AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC

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Feedback to the Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia

18 September, 2024

To the House Standing Committee,

The Australian Association of Psychologists incorporated (AAPi) thanks the House of Representatives Standing Committee on Health, Aged Care and Sport for the opportunity to provide information and recommendations on the health impacts of alcohol and other drug (AOD) use in Australia. The Australian Association of Psychologists Incorporated (AAPi) are the leading not-for-profit peak body representing psychologists Australia-wide. We advocate for ease of access and affordability so all Australians can receive the psychological help they need when they need it. AAPi is committed to advocating for the mental health and well-being of all Australians and recognises the profound impact that AOD use has on individuals, families, and communities across the nation.

Please see our responses to the Terms of Reference below.

a) Assess whether current services across the alcohol and other drugs sector is delivering equity for all Australians, value for money, and the best outcomes for individuals, their families, and society;

AOD treatment programs have been shown to be a cost-effective strategy; with every $1.00 spent, $8.00 in benefits is returned (Coyne et al., 2015). Even with the significant benefits associated with AOD treatment, problems exist within the AOD treatment sector. Australia has a large unmet demand for treatment services (Victorian Ombudsman, 2017). The publicly funded AOD treatment sector is chronically underfunded due to increasing demand for treatment (Ritter & Stoove, 2016; The Royal College of Physicians, 2017). The increase in demand for services has resulted in a gap in the number of available services, to which the private sector has responded by increasing the number of services they provide (The Conversation, 2018). Significant issues have been raised about the provision of treatment services by the private sector. These issues include the financial exploitation of patients and their families and the use of non-evidence-based therapies (Allen et al., 2019).

Some privately funded treatment services are known to cost up to $32,500 and often involve a prepayment model (Health Complaints Commissioner Victoria, 2022). A lack of informed consent around financial and treatment decisions has also been the subject of complaints (Health Complaints Commissioner Victoria, 2022). Other problems include the lack of restrictions on who may own and operate an AOD treatment facility (Henriksen, 2024). Concerns include poor access to appropriate treatment in a timely manner, limited availability of specialists in addiction medicine and addiction psychiatry and psychology, substandard post-treatment support, and exploitive pricing practices (Henriksen, 2024).

While there are many dedicated professionals and services within the sector, disparities in access and outcomes remain, particularly for vulnerable populations. Unfortunately, many of the most marginalised groups are impacted by unequal access. The transgenerational impacts of colonisation, which include dispossession, intergenerational trauma, racism, social and economic exclusion and marginalisation, place First Nations and Torres Strait Islander peoples in Australia at significant risk of AOD use and its associated harms. (Krakouer, Savaglio, Taylor, & Skouteris, 2022)

Youth AOD use and challenges are also of concern. Almost 40% of all people receiving drug and alcohol treatment in Australia are aged under 30 (Moensted, Little, Haber, & Day, 2024).

Numerous barriers exist for young people to access services. Young people are reluctant to engage in health and treatment services. Limited health literacy, lack of knowledge of services, difficulties navigating the health system, geographic isolation, poverty, social exclusion, language barriers and concerns about confidentiality are also significant barriers for young people seeking treatment.

For a large proportion of clients, their AOD services are provided by psychologists and other mental health professionals operating in the private sector in small private practices. Therefore, the current research on the barriers and facilitators of mental health service utilisation is also relevant when considering access equity and efficacy of AOD services. There is a shortage of psychologists in most rural and remote areas of Australia, leading to long wait times and limited access to services. The McKell Institute previously found that the supply of psychological services has not kept up with the demand for them, ultimately making mental health care more difficult to access. While there is no conclusive measure of the demand for mental health services, several data series can serve as useful proxies. For example, the proportion of adults in NSW experiencing psychological distress increased by 72% between 2013 and 2021. However, the number of psychologists per 100,000 people increased by only 33 per cent over the same period. Offering financial incentives, such as higher reimbursement rates, tax credits, or grants to providers delivering services in underserved areas, can encourage higher workforce numbers in these areas. Bulk-billing incentives are an area that we recommend being expanded to include all allied health providers currently eligible to provide Medicare services.

Affordability of services provided in the private sector is a significant issue for clients presenting with drug and alcohol use concerns. AAPi recommends an immediate increase in the Medicare rebate to 100% of the scheduled fee. This is only a stopgap solution and not a long-term one, as the evidence is clear that the Medicare rebate needs to be increased by far more than this for all to afford care. This nominal increase, approximately $15-25 per session, will make care more affordable for many in the short term while longer-term solutions are evaluated. AAPi's Private Practice Survey, conducted in late 2022, found that over 80 per cent of respondents would bulk bill more if all psychologists' rebates were raised to $150. Addressing the cost barriers to psychological treatment is also evidenced in Under Pressure: Australia's Mental Health Emergency. In a study by Richardson et al., 2008 , the impact of fee increases for mental health services on service utilisation and mental health outcomes in Australia is detailed. The fee increase led to a decrease in the number of patient services. A 10% increase in the rebate led to a 3.4% increase in service utilisation and a 1.3% increase in mental health outcomes.

Equalising funding across programs is another area that needs to be addressed. Chronic Disease items that are often used to address chronic health conditions experienced by substance-using individuals (such as heart disease) are funded at inappropriate levels compared to Better Access, which has a rebate that is 60% less. These items must be increased to those commensurate with the Better Access rebate to reduce the additional financial access burden. In addition, severely inadequate session numbers are available to provide evidence-based treatment for those with chronic health problems.

Another initiative that can be undertaken to ensure mental health practitioners are available in regional and remote areas is the expansion of MBS eligibility to provisional psychologists to enable an additional 8,000 provisional psychologists to offer their clients Medicare rebates. Provisional psychologists are, at a minimum, four or five-year educated psychologists embarking on a final period of supervised practice, overseen and mentored by a qualified psychologist. They have studied each of the competencies required for registration and are

gaining relevant experience and supervision to meet full registration requirements. If a patient were to see a provisional psychologist, they would have no access to a Medicare rebate and would need to pay entirely out of pocket to access this service. We are underutilising almost 8,000 provisional psychologists. Given the increasing demand for psychology services and increasing waiting lists to access psychologists, we believe the deployment of provisional psychologists is an ideal solution to improve the availability of much-needed mental health care support for Australians. Creating a provisional psychologist Medicare rebate will provide an assured funding stream for more placement opportunities, reducing the current bottleneck in advancing students into fully qualified psychologists.

b) Examine the effectiveness of current programs and initiatives across all jurisdictions to improve prevention and reduction of alcohol and other drug-related health, social and economic harms, including in relation to identified priority populations and ensuring equity of access for all Australians to relevant treatment and prevention services;

AAPi believes that while many existing programs and initiatives have made significant contributions to reducing AOD-related harms, there is room for improvement. We recommend thoroughly evaluating programs across all jurisdictions, focusing on evidence-based practices. Priority should be given to programs demonstrating measurable success in preventing and reducing AOD-related health, social, and economic harms, especially among identified priority populations. Moreover, ensuring these programs are culturally sensitive and accessible to all Australians is paramount. The co-occurrence of mental illness and substance use problems is common and is often reported by service providers as the '…expectation rather than the exception…' (Merkes, Lewis, & Canaway, 2010). Comorbidity must be adequately treated.

The literature states that models that support good practice include developing and maintaining linkages and partnerships with a diverse range of allied services to ensure specialised, coordinated treatment and continuity of care for clients is paramount. The overall level of qualified staff and the lack of difference between AOD and combined services in their level of staffing contrasts with the literature, where it is commonly reported that the AOD treatment workforce includes a high number of counselling staff with experience-based rather than formal training (Merkes, Lewis, & Canaway, 2010). Services must also have explicit policies and procedures, including those related to intake, comorbidity screening, treatment guidelines, referral, discharge planning, and client feedback (Merkes, Lewis, & Canaway, 2010).

For First Nations people, the most common component of best practice recommendations was 'culturally safe, appropriate, or responsive', which included a focus on cultural engagement, restoring cultural connections, First Nations-specific resources, support delivered 'on Country', aligning with First Nations peoples' cultures, values and traditions, and involving the local community. These cultural elements have been shown to positively influence the patient-clinician relationship, which is a key predictor of treatment effectiveness (Krakouer et al., 2022).

Improving access to services through providing culturally acceptable services and models of care is crucial to improving AOD-related outcomes among First Nations adults. Indeed, the emphasis on culture is crucial in ensuring the success of such programs. Specifically, First Nations clients valued when programs were delivered by local First Nations community members, leaders or Elders. Internationally, support models involving the local community facilitate trust and rapport, encouraging engagement, program uptake and promoting awareness of the service across diverse, international First Nations communities (Krakouer et

al., 2022). While it is acknowledged that in practice, many First Nations peoples in Australia will receive treatment from non-Indigenous health workers, the current findings highlight that Aboriginal and/or Torres Strait Islander clients perceive that having a worker who is also Aboriginal and/or Torres Strait Islander is generally more acceptable.

Practical implications may include ensuring that First Nations clients can choose their worker to potentially enhance engagement. This warrants a greater focus on building the workforce capacity of local First Nations AOD workers and counsellors to increase the reach and access to community-based AOD treatment for First Nations peoples across Australia (Krakouer et al., 2022).

c) Examine how sectors beyond health, including for example education, employment, justice, social services and housing can contribute to prevention, early intervention, recovery and reduction of alcohol and other drug-related harms in Australia; and

The intersection of AOD issues with sectors beyond health, such as education, employment, justice, social services, and housing, cannot be overstated. AAPi advocates for a holistic approach to AOD prevention, early intervention, and recovery that leverages the strengths of these sectors. We recommend developing integrated, cross-sector strategies that address the root causes of AOD-related harms, such as social determinants of health, and that provide comprehensive support for individuals and families affected by AOD use.

Young people benefit from a treatment system that allows them to account for the unique conditions of their lives. Trauma, poverty and entrenched disadvantage are not prerequisites for substance use but are strong risk factors (Moensted, Little, Haber, & Day, 2024). Young people who experience disadvantage are both over-represented and underserviced in the Australian system. Responses to substance use must, therefore, comprehensively engage with the drivers of disadvantage and incorporate holistic approaches such as wraparound supports for intersecting needs. Broader strategies to reducing poverty, increasing retention in education and training, reducing un- and underemployment, providing affordable and secure housing, increasing access to suitable primary health care and early childhood services, including psychology services, support for navigating the justice systems and promoting positive community connections and opportunities for meaningful and active participation may prevent or reduce morbidity and mortality and the need for youth AOD treatment (Moensted, Little, Haber, & Day, 2024).

We recommend targeted changes to the accessibility and affordability of psychological support for Australians struggling with AOD use. Access to affordable psychology services in Australia remains out of reach for many, particularly those grappling with AOD issues. The cost barrier often prevents individuals from seeking essential mental health support, exacerbating their substance use challenges. This disparity highlights a critical need for enhanced accessibility measures that prioritise affordability, ensuring no Australian is left without the vital care they require to navigate complex issues like addiction.

Currently, psychology sessions rebated under Medicare are capped at a rate that often falls short of covering the true costs of quality mental health care and leaving the client paying significant costs out of pocket. Increasing the rebate to $150 per session for all psychologists would significantly improve accessibility to necessary services. This adjustment is crucial in supporting Australians managing substance use issues, as it allows psychologists to offer sustained, effective treatment without financial strain on clients, promoting better long-term

health outcomes and reducing the burden on individuals and families affected by addiction (McKell, 2023).

The shortage of psychologists in Australia's mental health workforce is an ongoing crisis that demands urgent attention. To address this, establishing a Medicare item number for provisional psychologists in their final two years of supervised study could alleviate pressure on senior practitioners. This initiative would empower provisional psychologists to manage lower-tier mental health concerns, freeing up experienced professionals to focus on complex challenges like AOD use and optimising the distribution of resources and expertise within the healthcare system.

Supporting more psychologists to live and work in rural and regional areas is essential, especially in communities disproportionately affected by substance use issues. By incentivising psychologists to practice in these areas through targeted initiatives such as subsidised education and infrastructure development, communities can benefit from increased access to specialised psychological care. This holistic approach improves local health outcomes and strengthens community resilience by fostering sustainable support networks and reducing the social and economic impacts of substance use.

d) Draw on domestic and international policy experiences and best practice, where appropriate.

Savic et al., (2017) identified several best practice strategies at the funding, organisational, service delivery and clinical levels. Ensuring that integrated care is included within service specifications of commissioning bodies and is adequately funded was found to be critical in effective integration. Cultivating positive inter-agency relationships underpinned and enabled the implementation of most strategies identified. Staff training in identifying and responding to needs beyond clinicians' primary area of expertise was considered important at a service level.

Sharing client information (subject to informed consent) was also critical for most integrated care strategies. Case management was found to be a particularly good approach to responding to the needs of clients with multiple and complex needs. At the clinical level, screening in areas beyond a clinician's primary area of practice was a common strategy for facilitating referral and integrated care, as was joint care planning (Savic et al., 2017).

Training of clinicians and case managers was one of the strategies identified by several studies to improve integrated working. One of their recommendations for enhancing collaboration was staff training in identifying and addressing comorbidity but also with respect to understanding the impact of comorbidity. It was also identified that AOD clinicians need to be trained to identify and respond to broader life and wellbeing issues (Savic et al., 2017). They also highlighted that training needs to include guidance about roles and responsibilities in addressing issues beyond a clinician's primary area of expertise. Training could also provide clinicians with an understanding of the different treatment models used by different agencies and how clients access care. They also cited the importance of ongoing coaching activities in reinforcing knowledge gained through training and facilitating implementation (Savic et al., 2017).

Thank you for allowing us to provide our recommendations to the inquiry. We look forward to working with you to better support the experience of all Australians living with AOD challenges, as well as their families and communities.

Sincerely,

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