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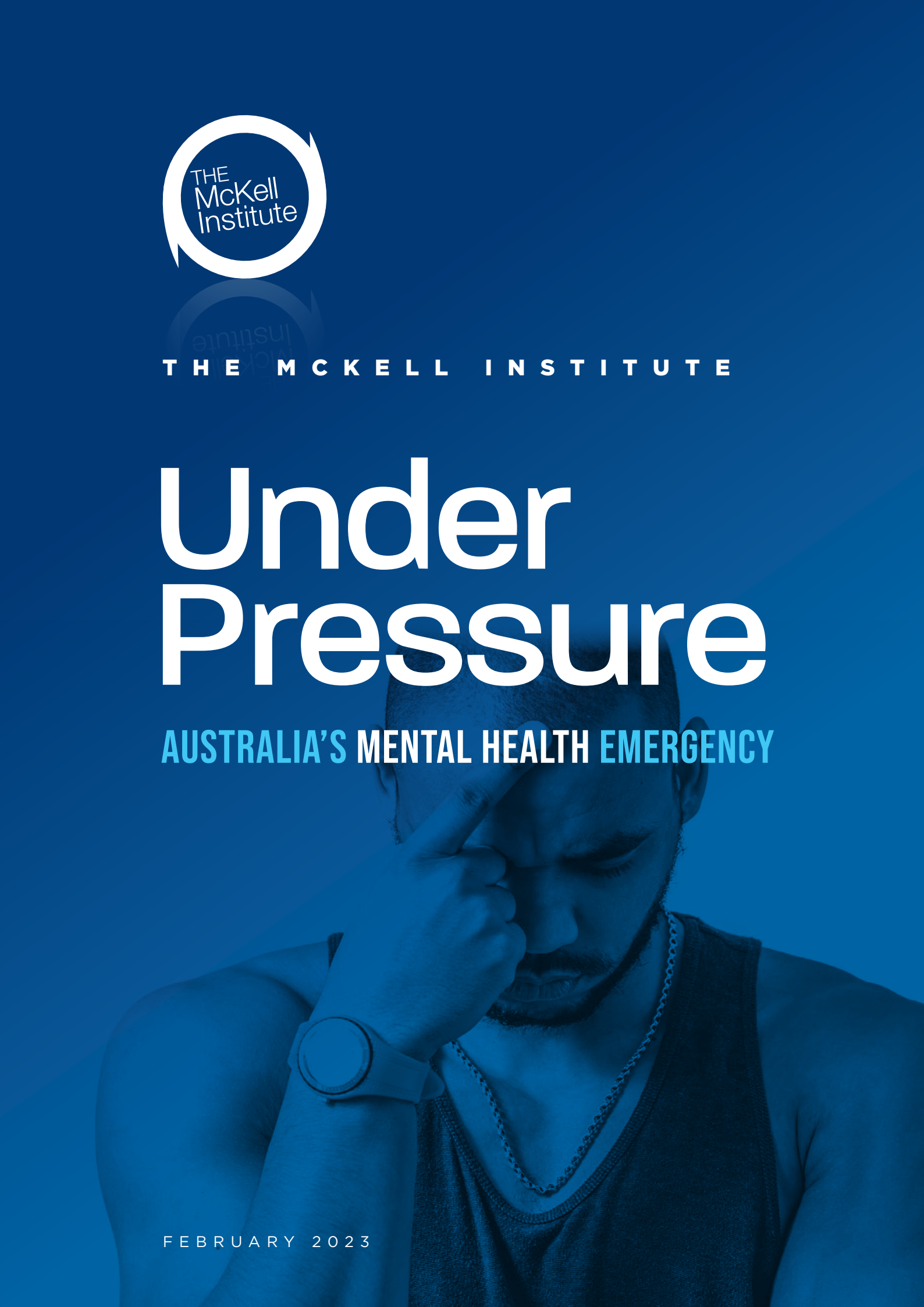
Under Pressure

AUSTRALIA'S MENTAL HEALTH EMERGENCY



FEBRUARY 2023

ABOUT THE MCKELL INSTITUTE

The McKell Institute is an independent, not-for-profit research organisation dedicated to advancing practical policy solutions to contemporary issues.

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ABOUT THIS REPORT

THIS REPORT HAS BEEN PREPARED BY **THE MCKELL INSTITUTE** WITH SUPPORT FROM **THE AUSTRALIAN ASSOCIATION OF PSYCHOLOGISTS INC.**

This report discusses suicide, suicidal ideation, and self-harm. If you or someone you know needs support, please reach out to your trusted healthcare professional OR CALL **Lifeline** on **13 11 14**

ACKNOWLEDGEMENT OF COUNTRY

This report was written on the lands of the Darug and the Eora Nations. The McKell Institute acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Owners of Country throughout Australia and their continuing connection to both their land and seas.

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EXECUTIVE SUMMARY

The mental health crisis in Australia is undeniable. According to pre-pandemic figures, almost one in five Australians experience mental illness each year, and almost 50 per cent of Australians experience mental illness during their lifetime. Many don't receive the treatment or support that they require. Accessing help can be difficult because of the availability of mental health professionals and the prohibitive costs. Not only that, the complete impact of the pandemic on mental health has yet to be fully understood, but the early indicators are worrying.

Since the onset of the COVID-19 pandemic, the number of individuals experiencing high levels of psychological distress has increased dramatically. In 2017, approximately 15 per cent of young workers reported high levels of psychological distress, however, this figure has doubled to more than 30 per cent since the onset of the pandemic. Not only that, but workers' compensation claims for mental stress have skyrocketed, increasing 73 per cent between 2000-01 to 2019-20. These claims also had the highest mediation cost, increasing by 273 per cent from $14,500 in 2000-01 to $53,900 in 2019- 20.

Simply, the drivers of mental ill-health are increasing, as is demand for services, but unless something is done to lower costs and increase the professional health services workforce, the gap between demand for mental health services and supply of those services will continue to grow.

PART 1 of this report explores the worsening mental health of Australians in more detail. This can be difficult to measure, so we look at psychological distress, workers' compensation claims for mental health-related issues, and rising suicidality and self-harm trends as indicators of the worsening mental health of Australians. **PART 2** focuses on some of the external drivers of mental ill-health, including climate change and extreme weather events, the COVID-19 pandemic, and the cost of living crisis.

In **PART 3** of the report, we look at the barriers to mental healthcare, finding that the shortage of available psychologists in Australia is particularly acute. As demand increases, there is more strain on the workforce, and many psychologists have either had to institute waiting lists or have closed their books to new patients entirely. Finally, Part 4 explores several recommendations that would help improve access to mental healthcare services over the short run and which can guide longer-term reform.

KEY FINDINGS

1 Demand for mental health services is increasing:

- In 2020-21, over two in five Australian adults (aged 16-85 years) reported having experienced a mental disorder over the course of their lifetime. One in five had a 12- month mental disorder—this refers to situations where people reported having experienced a mental disorder in their life and had significant symptoms of that disorder in the 12 months before the survey.
- In 2017, approximately 15 per cent of young workers reported high levels of psychological distress. This figure has doubled to more than 30 per cent since the onset of the pandemic.
- From 2000-01 – 2019-20, serious workers' compensation claims for mental health conditions grew by 73 per cent and represented 28 per cent of all disease claims in 2019-20.
- Since the beginning of the pandemic, psychologists have seen an increase in the demand for their services, with a 77 per cent increase in 2021 and a further 63 per cent increase in 2022. At the end of 2022, 38 per cent of psychologists were unable to see new clients. During the height of the pandemic, this figure increased to 46 per cent.

2 Mental ill-health comes at an economic cost to Australia:

- Mental stress claims also have the highest median compensation paid by mechanism of disease for all years in the Safe Work series (2000-01 and 2014-15 to 2019-20). In 2019-20, the median cost of a mental stress claim was $53,900. The largest rise in median compensation payments from 2000-01 to 2019-20 was for mental stress, increasing by 273 per cent from $14,500 in 2000-01 to $53,900 in 2019-20
- In 2018-19, the annual cost to the economy of mental ill-health and suicide in Australia was estimated to be up to $70 billion.

3 Mental health workforce shortages can be alleviated by mobilising provisional psychologists:

- Three out of four psychologists now have waitlists. Additionally, 52.84 per cent of clients on waiting lists are waiting longer than 4-6 weeks, and 27 per cent have to wait longer than two months.
- The proportion of adults in NSW experiencing psychological distress increased by 72 per cent between 2013 and 2021. At that same time, the number of general psychologists per 100,000 people only increased by only 33 per cent.
- In the last five years, the number of workers' compensation claims relating to mental stress has increased by 65.15 per cent.
- 7,977 provisional psychologists are unable to provide their clients with Medicare rebates.
- Allowing provisional psychologists to offer their clients Medicare rebates would increase the total number of individuals able to provide psychological services by 22.5 per cent, substantially addressing the demand for mental health services and the availability of professionals to address it.

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PART ONE:
THE MENTAL HEALTH OF AUSTRALIANS IS DECLINING AS THE DEMAND FOR SUPPORT IS INCREASING

Mental health is essential to our overall health and wellbeing. Mental illnesses and/or disorders are characterised by a disturbance in an individual's cognition, emotional regulation, or behaviour and are usually associated with distress or impairment in important areas pertaining to the function of everyday life.[1]

Within Australia's mental health landscape, two of the largest barriers to access are the cost of services, including high out-of-pocket fees and the timeliness of services (insofar as there is a shortage of available psychologists and waiting lists are prohibitively long).

The McKell Institute previously found that between 2013 and 2021, there was a 34.5 per cent increase in the usage of mental health services. From 2019 to 2021 alone, national crisis calls increased by 37 per cent.[2] Further, in 2020-21, over two in five Australian adults (aged 16-85 years) reported having experienced a mental disorder over the course of their lifetime.[3] One in five had a 12-month mental disorder, with anxiety being the most common group of 12- month disorders. The 12-month disorders refer to situations where people report having experienced a mental disorder in their life and had significant symptoms of that disorder in the 12 months before the survey.

In addition to tracking the increase in anxiety and depression-related illnesses, measuring the levels of psychological distress also sheds light on the mental health and wellbeing of Australians. This can be done using the Kessler Psychological Distress Scale (K10), which was developed to yield a global measure of psychological distress based on an individual's level of nervousness, agitation, psychological fatigue, and depression over the preceding 30 days.[4] Before the pandemic in 2017-18, approximately one in eight Australians aged 18 years or over experienced high or very high levels of psychological distress.[5] Those who lived in the most disadvantaged areas across Australia were more than twice as likely to experience high or very high levels of psychological distress.[6]


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NEVER OPERATE, SERVICE
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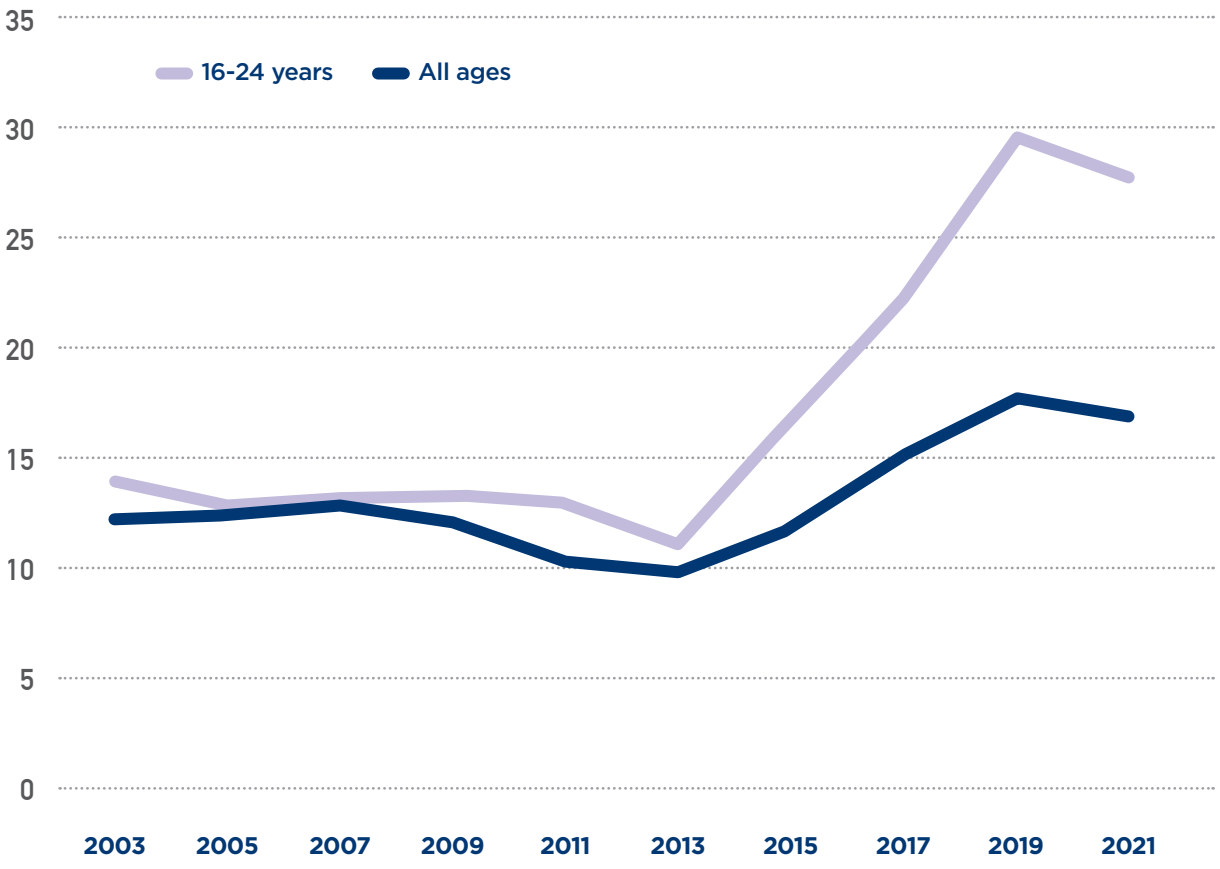
PROPER INSTRUCTIONS.
READ OPERATING MANUAL
FURTHER INSTRUCTIONS.

The Australian National Health Survey has collected data on the prevalence and risk factors around long-term conditions every three years for the past 30 years.[7] The survey assesses mental health according to the K10.

In 2020-21, the ABS conducted the first study in the latest series on the National Study of Mental Health and Wellbeing, which is part of a wider piece of work on intergenerational health and mental health.[8] In a release of its preliminary findings, the ABS reported that 15 per cent of Australians aged 16-85 experienced high or very high levels of psychological distress. Of those Australians experiencing psychological distress, only 13 per cent saw a General Practitioner (GP) and just eight per cent saw a psychologist.

Over the last ten years, we have seen a worsening of mental health symptoms in Australian workers aged 18 to 34. This trend has increased dramatically in response to the COVID-19 pandemic. In 2017, approximately 15 per cent of young workers reported high levels of psychological distress, however, this figure has doubled to more than 30 per cent since the onset of the pandemic.[9] The annual New South Wales Population Health Survey shows that since 2013, psychological distress in young people aged 16-24 has increased at rates dramatically higher than other age groups (see Figure 1).[10]

FIGURE 1 PERCENTAGE OF HIGH OR VERY HIGH PSYCHOLOGICAL DISTRESS IN ADULTS BY AGE (YEARS)



Source: Centre for Epidemiology and Evidence.[11]

An alternative method of measuring the mental health of Australians that accounts for a level of severity is to look at the rise in mental health claims through the workers' compensation system. National data collected on accepted workers' compensation claims over the past 20 years indicates a sustained increase in the claims for work-related injuries attributed to mental health conditions.[12]

TABLE 1 NUMBER OF SERIOUS CLAIMS BY DISEASE, 2000-02 AND 2014-15 TO 2020-21

NATURE OF INJURY OR DISEASE	2000 – 2001	2015 – 2016	2016 – 2017	2017 – 2018	2018 – 2019	2019 – 2020	% chg	2020-21p
DISEASES								
Mental health conditions	**6,607**	**6,931**	**7,813**	**8,641**	**10,729**	**11,410**	**73**	**12,155**
Digestive system diseases	3,233	2,305	2,234	2,132	2,223	2,141	-34	1989
Nervous system and sense organ diseases	1,595	1,115	1,170	1,193	1,234	1,379	-14	1474
Skin and subcutaneous tissue diseases	853	440	461	425	464	467	-45	460
Respiratory system diseases	281	206	244	240	454	338	20	264
Neoplasms (cancer)	61	37	64	46	75	79	30	52
Infectious and parasitic diseases	298	221	216	174	223	284	-5	608
Circulatory system diseases	190	112	118	111	140	130	-32	103
TOTAL: DISEASES	**13,297**	**11,451**	**12,403**	**13,073**	**15,626**	**16,308**	**23**	**17,218**

Source: Safe Work Australian workers' compensation statistics 2020-21[13]

From 2000-01 to 2019-20, serious claims for diseases increased by 23 overwhelmingly due to an increase in the number of serious claims conditions, which grew by 73 per cent over the stated period, and represented 28 per cent of all disease claims in 2019-20 (see Table 1).[14] By comparison, the number of claims for most other disease types decreased over that same amount of time.[15]

While these numbers might seem staggering, they must also be considered in light of Australian population growth over the past two decades. Between June 2001 and June 2020, Australia's population grew by 33 per cent, which is a significant increase, although still less than half of that seen in mental-health-related workers' compensation claims.

Further, the median time lost for successful mental health-related claims experienced a 157 per cent change between 2000-01 and 2019-20, rising from 11.4 working weeks in 2000-01 to 29.3 working weeks in 2019-20.[16] Mental stress claims involved the longest median time lost for all years in the series. By 2019-20, the median time lost for these claims had risen more than three times the median time lost for all claims (29.3 working weeks, compared to 7 working weeks for all claims).[17] Here, injured workers can receive compensation for a psychological injury such as PTSD, anxiety, and/or depression if the worker meets the scheme's definition of 'worker' and if work is a significant contributing factor to said psychological injury.[18]

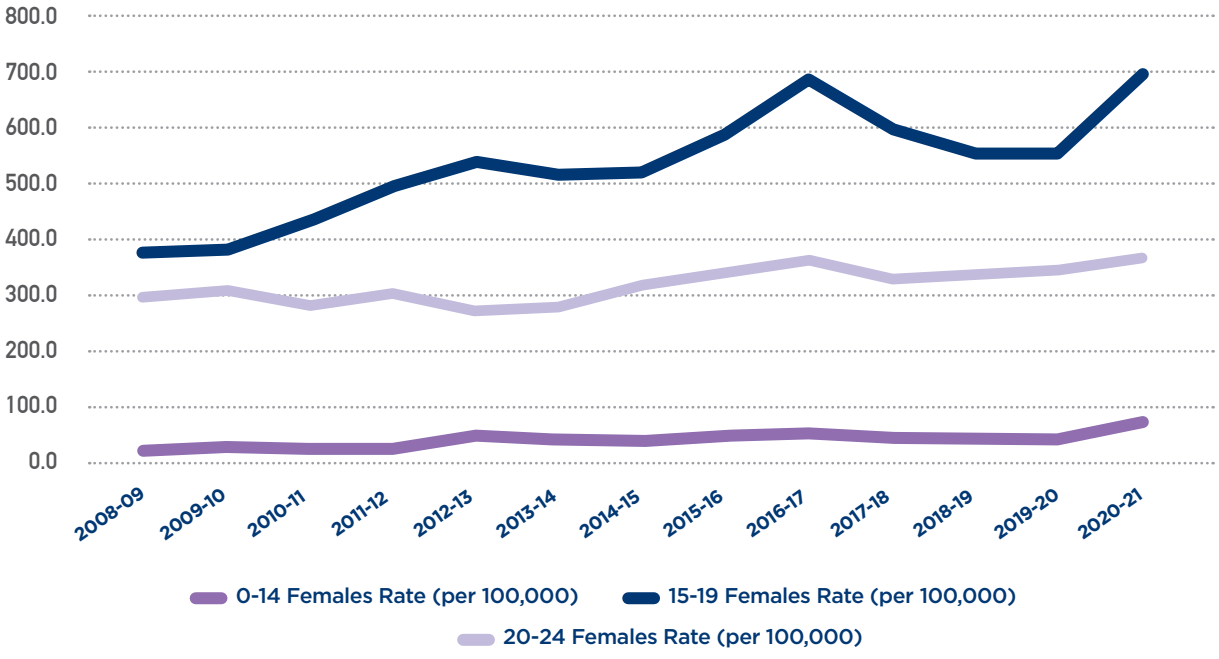
Additionally, mental stress claims have the highest median compensation paid by mechanism of disease for all years in the Safe Work series (2000-01 and 2014-15 to 2019-20).[19] In 2019- 20, the median cost of a mental stress claim was $53,900. The largest rise in median compensation payments (again, by the mechanism of disease as opposed to its nature) from 2000-01 to 2019-20 was for mental stress, increasing by 273 per cent from $14,500 in 2000- 01 to $53,900 in 2019-20.[20] While the mental health landscape and trends in Australia are broader and more complicated than those cases that end up in workers' compensation claims, it is nevertheless useful to look at workers' compensation claim trends as a proxy for broader workplace impacts on mental health and costs.

Suicidality and self-harm are on the rise

The odds of dying by suicide are higher among those from the lowest income group when compared to the highest income group.[21] The probability of dying by suicide was higher among those experiencing longer periods of unemployment. Those who were unemployed for four years were estimated to be twice as likely to die by suicide compared to the employed group.[22] The odds of dying by suicide are higher among those with higher levels of income uncertainty compared to those with lower variations in income, regardless of overall income levels. [23]

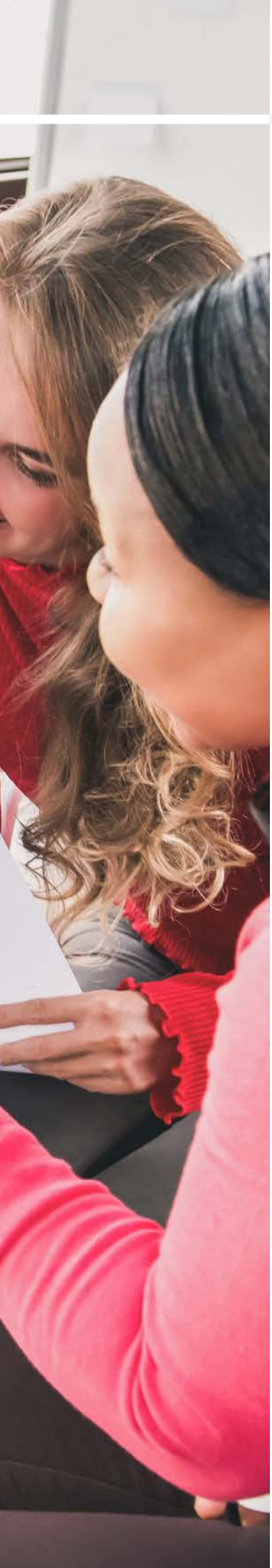
Yet, the mental health crisis is not limited to working-age adults and those who can make workers' compensation claims. According to the Australian Institute for Health and Welfare, there has been an increase in the intentional self-harm hospitalisation rate for females aged 0-14 years (from 41 per 100,000 population in 2019–20 to 70 in 2020–21). Intentional self- harm hospitalisations in this age group have been following an upward trend for a while, increasing from 19 hospitalisations per 100,000 in 2008–09 (see Figure 2). In 2020–21, there were nearly 30,000 hospitalisations due to intentional self-harm in Australia. Of these, two- thirds were female (66 per cent, or over 19,800 hospitalisations in 2020-21 compared to 63 per cent, over 18,000 hospitalisations in 2019-20).[24]

FIGURE 2 INTENTIONAL SELF-HARM HOSPITALISATIONS IN FEMALES, 2008-09 TO 2020-21



Source: AIHW National Hospital Morbidity Database, supplementary table NHMD S4[25]

Demand for mental health services in Australia is increasing. There are also significant external social and environmental factors that contribute to the decline in mental health, namely, an increase in the frequency and severity of extreme weather events, the COVID-19 pandemic, and the cost of living crisis (to be discussed below). Furthermore, access to services to alleviate mental ill-health are prohibitively expensive and waitlists and workforce shortages are also nigh on insurmountable barriers to better health for everyday Australians.



PART TWO:
WHAT IS DRIVING MENTAL HEALTH ISSUES IN AUSTRALIA

There is a long-term trend in terms of the rise of mental ill-health. While this can be linked to increased awareness and better reporting mechanisms, it is also due to external social and environmental factors that exacerbate or trigger mental illness. Thus, while some people might have a genetic predisposition to mental illness, biology isn't the only determining factor that shapes and impacts an individual's mental health.

External factors, be they social, environmental, or financial also affect mental health and wellbeing. These external drivers will always be a factor in shaping how people perceive and interact with the world around them. Therefore, we need to ensure that we, as a nation, are providing as much support as possible to those in need.

Climate change and extreme weather events negatively impact mental health

Climate change is irrefutable. That change is impacting extreme weather events, which are increasing in both severity and frequency around the world. There is a strong link between mental health disorders and extreme weather events, with impacts that include increased rates and occurrences of people who suffer from anxiety and mood disorders, sleep disruption and deprivation, acute stress reactions and post-traumatic stress disorders, and suicide and suicidal ideation.[26]

Other impacts and consequences of the link between mental health and climate change are the effects on individuals and communities in their everyday lives, perceptions, and experiences, coping with climate change and its implications. This may also trigger a reduction in daily activities and the loss of a sense of self and place, potentially exacerbating existing mental health risks. These responses can linger for months, or even years, after an event.

The Royal Commission into National Natural Disaster Arrangements found that the mental health effects of natural disasters can endure over long periods and that it may also take time for the symptoms to present themselves.[27] Following the Victorian bushfires in 2009, 21.9 per cent of people who lived in highly impacted areas were still reporting symptoms of mental health disorders five years later.[28] Further, a recent Curtin University study also found that children and adolescents require elevated support for years following natural disasters and they reported significantly higher rates of depression and anxiety.[29] With natural disasters anticipated to increase, the pressure on Australia's mental health system will continue to grow.

COVID-19 has exacerbated and triggered mental illnesses

Over the course of the pandemic, the World Health Organisation (WHO) has repeatedly expressed concerns over the mental health and psychological impacts and ramifications of the outbreak.[30]

As well as the anxiety and the global concern associated with the fear of contracting the virus, as well as the fear of long-lasting symptoms or death for those who are already ill, the public

health measures enacted to curb the further spread of the virus only served to exacerbate or even trigger mental illness.[31]

Social distancing restrictions, which placed limits on an individual's activities outside the home to those that were considered absolutely essential, were found to increase social isolation and loneliness,[32] alcohol abuse,[33] and domestic violence.[34] In April 2020, a survey of over 1,500 Australians found that 22.1 per cent of respondents reported symptoms of anxiety, and 21.9 per cent reported symptoms of depression.[35]

Overall, ongoing research into the impact of the COVID-19 pandemic on mental health has made it clear that increased mental health support will be of paramount importance as the world continues to face the consequences of the pandemic.[36]

There is a cost of living crisis in Australia

Health and socioeconomic positions exist on a gradient, where the least well-off people in society often face the worst health outcomes, while the inverse is also true. This means that social inequalities impact health inequalities.[37]

According to Suicide Prevention Australia's annual State of the Nation report, 40 per cent of Australians feel more distressed over finances when compared to the previous year. It is the first time that economic stress has overtaken social issues such as drug abuse, loneliness, and family dysfunction as the primary reason for self-harm.[38]

According to 2022 YouGov polling on suicide prevention, the top three circumstances causing increased and sustained levels of distress are the cost of living and personal debt (40 per cent), social isolation (26 per cent), and family and relationship breakdowns (23 per cent).[39]

PART THREE: UNDERSTANDING THE BARRIERS TO ACCESS

As of 2021, the former federal government was only reaching 35 per cent of its psychology workforce target.[40] This presents substantial challenges that the new Government must address to improve access. The workforce shortage is so grave that one in three psychologists have reported closing their books to new patients due to overwhelming demand.[41]

Three out of four psychologists now have waitlists.[42] Additionally, 52.84 per cent of clients on waiting lists are waiting longer than 4-6 weeks, and 27 per cent have to wait longer than two months.[43] Hundreds of hospital-based psychology positions are unfilled, with patients (children included) waiting up to two years for care.[44]

Access and costs of services are chief concerns when it comes to the Australian mental health system

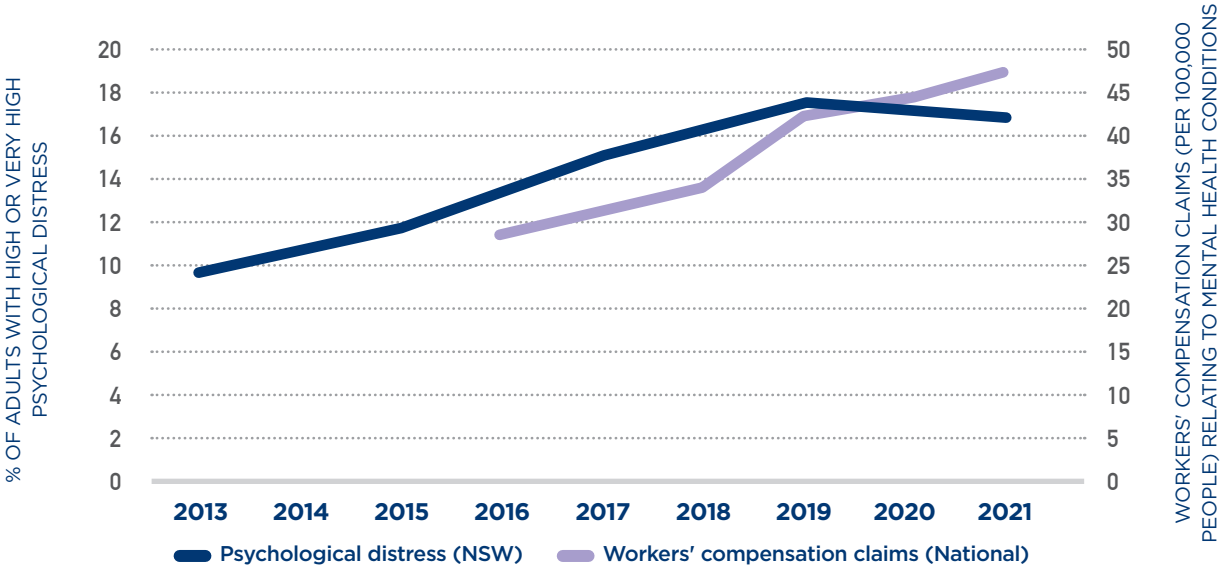
As should be clear by now, mental ill-health and suicide are significant public health issues in Australia. These issues have only been heightened by the COVID-19 pandemic.

Despite this, the supply of psychological services has not kept up with the demand for them, ultimately making them 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 per cent between 2013 and 2021 (Figure 3).* The number of general psychologists per 100,000 people, however, increased by only 33 per cent over the same period (Figure 4).

** National data covering this same period is unavailable.*

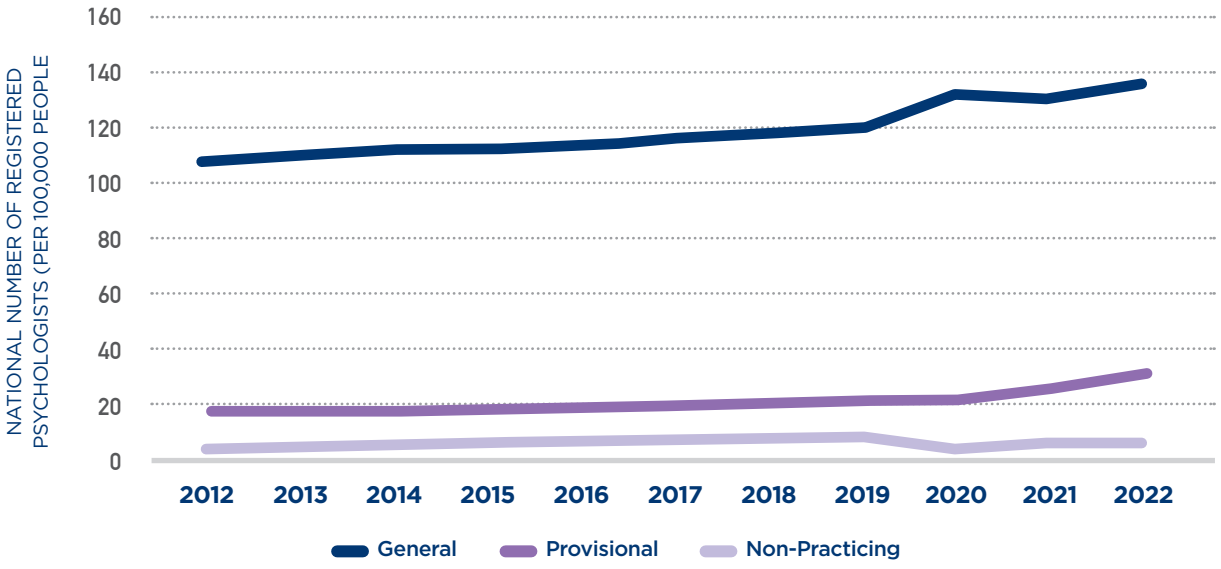
Another proxy for the demand for mental health services is the number of mental-health- related national workers' compensation claims per 100,00 people. Data is only available from 2016, but in the five years between 2016 and 2021 alone, this metric increased by 65.15 per cent (Figure 3), while the number of registered psychologists per 100,000 people increased by just 21 per cent (Figure 4).

FIGURE 3 DEMAND FOR MENTAL HEALTH SERVICES



Source: Author calculations using HealthStats NSW[45], Safe Work workers' compensation statistics[46], and ABS population data[47]

FIGURE 4 SUPPLY OF PSYCHOLOGICAL SERVICES

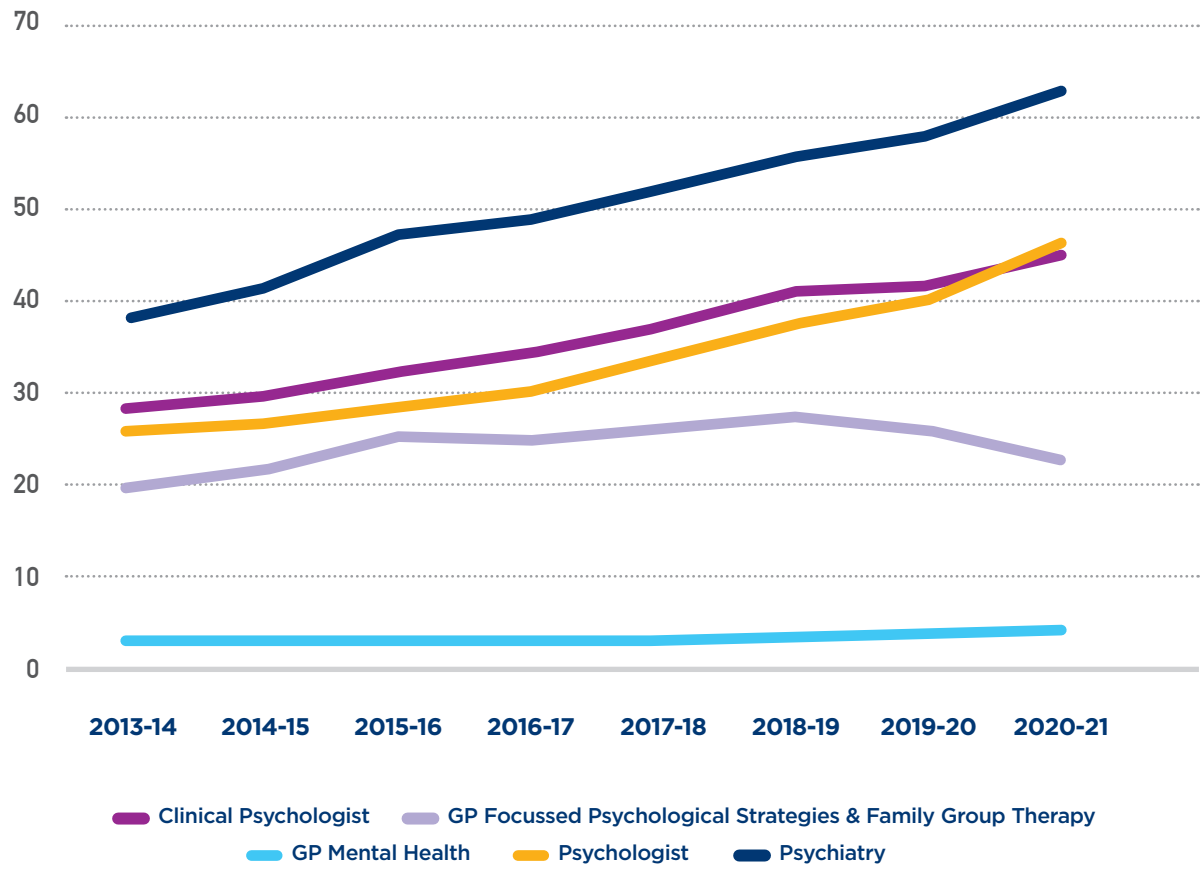


Source: Author calculations using registration statistics from AHPRA[48] and ABS population data[49]

The cost of services and high out-of-pocket expenses is one of the top concerns when it comes to people accessing mental health care. Second to that is accessibility in terms of the timeliness of that service, where waiting lists act as a barrier to entry into the mental health system.

Regarding prohibitive costs of services, out-of-pocket payments for mental health care in Australia have been rising consistently over the period of 2013-21 (Figure 5—adjusted for inflation and reported in 2021 dollars), at a considerably faster rate than the overall expenditure on mental health care.[50] Over that same period, out-of-pocket payments for psychologists have nearly doubled.[51]

FIGURE 5 AVERAGE OUT-OF-POCKET PAYMENT (REAL) PER SERVICE, BY PROFESSION



Source: Author calculations using AIHW Medicare-subsidised services data[52]

In terms of timeliness, since the beginning of the pandemic, psychologists have seen an increase in the demand for their services, with a 77 per cent increase in 2021 and a further 63 per cent increase in 2022.[53] According to the Australian Association for Psychologists Incorporated (AAPi), at the end of 2022, 38 per cent of psychologists were unable to see new clients. During the height of the pandemic, this figure increased to 46 per cent. This issue of timeliness of service, created by a shortage of available and qualified psychologists, will be discussed in more detail over the page.

The consequences of inaction are socially and economically dire

In 2020, the Productivity Commission (PC) published its final report on the Mental Health Inquiry. The Commission found that Australia's current mental health system does not sufficiently cater to those in need, and that reform of the system would engender significant benefits to the quality of life for those suffering from mental illness valued at up to $18 billion per annum, with the added yearly benefit of $1.3 billion due to increased economic participation.[54]

According to the report, in 2018-19, the annual cost to the economy of mental ill-health and suicide in Australia was estimated to be up to $70 billion. Breaking that down, the direct expenditure on mental healthcare and support services is approximately $16 billion, and the annual cost of lower economic participation and lost productivity was up to $39 billion. The total annual cost of replacing the support provided by carers of those with mental illness was about $15 billion.[55] Not only that, but the cost of disability and premature death due to mental illness, suicide, and self-inflicted injury was equivalent to a further $151 billion per year.[56]

Thus, investing in mental health care services will be economically and socially beneficial in the long term. This will allow those in the community to access affordable and timely services, rather than escalating their care needs through emergency departments, as well as a loss of productivity.

Better Access needs to be maintained

The Better Access to Psychiatrists, Psychologists, and General Practitioners through the Medicare Benefits Schedule Initiative (Better Access) commenced in November 2006 and consists of a series of item numbers on the Medicare Benefits Scheme (MBS).[57] The MBS lists services that the Australian Government provides rebates for, assisting consumers in paying for these services. Each service is associated with a schedule fee, and the rebate is paid as a percentage of the schedule fee.[58]

Within the scheme of Better Access, rebates are available for the following services:

1. preparation and review of mental health treatment plans and provision of mental health care consultations by general practitioners (GPs) and other medical practitioners,
2. delivery of psychological therapy services by clinical psychologists, and
3. delivery of focussed psychological strategies by GPs, other medical practitioners, psychologists, social workers, and occupational therapists.[59]

In December 2022, an independent evaluation of Better Access found that while the scheme had broadened access to mental health services to some degree, it is not delivering for all Australians equally. However, for those who did receive treatment through Better Access, the outcomes were largely positive, no matter how those outcomes were measured.[60]

While Better Access improved access to mental health support for some portions of the population, the predominant reason people in lower socioeconomic brackets were not able to access psychologists was that the Medicare rebates were too low. Those people still had to pay out-of-pocket expenses, which were too high.

This was also raised by allied health professionals who, in their submission to the Better Access Evaluation, stated that concerning affordability, they were often forced to charge significant co-payments because the rebates were too low, meaning that the cost of care is prohibitive for people in the lower socioeconomic tiers. In terms of the timeliness of care, and due to a workforce shortage, waiting lists also account for a high barrier to access.[61] Again, as a solution to this, expanding eligibility requirements to additional providers such as provisional psychologists would greatly increase the number of professionals who could address the shortage.

As of the September 2022 quarter, this would allow 7,977 provisional psychologists to offer rebates to their clients, thereby making their services more affordable, and opening them up to ease the demand on psychologists already eligible to provide Medicare services. The inclusion of these 7,977 provisional psychologists would increase the number of professionals delivering subsidised psychological services by 22.5 per cent, significantly addressing the rise in demand for mental health services.

CASE STUDY

THE UK MODEL OF IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) WORKS

The Improving Access to Psychological Therapies (IAPT) programme was introduced in England in 2008. It is a national-level dissemination programme for the provision of evidence- based psychological treatments for anxiety and depression. Evidence suggests that IAPT enables access to therapies for many patients. In 2020, approximately 4.9 of 7.5 million referrals received psychological treatment (with national statistics being introduced in 2012).[62]

IAPT services have three unique features that contribute to its efficacy and scalability: firstly, a stepped care model of service provision; secondly, the implementation of evidence-based and highly standardised and protocol-driven treatments; and thirdly, the systematic use of routine outcome monitoring.[63]

As the IAPT initiative expanded, to avoid a workforce shortage, the program depended on the recruitment and/or creation of a new mental health workforce.

This resulted in the establishment of the Psychological Wellbeing Practitioner (PWP) role.

These PWPs, who are more junior members of staff, conduct the initial assessments.[64] In other words, as one of the unique features that the IAPT programme offers, the stepped care model requires the PWPs to manage first contact, patient appraisal, as well as low-intensity treatment.

Stepped care consists of the delivery of increasingly intense and frequent psychological treatments that are dispensed sequentially and according to an individual's needs.[65]

Due to the nature of the model, a substantial proportion of patients initially receive 'low intensity' treatments (such as self-help or psychoeducational classes) delivered at step 2. Those patients who fail to respond to low-intensity treatment are 'stepped up' to step 3 for more traditional 'high-intensity' face-to-face treatments.[66]

With the stepped care model and the creation of the PWP workforce in place, IAPT now sees over one million people a year, with waiting times being much improved since the program started. The latest data shows the average wait time for people to be seen is 19 days.[67]

PART FOUR: RECOMMENDATIONS

Addressing access to mental healthcare will require substantial long-term changes to the provision of health services in Australia. The separate but related issues when it comes to barriers to access are those of cost and the undersupply of services (due to the demand for services outstripping the supply of available mental health professionals).

In the long run, Australia should aspire to universal access to mental health services for every citizen. Access and intensity should be based on need, with the number of sessions determined by clinical assessment. In this way, sessions would be delivered flexibly and responsively based on the patients evolving treatment needs.

This could be achieved by implementing a nationally integrated MBS and stepped care mental health system. Stepped care is an approach to mental health support that is person-centred, supporting people across a range of needs and severity. For instance, provisional psychologists might be the ones who treat and support those with low to medium-range issues and experienced psychologists would be freed up to deal with the more chronic and complex cases. In this way, the stepped care model is one where service intensity is matched to an individual's treatment needs and the severity of their mental health issues.

In consultation with the healthcare industry, the Government would provide certain guidelines to clinicians for the parameters under which patients would be classified into separate categories (mild, intermediate, severe), all of which would require different levels and modes of treatment. The most complex cases would receive an ongoing and uncapped number of sessions, while the intermediate and mild cases might receive capped sessions which could be revisited by their clinician along the way.

It should be noted that while a stepped healthcare model has technically been adopted in Australia, and is the explicit policy of the Primary Health Network initiative, its implementation has been less straightforward. Further, Australia trialled a stepped mental healthcare model in 2013 called NewAccess (which was based on the UK's IAPT program), so the initiative's theoretical and implementation strengths and weaknesses would need to be revisited to make sure the efficacy of a stepped care model was maximised.

In the shorter term, increasing the subsidy for mental health services will be essential to providing and improving access. However, the immediate priority should be ensuring we have the workforce to cope with the demand. Allowing provisional psychologists to offer their clients rebates would provide an almost 8000-person infusion to the workforce, which represents a 22.5 per cent increase in employment. In time, the system needs to be reshaped and remodelled and the eligibility criteria could be expanded to include accredited counsellors and mental health nurses, but for the time being, allowing provisional psychologists to offer their clients the MBS rebates would be a good first step.

The additional recommendations below would further assist in the improvement of both access and affordability.

RECOMMENDATIONS TO IMPROVE AFFORDABILITY

1. Provide access to additional subsidised psychological therapy sessions under the current MBS for those with more complex needs.

With the limited supply of psychologists, the mental health care system should prioritise greater access to those with complex needs, until a more universal stepped care model can be adopted.

2. Increase the Medicare rebates for mental health services.

The Medicare rebate for mental health patients should be increased. This would decrease the out-of-pocket expenses, ensuring that mental health services would be more accessible for those in lower socioeconomic areas and increase bulk billing.

3. Offer more incentives to mental health practitioners working in regional and rural areas.

Prioritise certain areas and cohorts for rebates, further expanding the accessibility of the system to those in need.

a. This would include the introduction of rural and remote area incentives, enticing practitioners to service more regional areas and alleviating the build- up of demand currently faced by regional practitioners.

b. This would also include student/ provisional psychologist placements in rural and remote areas, where they would be supported through their provisional registration and could begin to address demand in under-serviced areas.

RECOMMENDATIONS TO IMPROVE THE AVAILABILITY OF SUPPORT

4. Expand MBS eligibility to provisional psychologists

We recommend expanding the eligibility criteria of those who can access Medicare rebates. This would allow provisional psychologists to offer rebates to their clients. In other words, provisional psychologists could offer services at the same price as fully qualified practitioners, which would improve access and timeliness of service as more people would be able to afford service which would ease demand on fully accredited psychologists.

5. Improve career pathways for psychology students

Create a career pathway for those studying psychology, so that they're practice-ready when they finish. One way to achieve this would be to reinstate the 4+2 internship program, which is an intensive supervised training program for those who have finished their study in psychology.

5. Provide more Commonwealth Supported Places for psychology students

Provide a minimum number of Commonwealth-supported places for students studying psychology. This would mean that places with no, or reduced, fees would be earmarked for those wanting to train as psychologists. The number of these places would align with and be determined by workforce demands and job vacancies.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REFERENCES

1. WHO. (2022). Mental Disorders. *World Health Organization*. Accessed online: https://www.who.int/news- room/fact-sheets/detail/mental-disorders
2. The McKell Institute. (Forthcoming). Communities in Crisis. Lifeline QLD supporting those in need. *The McKell Institute and Lifeline.*
3. Australian Bureau of Statistics. (2022). National Study of Mental Health and Wellbeing. *ABS*. Accessed online: https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-21
4. Australian Bureau of Statistics. (2018). Mental Health. *ABS*. Accessed online: https://www.abs.gov.au/statistics/health/mental-health/mental-health/2017-18
5. Australian Bureau of Statistics. (2018). Mental Health. *ABS*. Accessed online: https://www.abs.gov.au/statistics/health/mental-health/mental-health/2017-18
6. Australian Bureau of Statistics. (2018). Mental Health. *ABS*. Accessed online: https://www.abs.gov.au/statistics/health/mental-health/mental-health/2017-18
7. Black Dog Institute. (2021). Modern work: how changes to the way we work are impacting Australians' mental health. *Black Dog Institute.* Accessed online: https://www.blackdoginstitute.org.au/wp- content/uploads/2021/10/modern_work.pdf
8. Australian Bureau of Statistics. (2021). First Insights from the National Study of Mental Health and Wellbeing, 2020-21. *ABS.* Accessed online: https://www.abs.gov.au/articles/first-insights-national-study-mental-health- and-wellbeing-2020-21
9. Black Dog Institute. (2021). Modern work: how changes to the way we work are impacting Australians' mental health. *Black Dog Institute.* Accessed online: https://www.blackdoginstitute.org.au/wp- content/uploads/2021/10/modern_work.pdf
10. Australian Institute of Health and Welfare. (2022). Mental health of young Australians. *AIHW.* Accessed online: https://www.aihw.gov.au/getmedia/ba6da461-a046-44ac-9a7f-29d08a2bea9f/aihw-aus- 240_Chapter_8.pdf.aspx
11. Centre for Epidemiology and Evidence. HealthStats NSW. *Sydney: NSW Ministry of Health*. Accessed online: https://www.healthstats.nsw.gov.au/#/r/106323
12. Black Dog Institute. (2021). Modern work: how changes to the way we work are impacting Australians' mental health. *Black Dog Institute.* Accessed online: https://www.blackdoginstitute.org.au/wp- content/uploads/2021/10/modern_work.pdf
13. Safe Work. (2022) Australian workers' compensation statistics 2020-21. *Safe Work.* Accessed online: https://www.safeworkaustralia.gov.au/sites/default/files/2022- 12/australian_workers_compensation_statistics_2020-21.pdf
14. Safe Work. (2022) Australian workers' compensation statistics 2020-21. *Safe Work.* Accessed online: https://www.safeworkaustralia.gov.au/sites/default/files/2022- 12/australian_workers_compensation_statistics_2020-21.pdf
15. Black Dog Institute. (2021). Modern work: how changes to the way we work are impacting Australians' mental health. *Black Dog Institute.* Accessed online: https://www.blackdoginstitute.org.au/wp- content/uploads/2021/10/modern_work.pdf
16. Safe Work. (2022) Australian workers' compensation statistics 2020-21. *Safe Work.* Accessed online: https://www.safeworkaustralia.gov.au/sites/default/files/2022- 12/australian_workers_compensation_statistics_2020-21.pdf
17. Safe Work. (2022) Australian workers' compensation statistics 2020-21. *Safe Work.* Accessed online: https://www.safeworkaustralia.gov.au/sites/default/files/2022- 12/australian_workers_compensation_statistics_2020-21.pdf
18. Safe Work. (2022). Workers' compensation for psychological injuries. *Safe Work.* Accessed online: https://www.safework-australia.gov.au/workers-compensation/workers-compensation-psychological-injuries
19. Safe Work. (2022) Australian workers' compensation statistics 2020-21. *Safe Work.* Accessed online: https://www.safeworkaustralia.gov.au/sites/default/files/2022- 12/australian_workers_compensation_statistics_2020-21.pdf
20. Safe Work. (2022) Australian workers' compensation statistics 2020-21. *Safe Work.* Accessed online: https://www.safeworkaustralia.gov.au/sites/default/files/2022- 12/australian_workers_compensation_statistics_2020-21.pdf
21. Australian Institute of Health and Welfare. (2022). New analyses and data updates to the AIHW's suicide and self-harm monitoring system. *AIHW.* Accessed online: https://www.aihw.gov.au/news-media/news/2022- 1/july-2022/new-analyses-and-data-updates-to-the-aihws-suicide
22. Australian Institute of Health and Welfare. (2022). New analyses and data updates to the AIHW's suicide and self-harm monitoring system. *AIHW.* Accessed online: https://www.aihw.gov.au/news-media/news/2022- 1/july-2022/new-analyses-and-data-updates-to-the-aihws-suicide
23. Australian Institute of Health and Welfare. (2022). New analyses and data updates to the AIHW's suicide and self-harm monitoring system. *AIHW.* Accessed online: https://www.aihw.gov.au/news-media/news/2022- 1/july-2022/new-analyses-and-data-updates-to-the-aihws-suicide
24. Australian Institute of Health and Welfare. (2022). New analyses and data updates to the AIHW's suicide and self-harm monitoring system. *AIHW.* Accessed online: https://www.aihw.gov.au/news-media/news/2022- 1/july-2022/new-analyses-and-data-updates-to-the-aihws-suicide
25. AIHW. (2022). Data tables: 2020-21 National Hospital Morbidity Database—Intentional self-harm hospitalisations. *AIHW.* Accessed online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/data- downloads
26. Palinkas, L. A., & Wong, M. (2020). Global climate change and mental health. *Current opinion in psychology, 32, 12-16.* Accessed online: https://reader.elsevier.com/reader/sd/pii/S2352250X19300661

27. Royal Commission into the National Natural Disaster Arrangements. (2020). The Royal Commission Report. *The Royal Commission into National Natural Disaster Arrangements.* Accessed online: https://naturaldisaster.royalcommission.gov.au/publications/html-report/chapter-15
28. Royal Commission into the National Natural Disaster Arrangements. (2020). The Royal Commission Report. *The Royal Commission into National Natural Disaster Arrangements.* Accessed online: https://naturaldisaster.royalcommission.gov.au/publications/html-report/chapter-15
29. Newnham, E. A., Mergelsberg, E. L., Chen, Y., Kim, Y., Gibbs, L., Dzidic, P. L., ... & Leaning, J. (2022). Long term mental health trajectories after disasters and pandemics: A multilingual systematic review of prevalence, risk and protective factors. *Clinical Psychology Review,* 102203. Accessed online: https://www.sciencedirect.com/science/article/abs/pii/S0272735822000885
30. World Health Organisation. (2022). European framework for action on mental health 2021-2025. *WHO.* Accessed online: https://www.who.int/europe/publications/i/item/9789289057813
31. The McKell Institute. (Forthcoming)). Communities in Crisis. Lifeline QLD supporting those in need. *The McKell Institute and Lifeline.*
32. Zhang, W. R., Wang, K., Yin, L., Zhao, W. F., Xue, Q., Peng, M., ... & Wang, H. X. (2020). Mental health and psychosocial problems of medical health workers during the COVID-19 epidemic in China. *Psychotherapy and psychosomatics, 89*(4), 242-250. Accessed online: https://www.karger.com/Article/FullText/50763933
33. Wu, P., Liu, X., Fang, Y., Fan, B., Fuller, C. J., Guan, Z., ... & Litvak, I. J. (2008). Alcohol abuse/dependence symptoms among hospital employees exposed to a SARS outbreak. *Alcohol & Alcoholism, 43*(6), 706-712. Accessed online: https://academic.oup.com/alcalc/article/43/6/706/250093
34. Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: the need for prevention and early intervention. *JAMA internal medicine, 180*(6), 817-818. Accessed online: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2764404
35. Czeisler, M. É., Wiley, J. F., Facer-Childs, E. R., Robbins, R., Weaver, M. D., Barger, L. K., ... & Rajaratnam, S.M. (2021). Mental health, substance use, and suicidal ideation during a prolonged COVID-19-related lockdown in a region with low SARS-CoV-2 prevalence. *Journal of psychiatric research, 140,* 533-544. Accessed online: https://www.sciencedirect.com/science/article/pii/S0022395621003563
36. Rossell, S. L., Neill, E., Phillipou, A., Tan, E. J., Toh, W. L., Van Rheenen, T. E., & Meyer, D. (2021). An overview of current mental health in the general population of Australia during the COVID-19 pandemic: Results from the COLLATE project. *Psychiatry research, 296,* 113660. Accessed online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7836867/
37. Garratt, K. (2022). World Metal Health Day: Rising cost of living and mental health. *UK Parliament.* Accessed online: https://commonslibrary.parliament.uk/world-mental-health-day-rising-cost-of-living-and-mental- health/
38. Suicide Prevention Australia. (2022). State of the Nation in Suicide Prevention. A survey of the suicide prevention sector. *Suicide Prevention Australia.* Accessed online: https://www.suicidepreventionaust.org/wp- content/uploads/2022/09/SPA_StateNationReport_2022_FINAL-1.pdf
39. Suicide Prevention Australia. (2022). State of the Nation in Suicide Prevention. A survey of the suicide prevention sector. *Suicide Prevention Australia.* Accessed online: https://www.suicidepreventionaust.org/wp- content/uploads/2022/09/SPA_StateNationReport_2022_FINAL-1.pdf
40. ACIL Allen. National Mental Health Workforce Strategy. Background Paper. *ACIL ALLEN.* Accessed online: https://acilallen.com.au/uploads/media/NMHWS-BackgroundPaper-040821-1628485846.pdf
41. Dalzell, S. (2022). Universities lose Commonwealth funding for postgraduate degrees needed to boost psychologist numbers amid 'mental health crisis'. *ABC.* Accessed online: https://www.abc.net.au/news/2022- 05-19/unis-lose-money-on-degrees-needed-to-boost-psychologist-numbers/101078968
42. Rizmal, Z. and Kewley, L. (2022). One in three psychologists have closed their books and children are being left behind. *ABC.* Accessed online: https://www.abc.net.au/news/2022-02-23/children-mental-health-treatment-psychologist-shortage-regions/100854252
43. AAPi. (2022). Private Practice Survey Results. Media Release. *AAPi.* Accessed online: https://aapi.org.au/common/Uploaded%20files/AAPi%202022%20survey%20MR%20_%20Nov%202022.pdf
44. Wong, D. et al. (2022). We can't solve Australia's mental health emergency if we don't train enough psychologists. Here are 5 fixes. *The Conversation.* Accessed online: https://theconversation.com/we-cant- solve-australias-mental-health-emergency-if-we-dont-train-enough-psychologists-here-are-5-fixes-190135
45. NSW Government. (2022). High or very high psychological distress in adults. *NSW Government.* Accessed online: https://www.healthstats.nsw.gov.au/#/indicator?name=-mental-hidistress- phs&location=NSW&view=Trend&measure=prevalence&groups=Age%20(years),Sex&compare=Sex,Age%20(y ears)&filter=Sex,Persons&filter=Age%20(years),16-24%20years,25-34%20years,All%20ages
46. Safe Work. (2022) Australian workers' compensation statistics 2020-21. *Safe Work.* Accessed online: https://www.safeworkaustralia.gov.au/sites/default/files/2022- 12/australian_workers_compensation_statistics_2020-21.pdf

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47. ABS. (2022). 3101: National, state and territory population. Accessed online: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/jun-2022#data- downloads
48. AHPRA. (n.d.). Registration statistics. *AHPRA.* Accessed online: https://www.psychologyboard.gov.au/About/Statistics.aspx
49. ABS. (2022). 3101: National, state and territory population. Accessed online: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/jun-2022#data- downloads
50. Rosenberg, S., Park, S. H., & Hickie, I. (2022). Paying the price–out-of-pocket payments for mental health care in Australia. *Australian Health Review, 46*(6), 660-666. Accessed online: https://www.publish.csiro.au/AH/pdf/AH22154
51. Rosenberg, S., Park, S. H., & Hickie, I. (2022). Paying the price–out-of-pocket payments for mental health care in Australia. *Australian Health Review, 46*(6), 660-666. Accessed online: https://www.publish.csiro.au/AH/pdf/AH22154
52. AIHW. (2022). Medicare-subsidised services data. *AIHW.* Accessed online: https://www.aihw.gov.au/mental- health/topic-areas/medicare-subsisded-services
53. AAPi. (2022). Private Practice Survey Results. Media Release. *AAPi.* Accessed online: https://aapi.org.au/common/Uploaded%20files/AAPi%202022%20survey%20MR%20_%20Nov%202022.pdf
54. Australian Institute of Health and Welfare. (2022). Mental Health Services in Australia. *AIHW.* Accessed online: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report- content/summary-of-mental-health-services-in-australia/overview-of-mental-health-services-in-australia; Productivity Commission. (2020). Mental Health. Productivity Commission Inquiry Report. Vol. 1. Productivity Commission. Accessed online: https://www.pc.gov.au/inquiries/completed/mental-health/report/mental- health.pdf
55. Productivity Commission. (2020). Mental Health. Productivity Commission Inquiry Report. Vol. 1. *Productivity Commission.* Accessed online: https://www.pc.gov.au/inquiries/completed/mental- health/report/mental-health.pdf
56. Productivity Commission. (2020). Mental Health. Productivity Commission Inquiry Report. Vol. 1. *Productivity Commission.* Accessed online: https://www.pc.gov.au/inquiries/completed/mental- health/report/mental-health.pdf
57. Pirkis, J. et al. (2022). Evaluation of Better Access – Main Report. *The University of Melbourne.* Accessed online: https://www.health.gov.au/sites/default/files/2022-12/main-report---evaluation-of-the-better- access.pdf
58. Pirkis, J. et al. (2022). Evaluation of Better Access – Main Report. *The University of Melbourne.* Accessed online: https://www.health.gov.au/sites/default/files/2022-12/main-report---evaluation-of-the-better- access.pdf
59. Pirkis, J. et al. (2022). Evaluation of Better Access – Main Report. *The University of Melbourne.* Accessed online: https://www.health.gov.au/sites/default/files/2022-12/main-report---evaluation-of-the-better- access.pdf
60. Pirkis, J. et al. (2022). Evaluation of Better Access – Main Report. *The University of Melbourne.* Accessed online: https://www.health.gov.au/sites/default/files/2022-12/main-report---evaluation-of-the-better- access.pdf
61. Pirkis, J. et al. (2022). Evaluation of Better Access – Main Report. *The University of Melbourne.* Accessed online: https://www.health.gov.au/sites/default/files/2022-12/main-report---evaluation-of-the-better- access.pdf
62. Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology, 60*(1), 1-37. Accessed online: https://bpspsychub.onlinelibrary.wiley.com/doi/full/10.1111/bjc.12259
63. Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology, 60*(1), 1-37. Accessed online: https://bpspsychub.onlinelibrary.wiley.com/doi/full/10.1111/bjc.12259
64. Green, H., Barkham, M., Kellett, S., & Saxon, D. (2014). Therapist effects and IAPT Psychological Wellbeing Practitioners (PWPs): A multilevel modelling and mixed methods analysis. *Behaviour Research and Therapy, 63,* 43-54. Accessed online: https://eprints.whiterose.ac.uk/103217/3/Therapist%20effects%20in%20PWPs%20BRAT%20(3rd%20submission).pdf65
65. Green, H., Barkham, M., Kellett, S., & Saxon, D. (2014). Therapist effects and IAPT Psychological Wellbeing Practitioners (PWPs): A multilevel modelling and mixed methods analysis. *Behaviour Research and Therapy, 63,* 43-54. Accessed online: https://eprints.whiterose.ac.uk/103217/3/Therapist%20effects%20in%20PWPs%20BRAT%20(3rd%20submission).pdf65
66. Green, H., Barkham, M., Kellett, S., & Saxon, D. (2014). Therapist effects and IAPT Psychological Wellbeing Practitioners (PWPs): A multilevel modelling and mixed methods analysis. *Behaviour Research and Therapy, 63,* 43-54. Accessed online: https://eprints.whiterose.ac.uk/103217/3/Therapist%20effects%20in%20PWPs%20BRAT%20(3rd%20submission).pdf65
67. Clark, D. (2019). IAPT at 10: Achievements and challenges. *NHS.* Accessed online: https://www.england.nhs.uk/blog/iapt-at-10-achievements-and-challenges/

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