Submission No 75

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: The Australian Clinical Psychology Association (ACPA)

Date Received: 6 September 2023

UPPER HOUSE INQUIRY INTO EQUITY, ACCESSIBLITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Australian Clinical Psychology Association (ACPA) SUBMISSION Prepared by Professor Caroline Hunt on behalf of ACPA.

The Australian Clinical Psychology Association (ACPA) is the national professional body that represents clinical psychologists who hold the accredited post-graduate qualifications that meet the criteria established by the Psychology Board of Australia (PsyBA) for endorsement in clinical psychology. ACPA therefore represents a key group of stakeholders in the mental health landscape in Australia. Our members hold the highest level of professional qualifications in psychological assessment and treatment of mental health issues and the management of acute psychological conditions.

We thank and acknowledge senior psychologists in NSW Health and members of the ACPA Board who contributed to sections of this submission.

Findings from recently commissioned reports such as the Productivity Commission Inquiry Report into Mental Health, the Report of the National Suicide Prevention Officer, the Victorian Royal Commission, the National Mental Health Workforce Strategy and the Select Committee on Mental Health and Suicide Prevention have highlighted enduring gaps with respect to the delivery of high quality and evidenced-based care, leading to poor outcomes for Australians with mental health problems. These issues include a lack of commitment to properly fund the mental health system, and a lack of coordination of services at the state and federal level. The resultant assortment of different funding models (e.g., state-funded public mental health services, federally funded Better Access or the NDIS) allows individuals to fall through the gap, particularly those individuals who are too complex for primary care, but not sufficiently at risk to warrant acute inpatient care. There are also differences in access to quality services depending on where people live. Those that tend to miss out on quality care are those in rural and regional areas.

ACPA calls for a commitment from government to fully fund an integrated mental health service that provides the right level of treatment when and where an individual is most likely to benefit and achieve the optimal mental health outcomes.

ACPA notes that the NSW Upper House Committee has called for submissions to its Inquiry. ACPA has considered the Terms of Reference of the Inquiry and has responded to each in turn, below.

(a) equity of access to outpatient mental health services

ACPA argues that those with mental health problems need to be able to easily access evidence-based treatment delivered by practitioners who have the requisite knowledge, training and competencies. Individuals accessing public mental health services are typically vulnerable, have complex presentations, limited finances and therefore cannot access clinical psychologists in the private sector. If clinical psychologist roles in community mental health services "disappear" then access to clinical psychologists is further reduced, particularly as there are many psychologists in private practice who do not have the resources, support, or desire to see clients with psychotic or personality disorders.

Clinical psychologists are trained to provide the specialist interventions that these clients require, particularly those with severe, complex, or enduring conditions. In fact, many psychological interventions were developed and rigorously evaluated by clinical psychologists who are some of the most prominent and internationally recognised mental health researchers in Australia. There are too many examples to provide a comprehensive list here, but a sample includes Exposure-Based CBT for PTSD (Bryant, et al., 2019), Integrated Family Intervention (Dadds & Hawes, 2006), Triple P (Sanders et al., 2008), Project Air (Grenyer et al., 2018), Cool Kids (Rapee et al., 2006), and psychological intervention for young people with bipolar disorder (Macneil, Hasty, Conus, Berk, & Scott, 2010). Many of these approaches require an investment in, and development of, specialist clinics utilising multidisciplinary teams, and which are based in the community.

Some Local Health Districts in NSW do not employ any clinical psychologists, affecting access to evidence based psychological interventions. Where clinical psychologists are employed, there are very few specific clinical psychology positions compared to generic mental health positions, and there is constant pressure on these workers to conduct generic case management duties, further resulting in reduced access to specialised clinical psychology assessments and interventions. Individuals with complex presentations and severe or enduring mental illness require long-term therapeutic interventions, resulting in long waiting times for treatment. Jackson et al. (2021) argue strongly for an increase in the number of clinical psychologist specialist positions in the public system. To facilitate this increase, there needs to be a re-evaluation of career pathways and structures for clinical psychologists in state mental health that includes appropriate remuneration and the development of leadership roles.

Retention of senior and highly skilled practitioners in the workforce is a significant issue for clinical psychologists. There is little financial recognition of the significant increase in role and responsibility when moving into a senior position in public mental health as a psychologist and as a result psychologists are disincentivised from remaining in public mental health. There should be defined career structures for clinical psychologists with appropriate salaries for each level. Clinical psychologists have exited the public sector primarily because of the lack of a recognition of the speciality, lack of career structure, opportunity for career progression, inadequate remuneration relative to what can be earned in private practice, lack of opportunity and autonomy to provide treatment/therapy and lack of leadership positions. We note that the NSW Psychology Award is currently overdue, and we anticipate that a new Award will address these structural issues.

We are concerned that multi-graded positions on community mental health teams will limit access to psychologists and clinical psychologists because they are more likely to attract other health professional such as nurses, social workers, and occupational therapists. Such multi-graded positions do not allow psychologists to work at the top of their scope of practice which in turn leads to issues with attracting and retaining clinical psychologists in these roles.

In terms of training pathways, ACPA argues for the establishment of formal paid registrar clinical psychology positions in the public sector, plus a requirement that registrars serve a certain fixed period in this system. This model is widely accepted as working well for medicine.

Further, we need to expand the pipeline of supervised training of clinical psychologists, which provides an unrecognised workforce that delivers a broad range of high-quality, low-cost mental health services to the public. The impact of expanding this workforce has not been realised. The current degree-based clinical psychology intern workforce provides around 58,000 occasions of service nationally in NSW alone. In addition, it is estimated the post-graduate clinical psychology registrar program provides around 300 supervised clinical psychology registrars annually in NSW. Expansion and increased support for these schemes and the skilled workforce they produce will be of clear benefit to the public.

To properly serve the needs of complex populations within the mental health services, specialist psychologists, namely clinical psychologists, neuropsychologists and forensic psychologists, should be employed to provide expert clinical assessment and intervention across their particular scope of practice.

Recommendations

- The new Psychology Award to offer clear and attractive career pathways within the public mental health sector.
- Include paid clinical psychology registrar positions within each State-based mental health facility that will provide the incentive for graduates to start their careers, and encourage their retention, in the public sector.
- Recognise clinical psychology expertise within multidisciplinary teams, including the specification of clinical psychologist roles within each State-based mental health facility that involve decision-making responsibilities and leadership.
- Recognise mental health services that are provided by clinical psychology interns and clinical psychology registrars and incorporate this valuable workforce into the architecture of mental health services.
- Establish training scholarships for clinical psychology postgraduate places who are bonded to work in rural and regional areas for a specified time.

(b) navigation of outpatient and community mental health services from the perspectives of patients and carers

As a professional organisation, ACPA defers to the voices of lived experience to respond to this point. However, we frequently hear from our clients of the challenges and complexities around accessing and engaging with mental health services. These act as a barrier to better community engagement and foster stigma around mental health issues and accessing mental health services and support. Patients and carers need multiple pathways to finding the right care for their needs ("no wrong door").

There is a need for better integration between inpatient and community mental health services. It is difficult for an individual to access community mental health services for a mental health concern if there is not a primary diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or high risk of suicide. Even then, it is difficult to access a clinical psychologist for the treatment of any comorbid anxiety or mood disorders or personality disorder unless there are specialised psychology clinics established with their own referral process.

Compounding this problem is rigid adherence to and poorly defined "moderate to severe" eligibility criteria for community mental health services. The definition tends to apply to schizophrenia, schizoaffective disorder, bipolar disorder, or high risk of suicide with everything else typically considered "low-moderately severity". Even patients with psychotic disorders may be discharged from care if their symptoms are relatively stable. Individuals with NDIS support may be refused to be seen by community mental health teams as it is seen as "double dipping." Overall, limited resources results in early discharge and withdrawal of assistance when small gains are made.

(c) capacity of State and other community mental health services, including in rural, regional and remote New South Wales

The migration of the mental health workforce to the private sector has resulted in difficulties in attracting, recruiting, and retaining experienced clinicians in the public sector. Rural and regional areas are even more affected than metropolitan areas.

The National Health Workforce Data Set (2020) indicates that 82.7% of employed psychologists work in metropolitan areas (120.1 FTE per 100,000 population). Only 7.2% work in regional areas, 9.1% in rural towns, and 0.6% in remote communities. The largest workplace for psychologists is private practice (14,317 or 45.3% of employed psychologists).

The National Skills Commission also provide data on the workforce distribution of clinical psychologists which suggests distinct shortages in regional, rural, and remote areas. Around 70% of clinical psychologists live in capital cities, compared with the "all jobs" average of 62%. The regions with the largest share of clinical psychologist workers are reported to be the inner suburbs of Melbourne, north-west suburbs of Perth, and the northern suburbs of Sydney. It is also argued that of those psychologists who do locate to rural areas tend to be the youngest and least experienced health practitioners (Vines & Wilson, 2020).

Increased subsidies and internships in public, community and private settings will be critical to correcting this maldistribution. Attracting and recruiting new graduates to public sector mental health to maintain the psychology workforce pipeline can be achieved by providing well supervised training placements and new-graduate supervision (registrar programs) from experienced clinicians who have been formally allocated time to supervise. There are already existing educational and regulatory/accreditation structures for placements and registrar programs in clinical psychology. Funding for such placements and internships should be prioritised in areas of geographical and economic need. One way forward is the provision of tied scholarships for those from rural and remote backgrounds to undertake a clinical psychology training program. Another consideration is to provide substantive incentives for clinical psychology graduates to work in rural and regional areas, including training scholarships for clinical psychology postgraduate places or cancelling HECs debt for those who are bonded to work on rural and regional areas for a specified time.

Retention of existing clinical psychologists in the public sector workforce is essential and could be enhanced with attention to the following five factors that are known to be effective:

1. Progression and career development opportunities. There are currently few opportunities and these often require ceasing direct clinical work.
2. Salary levels are a perceived barrier in mental health to earning senior grading appointments.
3. Management leadership style is perceived as focussed on structure and operations compliance.
4. Lack of autonomy.
5. Workplace environment. Workplaces don't always feel pleasant and safe. Community services are often crowded, with no room for interns.

Existing resources could also be distributed better. As mentioned above, the use of clinical psychologists for case management in some Local Health Districts is a waste of therapeutic resources.

Recommendations

- Increased subsidies for placements and registrar programs in public community mental health services.
- Funding for such placements and programs should be prioritised in areas of geographical and economic need.
- Establish training scholarships for clinical psychology postgraduate places who are bonded to work in rural and regional areas for a specified time.
- Offer a 20% discount on HECS debt for each year of service in public health services capped at 5 years (when 100% of HECS debt is cancelled) to incentivise attraction and retention of clinical psychologists in public health.

- Improve the retention of clinical psychologists in the public sector through addressing progression and career development, increased salaries, better management leadership style, increased autonomy, and an enhanced workplace environment.

(d) integration between physical and mental health services, and between mental health services and providers

Integration between physical and mental health services

There has been more focus on integration in recent years with the establishment of clinics such as the Collaborative Centre for Cardiometabolic Health in Psychosis (ccCHiP) in the Sydney Local Health District. However, this is not consistent across all LHDs with rural and remote exhibiting less integration.

On a related matter, it is rare to find inpatient mental health services with frequent and timely access to comprehensive physical health assessments (e.g., bloods etc). Furthermore, medical psychiatry units are few and far between leading to siloed approaches to care.

Integration of care and supporting multidisciplinary teamwork approaches.

Clinical psychologists have a strong grounding in the skills needed to provide training, consultation, guidance and supervision to multidisciplinary teams and professionals working in mental health and this expertise needs to be explicitly recognised. Clinical psychologists can also contribute their expert knowledge to complex case and high-risk patients within community services. In many ways, the extensive expertise of clinical psychologists is underutilised within our mental health systems. Better use of this expert workforce in leadership and decision-making would address issues of shortages in psychiatry and has the potential to carry cost savings.

The way in which the skills can be brought together to provide the best care within a multidisciplinary team needs to be defined, such as the provision of time limited psychological therapy to case managed clients. For example, an episode of an acute psychotic disorder will require both psychiatry (psychopharmacotherapy) and clinical psychology intervention (formulation driven psychological management of symptoms and functional recovery). The individual can be supported in their ongoing day to day living (as well as assisting with housing, education, and employment issues) by a psychosocial support or peer worker during the acute episode and after it has ameliorated. Psychosocial support or peer workers embedded within clinical teams will be assisted to understand the formulation and work with the client in a manner consistent with this approach. A well-trained and supported lived experience workforce will instil a strengths-based approach to care, provide hope for recovery, and support clients to engage with their clinical teams. ACPA recommends future research to establish an evidence base for lived experience work as none exists at present.

To facilitate integrated care, the public requires a clear, recognisable, well-supported system that enables appropriate referral to practitioners trained in the specific area of expertise they require. A system of triage is critical to ensure that individuals get the mental health

care they need when they need it. Health workers in primary care settings, particularly GPs, need to be competent in assessing need, and being aware of where the right help can be accessed. Not all mental health presentations require intensive interventions, which should be reserved for those whose functioning is most impaired. There will be some individuals with high levels of functional impairment who will require referral to acute state-based care, others who are better functioning who will be more suitable for individual psychological treatment through clinical psychologists in community health or supported by Better Access, and others with longer term needs who will require team-based community care.

Unfortunately, in many current service models, clinical psychologists, even when employed in specialist positions, cannot contribute their full capabilities, usually because of short in-patient stays or high caseloads in community mental health clinics.

Recommendations

- Develop clear referral pathways from primary care (based on patient need and evidence-based knowledge of **what help is needed**, and **from whom**).
- Develop clinical thresholds that differentiate those who would benefit from online treatments from those requiring face-to-face psychological strategies, and further differentiating those requiring psychological strategies from those requiring multidisciplinary care through community mental health hubs or into the public mental health system.
- Facilitate the establishment of community mental health hubs, prioritising areas that currently lack access to quality mental health care for persistent and complex mental health problems. The effectiveness of such hubs will depend on how they are structured and staffed and how appropriate triaging is arranged within those hubs.
- Facilitate and fund research to establish an evidence base for lived experience peer support work.

(e) appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, counsellors, social workers, allied health professionals and peer workers

Matching workforce competencies with the mental health needs of the population.
We need to delineate which specific competencies and skills brought by which specific professional groups will best manage the mental health problems of the population. Not every presentation to mental health services requires the same intensity or type of intervention approach. Indeed, the 2022 Better Access Evaluation indicated while many people accessing services had moderate or high levels of psychological distress, a significant minority had low psychological distress.

There are issues with multi-graded or multi-classified positions which affects uniform and equitable allocation of health staff across all disciplines. Multi-grading of positions has opened positions on mental health teams to disciplines who have not traditionally had mental health training, (e.g., speech therapists, dietitians, exercise physiologists). Often, there is an implicit assumption that all mental health professionals can provide *psychological*

treatment to the public. This assumes a one-size-fits-all approach in that health professionals of different discipline backgrounds can equally discriminate between various clinical presentations and provide appropriate treatment. This is not the case. Mental health problems that are persistent, severe, or complex require appropriately qualified clinicians and interventions for treatment. A fundamental problem is that we have a mental health workforce that is not fit for purpose and incapable of providing appropriate assessment of patient/client's 'condition', let alone treatment. Limited psychology input in leadership or management roles leads to a lack of strategic direction and advocacy over psychology services, service development decisions and staffing to achieve the highest level of clinical psychology expertise and care.

To fully understand mental health workforce needs, we require a mapping of the competencies of the workforce against the specific needs of the population. For example, interventions for high frequency and high functioning single anxiety disorders and mild to moderate depression can be managed well within the structure of private psychology practices and by psychologists with general registration sometimes in less than 10 sessions. However, more complex presentations (e.g., anxiety disorders with significant severity or impairment such as OCD, PTSD, social anxiety disorder, generalised anxiety disorder, or panic disorder, severe eating disorders, personality disorders, co-morbid mental health presentations, or dual diagnoses and dual disabilities) or those conditions that are chronic or resistant to standard treatment will require referral to mental health specialists, including clinical psychologists and psychiatrists. Clinical psychologists are trained to have a deep understanding of models of treatment and proficiency in delivery of formulation-driven (in addition to diagnosis driven), evidence-based psychological treatments for complex presentations.

Clear and well-defined scopes of practice for all mental health professionals

ACPA argues that nationally consistent scopes of practice for the mental health workforce need to be defined, particularly for the newer workforce groups. ACPA argues for established and transparent requirements for mental health competencies to be included within the curricula of existing professions. This may present difficulties for the newest group of peer workers or mental health support workers as there are no documented standards or position descriptions. There is consensus in the literature that peer support workers should be embedded within clinical teams, should have access to appropriate training and supervision, should be remunerated fairly (i.e., these should not be volunteer positions), work within clear governance structures, and there should be regulation of the profession. There should be attention paid within teams to power imbalances and hierarchies and support for peer workers to contribute to the team and be heard. Without these, there are risks to both the clients and the peer workers themselves. Support is often sourced in neighbouring LHDs which is appropriate, but we are not aware of a document policy for this situation.

In relation to peer work, there are also challenges in integrating an empiricist approach with other approaches to mantal health work. There are inconsistencies in messages and information, a lack of coherence in approaches, at times competing clinical (theoretical) ways of working, duplication, and difficulty prioritising different aspects of care. Risk mitigation strategies are needed such as clearly defining roles and ensuring that clear

constructive interactions and communication can be maintained. There is a very important role for peer work and service co-design provided these risks are acknowledged and managed.

At present, peer workers are in short supply, and many in this work force do not have sufficient training, with others experiencing high levels of distress which places them at risk. Relatedly, mental health generalist roles created within the public health system, which are open to individuals of various 'allied health' training background (nurses, social workers, psychologists, clinical psychologists, etc.), mistakenly assume one-size-fits-all approach, which introduces the risk that people seeking mental health support receive varying and sub-standard clinical care.

Recommendations

- Conduct government workforce planning that determines **who** needs mental health services, **what kind of services are needed**, and **from which mental health professionals these services are provided.**
- Establish nationally consistent and defined scopes of practice for the mental health workforce, particularly for the newer peer workforce groups.
- Collect and use reliable workforce data that differentiates between key mental health professions.

(f) the use of Community Treatment Orders under the Mental Health Act 2007

ACPA supports any move to create an improved mental health system in New South Wales that places the human rights of the individual at its core. The system must aim to achieve a balance of respecting the needs and desires of an individual with a mental illness through consultation and wherever possible supported decision-making practices, along with an acknowledgement that there may be circumstances and situations where a Community Treatment Order (CTO) is required as a last resort.

The need for increased autonomy for individuals with mental health disorders.
Reducing the use of compulsory treatment gives patients more control over their own treatment and will improve outcomes for some individuals. Evidence suggests that voluntary treatment is associated with better outcomes for some individuals, particularly where they have a strong support network in place (Tew et al., 2012).

For individuals with a mental disorder, being on a CTO means lacking choice and control, an emphasis on medication, fear of the threat of hospitalisation, and an absence of recovery-oriented practice and ongoing support. In Australia, rates of CTO use are relatively high compared to international rates (Light, Kerridge, Ryan, & Robertson, 2012). Individuals subject to CTO s report experiences of coercion, a lack of choice, services that focus on medication as the primary treatment, and medication adherence as the main reason for them being placed on a CTO.

For staff, recovery-oriented practice in the presence of CTO is challenging, with CTO s being seen to be a primary way to manage risk.

Cost-effectiveness versus preserving public health.

Compulsory treatment can be expensive and resource intensive. In reducing the use of compulsory treatment, already scarce resources are likely to be redirected towards more cost-effective and evidence-based treatments for those that voluntarily engage with services. However, for some individuals with a more complex mix of severe mental illness and psychosocial needs and who may not be able to access subsequent psychological treatment voluntarily, CTOs can provide a pathway to recovery. The elimination of CTOs for those without the capacity or supports to remain in treatment may result in more frequent and costly acute presentations and early discharges, both of which existing services are ill-equipped to manage.

Removing the need for compulsory treatment requires alternative approaches to treatment and support and adherence to recovery-orientated models of practice. This requires close collaboration between mental health professionals, policymakers, and individuals with lived experience of mental illness and their families.

ACPA supports the reduced use of compulsory treatment and working with individuals to help them access care in their preferred manner. When mental health treatment is approached in a person-centred manner within recovery-oriented models, and where clinicians and individuals with mental illnesses work together, it is likely that compulsory treatment requirements will not be required. ACPA hopes that there will be a reduction in the use and duration of compulsory treatment over time. Most clinicians support this, and indeed are already aiming for this.

Recommendations

- Review the use of CTOs using a recovery-oriented practice approach.
- Reduce reliance on CTOs in managing risk by focusing on training of all mental health professionals.

(g) benefits and risks of online and telehealth services

A large proportion of Australians with mental health problems never seek professional help for their problems or take too long a time in accessing that help. The key reasons people do not seek help include affordability, poor physical health, and geographic inaccessibility. This is particularly relevant for young people. Telehealth, when combined with the option of face-to-face care, improves access to important psychology care for a range of Australians. From a clinician perspective, use of telehealth can increase follow-up care and the number of appointments able to be offered (as there is no travel time for clinicians or clients). Early career clinical psychologists in rural and remote areas can be offered supervision by experienced clinical psychologists in metropolitan services. This can assist with attraction and retention of clinicians in these under resourced areas.

Good quality mental health service provision will support access to both face-to-face and telehealth psychological services. Ideally clients will have access to integrated care delivered within their own health care communities. However, many individuals will not have access to computers to be offered telehealth services. Hybrid methods can mitigate some of the risks of telehealth.

Individuals seeking mental health care are advantaged when psychologists have links to local health care providers and knowledge of services and supports available within the individual's local area. This allows for social prescribing, referral to local services and the capacity to respond when client safety is at risk with the provision of face-to-face care. Psychological assessment and formulation are an integral step in good clinical care. Face-to-face assessment facilitates important clinical observations of the client (e.g., non-verbal communication, physical appearance, functioning, hygiene, behaviour, etc.) which are especially beneficial in the early stages of the therapeutic relationship. The initial session is also where a psychologist can assess the level of risk for the client and a safety plan can be clearly set out in advance of conducting remote sessions. Furthermore, the suitability and privacy of the space in which they will be conducting telehealth can be confirmed.

The risk of an over reliance on telehealth in the broader mental health system is the development of models of care which are characterized by high-volume, rapid client turnover, and reduced effectiveness, leaving little time for appropriate diagnosis, formulation, treatment planning and preventative interventions to support longer-term wellbeing. On-demand single-session telehealth services may result in fragmented care with conflicting recommendations from multiple, unconnected health professionals, compromising client safety, with the potential to undermine confidence in the effectiveness of psychological therapy.

ACPA supports the expansion, integration, and promotion of supported online treatments such as the MindSpot Clinic (Titov et al., 2017). The benefits of services such as MindSpot include increased access to consumers across Australia, provision of clinical and cost-effective care, and integration with primary care. We recommend that such online services must be built on a strong research evidence base, and monitor, report and evaluate outcomes as part of routine care. Minimum criteria for funding of such services should therefore include an evidence-base, strong governance, integration with primary care, and routine measurement of clinical outcomes and experiences.

Recommendations

- Quality and safety around telehealth services requires monitoring and evaluation - the purpose and scope of the telehealth service needs to be clearly communicated to consumers and to be clear to clinicians.
- Apply principles of (i) evidence-based interventions, (ii) strong governance, (iii) integration with primary care and (iv) routine measurement of clinical outcomes and experiences as minimum criteria for funding the expansion of online treatment services.

(h) accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability

Some metropolitan services have established Aboriginal Mental Health teams and have employed Indigenous clinicians, but this varies across Local Health Districts. There remain many gaps in this area and a lack of understanding of the barriers to care. Specific Aboriginal positions are difficult to recruit to and remain vacant leading to significant gaps.

The number of Aboriginal and Torres Strait Islander people entering the mental health workforce must be increased to ensure that Aboriginal knowledge and strategies become embedded in mental health care. Only 0.8% of psychologists in the National Health Workforce Data Set identify as being of Aboriginal or Torres Strait Islander background, relative to being 3.3% of the total Australian population. There are currently no scholarships to support Aboriginal and Torres Strait Islander training positions in NSW. ACPA calls for additional programs and increased support for Aboriginal and Torres Strait Islander peoples to access training programs and enter the profession. These programs need to start at entry to the university sector, and continue through to postgraduate professional training, with the provision of training scholarships and requirements for higher education providers to provide adequate support for this health workforce.

LGBTQIA+ individuals represent another vulnerable segment of Australian society, contributing to adverse mental health outcomes and increased risk of suicide. Estimates indicate that at least 3-4% of the population identify as LGBTQIA+ (Carman et al., 2020). Despite this large number, mental health care tailored to the specific needs of LGBTQIA+ individuals is disappointingly rare. Notwithstanding the suffering to the individual, severe mental health and suicide behaviours are costly from a health economics perspective. To address this challenge, state-level initiatives coordinated with local health services are needed that focus on training mental health staff to better understand the needs and challenges of LGBTQIA+ individuals. Programs that seek to provide tailored and evidence-based care must be funded on an ongoing basis and be of sufficient duration to allow feedback from LGBTQIA+ consumers to be incorporated to further improve service provision. Importantly, programs and services must be developed in consultation with key stakeholder organisations.

People with a disability can contribute significantly and equally to the Australian mental health workforce, while also helping prompt a culture-change in how individuals with disabilities are seen. Nevertheless, individuals with disabilities are not prominent in the professional landscape of mental health care.

Recommendations

- Increase Government support for a significantly expanded Aboriginal and Torres Strait Islander mental health workforce, with increased scholarships and funding for training and education across the key professions.

- Increase training of mental health staff to better understand the needs and challenges of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability and state-level program development.
- Training incorporates community and stakeholder feedback as a formal stage of implementation.
- Increase Government support for greater inclusion of individuals with disabilities in the mental health workforce.

(i) alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

This is a vexed question because the Police, Ambulance Services, and PACER are very different and will therefore be different in their approach to people experiencing acute mental distress. None are currently operating satisfactorily in this context. An ability of the responder to conduct a quick but accurate assessment of the likely cause of the mental health crisis is critical.

A police response to a mental health emergency is often heavy-handed and can be extremely threatening to the person with an acute mental health crisis, potentially exacerbating their distress. Is this their job? Ambulance crews may be better trained in dealing with mental health crisis and being able to differentiate, for example, acute psychosis from a withdrawal delirium, which need very different interventions. But is this the best use of an ambulances crew's time? PACER teams tend to be under-resourced and over worked with an existing case load to manage, and as such will only respond when there is clear and imminent risk to the individual or to others. Furthermore, PACER teams are not available uniformly across all Local Health Districts.

ACPA argues for an expansion of Safe Havens across NSW as an alternative to Emergency Departments. Suicide Prevention Outreach Teams (SPOT) also require expansion and better integration with Community Mental Health Teams and Assertive Outreach Teams.

Another important initiative that requires extension is the Gold Card Clinics which form part of the Project Air Strategy for personality disorders. However, these clinics are not operational in all Local Health Districts due to a lack of resources. These approaches provide stepped care models to address those with personality vulnerabilities starting with very brief 4-session intervention, then 12-week Dialectic Behaviour Therapy (DBT)-based groups, and up to 14-month DBT groups. The approach features a co-coordinator who has overall responsibility.

Recommendations

- ACPA supports the expansion of key services focussed on supporting those experiencing mental health crises (Safe Havens, SPOT teams, Gold Card Clinics)

- ACPA recommends the establishment of an expert group to make recommendations on how emergency support services are best established and integrated with inpatient and community mental health services.

(j) any other related matter.

Recognition of areas of specialty areas in psychology

Clinical psychologists have advanced training in the assessment, formulation, diagnosis, and treatment of mental health disorders. Clinical psychology is founded on a psychology degree followed by postgraduate training and a registrar program (totalling a minimum of eight years of required education, training, and supervision) and the development of competencies in the treatment of serious mental health disorders. Hence, clinical psychologists have high levels of expertise in mental health disorders. This advanced education and training of clinical psychologists in mental health is acknowledged in most organisations and jurisdictions (e.g., higher rebates provided by the MBS, NDIS, DVA, State industrial Awards, etc.).

Disappointingly, there is misinformation in circulation that explicitly devalues the worth of qualifications and credentialling. Paramount to effective service delivery is protection of the public through recognition of accredited training and allocation of expertise to the right level of intervention for patient needs, supported by the regulatory framework under which we work and upon which the National Law (2009) is founded.

Clinical psychology is an internationally recognised specialty that is differentiated and acknowledged as such in all other comparable jurisdictions: United Kingdom (since 1973), Ireland, Canada, the USA, New Zealand, Norway, Sweden, Finland, India, Singapore, and South Africa.

In addition to clinical psychology, Areas of Practice Endorsement (AoPE) are major training pathways in psychology practice. Clinical psychologists, clinical neuropsychologists, educational and developmental psychologists, forensic psychologists, health psychologists, and counselling psychologists all undertake specialised training that offer higher-level services to the public within mental health and areas aligned with mental health services.

Recommendation

- Recognition of specialist and high-level competencies derived through advanced accredited education, training and supervision is a paramount foundation of appropriate delivery of care. Clinical psychology, an internationally recognised specialty providing advanced skills in the assessment, formulation, diagnosis, and treatment of mental health disorders, must be differentiated, and recognised in National and State regulations and Industrial Awards to ensure growth of this skilled workforce through appropriate incentivisation and appropriate workforce roles.

Conclusion and Summary of Recommendations

ACPA wishes to thank the NSW Government and the Upper House Committee for providing the opportunity to contribute our views and experiences with outpatient and community mental health care in New South Wales. We look forward to working with the government and Minister Jackson in ensuring high quality, accessible, and equitable access mental health care in NSW, and psychology care.

Summary of recommendations

Equity of access to outpatient mental health services

- The new Psychology Award to offer clear and attractive career pathways within the public mental health sector, including paid clinical psychology registrar positions within each State-based mental health facility that will provide the incentive for graduates to start their careers, and encourage their retention, in the public sector.
- Recognise clinical psychology expertise within multidisciplinary teams, including the specification of clinical psychologist roles within each State-based mental health facility that involve decision-making responsibilities and leadership.
- Recognise mental health services that are provided by clinical psychology interns and clinical psychology registrars and incorporate this valuable workforce into the architecture of mental health services.
- Establish training scholarships for clinical psychology postgraduate places who are bonded to work in rural and regional areas for a specified time.

Capacity of State and other community mental health services, including in rural, regional and remote New South Wales

- Increased subsidies for placements and registrar programs in public and community mental health services.
- Funding for such placements and programs should be prioritised in areas of geographical and economic need.
- Establish training scholarships for clinical psychology postgraduate places who are bonded to work in rural and regional areas for a specified time.
- Cancel student HECs debt for clinical psychologists who commit to work in rural and regional areas for a specified time, so these specialists are encouraged to work in these areas alongside doctors and nurses.
- Offering a 20% discount on HECS debt for each year of service in public health services capped at 5 years (when 100% of HECS debt is cancelled) to incentivise attraction and retention of clinical psychologists in public health.

Integration between physical and mental health services, and between mental health services and providers

- Develop clear referral pathways from primary care (based on patient need and evidence-based knowledge of **what help is needed**, and **from whom**).

- Develop clinical thresholds that differentiate those who would benefit from online treatments from those requiring face-to-face psychological strategies, and further differentiating those requiring psychological strategies from those requiring multidisciplinary care through community mental health hubs or into the public mental health system.
- Facilitate the establishment of community mental health hubs, prioritising areas that currently lack access to quality mental health care for persistent and complex mental health problems. The effectiveness of such hubs will depend on how they are structured and staffed and how appropriate triaging is arranged within those hubs.
- Facilitate and fund research to establish an evidence base for lived experience peer support work.

Appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, counsellors, social workers, allied health professionals and peer workers.

- Conduct government workforce planning that determines **who** needs mental health services, **what kind of services are needed**, and **from which mental health professionals these services are provided.**
- Establish nationally consistent and defined scopes of practice for the mental health workforce, particularly for the newer peer workforce groups.
- Collect and use reliable workforce data that differentiates between key mental health professions.

The use of Community Treatment Orders under the Mental Health Act 2007

- Review the use of CTOs using a recovery-oriented practice approach.
- Reduce reliance on CTOs in managing risk by focusing on training of all mental health professionals.

Benefits and risks of online and telehealth services

- Quality and safety around telehealth services requires monitoring and evaluation - the purpose and scope of the telehealth service needs to be clearly communicated to consumers and to be clear to clinicians.
- Apply principles of (i) evidence-based interventions, (ii) strong governance, (iii) integration with primary care and (iv) routine measurement of clinical outcomes and experiences as minimum criteria for funding the expansion of online treatment services.

Accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability.

- Increase Government support for a significantly expanded Aboriginal and Torres Strait Islander mental health workforce, with increased funding for training and education across the key professions.

- Increase training of mental health staff to better understand the needs and challenges of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability and state-level program development.
- Training incorporates community and stakeholder feedback as a formal stage of implementation.
- Increase Government support for greater inclusion of individuals with disabilities in the mental health workforce.

Alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

- ACPA supports the expansion of key services focussed on supporting those experiencing mental health crises (Safe Havens, SPOT teams, Gold Card Clinics)
- ACPA recommends the establishment of an expert group to make recommendations on how emergency support services are best established and integrated with inpatient and community mental health services.

Recognition of areas of specialty areas in psychology

- Recognition of specialist and high-level competencies derived through advanced accredited education, training and supervision is a paramount foundation of appropriate delivery of care. Clinical psychology, an internationally recognised specialty providing advanced skills in the assessment, formulation, diagnosis, and treatment of mental health disorders, must be differentiated, and recognised in National and State regulations and Industrial Awards to ensure growth of this skilled workforce through appropriate incentivisation and appropriate workforce roles.

References

Bryant RA; Kenny L; Rawson N; Cahill C; Joscelyne A; Garber B; Tockar J; Dawson K; Nickerson A, 2019, 'Efficacy of exposure-based cognitive behaviour therapy for post-traumatic stress disorder in emergency service personnel: A randomised clinical trial', *Psychological Medicine*, vol. 49, pp. 1565-1573. http://dx.doi.org/10.1017/S0033291718002234

Carman, M., Farrugia, C., Bourne, A., Power, J. & Rosenberg, S. (2020). *Research matters: How many people are LGBTIQ?* A factsheet by Rainbow Health Australia. https://www.rainbowhealthvic.org.au/media/pages/research-resources/research-matters-how-many-people-are-lgbtiq/4170611962-1612761890/researchmatters-numbers-lgbtiq.pdf (accessed September 2023).

Dadds, M., & Hawes, D. (2006). Integrated family intervention for child conduct problems: A Behaviour-Attachment-Systems Intervention for Parents. Brisbane, Queensland: Australian Academic Press.

Grenyer, B. F. S., Lewis, K. L., Fanaian, M. & Kotze, B. (2018). Treatment of personality disorder using a whole of service stepped care approach: A cluster randomized controlled trial. PLoS One, 13 (11), e0206472-1-e0206472-13.

Jackson, H., Hunt, C. & Hulbert, C. (2021). Enhancing the contribution of clinical psychology: An under-utilised workforce in public mental health services. *Australasian Psychiatry*. Published online 24th February 2021. Doi: 10.1177/1039856221992649

Light, E., Kerridge, I., Ryan, C., & Robertson, M. (2012). Community treatment orders in Australia: rates and patterns of use. *Australasian Psychiatry*, *20(6)*, 478-82. doi: 10.1177/1039856212466159.

Macneil, C., Hasty, M., Conus, P., Berk, M., & Scott, J. (2009). Bipolar Disorder in Young People: A Psychological Intervention Manual. Cambridge: Cambridge University Press. doi:10.1017/CBO9780511757389

National Skills Commission, Skills Priority List 2021. https://www.nationalskillscommission.gov.au/topics/skills-priority-list (accessed August 2022)

Rapee, R. M., Lyneham, H. J., Schniering, C. A., Wuthrich, V., Abbott, M. J., Hudson, J. L., & Wignall, A. (2006). *The Cool Kids® Child and Adolescent Anxiety Program Therapist Manual*. Sydney: Centre for Emotional Health, Macquarie University.

Sanders, M. R. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting." *Journal of Family Psychology*. **22** (3): 506–517

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *The British Journal of Social Work*, *42*(3), 443-460.

Thomas, N., McDonald, C., de Boer, K., Brand, R. M., Nedeljkovic, M., & Seabrook, L. (2021). Review of the current empirical literature on using videoconferencing to deliver individual psychotherapies to adults with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*.

Titov, N., Dear, B.F., Staples, L. G., Bennett-Levy, J., Klein, B., Rapee, R. M., Andersson, G., Purtell, C., Bezuidenhout, G. & Nielssen, O. (2017). The first 30 months of the MindSpot Clinic: Evaluation of a national e-mental health service against project objectives. *Australian and New Zealand Journal of Psychiatry*, *51*(12), 1227–1239.

Vines, R.F. & Wilson, R. (2020). Integrated primary health care in rural and remote contexts: The Australian experience. In Carey, T. & Gulifer, J. (eds.) *Handbook of Rural, Remote, and very Remote Mental Health*. Doi: 10.1007/978-981-10-5012-1_9-1