent transitions to secondary care, such as hospitalisation”¹¹ (APS White Paper, p.16). It is important that evaluations of BA and other mental health services include only cases where the structure of the service aligns with the evidence base for effective psychological assessment and treatment. To assess the effectiveness of psychological interventions within a program where the level of intervention cannot be delivered to individuals who require more than 20 sessions per annum can be likened to assessing the effectiveness of a pharmaceutical agent while only administering half the required dose.

Evaluation using appropriate measures

Program evaluation is a complex field and one of the consistent issues that causes confusion for stakeholders is the inappropriate use of measures to assess program effectiveness, such as inappropriately measuring the effectiveness of a mental health program against population-level data such as suicide rates.

Evaluating specific programs against larger, population-level policy objectives (such as reduction in the rate of suicide) is problematic as such policy objectives are multi-dimensional and should not be assessed with reference to a single funded program. For example, given the prevalence of mental illness among people who complete suicide is approximately 50%,¹² half the individuals who complete suicide would not meet the diagnostic criteria for a referral for MBS subsidised psychological services.

a e.g. psychologists who offer focussed psychological therapy are ineligible to provide the gold standard evidence based treatment for PTSD - Eye-movement desensitisation and reprocessing

As discussed in the paper by Lee and Frost,¹³ BA was designed to reduce distress among those who received treatment for specific disorders under a capped number of sessions not as a suicide prevention program nor was it designed to reduce the levels of distress among those who have not engaged with psychological treatment. Previous evaluations of the BA initiative have sought to assess the effectiveness of psychological treatment among those who have received treatment and has found that psychological treatment reduces the severity of mental health symptoms (commonly referred to as distress)¹⁴ using non-specific psychological distress measures such as the K10. One of the strengths of the program identified by Pirkis and colleagues¹⁴ was the significant increase in treatment rates for people with a mental health disorder since the introduction of BA in 2006. Later published commentary¹⁵ drew erroneous conclusions about the effectiveness of BA by drawing links between the introduction of BA and population levels of distress and suicide rates, which includes Australians who had not accessed psychological care. Research by Harvey and colleagues¹⁶ analysing changes in the prevalence rates of probable common mental health disorders between 2001 and 2014, found that while prevalence rates had not significantly declined since the introduction of BA, the overall severity of distress had reduced. To draw the conclusion that BA is ineffective by measuring it against population-levels of suicide rates and distress among those who had not received treatment is not an appropriate evaluation or interpretation of the program's effectiveness.

Evaluation should be set in the context of the specific program's stated objectives and use appropriate measures. This is where employing program logic for the design and evaluation of programs can substantially benefit decision makers responsible for improvement and reform. As discussed above, evaluations should not be limited to outcome or activity-based data collection such as number of contacts, occasions of service or population outcomes such as progress against Contributing Lives Outcomes mentioned in chapter 25 of the Draft Report. Instead program evaluations should be logically linked to the program's effectiveness in treating the specific mental health problems the program was designed to address. Previous commentary and discussion about the effectiveness of BA has been flawed due to these inconsistencies.

The APS emphasises the need for appropriate measures to be used in the evaluation of programs. Appropriate and targeted measures should be used to evaluate the effectiveness of a program, such as specific measures that have been determined by a body of research to be reliable and valid for measuring symptom reduction for the particular mental health disorder (such as the Beck Depression Scale, Beck Anxiety Scale or the Depression Anxiety and Stress Scales for measuring depression and anxiety symptoms) and functional behaviour measures to assess the individual's ability to function more productively in their day to day life.

APS Recommendation 2

The APS supports the evaluation of psychological services provided under the MBS Better Access initiative. The evaluation of Better Access should include:

- An evaluation of the effectiveness of all items delivered within the initiative, including the development of mental health treatment plans and reviews
- An assessment of the extent to which Better Access, as it currently operates, aligns with the evidence base
- Employing program logic to plan amendments to Better Access and the evaluation of the program
- Evaluation using appropriate effectiveness measures of mental health and not evaluation against larger population-level policy objectives or activity-based inputs such as number of contacts, occasions of service or similar illogically linked outcome measures.

Mental Health Treatment Plans and Reviews

The APS supports and values the role of general practitioners (GPs) in primary care for mental health. The role of GPs is important for investigating any physical explanations or comorbidities that can cause or exacerbate psychological symptoms. We do however believe the current structure of mental health care plans, referrals and reviews could be improved for the benefit of GPs, psychologists and most importantly for consumers. The APS supports recommendations 5.8 and facets of 5.4 that increase the flexibility of referrals by enabling consumer choice of mental health practitioners, extending the review period from 6 to 10 sessions and moving away from calendar year to any 12 month period from initial referral to claim the maximum number of allowable sessions; similar to other specialist referrals.

Relevant to information request 5.2 regarding mental health treatment plans, the APS has provided recommendations in our White Paper¹ about how this process could be strengthened. Recommendation 2 in the White Paper includes:

- Increasing the maximum number of allowable sessions per referral from 6 to 10 sessions.
- Increasing the number of available sessions for clients who require more intensive psychological services to stabilise their mental health, encourage continuity of care, prevent deterioration and relapse and to allow the delivery of evidence-based interventions that support recovery
- Stepping consumers through levels of psychological care according to the nature of the mental health disorder, the expertise of the psychologist and the needs of the consumer (number of sessions required to achieve effective clinical

outcomes; up to 20 sessions for low intensity treatment needs and up to 40 for clients with a specific diagnoses and high intensity treatment needs)

- Regularly measure and review outcomes to determine treatment progress and to ensure responsiveness is embedded in the delivery of psychological services within Medicare
- Broadening eligible referrers to include all medical practitioners registered with the Australian Health Practitioner Regulation Agency to enhance collaboration, reduce administrative burden on the consumer and reduce the cost to government.

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

- Require reviews after each block of sessions (maximum of 10 sessions)
- Introduce pre- and post- outcome measures for each block of sessions
- Require a psychological report to be provided to the referring practitioner prior to each review
- Introduce review criteria after each course of treatment (up to 10 sessions). This review criteria enables the referring practitioner to determine the efficacy of treatment and make decisions about the next step of psychological care according to consumer needs. The recommended review criteria is outlined in detail on page 18 of the White Paper¹ and includes amendments to the current triage and referral processes, the embedding of outcome measures and communication (reporting) between health professionals, and simplifying the initial triage process.

Additionally to ensure mental health experts can work to the top of their scope and to simplify the options for medical practitioners, the APS recommends that MBS services are redesigned as outlined in recommendation 1 of the White Paper.¹ This includes redesigning the structure of psychological service delivery within the MBS Better Access initiative to recognise the advanced skills and training of psychologists in assessing and treating mental health problems. This would include adding assessment items into the MBS to assist GPs with their decision making and relieve the burden on GPs to have complete expert knowledge in mental health. As outlined in the APS White Paper, this necessitates the introduction of Initial Assessment items and Independent Assessment items (recommendations 12 and 16, respectively).

In relation to other questions within information request 5.2 regarding mental health treatment plans (MHTP) the APS suggests that instead of overburdening GPs, MHTPs should not include a doubling up of assessments first by the GP and then by the mental health professional who has advanced skills and who has the sufficient time required to make a thorough assessment and treatment plan for the consumer. Shortening the GP's

assessment by delegating this responsibility to the mental health experts decreases barriers for consumers such as repeating their story, costing them time and money for extended GP consultations and ensuring the correct level of expertise is used when assessing mental health problems. The APS recognises the importance of a collaborative approach to mental and physical health and the need for GPs to understand and screen for mental health problems among their patients. MHTPs have served to enhance and support the GPs response to mental health problems, facilitate collaboration and act as an educational tool. The APS is supportive of these functions and believes MHTPs could be better designed to enhance this collaborative working arrangement. The APS's detailed response to the PC's Information Request 5.2 regarding mental health treatment plans is provided in Appendix.

Improving the integration and usefulness of evidence

As highlighted in the Draft Report, research is conceptualised, funded and conducted through numerous streams and using different sources and dissemination strategies. Achieving the outcomes for an improved evidence-base in a cohesive manner that integrates monitoring, evaluation and research will require active coordination. A highly coordinated network is required to collate, integrate, critically analyse, synthesise, interpret and disseminate a broad range of findings in a way that is meaningful for stakeholders, such as best practice guidelines, educative resources, standards of mental health care and mental health frameworks. The APS is concerned that efforts to strengthen data collection, monitoring, reporting, evaluation and research will continue to be siloed unless there is a strategy for critically evaluating the evidence in a useful manner.

As experts in mental health and wellbeing, psychologists and psychological scientists are expertly trained in evidence-based practice and have the skills to synthesise the research base in a manner that is objective and able to be applied to mental health services for consumers. As the mental health reform agenda includes expanding the range of mental health practitioners, this introduces significant differences in the level of education, training and the skill base of practitioners. Importantly, many mental health practitioners providing low intensity care do not have the skills required to analyse the evidence in an expert manner.

Enabling quality evidence to be synthesised appropriately is a high-level skill that is not included in the training and abilities of many mental health practitioners as they are not required to undertake the extensive level of training in statistical analysis and research methodology that psychologists are required to undertake to obtain registration with AHPRA. For example, psychologists are required by AHPRA to ensure they are constantly re-evaluating the evidence-base to ensure they

are up to date with the latest findings. Without the appropriate skill level required to expertly analyse the evidence, consumer safety is compromised. For example, while the APS supports recommendation 25.9 to establish a Clinical Trials Network in mental health, we are concerned that the results from these trials may be misinterpreted and misapplied in practice. One study is insufficient to claim that it alone is evidence for the effectiveness or efficacy of a particular approach, service design, or psychological treatment. Evidence from clinical trials is only one piece of evidence that contributes to the evidence-base and the findings can be misinterpreted and misapplied if they have not been contextualised within the broader field of mental health research and practice. This loop from research to practice represents a continual improvement strategy designed to strengthen the evidence base but can only be achieved using the high-level skills of research experts.

To further strengthen the response to mental health, research can be practice-informed. For example, barriers to the implementation of evidence-based practice can be explored using practitioner knowledge and professional insights to elucidate research gaps.³ However, this research can be biased and have methodological flaws if it is not expertly conducted by skilled researchers. The PC's focus on translating evidence into practice is a medium to long term objective given the average lag time. For example, Australian Clinical Trials Alliance (ACTA) reports the median time from the beginning of a clinical trial to the publication of the research is 5 years² and only after that is the research translated into practice. Together this means that the research from clinical trials will not be published in the next 5 years, the results can be misinterpreted if not expertly synthesised with the body of research and in the meantime reform agendas and continual improvement activities are progressed. This leaves a significant gap in the knowledge base without a credible source of integrated and up to date evidence that is accessible by practitioners providing services and program and service designers. The APS consider this gap a risk to the mental health system and consumers if it is not appropriately addressed.

As experts in mental health evidence and research, the psychology profession is a leader in producing and establishing the mental health evidence-base and translating credible research findings into practice. However, mental health evidence is not well disseminated in Australia. Currently Australia has a disparate way of establishing important and useful information that is a credible source of advice and guidance for a broad range of stakeholders. Within and outside of Australia, centres for clinical excellence provide this function; however they are typically focused on specific issues such as the Orygen's National Centre for Clinical Excellence in Youth Mental Health, the National Health and Medical Research Council, the Australian institute of Criminology, and the Australian Clinical Trials Alliance. An international example is the National Centre for Clinical Excellence in the UK.

The APS recommends the Australian Government invest in establishing an overarching National Centre for Excellence in Mental Health to bring together the disparate sources of information about mental health in Australia, improve the cohesiveness of mental health information, and provide expertly synthesised and critically evaluated advice to stakeholders through the development of resources such as:

- Clinical Guidelines (see NICE and the NHMRC)
- Educative resources such as translating research to practice and vice versa (e.g. Orygen)
- Briefs for specific and emerging issues, including who is conducting research in particular areas (such as trends and issues or statistical bulletin related to mental health like the Australian Institute of Criminology), and
- Information about clinical trials, current research directions, and statistical information derived from the data, monitoring and evaluation activities.

An Australian Centre for Excellence in Mental Health will provide the mechanism for continual improvement of mental health practice, systems and evidence. It has the potential to link current centres together in a collaborative manner to create a central source of credible information for stakeholders.

APS Recommendation 3

The APS recommends the establishment of an Australian Centre for Excellence in Mental Health to provide expertly synthesised and critically evaluated advice to mental health stakeholders.

2. Cognitive impairments and mental health

The APS has identified a service gap in the Draft Report that, if left unaddressed, will leave any program of support unbalanced and ineffective in the long term. The interaction between cognitive functioning and mental health is very strong and needs to be addressed. For example, there is strong link between dementia, depression and anxiety however dementia is considered part of the broader health scheme as a neurological disorder. Among younger people and people with mental health problems, cognitive impairment is an area of need that remains unaddressed within our mental health system.

In its 2014 Review of Mental Health Programs and Services,¹⁷ Australia's National Mental Health Commission identified a specific gap in clinical neuropsychology service provision. Assessment and treatment of cognitive dysfunction is not part of routine mental health care in Australia, and when it is, waitlists are extremely long. For example, a survey of 532 headspace clinicians Australia-wide found that only 1 in 10 young people who needed a neuropsychological assessment were able to have one completed.¹⁸ The key barrier identified was that neuropsychological assessments were not publicly funded.

Cognitive impairment is a core feature of many mental health conditions, affecting up to 75% of people with psychotic disorders¹⁹ and 30% of youth attending headspace clinics nationally.¹⁸ Our colleagues at Orygen have demonstrated that better access to neuropsychological services provided by neuropsychologists improves diagnosis, treatment and functioning of youth attending mental health services.²⁰ Of all factors, cognitive impairment is the strongest predictor of poorer functioning outcomes in employment, education or training for people with mental illness.^{21,22} Cognitive impairment also compromises a person's treatment decision making capacity, which can be better supported if cognition is properly assessed. Diagnosis and treatment planning is greatly enhanced through the involvement of neuropsychological assessments as part of the multidisciplinary approach needed to address complex mental health concerns.^{18,23,24}

Evidence shows that many of the complexities of mental health care are caused by cognitive contributions and comorbidities.²⁵⁻²⁷ The presence of cognitive impairment can have a significant impact on the person's capacity to engage with and benefit from therapy, requiring appropriate modifications.^{28,29} Neuropsychology is a collaborative process, which serves to help a person with a mental health condition understand themselves better and guides the treating team towards appropriate treatment to optimise functional recovery.

Neuropsychological assessments for people with diagnosed mental illness helps uncover cognitive comorbidities and delineate the needs of the person to help provide more targeted care and therapeutic intervention. This has also been shown to improve education and employment outcomes. This represents a huge unmet need that is contributing to the mental health crisis and causing an impediment to successful outcomes.

APS Recommendation 4

The APS recommends that the PC give explicit attention to the role of cognitive functioning in mental health, and consider recommending the systematic funding of neuropsychological assessments within the mental health system (both public and private).

3. Workforce

The APS agrees that Australia needs a broad, diverse and robust healthcare workforce with the capacity to meet the heterogeneous needs of consumers with mental health problems and supports the intention of recommendations to build an appropriately skilled workforce. However, the APS has several concerns with the PC's findings and recommendations in relation to workforce structure, numbers, and training needs.

Mental health workforce structure

In response to inefficiencies, complexities, and fragmentation in the mental health system, and the need for sustainable reform, the stepped-care model has been adopted nationally. In the implementation of stepped-care the APS recognises:

- Safety and quality as the underlying principle that drives delivery of mental health services
- That to maintain consumer confidence, mental health services need to be safe and of consistently high-quality.

The APS strongly supports the PC's focus on improvements within the framework of a stepped care model and appreciates its recognition that the stepped care model represents a spectrum of service interventions along a continuum of care. Rather than a set of discrete, siloed activities, stepped care should be operationalised as a spectrum of integrated services designed in a way so that transitions are smooth and continuity of care is maintained even when there are changes in what services the consumer accesses. However, while the stepped care model is conceptually useful, there are complexities at the boundaries of the steps and from a workforce perspective defining which professional competencies are most required, for which consumer needs and who is best placed to provide services at that level. It is the view of the APS that there needs to be clarity regarding what is required at each step and which health professional is best placed to provide the necessary services to most effectively meet consumer needs. For example, it would be useful to define which health workers are best placed to provide low and high intensity services, which to conduct assessment, triage and referral, and which to assess the triggers for transitioning consumers across the stepped care model.

Further, the APS considers that the most cost-effective way to structure the workforce is to ensure all mental health professionals work to the top of their scope of practice according to their professional training and expertise. This would (amongst other things) clarify workforce needs for delivering services at each point in the spectrum by enabling clear care pathways and transitions according to the level of care the consumer requires.

There is currently no robust evidence to help funding bodies and service delivery agencies determine the right mix of treatment and providers at each step nor clear criteria regarding which features should be used to determine the most appropriate intensity or 'step' of service a consumer requires. The APS is

concerned that role ambiguity contributes to confusion within the stepped-care model for clinicians and consumers, may compromise the quality and safety of mental health care and potentially result in less than optimal utilisation of the workforce. As a result, the APS emphasises the need for role clarity and suggests that competencies for each profession are thoroughly mapped and linked to the stepped care model of mental health care in Australia. This is in line with the Mental Health Commission's recommendations¹⁷ and the Government's response³⁰ that referrers should be encouraged by the guidelines and supported in practice to refer consumers early in their treatment to the appropriately matched provider and that provision of easily accessible information about the diversity of providers be made available.

APS Recommendation 5

For the benefit of the consumer and the mental health system, the APS recommends thoroughly mapping competencies of mental health professionals within the stepped-care model.

Mental health workforce function

From a workforce capacity perspective, it is important to configure roles to achieve an optimal utilisation of the available workforce, including facilitating mental health professionals working to the top of their scope of practice. It is important to note that there are both between- and within-profession specialisations that are relevant to professional practices and consumer care. The regulatory framework that underpins most professions, is an important component of ensuring that quality and safety standards are built into the system for consumers, at whichever level of service intensity they might require, particularly those most vulnerable. This ensures a system where consumers can access the right care for their needs, at the right time, at the right level of intensity. One of the distinguishing features of the psychology profession is that its range of expertise extends across almost the full spectrum of the stepped care model. While consumer needs for psychological assessment and treatment, across each level of intensity within the stepped care model are well matched by the core competencies of all registered psychologists and others that require a different or more advanced level of training and expertise, consumers whose mental health issues are confounded by complexity or severity, can benefit from the more advanced training and expertise held by psychologists who hold an area of practice endorsement (e.g., clinical, neuropsychological). In general, the skills necessary to provide assessment and treatment vary according to the nature and complexity of the presenting mental health problem.

The APS considers that, in identifying how to address consumer

needs across a stepped care model, it is important to articulate both the shared and unique contributions of the various health professions. For example, as discussed in recommendation one of the APS White Paper, psychologists have advanced expertise and skills to provide psychological therapy and are distinct from other health professionals due to the depth of psychological expertise, training and skills. Mental health consumers have diverse treatment needs and stand to benefit from increased recognition of the diverse skills within the psychology profession and between mental health professionals. This will enhance the availability of treatment, simplify the referral pathways and build consumer knowledge. This stratification of mental health interventions, as recommended by the Mental Health Commission,³¹ aligns the needs of the consumer with the skills and training of the treating professional.

Psychologists working at the top of their scope could be expected to have less direct involvement in the low intensity end of the spectrum as identified in the stepped care model, where other mental health workers (with a lower level of mental health training and expertise) are best placed. However, it is important that the lower intensity workforce is appropriately supported and supervised and that there are effective mechanisms to ensure that the care remains appropriate over time as the consumer's needs change. It is the view of the APS that the duty of care to the consumer demands that there is clinical oversight of lower intensity workers by mental health experts such as psychologists and psychiatrists, so that any change in condition is detected early and appropriate action initiated.

The APS continues to have concerns about the safety and quality of mental health services as outlined in our response to the PC's request for further information about the role of psychologists within an Australian version of the UK's IAPT system.³² The APS acknowledges the role and value of low intensity workers in the mental health system and the development of the low-intensity workforce as part of a broader strategy to strengthen and optimise the use of the available workforce. The development and use of that workforce must be carefully structured (including appropriate training and supervision), to ensure good clinical governance, especially with high risk groups. We emphasise that such workforce development needs to be executed in the context of an evidence-based mental health framework that is driven by the science of psychological functioning. That is, the overarching framework needs to cover the full spectrum of mental health needs including psychosocial supports, and services need to be developed, organised, delivered and assessed within this framework. This will reduce fragmentation and facilitate bidirectional transitions along the continuum of care as the consumer's needs change.

To ensure the safety and quality of services, training other workers to deliver services requires the expertise and clinical oversight, leadership and supervision that psychologists and other mental health experts are trained to provide. This includes being involved in training low intensity workers, providing clinical

oversight (including supervision), consulting across the model and also applying their skills and training in service development, clinical reviews and audits and research and development for continuous improvement. While the APS notes and endorses the importance of psychosocial support and calls for an enhanced role for those with lived experience in the mental health system, the APS emphasises that this should not occur at the expense of appropriate clinical mental health care.

Additionally, the APS notes the call for training more mental health nurses and psychiatrists. The APS supports strengthening of the mental health workforce. The role of mental health nurses is important for screening both the physical and mental health of individuals and supporting consumers in primary care settings. However, the expertise in assessing and treating mental health disorders firmly sits with mental health specialists such as psychologists and psychiatrists. The APS notes the PC's draft recommendation for specialist registration of mental health nurses. A review of mental health nurse training programs in 2011³³ found that there were significant inconsistencies in postgraduate training programs for psychiatric or mental health nursing, with only two programs identified as meeting the Australian College of Mental Health Nursing's credentialing criteria at the time. A review of the training for mental health nurses demonstrates that their level of expertise in mental health assessment and treatment is not yet sufficient to conduct thorough assessments of psychological functioning, especially for complex mental health problems. The APS recommendation for mapping the competencies of mental health professionals across the stepped care system will assist in identifying workforce development needs, including the role of mental health nurses, to build a strong mental health system in Australia.

The APS agrees with the need for more psychiatrists. In the UK, psychologists (particularly those with doctoral level training) work closely with psychiatrists and there is substantial overlap and complementarity in the expertise they provide. There is a role for the already available workforce of psychologists to be strengthened within Australia's mental health system to bridge this gap. There are currently a large number of psychiatrists and psychologists who work collaboratively to provide mental health interventions for consumers. These models build on the unique contributions of each profession and also the overlap in their knowledge and skills. Given the current shortages of psychiatrists, and the high level of training in diagnosis, assessment, formulation and treatment of mental illness undertaken by psychologists, there is a role for psychologists, particularly for those with an area of practice endorsement working to the top of their scope, to alleviate the burden on psychiatrists through balanced collaborative working arrangements. There is also a role for introducing a specialist registry for appropriately trained psychologists for the purpose of identifying those psychologists with advanced skills who can reduce the burden on psychiatrists and to work alongside the available psychiatry workforce now and into the future. This strategy would be less expensive and

result in the appropriately identified psychologists in the short term who are expertly trained and can assist with the current and continual shortage of psychiatrists in Australia.

APS Recommendation 6

The APS recommends:

- The PC consider system changes that will support mental health professionals to work at the top of their scope within the stepped-care model.
- Establishing a specialist registry for psychologists with the relevant training and expertise to alleviate the current burden on psychiatrists.

Workforce numbers

The APS notes the PC's assessment of workforce numbers, and particularly its assertion that there is *"no evidence of a need for more psychologists"*,³⁴ p.29. It is not apparent from an evidence-based standpoint how this conclusion was reached. The total number of registered psychologists is not equivalent to the number involved in the mental health system and therefore any assessment based on the total number of registered psychologists in Australia will significantly distort the workforce picture.

According to data produced by the Department of Health, based on the workforce survey administered by AHPRA³⁵ (in 2017) in terms of total figures, there were 91.1 full time equivalent psychologists per 100,000 population. This compares with an estimated concentration of psychologists in Western Europe that varies between 100 and 150 per 100,000.³⁶

At any time, a proportion of total registrants will be non-practising, provisionally registered (and therefore subject to restrictions), on leave, retired, working part-time or outside the profession. The Department of Health³⁷ data shows that in 2017:

- approximately 76% of registered psychologists were 'employed' and of those, 88% were employed in roles defined as 'clinicians'
- approximately 42% of the psychology workforce reported that the principal area of their main job was counselling
- some 27% reported that the principal area of their main job was mental health intervention^b

- around 40% of psychologists were in solo or group private practice.^c

The APS considers that the rationale for the PC assessment of workforce capacity as it relates to psychologists should be articulated and the assessment revisited, as required.

APS Recommendation 7

The APS recommends that the PC reconsider the psychology workforce numbers and the demand and supply for psychologists in Australia.

Workforce distribution

The longstanding difficulties associated with recruiting and retaining appropriate mental health workers in rural and remote areas substantially contributes to the disparate mental health outcomes in these communities compared with their metropolitan counterparts.³⁸ For example, the psychologist workforce is unevenly distributed across states and territories, with (according to Department of Health statistics) a low of 71 FTE per 100,000 in Northern Territory and a high of 159.9 per 100,000 in the Australian Capital Territory. It is also unevenly distributed across remote areas, ranging from 24.6 psychologists per 100,000 population in very remote areas to 105 per 100,000 population in major cities.

In 2017, 95.3% of psychologists worked in either major cities or inner regional areas. There are clearly issues of distribution of psychologists, with significant implications for consumer access to services. There need to be systematic workforce development strategies to address the maldistribution of psychologists across Australia. For example, there is evidence that students who do clinical placements and internships in regional, rural and remote communities are more likely to choose to work in such communities at some point in their career.³⁹ Members of such communities who are exposed to training opportunities in their own localities will often be the providers of such services in the future (e.g., regional, rural and remote GPs are often original residents of the area).¹⁸

The APS has long advocated for incentives to increase the number of psychologists in regions where the number of providers is low, which is typically in rural and remote communities. While medical professionals are subsidised and incentivised in several ways to provide services to rural and remote communities, these

b other categories were cognitive assessment, psychology management, consulting, research, behavioural assessment, organisational practices, teaching and supervision, rehab, medico-legal, personal development, recruitment, training, community engagement, health promotion

c 10% in schools, 11% in community health or mental health service, 7% in hospitals, 5% in tertiary education

incentives have not been extended to mental health providers. For example, GPs are incentivised with the practice and workforce incentive programs.⁴⁰ In box 24.2 on page 974 of the PC draft report, the lack of incentives for rural and remote mental health professionals likely explains the shift in providers of mental health services from being majority allied health, particularly psychologists to more GP provided mental health services in rural and remote Australia. The recommendation to pool MBS funding only for allied health providers of mental health services is not the only way to incentivise mental health providers to rural and remote communities.

The APS has outlined several workforce distribution strategies to encourage psychologists to provide services outside major cities and inner regional areas.⁴¹ These include:

- Flexible primary care service models to ensure psychologists are embedded in rural primary care setting. Research shows that embedding mental health experts in primary care settings, particularly in rural and remote areas, reduces stigma, increases accessibility, and is efficacious and cost-effective.⁴²⁻⁴⁴
- Implement and incentivise a 'grow your own' rural pipeline for the psychology profession to recruit and retain psychologists in regional, rural and remote (RRR) areas.^{39, 45}
- Provide incentives for higher education providers to provide 5th year psychology programs by distance education and set a quota of students in such courses who must be from regional, rural, remote backgrounds
- Provide financial assistance and mentoring programs such as that available to rural students studying pharmacy and funded by the Department of Health⁴⁶ (e.g., Rural Pharmacy Scholarship Scheme, Rural Pharmacy Scholarship Mentor Scheme) to all RRR students studying accredited psychology programs
- Implement a pilot of a supported rural psychology internship program that links rural organisations with the profession to support them to manage the regulatory burden of the internship program
- Encourage growth of models of distance education postgraduate training opportunities that enable attendance by people living in RRR; this will likely require quotas in programs at regional universities for RRR students (such as those that currently exist for GPs)
- Remove or reduce HECS-HELP debt for psychologists who practice for a period of time in RRR areas, with higher reductions provided for practicing in more remote areas
- Extend existing RRR incentive programs to psychologists in the public sector (relocation costs, accommodation, rural loadings, access to CPD).

The following strategies could be employed to encourage more equitable distribution of a mental health workforce and provide viable opportunities for privately practising psychologists to develop their practice through community permanency and financial sustainability:

- Provide assistance for psychologists in private practice in RRR areas to take on interns and registrars, similar to programs available to pharmacists in RRR (e.g. Pharmacy Intern Incentive Allowance)
- Appropriately fund workforce agencies to provide the required incentives for psychologists to move to RRR and commence practice
- Provide supported access to continuing professional development for RRR psychologists as currently occurs for RRR medical practitioners and pharmacists.

APS Recommendation 8

The APS recommends that workforce distribution strategies be developed to encourage psychologists to provide services in areas outside major cities and inner regional areas.

Psychologists in the public sector

In addition to workforce numbers and geographical distribution, there are reported difficulties in recruiting to the public sector. Mental health service provision is often a pressured and difficult environment characterised by heavy workloads and inadequate professional support. As a result, professionals in this environment are often at a higher risk of burn out and find it stressful to work within a system that is struggling to cope with demand. There are reports of practitioners leaving public health jobs because of the pressure of working within a system that is overwhelmed.

In private practice, there is arguably greater capacity for practitioners to control the work environment and workload, and therefore to manage stress and avoid burnout. This self-management of workload in some cases would mean fewer services being provided which impacts on access for consumers, income for the practitioner and/or fees charged. Practitioners in private practice need to balance these issues in the way they manage their practices.

APS members have expressed concern that there is a trend in the public system towards generic case management roles, and a dilution of the professional practice elements of the role as psychologists are not able to work to the top of their scope. Psychologists with post graduate training who hold an Area of Practice Endorsement are recognised by the Psychology Board

of Australia as having high level skills in their endorsed areas of practice (e.g., counselling, clinical). However, in case management roles they are being given tasks that require generic mental health skills that could be provided by other professions, such as accredited mental health nurses, social workers and occupational therapists. Employing psychologists in roles where they can work to the top of their scope is not only a more efficient use of public money, but would also enable consumers access to the expert psychological services required to reduce the burden of mental health. Additionally, psychologists in case management roles have reported dissatisfaction that they are not able to utilise their specific professional skills, or the full range of them. This can be a significant disincentive to working in the public sector. The APS considers that the public system, properly reformed and supported, could be an attractive employment option for many mental health professionals, including psychologists. The APS recommends reform that includes:

- Making sure that the system allows practitioners working in multidisciplinary care settings to utilise their skills and work to their full scope of practice.
- Improving the management of workloads so that practitioners are not overwhelmed and struggling to cope (risking burnout and leaving the system).

Improvements in these areas would contribute substantially to improved value in the system through reduced costs associated with high employee turnover and other employee costs, and through the benefits achieved by better aligning practitioner skills to consumer needs. Access and system quality are enhanced when each profession utilises its unique training and specific skills for the consumers benefit. Mental health consumers have diverse treatment needs and benefit from increased recognition of these diverse skills to form a better match between the needs of the consumer and the skills and training of the treating professional. This aligns with the Mental Health Commission's recommendation of a stepped care approach to ensure a range of service types, making the best use of available workforce to better match with individual and population need.

APS Recommendation 9

The APS recommends that governments:

- Increase the number of psychologist positions within the public health systems
- Improve workload management within public health for all health practitioners in the system
- Review case management arrangements to ensure that psychologists and other health professionals are not de-skilled by placement in generic roles within the public health system and are instead working to the full scope of their practice.

4. Workforce training

Enhanced roles for teachers and general practitioners

The APS supports measures to strengthen early identification of mental health issues in all contexts and across all touch points for consumers with mental health problems. While the APS agrees that there is a role for teachers and other professionals in that process, it considers that the role of each professional across the stepped care model needs to be clarified. Professionals such as teachers should be supported to operate effectively in their areas of expertise but not expected to become experts in mental health. That is, it is important for mental health awareness and support to be improved in schools and engaging and training teachers to be aware and to detect potential mental health problems among students is an important step. However, the APS does not support an expectation that teachers diagnose (however informally) or treat mental health conditions, and certainly not without supervision, support and oversight by a qualified mental health practitioner.

Similarly, the APS acknowledges the key role played by GPs in identifying and assisting in the management of mental health issues with their patients. While the APS would support measures to better equip doctors to discern and respond to presenting mental health issues, it does not support proposals to train them to provide mental health interventions independently of other mental health professions. The APS acknowledges that GPs, particularly in rural and regional areas, are sometimes acting as 'gap fillers' in the absence of other mental health services in their area and these doctors need to be supported. However, the focus should be on closing the gaps, not equipping medical practitioners to be better 'gap fillers'.

APS Recommendation 10

To ensure the quality and safety of mental health care, the APS recommends that:

- the PC review the intended parameters of the enhanced roles of teachers and GPs (Recommendations 11.5, 11.6 and 17.5), and
- these training needs are mapped against these parameters and ensure professionals understand their role within the broader system.

Wellbeing in schools

While the APS supports the PC's recommendations to upskill and train teachers to strengthen knowledge of social and emotional development, it is concerned that implementing such a program without expert mental health professionals (including educational and developmental psychologists) employed

within a school could lead to substandard detection and care of children and young people, particularly if there continues to be a lack of appropriate referral pathways and specialised child services for assessment and treatment. As outlined in recommendation 9 of the APS White Paper,¹ the effectiveness of treatment with children is enhanced when parents, family, carers and support people are involved in the young person's care.^{47,48} The recognition of problems without the follow up care has the potential to detrimentally impact on these 'identified' children rather than improve their mental health and wellbeing.

Under information request 18.2, the PC has sought advice on the type and level of training that should be provided to teaching staff to better support students' mental health and well-being. It is the view of the APS that psychologists who are already embedded in many schools are best placed to deliver and co-ordinate training for teaching staff. The APS is willing to provide the PC with a model for this work.

The APS sees a strong need for greater numbers of school psychologists, as outlined in our follow up submission to the PC regarding psychologists in schools.⁴⁹ There is currently a ratio of approximately one psychologist for every 1,151 students in Australian schools (with jurisdictional variance). APS members report that in some low socioeconomic areas where there is a larger ratio of children with complex needs, ratios of psychologists to children are approximately 1:2,800. The APS recommends a benchmark of a minimum of one psychologist to 500 students.

In settings where teachers with wellbeing responsibilities feel under-trained and over-burdened, the safety and quality of mental health detection and care may be compromised. Investing in mental health within schools facilitates mental health prevention and early interventions. For example, youth suicide remains a substantial problem in Australia with a majority of these youth never accessing GP or headspace services. School is an excellent touch point for preventing youth mental health problems and suicide. However there needs to be the appropriate mental health care in schools provided by adequately trained and registered (therefore accountable) health practitioners. There must be improvements in this area if we are to address the prevention and early intervention objectives and recommendations of the Productivity Commission's report.

APS Recommendation 11

The APS recommends that in addition to student wellbeing coordinators:

- Psychologists are employed within schools at the ratio one psychologist to every 500 students, and
- Clear roles are defined for student wellbeing leaders to ensure they work within a well-defined role and understand referral and care pathways.

5. Funding and structuring reform

In relation to the PC's proposals for major structural reform (specifically, the Renovate and Rebuild models), the APS has some major concerns, particularly regarding potential reduction in consumer choice that may result. We consider that system reform would be premature ahead of proper evaluation of key components of the current arrangements, as discussed earlier. Further, the reform proposals, as presented, do not appear to address some of the weaknesses that currently exist within the mental health system in Australia.

The APS views the current system weaknesses as an opportunity for setting a reform agenda, rather than implementing major reform. While there are clearly benefits in structural reform in terms of governance and the integration and commissioning of services, the APS is concerned that current system weaknesses would continue under either reform model. The system weaknesses should be articulated more precisely and the future system must be evidence driven, have strong governance arrangements, exist within a culture of continual improvement and remain flexible to reforms that strengthen the system over the longer term.

General APS concerns are that:

- Physical and mental health are inextricably linked and should be more structurally integrated than they are in the current model or proposed reforms;
- Siloing is a major issue that is insufficiently addressed in the current or proposed structural reforms;
- Workforce collaboration requires a more integrated approach that considers mental illness, functional capacity, psychosocial needs, especially for consumers with multiple problems impacting on their mental health;
- The allocation of professionals across a reformed system is unclear and further work is required to clearly articulate roles and to assist with clarifying care pathways;
- Reforms focus on selected aspects of primary care without the larger consideration of bridging existing gaps in state and community-based services.

The APS supports the intention of the PC to address current gaps in our system through structural governance and funding reforms. The APS does not support **recommendation 24.4** that allows agencies such as PHNs and RCAs to cash out only MBS-subsidised services for psychologists and allied health professionals providing psychological interventions within the Better Access initiative. The APS strongly opposes cashing out in the context of a trial. Any trial or experiment regarding innovative funding models or approaches should be initially tested as an adjunct to current entitlements. The APS considers that it would be unethical to deprive consumers in areas designated as trial sites, from access to MBS services, on the basis of postcode. MBS services form part of a scheme for universal access to health care, including mental health care.

APS concerns with the Rebuild model

- **A need for stronger independence at the governance level.** The rebuild model envisages decision-making power sitting with state and territory governments, with ministers empowered to appoint (and dismiss) RCA Board members and State Local Health Networks to provide infrastructure for hospital and community based mental healthcare. It is important for clear, transparent processes and governance arrangements to be put in place to ensure appropriate accountability.
- **Continued implementation issues.** Within the rebuild model there is little detail about how the states would responsibly balance primary care/low intensity services with expensive hospital/acute services. In principle, management of the mental health system by states and territories should mean easier engagement with other state-based services (such as housing and education). However, we consider that such integration has been a consistent problem in the current system that the states have been unable to address sufficiently and this has led to failure to address gaps and an emergence of the "missing middle". This may be the result of insufficient direction about how to operationalise reform objectives during the implementation stage. Further, the APS is concerned that a failure to ensure the right measures are used when assessing the effectiveness of implementation plans and higher level mental health policy objectives will impede success under this model.
- **Administrative costs reduce funds for treatment services.** The APS is concerned with the potential for cost-shifting within this model and for funding for direct service provision to be diverted to administrative costs.
- **Risk of status quo in commissioning services.** Effective commissioning of services requires selecting services based on, among other things, positive evaluation, analysis and consultation.⁵⁰ Ongoing innovation and evaluation, as part of the commissioning cycle, is needed to ensure that services are led by consumer needs analysis. However, the expectation that shifting to an RCA would impact minimally on services and service providers suggests that RCAs would simply seek to purchase services. The APS considers that, should the rebuild model be recommended, RCAs should be tied to a much larger strategic and operational agenda for primary mental healthcare.
- **Continued lack of strategic direction for implementation.** The APS has concerns about the suggestion that alternative models of governance and implementation would emerge organically under a state-based solution. It is preferable for consumers that this occur at a higher level of strategic planning rather than at the level of local governance. This is particularly important given the current model for commissioning services (known to be short-term) also has its own inherent problems such as:

- Continuity of care given high staff turnover; this is a problem for consumers when therapeutic relationships are a predictive element in treatment success
- Infrastructure considerations
- In an environment of competitive tender, a tendency for positions to be lower-paid, thereby attracting staff with less experience and/or lower qualifications.

The APS suggests that the PC consider a higher level of strategic direction on this issue regardless of which governance structure is being recommended.

- **Failure to engage the primary care sector could undermine the success of the rebuild model.** Given reforms in mental health over the past 20 years and the recent major reform to primary care with the introduction of PHNs the APS is concerned that the primary care sector may not fully engage in implementing another major reform. Given that primary care professionals are integral to redesigning the system, delivering services and ensuring data collection to assist with monitoring and evaluative functions, a lack of engagement poses a risk to the success of the reform agenda

APS concerns with the Renovate model

The APS considers that more can be done to bridge gaps without the need for a major structural reform. The APS preferences the Renovate option until such time as there is more clarity about what works and what does not work for the benefit of consumer, the system and governments. We consider that a reform agenda should be structured progressively in line with a strategic and long term approach that aims to build an effective system grounded in evidence.

While the APS preferences the Renovate model, specific concerns include:

- **Lack of evidence that treatment is effective.** There is currently a lack of evaluation and evidence about the effectiveness of PHN assessment and treatment services. While an evaluation framework will assist with ensuring services are effective in addressing mental health problems, the current structure of evaluation continues to focus on the occasion of services, or number of people treated, rather than level of mental health symptoms. Without appropriate evaluation there is a risk that the mental health system will be based on a model that is ineffective.
- **Lack of evidence about the cost efficiency of PHNs.** The risk for the economy is the inefficient operation of services like the PHN when the service model has not been evaluated for both effectiveness and efficiency in healthcare delivery. As highlighted in the Draft Report the cost of PHNs and their effectiveness is vague and there is yet to be sufficient analysis to justify continued reform based on this model. The APS suggests that evaluation is strengthened and the

reform agenda continued based on evidence from systematic evaluations of service delivery models, including PHN services.

- **Service use issues remain unaddressed.** As noted by the PC, PHNs have been tasked with identifying under-use and over-use of services (which the APS assumes will shift to RCAs in the rebuild proposal) yet, to date, it appears that PHNs have not been able to accomplish this analysis. The governance structure in the proposed renovate model is not likely to enable this measure of efficiency to be determined.
- **Staff recruitment, retention and substitution.** As noted by the PC, there have continual problems with recruiting and retaining staff due to the 3-year block funding arrangement. While the PC have recommended block funding be extended to 5 years, the APS considers it likely that there will continue to be problems with attracting high quality and expert mental health clinicians into PHNs because of their current operational arrangements. Further, PHNs are incentivised through block funding to minimise costs, including staff costs and this had led to the substitution of lower cost workers to undertake tasks that require a higher level of expertise to ensure effectiveness. Without evaluation of the effectiveness of treatment services provided by a range of providers there is a risk that the quality and safety of services is compromised due to cost saving. This is exacerbated by the failure to quarantine funding for assessment and treatment services.

APS Recommendation 12

The APS recommends the PC focus on setting a reform agenda rather than recommending another major reform.

Activity-based funding

Activity-based funding (ABF) models are known to be efficient for health systems although they require significant adjustments to ensure ABF works in mental health to advance the reform agenda.⁵¹ For example, when applied to mental health services there are concerns that mental health consumers are discharged from hospitals quicker but potentially more unwell. As noted by the PC, there are currently incentives under ABF for LHNs to shift care into hospitals from community based mental health care services who are block funded. However, also noted was the problematic implementation of ABF for mental health care due to the absence of safety, quality and effectiveness indicators within the current model and the lack of evaluation about the efficacy of the proposed Australian Mental Health Care Classification (AMHCC) ABF model for mental health care being considered Independent Hospital Pricing Authority.

The APS share the PC's concerns that the current structure of ABF for mental health care and the proposed AMHCC has not

been piloted or assessed as fit for purpose within the mental health system. There are widely held concerns about prematurely implementing ABF for mental health services prior to evaluation because of the potential for poor consumer outcomes which without being appropriately addressed would undermine the reform agenda through perverse incentives.^{51, d} The identified risks of prematurely implementing ABF for mental health services include:

- **Shifting from person-centred care to cost efficient care and creating a system that values cost over the best interests of the consumer.** This includes introducing ABF incentives to minimise the costs of an episode of care in order to make a profit leading to the withdrawal of expensive services and driving away activity such as more complex and time-consuming cases in favour of simpler cases to increase throughput and therefore funding. In this way the problem of the missing middle will continue.
- **Inadequate quality and safety of mental health services and care due to problems implementing ABF in a way that works to address mental health problems.** For example, substituting less qualified and thus less safe staff because they are cheaper and the absence of a reliable way to categorise mental health care as diagnostic categories are insufficient to capture whole of person mental health indicators.
- **Inadequate incentives or measured activities that take account of psychosocial needs and complexities that contribute to the consumer's mental health problem.**
- **Compromised best practice as there is a lack of incentives for best practice care when they are not incorporated into ABF models.** For example, using inappropriate indicators such as occasions of care, time spent on activities etc. can lead to ineffective care as time spent with a consumer delivering health (or on consumer related activities) is not a measure of how effective the care has been at delivering better outcomes for the consumer.
- **Insufficient clinical information systems to support ABF for mental health care.** Implementing ABF across contexts relies on significant investment in clinical information systems (IT infrastructure, hardware and software as well as knowledge management systems and processes). There is a risk that jurisdictions across Australia will not have resources available to fully implement "gold standard" systems. Additionally, there is a need to ensure systems and processes are introduced that match evidence-based practices of clinicians.
- **No change in consumer outcomes based on validated and reliable measures of mental health.**

APS Recommendation 13

The APS recommends that the implementation of ABF models in mental health care is delayed until:

- The AMHCC model is piloted in different contexts and assessed against consumer outcomes measured appropriately for both mental health and psychosocial outcomes over the long term, and
- Clinical and functional measures, best practice and quality and safety indicators are integrated into the model, and
- There is sufficient investment in clinical information systems to support ABF within mental health care organisations.

d Independent Hospital Pricing Authority and within the Activity Based Funding National Framework and Implementation Plan

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Appendix: Responses to specific recommendations

Draft Recommendation 5.1 — Psychiatric advice to GPs

In line with the expert mental health role psychologists and psychiatrists have within the mental health care system described in this submission, the APS believes this initiative should be extended to psychologists as they are best placed to work with psychiatrists in providing care to consumers. For example, when consumers are working with psychologists who may recognise major medication concerns, the psychologist can seek advice from the treating psychiatrist on the best way to manage the issue to ensure the safety and quality of healthcare.

Draft Recommendation 5.2 — Assessment and referral practices in line with consumer treatment needs

The APS chairs the Department of Health National Assessment, Triage and Referral Project that was tasked with providing guidelines for PHNs on best practice in initial assessment and referral for mental health care. Guidance has been developed and is currently being piloted. There needs to be greater investment to support PHNs to implement these systems and for further research to ensure system is effectively matching consumers with the highest quality and safest services available.

Draft Recommendation 5.3 — Ensuring headspace centres are matching consumers with the right level of care

The APS supports the integration of stepped care model. However, headspace is already unable to service the high numbers of young people accessing their services. Low intensity services do not operate without staffing (e.g. group programs, clinician-supported online programs). Consideration needs to be given to how staffing levels will be increased to avoid staff being drawn away from clients with moderate to severe issues in order to meet targets for low intensity.

Draft finding 5.1 — The Link-me trial may improve assessment and referral practices

As discussed in the main submission, the Link-Me trial is encouraging and the APS supports the improvement of assessment and referral practices using decision support tools. However, the methodology of this trial needs to be critically reviewed within the larger body of evidence and for its applicability across the Stepped Care Model.

Draft Recommendation 6.1 — Supported online treatment options should be integrated and expanded

The APS supports the notion of online treatment where there is supporting evidence for its effectiveness. However, online treatment is not a substitution for face-to-face treatment in some cases and the role of online interventions is different across the stepped care model. For example, there is substantial evidence for the effectiveness of online treatment for common mental health disorders at the low intensity end of stepped care; however supportive online programs can assist and be incorporated into treatment across the model but would not be a substitution for multidisciplinary care models with face to face interventions. Further, the APS believes it should remain the consumer's choice about the type of service they receive and they should not be mandated to use online treatment services.

Draft Recommendation 5.4 — MBS-rebated psychological therapy

Refer to section regarding the evaluation of MBS services in the main submission.

Information request 5.1 — Low-intensity therapy coaches as an alternative to psychological therapists

There were multiple problems with the methodology and analysis used by the evaluators that could be used to critique conclusions about the efficacy and effectiveness of New Access. In addition to methodological weaknesses (e.g. how they determined a positive client outcome), people did not use the service unless it was heavily marketed (including men who were the target market), GPs did not trust the service and were reluctant to refer, and it was a very high cost service for PHNs to run. As discussed in the submission, there is a need to further evaluate these models for effectiveness of treatment services and the cost effectiveness of the service models. This includes independent evaluation of whether the consumers were the right fit for that type of service. This requires a comparison of the triage and assessment to ensure the consumer was appropriately allocated to a low intensity intervention. Additionally, longitudinal follow up is necessary.

Information request 5.2 — Mental health treatment plans

1. *What should be added to the MHTP or MHTP Review to encourage best-practice care?*

The APS outlines our view in the section on mental health treatment plans and review in the main submission.

2. *Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?*

Yes. The full assessment and diagnosis are typically incomplete, incorrect or require adjustment upon

assessment by the expert treating mental health professional. It should be optional for GPs to complete the diagnostic assessment upon initial referral and instead should be included as an option for GPs.

3. Are there additional or alternative clinical thresholds (to a mental disorder diagnosis) that a consumer should meet to access Psychological Therapy Services or Focused Psychological Strategies?

Yes. There are many consumers such as those with suicide ideation who do not meet criteria for a mental health disorder. These individuals are at risk of developing mental health problems and more importantly completing suicide. For example, in QLD psychological autopsies of people who have completed suicide reveal that approximately 47% did not meet criteria for a mental illness diagnosis. Individuals who express suicide ideation should be able to access MBS subsidised psychological services. A review of eligible disorders should be conducted to ensure universal access to MBS services.

4. Should consumers continue to require a MHTP for therapy access if being referred by a GP?

A referral for therapy should be adequate and a MHTP is not necessary or helpful but increases the administrative burden to consumer, GP and treating mental health professional. A mechanism to activate MBS rebates for referrals to psychological services is necessary but could be redesigned to be a screening and investigation of physical health. This will ensure any contributing factors to the consumers' psychological wellbeing are detected and managed by both the medical practitioner and the mental health provider upon referral.

5. What new clinical thresholds, if any, should be introduced to access additional sessions beyond the first course of therapy? Should these be part of or separate to the MHTP Review? Should a MHTP Review be required to access additional sessions, instead of just a new referral?

Yes. As outlined in the main submission and in the APS White Paper, re-referrals should require a report from the treating practitioner after 10 sessions or the cessation of treatment and a review by the GP to ensure the consumer's mental health care is efficacious. This process can be done without the current structure of a MHTP but instead as a re-referral process.

6. How could audits be used to ensure that clinicians are assessing, referring and managing patients in line with best-practice and the stepped care model?

Random audits are conducted by many regulatory organisations such as AHPRA. Audits of Government funded programs are necessary to ensure federal funds are being appropriated effectively. Increased reporting,

communications and review criteria as outlined, in the main submission and the APS White Paper will simplify the audit process for GPs and treating mental health professionals. These reporting mechanisms also enable measurement and evaluation of Better Access initiative.

7. What information should clinicians be required to give the consumer when completing a MHTP or MHTP Review? Should they be required to give the consumer the completed and reviewed Plan?

Yes. Increasing transparency is important and the report and subsequent review should be discussed with the consumer to increase transparency and enhance consumer autonomy and choice.

8. Should GPs continue to receive a higher rebate for MHTPs and MHTP Reviews than for standard consultations?

The APS does not necessarily see the need for MHTPs as they are currently designed. Encouraging GPs to consider and manage mental health can act as an educative function and facilitate stewardship. The APS is concerned that the level of remuneration for psychologists is a barrier to accessing effective treatment for consumers and should be increased to reduce cost barriers, particularly for consumers who have complex psychosocial needs such as low socioeconomic means.

Draft Recommendation 5.7 — Psychology consultations by videoconference

The APS supports this recommendation. However to operationalise this recommendation the Productivity Commission should also consider that professions utilising videoconferencing technology will require financial support to establish secure software platforms.

Promotion of tele-health services in media services is recommended to increase knowledge of existing services and to encourage increased acceptance and participation. The APS also recommends further provision of educational and marketing resources for both providers and referrers (i.e. general practitioners) to encourage greater uptake of tele-health items.

Draft Recommendation 11.1 — The National mental health Workforce Strategy

Refer to section regarding workforce in the submission.

Information request 7.1 — Freeing up psychiatrists for people who need them most

As discussed in the submission, the current system structure allows considerable scope for stepping up from psychologist

intervention to psychiatric intervention but much more limited scope for consumers to step down from psychiatry to psychologist intervention. Providing consumers greater session eligibility with psychologists would allow psychiatrists to more actively step consumers down allowing more availability for the limited psychiatry workforce to see those consumers whose needs are most acute. The advanced training of psychologists means that the psychology workforce is well placed to relieve psychiatrists of many of the non-medical roles that currently limit their clinical workload.

Draft Recommendation 11.4 — Strengthen the peer workforce

From a consumer safety perspective, the APS is concerned to ensure that the use of peer and lived experience workers in the construction or allocation of the psychological workforce, is appropriately targeted and supervised, to ensure good clinical governance, especially with high risk groups. While the APS notes the importance of psychosocial support, and consumer calls for an enhanced role for those with lived experience in our mental health system, we emphasise that this should not occur at the expense of, or at odds with, appropriate clinical mental health care / treatment.

Draft Recommendation 10.4 — Care coordination services

The APS support this recommendation. Specialist and Support Coordination services under the NDIS are typically under-funded, and frequently, an individual who receives Specialist Support Coordination in their first plan only receives Support Coordination in subsequent plans, despite the fact that their needs have not as yet changed. Support Coordination for individuals with a primary presentation of mental health requires time and engagement to develop a relationship of trust, along with their families and supporters and this is usually not achieved within short time frames. These care coordination services should be structured to ensure the stability of staff and minimised to minimise change for the consumer with complex care needs.

Draft Recommendation 12.3 — NDIS support for people with psychosocial disability

As the NDIS rolled out and programs that provided psychosocial supports were transferred across, many consumers either opted out due to the stress of change or were deemed ineligible under the NDIS system. Any available safety nets were poorly communicated and as a result uptake has been lower than expected. In addition, the NDIS system has seemingly taken any opportunities to reduce funding for many consumers with exceptionally complex needs. The following example

demonstrates the significant impact these funding changes, inconsistent policies, and lack of appropriate care coordination can cause for consumers:

Sam (alias) is a consumer with schizophrenia and an intellectual disability who relocated from regional Victoria to Melbourne to be nearer to his sibling. His elderly, unwell mother temporarily moved in with him to ensure his mental health did not deteriorate during this time. With limits to her capacity, Sam's mother is unable to assist him with any activities of daily living and he had 24/7 supports in place through the NDIS. In his next plan, his funding was almost halved with the planner arguing that Sam's mother could assist in providing for his support needs. He subsequently lost his 24/7 funding which meant that his mother had to attend to him overnight and he lost his Specialist Support Coordination funding which was replaced with Support Coordination. This resulted in a lack of support required to keep Sam well and functioning. He was hospitalised for a period of more than 6 months due to his deteriorating mental health. The service provider then had to go through the process, along with family members, of a Request for an Unscheduled Plan Review.

Despite the introduction of the Complex Support Needs Pathway, many planners appear to be unprepared and under-skilled to deal with the complexities of dual disability and mental health issues. Given the significant underspend in the NDIS, the argument that testing ineligibility adds to the workload of the NDIA seems unsustainable when the answer should be to spend available funds increasing both the skills and the existing workforce of the NDIA.

Draft Recommendation 13.3 — Family-focused and carer-inclusive practice

The APS commends the Productivity Commission on this recommendation, as it represents a significant change for mental health services. To strengthen this recommendation, the APS recommends a forum or guidelines ensure this change is implemented appropriately.

Homelessness (Draft recommendations 15.1 and 15.2)

The APS supports increased emphasis on housing for people with a mental illness. The APS supports **recommendations 15.1 and 15.2** regarding enhanced housing services for people with mental health problems, including that mental health training and resources should be provided to social housing workers and that no individuals released from mental health care should be discharged into homelessness.

As summarised in a research report by VicHealth, housing suitability, affordability and security of tenure are three elements of housing that have an impact on health.¹ For example, a decline in mental health is associated with losing the ability to pay for housing.² Further, As discussed in the Vic Health report,

the inability to pay for adequate housing limits the individual's choice of dwelling and location which can impact on the individual's privacy and perceived safety and in turn on their health and wellbeing. People with mental health concerns are at increased risk of homelessness, sleeping rough or sleeping and living in insecure and unsafe situations. These aspects of housing instability can compromise the individual's recovery and exacerbate their mental health problem.

Additionally, appropriate housing and homelessness are a major issue for offenders and the instability of housing places offenders at an increased risk of both mental health decline and further offending. The recommendations for housing should also extend to prisoners released with a mental health problem and more generally for all prisoners given being imprisoned increases the risk of mental health decline, including higher rates of substance use, suicide and recidivism.

The APS recommends expanding the housing recommendations in the following ways:

- Residential services should also adopt a trauma-informed approach
- Lead tenancy models and head-leasing should continue to be provided as safe environments for those in private rental who require safety and additional supports in an otherwise unaffordable market, and
- Ensure forensic populations are also not released into homelessness.

The Justice System (Chapter 16)

The APS strongly supports a systematic approach to embedding mental health professionals in the system to improve the capability and responsiveness to mental health presentations within emergency services, particularly police (**recommendation 16.1**). There needs to be continual evaluation of the effectiveness of these services such as those underway in the UK.³

The APS strongly supports the development and implementation of National Mental Health Standards within correctional facilities with the understanding that the prevalence and complexity of mental health problems among this population group are higher than the community (**recommendation 16.2**). However, not all offenders are held in correctional facilities and the needs of offenders within the community should also be considered as the standards of health care among this group are poor. The APS contends that minimum standards are critical and need to be applied to the unique physical and social environment within prisons.

With respect to National Mental Health Standards for Offenders the APS recommends:

- Standards for emergency service responses to mental health presentations

- The implementation of these standards to be measured and evaluated across Australia and reported by the National Mental Health Commission; especially given prisons represent a depriving environment that increases the risk of exacerbating mental health problems
- The standards extend to post-release care
- The standards stipulate psychological treatment and not simply pharmacological treatment
- The standards extend to the custodians and their staff in terms of obligation to the good order and security of the prison and standard of training
- The standards include measures of trauma-informed practice and care.

Workforce capacity and skills in both mental health and offending behaviours

There need to be well-resourced, appropriately qualified practitioners within community-based service for both offenders and at-risk youth. These services should include multidisciplinary teams to provide interventions for mental and physical health and include practitioners who are highly skilled at providing interventions to reduce offending behaviours (forensic assessment and intervention). These services should include social wrap-around teams/services given the socioeconomic disadvantage faced by many offenders both in the community and upon release from correctional facilities.

Screening and assessment of offenders and people at-risk of offending

The APS supports **recommendation 16.3** to introduce screening and assessing of mental health care of individuals in correction facilities. Increased and timely access to mental healthcare within correctional facilities would assist consumers to have their active mental health symptoms addressed more quickly with the result that forensic patients' psychological treatment readiness is increased. However, there needs to be an equal emphasis on the mental health needs of community-based offenders and prisoners.

The types of mental health presentations and needs of offenders in custody can be quite different to those in the community (environmental and psychosocial determinants), including at the individual level. To reduce the risk of poor outcomes such as recidivism, homelessness, suicide, substance use and unemployment, both populations (prison/community) and their respective treatment needs, must be considered. This includes assessing mental and physical health, psychosocial needs and criminogenic factors.

The APS cautions the PC on the use of screening checklists as these are often misleading in offender, victim and juvenile or at-risk youth populations. The APS considers that screening checklists silo the issues and pathologise the individual rather

than conducting a whole of person assessment and subsequent interventions. A broader assessment is needed to understand the function of any presenting 'symptoms' (e.g. as maladaptive coping, safety mechanisms, response to situational stressors, medication or substance effects, intellectual disability, family environment, the individuals' reality rather than a delusion/paranoia). Functional behavioural assessments are required among this population to assist with treatment planning and to understand the individual's psychosocial service needs.

Offenders represent one of the most socially disadvantaged groups within our community with higher rates of unemployment, homelessness, socioeconomic disadvantage and instability such as homelessness. Currently, treatment options for offenders are limited. For example, within MBS Better Access the mental illnesses most prevalent among offending populations such as paraphilia's, personality disorders, Foetal Alcohol Syndrome and neurodevelopmental disorders either do not meet the criteria for access or the number of sessions are insufficient to provide effective interventions for both mental health and offending behaviour. This leaves offenders with limited option but at the most risk and burden to the community, public and government.

The APS recommends strengthening and expanding **recommendation 16.3** in the following ways:

- Screening and assessment to include community-based offenders and as well as prisoners
- Comprehensive and nationally consistent assessments to be required for offending populations to ensure the safety and quality of services and to ensure treatment planning is appropriately informed
- The availability of both community based and correctional facility assessment, treatment and psychosocial services for offenders and at-risk youth to be increased.

In relation to **information request 16.1** regarding transition support for people with mental illness released from correctional facilities, the APS provide the following information.

Early mental health and offending behaviour intervention reduces risk of harm (self and others), recidivism, reduces responsivity (to longer term interventions) issues and challenges (i.e., active mental health symptoms), improves capacity for at risk individuals to re-engage in activities of daily functioning and connection with personal and professional supports. However, the transitions for offenders are multiple and repeated and not confined to just those offenders released from correctional facilities. This means that Individuals at increased risk of mental disorder will present across several touch points within the justice system and not just upon release from prison. It is important that all transitions and touch points for offenders are considered. This requires expanding the transition support more broadly than simply upon release from correctional facilities. This should include but is not limited to:

- Identifying and comprehensively assessing individuals exhibiting signs and symptoms of mental illness during early stages of statutory intervention (e.g., first police contact, watchhouse, etc.).
- Early multidisciplinary assessment and treatment for forensic patients (e.g. psychiatry managing medication, psychologist managing CBT for psychosis, Social worker managing links to the community).
- Ensuring capacity within prisons to enact involuntary treatment and assessment for forensic patients, rather than forensic patients having to wait for open beds in forensic hospitals/treatment facilities, and
- Multidisciplinary mobile support teams for those consumers who are not able to travel into forensic hospitals.

The APS supports in principle **recommendation 16.4** to ensure culturally appropriate service are available in correctional facilities for Aboriginal and Torres Strait Islander people. However, culturally appropriate services should be strengthened for services both within correctional facilities and the community. Organisation also needs to have training and knowledge of area and clients so there is an understanding of difficulties in implementing services to gain a desired outcome. This means the services must be both culturally appropriate and informed. The APS recommends that the minimum standard within organisations providing these services includes:

- workers within the organisation have an Indigenous First Aid Certificate
- at least one person in the team has tertiary qualifications in mental illness.
- there is consistent evaluation of the organisation to ensure that its work is client centred and effective and to enable continuous improvement
- there is a good working knowledge of surrounding communities, and
- there are wrap around services such as the Winnunga Holistic program.

There is limited research in the area of effective programs for Aboriginal and Torres Strait Islanders both mental illness, social disadvantage and who are at-risk or have offended. A strong evaluation process within these services is necessary to better understand what works among this population.

Regarding trauma-informed care, it is important to understand that trauma is pervasive among both men and woman offenders and particularly among Aboriginal and Torres Strait Islander people. A trauma-informed approach is essential for all forensic populations regardless of cultural identity or gender.

The APS recommends that services employ Trauma-Informed Practice within a strengths-based framework that:

- includes an understanding of and responsiveness to the impact of trauma

- emphasises physical, psychological, and emotional safety for everyone, and
- creates opportunities for survivors to rebuild a sense of control and empowerment.

Further to this recommendation, the APS concurs with published recommendations for addressing trauma in mental health and substance use treatment when implementing trauma-informed practices and organisations should consider:^{4,5}

- Engaging leadership as the top-down recognition of the importance of trauma is essential for it to become embedded in the system.
- Making trauma recovery consumer-driven so the voice and participation of consumer/survivors is at the core of all activities, from service development and delivery to evaluation.
- Emphasising early screening for trauma to ensure an assessment of the impact of trauma and referral for integrated trauma services becomes common practice.
- Developing the workforce through orientation, training, support and cultural competencies related to trauma.
- Instituting practice guidelines by developing rules, regulations, and standards to support access to evidence-based and emerging best practices in trauma treatment (for example the guidelines published by the International Society of Traumatic Stress Studies⁴)
- Avoiding recurrence by implementing procedures to avoid re-traumatization and reduce impacts of trauma.

In relation to the focus on practical application of culturally appropriate services, these services need to broaden their approach to include psychosocial and family centric practice (kinship) to facilitate a cultural appropriate wrap-around service. The APS suggests the following are considered in the design of these services:

- 1:1 case worker ratio (e.g., Northern Australian Aboriginal Justice Agency NAAJA)
- Access to programs regardless of sentence or remand status (prisoners on remand are not eligible for treatment or work programs)
- Providing culturally appropriate life skills program e.g. literacy and numeracy, and compensatory strategies, empowerment strategies such as refusal skills
- Continuity of care practices that are culturally appropriate such as prison doctors providing a handover and continuity of care including medical review and medication scripts to be provided to doctor of clients or forward to the remote clinic in the person's community.

In relation to **recommendations 16.5, 16.6 and 16.7** the APS have some concerns about ensuring that all people with a disability, both physical and mental are included in this recommendation, especially given the significant overlap and comorbidities. For

example, people with co-occurring disorders, comorbid mental illness with disabilities have greatest need for justice strategies. There is some confusion in the use of terminology and the APS recommend ensuring that the term disability is inclusive of both mental and physical disabilities. For example, offenders with intellectual disabilities are more likely to receive custodial sentences than non-disabled offenders. This highlights the need for strategies to assist them navigating justice systems and diversion strategies as opposed to custodial sentencing. Research within Australia and internationally highlight increased rates of impaired fitness for trial for children, juveniles and adults, with disabilities and mental illnesses being unable to participate in legal proceedings.⁶ Mechanisms need to be implemented to ensure people with disabilities as victims, witnesses, suspects or defendants are supported in the justice system.

Further, there is an inconsistent application for communication supports across Australia, with South Australia leading the way in ensuring communication partners are provided for both victims and offenders with complex communication problems through their new scheme commencing in February 2020. Currently, most other states provide this service for victims and/or witnesses only, leaving a large proportion of offenders with complex communication needs without comprehensive supports to ensure equitable access to justice. The APS believes the PC can lead the way by recommending that disability justice strategies include the requirement for all states and territories to provide communication partners and that disability justice strategies apply in the broadest sense to encompass both mental and physical disabilities. This recommendation aligns with the Australian Human Rights commission⁷ examining equitable access to justice for people with disabilities. There is also a need to ensure these communication partner services are adequately funded across Australia.

Draft recommendation 17.3 — Social and emotional learning programs in the education system and Draft recommendation 17.4 — Educational support for children with mental illness

While the APS supports improved education regarding mental health and social and emotional wellbeing among for young people and professionals within the education system. Members who work with children and young report that:

- It is imperative that mental health professionals in schools should be adequately trained in dealing with families that are in distress or crisis and understand their role in referring families to appropriate services. Teachers should be supported to work according their strengths in their own area of expertise and not be expected to also be experts in mental health.
- Teacher well-being should be carefully addressed if taking on responsibilities in this area.

- At present students with mental health concerns need to be on a mental health plan which labels them when they do not have a long-term illness but may have an adjustment concern that can be addressed and then moved into recovery. MBS-rebated health professionals should be required to provide recommendations to parents, carers and teachers at the time of their report to the referring medical practitioner so that parents, teachers and practitioners work together for the best outcomes for young people.
- The more support families receive, the better young people are protected. State and Territory Governments need to expand the provision of parent education programs focusing on enhancing parenting practices and improving parent-child relationships as they significantly affect children's mental health.

Draft recommendation 17.5 — Wellbeing leaders in schools

See sections on wellbeing leaders in the main submission

Draft recommendation 17.6 — Data on child social and emotional wellbeing

There is a need to expand the collection of data on child social and emotional wellbeing, such that children's social and emotional development is assessed at critical times, such as mid-adolescence when onset of mental illness typically emerges.

Information request 18.1 — Greater use of online services

Tertiary education institutions should have a whole-of-institution 'Healthy Universities' approach in place, such as the Okanagan Charter⁸ developed in 2015 in collaboration with researchers, practitioners, administrators, students and policy-makers from 45 countries representing both educational institutions and health organisations. As part of this approach, services should be provided to distressed students⁹ including on-campus face-to-face counselling and psychological services; evidence-based anonymous telephone and online services; and recognised effective online programs. Research has shown that offering a range of service types is to enhance engagement with services by providing the young person with a choice.

Information request 18.2 — what type and level of training should be provided to educators

Educator training should be a core component of initial and continuous professional development training for tertiary educators. The APS believe that all staff in the tertiary sector should complete mental health first aid training, or a variant of

this. Mandatory completion would ensure all staff receive base level training just as they do for other areas of human resource compliance e.g. privacy, respectful behaviour, digital security. Staff are well placed to detect and support students with mental health concerns.

The APS argues that there needs to be an institution-wide approach to student (and staff) mental health and wellbeing (e.g., Okanagan Charter⁸). Such an approach includes the provision of psychological support services to students, and the design and delivery of curricular environments that support student success and wellbeing, including the development of self-management capacity as a graduate capability. Tertiary education institutions can take a population approach to psychological health and wellbeing, by shaping their curriculum environment and by providing opportunities within the curriculum to develop self-management capability. By doing so, educators can contribute to early intervention, prevention, and the promotion of wellbeing, and thus shifting the student wellbeing distribution from languishing to flourishing.¹⁰

Draft recommendation 18.2 — student mental health and wellbeing strategy in tertiary education institutions

The APS strongly agrees with this recommendation – see Information Request 18.2. In particular, we recommend a prevention and wellbeing optimisation approach, by ensuring that all academic programs include curriculum environments that support student learning, and the development of self-management as an institution-wide graduate capability.

In terms of training in the development of self-management capability, examples such as those at UNSW Sydney and elsewhere could be given,¹¹⁻¹⁵ and support to integrate strategies into educator's units and programs could be provided by experienced trainers. In addition, some universities have for-credit units that focus on the theory, research and practice on self-management, and enable students to gain the knowledge, and some personal skill, in self-management. Academic program development and assurance processes should be utilized to ensure that this graduate capability is progressively developed across the degree program, in the same manner as any other graduate capability.

Information request 18.3 — International students access to mental health services

International students can rarely adjust their study demands and still comply with their visa requirements. A reduced study load is often a flexibility that is available to a local student, but it is not a simple matter to provide this to an International student. A case must be made for compassionate or compelling circumstances (for example serious medical reasons, bereavement or trauma).

It is unclear whether mental illness constitutes grounds for flexibility in study plans.

What is needed in both the tertiary and school sectors are funds to develop transition programs for newly arrived international students that directly addresses stigma by providing psycho-education on mental health and information on help-seeking and service access. To date research in this area has focused on the tertiary sector, the school sector is poorly understood.

Psychological health and safety in workplaces (Chapter 19)

The APS strongly supports legislating psychological health and safety and codes of practice as initial policy levers required to begin the process of reform within Australian workplaces. The APS provides qualified support to lower insurance premiums for employers to implement workplace initiatives, no liability treatment during the claims process, and disseminating information regarding workplace interventions.

The APS supports **recommendation 19.1**. At the policy level, health and safety legislation, labour laws and Codes of Practice are important initial catalysts for organisational action. However, as discussed in the PC's report titled *Identifying and Evaluating Regulation reforms*,¹⁶ employers need support to operationalise these regulatory reforms. The APS emphasises that mechanisms that lead to psychological injuries are different to those that cause physical injuries. This complexity means organisations are hesitant to implement systematic strategies to manage risks, not understanding how to identify hazards, how to assess potential and actual impacts to worker wellbeing, and what strategies will be most effective in mitigating these risks.¹⁷

The APS supports **recommendation 19.2** and recommends that workplace reforms are supported by an implementation strategy with associated policy levers to ensure the reforms are operationalised effectively in workplaces and intended outcomes are achieved on the ground. This should include:

- Codes of Practice that stipulate the minimum standard requirements whilst also having a degree of flexibility, to be applicable to both small, medium and large organisations.
- Capacity building among regulatory agencies, including the ability to enforce the legislation, Codes of Practice and other regulations.

The APS supports **recommendation 19.5** in principle for disseminating information about workplace interventions but recommends that the PC's stance on this issue be strengthened. Despite significant empirical evidence demonstrating that system level approaches to address work-related stress are effective, organisational practice tends to be dominated by secondary and tertiary level interventions targeted at the individual.¹⁸⁻²⁰ While secondary and tertiary interventions are important, the government, employers and regulators need

to better understand integrated approaches to ensure that primary interventions at the organisational level are given the appropriate weight.

The APS recommends that a national framework be developed to assist employers to implement reforms that place appropriate weight across primary, secondary and tertiary interventions in a balanced manner.

The APS supports in principle **recommendation 19.3** to incentivise employers who implement workplace initiatives with lower premiums but considers that further work is required to develop standardised guidance on what initiatives are most likely to reduce risks. A recent systematic review showed that interventions with a greater impact contained multiple components and also provided opportunity for contact with the workplace, but that degree of impact also depended on the disorder targeted.²¹ The unintended consequence of rewarding organisations for implementing strategies that are thought to have a positive impact, is that based on the organisational context and implementation strategy, even an intervention thought to be good practice may not result in intended benefits.

The APS recommends that the PC qualify its recommendation to reward organisations with lowered premiums only where they can demonstrate improvements across agreed, best-practice lead and lag indicators or other relevant measures.

The APS supports in principle **recommendation 19.4** to provide clinical treatment for all mental health related workers compensation claims, regardless of liability. As noted by the PC, the significant issue with no-liability treatment is who pays if the claim is ultimately rejected. It would not be appropriate to attempt to recover funds from the worker as this could lead to unreasonable financial pressures that could further exacerbate mental ill-health, regardless of whether the injury or condition was deemed work-related. The APS strongly supports the NSW model for no liability treatment with both time and cost caps.

In relation to **information request 19.1** regarding who should fund the no-liability treatment, the APS suggests that further work be undertaken to analyse and clarify the nature of claims that currently tend to be rejected, the type of psychological injuries that appear and the best practice treatment for those conditions. This analysis will likely provide further evidence as to how likely claims are to be rejected and elucidate the cost of treatment under a no liability scheme. This has the benefit of better understanding the costs involved to make an informed decision about how no-liability treatment should be funded.

In relation to **information request 19.2** regarding specific personal days for mental health and wellbeing, the APS believes that employees should have the freedom to use their personal leave as they see fit, including to manage stress. The APS considers that designating days for 'mental health' would carry the same issues that arise in relation to disclosures through provision of a medical certificate. Further, while having

designated mental health days may provide data regarding mental-ill health, this would likely be inaccurate as there would be nothing to prevent an employee using a day of standard personal leave for mental health (if they did not want their employer to know why they were not present at work) or using a mental health day for another purpose. If the purpose is to ensure that employees have the freedom to take a personal day to care for their mental health and wellbeing, this objective could be achieved through reforms that disallow employers to require a medical certificate for every absence.

Draft recommendation 20.1 — National stigma reduction strategy

The APS welcomes a national stigma reduction strategy that focuses on the experiences of people with mental illness that is poorly understood in the community. Such a strategy would need to incorporate training and continuing professional development for all mental health professionals.

The Health Foundation²² has identified that how evidence is communicated to the general public is critical in building awareness and understanding and ultimately contributing to social change. It is not sufficient to communicate the evidence and expect people to change their attitude. People's underlying views and beliefs shape the way they interpret information, and therefore a deeper understanding of such beliefs will be required to design and implement careful and effective communication.

Draft recommendation 21.1 — Universal access to aftercare

This is a highly vulnerable patient population and they should be assisted by practitioners best equipped to deal with severe and complex presentations. Where psychosocial support is offered in this space by peer workers (an emerging trend in many states), consumer safety should be paramount, with appropriate clinical oversight, and psychosocial support provided as an adjunct (and not an alternative) to thorough assessment and treatment of any underlying mental health conditions.

The APS suggests the establishment of post-admission services for clients discharged from hospital emergency services presenting with suicidal ideation or having made an attempt. These services could be provided by both state and federally funded services. State based services could be co-situated at community mental health services, or could incorporate discharge planning services for patients with presentations involving suicidality, to ensure appropriate treatment arrangements are in place on discharge from hospital. Federally funded services could be offered via private practices offering suitable follow-up tied to a memorandum of understanding. Such a service currently exists in the NSW Victims of Crime where suitably approved clinicians are mandated to provide a service to

a referred victim within three working days of receiving a referral.

Currently, many post suicide clients are discharged without follow-up. Appropriate services would form a safety-net for these clients in liaising with the clients' current psychologist or linking them into a new treatment provider. Such a service has the potential to significantly improve mental health outcomes and reduce successful suicides and morbidity if staffed or service-led by clinicians who are trained to provide relevant evidence-based care.

Information request 23.1 — Architecture of the future mental health system

Refer to the section on reform in the submission

Draft recommendation 24.1 — Flexible and pooled funding arrangements

Refer to the section on reform in the submission

Draft recommendation 24.4 — Toward more innovative payment models

Refer to the section on reform in the submission

Draft recommendation 25.9 — A clinical trials network should be established

Refer to the section on strengthening evidence in the submission

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