Supplementary submission on mental health to the Senate Select Committee on Health – September 2015

Introduction

The Australian Psychological Society (APS) is the national professional organisation for psychologists, with over 22,000 members across Australia. Psychologists are experts in human behaviour and use evidence-based psychological interventions to assist people to overcome ill health and optimise their health and functioning in the community.

The APS has previously provided input to this inquiry by the Senate Select Committee on Health through a submission in September 2014. In that submission, the APS highlighted the principles of equity and universality that underpin the Australian health care system, the centrality of primary care and prevention, the role of social determinants of health and the importance of recognising and addressing psychological factors across all areas of health. In addition, that submission outlined the need for greater investment in health promotion and illness prevention and early intervention, and identified specific initiatives to improve interactions and integration across the health system, to achieve better outcomes for all Australians and particularly for Indigenous people and rural and remote communities, and to enable more comprehensive workforce planning for the future.

The themes of the APS' previous submission to the Committee are broadly consistent with the findings of the final report of *National Review of Mental Health Programmes and Services* (the Review), which was completed in November 2014 and released by the Government in April 2015.

In general, the APS agrees with the Review that mental health funding needs to be shifted down the spectrum of services towards the early intervention end. There is clear evidence for the benefit of identifying and treating people early, before their condition becomes more serious. Investing more in mental illness prevention and early intervention will reduce spending in more costly areas such as hospitals and social and welfare services.

The APS fully supports the development of a stepped care model for dealing with mental illness in the primary care system with the following features:

1. Greater emphasis on mental health promotion and illness prevention – in child care, schools, workplaces and aged care. There is huge gap in children's mental health services in Australia.
2. More effective assessment and efficient pathways to care
3. If GPs are to be the gate-keeper to services, they should undertake a 'preliminary' assessment and determine whether the person has a high or low prevalence disorder and any associated physical health problems
4. People with high prevalence disorders comprise 80 – 90% of mental health consumers and people with low prevalence disorders comprise only 10 – 20%

5. If the person has a high prevalence disorder at a mild level they could be referred to an e-therapy program (preferably therapist-assisted) as long as there is a pathway to therapeutic services if e-therapy is found not to be appropriate
6. If the person has a high prevalence disorder (such as anxiety or depression) at a moderate to severe level, they should be referred to a psychologist (or psychiatrist) for a comprehensive assessment and development of a treatment plan.
7. For most people with high prevalence disorders, Better Access (funded under Medicare) has proven to be an effective and cost efficient service with evaluation showing good treatment outcomes. These people don't need more expensive coordinated, team-based care.
8. However, some people with more complex high prevalence disorders such as Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder and eating disorders need more than the 10 sessions allowed under Better Access (as research evidence shows), hence the number of sessions available should be extended for this group of people.
9. Also some people such as those that are indigenous or homeless or are suicidal need a more flexible system and are better referred to the Access to Allied Psychological Services program
10. People with low prevalence mental disorders (such as schizophrenia and bipolar disorder) would be better supported in the community if specialist treatment items of sufficient number for treatment of the major symptoms of these disorders were available and delivered by appropriately trained psychologists

However, some of the Review's recommendations for pursuing their aims raise serious concerns.

Central to the Review's final report are proposals to 'cash out' mental health programs (including Better Access or some part thereof) and give the funding to the Primary Health Networks (PHNs) to administer. Most mental health consumers (80 to 90 per cent of people with mental illness who have high prevalence disorders) do not need coordinated team-based care. Administering funding for these people through PHNs would add another layer of costs for administration and decrease funding for the frontline services so desperately needed.

Only 10 to 20 per cent of people with mental illness have low prevalence disorders such as psychosis and bipolar disorder. This group comprises most of those who have chronic and complex conditions – and as far as possible the system needs to keep these people out of hospital and other acute care settings by providing more services in primary care

PHNs could be considered for distributing funding only for the 10 per cent of people with mental illness who need coordinated clinical and support services. However, a vast improvement in PHN clinical management to ensure quality and safety of commissioned services (i.e. better than the processes seen in many Medicare Locals) would need to be securely in place before such action was taken.

The present document aims to outline particular issues of relevance to this Committee's terms of reference in relation to mental health. In particular, this submission focusses on proposals put forward by the Review and recommendations for the Government's yet-to-be released response.

Mental health needs in the community

More than 80 per cent of people with mental illness have high prevalence disorders (such as depression and anxiety).

- People in this group can be effectively treated directly through psychological services in the community and generally do not require team-based coordinated care (see above Box insert).
- Service needs for people with chronic and complex mental health conditions can be complicated, meaning comprehensive biopsychosocial assessments conducted by trained and qualified health professionals (ideally psychologists and medical practitioners jointly) are required to appropriately match services to need.

Only 10 to 20 per cent of people with mental illness have low prevalence disorders (such as bipolar disorder and schizophrenia) that may need more integrated and coordinated clinical and support services.

- For these 10 per cent of consumers, more integrated and coordinated clinical and support services are needed, including more extensive evidence-based psychological services. Very effective psychological treatments are available for managing, treating and recovering from chronic mental illness
- At times, these consumers will require not only coordinated services, but acute in-patient-based care. In addition, people in this group often have very poor physical health outcomes, and are more likely to be high users of health and social services.

Mental health and promotion, prevention and early intervention

Good mental health can play an important protective role across a broad range of areas in population health and wellbeing. Initiatives in mental health promotion and mental illness prevention and early intervention can deliver significant benefits in reducing system-wide costs and increasing productivity and economic gains.

- The APS supports the Review's objective of rebalancing expenditure towards effective mental health promotion, mental illness prevention and early intervention and away from more expensive acute residential and hospital services. Australia's resources in mental health are heavily weighted towards the acute and severe end of the spectrum. This expenditure is not only expensive but also inefficient and not matched to need in the community. Timely and effective psychological services are important avenues of early intervention and help prevent disorders from escalating into more severe or chronic conditions and the associated demand on acute as well as social and welfare services.

Effective mental health promotion and prevention interventions should be universally available and provided in everyday settings that enable good access to wide sections of the community,

such as early childhood services and schools (e.g. *KidsMatter)*, workplaces and aged care services.

Increased investment is needed in mental health services for children, adolescents and young adults, as the earlier problems are detected the easier they are to treat. Mental health promotion and prevention for children and young people could be effectively implemented by systematically implementing *KidsMatter Early Childhood* across all Australian early childhood and long day care services, *KidsMatter* across all Australian primary schools and mental health promotion and prevention programs for youth in secondary schools (such as *MindMatters*). In addition, new service models for children with mental health problems should be developed. These should be delivered through existing services to provide integrated and holistic approaches to early intervention, including comprehensive psychosocial assessments for children and their families, treatment plans and locally-coordinated services. Child mental health services represent a significant gap in Australia's current mental health system.

In workplaces, mental illness prevention programs could be facilitated across Australian workplaces, targeting both existing employees and retiring workers, funded by businesses, superannuation providers and private health insurance companies.

In aged care, mental health promotion and prevention in aged care services, as well as funded access to behaviour management interventions, would contribute to lower intensity care and lower medication costs. Residents should have access to neuropsychological assessments to assist in identifying early dementia and differentiating it from depression in order to ensure appropriate treatment is provided.

As part of a stepped care model in primary care, **identification and early intervention in mental illness** can help prevent conditions from becoming more serious. As gate-keepers to primary care services, initial assessments by GPs are key to ensuring people are referred to the right service at the right time.

- For high prevalence disorders such as moderate to severe depression and anxiety, early intervention and treatment can be cost-efficiently and effectively managed through accessible primary care pathways to psychological interventions. The existing fee-for-service and Medicare rebate arrangements through Better Access provide access to effective, cost-efficient and evidence-based psychological treatment for a large proportion of people with common mental illnesses. e-therapy psychological interventions have a growing research base demonstrating their efficacy, and can be increasingly utilised – where appropriate – for self-management of mild high prevalence disorders as a cost-efficient first-line treatment. Investment in e-health should be targeted to services with demonstrated safety, quality and effectiveness (including e-therapies that are therapist assisted) and if there are clear pathways for consumers to 'step-up' to face-to-face professional services when needed.

Proposed changes to Better Access

Better Access was a landmark mental health reform introduced in 2006 under the Howard Government and then Health Minister, Tony Abbott, providing Medicare rebates for effective, evidence-based psychological treatment. Better Access provides a non-stigmatised pathway to services through the primary care system and has been credited for significantly increasing treatment rates for mental disorders in Australia, from 37 per cent in 2006-07 to 46 per cent in

2009-10. Better Access is also cost-efficient, enabling nearly 4 million sessions of psychological treatment each year, and accounts for just 4 per cent of the Commonwealth's total annual expenditure on mental health.

Better Access came under significant scrutiny by the Review and the report's recommendations contain changes to existing arrangements. Some of these are welcome and others are very concerning.

Increased maximum annual session allowance to 16

The APS welcomes the Review's proposal to increase the maximum annual session allowance under Better Access to 16 sessions. It is estimated that increasing the number of Better Access sessions available per year will provide vital support for more than 33,000 people with moderate to severe levels of high prevalence disorders, such as Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder and eating disorders. Provision of additional treatment sessions should not be limited to clinical psychologist providers (as suggested by the Review's recommendation) but rather should be available to the broad range of psychologists who can provide effective services to consumers with more complex mental health needs.

Optional use of GP Mental Health Treatment Plan

The APS supports streamlining referral processes under Better Access by enabling direct referrals to psychologists via a letter from the GP and making preparation of Mental Health Treatment Plans optional for GPs. This would save time and money, freeing up consultation time for GPs, and streamline the process for consumers, as currently assessments are often repeated by the treating psychologist in order to develop a comprehensive psychological treatment plan. This change would remove an area of significant duplication, leading to savings that can be redirected towards the additional sessions.

Cashing out Better Access

One of the key concerns of the APS is the Review's proposal that the Government:

> *[e]xamine cashing out Better Access benefits paid for services provided by registered psychologists who do not have an additional endorsed qualification and distributing those funds on a weighted population basis to regional purchasers for psychological services on a salaried or sessional basis.*

The APS notes that the recommendation is for Government to *examine* – rather than implement – cashing-out of Better Access, and that there are a number of elements of this recommendation that are unclear and open to interpretation. In the absence of more detailed information in the Review) the APS has inferred that 'regional purchasers' refers to PHNs and that the funds proposed for 'cashing-out' from Better Access would be quarantined for delivery of psychological services and administered under a capped-funding model.

The APS is extremely concerned that cashing out Better Access in this way would decrease – rather than increase – funds available for psychological services and the number (and potentially quality) of frontline treatment services that are delivered in the community. The proposal would **reduce the cost-efficiency** of the psychological services Better Access currently provides and **decrease overall access to services**.

- Delivering Better Access through PHNs would see relatively more funding directed to administration, decreasing cost-efficiency and reducing resources available for service delivery and ultimately decreasing consumers' access to services.
- Converting Better Access to a capped-funding model would risk consumers missing out on vital treatment services if funding runs out.
- The likelihood of these impacts is clearly demonstrated by Medicare Locals' administration of capped-funding for the Access to Allied Psychological Services (ATAPS) program.
    - ATAPS is 2 to 10 times less cost-efficient than Better Access due largely to higher administration costs, and routinely runs out of resources.
    - Inappropriate demand management strategies have been used in some ATAPS services, such as by restricting the number of available sessions (including to fewer than are available under Better Access).

It is not clear how funding 'cashed-out' from Better Access would be spent and whether the high quality treatments and interventions currently provided by psychologists under Better Access would be continued.

- The Review does not provide details regarding the *type of 'psychological services'* to be funded, the *type of consumer needs* to be targeted, the *eligibility criteria* to be applied, and what *type of health professionals* would deliver services. These issues could be resolved in various ways, with very different potential implications for consumers, access to service, pay and working arrangements for service providers, and workforce availability. It is entirely inappropriate that dismantling Better Access – an effective and cost-efficient existing initiative – is being considered before these critical implementation issues have been canvassed.
- 'Psychological services' encompasses a broad range of activities – many of which can only be safely and effectively delivered by highly-trained and registered psychologists. Psychologists are a regulated health profession, and subject to high training requirements and high standards of safety and quality in all services they provide.

Delivering Better Access funding through PHNs **could see funding shift in the wrong direction**, moving it away from early intervention and people who do not require coordinate care, and towards the chronic/severe end of mental illness.

- According to the PHN Grant Programme Guidelines, one of the two PHN objectives is to improve coordination of care. In mental health, coordinated care is generally required for only a small proportion of people who experience severe or low prevalence disorders. By contrast, around 80 to 90 per cent of people with mental illness have high prevalence disorders that can be effectively treated directly through the early interventions and treatments delivered by psychologists under Better Access.

PHNs have not yet demonstrated they have the **capacity and capability** to deliver mental health programs as the centre of the mental health 'system architecture' (as proposed by the Review). The APS is particularly concerned about:

- the limited financial resources of PHNs
- the expertise required of PHN staff to appropriately manage mental health programs, including the selection of service providers

- commercial incentives for PHNs to prioritise low-cost programs and to select lower-cost and less-experienced service providers, with the associated quality and safety risks of doing so, particularly in rural and remote areas where they have little or no support.

Cashing out Better Access **could disproportionately weight PHN activities and overwhelm other priorities** across the primary care system.

- Part of the Review's vision for PHNs in mental health was that funding cashed out from exiting mental health programs into PHNs should be quarantined for spending in mental health (Recommendation 8.11). In principle, the APS supports this proposal.

The **processes and implications of redistributing Better Access funding on a weighted population basis are not yet clear**. More information is needed, including:

- details of the funding formula (i.e. where additional loadings would apply and the relative weighting of those loadings)
- the timeframe over which funding for PHNs would be provided (i.e. annually, or every three/five/ten years?)
- whether indexation would apply to funding, and if so, at what rate
- resourcing implications for different PHNs, including whether funding (and therefore access to services) would be decreased in some areas.

Psychological services should continue to be widely accessible as an integral component of Australia's universal primary care system.

- No other health or medical service subsidised through Medicare has been identified by the Review or elsewhere for cashing-out into pooled PHN funding arrangements.
- Fee-for-service arrangements are the best and most cost-efficient funding option for more than 80 per cent of mental health consumers.
- Just as the services provided by GPs and other health professionals will continue to be funded outside of PHN arrangements, so too should psychological services continue to be available on a demand-driven basis through the Medicare Benefits Schedule (MBS).

Cashing-out Better Access as proposed by the Review would run counter to both the core objectives of the Review and the stated programme objectives and target populations for PHN activities. It would also represent a fundamental departure from the principle of universal access that underpins both the Better Access initiative and the MBS, with detrimental impacts on access to vital early intervention and treatment services in the community.

The APS is therefore strongly opposed to any reforms that would cash-out Better Access funding to PHNs.

For nearly 10 years, Better Access has provided effective and cost-efficient access to psychological treatment services for the vast majority of people who experience mental illness. These significant and hard-won achievements of Better Access need to be protected and built upon.

Demand for psychologists' services is already outstripping supply, with waiting lists and many people not accessing services at all. It is therefore vital that existing levels of services are maintained and not reduced.

Better Access and chronic/complex conditions

In some cases, the current arrangements under Better Access may not provide the appropriate level of support. For example, people with severe and chronic/complex mental health conditions such as Obsessive Compulsive Disorder or Post Traumatic Stress Disorder often require more than the 10 sessions allowed under Better Access and on an ongoing basis. People with low prevalence disorders, such as psychosis and bipolar disorder, often need ongoing and often lifelong psychological treatment. These people should have access to subsidies for an additional 30 specialised psychology treatment sessions per year.

In addition to extra sessions, the ATAPS model can also provide a valuable adjunct service in such cases. Previously funded through Medicare Locals, ATAPS should be continued through PHNs for the provision of psychological services, but only in targeted areas and for populations where more flexibility is required (such as the existing niche programs under Tier 2 of ATAPS). ATAPS is also useful to bolster services for people in rural, regional and remote areas and people on low incomes.

Further detail about psychology and the prevention and management of chronic disease (including chronic mental illness) can be found in the August 2015 submission by the APS to the *House of Representatives Standing Committee on Health's Inquiry into Chronic Disease Prevention and Management in Primary Health Care* (Attachment A).

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Demand for psychologists' services is already outstripping supply, with waiting lists and many people not accessing services at all. It is therefore vital that existing levels of services are maintained and not reduced.

The APS recommends the Government:

1. **Continue funding Better Access through the MBS** (i.e. do not cash out into pooled PHN funding arrangements).

2. Realise **savings by making the development of GP MH treatment plans optional** for GPs and streamlining the referral process.

3. **Increase the number of available Better Access sessions** (paid for by savings from the GP MH treatment plan) to a total of 16 sessions per year (including additional 'exceptional circumstances' following assessment) for people with high prevalence conditions.

4. Provide an **additional 30 specialised psychology treatment sessions per year for people with chronic/complex mental health conditions** who have ongoing and often lifelong need for psychological treatments.

5. **Maintain ATAPS funding through PHNs** for the provision of psychological services where there are assessed gaps in Better Access, including continuation of services for people in rural, regional and remote areas, people on low incomes, and Tier 2 programs for particular groups who need more flexible services responses than are available under Better Access.

Better Access in rural/remote areas

The APS commends the Review's focus on the need to improve access to mental health services in regional, rural and remote locations. This is a critical issue for all health professionals, and not just psychologists: similar patterns of workforce distribution are found for a range of mental health professionals, with distribution poorest amongst psychiatrists.

Improving the geographic distribution of health professionals must be targeted towards the root causes of the problem. In psychology, these causes can be summarised as follows.

- Professional training requirements and significant capacity constraints in the higher education system mean that demand for psychologist services is likely to continue to outstrip future supply.
- Restrictions on workforce supply disproportionately affect rural and remote areas, which are commonly viewed as less attractive places to live (an issue that affects recruitment of all health and non-health workforces to these areas).
- The psychology workforce has never received federally-funded incentives for rural practice, despite such incentives being available to GPs and pharmacists for many years leading to demonstrable improvements in workforce distribution.
- Unlike medical and nursing staff, there are limited financial incentives available to psychologists in the (largely state-funded) public sector rural and remote workforce, and long-standing recruitment challenges in rural and remote areas have constrained the number of psychologist positions in the rural/remote public sector.
- Small populations in rural and remote areas limit the financial viability of private psychology practice and – with the lack of funded places in the public sector – there are few opportunities for psychologists to combine salaried and private practice to create a sustainable income.
- Referrals to psychologists in rural and remote areas are constrained by the shortage of GPs in rural and remote areas and the inability of other health providers who service rural and remote areas (e.g. remote area nurses, doctors in the Royal Flying Doctor Service) to make referrals through Better Access.

Given the barriers to services in regional, rural and remote areas, **the APS welcomes the Review's recommendations to**:

- provide targeted scholarships for rural postgraduate study, financial and relocation incentives and support for professional development and mentoring (Recommendation 13.14); and
- place a rural loading on Better Access rebates (Recommendation 13.15).

The APS further recommends that these strategies could be significantly enhanced by the **provision of support for psychology graduates to complete their internship in rural and remote Australia**, similar to current arrangements in pharmacy.

The APS also encourages changes to **enable the use of telehealth for the provision of Better Access services**.

In doing so, consideration should be given to preferring the provision of telehealth (under Better Access) for providers in regional, rural and remote regions who service rural consumers.

- This would increase recruitment and retention by making rural private practice more financially viable, while also fostering the delivery of culturally appropriate (i.e. rural to rural) services.
- It would also provide a quick response to improve access to services in rural and remote areas while longer-term workforce strategies are implemented.

However, the APS is concerned about the effectiveness of some of the Review's other recommendations.

The APS strongly opposes the proposal to limit use of Better Access by newly registered psychologists (and other allied health practitioners) to those who practice in rural/remote areas and to only allow them to provide Better Access services elsewhere in Australia after obtaining higher qualifications (Recommendations 13.11 and 13.12).

This proposal is likely to decrease – rather than increase – access to psychological services, not just in rural and remote communities but *across all areas of Australia*.

- The proposal would significantly undermine the attractiveness of entering the psychology profession and reduce enrolments in university psychology courses. This would have major impacts on psychology training pipelines and workforce sustainability.
- Very few psychologists in rural and remote areas are qualified as supervisors. This would restrict the registration opportunities needed for endorsement for newly registered psychologists who re-locate to rural/remote areas, and therefore limit the longer-term supply of endorsed psychologists in both urban and rural/remote locations.

The proposal may be contrary to the Constitutional prohibition on civil conscription, and also raises serious equity and quality concerns, as it will direct less experienced psychologists to rural and remote areas and facilitate the concentration of more experienced and endorsed psychologists in urban areas.

Further, the proposal could lead to oversupply of psychologists in some rural locations with populations lower than 50,000 that already have an adequate psychology workforce (e.g. in attractive regional centres and coastal locations).

There are many alternative and more appropriate approaches that could be considered instead for increasing psychological service provision in rural/remote areas.

The APS recommends the Government consider the following options for attracting psychologists to rural and remote areas.

- ***Facilitate blended models of private and public practice to make rural private psychology practice financially viable***

  For example, by funding psychologist positions in rural/remote public sector services in health, mental health, education and other social sectors.

- ***Increase the capacity of rural and remote organisations to employ psychologists***, such as through wage subsidies for rural health organisations.

- ***Increase the capacity of rural and remote organisations to provide supervision for psychology students who are in professional training.***

  Offer financial incentives for psychologists in rural and remote areas to supervise psychology students.

- ***Provide incentives and requirements for psychology students to train and work in rural and remote areas.***

  Introduce mandatory rural/remote placements for students in professional post-graduate training, and implement bonded rural psychology scholarships (similar to the Bonded Medical Places Scheme that operates for medical students) with places prioritised for students from rural, regional and remote areas.

- ***Broaden Better Access referral pathways***

  Health providers in rural and remote areas (e.g. remote area nurses and doctors with the Rural Flying Doctor Service) should be able to make direct referrals to psychologists under Better Access.

- **Flexible use of Medicare funds to increase access to culturally-appropriate psychological services in remote areas**

  The *Section 19(2) Exemptions Initiative (Improving Access to Primary Care in Rural and Remote Areas Initiative)* enables flexible use of Medicare benefits in approved areas such as remote communities. This exemption could be used to fund trial collaboration between the APS and Aboriginal Community Controlled Health Organisations (ACCHOs) to recruit psychologists for delivery of quality and culturally-appropriate psychology services in remote communities. This could be supported by an agency such as the Royal Flying Doctor Service in providing transport to facilitate a 'fly-in fly-out' (FIFO) model in communities where recruitment is not possible.

In addition, **the APS recommends more robust data be collected on the psychology workforce** in order to develop a more sophisticated approach to 'areas of identified need' for the psychology workforce and to enable a more targeted approach to reform.

Mental health and primary care

The Review proposes PHNs should form the 'system architecture' for mental health in Australia. In principle, the primary care system can play an important role in supporting mental health care arrangements, providing an interface between mental health and the primary care system, and forming an important component of the overall system to support people with mental health problems.

In order to successfully implement the Review's proposed vision for PHNs in mental health, a number of conditions will first need to be met.

- PHNs must be able to demonstrate they have the required capacity to undertake increased responsibility in mental health, including mental health representation in PHN staff, on Boards and Clinical and Community Councils, and mechanisms for collating, assessing and meeting the needs of mental health consumers and services available at the local level.
- Decisions around which mental health programs are cashed-out to PHNs must be guided by clear evidence that doing so will be more effective and cost-efficient than under existing funding arrangements.
- Clear criteria and objectives to guide mental health spending are needed, to ensure continuity of service access, availability and quality. In addition, guidelines should be developed to assist PHNs to balance funding priorities both within mental health and with other existing responsibilities across primary care. For instance, it is unclear how PHNs would balance priorities between complex/chronic (mental health) conditions, early intervention and population health initiatives.
- Given the corporate structure of PHNs presents commercial incentives for PHNs to fund low-cost service delivery options, safety and quality guidelines should apply to PHNs and the services they fund.
- The potential interaction between the PHN role in chronic/complex illness and the services that will be available through the National Disability Insurance Scheme (NDIS) needs to clarified.
- To ensure accountability and transparency of PHNs and the services they fund, work is needed to develop, test and implement appropriate indicators of mental health outcomes. Additional support may also be required to build the capacity of PHNs and service providers to administer and interpret such data.

Without more detailed information on these and other implementation issues, it is not possible to assess the likely impacts of a greater role for PHNs in mental health on service continuity and levels of service access in the community. The APS therefore recommends the Government proceed with caution in this area, including further consultation to develop a nationally consistent approach to implementation and evaluation of this proposal.