Submission to the Productivity Commission Inquiry into Mental Health

Draft Report: Volume 1

Chapter 5

The role of LiCBT coaching services in the low intensity sector

Declaration of interest

Peter Morris retired from the Department of Health and Ageing in 2013 and subsequently has consulted to various clients, including Beyond Blue. Any data about NewAccess is included with the permission of Beyond Blue. However the views expressed in this submission are those of Peter Morris alone and do not represent in any way the views of Beyond Blue.

The Commission's approach to low-intensity services[1]

The Commission considers in Chapter 5 of its Draft report options for matching consumers with the right level of care under the model of stepped care. The Commission identifies low-intensity services as the second step in this model after self-management. Medication is then cited, followed by psychological therapy.

The Commission reports close to 1.5 million people receiving psychological therapy, with 1.3 million of these funded by MBS, 56,000 through *headspace*, and 190,000 through PHN-commissioned services.

The Commission contrasts the number of people receiving psychological therapy with those receiving low-intensity treatment – a mere 13,000 through MBS-funded group therapy, Beyond Blue's New Access program and online treatment services, a further 30,000 through *headspace*, and some 200,000 to 400,000 receiving short-term support over phone counselling services.

The Commission estimates that roughly 450,000 people – or slightly more than a third of those currently accessing MBS-rebated psychological therapy – could have their needs better met through low-intensity services. The Commission notes that 'Consumers would continue to receive appropriate care, but with a lower treatment burden, both in terms of their time and cost.'[2] The Commission, in Chapter 6, proposes this demand be met by expanding online treatment services to accommodate 150,000 participants per year, with demand mobilised under a 'national information

[1] Abstracted from Productivity Commission: *Mental Health – Productivity Commission Draft Report Volume 1*; 2009; Chs 5 & 6.

[2] Ibid, p210.

campaign to raise awareness of the quality and safety of the treatment and to increase the take-up of services.'[3]

The Commission favours an expansion of online services to fill the low-intensity gap on the grounds that online services offer advantages in cost, accessibility and clinical efficacy.

The Commission observes that:

> 'The benefits of increasing the role of LiCBT are less clear cut ……. New Access has so far struggled with scale, and has failed to demonstrate cost-effectiveness (box 5.4). Nevertheless, there is potential for a greater share of therapy to be provided by low-intensity therapy coaches, and this may in some cases be more cost-effective than seeing a psychological therapist ….
>
> 'Commissioning agencies (PHNs or Regional Commissioning Authorities (RCAs – Chapter 24) are well placed to continue to investigate and experiment with different low-intensity services, and to commission the services that are best suited to the population in their region. However, they should continue to be limited to commissioning services that have an established evidence base (DoH 2019k).'[4]

The Commission endorses providing for consumer choice amongst low-intensity services, or 'choice along the step, not choice between steps.'[5] The Commission sees PHNs sharing responsibility with clinicians for referral to services. The Commission notes referrals are not usually required for self-help services and low-intensity services. The Commission does not support allowing self-referral to MBS-rebated services.

Comment

The Commission's analysis is welcome in:

- highlighting the potential for low-intensity services in the stepped model of mental health care);
- estimating latent demand of 450,000 persons per year for substitution of psychological-therapy with low-intensity services;
- pointing to the deficit in low-intensity services available to meet this demand;
- identifying online treatment services as a cost-effective, highly accessible model to fill this deficit; and
- stressing the need for a national information campaign to mobilise the latent demand for online services.

The Commission's analysis would benefit, however, from further consideration of:

- the latent demand for low-intensity services treating mild-to-moderate mental illness;
- the potential role of LiCBT coaching services in meeting this demand; and
- the need for governance of the low-intensity sector.

[3] Ibid, p 243.

[4] Ibid, pp 210-211.

[5] Ibid, p 12.

Latent demand and the treatment deficit

The Commission 'estimates that roughly 450,000 people – slightly more than a third of people currently accessing MBS-rebated psychological therapy (Including through headspace centres) – could have their needs better met through low-intensity services.'[6] Based as it is on substitution of low-intensity treatment for psychological therapy, this estimate does not account for latent demand amongst those not accessing treatment.

Mild-to-moderate anxiety and depression are estimated to account for around 17 percentage points of the 20 per cent of Australians experiencing mental illness in any given year – something in the order of 3.2 million Australians annually.[7] The bulk of the 1.5 million people reported by the Commission to be receiving psychological therapy annually can be expected to fall in the cohort of those suffering mild-to-moderate anxiety or depression.[8] This leaves around 1.7 million people untreated for mild-to-moderate anxiety or depression. This treatment deficit may reflect barriers in cost, accessibility or stigma. It may also reflect a lesser severity of symptoms, or higher tolerance of symptoms. It is difficult to avoid the inference, however, that there is significant latent demand – likely to be counted in the hundreds of thousands - for treatment amongst the presently untreated population.

Taking account of both substitution of treatment and those not accessing treatment, It is very likely that the Commission's estimate of demand for low-intensity services should be at least doubled to something approaching 1.0 million Australians annually. Indeed, there are two policy objectives to be considered here. The first, correctly identified by the Commission, is that of better matching mental health need to the lowest cost tier of clinically effective treatment – leading to substitution of lower-intensity services for psychological therapy. The second objective, however, should be to fill the treatment deficit for the 1.7 million Australians not currently accessing treatment. In so far as low-intensity services address the three major impediments for this cohort – cost, accessibility and stigma – mobilising low-intensity services to meet this demand should be a priority of the highest order.

LiCBT coaching services

The Commission's favour for supported online treatments for mild-to-moderate mental illness is well-founded, indeed compelling, and not in contention here.

The Commission's consideration of LiCBT coaching services – exemplified in Beyond Blue's New Access program - is less satisfactory.

Clinical efficacy

The evidence of clinical efficacy for LiCBT is sufficiently strong that the UK's National Institute for Clinical Excellence has formalised clinical guidance indicating LiCBT for the treatment of mild-to-moderate anxiety and depression.[9] Subsequent UK research demonstrated the ability to deliver

[6] Ibid, p 210.

[7] Beyond Blue: https://www.beyondblue.org.au/media/statistics

[8] That is, at least 17%, but likely higher as psychological therapy will be biased towards those conditions not subject to psychiatric or acute care.

[9] NICE, *Depression in adults quality standard, QS8*, March 2011. The evidence on therapeutic equivalence between low and high intensity CBT is reviewed in Linde et al: 'Effectiveness of psychological treatments for depressive disorders in primary care: systematic review and meta-analysis', Annals of Family Medicine, Vol 13 No1, January /February 2015.

LiCBT with sustained clinical efficacy via trained coaches operating under clinical supervision. Two site trials hardened the evidence for what ensued as national roll-out, through the UK National Health Service, of LiCBT under the Innovative Access to Psychological Therapies Program as the first tier of treatment for mild-to-moderate anxiety and depression. The program in its first three years treated more than 1.134 million people of whom more than 683,000 completed a course of treatment and these yielded recovery rates in excess of 45% and delivered measured productivity outcomes in retirement of sickness benefits and return to work.[10] The program has been continued by successive UK governments since its inception in 2008 and in 2017-18 there were 1.4 million referrals into IAPT and over 500,000 people completed a course of treatment.[11] Beyond Blue, with funding assistance from the Movember Foundation, invested heavily in feasibility studies and three site trials over the seven years to 2017 to test the viability of the LiCBT model in the Australian context. The Australian trials outperformed the UK IAPT in retention and recovery rates by significant margins.[12]

Uptake

The Commission argues that New Access has failed to gain traction, comparing recruitment of 2,000 consumers to New Access with 4,000 consumers to online treatment services. However both treatment cohorts are so small as to be insignificant relative to the latent demand for low-intensity services, and no inference can be drawn from comparison of the numbers. The treatment cohorts reflect nothing other than that both New Access and supported online treatment services are in their infancy, are poorly funded, and are seeking to serve population-level demand in the absence of community awareness of their purpose, value, safety and quality.

Funding, organisation and the service model

The relevant contrast between LiCBT coaching services and supported online treatments lies in their respective funding, organisation and service models.

The supported online treatment services are, I understand, typically university based. They are autonomous in their organisation, marketing and reach to the national market.

LiCBT coaching services, under the New Access banner, are by contrast funded through the federated model of the PHNs. Beyond Blue licenses the intellectual property in New Access to providers supplying the service under commission from PHNs. Marketing is fragmented under the control of individual PHNs. Service delivery is fragmented, resulting in individual telephone services for each participating PHN. Face-to-face services are similarly fragmented. And service providers, in consequence, are themselves fragmented, struggling to meet the fixed costs of governance, training and clinical supervision for micro-workforces of coaches dispersed amongst geographically disparate PHNs.

A logical construct for LiCBT coaching services in the Australian context of wide geographical dispersion would be to anchor it on a national telephone and online service, accessed through a single portal, and providing 24 hour access with comprehensive geographic reach across Australia. In this construct, LiCBT coaching services will deliver the same critical advantages as supported

[10] UK Department of Health: IAPT three-year report: The first million patients, November 2012, p 15.

[11] Moller, Ryan, Rollings and Barkham: 'The 2018 UK NHS Digital annual report on the Improving Access to Psychological Therapies programme: a brief commentary.' *BMC Psychiatry* **volume 19**, Article number: 252 (2019)

[12] EY: beyondblue NewAccess Demonstration Independent Evaluation: Summary of Findings – Reporting to August 2015. P 10.

online treatments in accessibility and cost. LiCBT coaching services will complement the supported online treatments in offering a fully inter-active, guided treatment where the supported online treatments offer partial guidance. A mature market would see consumers choosing amongst the options of access channel (online or telephone) and guidance level (partial or full) to meet their particular needs.

It can be expected that a significant number of consumers would still prefer face-to-face coaching. This could continue to be provided under commission from PHNs, with PHNs otherwise exiting the commissioning of telephone services. On this view, PHNs would be reflecting locally-specific demand for face-to-face services, something which central organisations are not well placed to do.

It should be recognised, however, that face-to-face coach-supported services, like their online and telephone counterparts, must be founded on governance, training and clinical supervision that can assure fidelity to model, clinical efficacy, safety and quality in delivery. Whereas telephone and online services are intrinsically centralised and therefore manageable in maintaining their internal infrastructure, the federated structure of PHNs acts against any natural concentration of service providers for LiCBT coaching services. PHNs should be able to commission from a small market of a select few providers, each sufficiently resourced to sustain internal infrastructure, and each independently accredited to deliver LiCBT coaching services.

The contradiction in the PHN funding model

In sum, tethering the rollout of LiCBT coaching services in Australia to the PHN funding model has greatly limited – and always shall limit – their population reach. The PHN model precludes the essential channels for broad population reach – online chat and phone. The PHN model precludes mobilising latent demand through national branding and marketing. Even in the commissioning of local face-to-face services, the PHN model struggles to find funds and is expected to purchase in a contestable market which is wholly uninformed by comparative evidence and accreditation of low intensity services. And for those providers seeking to serve the PHN market, there is no regulatory framework that rewards standards through accreditation and encourages concentration by, for example, empanelling a select number of the most capable providers.

Ultimately, the dilemma for low-intensity services such as LiCBT coaching services is that they should be staged as universal service offerings directed at meeting latent demand of around 1 million persons annually, but are instead corralled into a PHN funding model designed for a quite different purpose. PHNs are well placed to patch in universal services where they fail to meet locally-specific needs. PHNs are also well placed to coordinate the delivery of universal services to achieve seamless pathways of care. PHNs are not funded, and are certainly not organised, to mount national service offerings directed at major population reach. This poses a contradiction for current policy which explicitly sees PHNs as the home of low intensity services in primary mental health care[13] – a contradiction the Commission has correctly bypassed in proposing central funding of supported online treatment services.

[13] The contradiction is expressed in Department of Health: 'PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Low intensity Mental Health Services for Early Intervention 2019' which notes: 'Based on population estimates of need derived from the National Mental Health Service Planning Framework, up to 10,500 people per 100,000 population could benefit from low intensity services provided through digital, face -to- face or other modalities.' That is to say, guidance to PHNs suggest the objective of delivering low intensity services to over 10% of the Australian adult population annually, on a budget for all 31 PHNs of $1.45 billion over the three years to 2020-21, of which only $399 million is prioritised for 'hard to reach populations' (ie not otherwise prioritised to specific cohorts' – averaging $4.3 million per PHN per

Comparative costs

The Commission's view that LiCBT coaching services are not cost-competitive with MBS-rebated psychological therapy merits comment.

The Commission is comparing a service in its infancy where latent demand has yet to be mobilised to deliver the scale essential for cost optimisation, with a mature sector of private psychological practice. The training costs of coaches (six weeks plus 12 months supervision)[14] are relatively trivial and are fully transparent in the New Access costing model, whereas they are relatively high (minimum 4 years undergrad plus 2 years post-grad)[15] and subsumed in the Commonwealth's education budget for psychological therapy. The full course-of-treatment costs for New Access are transparent, where the full course-of-treatment costs for psychological therapy, which include two GP consultations at MBS rates for Mental Health Treatment Plans as well as any extension in psychological therapy sessions, are not. There are no costs to the consumer in the New Access model, where there can be very significant gap payments for the consumer in the psychological therapy model.

The comparison of costs posed by the Commission is one of a block-funded service not yet operating at scale with all overheads amortised and no out-of-pocket costs to the consumer, versus the government rebate for a fee-for-service which excludes extensive training costs, GP treatment plan costs, and out-of-pocket costs to the consumer.

It should also be noted that where clinical results are systematically reported for New Access, there is no reporting of clinical results for psychological therapy rebated under MBS.

The very intent of the UK's IAPT program, and of Beyond Blue's major investment in proving up LiCBT coaching services into the New Access model, has been to deliver a clinically effective intervention at greatly reduced labour cost in order to meet the massive treatment deficit for mild-to-moderate anxiety and depression. The Commission's cost comparison of New Access with MBS-rebated psychological therapy falls well short of testing the potential cost efficiency of New Access in addressing this policy objective..

Governance

New Access, and, I expect, the supported online treatment services cited by the Commission, are well-credentialed services. The low-intensity sector at large, however, lacks governance which can assure the commissioning bodies (PHNs and RCAs) and consumers that publicly funded services in the sector are indeed founded on evidence and governed appropriately to assure the safety and quality of the service on offer. There is urgent need for governance of the low intensity sector in order to:

- asses evidence and specify service standards for interventions;
- establish accreditation arrangements for service providers;

year for each of the three years. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/145-billion-to-strengthen-mental-health-services-and-support-job-security

[14] Beyond Blue: https://www.beyondblue.org.au/get-support/newaccess/faqs

[15] Psychology Board of Australia: 'Registration Standard: General Registration', 2 May 2016. file:///C:/Users/Peter%20Morris/Downloads/Psychology-Board---Registration-standard---General-registration---effective-2-May-2016.PDF

- establish accreditation of training for the non-professional (para-clinical) workforce;
- establish workforce registration arrangements for the non-professional (para-clinical) workforce;
- establish performance reporting, including clinical outcomes, for the sector; and
- establish an evaluation framework to be mandated on innovative services (where evidence is still evolving) as a condition of public funding.

Where appropriate, references should be made to NHMRC for clinical guidance on best practice.

Policy directions

While low-intensity services may be purposed to many policy objectives, the case for filling the massive treatment deficit in mild-to-moderate mental illness is overwhelming. Policy should seek to achieve population reach for this cohort on an escalating basis over a period of, say, ten years: that is, building to an annual caseload of 1 milliion people per year by the tenth year. This will require investment in a major, ongoing public promotion campaign aimed at mobilising latent consumer demand for the LiCBT services on offer. The services should be offered, initially, as a suite of national telehealth services (online and phone, both clinician guided and coaching), supplemented locally by PHN commissioned face-to-face services. Access should be via a common online portal and single national phone line, with no wrong door and warm transfer of consumers amongst the delivery channels (national online, national telephone, local face-to-face) according to choice. Rollout should be reviewed every two years to adjust funding by channel and type of intervention according to consumer demand. Governance of the low intensity sector should be established to assure transparency of evidence for interventions on offer, and to assure safety and quality in their delivery. NHMRC should be engaged in formalising clinical guidance for the sector, and Government should engage the relevant colleges and professional associations in a process of learning and clinical buy-in to the sector. A major evaluation of the sector, including economic evaluation of cost effectiveness, should be staged at the fifth and tenth years of rollout.