



Submission by: Association of Counselling Psychologists (ACP)

Author: Duane Smith

Productivity Commission Mental Health Inquiry (April 2019)

Draft Report (October 2019)

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Contact: Duane Smith

Executive Chair: Association of Counselling Psychologists (ACP)

counsellingpsychologists@gmail.com

Productivity Commission Mental Health Inquiry Draft Report (October 2019)

The author, on behalf of the Association of Counselling Psychologists (ACP), thanks the Productivity Commission for their extensive review and draft report and the further opportunity to contribute.

The ACP represents members across Australia, promoting and advocating counselling psychology as a field of psychological practice. Counselling psychologists can be found in a range of settings offering Medicare rebated treatment within government and non-government organisations, hospitals, educational institutions and private practice. Counselling Psychologists provide assessment, formulation, diagnosis, treatment and management of psychological problems and complex mental health disorders. Counselling psychologists are experts in the provision of evidence based psychological therapy. This submission focuses only on addressing those recommendations in the draft report within the scope and expertise of the profession of counselling psychology.

Counselling Psychology

Psychology as a discipline and profession has a fundamental role to play in mental health services. Psychology is a regulated health profession under the authority of the Australian Health Practitioner Regulation Agency (AHPRA) and the Psychology Board of Australia (PsyBA). Registration with the PsyBA is essential to practice as a psychologist in Australia, and psychologist titles are protected.

All psychologists have 'general' registration, following the completion of a minimum of six years of training and there currently exists three pathways to registration. The first pathway, known as the '4 + 2' pathway requires completion of four years of undergraduate study in psychology, followed by a two year internship under the supervision of a psychologist. The second pathway, known as the '5 + 1' pathway, requires completion of four years of undergraduate study, a one year Masters in general psychological practice, followed

by a one year internship under the supervision of a psychologist. The third pathway involves four years of undergraduate study, followed by either a two year Masters, three year Doctorate, or four year combined Masters/Doctorate program in one of nine areas of practice (clinical psychology, clinical neuropsychology, community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology, organisational psychology, and sport and exercise psychology). These nine fields are referred to as areas of practice endorsement (AOPE).

Psychologists who have trained via the third pathway are eligible to work towards an additional qualification (from what is required for general registration as a psychologist) through engaging in advanced supervised practice in one of the nine areas of endorsement recognised by the PsyBA. Like all AOPEs, a minimum of eight years of study and supervised practice are required to gain endorsement as a counselling psychologist, which permits use of the title 'counselling psychologist.'

ACP - Overview of Draft Report and Recommendations

The Productivity Commission's Mental Health Inquiry and subsequent Draft Report (October 2019) provided an unprecedented opportunity for a comprehensive review of mental health services in Australia. The inquiry's broad approach to reviewing the provision of mental health services and inclusion of other psychosocial sectors, including education, housing, employment, social services and justice, is to be commended and in line with the systemic and holistic approach to mental health, long supported by counselling psychologists.

The report and draft recommendations are in the majority, consistent with a holistic and systemic philosophy, which provides whole-person care that supports mental health alongside other biopsychosocial aspects, rather than mental health being addressed in isolation.

After extensive review, the ACP is supportive of the majority of draft recommendations in the report. The ACP would like to submit further comments in relation to a number of the specific recommendations and information requests.

DRAFT RECOMMENDATION 23.3 — STRUCTURAL REFORM IS NECESSARY

INFORMATION REQUEST 23.1 — ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

The Productivity Commission has proposed two distinct models for the architecture of the future mental health system:

** The Renovate model, which embraces current efforts at cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs).*

** The Rebuild model, under which State and Territory Governments would establish 'Regional Commissioning Authorities' that pool funds from all tiers of government and commission nearly all mental healthcare (Regional Commissioning Authorities would take over PHNs' mental health commissioning responsibilities and also commission more acute mental healthcare) and psychosocial and carer supports (outside the NDIS) for people living within their catchment areas. At this stage, the Rebuild model is the Commission's preferred approach. How could the Rebuild model be improved on? Are the proposed governance arrangements appropriate? Should RCAs also hold funding for, and commission, alcohol and other drug services? If you consider the Renovate model or another alternate approach is preferable, please describe why, and outline any variations you consider would be an improvement.*

ACP Comments:

The ACP appreciated the positives aspects of developing a Rebuild framework that is state and regionally accountable (rather than federal), that is responsive to regional specific mental health demands for service and shifts the burden to the state to address gaps in service and

ultimately reducing acute bed costs through better early intervention, prevention and managed co-ordinated stepped care.

Whilst we recognize implementation and governance details are yet to be determined, the following paragraph in the report raises concerns:

“The size of each RCA’s funding pool would be linked to the volume of MBS rebates for allied mental healthcare in their region and each RCA would be permitted to contract with MBS-subsidised allied mental professionals, so as to create a single budget from which all such mental healthcare in a region would be funded”.

The ACP would ask the Commission to consider the following points:

- The cost of establishing another very large bureaucracy in addition to the current Medicare system
- *“Approximately 1.3 million people currently receive MBS-rebated sessions of face-to-face psychological therapy (individual or group) each year” (Pg 20).* The RCA’s would be required to administer and manage funding and service contracts to over 26,000 psychologists (NIMH- Mental Health Services In Brief, 2019) currently in the system.
- *“Double Handling”* – Currently the MHTP referral system, is a direct and mostly timely referral system which is a direct GP – Psychologist referral pathway. The introduction of *“another step”*, where GP referrals – RCA will have to be again triaged and then allocated will only increase the time it takes for a client to access support. The previous ATAPS program and PHN/Division of General Practice Suicide Prevention programs encountered these issues systemically, which resulted in long waitlists, large administration costs and longer waiting times to access psychologists
- Consumer choice -The impact on consumer choice of the abolition of existing private MBS GP direct to psychologist referral system?. Current clients with current

relationships with psychologists under the current system would choose their current psychologist due to the evidence based therapeutic relationship already built. The need for mental health support can be episodic over an individuals' lifetime - will they be able to access their known psychologist under a new RCA system ?. Can consumer choice be upheld under a new system where an RCA may dictate allocation to a psychologist from a designated "pool" of practitioners. If so, this approach is not client centred.

- What are the consequences for the private practice psychologists in the current private practice system ? The implementation of this framework will be extremely disruptive to large number of psychologists in private practice.
- Has the Commission reviewed existing PHN data and non PHN data to quantify the extent of non- PHN (GP – direct to private practice psychologist referrals) that are currently in the system?

Possible Alternative Framework for Consideration: A Balance of Rebuild and Renovate

The Commission adopts the **Rebuild** Model and implements RCA's for the administration and management of state/regional public mental health services (**only**). The RCA's funding pool would be based on the annexation of a **percentage** of the volume of MBS rebates for allied mental healthcare in their region and predicted per capita federal mental health budget that is external to MBS funds.

Continue and **Renovate** the current GP-direct to psychologist MHTP private referral system. The existing private referral system will remain funded and supported through the current federal MBS system.

To increase accountability from both public and private systems, develop the **same** online navigation platforms, Clinician Supported Online Treatment system, “standardized decision support tools”, that are client centred, not just diagnostically symptom/disorder based, that also incorporate systemic and developmental considerations and assessment of the individual, including but not limited to, developmental risk variables, adverse childhood experiences, social determinant risk factors and clearly outline processes of allocation into stepped care service provision and contain integrated collaborative case management communication portals utilising effective outcome measurement tools.

INFORMATION REQUEST 5.2 — MENTAL HEALTH TREATMENT PLANS

How should the requirements of the Mental Health Treatment Plan (MHTP) and MHTP Review be changed to ensure that GPs assess, refer and manage consumers in line with best practice (as laid out in the Australian Department of Health’s guidance)?

- *What should be added to the MHTP or MHTP Review to encourage best-practice care?*
- *Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?*
- *Are there additional or alternative clinical thresholds (to a mental disorder diagnosis) that a consumer should meet to access Psychological Therapy Services or Focused Psychological Strategies?*
- *Should consumers continue to require a MHTP for therapy access if being referred by a GP?*
- *What new clinical thresholds, if any, should be introduced to access additional sessions beyond the first course of therapy? Should these be part of or separate to the MHTP Review? Should a MHTP Review be required to access additional sessions, instead of just a new referral?*

- *How could audits be used to ensure that clinicians are assessing, referring and managing patients in line with best-practice and the stepped care model?*
- *What information should clinicians be required to give the consumer when completing a MHTP or MHTP Review? Should they be required to give the consumer the completed and reviewed Plan?*
- *Should GPs continue to receive a higher rebate for MHTPs and MHTP Reviews than for standard consultations ?*

ACP Recommendations:

It is in the view of the ACP, that the inquiry's broad approach to reviewing the provision of mental health services and inclusion of "broader picture" social determinant risk factors and psychosocial sectors, including education, housing, employment, social services and justice, is to be commended and in line with a new systemic and holistic approach to mental health.

While the medical model is central to effective healthcare, expanding the model to include social determinants of health and mental health will lead to a more holistic focus and approach to healthcare. The current system does not recognise mental health on a continuum and that deficits in functioning (including capacity to work) can be episodic in nature and fluctuate over time and in severity.

The current MHTP system preferences the medical model of psychiatric diagnosis. To continue to base assessments on biomedical psychiatric diagnostic criteria is clearly out of step with current research around mental health and even at odds with the current holistic functional psychosocial disability assessment through the NDIS. *"Mental health conditions for which the impact of the impairment varies over time (episodic) can remain across a person's lifetime and can be considered likely to be permanent."* (NDIS, 2018, p. 2).

The issue that exists however is - how to transition this paradigmatic shift “into practice”, given the predominantly biomedical diagnostic approach embedded within the current system. The initial GP visit and MHTP process is the major “initial entry point” into the MBS funded mental health system to seek referral for treatment from a psychologist.

As GP’s are “gatekeepers” to accessing mental health support, the ACP recommends major reform and reworking of the current MHTP assessment and referral processes to support the recognition of a more holistic and systemic approach to mental health services.

The ACP agrees with the gatekeeper role of the GP in the current system, but as recognized in the report (Draft Recommendation 11.5 Further Mental Health Training for Doctors, Pg 64), GP’s need further training and support in managing patients with mental health issues, particularly those patients with serious, chronic and complex mental health disorders.

“despite the extensive knowledge and experience required to do so, and the frequency at which GPs see people with psychological problems, many GPs have received only limited training in mental health”. (Pg 206)

It is the view of the ACP that increased training for GP’s in mental health is essential if they are to continue to be in a gatekeeper role but also recognises that GP’s diagnose from a biomedical symptom based diagnostic framework, are also time poor and may not be able to take full detailed mental health histories and correctly formulate/conceptualise the mental health support needs of the individual. This is vital in engaging an individual into the right “step” in a stepped care system. The current MHTP process impedes a more holistic and systemic client focused approach.

Psychologists, however, are highly trained in the assessment, diagnosis and treatment of mental health issues. Counselling psychologists and clinical psychologists have advanced

training in assessment, diagnosis, treatment, and management of serious, chronic, and complex mental health disorders.

Reforming the Stepped Care Model with the MHTP: The need for a new system with integrated MHTP Processes

The ACP recommends the following changes to the current MHTP assessment and referral system:

- Reduce the burden on GP's by enabling GP's to allocate individuals to an "initial" stepped care pathways after a brief assessment. (Rework the existing MHTP form and requirements)
- Reduce "doubling up" on mental health assessments" by tasking psychologists to complete thorough standardized mental health full assessments and further determine appropriate stepped care service pathways.
Low – Moderate Intensity Care Assessments can be conducted by registered psychologists and mental health nurses;
Low, Moderate, High and Complex Intensity Care Assessments can be conducted by counselling psychologists, clinical psychologists and psychiatrists.
- Preserve and retain reporting requirements to GP's to assist support oversight and management of the MHTP

Furthermore, The ACP recommends abandoning old legacy IT health systems and invest in the development of a new cloud based future proof online navigation portal/platforms for GP's, Psychiatrists and all MBS funded Allied Health professionals with the following integrated features:

- Online mandatory MHTP standardized assessments, that are not just diagnostically symptom/disorder based, but incorporate systemic and developmental considerations and detailed assessment of the individual, including but not limited to, developmental risk variables, adverse childhood experiences and social determinant risk factors.

- These standardised assessment are conducted by psychologists or psychiatrists on initial MHTP referral from GP's (New MBS Assessment Item numbers needed)
- Standardised mental health decision support tools that are integrated into the assessment portal are easily utilized by GP's collaboratively with psychologists, psychiatrists and other allied health professionals as needed, to determine clear allocation pathways into stepped care service provision based on the assessment and tailored to support needs of the individual.
- Integrated Clinician Supported Online Treatment system for low intensity support including self help information and resources.
- Integrated collaborative care, case management communication portals in all stepped care pathways including Multi Disciplinary Team (MDT) supports for those individuals with complex and acute care needs.
- Integrated best practice feedback and outcome measurement tools throughout all service pathways and engagement.
- Secure data encryption with client/practitioner service level confidentiality protection ie the client chooses who has access to personal data and controls permissions.
- Integrated AI data analysis of aggregate de-identified data to enable variable comparison to predict trends and establish benchmarking and funding accountability.

DRAFT RECOMMENDATION 5.4 — MBS-REBATED PSYCHOLOGICAL THERAPY

MBS-rebated psychological therapy should be evaluated, and additional sessions trialled.

In the short term (in the next 2 years)

The Australian Government should commission an evaluation of the effectiveness of MBS-rebated psychological therapy. As part of this evaluation, the Australian Government should undertake trials allowing up to 20 sessions of individual or group therapy in total over a year for consumers whose clinical condition requires more than the current 10 sessions. The trials

should allow a GP to re-refer a consumer after the first 10 sessions rather than the present 6 sessions.

The Australian Government should change the MBS so that the maximum number of sessions of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies) is per 12-month period, as opposed to per calendar year.

In the medium term (over 2 – 5 years)

Based on the results of these trials and evaluation, the Australian Government should determine whether to:

- roll out the trialled changes above*
- continue funding psychological therapy through the MBS, or whether some other mechanism is more appropriate*
- make any other changes to increase the effectiveness of MBS-rebated psychological therapy.*

ACP Recommendations:

The ACP welcomes the above draft recommendation of evaluation and trials of the MBS – rebated psychological therapy and fully supports the recommendations contained within the APS White Paper -The Future of Psychology in Australia, (June, 2019). The APS White Paper clearly outlines a pathway to integration with a stepped care model. We urge the Commission to adopt the White Paper recommendations as part of the final report.

Final Comments:

Whilst the ACP welcomes the Commissions’ extensive focus on developing a new client orientated mental health system taking into consideration social determinant factors and incorporating more holistic, collaborative and systemic treatment approaches, the draft report has limited comment on and has not extensively reviewed the effectiveness, impacts,

side effects or new research on treatment outcomes of the use of psychiatric medication (Anti-depressant, anxiolytics, antipsychotics).

While the medical model and use of psychiatric medications is central to effective healthcare, Anti depressant and Anxiolytics are often used as a first line treatment response within the current system with those clients with depression and anxiety presentations.

"Australians have almost 20 million GP consultations per year for mental health problems, with mental health being one of the main reasons people go to their GP". Pg 28

"GPs often treat with medication — about 15% of the population received a mental-health-related prescription from their GP in 2017-18. Three quarters of these were for antidepressant medications (AIHW 2019a, table PBS.3)". Pg 205

"4.2 Million patients received mental health related prescriptions in 2017-18 (AIHW 2019). Pg 6"

The costs of the use of psychiatric medications to the overall federal mental health budget through the Pharmaceutical Benefits Scheme (PBS) or RPBS is not reported. Out of pocket consumer expenses, is also not reported. A full mental health inquiry should, include a review of psycho-pharmacological treatment outcomes and costs.

A mental health system that remains predominantly biomedical and diagnostically disorder orientated has vast challenges if it is to accept systemic treatment approaches outside the current predominantly diagnostic- disorder- medication- treatment based system.

The ACP submitted a 76 page document to the Productivity Commission- Mental Health Inquiry. On behalf of the ACP, I would like to thank the Commission again for the opportunity to respond to the Draft Report.

Yours sincerely,

Duane Smith
Counselling Psychologist
Executive Chair, ACP