MindSpot

MQ Health
MACQUARIE UNIVERSITY
HEALTH SCIENCES CENTRE

Response to the Productivity Commission Mental Health Report (October, 2019)

Inquiry into the role of improving mental health to support economic participation and enhance productivity and economic growth

Tuesday, 21 January 2020

CONTENTS

EXECUTIVE SUMMARY

MindSpot is pleased to provide the following responses to the Productivity Commission's Mental Health Report (PC Report; October 2019).

MindSpot commends the Commission on their comprehensive analysis of the Australian mental health system. Our responses reflect the perspective of a digital mental health service (DMHS), however, many our responses are relevant to the broader mental health system.

Our general comments are summarized as follows:

1. **DMHS and Stepped Care:** We recommend the Commission further consider the potential contribution and benefits of digital mental health services at all levels of stepped care.
2. **Avoid the creation of Parallel Mental Health Systems:** We encourage the Commission to support the integration of existing and digital mental health services, where possible.
3. **Promoting Self-Help and Resilience:** We encourage the Commission to more assertively emphasise and support peoples' ability to manage their mental health.

Our main responses to the Information Requests (IR) and Draft Recommendations (DR) are summarized as follows:

1. **IR 5.1:** We endorse the use of low-intensity therapy coaches across Australia, providing robust systems are used for competency-based training, support, supervision, and accountability, similar to those used in the Beyond Blue *NewAccess* program.
2. **DR 5.6:** MindSpot is pleased the Commission recognises the potential of the Practitioner Online Referral and Treatment Service (PORTS) operating in Western Australia and funded by WAPHA as a way of integrating DHMS into primary care.
3. **IR 6.1:** We support the translation and modification of online treatment materials to serve culturally and linguistically diverse groups, guided by identified demand.
4. **DR 6.1 and 6.2:** MindSpot strongly supports the integration, expansion and promotion of online treatment options with proven clinical and cost effectiveness. We recommend that any expansion build on models with a strong evidence basis and are subject to a rigorous process of ongoing evaluation.
5. **DR 11.1:** MindSpot strongly supports the National Mental Health Workforce Strategy and recognises that reform can only be successful if we have a trained and competent workforce.
6. **DR 18.2:** MindSpot strongly supports the recommendation that all tertiary education institutions have a student mental health and wellbeing strategy. We believe that such strategies should include DMHS tailored to the particular needs of students and young adults.
7. **DR 22.5 to 25.7:** We strongly endorse the recommendations to build a culture of evaluation and improvement in all mental health services, to ensure that consumers receive care based on actual scientific evidence. We note that this a significant undertaking, requiring new systems and infrastructure and requiring engagement and support from multiple stakeholder groups.

We invite opportunities for further questions and discussions. We also wish to acknowledge the continued support and assistance of the Australian Department of Health and WAPHA.

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INTRODUCTION

The MindSpot Clinic (*MindSpot*) welcomed the October 2019 Productivity Commission Report on Mental Health (*PC Report*). We commend the Commission on their comprehensive analysis of the Australian mental health system. We note that recommendations in the MindSpot Submission (April, 2019) to the Commission are consistent with many of the draft recommendations in the PC Report.

The purpose of this, our second Submission (January, 2020) is to provide additional commentary with the aim of assisting the Commission to prepare their Final Report. We would like to start by endorsing several of the opening remarks in the PC Report including that:

- *"Substantial reform of Australia's mental health system is needed and there is no quick fix".* (Vol 1, p 6).
- *"… Benefits, while potentially substantial and widespread, may not be evident for many years into the future."* (Vol 1, p7).

We encourage the Australian Government to adopt these phrases as mantras, both to guide reform over the years to come and to firm their commitment to developing the culture of measurement and evaluation which is required to guide meaningful reform.

Given the subject matter, our comments are primarily concerned with digital/online mental health services (DMHS). However, we note that many of our suggestions are also relevant to other parts of the mental health system. Our response is organised into the following sections:

1. Section 1: General Responses to the PC Report
2. Section 2: Specific Responses to Recommendations in the PC Report
3. Section 3: Changes to the PC Report Relevant to MindSpot

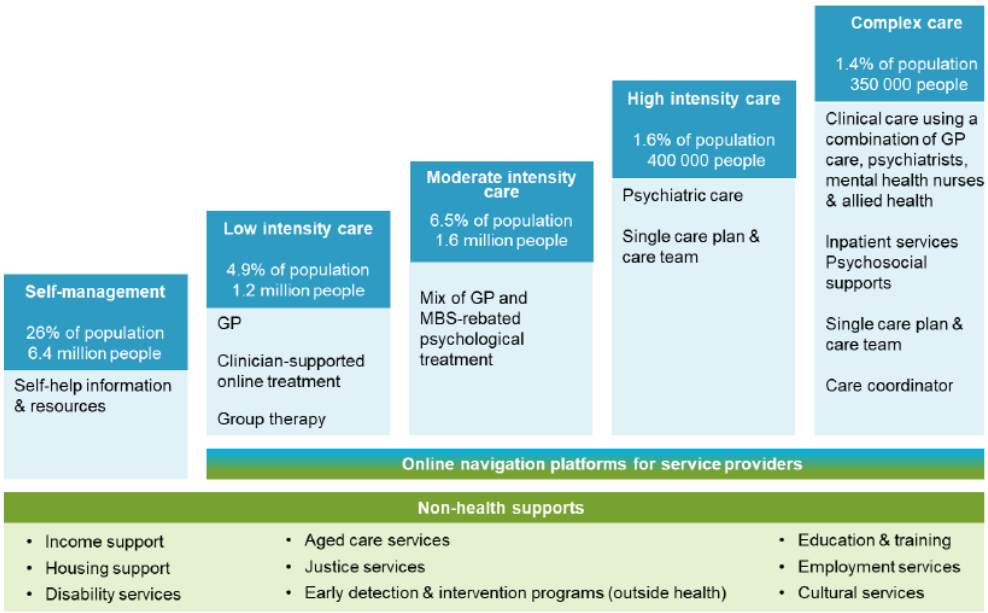
SECTION 1: GENERAL RESPONSES TO THE PC REPORT

A. Digital/Online Mental Health Services and Stepped Care

As noted in the PC Report (Figure 3, p 18, image below), clinician-assisted online treatment can make an important contribution at level 2 of the Stepped Model of Care. This level provides low intensity care to a potential pool of 4.9% of the population or 1.2 million people.

Because they can be accessed by a large proportion of the population, clinician-assisted online treatment and other DMHS, can assist consumers across the five levels of stepped care regardless of severity, with specific content and contact modified for each level.

Figure 3 **Stepped model of care**
Estimated number of people requiring each level of care



For example, information on developing and maintaining mental wellbeing should be available to consumers across the five levels, including in self-guided or self-help formats. Specific information on managing wellbeing in the context of acute psychosis could be targeted to those at levels four and five and their carers.

Based on the experience of MindSpot, access to evidence-based information can assist consumers to make informed decisions about managing their mental health. In addition, access to self-directed information with proven efficacy which may reduce the requirement for further services, for some consumers.

B. Avoiding a Parallel Mental Health System

Further to our comments about stepped care, we also wish to briefly address the future relationship between DMHS and the wider mental health system. While MindSpot recognises that there is a strong argument for long-term funding of stand-alone DMHS such as MindSpot, we also believe it is critical that existing services are encouraged to use digital mental health tools. This will serve several aims, including:

1) Providing existing services with resources for measuring, monitoring and reporting outcomes
2) Training clinicians in the use of digital mental health tools and resources
3) Improving the consistency in the delivery of treatments and adoption of evidence-based clinical processes
4) Reducing confusion for consumers seeking services or health professionals looking to refer consumers
5) Reducing duplication of effort in assessment and treatment and providing stepwise escalation of care according to clinical need

We note, however, that integration with existing services, especially services provided for profit, is complex and difficult and has not been particularly successful in parts of Europe, where large-scale programs aimed at integrating digital and traditional care have met with limited success. Hence, efficient integration of DMHS in the wider Australian mental health system will require considerable attention, planning and resources, as well as engagement and commitment from multiple stakeholder groups.

C. The Role of Individual Behaviour and Choice in Mental Health

The Inquiry Background and Approach section of the PC Report provide a comprehensive narrative about the costs and determinants of mental health, mental ill-health and suicide. For example, Figure

Figure 1.2 **The many interconnected determinants of mental health**

1.2 describes the many interconnected determinants of mental health (p119; see image below), including social inclusion, supportive environments, psychosocial services, participation in and contribution to the community, personal history and healthcare.

We believe DHMS have an important role to play in both researching the determinants of what we consider to be good mental health using large samples, and in delivering the information derived from that research to the very large subclinical and at risk population.

In addition, and as indicated in the MindSpot Submission (April, 2019), MindSpot encourages the Commission to broaden this perspective to examine the actions of individuals, communities and Governments that enhance or impair mental health. We believe a narrative that includes strong reference to the role of personal responsibility, ability and action in developing and maintaining good mental health will more effectively promote self-help and resilience. We also believe that information about the role and actual outcomes of mental health services will support consumers to develop realistic expectations about what mental health services can and cannot achieve.

SECTION 2: SPECIFIC RESPONSES TO RECOMMENDATIONS IN THE PC REPORT

While we support many of the recommendations in the PC Report, we will only respond to those most salient to MindSpot services. Our responses to the Information Requests (IR) and Draft Recommendations (DR) are presented in the sequence they appear in the PC Report.

A. IR 5.1 – Low-Intensity Therapy Coaches as an Alternative to Psychological Therapists

As noted in the PC report, several programs are now offering low-intensity psychological services delivered via credentialed mental health professionals or coaches. There are relatively few mental health coaches in Australia but an excellent example of such a workforce is operated by the NewAccess program offered by Beyond Blue, which is delivered by at least 10 PHNs across Australia.

NewAccess provides coaches with almost two months of intensive training, 12 months of on-the-job training, and regular supervision and support. NewAccess is one of the few programs to conduct routine outcome monitoring using validated clinical measures of symptom severity. Reported outcomes of NewAccess indicate the program consistently achieves clinically significant reductions in symptoms of anxiety and depression (EY, 2015).

Given the comparatively low number of mental health professionals compared to the estimated number of people with clinically significant conditions, particularly outside of metropolitan areas, MindSpot endorses the further evaluation and use of low-intensity therapy coaches across Australia. We note that programs using low-intensity therapy coaches provide consumers with choice about who provides a service, and that choice is an increasingly important feature of contemporary mental health services.

We note, however, that services employing low-intensity therapy coaches should provide robust systems for competency-based training, support, supervision, and accountability, similar to those demonstrated as effective by NewAccess. There are significant infrastructure requirements to support this new workforce including: accessible training programs, national funding, methods of virtual care, online and telephone delivery models, and promotional campaigns. Promotional campaigns and relevant marketing are particularly important given that low-intensity therapy coaches are still relatively new in Australia.

The question of who would most benefit from services provided by credentialed coaches is an important one. Given that the role of credentialed coaches is to support consumers to learn evidence-based skills, it is likely that such services should be primarily directed at consumers with lower levels of severity. However, it is likely that some consumers with more complex needs would also benefit from learning such skills, hence these services could be adapted for consumers at different levels of stepped care.

B. DR 5.2 – Assessment and Referral Practices in Line with Consumer Treatment Needs

MindSpot fully supports the recommendation that assessment and referral practices be aligned with consumer treatment needs and preferences. The success of this recommendation is dependent on effective methods of measuring, reporting, and interpreting results, a theme re-visited throughout this Submission.

C. DR 5.6 – Practitioner Online Referral and Treatment Service

MindSpot is pleased the Commission recognises the potential of the Practitioner Online Referral and Treatment Service (PORTS), funded by the WA Primary Health Alliance (WAPHA), and operating in Western Australia. PORTS is a sister clinic to MindSpot and is specifically designed and resourced to work in primary care. PORTS has demonstrated the potential of DMHS even amongst hard to reach populations across a huge land area and in disadvantaged sections of the community. The PORTS model demonstrates how DHMS can integrate with the existing mental health system and a stepped care approach, and also provides the potential to further evaluate the economic value of DHMS. We would be pleased to discuss PORTS further with the Commission and with PHNs.

D. IR 6.1 – Supported Online Treatment for Culturally and Linguistically Diverse (CALD) People

Via research efforts at our research clinic, the eCentreClinic, Macquarie University, and in collaboration with partners overseas, we have conducted several trials of online interventions that have been translated from English into Chinese, Arabic, and French languages (Kayrouz et al., 2015; 2016; Lu et al., 2013; Robichaud et al., 2019).

Several of our key findings to date may be of interest to the Commission. These include:

- Historically, the cost of translating content of online treatments has been considerable (approximately $50,000 for translation of a 5-module intervention and the associated materials). Operationally, delivering services in languages other than English is complex and expensive, and requires employing therapists and ideally senior therapists who speak the target languages, and developers who can create and update websites and content. Combined, these factors, together with the absence of strong acceptance or demand from CALD populations have prohibited the routine delivery of supported online treatment for non-English speaking Australians.
- Our understanding of the literature and our clinical and research experiences indicate that although target communities may report significant interest in translated material (Kayrouz et al., 2015) when available, uptake can be very low. At least three factors affect uptake:
    - Concern with privacy, confidentiality, and stigma/shame, particularly by non-English speaking communities who have re-located from places with repressive or authoritarian regimes, and who prefer not to share personal details with health professionals.
    - Beliefs about mental health and wellbeing by migrants which are not aligned with our dominant Western views.
    - We have observed that people from culturally and linguistically diverse communities may present with high levels of psychological distress which may appear to require mental health services, but which are natural reactions to unmet social or other needs. When those other needs, such as housing or employment, are addressed, the person's psychological difficulties resolve.

- In addition, we have been surprised at the proportion of individuals from culturally and linguistically diverse groups who, when presented with the choice between a 'translated' or 'mainstream' intervention, opt for the 'mainstream' version (e.g., Kayrouz et al., 2016; Titov et al., 2018). Such individuals often report that they are keen to practice their English language skills, and do not wish to be seen as 'different'.
- Notwithstanding these challenges, we strongly support exploring how to best translate and then deliver DMHS and interventions for people from culturally and linguistically diverse groups. In particular, we note that the recent creation of automated translation tools, such as Google Translate, offers enormous opportunities for reducing costs. In addition, we note that providing automated services can also significantly simplify the operations and reduce the overall costs of developing and operating such service models.

- Our response to the specific questions posed in the PC Report are included below:
  1) *In what circumstances would the delivery of supported online treatment be cost-effective?*
     - We recommend taking a pragmatic but cost-effective approach with several steps, beginning with translating and delivering relatively simple, but helpful content, such as fact/tip sheets. This will provide the opportunity to gauge actual interest and demand and to build credibility with the target communities, before a higher level of investment and commitment is made.
  2) *What constraints would need to be considered?*
     - A significant challenge affecting planning is the absence of data about true demand. As indicated above, a gradual approach will help establish demand.
  3) *Which language or cultural group should be the focus of any trial expansions?*
     - Given changes in Australia's demographic profiles, we recommend that recent ABS data about country of origin, language spoken at home, and similar data are examined to inform trials.

E. DR 6.1 – Supported Online Treatment Options Should Be Integrated and Expanded

MindSpot is very pleased to endorse the recommendation to expand, integrate and promote supported online treatments and services. The primary benefits of services such as MindSpot are identified in the PC Report and include providing clinically effective care to people across Australia, many of whom would not otherwise access care. Additional benefits include providing referral pathways from primary care, routine outcome measurement and reporting, fidelity of service delivery, cost-effectiveness, and providing care that is timely, is consistent with treatment needs, and does not impose undue burden on either consumer or their carer (Titov et al., 2017).

We also commend the Commission for recognizing that scaling up the capacity of this sector requires careful consideration, planning, and investment. In particular, we note that appropriate attention should be given to workforce development, integration with primary care, integration with health data systems, and quality assurance. Our concern is that poorly managed and poorly integrated expansion may not deliver the same level of benefit to consumers and carers achieved at the current scale. We also encourage the Commission and funders to be clear about the true value proposition of this sector, which is that DMHS are not a replacement for existing services, but can greatly improve the reach of services and efficacy of the mental health system as a whole. Finally, we note that such services need to maintain high safety and quality standards and we draw the Commission's attention to the work conducted by the Australian Commission for Safety and Quality in Health Care on developing a

national standards and certification framework (ACSQHC, 2020) as providing a minimum standard framework for this sector.

With regards to funding, given the low cost per service of online treatment and the proven ability of DHMS to improve access to care for disadvantaged Australians by reducing a range of barriers to care, and the experience of attempts to commercialise DHMS elsewhere, we would recommend that stand-alone DHMS continue to be funded by the Commonwealth, either in the current system or via a Medicare rebate for those services which meet national accreditation standards, once those standards are developed and adopted.

F. DR 6.2 – Information Campaign to Promote Supported Online Treatment

MindSpot also strongly supports the recommendation to promote supported online-treatment services, noting that such campaigns should target different user groups such as consumers, carers, and health professionals, who will use supported online treatments in different ways. We also wish to draw the Commission's attention to the substantive work conducted by the e-Mental Health in Practice (eMH Prac) project, based at the Queensland University of Technology (eMH Prac, 2020). eMH Prac has developed educational and promotional campaigns targeting allied health professionals and primary care and has considerable knowledge and experience in this area.

G. DR 11.1 – The National Mental Health Workforce Strategy

MindSpot strongly supports this recommendation and recognises the need to train the future, as well as the existing mental health force in the safe and effective use of digital mental health services. Since launching MindSpot we have consistently noted that new graduates in psychology, social work, and nursing typically have limited (if any) knowledge about digital mental health services, or measurement of outcome, and have had no training or experience the safe and effective delivery of DMHS.

This is a challenging situation, and one which places the sector at considerable risk. To address this gap, MindSpot has begun training interns and registrars in the MindSpot Academy. The Academy is now currently providing up to 15 therapists each year with training and supervision in the safe and effective delivery of digital mental health care. Most of these therapists are currently located in the Eastern states, but we are expanding the number of places and extending these opportunities, with the aim of offering 'virtual' placements across Australia. We also plan to extend training opportunities to experienced mental health professionals and for staff involved in service planning, evaluation and reporting. We would be pleased to co-ordinate and collaborate with the National Mental Health Workforce Strategy on this initiative.

H. DR 18.2 – Student Mental Health and Wellbeing Strategy in Tertiary Education Institutions

MindSpot strongly supports the recommendation to require all tertiary education institutions to develop comprehensive student mental health and wellbeing strategies. Research across several countries has found higher levels of psychological distress and disorder among students in tertiary institutions compared to the general population (Auerbach et al., 2018). Tertiary institutions often provide a range of services including prevention and wellbeing activities, group and individual treatment, crisis and post-crisis management often in collaboration with GP or other primary care services and sometimes with specialist psychiatric care. However, unfortunately, most tertiary education institutions have insufficient capacity to meet the potential demand, partly because clinical service models are often

limited to models of face-to-face service provision, but also because of the high demand for services. Consequently, an increasing number of tertiary education institutions are now considering how to integrate DMHS as a strategy to both improve access as well as to increase service capacity.

We draw the Commission's attention to the example of the UniWellbeing Course, developed by the eCentreClinic, Macquarie University. This evidence-based intervention treats anxiety and depression in students and is now routinely used by the Campus Wellbeing service at Macquarie University with more than 300 students each year. The UniWellbeing intervention has been evaluated in both clinical trials and routine care, is highly acceptable to consumers and produces significant improvements in mental health (Dear et al., 2019). Consistent with expectations of contemporary mental health services, the UniWellbeing course includes routine measurement of clinical outcomes and consumer experience, which facilitates quality assurance activities. We would be pleased to provide more information about this model to the Commission.

I. DRs 22.5 to 25.7 - Evaluation

MindSpot is very pleased to support the recommendations relating to evaluation (22.5, 25.1, 25.4, 25.5, 25.6, 25.7). We specifically support the recommendation that the National Mental Health Commission (NMHC) play a significant role in leading the evaluation of mental health and suicide prevention programs, and others. We encourage the NMHC to adopt a broad view to facilitating the development of a culture of evaluation by considering how to promote change across multiple stakeholder groups. For example, the following key stakeholder groups can be targeted with specific activities:

- Consumers and Carers: May benefit from education and promotions about the importance of routine evaluation with the aim of creating awareness that measurement is a necessary and valuable activity. This will also create public expectations that measurement is a natural activity of high-quality mental health services.
- Mental Health Professionals: Providing nationally mandated education, training and resources to mental health professionals about how to routinely administer, interpret and report brief measures of outcome and experience to consumers will also facilitate uptake.
- Regulatory Bodies: Requiring professional groups and governing agencies including the Australian Health Practitioners Regulation Agency to include criteria about routine outcome measurement and reporting as part of the annual registration of mental health professionals, will highlight the importance of this activity.
- Infrastructure Providers: A national data infrastructure is necessary to support data collection, monitoring, evaluation and interpretation activities, and is therefore a necessary condition for the successful development of an evaluation culture.
- Funders: Funders need to consider financial incentives or penalties for not collecting and reporting outcomes.

We acknowledge that there is already a large amount of data collected, and the process of data collection often reduces the time available for patient care. Hence, we would recommend that measurement be clearly for the benefit of individual consumers and for improving the effectiveness of services. Given the massive complexities associated with developing a culture of evaluation, we recommend that systems of data collection and reporting are trialed on a smaller scale, before national roll-out. This would provide the opportunity for learning and improvement of systems and processes, as well as identifying success stories, which will subsequently assist with promoting larger scale change.

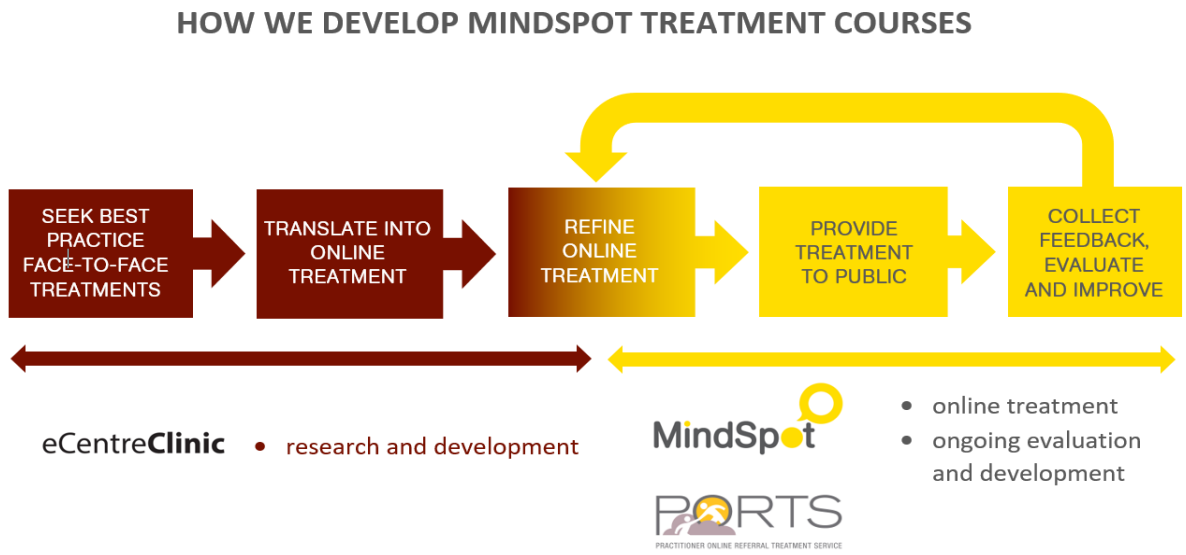
SECTION 3: CHANGES

TO THE PC REPORT RELEVANT TO MINDSPOT

- The Commission's reporting in the PC Report of MindSpot and PORTS' activities was accurate and comprehensive. The only change we recommend relates to the data reported in Volume 1, p 204, Box 5.1, final bullet point "4000 using supported online treatment (MindSpot Clinic 2019)".
    - We recommend the Commission modify this bullet point to note that "21,000 people per year register to use the MindSpot assessment and treatment services, of whom 4,000 receive online treatment".

ABOUT MINDSPOT

The MindSpot Clinic, PORTS and the eCentreClinic, Macquarie University, deliver services to more than 25,000 Australians each year. By using technology to deliver services, these clinics reduce barriers to care. Treatments are initially developed and evaluated in clinical trials at the eCentreClinic and are then delivered at MindSpot and PORTS clinics using translational research.



Details of each clinic are included below. As noted, despite the low public profile of these clinics, their reach and significance is considerable. Moreover, the treatments and service models used at MindSpot are of considerable international interest and are being used or considered for use in Canada, New Zealand, the US and UK.

1. The MindSpot Clinic

The MindSpot Clinic is the world's first national digital mental health service. MindSpot is fully funded by the Australian Department of Health and provides services free to consumers across Australia.

MindSpot provides confidential online and telephone mental health assessment and treatments courses. It also supports consumers to locate and access local services that can help. The treatment courses are clinically effective are were developed and evaluated at the eCentreClinic with consumer input in clinical trials with more than 9,000 people.

MindSpot reaches consumers across Australia, including significant numbers of consumers in rural and remote locations, Indigenous Australians, and people who had no previous experience with mental health care. The evaluation showed that the outcomes of MindSpot treatment are comparable to those provided by high quality face-to face CBT treatments. The treatment courses produce significant clinical improvements in at least 70% of people and more than 90% of consumers report they would recommend the treatments to a friend. An independent study concluded MindSpot provides a highly cost-effective model of care [Yu-Chen Lee et al., 2017]. A recent report showed MindSpot produces excellent outcomes when compared with digital clinics from other countries [Titov et al., 2018].

Demand for MindSpot is increasing, and today more than 20,000 Australians register to use MindSpot each year. To date, more than 100,000 Australians have registered to use MindSpot.

2. PORTS

The Practitioner Online Referral and Treatment Service (PORTS) is a State-wide primary mental health service commissioned by the Western Australia Primary Health Alliance (WAPHA).

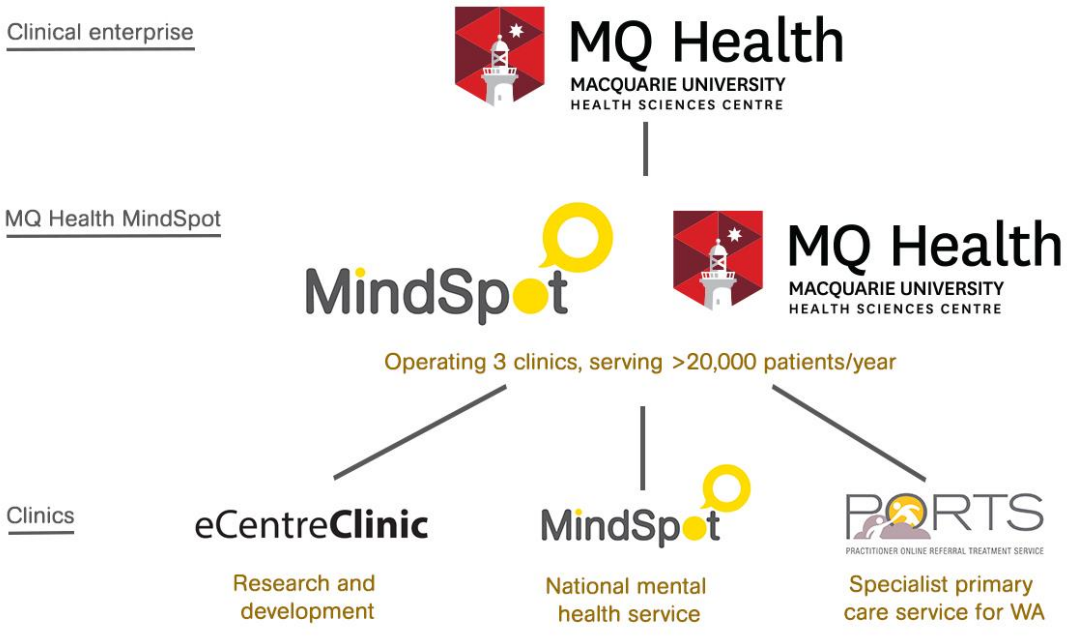
PORTS assists GPs in caring for consumers with anxiety, depression and substance use problems. Since launching in 2017, >700 GPs from across WA have registered with PORTS and >3,000 GP-referred consumers have undertaken PORTS services with strong growth expected in the next 12 months. The service models was co-designed with GPs to help them to quickly refer consumers to care.

PORTS provides mental health assessments and free telephone or online treatment courses to help Western Australians aged 16 years. PORTS also co-ordinates with other services to facilitate consumers' access to face-to-face services or crisis services, if required. The referral service provides timely reporting back to the GP and allows them to track consumer progress.

3. eCentreClinic

The eCentreClinic is our research clinic where we develop and evaluate treatment programs for common mental health mental conditions and chronic physical health conditions. All treatments are co-designed in collaboration with consumers and then evaluated in clinical trials.

To date, the eCentreClinic has conducted more than 70 clinical trials involving more than 9,000 people, developed more than 15 online treatments, and published more than 100 scientific papers describing outcomes and cost-effectiveness.



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