Submission to the Australian Government Productivity Commission Inquiry into Mental Health

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Summary

This brief submission discusses the economic effect of the introduction of the Better Access to Mental Health Initiative in November 2006, reviews the concept of evidence-based practice then suggests outcome measurement as an alternative, and finally makes a number of proposals to optimise economic and therapeutic outcomes concurrently without an increase in public expenditure. First-line mental health intervention ("counselling and psychotherapy") only is considered, mental health issues requiring formal diagnosis and treatment by clinical psychologists or psychiatrists are viewed as out of scope.

Respondent's Background

The respondent has a Graduate Diploma in Counselling and Psychotherapy and is a former member of the Australian Counselling Association. He was in private practice as a counsellor and psychotherapist in the Sydney CBD, 2007-2010.

Economic effect of BAMHI

The Better Access to Mental Health Initiative was introduced in November 2006. At the time of introduction, psychologists, psychotherapist and counsellors had similar standing in the public mind. The hourly session fee for any of these professionals in private practice, if experienced, tended to be around $110, paid for in full by the client. Counsellors and psychotherapists were excluded from the rebates offered in the new programme and the availability of treatment in private practice by these providers is now minimal.

Today counselling and psychology is largely provided by psychologists (1). While charges vary, it is common to price sessions at the APS standard session fee of $251 (2). Sessions can now be as short as 45 minutes, compared with the one hour which was standard in 2006. At the recommended charge, the client receives a rebate from Medicare of $84.50, leaving a gap fee paid by the client of $166.50.

The APS has been able to raise the standard session fee due to supply-side restriction. With fewer providers of the service and increasing demand there was a classic economic outcome: an increase in prices.

Expenditure on Medicare rebates by the Australian Government has risen from $0 at introduction to $1.2B (2016-1017, 1).

The economic outcome can be characterised as a failure - a significant increase in consumer prices and a huge rise in government expenditure. There has been little evidence offered of a concomitant rise in positive healthcare outcomes.

Pyschology, Mental Health Care and Evidence-based Practice

Without an overarching theory of human consciousness, psychology is still in the observational stage of its development as a science. Claims that such and such a practice is "evidence-based" must be treated with caution and do not provide a firm foundation for government policy. Some controversies within the profession support this view:

- government policies in Australia and the UK largely reject "depth" psychological methodologies in favour of modalities such as CBT, claimed to be 'evidence-based', while the former disciplines are still strongly accepted in European and Latin countries. One cannot help being reminded of when monetarism became orthodoxy in the economic field
- there is continuing debate that Bayesian statistics are more appropriate to psychological research than the commonly used frequentist model
- the challenge to psychology commonly called the 'replication crisis' (for example, see 3) calls into question the validity of much of the psychological and other social science research on which policy has been based to date.

We know that psychological interventions support mental health, without always being able to prove it. However, as a society, this is not foreign territory to us. For example, the literature is clear that belief in a god or spiritual practice contribute both to a feeling of well-being and longevity (e.g. 4). One does not attempt to prove that the religious practices themselves are either rational or evidence-based.

Fortunately, there is a straightforward way for government policy to cut through these and other complexities: a commitment to outcome measurement. Michael J. Lambert, a leading researcher in this field, has stated that:

- outcomes are not significantly better with increased length of practitioner training or well correlated with practitioner experience (5, 6)
- the most effective practitioners can have up to 10 times better patient outcomes than the average practitioner (5, see also 7)
- outcomes are not significantly affected by psycho-therapeutic modality (5).

With the smartphone being ubiquitous, it is relatively straightforward to collect data from clients. Participation by a client can be voluntary and incentivised by a small Medicare rebate. Only a few questions need be asked; at commencement of treatment and, say, 3, 6 and 12 months later. It is not within scope for this submission to propose a tool, but the Personal Wellbeing Index (8) provides an example of a minimum number of questions potentially yielding valuable outcome data. Once an infrastructure is in place it will be straightforward to assess the usefulness of different assessment tools. When statistically significant data is available from clients of a service provider, median results for that professional can be made available on a public website.

This submission proposes that publicly available treatment outcome data will contribute to a system of mental health provision which optimises both economic and healthcare outcomes, benefiting both consumer and taxpayer through creation of an efficient marketplace for services.

Proposals

1. a Medicare rebate of around $50 be provided to counsellors and psychotherapists recognised as qualified by and registered with a professional association / peak body such as ARCAP.
2. the Medicare rebate for all practitioners providing a standard consultation, including psychologists, be reduced to this same amount over a 3 year period.

These two measures will have the effect of increasing the supply of service providers without necessarily increasing government expenditure after the first 3 years have elapsed.

3. all providers accepting a Medicare rebate be required to accept that the total client billing per session, including any booking / registration / programme fees not exceed a maximum set by the Department of Health.
4. professional bodies responsible for registering service providers be required to submit any changes to registration processes for approval by the Department of Health. The Department will be required to assess if the changes will have the effect of restricting the supply of service providers, to demand evidence for the healthcare and economic benefits of the changes and to discourage rent-seeking behaviour on the part of professional associations.

5. all clients receiving a Medicare rebate for counselling and psychotherapy to be offered voluntary participation in outcome measurement. A small rebate of, say, $10 per completed questionnaire to be offered to the client for their first participation in the programme. An easy to understand metric or metrics for the outcomes for each provider to be made available on a publicly searcheable database.
6. the publicly available service provider database to specify the provider's session fee. Concessional fees for clients on Australian Government income support or with the NDIS to also be shown if available.
7. the psycho-therapeutic modalities available to service providers to use and still qualify for a rebate to be expanded after review of submissions. At a minimum, relationship counselling and brief therapies such as Solution Focused Brief Therapy should be considered for inclusion.

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