

Submission to the Productivity Commission

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

EXECUTIVE SUMMARY AND RECOMMENDATIONS

The following recommendations are proposed by MindSpot, which represents three Australian digital mental health clinics treating high prevalence mental disorders including anxiety and depression. Together, these clinics serve 25,000 Australians each year. Key characteristics of these clinics include:

1. all contact with consumers occurs via telephone, online, or other technology
2. symptoms, disability, and service satisfaction are measured regularly
3. commitment to evidence-based practice.

These characteristics allow MindSpot to deliver highly accessible and clinically and cost-effective services to people across Australia.

We recommend:

1. **the Commission's proposed assessment approach be broadened to include causes and contributors to mental health and ill health** with the aim of identifying the things that individuals, communities, and Governments do that enhance or impair mental health.
2. **the Commission support a study to scope the number and types of mental health services, their possible overlap and gaps in service provision.** The aim of this exercise is not to create a comprehensive Service Atlas, rather, it should document the actual network structure of the service eco-system to inform future attempts at better planning, funding, and coordinating mental health services and infrastructure.
3. **the Commission support up-scaling of digital mental health services like MindSpot and PORTS in rural and remote Australia.** However, we note that such digital mental health services should not replace, but rather should complement existing services, and in many cases act as a gateway or triage service to improve access to care.
4. **public health campaigns be supported to educate the public about the difference between healthy and pathological mental health, and importantly, what individuals can do without having to see a health professional.** Further, such campaigns should emphasize the importance of preventive activities and active participation for those who participate in treatment.
5. **that mental health services subsidized by the Medical Benefits Schedule (MBS) should report both treatment patient reported outcome measures (PROMS) and patient reported experience measures (PREMS).** We stress the importance that these be phased in with sufficient time to allow appropriate selection of brief but reliable measures, and to allow both providers and funders the opportunity to develop efficient and safe methods for collection, storage, analysis, and reporting.

We welcome questions from the Commission and opportunities to provide additional information. Finally, we wish to acknowledge the support and assistance of the Australian Department of Health and the West Australian Primary Health Alliance (WAPHA) for their support and encouragement in developing this successful model of digital mental health service, which is reducing barriers to care for thousands of Australians each year.

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INTRODUCTION

We welcome the Productivity Commission's inquiry into the role of improving mental health to support economic participation and enhance productivity and economic growth.

This submission draws on the experiences of our research and clinical work with three world-leading digital mental health services, the [MindSpot Clinic](#), [PORTS](#), and the [eCentreClinic](#), collectively called **MindSpot**. MindSpot is a part of [Macquarie University's](#) clinical enterprise, [MQ Health](#). The mental health services delivered by MindSpot are provided entirely using technology; that is, the consumer and health professional are in different locations in Australia, and communicate using technology (e.g., telephone, online, secure email).

MindSpot was developed to deliver high quality and accountable mental health care. It has demonstrated it provides clinically and cost-effective services, is clinically safe, and reduces barriers to care for a broad cross section of the Australian population [Titov et al., 2017]. MindSpot has also demonstrated how digital services can complement existing mental health service models to improve the quality of care experienced by consumers. Finally, MindSpot demonstrates a rare working example of translational research, that is, research that results in improvements in clinical practice.

In brief, the three clinics comprising MindSpot now serve more than 25,000 people each year. Since launching in 2013, MindSpot has provided mental health services to more than 100,000 Australians. Whilst we remain enthusiastic about our services, we also stress that services such as MindSpot are not a panacea, but should complement traditional, high-quality mental health services.

MindSpot treatments are now being used in Canada and the US, and are under consideration by the national health services in the UK, New Zealand, and other jurisdictions. Additional details about MindSpot are included at the end of this submission, including data about the reduction in disability and potential increase in economic and social participation due to MindSpot treatment.

The issues addressed in this submission include the following:

1. Assessment Approach
2. Structural Weaknesses
3. Health Workforce in Regional and Rural Australia
4. Questions on Funding Arrangements
5. Questions on Monitoring and Reporting of Outcomes
6. **MindSpot Case Study: Evidence of Supporting Economic and Social Participation**

RESPONSES TO THE PRODUCTIVITY COMMISSION ISSUES PAPER

1. ASSESSMENT APPROACH

The Commission's proposed assessment approach examines the consequences, effectiveness and cost of current programs and supports, seeks to identify gaps in the latter, and how to increase their effectiveness. This is a traditional and logical approach but excludes consideration of the causes or contributors to mental health problems. Not all the causes are known, but there are some behaviours by individuals, communities, business, and Governments that are known to enhance or impair mental health.

For example, excessive alcohol consumption is both a direct and indirect cause of mental health problems [Jané-Llopis et al., 2006]. Consumption patterns can be modified by changing individual, community, business and Government actions and attitudes. Similarly, there are social factors which strongly influence mental health problems. Financial and housing problems are examples which have considerable effects, and again, can be mediated by changes in individual, community, business and Government actions and attitudes.

Modifying the assessment approach to include such factors will begin a discussion about the broader context of mental wellbeing. It will challenge all parties to take more responsibility for reducing risks, with the aim of reducing subsequent demand and need for services.

We recommend the Commission's proposed assessment approach be broadened to include causes and contributors to mental health and ill health with the aim of identifying the things that individuals, communities, and Governments do that enhance or impair mental health.

2. STRUCTURAL WEAKNESSES

Past reforms have sought to improve the accessibility, quality, and co-ordination of mental health services [e.g., Department of Health 2015; NMHC 2018a and 2018b]. Improvements have occurred, but impact of reform is limited by fundamental structural weaknesses in planning and integration.

We argue that a profound weakness in the strategic planning of services relates to the absence of service-level data about clinical and other outcomes [Jorm et al., 2017; Jorm 2018]. For example, in 2016-2017, the Australian Government spent \$1.2 billion on benefits for Medicare-subsidized (MBS) mental health-specific services [AIHW]. Undoubtedly, many of these services are helpful and reduce distress, symptoms and burden [e.g., Pirkis et al., 2011]. Unfortunately, the data obtained from MBS funded mental health services relate to activities, not outcomes [Medicare Benefits Schedule, 2019]. As a consequence, little is known about the consumers using such services, their diagnoses, symptom severity, level of disability or impairment, social and environmental difficulties, or other information which helps inform treatment planning. In addition, little is known about the actual clinical outcomes of MBS subsidized services on consumers' mental health and impairment. This also means the Australian Government may be funding services which are ineffective or even producing harm. We address this issue further, under the section *Questions on Monitoring and Reporting of Outcomes*, below.

With respect to integration, we note that Australia does not have a true system of mental health care. Instead, we have a substantial number of service nodes and independent networks, which lack common objectives, processes, data systems for patient records, and often compete for funding and consumers. The complexity of the current eco-system of Federally funded services, State-funded services, private providers, and the NGO sector lead to enormous duplication, risk, and confusion for consumers and carers. Even service providers are unable to keep up with the ever-changing eco-system of funded services. We argue that reform requires comprehensive understanding of the entire network of services, which requires a scoping exercise.

We recommend the Commission support a study to scope the number and types of mental health services, their possible overlap and gaps in service provision. The aim of this exercise is not to create a comprehensive Service Atlas, rather, it should document the actual network structure of the service eco-system to inform future attempts at better planning, funding, and coordinating mental health services and infrastructure.

3. HEALTH WORKFORCE IN REGIONAL AND RURAL AUSTRALIA

One third of Australians live in regional and remote Australia. The provision of health services including mental health services in such regions is therefore, an area of national priority. Difficulties in delivering mental health services outside metropolitan Australia are well documented [e.g., AIHW, 2015, Mental Health Services in Australia, 2015]. Challenges include:

1. the recruitment and retention of suitably trained health professionals
2. the provision of training, clinical supervision, professional development
3. career development opportunities for health professionals.

We propose that digital mental health services have enormous potential for supporting local traditional mental health services to deliver effective mental health care. We note that tele-health services (that is, consultations delivered via video-conferencing) are already funded via the MBS.

Uptake of tele-health by psychiatrists and medical specialists has been moderate, with relatively low uptake by allied health professionals, although the latter items were recently introduced in the MBS.

In contrast, the experience at MindSpot has been that there is considerable demand for digital mental health services by regional and rural consumers. This is shown visually in Figure 1, which shows the location of consumers receiving treatment from MindSpot in 2016-2017. Of note are the large number of dots in locations where few if any mental health professionals are located, including many of the offshore island that are part of Australia (not shown in Figure 1).

Almost 40% of the 100,000 Australians who have registered to use MindSpot are from regional and rural Australia, including older adults, Aboriginal and Torres Strait Islanders, and people experiencing financial hardship. Our results indicate that these consumers obtain strong clinical outcomes, result in a 50% reduction in days out of role following treatment, and are highly valued by consumers and GPs.

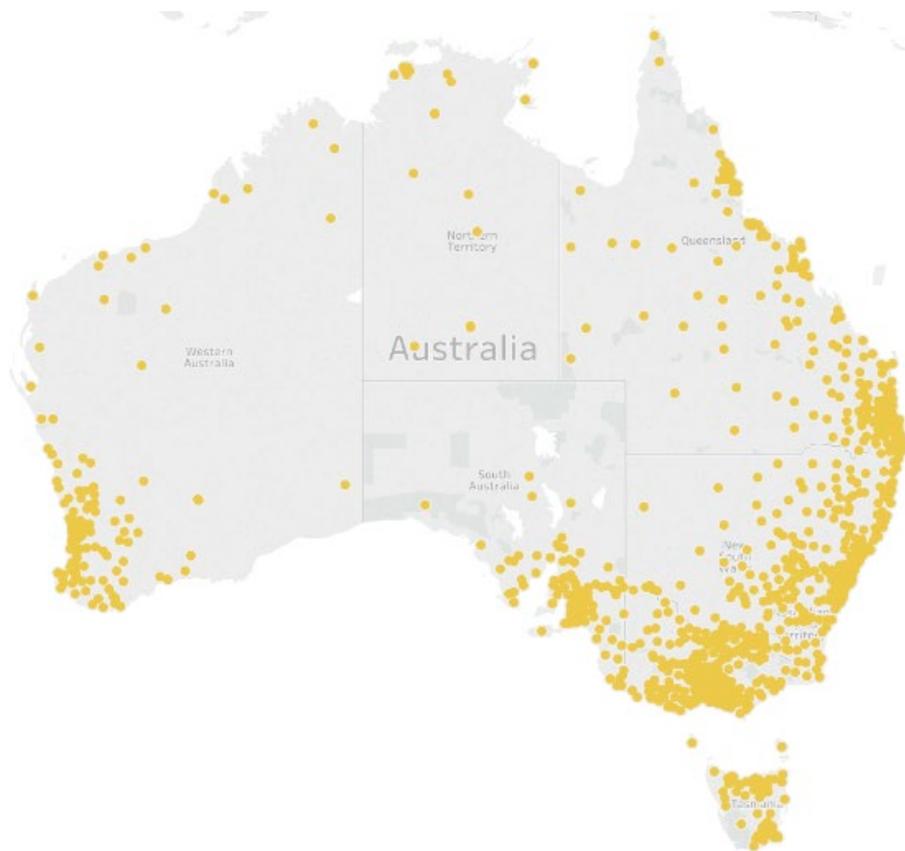


Figure 1: Locations of MindSpot consumers 2016–2017

We recommend the Commission support up-scaling of digital mental health services like MindSpot and PORTS in rural and remote Australia. However, we note that such digital mental health services should not replace, but rather should complement existing services.

4. QUESTIONS ON FUNDING ARRANGEMENTS

Growth in mental health expenditure is appropriately being driven by an increased recognition of symptoms and disorders by consumers who previously may not have sought treatment. However, some demand is also driven by limited understanding of differences between normal vs. pathological levels of emotional distress. This is unfortunate, as some levels of anxiety, stress, dysphoria and low mood are part of the normal human experience. While unpleasant, such feelings help people recognize problems in living or circumstances that require change. Other symptoms of distress require learning to accept that some circumstances cannot be changed. This is a normal part of gaining maturity and for the most part, do not require or benefit from intervention by mental health services.

The risks associated with medicalizing normal distress are substantial both for the individual, who can lose their sense of agency and personal responsibility, and for the broader society, which may encourage over-dependency on health professionals. This can lead to over-servicing of individuals and communities, with no discernible benefit. Anecdotally, MindSpot therapists often report about consumers who have previously received MBS funded services for several years, but who are unable to describe what psychological coping skills they learned during treatment. These consumers appear to have obtained no discernible benefit, but presumably were provided with a service at significant cost to the MBS, as well as significant out of pocket expenses for the consumer. Paradoxically, such over-

servicing can result in dependence on counsellors and therapists, which increases disability and impairment, the costs of which to the individual, community and economy are substantial.

Recovery from conditions such as anxiety and depression usually require people to make change in their lives, specifically, changes in how they think and what they do. This often requires people to learn and adopt new skills or re-engage with skills they may have stopped using. Effective learning requires effective teaching and therapy, as well as session-by-session monitoring of symptoms. We will return to the importance of monitoring clinical outcomes later in this submission. Our point here is the importance of educating the public to recognize the difference between healthy and pathological mental health, and importantly, what they can do about it without having to see a counsellor or psychologist, and what they should expect when they see a mental health professional.

We recommend public health campaigns be supported to educate the public about the difference between healthy and pathological mental health, and importantly, what they can do about it without having to see a counsellor or psychologist. Further, such campaigns should emphasize the importance of preventive activities and active participation for those who participate in treatment.

5. QUESTIONS ON MONITORING AND REPORTING OF OUTCOMES

A theme running throughout this submission concerns the lack of data from mental health services to guide informed decisions about policy and funding, particularly from services rebated by the MBS. As noted, many of these services are helpful and reduce distress, symptoms and burden. Unfortunately, this is not always the case. Consequently, it is likely in some cases that the Australian Government is funding services that are unlikely to result in benefit but may instead result in dependence on health professionals or even deterioration.

To make informed decisions about the nature, structure and funding of health services, it is reasonable to expect that decision makers have access to data about:

- the characteristics of consumers (e.g., demographics, presenting symptoms, treatment history)
- presenting problems and symptoms
- immediate and long-term clinical outcomes
- the acceptability of services to consumers and other stakeholders
- the effects of the service on other health and social services
- the broader impact of the service on the consumer's engagement in vocational activities.

Such data is also essential in supporting service providers to evaluate and improve their own services.

Data collection is a complex exercise, and one which requires additional resources and systems at the level of both funded services but also for the funder, who needs mechanisms for collecting de-identified data from commissioned services, as well as systems for secure storage, analysis and interpretation. These are non-trivial undertakings and if implemented poorly can result not only in unreliable data, but also a considerable waste in effort. It should also be noted that mental health services cannot always produce clinical improvements, particularly when consumers present with severe and chronic symptoms and challenging social circumstances. In those cases, the aim is often to support consumers not to deteriorate further. Notwithstanding such realities, measurement should still occur, with focus shifting to consumers experience of treatment quality, rather than outcomes.

CASE STUDY

A local example of successful administration of outcome measures in routine clinical care and use of this data for planning of services is the national MindSpot Clinic [Titov et al., 2017; Titov et al., 2018]. MindSpot provides online and telephone assessment and treatment services each year to 20,000 Australians with high prevalence mental conditions including anxiety and depression. MindSpot administers patient-reported clinical outcome measures (PROMS) each session during treatment, and patient-reported experience measures (PREMS) at several timepoints during both assessment and treatment to measure satisfaction and acceptability of services. This data is reported back to the Australian Department of Health to allow benchmarking against other services, but also provides MindSpot leadership with data to inform service developments and improvements. However, it has not been possible to compare MindSpot outcomes against psychology services subsidized by the MBS, primarily because there is no data available from the MBS.

We recommend that mental health services subsidized by the MBS should report both treatment patient reported outcome measures (PROMS) and patient reported experience measures (PREMS). We stress the importance that these be phased in with sufficient time to allow appropriate selection of brief but reliable measures, and to allow both providers and funders the opportunity to develop efficient and safe methods for collection, storage, analysis, and reporting.

6. MINDSPOT CASE STUDY: EVIDENCE OF SUPPORTING ECONOMIC AND SOCIAL PARTICIPATION

Consumers using MindSpot regularly complete patient-reported outcome measures (PROMS) and patient-reported experience measures. In addition, MindSpot also measures economic and social participation, and has commissioned analyses of the cost-effectiveness of MindSpot Clinic treatment.

Outcomes are summarized below.

1. Patient-reported outcome measures (PROMS)

MindSpot clinics regularly administer valid and reliable patient-reported outcome measures (PROMS) to measure symptoms of anxiety and depression. These measures are administered at assessment, weekly during treatment, and at three-month follow-up. These measures allow monitoring of consumer safety, progress during treatment, and also help identify consumers who are not benefiting from treatment, and require a change in treatment. These measures also inform MindSpot about the quality of care, provide a feedback mechanism for staff development, and provide a benchmark for service development.

Detailed results of PROMS are available in published reports [Titov et al., 2017; 2018]. However, in summary, the results of PROMS indicate the following:

- Most consumers using MindSpot services have moderate to severe symptoms of anxiety and depression at assessment
- Most have had significant symptoms for >1 year
- Following treatment, 70% experience a clinically significant reduction in symptoms
- Following treatment, consumers experience an average reduction of 50% of symptoms
- Gains obtained at treatment are sustained at three-month post-treatment

2. Patient-reported experience measures (PREMS)

MindSpot clinics regularly administer patient-reported experience measures (PREMS). These measures, combined with analyses of PROMS, provide a rich source of information to guide service improvements. Detailed results of PROMS are available in published reports [Titov et al., 2017; 2018]. However, in summary, the results of PREMS indicate the following:

- More than 90% of consumers report that they would recommend MindSpot to a friend with similar symptoms
- More than 90% report that treatment was *worth the time*

3. Economic and social participation

MindSpot clinics measure *days out of role* and *impact of physical health problems* (i.e. disability, impairment, absenteeism, employment) using the Kessler 10 Item Scale PLUS (K-10 PLUS). *Days out of role* is used by the Australian Bureau of Statistics and Australian Institute of Health and Welfare as a proxy for the functional impact of mental and physical ill-health.

Assessment of 1,318 consumers treated at MindSpot showed disability, as indicated by days out of role is reduced by approximately 50% following treatment, and was maintained at three-month follow-

up. As shown in Table 1 and Figure 2, below, on average (SD) at assessment MindSpot consumers reported 5 whole-day and 9 part-days out of role, which reduced to 3 and 5, respectively, following treatment. These reduced further to 2 and 4, respectively, at three-months post-treatment, indicating gains are sustained. Consistent with this, as indicated in Table 1, reductions were also observed in the number of visits to health professionals. These data indicate treatment provided by MindSpot is significantly reducing disability.

	Assessment	Post-Treatment	Post-Treatment (three-month follow-up)	% Disability Change at Post-Treatment	% Disability Change at Follow-Up
Whole days out of role	4.5 (7.0)	2.5 (5.3)	2.2 (5.4)	44	53
Part days out of role	8.9 (8.3)	5.2 (7.3)	4.2 (6.8)	42	56
Visits to health professional	1.2 (2.2)	1.0 (1.7)	0.9 (1.6)	17	33

Table 1: Changes in disability from assessment to post-treatment (n= 1,318)

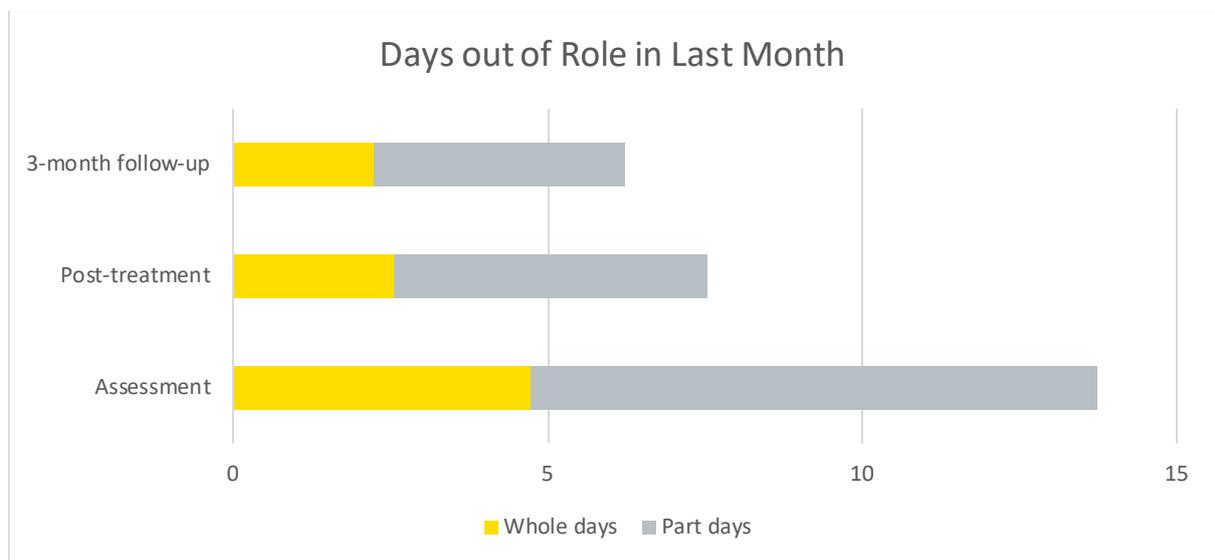


Figure 2: Changes in disability from assessment to post-treatment (n= 1,318)

4. Cost effectiveness of MindSpot treatment

MindSpot commissioned the School of Health and Social Development, Deakin University, to conduct an independent analysis of cost-effectiveness of MindSpot treatment [Yu-Chen Lee et al., 2017]. They developed an economic model using a one-year decision tree and examined probability of outcomes using datasets from MindSpot and from the Australian National Survey of Mental Health and Wellbeing

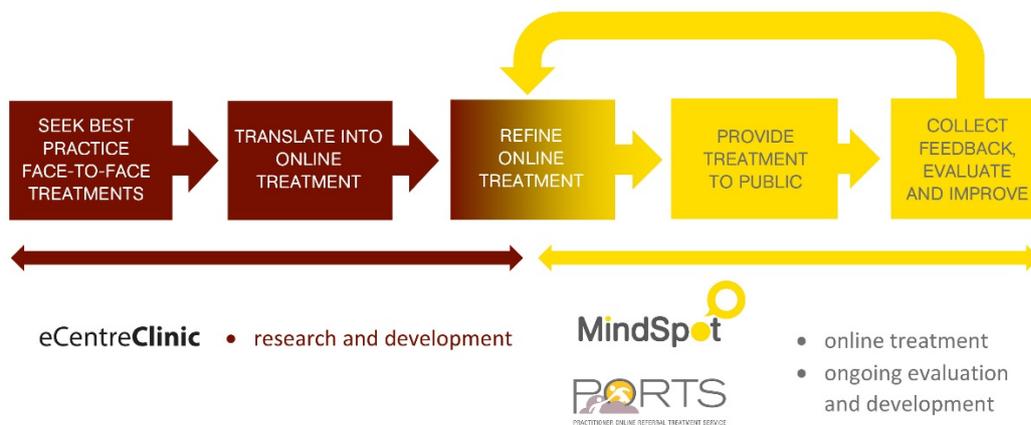
[ABS, 2007], using the EuroQol Five Dimension – Five Level to derive utilities, and used sensitivity analyses to examine the robustness of results of key model parameters.

In summary, the study found that treatments offered at MindSpot were highly cost-effective with current routine care in Australia [Yu-Chen Lee et al., 2017].

About MindSpot

The MindSpot Clinic, PORTS and the eCentreClinic 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.

HOW WE DEVELOP MINDSPOT TREATMENT COURSES



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 and 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 were 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 treatments for high prevalence mental disorders. All treatments are co-designed in collaboration with consumers and then evaluated in a series of clinical trials; to date, we have conducted more than 70 clinical trials tested in more than 9,000 people.

The eCentreClinic team have developed 15 online treatment programmes and published more than [100 scientific papers describing outcomes and cost-effectiveness](#).



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