Submission into the Australian Government Productivity Commission Inquiry into Mental Health.

09 April 2019

Thank you for the opportunity to provide a submission to the Productivity Commission inquiry into mental health outcomes in our community. I am a registered psychologist (since 1989), BSc(Psych, hons), PhD (clinical) working in private practice, and have 30 years' experience working across the lifespan with the most complex of clients and having had specialised training in many psychological therapies (e.g. EMDR, DBT, CBT, ACT, IPT, EFT). My submission focuses primarily on the Better Access Medicare program and the planned Adult Headspace Centres. I will address the questions posed by the Productivity Commission.

Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?

Ten Medicare sessions for clients with complex psychological conditions through the Better Access Program is inadequate. Even the founder of Cognitive Behaviour therapy, Aaron Beck, has written to the Australian Government to support the evidence that 10 sessions are not enough (http://drben.com.au/?p=1076). Clients either run out of sessions early and can no longer afford to pay, leaving them prone to relapse or psychologists either sacrificing their livelihood providing free sessions or very low cost that would not meet business costs. Alternatively clients try to maximise the year with 10 sessions and attend monthly, which is not frequent enough for improved outcomes in the early stages or for maintenance of gains made. I find that frequent sessions in the beginning of therapy result in quicker more effective outcomes than staggering over the year, but most clients with complex conditions benefit from further maintenance sessions to precent relapse.

To put into perspective the inadequacy of the Australian Government having already cut sessions from 18 to 10 per year, in Germany clients are allowed 80+ sessions, with no requirement to see a GP (https://www.newpathspsychology.com.au/psychology-medicare-good-bad-vision/?fbclid=IwAR1GohOnUtFF3UkWoedSJ-iKs3ecXqf0QWcCU_1kvxyMgx0JQzV2j1HCfJc). However, this does not mean that clients will abuse this, in fact the opposite has been found to be true. Research demonstrates that where people have been given unlimited access to psychological therapy, allowing them to access as much therapy as they desire. Some access large amounts of therapy, some access just a few sessions - as we might expect. Pooled together, the average amount of sessions people access is between 7-9 appointments (http://societyforpsychotherapy.org/what-do-we-know-about.../). This shows that the number of sessions people use are not going to blow out as wildly as one might imagine. Importantly, setting an arbitrary maximum cap at ten sessions prevents those people who actually need that amount from obtaining it.

This has serious deleterious consequences. When people don't receive the psychological support they require, their distress often manifests in lowered productivity at work, costs in family life, relationships, drug/alcohol use, and physical health. This is a great burden for our society socially and economically- one night in hospital for a mental health issue costs, on average, $1000 per day.

I am highly concerned about more funding being taken away from the Better Access program towards headspace when there is no evidence base, and Government is being swayed by a few powerful psychiatrists. I will discuss thus further below.

Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?

Each year we see more funding taken away from the Better Access Program towards Headspace and Primary Health Networks.

The airwaves and printed media have been bombarded over the past few months, increasingly over the past few weeks, as the Federal election and Budget impend. I have read and heard many politicians and a few well-known psychiatrists (e.g. Ian Hickie, Patrick McGorry and John Mendoza), criticise the Better Access Program. These critics fail to appreciate how the Medicare system is intended to function or how it is actually used by the wider general public. What is needed is a re-design of Medicare-supported psychological care to align with how the public actually uses therapy. It is beyond me why these Psychiatrists, not working at grass roots like myself, are allowed to spread false narrative and speak on behalf of psychologists when they are psychiatrists, as well as denigrate them in the process.

Here is a case in point. Ian Hickie makes comments such as, "*Unfortunately in our area, individual practitioners operating on their own, small businesses, do not deliver good outcomes, and the evidence has been absolutely clear*" (Feb 18th 2019, ABC Interview with Norman Swan). He is actively trying to eliminate small private practices like mine that provide a vital, highly effective service, evidenced by positive outcomes. Prof Hickie has repeatedly argued that psychological services have not been evaluated. This is not true. In 2011, the Better Access evaluation (Pirkis et al, 2001) demonstrated that the program was providing positive therapeutic outcomes for people with moderate and severe mental health problems (not the 'worried well', as Ian Hickie frequently refers to them).

Data overwhelmingly demonstrates that our community saves money and lives by investing in psychological care. As demonstrated in drben.com.au, providing clients access to psychotherapy reduces dependence on medications, the need for ongoing consultations with primary care physicians, length of in-patient stays at hospital, and general health care expenditures by 60% to 90% (Chiles et al., 2006; Kraft et al., 2006). In Australia, the average estimated cost for a single night in a psychiatric hospital is over $1000. More recently, research based on over 22,000 clients across a five-year period, suggests that outpatient psychotherapy helps by reducing work disability days (by 41.8%), hospitalisation days (by 27.4%), and inpatient costs (by 21.5%). The long-term effects reveal that the number of sick days was lower (by 23.8%) one year after psychotherapy (Altman et al., 2016). In terms of economic productivity, for every dollar we spend there is a $2 to $3 return on investment. And when we factor in health costs, for every dollar we spend we see 3 to 5 times the benefit in health returns (Chisholm et al., 2016). Psychological health care provides more economic benefits than general practitioner , followed by psychiatrists, yet the funding system is stacked opposite. If so much funding is allocated towards increasing awareness for mental health concerns, then surely it makes sense for us to grant people access to enough support to recover.

A recent article written by Rosenberg and Hickie (2019) in the Medical Journal of Australia (MJA), was riddled with inaccuracies about the Better Access program and psychologists (https://insightplus.mja.com.au/2019/7/mbs-mental-health-review-more-of-the-same/?fbclid=IwAR3T1T1vVRXqH2W0J3AYVqwIPUQ95M2sOp8jB2rnbBD3WUGMPHpA6JtVb-c)As noted in the comments section of this MJA article, a consumer's comment captured the negative implications of Hickie's push towards Team Based centres:

"*Better Access has been a life saver for me and many of my peers. It is the number one issue that gets raised in the peer support networks I am involved with. The hypocrisy of Hickie's stance is sickening, considering that he was a major driver for sessions being cut in the first place, given the fierce public campaign he ran and lobbying of federal politicians. It is shameful and disrespectful to mental health consumers.*

Disadvantaged people like me, who have been caught up in the mental health system for years, want to be able to have the freedom of choice to access what services we need. We are the experts. We have experienced the styles of centre-based service provision that Hickie and Rosenberg propose. Those types of services have caused us considerable harm.

They remove choice and stop us from seeking help from a preferred practitioner. You have very limited options of service provider under centre-based models of care. That type of service provision has caused me great harm over the decades, due to not being in control of who you get to see, sometimes strict access criteria, inept and non-trauma informed staff, limited number of sessions or limited time you can access the service before being kicked out."(MJA, 2019)

A psychologist in private practice noted the benefits of face-to-face treatment over e-treatment:

"*As for online so called e therapies and resources, whilst there is role for these, there are already a proliferation of websites, YouTube videos posting motivational talks etc all accessible free on online . I actively encourage clients to utilise these and can be helpful, however, the power of the therapeutic relationship cannot be created with someone in deep, emotional pain staring at a computer screen, it comes from human connection, feeling human presence and teary client eyes looking into the eyes of someone who has compassion and humanity. Similarly, seeing a beaming face when positive healing and growth is reported and celebrated, these things occur in therapy rooms everywhere.*

For too long the same voices of academics and attention seekers and those with other agendas are being heard at the expense of those of us who work at the coal face and deal *with clients on a daily basis and who hand out plenty of tissues, worksheets, guidance but more importantly, authentic human connection (MJA, 2019).*

The following comment in the MJA (2019) provides evidence to defend the Better Access Program:

“ *Some other points to consider about the statement that the Better Access scheme “has had marginal, if any, impact on the prevalence of mental illness in Australia” and the recent study by Jorm* (https://journals.sagepub.com/doi/abs/10.1177/0004867418804066)*:*

** The majority of Australians with a diagnosed mental disorder (54%) do not access any form of treatment.*
** Of those who do access care, the proportion is half that of people with physical disorders.*
** ABS stats show that only around 7% of Australians access any mental health related services in Medicare. Only 3.2% of people see a psychologist.*
** While mental illness is often a factor to suicide, we must not ignore other big contributing factors such as economic distress, chronic pain, and isolation.*
** In Australia, men are three times more likely to take their own lives than women – and the highest rate of suicide is for middle aged men. Yet there is evidence that fewer than a third of male suicides are associated with depression.*

Given the above, why would we expect distress to decline across the entire Australian population? Is it sensible to rely on the national suicide rate as a yardstick to measure the effectiveness of this scheme?

Population level data tell us next to nothing about the positive impact of the Medicare scheme, simply due to the fact that most people in the Australian population never access the program. If we want to know what impact any program has, then look at studies where we actually have data on those people who accessed that program, not population-level statistics.”

How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?

Psychologists don’t need more incentives to deliver good outcomes- the majority of Australian Psychologists are “intuitive feelers”- this means we possess empathy and compassion and are driven by a desire to help others, and we are not driven by financial incentives. However, a non-endorsed psychologist attracts a rebate of $84.80. When running costs are taken into account, this means a psychologist is earning $30/hour. It would require seeing 8 clients a day, 5 days per week. The APS has reported that seeing more than 5 clients a day means that client service is compromised and places the psychologist at severe risk of burnout. It is not possible for most psychologists to deliver a good quality service and financially survive if fully bulk-billing. A one tier service would enable an increased rebate for all clients.

The bias in rebates is evident when comparing rebates for psychologists, GPs and psychiatrists. A GP only needs to have carried out a 6 -day course (1 day per module) to be able to provide focussed psychological services, hypnosis, CBT and IPT compared with 6 years for a registered psychologist (racgp.org.au- mental health training). Yet the rebate GPs attract is $132.74 for 40 minutes versus $84.80 for 50+ minutes for a registered psychologist, $124.50 for a clinical psychologist. How is this fair?

- **How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?**

Redistributing rebates equitably, as per above would fund more sessions for those in most need, particularly those with complex conditions, and also allow bulk billing for lower income consumers, often the most needy of psychological services. I am concerned about the APS proposal (2019) to require patients to return for an independent assessment after 3 sessions with a psychologist after initial referral to a psychologist using a Stepped Care Model. I have had discussions with general practitioners about this issue and they feel that it is unlikely many patients will return for this GP assessment- at least after the 6 session visit this is usually enough time for them to visit for another reason e.g. script, but time and extra costs will likely prevent the seamless process of therapy occurring. I suggest considering whether GPs need to be the gatekeepers when they are not experts in assessment and diagnosis of mental health conditions. At a minimum, the 6 session review could be eliminated and more funding be allocated to the Better Access program for treatment rather than review which the psychologist does anyway.

- **What government services and payments beyond those directly targeted at mental health should this inquiry seek to quantify, and how should this be done?**

Before allocating further funding towards more Headspace Centres, it is imperative that their efficacy be evaluated- the model used for young people has yet to provide evidence for its efficacy, it is much more costly that private practice, yet powerful psychiatrists such as Hickie and McGorry are allowed to make false statements. It is time that private practice outcomes were compared with those of Headspace- private practice allows choice, still allows a team-based approach to occur, and is more cost-effective. Compare my fees of $150 (very few psychologists charge the APS recommended fee of $250), with the average cost of service at Headspace being $339 (range $136-over $1000, https://www.abc.net.au/news/2016-12-16/headspace-only-small-benefit-for-youth-mental-health/8125698). I also take a team-based approach, but not everybody with severe cases needs a suite of medical and health professionals, and it’s difficult enough for a severely depressed client to get to see one health professional, not to mention those with social anxiety.

Over the last decade, significant misinformation has been provided to government and professional bodies such as Medicare, WorkCover, DVA, NDIS, claiming the superiority of clinical psychologists over other psychologists (for example, the multiple submissions made by the Australian Clinical Psychology Association and submissions by the Australian

Psychological Society to varied organisations (APS 2018, 2019). The result of these non-evidence- based assertions and misinformation has led to the development of the two-tier Medicare rebate system, two-tier DVA and most recently a proposed two-tier NDIS system, ensuring that clinical psychology services receive significantly higher rebates than all other psychology services. All the research data points to no significant difference in competencies between clinical psychologists and other psychologists (e.g. Pirkis et al, 2001; O'Donovan et al., 2005; Anderson, 2016).

I recommend removing the two-tier system in favour of one tier for four reasons: a) no evidence base to support a two tier, v) negative impact on the community, including financial sustainability 3) negative impact on the psychology profession and discriminatory practice 4) barriers to bridging courses for those not endorsed. I will address each point below:

Negative impact on the community

The plan by the APS to introduce a three tiered system is not based on any evidence. (Pirkis et al., 2011; Anderson 2016). The two-tier system limits access to experienced practitioners who are unable to practise in areas where they have specific expertise. Clients are restricted in their choice of practitioner due to this arbitrary and discriminatory division. Marked inequity in Medicare funding allocated to members of the public via different rebates according to type of psychologist seen. From July 2015 to December 2016, the cost to government of psychological rebates was almost $485 million dollars. More than half of this was spent on clinical psychologists, who represented only a fifth of the workforce (Dept. Human Services, 2016, Medicare data). With their growth increasing at 10% per year, in the next 5 years, rebates for clinical psychology services will absorb almost the entire current Better Access funding for mental health. Having one tier will positively address this problem. The cost of Medicare rebates is accelerating out of proportion to the delivery of public good. For example, a single-tier Medicare rebate of $105 would provide millions of psychological services for clients without impairing the current levels of Better Access funding over the next five years.

Artificial delineation and proposal by the APS to further delineate by restricting treatment of complex conditions to clinical psychologists means there will be unnecessary restriction of consumer choice, restriction of trade practice, burnout in remaining psychologists and is going to cause much more damage than good. It is difficult enough for consumers in regional and rural areas to access a psychologist- proposing a stepped model and hoping that those with milder conditions will be catered for is not going to work

If the APS and Government truly cares about the welfare of our community, it must abandon not only the two tiered model, and give up on trying to repackage its recently proposed three-level model of psychology service provision (that was rejected by the Mental Health Reference Group and the Federal Government) under Medicare. All registered psychologists are qualified to provide psychological therapies at all levels of service provision, depending on their training, experience and competency. The APS should not promote any models that presume any sub-section of registered and practising psychologists as unqualified, incompetent and/or inferior. The APS Expert Committee Terms of Reference must be reviewed and changed to abandon differentiation based on endorsed of practice as defined by the Psychology Board of Australia and/or APS College Membership or equivalent. The APS must advocate for and promote all psychologists in a fair and equal manner.

Stepped Care Model

It is irresponsible and against our code of ethics of evidence-based practice that the APS are recommending the Stepped Care Model. In their current stance the APS state that they have researched stepped care and believe it to be the best approach. This model that has not been inadequately researched, there has limited evidence to support its efficacy and has not been thoroughly investigated as best practice in psychological care. For example, UK research by Richards, et al (2010) suggest that attrition rates from services are no better with stepped care and referrals of people up to more severe treatment levels are low. The APS proposal is reactive and unlikely to result in improved access to mental health services.

Focussed Psychological Strategies dictates a restrictive set of psychological techniques (See Appendix A). All psychologists are educated and trained in the main therapeutic approaches of psychology and psychotherapy. However, many have completed further non-university-based study in areas such as Acceptance and Commitment Therapy, Schema Therapy, EMDR and other Trauma-Focussed Therapies, Narrative Therapy etc. If psychologists have completed further training in these areas and receive certificates of competency, they should be allowed to use the evidence-based approach that is most suited to the client. For example, EMDR requires therapists to be certified by the international EMDR Institute and is now considered an evidence-based practice. This certified training is not part of any clinical masters program and psychologists outlay thousands of dollar to be certified. Similarly, many non-clinically endorsed psychologists are advanced trained in ACT or Schema Therapy. However, due to the restrictions placed on the FPS, these therapies cannot be used with Medicare clients.

Inversely, there are no restrictions placed on clinical psychologists under the ‘psychological therapy services’ category. If these arbitrary restrictions must continue, the FPS strategies needs to be updated in light of new research on evidence-based practices.

It appears the Stepped Model is being equated to a medical model of care, and this underestimates the complexity of mental health disorders. Practical problems will arise: I frequently see clients who are referred with “anxiety adjustment disorder”, and low and behold after rapport is established, the “real issues” come out and they move to a complex condition e.g. trauma. I am trained and skilled in trauma therapy, I have already established an alliance with the client, they want to return to work with me, but suddenly they are no longer able to see me because I don’t have a Clinical Psychology endorsement. I fail to see how this framework is in the best interests of client or our community. The Stepped Care Model should enable greater access to sessions, as it stands it leads to a clinically contraindicated change in clinician/therapist.

I propose that the PHN be used as a trial of a longer-term study of the efficacy of the Stepped Care Model until more evidence is attained for its effectiveness. I would support a system based of equality with MBS- where all psychologists can be accessed by the public under one MBS item with equal rebate to clients and clinicians as all AHPRA registered psychologists deserve respect having attained the competency to provide psychological therapy treatment under Medicare. There is no evidence to date of any difference in patient/client outcomes for endorsed clinical psychologist compared with registered psychologists in clinical practice.

Conclusion

The MBS Taskforce Mental Health Reference Group is a nationally appointed committee comprising of key stakeholder representatives that has already deliberated over 300+ submissions for an extended period of time to make recommendations. The APS should stand together with the broader cohort of the MBS Taskforce and collaboratively work towards ensuring high quality mental health care for our community. Headspace centres need to be evaluated for effectiveness (including cost) before more money be injected there at the cost of the Better Access Program.

The above recommendations will

1. Decrease the cost of psychological services to the public.
2. Significantly increase the number of Australians able to access psychological support. A higher single tier will allow more psychologists to either fully bulk-bill or lower the amount of out-of-pocket costs for patients.
3. Better control the cost and sharing of psychological care delivery long-term and prevent a financial blow-out of the Better Access initiative.
4. Redress the systemic bias against those patients who receive treatment from psychologists under the lower-tiered rebate. This is vitally important to people in rural and remote areas where clinical psychologists are difficult to find.
5. Redress the partisan bias that favours one group of psychologists over others – unprecedented in Western countries and unsupported by any evidence of superior outcomes.
6. Allow patients to choose psychologists on a therapeutic needs-basis rather than choosing a psychologist based on a higher rebate.
7. Utilise and uphold the extensive depth and breadth of clinical practice expertise found within the broad scientific community of psychologists registered to practise in this country.
8. Ensure an increased availability of affordable, effective psychological assistance and reduce numbers in the public health system.

Yours sincerely

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References:

Altmann U, Zimmermann A, Kirchmann HA, Kramer D, Fembacher A, Bruckmayer E, Pfaffinger I, von Heymann F, Auch E, Steyer R and Strauss BM (2016) Outpatient

Psychotherapy Reduces Health-Care Costs: A Study of 22,294 Insurants over 5 Years. *Front. Psychiatry* 7:98. doi: 10.3389/fpsyt.2016.00098

Anderson, M (2016, Dec) Professor of Psychology, Halmstad University, Sweden – Independent Post Hoc Analysis of Pirkis, J., Ftanou, M., Williamson, M., Machlin, A., Spittal, M. J., Bassilios, B., & Harris, M. (2011). Australia's better access initiative: An evaluation. Australia & New Zealand Journal of Psychiatry, 45(9), 726-739.

Australian Psychological Society (2109). Australian Psychological Society (2109). APS Member Consultation paper. The delivery of psychological services under Medicare's Better Health Access initiative. March 25th, 2019.

Australian Psychological Society (2018) APS Submission to the MBS Review: Better Access to Psychiatrists, Psychologists and General Practitioners, August 11th

https://www.psychology.org.au/getmedia/5ee546ee-7a78-4807-a404-45d0d12adca7/2018-APS-submission-Better-Access-following-presentation-aug.pdf

Chiles, J., Lambert. MJ, Hatch, AL. (2006). The impact of psychological intervention on medical offset: A meta-analytic review. Clinical Psychology Science and Practice, 204-220

Chisholm, D, Sweeny, K, Sheehan, P, Rasmussen, B, Smit, F, Cuijpers, P, Saxena, S(2016). Scaling-up treatment of depression and anxiety: a global return on investment analysis Lancet Psychiatry, 3, 415-24

Kraft,S Puschner, B, Lambert M& Kordy, L (2006) Medical utilization and treatment outcome in mid- and long-term outpatient psychotherapy, Psychotherapy Research, 16:2, 241-249, DOI: 10.1080/10503300500485458

O'Donovan, A et al (2005). Does clinical psychology education enhance the clinical competence of practitioner? Professional Psychology Research and Practice, DOI: 10.1037/0735-7028.36.1.104

Pirkis, et al., (2011). Australia's Better Access initiative: an evaluation. Aust N Z J Psychiatry, 45(9), p726-39. doi: 10.3109/00048674.2011.594948 https://industry.gov.au/…/Docu…/2015Submissions/ACPA.pdf

Richards, D.A., Weaver, A., Utley, M., Bower, P., Cape, J., Gallivan, S., et al. Developing evidence based and acceptable stepped care systems in mental health care: an operational research project. Final report. NIHR Service Delivery and Organisation programme; 2010.

Rosenberg, S & Hickie, I. (Feb 25 2019). MBS mental health review: more of the same Medical Journal of Australia. https://insightplus.mja.com.au (comments also in this article)