

**Australian Government
Productivity Commission**

Inquiry into Mental Health

***Response to the Commission's Issues Paper –
The Social and Economic Benefits of Improving
Mental Health***

Occupational Therapy Australia submission

April 2019

Introduction

Occupational Therapy Australia (OTA) welcomes the opportunity to provide a submission in response to the Productivity Commission's issues paper, *The Social and Economic Benefits of Improving Mental Health*.

OTA is the professional association and peak representative body for occupational therapists in Australia. As of December 2018, there were more than 21,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and home modifications, and key disability supports and services.

Mental health service provision is a core area of practice for occupational therapists dating back to the beginning of the profession. Occupational therapists work across the spectrum of mental illness, providing services to people with mild, moderate and severe mental health conditions. They deliver services to people with relatively common conditions such as anxiety disorders, as well as more severe conditions that require targeted interventions, such as psychosis and trauma-related disorders. Occupational therapists also provide services that may have traditionally been considered the domain of other professions, such as psychotherapy and counselling.

Occupational therapists are accredited to provide services under the Commonwealth Government's Better Access to Mental Health initiative, with around 1,000 OTA members currently endorsed to work within this scheme.

OTA is also a member organisation of Mental Health Australia and is regularly represented at events such as Members' Policy Forums. We are strongly supportive of Mental Health Australia's efforts to promote closer collaboration within the sector.

The role of occupational therapists in mental health

Occupational therapists provide strengths-based, behaviourally-oriented and goal-directed services to improve mental health and wellbeing, and to help a person access personally relevant and valued roles in life. Friends and family members can benefit from occupational therapy input by learning how to deal with the demands of care-giving, allowing them independence and balancing their daily responsibilities.

Clients who are referred to an occupational therapist working in mental health are assisted to:

- Engage in activities that are personally relevant, such as specific vocational and leisure interests. Occupational therapists can assist people with mental illness to find meaningful work and undergo training to improve their career options, particularly where their ability to remain engaged for a sustained period has been affected as a result of their condition;
- Develop ways to enhance their social connectedness and community engagement;

- Develop skills and qualities such as assertiveness and self-awareness; and
- Develop or restore skills through strategies such as personalised behavioural/functional goal setting, psychoeducation, graded exposure and skills-based approaches, experiential learning, group and individual work, and adaptive learning strategies.

Occupational therapists develop and implement strategies to improve the physical health of people with mental illness, as they consider each person's care needs from a holistic perspective.

Occupational therapy differs from other Better Access accredited professions (psychology and social work) in this regard. It should be noted that people with mental health issues generally experience poorer physical health, and subsequently have a lower life expectancy.

Occupational therapists actively work with clients to support outcomes that enhance the individual's efficacy, such as enabling people to develop goals and meet them through both conceptual reframing and the supported practice of skills in real life contexts. This evidence-based approach results in the likelihood that people will develop sustainable approaches to their challenges in life, in both the present and future.

The above indicates a strong alignment with the following:

- The Fifth National Mental Health and Suicide Prevention Plan;
- National mental health priorities;
- Principles of recovery oriented mental health practice; and
- A stepped care model of treatment.

It is recognised that stepped care is central to the Australian Government's mental health reform agenda and should be used by Primary Health Networks (PHNs) to guide the procurement of mental health services via a commissioning approach. OTA believes that additional collaboration between disciplines is also needed in order to support the implementation of this approach across the matrix of providers and services.

OTA believes that a continuum of primary mental health services within a stepped care approach will support a range of service types, making the best use of available workers and technology to better align with the health needs of individuals and communities.

Responses to questions in the issues paper

Questions on specific health concerns (page 16)

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

OTA believes that intervention in early education is pivotal to preventing mental health conditions becoming barriers to effective participation in society later in life. Occupational therapists are equipped to play an integral part in addressing the economic costs of the mental health burden created by undiagnosed learning disabilities.

One occupational therapist reported that, as a national assessor completing file reviews and interviews with Disability Employment Services (DES) providers and clients, it was evident that many clients had learning difficulties that were not adequately addressed within the education system. The costs associated with supporting adults with complex mental health issues seem to be much greater than the provision of targeted early educational supports.

What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?

One key change would be early intervention addressing learning disabilities in primary schools, with a continuation of this support through secondary education.

An occupational therapist working with students with disabilities at one of Australia's leading universities noted that students who present with simple or complex mental health conditions have often been told and/or felt they were lazy or stupid at school and had trouble focusing. It seems that they arrive at this point due to the failure of multiple systems. Addressing learning differences at an early age would significantly alter mental health outcomes.

Students with complex mental health issues are enrolling at universities in large numbers. The way many of them describe their schooling experiences and family highlights the significant impact of an undiagnosed learning disability (and the generational impact). It is a theme repeated again and again.

The therapist also noted that despite these issues there are success stories. Students whose needs are identified early and are able to learn strategies experience vastly different outcomes. The two different ends of the spectrum are highlighted in the examples below.

Example 1

One young man who had always struggled at school and withdrew in year 12 was diagnosed with depression. He was fortunate enough to have parents who could pay for him to attend a clinic where he was diagnosed with attention deficit disorder (ADD). The clinic was able to support him through the diagnosis and assist him to develop strategies to support his goal of studying at university. He arrived at the occupational therapist's office well equipped for study and only required minimal adjustments to complete his exams. He was also linked in with ongoing ADD specific support.

Example 2

A young woman of about the same age from a low socioeconomic background had depression and anxiety, and had attempted suicide. She had spent one month in a private mental health facility prior to the beginning of the academic year. She described to the occupational therapist her goal and went on to talk of how she had failed English at primary school and secondary school. The therapist asked if anyone at the clinic had discussed learning disabilities with her, and she stated that they had not. Given her goal was to attend university, the therapist's professional opinion was that this should have been within the scope of her inpatient treatment. She reported that she could not afford to see a psychiatrist as an outpatient. In cases such as this, the stress of study will likely exacerbate the student's mental health issues and reinforce their sense of failure, leading to

worsening mental health symptoms. Like many in the student's situation, she attended just one appointment and has withdrawn from study.

There is a huge gap in Medicare-funded services to refer these people to and it is beyond the scope of many services to adequately meet their needs.

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

The ACE (Adverse Childhood Events) study (ongoing) in the United States points to the social and emotional wellbeing of parents as being instrumental in the emergence and ongoing mental health of children and young people. More emphasis is needed on addressing the question of 'how can I be a better parent to my child given the circumstances I face' in order to mitigate the downstream problems of child and youth mental ill health. These include behavioural difficulties, anxiety and depression, poor attention, sleep problems, substance use and the social sequelae which include school disengagement leading to social disadvantage (poor employment prospects, alcohol and drug use, increased involvement in the justice system and so on).

The Glasgow Project used the ideas of workers who were working with families and parents 'at the coalface' to develop programs that assisted parents in attuning to the needs of their children. This has meant a variety of different programs for different groups of people. The programs are assessed to see if they achieve the desired goals. This is an enormous challenge to policy makers as it changes the emphasis on how programs are developed and implemented. However, the success of the project makes it compelling evidence for change. The emphasis is on developing mentally healthy children by helping parents understand and meet the needs of their children rather than 'fixing' mental ill health.

Questions on health workforce and informal carers (page 17)

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

In a land as vast as Australia, and with a population as urbanised as Australia's, it is unsurprising that our health, aged care and disability workforce is stretched so thinly between our major cities. But while the problem comes as no surprise, it nonetheless remains a problem.

Key issues behind these workforce shortages include the difficulty of recruiting and retaining workers, high turnover rates, inadequate availability of senior/experienced staff, and an oversupply of part-time and casual workers.

The federal government should work to address this maldistribution as a matter of urgency, ensuring those Australians living outside our major cities and regional centres enjoy reasonable access to health services befitting one of the world's most advanced countries. The stated determination of all governments to 'close the gap' of Indigenous disadvantage is another compelling reason to ensure such access.

Education must play a key role in any long-term solution to this problem. Regular and meaningful rotations through regional and remote locations during the training of medical and allied health professionals heighten the possibility that the student will eventually settle and practice in such a location. This is most easily achieved by way of training networks that link major metropolitan hospitals with smaller regional and rural hospitals. While this is largely the responsibility of state and territory governments, the federal government should work with, and encourage, these governments to implement such arrangements.

The provision of rural-based scholarships and fellowships is another means of attracting students and recent graduates to locations outside our major cities.

OTA strongly supports the development of an Allied Health Rural Generalist Pathway, which is key to the provision of multidisciplinary care in rural and remote areas. We also join with other organisations in calling for the development and implementation of a comprehensive rural and remote health strategy.

Other issues preventing consumers from receiving timely access to services include:

- Long waiting lists to see psychiatrists;
- Geography – many consumers have to travel long distances to access clinical and social services. In some areas there is minimal or no public transport available, while those who drive have to contend with the cost of petrol and unreliable vehicles;
- The persisting stigma attached to mental illness in some rural and remote communities – for example, one person was told by a volunteer driving service that “we don’t transport people with mental illness”;
- Lack of housing and other support services for victims of domestic violence – how can people stabilise if their basic needs are not met?; and
- Persisting occupational deprivation – long waiting periods to access non-government support agencies. There is a focus on ‘reaching goals’ when many clients report that what they want is social contact and reassurance of ongoing support.

Provider travel

The matter of travel and travel costs is an essential matter for occupational therapy practice which is recognised by a number of government agencies/funders. Travel is a particular concern for providers who operate in rural and remote areas. Medicare rebates for occupational therapy services provided under the Better Access initiative are woefully inadequate, compromising the profitability of businesses and limiting therapists’ capacity to travel to clients in remote areas.

At a meeting of its Musculoskeletal Working Group on Monday 15 August 2016, the Department of Veterans’ Affairs (DVA) noted that, perhaps uniquely among the allied health professions, occupational therapists are required to consult in the client’s own environment, be it the home, a hospital or a residential facility.

There is also considerable academic evidence to support the need for occupational therapists to observe how a client functions across a range of settings. Howe and Briggs (1992) state that it is the responsibility of the occupational therapist to consider the whole context when undertaking an

assessment, including the home, school, workplace and community.¹ Dunn et al. (1994) state that occupational therapy is most effective when it is embedded in real life – that is, when the occupational therapist can modify an occupation in the actual setting where it takes place.² Ciampa et al. (2016), in a study looking at work integration, also support the need to undertake assessment in the setting where the occupation takes place.³

The challenge facing occupational therapists working in private practice is that they need to charge for the time they spend travelling to meet with clients, otherwise the viability of their business will be impacted. If therapists are not fully reimbursed, their ability to offer services outside a clinic-type environment will be limited. Some providers will choose to avoid doing off-site work due to the loss of income. This will subsequently affect the quality of care that a client receives, as home assessments are an integral part of occupational therapy. Assessments designed to determine a client's need for assistive technology and home modifications simply cannot be done in a clinic or over the phone, and private practices will be reluctant to offer these services if the travel costs they incur are not subsidised.

Telehealth

OTA recognises the opportunities that technology presents for improved service delivery in rural, regional and remote areas. e-mental health is an emerging area of practice for many occupational therapists and other mental health clinicians.

While the growth of telehealth might alleviate the problem of remoteness, there are obviously occasions when the health practitioner must be there with the client. This is particularly true of occupational therapists, who need to work with the client in the environment in which he or she is trying to function – i.e. the home, the workplace, the school.

Occupational therapists and other health professionals face a number of barriers to providing telehealth services to clients in rural and remote areas. These include access to videoconferencing technology in an appropriate clinical space, slow Internet speeds, and ensuring that patients have completed necessary tests and scans prior to a telehealth appointment. Older people may also require assistance to become familiar with the technology used to provide telehealth services.

The success of telehealth often depends on how clinicians adapt their practice/modify their services to work in a telehealth environment. There are a number of positive aspects, including improved care coordination for clients and the convenience of not having to travel a considerable distance to access services. Greater funding for telehealth service provision at both a federal and state level would also address many of the current challenges and might, in the longer term, prove a cost saving to the health system.

OTA welcomed the introduction of a new measure that allows consumers in rural and remote areas to claim rebates for video consultations provided through Better Access. However, we note that only \$9.1 million has been provided for this initiative over four years from 2017–18 to 2020–21. OTA

¹ Howe, M. C., & Briggs, A. K. (1982). Ecological systems model for occupational therapy. *American Journal of Occupational Therapy*, 36(5), 322-327.

² Dunn, W., Brown, C., & McGuigan, A. (1994). The ecology of human performance: A framework for considering the effect of context. *American Journal of Occupational Therapy*, 48(7), 595-607.

³ Ciampa, M. A., Roca, M., Torralva, T., Lischinsky, A., Manes, F., & Camino, J. (2016). Specific work integration program with a patient with traumatic brain injury. *J Neurol Ther*, 2(3), 8-14.

recommends that funding for this initiative be increased and extended beyond this period to ensure that those living in rural and remote Australia continue to have access to these essential services.

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

The allied health workforce is key to ensuring that mental health consumers receive integrated care. Allied health professionals are primary care providers (the first point of contact for people living with mental health issues and their carers) as well as secondary and tertiary (specialised services) providers. Occupational therapists promote a holistic approach to health care by assessing how the social determinants of health and other lifestyle factors affect a person's mental health and wellbeing.

Despite the breadth of roles and interventions performed by occupational therapists working in mental health, there remains a general lack of awareness and recognition of these. This is due in large part to the tendency to automatically associate mental health care with certain disciplines, such as psychology, psychiatry and nursing. The uniqueness of occupational therapy interventions lies in the fact that they are holistic, individualised, focused on the person's occupational goals and outcome-focused (i.e. a measurable change should be observed).

Occupational therapists' focus on functional skills can be considered both a unique strength and a weakness. Despite being proactive in enhancing people's functional capacity and enabling them to participate in everyday activities, the image of a person sitting in a psychologist's or psychiatrist's rooms seems more associated with mental health treatment. Observing people in their own environments (e.g. home, school, workplace) and modifying these environments to enable optimal participation is a core tenet of occupational therapy and can result in savings to the health system.

OTA is also regularly advised by members that GPs do not understand the role of occupational therapists in mental health, with many wrongly assuming that only psychologists are approved to provide services under Better Access. This lack of awareness has resulted in limited referrals to occupational therapists and remains an ongoing problem. It also appears to extend beyond GPs, with reports that employee assistance programs will not refer clients to occupational therapists who are accredited under Better Access.

OTA acknowledges that considerable work has been done to remove the stigma attached to mental health issues. Consumers are gradually becoming more aware of the services available to them, and are being encouraged to seek help if necessary. Despite this, there is a sense of disillusionment amongst consumers when services do not deliver, which can discourage them from requesting support in the future.

Questions on social services (page 21)

Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?

While most participants establish their eligibility for the National Disability Insurance Scheme (NDIS) by virtue of their pre-existing supports, OTA is aware of a gap into which some potential participants

are falling. In order to access NDIS funding for treatment and other supports, these would-be participants must first establish their eligibility by way of a detailed, costly and time-consuming functional assessment. The expense of such an assessment is often beyond the means of the would-be participant, meaning that therapists are not able to adequately assist people with psychosocial disability to access the scheme. In such cases the potential participant is denied access to a scheme for which they might otherwise be eligible. In order to address this problem, the Australian Government should give consideration to providing free or substantially subsidised initial assessments.

Questions on education and training (page 26)

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

Ensuring that learning issues are diagnosed early and accessing cost-effective services to support the needs of students are key barriers. Children fall behind very far, very early.

Early diagnosis of learning issues such as dyslexia, dysgraphia, ADD, attention deficit hyperactivity disorder (ADHD), auditory processing disorder (APD), sensory processing disorder (SPD) and autism spectrum disorder (ASD) is essential. Our education system misses the majority of children with these issues. Only children whose condition is severe enough to be 'ascertained', or whose parents can afford to pay for services, receive support to succeed academically.

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

Access to occupational therapy resources amongst others is not consistent across the country, with unclear referral pathways, variable availability of occupational therapy and differing policies and practices regarding the visitation of occupational therapists to classrooms. The availability of occupational therapists in rural areas is a challenge, particularly in more remote communities.

OTA has also heard from its members that families are often unaware of the resources that are available to them and are required to advocate strongly for access to supports, including occupational therapy. This can be quite burdensome for already overstretched families dealing with a range of additional support needs. It also further adds to the inequity of supports, with the advocacy skills of families a key factor in students accessing the full range of accommodations.

In addition, members identified a problem with multiple therapists visiting schools, and potentially the same classroom. OTA has heard reports of principals refusing access to classrooms for therapists because it is too disruptive when multiple therapists are supporting students. This is a logistical issue that requires attention, as the NDIS model of individual funding is likely to increase this phenomenon.

Other schools have opted for a preferred provider model, where the school engages a therapist to work with students and staff. This seems viable when the school is funding the therapy services. However, there are risks associated with this approach with regards to reducing individual choice, particularly if the student's individual funding or private health insurance is being used to pay for therapy. Further development of a consistent procedure for therapy input in the school setting is

required to ensure equitable access for students to required accommodations and supports. Services must be adaptable and responsive to the needs of individual students, with the capacity for families to provide input and be involved in their child's development.

The ideal model would be one whereby occupational therapists are embedded within schools and facilitate connections with other therapists and allied health professionals engaged in a private capacity. An occupational therapist who is embedded within the school would possess a greater and more valuable contextual understanding of the school environment, including teachers and other support staff, students and classroom dynamics.

An occupational therapist provided the following example of their son's experience of starting secondary school which highlights the importance of parents being able to advocate on behalf of their children.

At primary school my son had adjustments for dysgraphia and ADD. There was a meeting with the learning support unit from his chosen secondary school at the end of grade 6. Representatives from the unit also met with his primary school teacher, however the secondary school had not made any provisions in the first few weeks to accommodate his needs. This may be because the learning support unit was too weighed down in paperwork, formalising goals in the teaching and learning plans. The system prioritised children with much more significant and externally obvious needs, however my son's mental health was suffering during this time. His OT mother and OT student father were able to help him deal with this. At parent-teacher interviews I supplied a one page summary to teachers, and in less than ten minutes the issues were addressed.

Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health?

Teachers quite often lack appropriate levels of support, which impacts on their capacity to meet the individual needs of students with disability. Across Australia, current teacher training does not sufficiently educate trainee teachers on the needs of students with disability. In some cases this training is only optional, resulting in the majority of teachers and administrators lacking the requisite knowledge and experience to effectively support students with disability. Additionally, many teachers lack understanding of allied health professionals and occupational therapists specifically, and their role in supporting students and contributing to multidisciplinary teams.

It has also been reported that teachers are often unaware of their obligations under the Disability Discrimination Act.

It is common for there to be different levels of understanding across different schools, and even internally across different teaching staff. This is reflected in different attitudes and varying degrees of willingness to allow occupational therapists into classrooms to provide services to students.

This lack of knowledge and experience leads to:

- Viewing behaviour only through the lens of behaviour management, with insufficient regard for individual difference or other issues which may be triggering challenging behaviour (e.g.

the environment in which the child is functioning, sensory and other needs, communication issues, learning needs);

- Lack of understanding of how to reduce the impact of the disability for the student in the classroom/schoolyard;
- Lack of understanding about how the student's 'constitutional' factors/vulnerabilities impact occupational performance (e.g. everyday functioning) and how these may be attenuated;
- Lack of specialist knowledge to ameliorate, accommodate and compensate occupational concerns which impact on a student's learning and success at school, as well as extracurricular activities; and
- Limited knowledge and understanding by parents and educators of the role of occupational therapists in collaborating with schools to assist young people to engage and participate in their education.

The amount of time available to teaching staff to process the content of occupational therapy reports is a barrier and visits are often viewed as intrusive. Learning supports must be simple and easily implementable within the teacher's (and teacher aide's) context.

Questions on government-funded employment support (page 27)

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

OTA believes that creating opportunities for meaningful employment for people with mental illness is key to improving their overall health and wellbeing.

Governments need to invest in programs and services to get people with mental illness into meaningful work, and to assist those whose ability to remain in the workforce for a sustained period has been affected as a result of their condition. Additionally, governments should develop promotional strategies to encourage positive mental health in all work environments and direct people to appropriate supports if they feel stressed or anxious as a result of their job.

Research has highlighted the benefits of developing an objective measure of psychosocial disability, which can assist with identifying who will benefit from employment assistance.⁴ OTA believes there should be investment in further research into how the needs of people with psychosocial disability can be measured. This would also be useful for determining eligibility for government assistance programs such as the NDIS.

Employment programs should also extend to mental health carers, many of whom are forced to give up full time employment and move to a part time or casual role, or stop working altogether. Investment in peer support programs for carers would also be of value. Evidence suggests that peer support workers are able to assist carers to understand the importance of their role while still maintaining a focus on their own health and wellbeing.

⁴ Waghorn, G., & Hielscher, E. (2016). Cognitive and Clinical Indicators of Employment Assistance Needs From a National Survey of Individuals Living With Psychosis. *Psychiatric Rehabilitation Journal*, 39(2), 112-119.

Questions on funding arrangements (page 36)

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

OTA believes that the Better Access to Mental Health initiative has, as intended, enriched the mental health and wellbeing of people across Australia. We support the program wholeheartedly and wish to contribute to its ongoing implementation by making recommendations for its improvement.

The Better Access initiative is seen to:

- Encourage GPs to participate in early intervention and management of clients;
- Streamline access to psychological interventions in primary care; and
- Provide referral pathways to mental health providers, including occupational therapists, for appropriate assessment and treatment of people with mental disorders through individual and group sessions.

Despite this, there is currently a sizeable disparity between the rebates for services provided by psychologists, and those provided by occupational therapists and social workers through the Better Access to Mental Health initiative. This lack of consistency can lead to significant out-of-pocket expenses for consumers who are often not made aware of the differences in rebates prior to commencing treatment.

A number of therapists have reported that it is simply not financially viable to work in this space due to inequities within the system. Moreover, lower rebates devalue the important work of occupational therapists and social workers and make it harder for consumers to access their services.

OTA believes there should be a flat rate in respect to rebates across the professions.

Practice owners, irrespective of their profession, must cover operating costs, including rent, equipment, utilities, computers and insurance. Unless occupational therapists and social workers receive the same rebate as other health professionals, private providers may be squeezed out of the market.

Co-payments can prove prohibitive for many clients, some of whom decide to cancel appointments or delay their next appointment. This is particularly true of rural and remote consumers, whose income is, on average, lower than that of people living in metropolitan areas.

The work of occupational therapists often requires significant travel, and consultation and liaison with relevant others, in order to secure effective outcomes for clients. This is inadequately subsidised under the scheme.

There are also no MBS item numbers for liaison with other health professionals, which discourages contact between providers and is not in the best interests of the client. The time needed for good clinical practice (documentation, gathering collateral, communication, facilitating crisis management) is currently non-billable time. If the federal government is genuinely committed to the delivery of properly coordinated health care, clinicians should be remunerated for time spent case

conferencing. OTA has contributed information on this topic to an Allied Health Professions Australia (AHPA) submission to the review of MBS allied health items.

Conclusion

OTA thanks the Commission for the opportunity to respond to its issues paper. We would be happy to provide further information on any of the issues raised in our submission should this be required.

Please note that should the Commission wish to view OTA's written submissions to the review of MBS mental health items, which include our views on the limitations of the current Better Access rebate structure, these can be accessed from <https://www.otaus.com.au/advocacy/2018/mbs-review-of-mental-health-services>.