Occupational Therapy Australia

Productivity Commission – Final Review of National Mental Health and Suicide Prevention Agreement

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Introduction

Occupational Therapy Australia

Occupational Therapy Australia (OTA) is the professional association and peak representative body for occupational therapists in Australia. There are more than 30,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to engage in meaningful and productive activities.

OTA welcomes the opportunity to provide a response to the Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement (the National Agreement).

OTs and Mental Health

Occupational Therapists are a core part of the Australian mental health workforce. They bring a unique occupational focus, addressing the activities and occupations that are important and meaningful to a person's daily life, and assisting people to successfully engage in everyday activities. They are particularly effective at preventing hospitalisation and enabling people to live well at home and in their community. They draw on, and are trained in, occupational therapy specific tools and approaches as well as evidence based and structured psychological techniques (including CBT, DBT, EMDR and others).

Occupational Therapist (OTs) are highly qualified and skilled health professionals, who must meet the rigorous practice requirements mandated via AHPRA registration. Occupational therapy is one of three allied health professions eligible to provide Medicare Better Access to Mental Health services, alongside psychologists and mental health social workers.

OTs work across the spectrum of mental illness, providing early intervention, prevention, and treatment services to people with mild, moderate and severe mental health conditions. They work with people across the life course:

- Adults experiencing mental illness, including anxiety and depression as well as more complex mental illness such as schizophrenia and borderline personality disorder.
- Children and young people experiencing behavioural issues as a result of diagnosed or undiagnosed mental health conditions such as anxiety, depression, post-traumatic stress disorder, developmental trauma, Autism Spectrum Disorders, ADD/ADHD, intellectual disability and sensory processing differences.
- Older adults, including Behavioural and Psychological Symptoms of Dementia (BPSD).

Contact : For further information or to discuss the contents of this submission, please contact OTA via policy@otaus.org.au

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OTA's Response to the Final Review of the National Mental Health and Suicide Prevention Agreement

The OTA response will focus on the following areas of the National Mental Health and Suicide Prevention Agreement (National Agreement):

- Gaps in the System of Care,
- Psychosocial Supports outside the NDIS,
- Regional Planning and Commissioning, and
- Workforce.

We will also comment on the following area identified for the Productivity Commission's review in their Terms of Reference with some considerations for the development of a best practice model for psychosocial supports:

> c) the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved

Summary

The National Agreement is an important component of Australia's mental health system reform. It creates a framework for collaboration and joint responsibility between the Commonwealth and States and Territories. According to the National Mental Health Commission,[1] there was significant work in 2022-23 to establish the necessary governance structures and relationships to enable successful implementation of the National Agreement, and implementation is progressing well, with most milestones and outputs considered 'on track.' There has also been investment in a range of services, such as the National Early Intervention Service (NEIS), aimed at addressing the range of needs of people with mental health issues.

However, despite the progress on the agreed actions of the National Agreement, significant work and investment is required to build a mental health system that meets the increasing mental health needs of the Australian community, and to address workforce shortages that are creating additional barriers to the provision of required services

[1] https://www.mentalhealthcommission.gov.au/sites/default/files/2024-12/national-mental-health-and-suicide-prevention-agreement-2022-2023-annual-national-progress-report-summary.pdf

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Mental health issues are now the most common reason for people to see a GP [2]; mental health and substance use conditions are the leading cause of poor health in Australia (non-fatal "burden of disease")[3] and the prevalence of mental health conditions among young people has increased by an alarming 50% over the last decade[4].

In addition, there is a 32% shortfall across the mental health workforce[5], significant inequalities in accessability of services, especially for those in rural and remote areas and for those on low incomes, and vast gaps in services for people whose support needs are complex. Increasing rates of mental ill-health, in conjunction with increasing chronic disease and an ageing population, will place additional pressure on the primary health system, the workforce supporting it, and exacerbate the gaps already present in the mental health system.

OTs have a unique skill set that is a vital part of a multidisciplinary, best practice approach to supporting Australians living with mental health issues. As such, the OT workforce is a key component of the mental health service system. The success of this system requires, in part, government to adequately support the growth, retention and development of the OT workforce. This starts with recognition of the skills and scope of practice that OTs have, as well as policy mechanisms that enable OTs to practice at full scope, utilising these unique skills so that they can work with people at maximum potential.

Gaps in the System of Care

OTA's recommendations:

- Significant investment is required to address the unmet need that has been identified. Agreement must be reached through the next National Mental Health and Suicide Prevention Agreement between the Commonwealth and State and Territory Governments to ensure the funding is adequate and increases over time to address the identified gaps.

The National Agreement aims to

- reduce mental health and suicide prevention system fragmentation through improved integration;
- address gaps in the mental health and suicide prevention system;

[2] Royal Australian College of General Practitioners, General Practice Health of the Nation (2024) Health-of-the-Nation-2024.pdf

[3] Australian Institute of Health and Welfare, Australian Burden of Disease Study (2023) Mental health conditions and substance use disorders a leading cause of disease burden in 2023 - Australian Institute of Health and Welfare

[4] Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing (2008) and National Study of Mental Health and Wellbeing (2023), https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release

[5] Department of Health and Aged Care, National Mental Health Workforce Strategy 2022-2032, (2022), https://www.health.gov.au/sites/default/files/2023-10/national-mental-health-workforce-strategy-2022-2032.pdf, p16

- prioritise further investment in prevention, early intervention and management of severe mental health conditions.

However government expenditure on mental health is not commensurate with need, which is a significant barrier to ensuring the National Agreement's aims are met. Only 7% of government expenditure on health is spent on mental health[6], yet mental health and substance use conditions are responsible for 15% of the total burden of ill-health in Australia, and 26% of the non-fatal "burden of disease"[7].

The Productivity Commission Inquiry into Mental Health estimated that 154,000 people who need psychosocial support cannot access it under current policy settings.[8] The Unmet Needs Analysis Report[9] indicated the actual unmet need far exceeds these estimates.

Approximately 230,500 people with severe mental illness aged 12 to 64 years are estimated to have requires psychosocial support in 2022-23, but not able to access the supports they needed; it was estimated that 14.07 million hours of psychosocial support was required to address this gap. Additionally, it is estimated that in 2022-23 approximately 263,100 people with moderate mental illness aged 12 to 64 years required psychosocial support but not able to access these supports; it was estimated that 2.76 million hours of psychosocial support was required to meet the needs of this group.

Furthermore, it is estimated that 335,800 people aged 12–64 years with severe mental illness would benefit from 21.9 million hours of psychosocial support services. A further 311,500 people aged 12–64 years with moderate mental illness would benefit from 3.3 million hours of psychosocial support services.

Psychosocial Supports outside the NDIS

OTA's recommendations:

- The Government response to the NDIS Review to be released as a priority, and that clarity be provided on the funding, design and implementation of Foundational Supports for people with psychosocial disability.
- Commonwealth and State/Territory Governments must work with clinical peaks and those with lived experience to design psychosocial support models with clearly articulated roles and associated requirements for professions to work within those roles based on their scopes of practice and training and appropriate and safe clinical governance structures.
- Ensure mental health occupational therapy skills are recognised and utilised in the psychosocial supports area of the newly formed foundational supports sector and within psychosocial support services.

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[6] Australian Institute of Health and Welfare, Australian Burden of Disease Study (2023) Mental health conditions and substance use disorders a leading cause of disease burden in 2023 - Australian Institute of Health and Welfare
[7] Australian Institute of Health and Welfare, Expenditure on mental health services (2024) Expenditure - Mental health - AIHW
[8] https://www.pc.gov.au/inquiries/completed/mental-health/report
[9] https://www.health.gov.au/sites/default/files/2024-08/analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme-final-report.pdf

- Increase opportunity and access for those seeking mental health treatment through primary health care, including reducing red tape for referral to Mental Health OTs via Medicare.

OTA welcomes the National Agreement's recognition that psychosocial supports for people with mental illness and associated functional impairment are an important part of a well-equipped mental health service system, and inclusion in the Agreement that the Parties will work together to develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS.

OTA welcomed the NDIS Review's recommendation that supports for people with psychosocial disability should be combined with broader mental health reforms outside the NDIS to better support people with severe mental illness and complex needs, and the recommendation for the development of Foundational Supports for people with psychosocial disability.

OTA is concerned, however, that the Australian Government has not yet released its response to the NDIS Review and its recommendations, despite the announcement that the Commonwealth and State and Territory Governments would jointly fund Foundational Supports.

OTs are well placed to support the NDIS Review vision for a more comprehensive and supportive mental health system. Best practice psychosocial supports involve a multidisciplinary team, and an essential foundation for the design and establishment of services is a proper understanding of how different professions contribute to different roles.

It is essential that occupational therapy be firmly embedded in future service models to facilitate opportunities and evidence-based capacity building to enable people with mental ill-health and psychosocial disability to live full lives and work towards active participation in their communities . OTs have the skills and expertise to bridge gaps across mental health, disability and primary care systems. By recognising and integrating occupational therapy into a contemporary, equitable, and responsive mental health system, unmet needs can be addressed and individuals provided with the holistic support required to thrive.

Regional Planning and Commissioning

OTA's recommendations:

- Commonwealth and State/Territory Governments must work with clinical peaks to design commissioning models that support the involvement of large and small private occupational therapy and allied health providers with a local footprint and established local expertise in service delivery.
- Commissioning models should incorporate provider panels or similar structures that support the involvement of private providers alongside larger NGOs in service delivery and commissioning processes.
- PHN governance should mandate that PHN boards should include a dedicated role for an allied health representative to ensure that allied health service delivery and scope is included in the leadership of PHNs and can also factor down through the organisation.

OTA argues that there is a need to prioritise collaborative design of commissioning processes with the clinical and NGO sector that ensures the involvement of allied health professionals, including occupational therapists.

Commissioning processes must be designed appropriately to ensure that services can be established that meet the goals of government and the needs of consumers. This must be based on an understanding of who will undertake commissioning and what services will be commissioned. A key priority in the design will be ensuring that commissioning processes enable and strengthen existing local service capacity rather than overlaying new services with no local footprint. Allied health professionals, including occupational therapists, must be seen as a key part of the psychosocial support model and any commissioning process must recognise that a majority of occupational therapists with the necessary skill and expertise now work in the private sector.

Commissioning arrangements will be critical to workforce recruitment and retention. The scope of OT practice is not well understood by some commissioners of health services and individual clinicians, leading to their exclusion, or low utilisation, in certain settings.

OTA is also concerned that the governance of PHNs appears to be medically driven by the GP profession. OTA is not aware of the number of allied health practitioners engaged at the board level. Inclusion of a dedicated role for an allied health representative would ensure that allied health service delivery and scope is included in the leadership of PHNs and can also factor down through the organisation.

Workforce

OTA recommendations:

- Address OT and Allied Health workforce shortages as a priority, as identified in the National Allied Health workforce Strategy.
- Give greater recognition to the expertise and qualifications of OTs and their essential role in the provision of mental health services by enabling full scope of practice and increasing fees.
- Address the poor data collection for allied health and OT services.
- Fund OT services within Commonwealth mental health programs, including wraparound care for complex needs, Mental Health Medicare Locals and Head to Health expansion, Commonwealth Psychosocial Support Program and psychosocial foundational supports.
- Expand Medicare Better Access to cover the full scope of OT therapeutic interventions, including assessments and treatment.
- Increase Medicare rebates and annual limits for OT services to improve affordability and accessibility.

OTs are essential to a sustainable mental health system, supporting individuals' independence, rehabilitation, recovery, and overall wellbeing. Expanding access to occupational therapy will strengthen workforce capacity and reduce pressure on primary health and acute care services. OTs have a key role in preventing deterioration and hospitalisation, by supporting function, independence, and self-management. Early intervention and capacity building for people with mental health issues reduces long-term costs and improves quality of life.

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Demand for occupational therapy services is rising—projected to grow by 7.1% by 2026[10]— yet workforce shortages are worsening, with occupational therapy shortages experienced in every state and territory across Australia[11].

Workforce shortages are at a critical level, with 6,600 occupational therapy vacancies and an annual exit rate of 8% - significantly higher than the best practice rate of 4.7%[12]. Key factors driving attrition include burnout, insufficient early career support, and poor recognition of the full scope of occupational therapy practice.

The Scope of Practice Review identified poor access to quality clinical placements and mentoring as key barriers to workforce sustainability.

In addition, the Australian Council of Deans of Health Sciences estimated in their Allied Health Aged Care Workforce Model Report that there is an allied health workforce shortfall of 25,000 professionals over the next 10 years to meet demand in aged care alone.[13]

It is worth noting that in 2021 the Department of Health and Aged Care identified occupational therapy as the fastest growing registered health profession in Australia. Between 2015 and 2019, the occupational therapy workforce experienced an annual growth rate of 7%, compared with 3.7% for psychologists[14]. Despite new occupational therapy courses being established nearly every year, those graduating from university courses are not able to meet the current and projected demand for their services.

The key barriers to the uptake of OT services in mental health and primary care are linked to insufficient reimbursement and low recognition of the scope and availability of OT services.

Currently, the uptake of OT services in primary care settings is limited by service design, limited bulk service funding incentives, and limited range and availability of Medicare rebated services. Additionally, Medicare rebates for occupational therapists are also set at rates well below the true cost of service provision, creating issues for OTs providing services, and add additional costs for consumers when they are required to pay a gap fee. As most consumers are on a low income, this results in an inability for them to access OT services.

Two key strategies have been developed that identify issues impacting on the recruitment, training, and retention of an appropriately qualified and skilled workforce to meet current and future mental health and wellbeing needs, and recommends priorities to address them.

The National Mental Health Workforce Strategy is identified in the National Agreement, but OTA draws the Productivity Commission's attention to the National Allied Health Workforce Strategy and its potential contribution to addressing future mental health and wellbeing needs.

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[10] Department of Health and Aged Care, utilising the National Health Workforce Datasets

[11] Jobs and Skills Australia, 2024 Occupation Shortage List

[12] https://www.health.gov.au/sites/default/files/2024-08/analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme-final-report.pdf

[13] Australian College of Deans of Health Sciences 2023 https://acdhs.edu.au/allied-health-aged-care-workforce-model/

[14] Department of Health. (2021). Allied Health in Australia. Retrieved from https://www.health.gov.au/health-topics/allied-health/in-australia#allied-health-workforce-numbers

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1. National Allied Health Workforce Strategy

Australia's National Allied Health Workforce Strategy recommends priorities to address current and future allied health workforce issues in Australia over the next 10 years. A key goal outlined in this draft Strategy is to enable long-term workforce planning to help ensure a sustainable supply of well-qualified allied health professionals that better matches the existing and predicted population needs.

Allied health professionals play a significant role across the health and disability and mental health sectors by assisting consumers to reduce risk factors, prescribing health promotion activities, and managing complex and chronic health issues[15]. Additionally, allied health professionals are the second largest group in the care and support workforce, enabling consumers to maximise social, recreational and workforce participation [16]. Allied health services are also critical in supporting the goals of early childhood intervention frameworks, which aim to lay the foundations in infancy and childhood for positive development, health and wellbeing across the lifespan.

Demand for health services, including allied health, is rising due to Australia's growing and ageing population, and will continue for the foreseeable future. Workforce planning is essential considering four out of the five top causes of disease in Australia require ongoing support from multidisciplinary teams that include allied health services[17], and when data shows that more than 2.4 million Australians with chronic disease accessed Medicare-subsidised allied health services in 2019 at a cost of approximately $448.2 million[18,19].

Although allied health professionals play crucial roles in the health and support sectors, national shortages in some professions[20] – which are often exacerbated in regional, rural, and remote areas – mean that waitlists to access services are common[21]. Consequently, consumers are often not able to access essential services close to home. Shortages result from numerous and compounding challenges; some of which are common

[15] Davis S, Enderby P, Harrop D and Hindle L (2017) 'Mapping the contribution of Allied Health Professions to the wider public health workforce: a rapid review of evidence-based interventions', *J Public Health (Oxf)*, 39(1);177-183.
[16] NSC (2021). *Care Workforce Labour Market Study - Final Report* https://www.jobsandskills.gov.au/sites/default/files/2023-12/Care%20Workforce%20Labour%20Market%20Study_0.pdf
[17] AIHW (2024). *The ongoing challenge of chronic conditions in Australia* https://www.aihw.gov.au/reports/australias-health/chronic-conditions-challenge
[18] AIHW (2022). *Chronic Disease Management Services in Australia* https://www.aihw.gov.au/getmedia/00dd5984-61b7-4fa6-8560-21f122b6fd4d/aihw-phc-9-chronic-disease-management.pdf.aspx
[19] AIHW (2022b). *Use of chronic disease management and allied health medicare services* https://www.aihw.gov.au/reports/chronic-disease/medicare-chronic-disease-allied-health-items/contents/allied-health-services/spending-on-medicare-subsidised-allied-health-serv
[20] AGJSA (2023). *Current skills shortages* https://www.jobsandskills.gov.au/data/skills-shortages-analysis/skills-priority-list
[21] VAHI (2023). *Routine first appointments* https://vahi.vic.gov.au/specialist-clinics/routine-first-appointments?nid=8586,

across the broader health workforce, while others are unique to allied health[22,23,24]. Workforce shortages contribute to reduced access to care and poorer outcomes for consumers, increased workloads for health practitioners, and overuse of higher-cost services such as hospital care[25].

Retention of allied health workers is of particular concern and is negatively influenced by factors including lack of workforce supports, high clinical caseloads, and insufficient career development opportunities. Difficulties in recruiting allied health workers to rural and remote areas also increases the need to focus on retention of people already practising in these areas. Some important issues raised during the consultations for the draft Strategy included reduced attraction into the allied health workforce or to working in rural and remote areas; attrition from the workforce due to culturally unsafe workplaces, burnout, lack of lateral and vertical career progression, and lack of desire to stay long-term in a rural or remote area; and recruitment competition between sectors.

2. National MH Workforce Strategy

OTA welcomed the release of the National Mental Health Workforce Strategy, and its four pillars which lay out future actions-:

- Pillar 1, which aims to address workforce shortages, improve student placements, subsidies and incentives,
- Pillar 2, with its focus on maximizing scope of practice; strengthening coordinated care and multi-disciplinary care, and ensuring the workforce is distributed to support access to services particularly in regional and rural areas,
- Pillar 3 which focusses on workplace support for mental health workforce, and
- Pillar 4, which focuses on improving data collection and utilization for planning and evaluation, and improving access to technology.

The Strategy provides an overview of the current mental health workforce and expected demand in the future. It is based on University of Queensland analysis of mental health workforce demand from the National Mental Health Service Planning Framework (NMHSPF) versus workforce supply which was commissioned to inform the development of the National Mental Health Workforce Strategy.

The NMHSPF is a needs-based planning model for Australian mental health services. It quantifies the total mental health need in the community, and then estimates the workforce and other resources required to

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[22] Scanlan J, Still M, Stewart K and Croaker J (2010) 'Recruitment and retention issues for occupational therapists in mental health: balancing the pull and the push', *Aust Occup Ther J*, 57(2);102-110.

[23] Keane S, Lincoln M and Smith T (2012) 'Retention of allied health professionals in rural New South Wales: a thematic analysis of focus group discussions', *BMC Health Serv Res.,* 12;175.

[24] Terry D, Phan H, Peck B, Hills D, Kirschbaum M, Bishop J, Obamiro K, Hoang H, Nguyen H, Baker E and Schmitz D (2021) 'Factors contributing to the recruitment and retention of rural pharmacist workforce: a systematic review', *BMC Health Serv Res*, 21(1);1052.

[25] Kruk R (2023). *Independent review of Australia's regulatory settings relating to overseas health practitioners* https://www.regulatoryreform.gov.au/sites/default/files/Final%20Report%20-%20Overseas%20Health%20Practitioner%20Regulatory%20Settings%20Review%202023%20-%20endorsed%20by%20National%20Cabinet_0.pdf

deliver evidence-based, appropriate mental health care to those populations. The analysis was limited to the workforce providing services for people with mental health problems that are within the planning/funding scope of the NMHSPF (mental health system). Workforce supply was estimated using health services administrative data and the National Health Workforce Data Set. In some instances, full-time equivalent (FTE) staff were estimated based on available service activity data and NMHSPF assumptions about working hours.

The key findings of the National Workforce Strategy were:

- There is currently a 32% shortfall in mental health workers when compared to the 2019 NMHSPF target, and this shortfall is expected to grow to 42% by 2030 if current shortages are not addressed.
- There is a predicted need for 74,252 FTE mental health staff nationally in 2019, growing to 87,645 FTE by 2030.
- There is a moderate under-provision in FTE across nearly all mental health workforce categories, with the largest relative gaps being identified for: consumer and carer peer workers (5% and 14% of the NMHSPF target respectively); psychologists (35% of the NMHSPF target); and Indigenous mental health workers (37% of the NMHSPF target).
- The availability of mental health staff is generally lower in more remote areas compared to more populous regions. However, OTA is concerned that there is a lack of data on OTs and this has resulted in lack of recognition of OTs as an essential part of the workforce:
- The analysis identified several data gaps, including on full workforce delivering psychosocial support services, with the results being limited by available data.
- Some workforce types within categories have been combined (such as Occupational Therapist and Social Worker,) due to the existence of gaps in FTE 2019 data which do not allow for separate analysis of each workforce type.

While OTA welcomes the importance placed on workforce in the National Agreement, and the intent to address mental workforce shortages and implement initiatives to attract, upskill, retain and optimally distribute and utilise mental health and suicide prevention workforce, and to consult with professional bodies. However, there needs to be greater recognition of the OT and allied health workforce in provision of mental health services, and commitment to addressing the issues facing the OT profession.

Opportunities under the National Agreement to adopt best practice approaches

In relation to the opportunities for adoption of best practice approaches across Australia, OTA raises a number of issues and concerns for the Commission's consideration.

1. There is a lack of consensus on what is best practice, with a range of models and approaches currently in place across jurisdictions, and nationally. Considerable work is required to identify and incorporate best practice into potential models for future development.
2. Since the introduction of the NDIS over ten years ago, the mental health landscape has changed dramatically. Models that were successful before the NDIS may no longer be successful. The sector has learnt an enormous amount about the value and importance of co design. At the same time, the interface between the public health system and community mental health services has completely

changed. As a result of this, the way in which the allied health sector interacts with the provision of psychosocial support services has altered and this must be taken into account in the development of new approaches, to ensure allied health is not locked out of service provision outside the NDIS.

3. There have been many new and emerging ways of understanding mental illness and psychosocial disability. Contemporary models should be developed with the social model of disability considered for the overarching approach underpinning services for people living with psychosocial disability, and those requiring psychosocial support. The social model of disability and rights-based approaches – focused on self-determination, active participation, and active citizenship - have been described as more progressive approaches that align with broader disability policy and mitigate against the risk of policy segregation.
4. Occupational therapy needs to be firmly embedded in future service models to facilitate opportunities and evidence-based capacity building to enable people living with mental ill-health to live full lives and work towards active citizenship.
5. A nationally consistent system of mental health support and service delivery is required that provides a continuum of support to meet the needs of people at all stages of their mental health journey.

Conclusion

OTA values the intent of the National Mental Health and Suicide Prevention Agreement, and we have welcomed the opportunity to provide a response to the Productivity Commission's Final Review of the National Agreement.

We would be happy to discuss this submission, and the role of OTs to support the achievement of a sustainable mental health system, and the health and wellbeing of the Australian community.

OTA looks forward to the completion of the Productivity Commission's review, and the next stage of reform under the National Agreement.



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5 / 340 Gore St. Fitzroy VIC 3065 1300 682 878 OTAUS.COM.AU