

Response in relation to
Australian Government Productivity Commission
Inquiry into Mental Health Draft Report
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By:

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Introduction

A brief submission by a sole practitioner in private practice. David is based in Goulburn NSW a regional centre and also provides a psychological service to Braidwood, a small country town in rural NSW.

The following are responses to particular themes in the draft report.

There is insufficient inquiry in the report of pharmacological mental health treatment

As background

- In 2017-18 \$534 million was expended on Government prescription medication for mental conditions through 37.7 million mental health-related prescriptions (subsidized and under co-payment). This may actually under-report the cost and number of prescriptions as a number of prescriptions for mental health conditions are off-label prescriptions (eg anticonvulsive medication prescribed as mood stabilizers).
- 4.2 million patients (16.8% of the Australian population) received mental health-related prescriptions, an average of 9.1 prescriptions per patient, in 2017–18. 86% by GPs.¹ This does not include cost for consultations to attend a GP or Psychiatrist for diagnosis or to receive prescriptions.

There is clearly strong evidence for the benefit and efficacy of psychotropic medications. In particular in the case of BiPolar and Psychotic conditions medication should form the first line of treatment. There is a similar case for severe depression and some anxiety conditions for some patients.

That said, the expenditure outlined above constitute a very considerable investment which does not seem to have been reviewed or considered by the Productivity Commission. The comments in the report in relation to there being good evidence of studies in relation to outcomes of psychological treatment but not of the Better Access scheme are even more true for pharmacological

¹ <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services>

interventions. Initial drug trials generally screen out participants with co-morbid conditions (both physical and mental health) or taking other medications. Therefore, the interactions between the mental health drugs and prescription drugs for physical conditions is poorly understood.

In regard to those under 18, there are generally no drug trials available to medical practitioners to inform treatment in this patient group.

Whilst a properly constructed long term study of the efficacy of Better Access is supported, it would be beneficial to also undertake studies into the outcomes of pharmacological treatments of mood disorders for patients prescribed under the MBS. It would also be of value to compare some patients on drug only, psychological therapy only and combined antidepressants and psychological treatments. This should particularly concentrate on moderate level conditions as defined by the step care model.

Further, in my experience, patients are at times retained on mental health medications such as antidepressants for many years which the patients state has been without review. Often conditions such as anxiety and depression can be reactive and relate to an adjustment or current crisis. Consequently, it can be amenable to resolution or management through psychological therapies. In my experience, it is not uncommon even when this occurs for prescription medication to be maintained in some cases for a considerable time (years) without adjustment or review.

Even when dosage is titrated down, patients are often not aware of the withdrawal effects and misperceive these as a recurrence of the mental health condition. Can I suggest that the review consider ways of assisting GPs with tools to better evaluate the efficacy and dose for antidepressant and similar medication and provision of psychoeducation material about withdrawal.

A focus in the report on accessing Better Access but not other Medicare mental health consultations

There is a considerable emphasis in the report on psychological consultations and no detail on psychiatric consultations nor GP mental health consultations. I understand that for some GP MBS item numbers it will not be possible to determine how many are mental health consultations. That said the BEACH survey reported mental health consultations averaging 12% of all GP consultations².

Whilst in my experience Psychiatrists (and some GPs) generally focus on diagnosis and medication review, it is acknowledged in the report that some provide psychological treatment. For both groups (Psychiatrist and GP) the number of sessions is uncapped as opposed to the Better Access scheme which is capped at 10 sessions of treatment.

Whilst some Psychiatrists (and GPs) bulk bill, the report would also benefit from data regarding average gap payments for Psychiatrist consultations in particular, as I am aware of patients having to find a gap payment in the range \$150 to \$400 per hour long psychiatric consultation. In a productivity inquiry it could be argued that it would be more cost effective to consider, particularly given the limited numbers of Psychiatrists and the much higher cost per consultation that their focus should be on diagnosis and pharmacological treatment and provision of advice to GPs and Psychologists. That unless there is a compelling reason that where general psychological treatments are administered that these be through referral to be referred to Clinical Psychologists.

² <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/general-practice>

Better Access Medicare Program

As the productivity draft report identifies, the Better Access program has been highly successful in engaging patients in psychological treatment. Given the stigma usually surrounding mental health treatments this program has indeed created better access. Particularly around those with mild and moderate conditions seeking treatment.

It would be interesting to compare the demographics of Australians accessing treatment since Better Access was implemented compared to other advanced countries without government supported, GP referred programs provided by private practitioners.

One of the strengths of the program is the requirement to be referred by a GP. Patients who may be reluctant to self-refer are very likely to if referred by their GP. My experience is the referrals from GPs are appropriate and referral information is usually of a high standard. Another advantage of Better Access is the location of most psychologist services outside the typical public health settings, often with psychology services co-located in community medical practices or stand alone psychology practices.

The report indicates that 53% of Better Access Psychologist consultations there is a gap payment and this averages \$65. On one hand this is indicative of a strong financial endorsement by patients of the benefit they find from the treatment. It also points to the level of bulk-billing has been affected by the freeze on MBS rebates between 2013 until July 2019. That said, my practice has almost universally bulk-billed until the present time. That said it remains that 47% of psychological consultations are bulk billed.

The income generation model is quite different for psychology consultations which are typically are scheduled for an hour compared to increments of 15 minutes for GPs. This is particularly relevant where patients fail to attend a psychology session (and so no payment received for that session by the psychologist).

The current formulae under Better Access is for six treatment sessions with possible additional four in a calendar year once approved by the referrer. I operate in a regional town in NSW and in addition travel to a small rural town to provide service. For a significant number of the less mentally well patients, they do not have the means to pay for treatment once their allocation under Better Access is exhausted. The acknowledgement in the report of the inadequacy of the number of sessions to properly complete treatment in a number of cases is endorsed and applauded.

One of the issues with only (potentially) 10 sessions is the desire to see people regularly (eg weekly or fortnightly) for effective treatment contrasted with the knowledge that if the sessions are consumed over (say) three months that there will be a considerable period of the year, particularly if there is likely to be crisis intervention required where there will be little to no support able to be offered with very limited assistance from community mental health resources.

Face to Face vs Online Treatment Programs

The reports promotes a need for a 'people oriented system' which is pleasing. One of the founders of modern psychology, Carl Rogers spoke of three necessary and sufficient conditions required to engage with patients and foster therapeutic change. Whilst it is now acknowledged there may be

other necessary conditions ³, there is strong support for patients feeling heard and validated prior to introducing therapeutic interventions so as to increase working alliance and motivation to change.

Whilst I am aware of coaches and other forms of human contact, most of the online programs/apps I have viewed the required conditions referred to above are generally lacking particularly at the assessment and orientation component of the process. It would be interesting to gather data on the number of referrals by GPs to such programs compared to the uptake and commencement of such programs as well as drop-out rate compared to face to face programs. There are clearly benefits to online programs, but this may be most effective if it is augmented by face to face (including perhaps video-conferencing for a longer orientation and intake session) or as is often utilized now by Psychologists, utilizing online or app programs as additional psychoeducation and homework to the face to face treatment sessions.

Better Access Group Items

The report highlights the low uptake of group programs for high prevalence disorders under Better Access. There are a number of reasons for this, such as availability of a sufficient cohort of group participants at a particular time, practitioner comfort with group delivery, availability of evidence based manualized group treatments that are not proprietary, administrative time commitment eg preparation, marketing to GPs, screening and orienting patients, producing materials, financial risk if participants drop out and patient willingness to participate in community programs.

That said, there are advantages to group programs in particular the cost effectiveness of the group delivery model and often peer support which can extend beyond the life of the group. In general group programs maybe better delivered under a PHN commissioning model or through staff of the Local PHN. There are already some models for this such as Psychological strategies for Chronic Pain Management.

Preventative Programs with Young People

For children externalizing disorders (eg Oppositional Defiant Disorders, Attention Deficit Hyperactivity Disorder) there is a strong likelihood of future mental health concerns and issues ⁴. Parent training programs, typically taught in group settings (eg Triple P⁵, Defiant Children⁶ have been highly successful in reducing behaviours.

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https://www.researchgate.net/publication/51831552_Reassessing_Rogers'_necessary_and_sufficient_conditions_of_change

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Dadds, M. R. (1997). Conduct disorder. In R.T. Ammerman & M. Hersen (Eds.), *Handbook of prevention and treatment with children and adolescents* (pp. 521–550). NY: John Wiley

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Sanders, M. R. (1999). Triple P-Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child & Family Psychology Review*, 2(2), 71–9

⁶ Barkley, R. (2013) *Defiant Children a Clinician's manual 3rd Edition* NY: Guilford

Funding for such group programs is not currently available under Better Access for parent training as it is a requirement for the identified patient (ie the child) needs to be present. This is not helpful for much of the group program where the approach is to teach parents' skills and the child is attempting to disrupt attempts to more effectively parent them.

Acute Inpatient Admissions

I endorse all that is in the report about the need for much more structured transitional programs at discharge. In NSW we generally seem to have only short-term (often a week to three weeks) acute wards followed by discharge to the community with very limited support or monitoring.

I also support the claim in the report that there are gravely insufficient beds for people in acute need.

Secondly, in my experience, I am greatly concerned that persons admitted with acute mental health crises once diagnosed are managed solely through pharmacological interventions plus close observation. Many of my clients have complained that whilst being in psychiatric wards there are no programmed activities. There is no individual psychological treatment nor group programs, nor even structured recreational activities.

In contrast private psychiatric wards seem to have individual psychological treatment sessions as well as group skill training and psychoeducational sessions. Further there are structured opportunities for recreational and social activities.

Whilst people in such settings are different levels of wellness, it cannot be disputed that most would benefit from a structured, psychological treatment-oriented approach. This could even include online psychological treatment programs with additional mentoring and support from workers in the unit. It seems to me this situation has come about because of a focus on a medical hospital model with most non Doctor staff being primary mental health nurses. I think it is rare for the employment of Psychologists, OTs or Diversional Therapists in acute inpatient setting which make it even more difficult for the patients to benefit beyond the pharmacological therapy.

People who may have been actively suicidal or psychotic only days before, can be released back into the community with no rehabilitation or transition beyond the mandatory 3 day and 28 day follow up, which is may be via a phone call.

One aspect of the severe end of the stepped care model that is absent is the provision of short-term post-acute rehabilitation wards or day outpatient programs. The analogy I would make is similar to someone with a stroke being admitted to ICU then released back to the community without any rehabilitation.

Gaps in Services in the Stepped care model

Following on from the above point, there are very few specialist programs for severe and chronic or treatment resistant individuals. The ones that do exist (eg Gold Card Clinic program for those with personality disorders) and tertiary hospital-based programs such as the Westmead Eating Disorders Unit, Royal North Shore Pain Management Unit, University Units with a focus on children , anxiety or specific disorders.. These are world class and the intense programs (residential) which can arrest the

'revolving door' for that group at the higher end of the stepped care model who do not get sufficient intensive programs to make real and sustained progress.

Beyond Health

The report's inclusion of discussion into the social factors (such as housing, carer support, income support, justice system and education) is applauded and is very relevant, I would like to make the following submission.

There is little consideration of the grossly inadequate level of New Start payment and the effect this has on the mental health of recipients. This not only includes anxiety related to making ends meet but also ability to access medication, transport, healthy food, heating, childcare, appropriate accommodation, GP or allied health providers including mental health services.

For me another concern to qualify for Disability Support Pension applicants must achieve 20 points on the Tables. Mental Conditions are assessed at Table 5 Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011⁷. Unfortunately, these are written with the same criteria as for physical health concerns (eg the condition must be fully diagnosed, stabilized and fully treated). The criteria of fully treated is particularly difficult to meet with fluctuating conditions such as mood disorder and bipolar disorder.

There are many people who suffer mental illness who are deemed as not qualify as they cannot meet this very difficult criteria. In particular, this forces people with quite serious mental illness to seek work through application and cold calling and to undertake the mutual obligation requirements. There are also strong penalties for lack of requirement, often lodging of administrative forms when they are unwell. This is highly stressful for many of the people I see and exacerbates (rather than assists) their mental health.

Thank you for considering this submission.

⁷ https://www.dss.gov.au/sites/default/files/documents/05_2012/dsp_impairment_final_tables.pdf