

Introduction

This submission follows from my presentation to the Commission's public hearing on November 19, 2019 [<https://www.youtube.com/watch?v=1gxQ-HBCjgo&t=23688s>]. In this submission I will reiterate the points made at that hearing and expand on questions on notice raised at that time.

I am the Principal Psychologist and founder of ACT of Living, a private clinic of 8 mainly psychologist clinicians in Northcote, Victoria. Our clients comprise mostly adults referred by GPs and psychiatrists for treatment under the Better Access program, but also include those needing psychological treatment funded by bodies such as the NDIS, WorkCover and TAC, and of course self-funded psychological counselling.

Routine Outcomes Monitoring at ACT of Living

Since 2014 our practitioners have recorded session-by-session outcomes using assessment tools provided by the US-based Center for Clinical Informatics [cci-acorn.org/], headed by Dr Jeb Brown. The Center's customers comprise behavioral healthcare organisations, psychiatric hospitals, substance abuse treatment clinics and private practitioners, forming a network of clinicians known by the acronym ACORN for A Collaborative Outcomes Research Network [<https://acorncollaboration.org/>]. Since 2007 ACORN has delivered over 3 million questionnaires in more than 800,000 cases. The resulting database allows the ACORN tools to predict from a client's initial scores on the questionnaire, how quickly they should improve assuming competent practice from their clinician.

One of the most important findings from the research [<https://doi.org/10.1037/pst0000033>] the Center for Clinical Informatics conducts on these data is that those clinicians who simply log in to the system - presumably to determine their clients' progress - are more effective than those who do not. Their treatment effect size, even when initial case severity is taken into account, is 0.19 higher than those clinicians who rarely use the tool. Those clinicians who log into the tool most frequently are considered High Engagement clinicians, while those who rarely log in are categorised as Low Engagement. A client at the 50th percentile in the High Engagement clinician group had a better outcome than about 57% of clients in the Low Engagement group. This finding indicates that just having clinicians pay attention to their clients' progress produces better outcomes - resulting in shorter treatment times, fewer dropouts and greater value per dollar spent.

ACT of Living Experience

This finding across the entire ACORN database mirrors what we have found in our practice. By comparison with the overall ACORN database, which we might characterise as the average practitioner, our clinicians produce the following global outcomes across all clients:

- greater improvement on average (0.4 vs 0.7) [internal ACT of Living file research]
- longer engagement (5.0 vs 4.3 assessments completed) and a longer average treatment period (12.3 vs 10.6 weeks), indicative of a lower dropout rate (fewer 0-1 assessments)
- 50% higher rate of improvement per week (0.11 vs 0.07)
- greater proportion of patients improving (73 vs 68%) and a lower proportion severely deteriorating (4% vs 6%)

Precision Treatment & Therapist Client Fit

We are now starting to segment our database of cases by demographics and broad diagnostic categories (e.g. mood disorder, anxiety disorders, etc.) so that we can provide a best fit therapist for each client. And this “goodness of fit” will not be based on an intake manager’s intuition, nor based on the clinician’s training, nor on their belief that they work better with a specific demographic/diagnostic profile, but based on data from their actual track record with clients in those diagnostic categories.

For example, in looking at my own data over 6 years, I have found that I am reliably better at treating clients with anxiety and adjustment disorders than I am when working with those with depressive disorders.

Benefits

If the use of outcomes questionnaires such as the ACORN tools were to become standard across all mental health care settings and practitioners, several benefits would accrue to almost all stakeholders:

- There would be a global increase in standard of care due to workforce attrition of the least effective practitioners. If outcome statistics of practitioners were to be made available to the public, or even to employers, the least effective practitioners would likely leave the profession.
- Outcomes would improve for the majority of practitioners - not just for those already using these measures. [retrieved from <https://www.cci-acorn.org/orgcompare.asp> Nov 18, 2019]
- The divisive multi-tier system in Medicare could be retired and replaced by either outcomes-based payment or at least a rebate system that was agnostic with regard to training, professional affiliation or lobbying capabilities of professional bodies.
- Ensuring that clinicians link client diagnostic categories to treatment progress as measured by these tools, and then publishing their outcomes across diagnostic categories, would allow clients and treatment funders to select practitioners according to the likelihood of receiving the best available treatment.
- Deterioration and adverse event rates could be lowered. Mental health consumers, and their carers, experience a great deal of distress when a deterioration during treatment leads to either a cessation of treatment, or a change of provider. Failure to detect deterioration is the norm rather than the exception in common practice. This is so because, unfortunately, without measuring outcomes and deliberately looking for deterioration, clinicians are hopeless at detecting it. For example, in a sample of 49 psychotherapists in college counseling centers, clinicians markedly overestimated their rates of positive client outcomes (91%) relative to actual positive outcomes (40%), as ascertained by a standardized symptom measure. Furthermore, although therapists predicted that only 3 out of a total of 550 clients (0.5%) in their collective caseloads would deteriorate, outcome data revealed that 40 (7.3%) did so (Hannan et al., 2005). This was despite the clinicians being informed at the beginning of the study that about 8% of clients would deteriorate. In a similar vein, in another study, from a sample of 129 therapists in private practice (26.4% psychologists), the average clinician rated him- or herself at the 80th percentile of all therapists in terms of effectiveness and skills; 25% of respondents placed

themselves at the 90th percentile. None rated themselves as below average. Moreover, the typical therapist in the sample estimated the rate of client deterioration in his or her caseload to be 3.7% (Walfish, McAlister, O'Donnell, & Lambert, 2012) when we know it is normally around 8-10%. By way of contrast for the 800,000 cases in the ACORN database, the deterioration rate is 6%. I would submit that this is due to a global reduction in deterioration rates as the practitioners using the ACORN tools modify their in-session behaviour on the basis of feedback from their clients and reviewing their progress regularly. Reducing the occurrence of adverse outcomes by 25% against current practice would be of tremendous personal benefit to the patients involved, and of great financial benefit to those funding their treatment.

Challenges

In discussions with the Commission at the November 19 hearing and at a subsequent meeting in January this year, several challenges to the widescale implementation of routine outcomes monitoring using standardised tools such as ACORN, were raised with me. The following responses to those challenges are an attempt to make it more feasible for such implementation to be started more expeditiously. No doubt as yet unforeseen obstacles might also reveal themselves once implementation is started, and for that reason, the process had best be planned and overseen by a panel of experts in not only outcome monitoring, but also in knowledge transfer pertaining to mental health practitioners.

1. Client reluctance to complete session feedback items in the presence of the practitioner they are 'rating'.

There are two factors that tend to give rise to this problem. Fortunately their resolution is in the hands of the practitioner. Firstly, the practitioner may have failed to make clear to the client the purpose of the rating. The rationale for obtaining this feedback is to help the practitioner tailor their approach to suit the client. Secondly, the practitioner needs to ensure the client understands that they are rating the current session and what happened in it, rather than the practitioner per se. Once a less than optimal rating of the session occurs, the practitioner then needs to inquire as to what both client and practitioner could do to improve future sessions. The solutions developed may not all lie in the practitioner's control. But the value in asking this question is that the client's motivation tends to rise as they see that the practitioner is actively seeking to improve the treatment rather than conducting 'therapy by numbers'. In the absence of providing these rationales for the items on the scales, clients may well think that they are rating the practitioner rather than the session.

2. How can the culture of practitioners (and other stakeholders e.g. referrers, clients, policy makers) be changed to ensure implementing such a system is successful?

There is a vast literature on culture change in organisations which I will not refer to here for reasons of time and unfamiliarity. However that would be a good place to begin answering this question.

Somewhat further along to answering this question I can reflect that the associate practitioners at ACT of Living have all taken up the practice of using these tools with only one exception – and that mainly for a lack of time on my part to train him. Since 2017 all associates have been required by their contract with ACT of Living to use ACORN and in their routine clinical supervision with me it is frequently discussed.

So, the simplest way to ensure successful and widespread implementation would be to

demand it by tying it to existing incentives. The most universal and obvious of these, especially for private practitioners would be financial. Through the Better Access system, there could be a low fee item billable at say every five sessions when practitioners show evidence of administering the outcome measures at least 80% of the time.

Without such a financial incentive, many practitioners may be induced or inclined to take up this practice for other reasons. These can be leveraged to ensure greater uptake of the practice. Some of these reasons might be:

- ‘Credible messengers’ are either carrying out this practice or recommend doing so. In the current context, such sources of authority might be professional bodies the practitioner belongs to such as the RACGP, APS, AAPI, ACPA or AASW. But they could also be academic practitioner trainers, practitioner peers or even clients who have experienced the practice and are enthused about it.
- They perceive that not taking up the practice shows them as out of touch. This might eventuate if practitioner training schools graduate young practitioners who all habitually carry out the practice.
- They perceive that peers who carry out the practice are able to report improvements in their client treatment responses or are able to market their practices more successfully.
- They find that General Practitioners refer more clients to colleagues who carry out the practice.
- They have been trained in not only the use of the tools, but the benefits they offer and how to discuss them with clients, so they are confident to start and continue using them. The tethering of such training to continuing professional development or registration requirements would further ensure its widespread adoption.
- Their early adoption of the tools increases their status among peers as being for example, more knowledgeable.
- Early results from the tools provide valuable feedback on their practice. Note that this might not always be emotionally positive feedback, for example in the case of a practitioner who believes their results are above average, and finds out that they are in fact worse than average. The urge to ‘hide’ from the feedback by then refusing to collect it, can to some extent be countered through supportive supervision or peer consultation focused on using the feedback for practice improvement.

3. How do such tools measure outcomes with diverse populations?

As they stand, the ACORN questionnaires were developed in North America being used with populations that are majority Caucasian Anglo-Saxon, but also include significant sub-populations of Asian, African-American, Latin-speaking and First Peoples backgrounds. I believe the Center for Clinical Informatics would be willing to work with representatives of diverse populations to develop versions that are linguistically and culturally appropriate. There would I expect, be some time and expense involved in securing enough responses to standardise such ‘individualised’ measures. In all likelihood this would require a few hundred responses in order to provide them to a broader population.

4. A question regarding funding for team-based care was asked by Commissioner Abramson was asked at the November 19 hearing, however there has not been sufficient time to investigate an answer for this.

Appendix

Adult question bank for the General Distress Scale - the most common ACORN outcome instrument – can be found at <https://acorncollaboration.org/adult-question-bank>.