

The social and economic benefits of being a psychologist: dare we address the productivity of psychologists?

Discussion Paper 1

Australian Psychological Society, Social Determinants of Mental Health Advisory Group,
Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health

Hello everyone,

These are some of the thoughts I had during and following the first meeting, on 14 March 2019, of the Advisory Group on social determinants of mental health, to help develop the APS's response to the Productivity Commission inquiry into *The Social and Economic Benefits of Improving Mental Health*.

Our terms of reference

The draft terms of reference of the Advisory Group, to which we unanimously agreed, makes no reference to "structural" issues.

However, many of the topics that arose, very clearly and succinctly summarised by our Group leader, Ms Emma Sampson, relate to factors leading to inequality of access to mental health services. In fact, "Inequality as overarching framework" appears as Emma's first bullet point (section 4).

My view is that if we identify inequality of access as an issue, we are obliged to address "structural" issues in the health, mental health, education and justice systems.

Structural issues identified by the Productivity Commission

Under "Structural weaknesses identified in past reviews", the Productivity Commission Issues Paper (January 2019) states

"The (structural) problems are well known..

- *The concentration of resources in costly acute and crisis care...*
- *Fragmentation and limited coordination across services, providers and settings ..*
- *Services being designed with a focus on the needs of providers rather than consumers*
- *Inequitable access to care...*

Governments have a long history of efforts to improve outcomes but they have found it challenging to make progress on issues such as those listed above... We do, however, welcome input from participants on any areas that have been overlooked in the current reform agenda, and views on why it has historically been challenging to address the structural weaknesses in healthcare" (p.12, 13)

Structural weaknesses within the profession of psychology

I don't think it's very hard to come up with at least a couple of good reasons why "it has historically been challenging to address the structural weaknesses in healthcare". Professional groups are focused on the social and economic benefits of its members. As they should! Professional groups, therefore, will not readily give up (perceived) benefits from inefficiencies in the system, and anyone

within the profession drawing attention to them will be perceived to be acting against group interests.

It is not that difficult, I think, to see at least the third and fourth structural problem listed by the Productivity Commission, operating within the profession of psychology.

One of the most striking observations emerging from the 2017 forum on the present state of the profession of psychology in Australia, convened by the Sydney Branch of the APS, (ref 1), was that with regard to mental health there were “two Australias.... One Australia where people are getting ahead, experiencing choice, professional advancement and satisfaction, and the other Australia where people are falling behind, have no choice and are ‘used up as cannon fodder’”.

The two Australias refer not just to patient populations, but to the two very different mental health systems in which patients find themselves, including the psychologists (among other health professionals) who find themselves in these two systems.

Not surprisingly, the professional arc of psychologists often starts in the “under-privileged Australia” mental health system, then moving to the “privileged Australia” mental health system. In Sydney, for example, this may involve a geographical movement from the west to the east, from the public sector to the private sector, from working with patients with the most severe, treatment resistant mental health conditions to working with patients with less severe, more treatment-amenable mental health conditions. In this way, it is often the case that psychologists are faced with their most difficult clinical problems at the point in their career when they are least competent and can exercise the least social power, and face their least difficult clinical problems when they are at the peak of their skill development and social power.

From this standpoint, I think, we can see an interesting pattern at the group level. It is not simply that some mental health services might be designed with a focus on the needs of individual providers rather than individual consumers (although this may well be the case). Psychologists are caught up, and participate, in the creation of a mental health culture which drives expertise away from the population that needs it most.

That bloody elephant in the room, again

In brief, my observation is that the present two-tier system has become caught up in the drift of psychological expertise away from the most difficult and demanding patients.

Some of these very, very difficult areas, where expert psychological treatment has been shown to be particularly effective with regard to long-term social and economic benefits, include psychological intervention with:

- Treatment resistant population
- Early intervention in very unhealthy parent-child interactions
- Severe mental illness
- Disadvantaged individuals with mental health problems who end up in the justice and juvenile justice systems
- Chronic medically unexplained physical conditions

I think it is reasonable to allocate these categories of patients to specialist psychologists, with *demonstrated* expertise in alleviating these conditions in a relatively short period of time. For example, some, certainly not all, clinical psychologists may be able to be very effective in treating

severe mental illness (ref. 2). Some health psychologists may be able to be very effective in treating chronic medically unexplained physical conditions (such as pseudo-seizures, chronic pain, heart palpitations, muscle weakness, and so forth).

Thinking like an economist, I am not suggesting we dismantle the “two-tier” system, but removing the financial incentives associated with classes of psychologists. Rather than financially rewarding specialist psychologists for their past education¹, we reward, for example, clinical psychologists (with demonstrated expertise) by referring them the very difficult patients whom they are able to greatly help.

Rather like medical specialists. Do general practitioners resent psychiatrists, or oncologists, or neurosurgeons for getting more money for doing exactly the same thing that they do? No, I don't think so. I think they are glad to have specialists to refer patients whose conditions exceed their expertise.

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References

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2. Abbass, Town, Johansson, Lahti, Kisely (2019) Sustained Reduction in Health Care Service Usage after Adjunctive Treatment of Intensive Short-Term Dynamic Psychotherapy in Patients with Bipolar Disorder. *Psychodynamic Psychiatry* 47(1):99-112

¹ I will not take the space here to address factors leading to the inequality of access to “privileged” degrees.

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Discussion Paper 2

Australian Psychological Society, Social Determinants of Mental Health Advisory Group, Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health

Hello everyone,

I have prepared Discussion Paper 2 on the basis of my understanding, at our third and final meeting (28 February 2019), that it may be useful to the task left with National Office members of our Advisory Group, to develop further the arguments appearing in my discussion paper of 19 March 2019 (Discussion Paper 1). Thank you Emma Sampson and Anthea Rees for your interest.

The (giant) task left with the National Office team at that meeting, I understand to be, the integration of the content received from members of this Advisory Group with (a) the content received from members of the two other Advisory Groups (The “State/Territory mental health services” Advisory Group, and the “Justice system and mental health” Advisory Group), and (b) developments around the recently released Green paper (*APS Member Consultation Paper: The delivery of psychological services under Medicare’s Better Access Initiative*), to produce a draft submission to the Inquiry.

My (less giant) task, I understand to be, to expand the scope of my discussion of structural problems within the profession of psychology (Discussion Paper 1), to include a view of the Green paper from this standpoint.

I have also gone ahead and included a discussion of the paper *The runaway giant: ten years of the Better Access program*, by Dr Sebastian Rosenberg and Prof Ian Hickie (1 April 2019), which appeared on the online version of the Medical Journal of Australia this week. That paper, framed by its authors as a critique of the participation of psychologists in the Better Access initiative, provides a convenient illustration of another important source of the intractability of “structural weaknesses”¹ identified in mental health systems – the disguised enactment of inter-profession conflicts.

The Green Paper

The Green paper arises from an attempt by the APS to broker a compromise between members in private practice whose patients receive a lower rebate, and members in private practice whose patients receive a higher rebate. It would not be surprising, then, if the compromises, at best, do nothing to address the structural weaknesses mentioned in Discussion Paper 1, and at worst, add further inefficiencies. The latter appears to be the case.

Most of the eight recommendations are items on an “I want” list for psychologists in private practice, and therefore unlikely to be very controversial *within* this general group of private practice members. I won’t address these recommendations in detail here, but note generally, with respect to the terms of reference of our Advisory Group, the following.

¹ Productivity Commission Issues Paper, January 2019, p. 12.

1. The great rebate controversy continues to suck up APS organizational energies, which might otherwise be available to considering non-private practice interests (what economists call “opportunity cost” – the cost of opportunities lost when devoting limited resources to a particular pursuit),

2. Not surprisingly, the implicit position of the Green paper, reflecting the interests of the private practice members which animate it, is that channelling mental health funding to the private sector is somehow *more productive* than channelling those funds to psychologists working in the public sector, or to those thinking outside of the fee-for-treatment-services model. From what I have heard over our three meetings, my expectation is that not all members of this Advisory Group gladly share this assumption!

The recommendation in the Green paper generating the most interest among private practice Members is the proposed compromise solution to the two-tier controversy, the *three-tier* rebate scheme. It is tied to a particular take on the Commonwealth Government’s current “stepped care” mental health principle, with different rebates and session numbers to be made available for patients with “mild” (10 sessions annually), “moderate” (20 sessions annually) and “severe” (40 sessions annually) mental health disorders.

The way in which the three tiers of psychologists are matched to the three severity levels of disorders is very complex, but it appears to lead to quite perverse economic disincentives to effective treatment.

For example, the highest rebates and the largest number of sessions are available to patients with severe conditions seeing clinical psychologists. Should a patient show significant recovery, they are at risk of being classified as mild, resulting in a reduction in the rebate and the number of sessions. Thinking like an economist once more, it might be expected that the economic equilibrium of their clinical psychologist’s practice can only be restored by... the patient’s condition becoming more severe!

Other equally gruesome scenarios come readily to mind. The clinical psychologist grudgingly refers the no longer economically viable patient to a tier-one general psychologist (who is unable to access a higher rebate regardless of patient severity). Is this scenario likely to “heal” the split between the different tiers of psychologists?

An even more gruesome scenario. A sophisticated private practice games the new system by moving patients between its own senior and junior staff as the categorisation of the patients’ condition changes. What will it do to the therapeutic relationship when attachments are formed and broken according to fluctuations in the cash value of the patient through the course of their treatment?

Let me take the clinical illustration appearing in the February 2009 InPsych article, *A social determinants approach: The ‘missing link’ in case conceptualisation and treatment*, by Lissa Johnson and (our) Emma Sampson.

A woman or member of a racial minority group, for instance, who makes sexist or racist remarks at their own expense as a coping strategy, with adverse impacts on self-concept, could be helped to critically examine the broader societal origins of their self-disparagement, along with alternative ways of relating to themselves and others.

....Cognitively, self-talk that echoes socially-determined messages can be explored. For example, someone whose career path is adversely affected by automation or austerity

may have internalised the meritocratic assumptions of free-market ideology: namely that ‘the market’ rewards those who are worthy and discards those who are not. Such self-talk can be examined and socratically explored like any other cognition or belief, responded to mindfully, or incorporated into compassion-focused work, as a few examples.

What happens when these kinds of feelings, thoughts and attitudes are triggered by a clinic that operates on the principle of maximising their quarterly yield per client? Are they likely to be thoughtfully and critically explored by the psychologist *enacting* these principles? A psychologist immersed in this organizational culture, on which their livelihood and professional advancement depends? I don't think so.

To summarise, I have argued that the proposed three-tier model places psychologists at risk of one of the “well known” structural weakness identified in the Productivity Commission Issues Paper: “Services being designed with a focus on the needs of providers rather than consumers” (p.12). Therefore, in my opinion, the proposal, as it stands, has no place in the APS submission to the Productivity Commission inquiry.

The runaway giant

The paper by Dr Rosenberg and Prof Hickie from the Brain and Mind Centre, University of Sydney, states its position clearly in its title: the Better Access program, after ten years, is now a “runaway giant”. This does not sound to be a good thing!

However, the author's various criticisms fall into self-contradiction, their arguments are not logically sound, and they rely on a selective reading of the studies they reference.

1. Access

The first criticism that Rosenberg and Hickie make is the issue of fairness. They state in their lead sentence: “Australia urgently needs a new and *fairer* approach to the provision of quality Medicare-funded psychological services” [italics mine]

Other independent research has indicated that the Better Access program has failed to address key service gaps and socio-demographic challenges, particularly affecting people living in regional and rural areas. (p.1)

And what are these failures?

About 60% of all services under Better Access were provided to women in 2007- 2008 and this has remained unchanged. Young men aged 12-24 years comprised 7% of all Better Access service users in 2007-08 and 8% in 2016-2017. Inequitable access on the basis of rurality and gender is a problem in Better Access, as it is with many health programs. (p.1)

More women than men receive a referral from their GPs for emotional problems? Not that many young men turn to GPs for help with emotional problems? Is this so remarkable? I'm not suggesting that patterns of age and gender in referrals are not of interest – I am pointing out that these biases are in operation *before* the client shows up at the psychologist's practice. I note, however, that the lead sentence of the paper does *not* state: “Australia urgently needs a new and fairer approach to the provision of quality Medicare-funded *general practitioner* services”.

The paper referenced to illustrate inequitable access on the basis of geography (ref 1) refers to the association between remoteness of location and lower utilization of mental health services offered by psychiatrists and clinical psychologists. This would appear to reflect the geographical separation of the two Australias, discussed in Discussion Paper 1 (p. 2). I note, however, that the lead sentence of the Rosenberg and Hickie paper does *not* state: “Australia urgently needs a new and fairer approach to the provision of quality Medicare-funded *psychiatry* services”.

Furthermore, in the referenced paper, Meadows et al (2015) state that the geographical inequity was less for mental health services provided by GPs, general psychologists, occupational therapists and social workers. Professor Hickie is notorious for his mischievous public endorsement of “clinical” over “general” psychologists. Won’t the disenfranchisement of general psychologists increase the geographical inequity he points to as a “failure” of the Better Access program?

2. Cost

Rosenberg and Hickie also want to criticise the cost of the Better Access program for psychologists – cost would be the “giant” part of their “ten years of the runaway giant” critique.

The program has grown every year over the decade. In 2016 -17, it delivered 8.6 million services at a cost of \$820 million, or \$15.8 million every week.... [of this] interventions by psychologists accounted for over half of all services (p.2)

Hmm... 8.6 million services for \$820 million? That sounds like a lot of money but, then again, that’s purchased an awful lot of services. Is this a good thing or a bad thing? Unfortunately, the authors do not provide the number of psychiatry services and its annual cost to Medicare over the decade, to see if Better Access really is, proportionally, the “runaway giant” they claim it to be.

The authors do provide *some* useful context.

It is still the case that mental health receives 7.7% of the total health budget while accounting for 12% of the burden of disease. Without investments like Better Access, the proportion of mental health total health spending would have declined. (p.2)

So it’s a good thing? It’s a good giant delivering lots of good services?

3. Quality and outcomes

Nope, it’s a bad giant. In the next sentence they state:

Nevertheless, the program represents Australia’s willingness over the past two decades to “fix” mental health by prioritising increased access over systems that promote enhanced quality or monitor health or functional outcomes. (p.2)

So now they are saying that Better Access *increases* access? But that is now a bad thing? Without acknowledging this self-contradiction, they then shift to a quite different assertion – access has been traded for quality.

Better Access continues to operate with little or no accountability at the practitioner or national policy level. (p.2)

It would be interesting to learn the qualities intrinsic to psychology services under Medicare that work against “quality”, or, conversely, the qualities intrinsic to psychiatry services under Medicare that promote “quality”? We’d also like to learn how psychiatry services, in contrast, operate with better “accountability”. Unfortunately, the authors are silent on this point.

They do, however, recommend redirecting Better Access funding “towards more multi-disciplinary approaches typically associated with quality mental health care” and reference a paper from Prof Patrick McGorry’s research group (ref 2) on the cost effectiveness of youth mental health care interventions of the type he provides². The authors leave unexplained how a nostalgic return to the pre-Better Access model when psychologists knew their place, working as a member of a multi-disciplinary “team” under the direction of a psychiatrist, offers *generally* superior quality mental health care over sole practitioner psychological treatment. As to the question of cost-effectiveness, APS President, Ms Ros Knight, has succinctly stated, “Multidisciplinary mental health care is not necessary for the majority of Australians” (ref 3).

It is also unclear whether they also believe that defunding psychiatrists in private practice and folding them into multi-disciplinary teams would offer a similar improvement in the quality of mental health care they offer.

In essence, the Rosenberg and Hickie paper is engaged in the same “give the public money to me, not him” gambit fueling the present two-tier split within the profession of psychology in Australia (ref 4). The disguising of inter-professional rivalry in a pseudo-scholarly format is unhelpful to clear thinking and problem solving.

More giants, more elephants

I have argued that the three-tier solution to intra-professional conflict proposed in the Green paper does nothing to address the structural weaknesses identified in Discussion Paper 1, and illustrated further inefficiencies it might introduce.

I have also argued that inter-professional conflicts enacted by papers such as *The runaway giant* by Rosenberg and Hickie - who *are* the runaway giants? – distracts us from seriously considering the productivity benefits of addressing social determinants of mental health, over the current pharmacological approach. An interest in the former is not exclusive to the profession of psychology, but is shared by many medical practitioners, including psychiatrists, as well as other health and mental health professionals.

It is my view that the disguised enactment of inter-professional rivalries is as important a source of the structural problems identified in the Productivity Commission Issues Paper (January 2019) as the disguised enactment of intra-professional rivalries within psychology (Discussion Paper 1, p.1). I wish to be clear that inter and intra-professional rivalries and conflicts are, of course, inevitable and potentially productive. In contrast, *disguised enactments* are always unproductive, and stand in a similar relationship to social systems as the relationship between neuroses and individuals.

As I hoped to illustrate through both of these discussion papers, the mess they create gets in the way of thinking through issues pertaining to productivity.

² I will not take the space here to discuss the not particularly impressive clinical outcomes of the headspace program (Hilferty, Cassells, Muir, Duncan, Christensen, Mitrou, Gao, Mavisakalyan, Hafekost, Tarverdi, Nguyen, Wingrove, Katz (2015). Is headspace making a difference to young people’s lives? Final Report of the independent evaluation of the headspace program. [SPRC Report 08/2015] Sydney: Social Policy Research Centre, UNSW) or the controversies over Prof McGorry’s early psychosis treatment paradigm.

I look forward to your comments!

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References

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