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Productivity Commission Mental Health Draft Report

AAPi Submission, January 2020





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Australian Association of Psychologists Inc. Response to the Productivity Commission Mental Health Draft Report.

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Further information can be obtained by contacting Tegan Carrison via email
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We thank you for the opportunity to provide a response to the Productivity Commission Report on behalf of our membership. The Australian Association of Psychologists Inc (AAPI) is the largest not-for-profit member association for psychologists in Australia.

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Introduction

AAPI has limited its response to the Productivity Commission Report to those areas most closely aligned with the mission and values of the AAPI.

AAPI agrees with the Commission that a rigorous evaluation of Better Access is required. We would ask the commission to consider the focus on this evaluation being on the areas of funding, that is access, and number of sessions allowable under Better Access. In our opinion effectiveness between practitioner types has already been demonstrated. What has not been tested is effectiveness against numbers of sessions. Previous studies have been limited in what they could demonstrate because the number of sessions available was limited. Therefore, the known minimum of 20 sessions is never achieved and a proper evaluation of the better access program has not been possible.

AAPI asserts there is an immediate need to cease the two-tier Medicare Rebate for psychological services. There is no evidence of greater effectiveness associated with any particular subtype of psychologist or in relation to their endorsement status. As part of the ongoing work of the Productivity Commission, AAPI advocates for further peer reviewed, high quality research into the question of whether outcomes between registered psychologists and endorsed clinical psychologists differ significantly in a direction that suggests tertiary masters or doctorates in clinical psychology are correlated with better outcomes. Our hypothesis is that there is no significant difference in outcomes. To date, no such research exists that unequivocally supports higher education pathways. AAPI is strongly opposed to the two-tier Medicare Rebate for psychology, especially without clear evidence to justify this additional expenditure.

The two-tier system disadvantages clients and reduces access to psychology services. Furthermore, the community should not be expected to pay higher rebates/loadings for the services of endorsed psychologists when there is no evidence of greater outcomes or effectiveness. All psychologists should be on the one, higher rate allowing for more sessions to be bulk billed or gap payments minimised. A core tenet for improving mental health in Australia is improving access to appropriate services, and the access to a clients' preferred mental health clinician of their choosing. We are particularly concerned about access to psychological services in rural, remote and very remote areas. The current two-tier model for psychologists, with clients of clinical psychologists receiving a much higher rebate than clients of registered psychologists, is especially discriminatory to clients in rural and remote areas, where access to clinical psychologists is limited or non-existent. This is strongly opposed by AAPI and we ask the productivity commission to evaluate this

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and the benefits to the community of having all psychology therapy sessions eligible for the higher tier and thus improving access to vitally needed services.

AAPI agrees with the commissions' findings that current funding is inadequate, especially the reactive nature of input-based funding, which misses the complex nature of mental health and unmet need/demand. AAPI agrees that the capped 10 sessions currently offered under the Commonwealths Better Access Scheme is grossly inadequate for Psychology Treatment. AAPI supports the Productivity Commissions recommendation that this be increased to up to 20 sessions and would like to suggest that this be increased further to up to 40 sessions, similar to the new Eating Disorder Medicare Items for clients requiring this level of support.

AAPI would like the Productivity Commission to acknowledge the large role of Psychologists in all levels of care and service delivery. AAPI supports and values the input and contribution of psychologists across the spectrum from prevention, early intervention, treatment and continuing care and acknowledges the specialised skills that psychologists contribute. AAPI would like the Productivity Commission to acknowledge the important part private practice psychologists play in the mental health care in Australia, especially where publicly accessible services are lacking and urges the commission to investigate properly funded access to psychologists in private practice, through a one-tier Medicare rebate with little to no gap payments from those requiring this service. AAPI is supportive of a collaborative, multidisciplinary model of care and thank all those working tirelessly in the field.

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1. Early help for people

Start now	Start later
Incorporate social & emotional wellbeing checks into existing physical development checks for 0 to 3 year olds	Monitor & report on progress toward universal screening
All schools assign a teacher to be their mental health and wellbeing leader	Expand parent information programs on child social & emotional development
COAG-developed strategic policy on social and emotional learning in the education system, including development of national standards for teacher training	Strengthen skills in workforces of early childhood education and care, and schools to support child social and emotional development
Implement a new national stigma reduction strategy	Use data on wellbeing of school students to build evidence base for future interventions
Reduce stigma amongst health professionals	Evaluate best practices for partnerships between traditional healers and mainstream mental healthcare for Aboriginal & Torres Strait Islander people
Follow-up people after a suicide attempt	
Identify local priorities and responsibilities for suicide prevention	Apply lessons from suicide prevention trials
Indigenous organisations empowered as preferred providers of local suicide prevention activities for Aboriginal & Torres Strait Islander people	

AAPI supports the Productivity Commission recommendations for early intervention both with children and in management of suicidal clients where there is evidence supporting the approach. The AAPI calls on the Productivity Commission to cite the research it relies upon.

The AAPI supports the Productivity Commissions funding of practitioners who have the time and capacity to make a positive difference to clients whether they are in schools or the community. We do not support rebranding such as new wellbeing leader roles in schools. We support better funding of qualified psychologist- practitioners who can provide the long or short term benefits that good therapeutic engagement as opposed to placebo effects¹ delivers in the long run.

While talking about stigma it is important to acknowledge that stigma within mental health services may be strongly associated with diagnostic criteria. That is, the very fact of being diagnosed may be causal in relation to stigma. Once again, most current research seems to be suggesting that the

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common factors (especially the therapeutic relationship) are the most significant contributor to healing regardless of diagnosis, or treatment modality.

The AAPI supports Aboriginal and Torres Strait Islander Peoples being the drivers of their own recovery and Aboriginal Psychologists, such as Tracey Westerman, leading in the development of Aboriginal psychologists.

2. Improving peoples’ experiences with mental healthcare

Start now	Start later
Expand clinician-supported online treatment options	Expanded online portal for consumers, with timely & linked-up referral processes
Provision of acute & non-acute beds & ambulatory services that reflect regionally assessed needs	Access to face-to-face psychological therapy at a level commensurate with treatment needs
Improve the ED experience & provide alternatives	Strengthen the peer workforce
Provision of child & adolescent mental health beds separate to adults	Incentivise family-focused & carer-inclusive care
Mental health expertise as support to police & paramedics	Incentivise psychiatric advice to GPs
Navigation platform for mental health referral pathways	Single care plan with electronic sharing of information
Care coordinators for consumers with the most complex care needs	
Expand mental health nurse workforce	
Widen access to psychological therapy & psychiatric assessment by video	
Rigorous evaluation of Better Access	

Evaluation has been performed on Better Access with regards to Psychologists and General Practitioners. The lack of acceptance by some of the peer supported and reviewed research already conducted tends to suggest either an unrealistic expectation of research in the psychology space or a bias in favour of the application of medication alone as a treatment modality. See Dr Clive Jones and others at <https://reformaps.org/respources/research> and the heading “Responding to naysayers” for comment about the problems with research in the clinical psychology field. Results

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of bona fide research by Pirkis et al (2011) showed that there was marked improvement in Depression, Anxiety and Stress scores across all professions with effect sizes in the range of those experienced in other countries. We support the Productivity Commission report where it was acknowledged that for moderate level conditions face to face services are effective and cost effectively delivered under Better Access.

In relation to the Commissions estimate that 1/3rd of people with mild conditions could be better targeted using online resources- we do not support statements whereby no evidence is provided pointing in the direction of efficacy of untested approaches.

We agree with the report on pages 20 and 21 Volume 1 that greater flexibility of better access would allow practitioners to provide services as needed. The fact that some patients use less than their six sessions indicated that practitioners in general can be trusted to assess clients needs and to work with them on those needs.

Regarding the assertion that GP's need to manage referrals there is no evidence provided to support that assertion. However, generally it is agreed they may be the best person to "case manage" a client. However, a better approach would be for the patient to identify for themselves who should case manage them. There is an untested hypothesis, but an anecdotally supported one, which suggests that for some patients their psychologist or clinical social worker or mental health nurse or psychiatrist or GP would be the best person to case manage them. In other words, and in line with the Power, threat, meaning framework coming out of the experience of the UK, the person with whom the patient has formed the best relationship is most likely to best support their recovery. The idea that treatment plans and diagnoses are the most important aspect of recovery is almost completely unsupported by the research. The therapeutic relationship and client factors account for roughly 80% of therapeutic change and that science has not changed as a result of the increasing emphasis on specialism in mental health.

The fact that mental health care has worsened over the last 15 years since the destruction of the divisions of GP's, lends support to the idea that centralisation of systems does not increase effectiveness of treatments. The Governments since Divisions of GP's were decommissioned, have contributed to a layer of governance in PHN's that does not translate into the effective service delivery or gap closing that it supposedly has been intended to deliver. Large hubs cannot be flexible. Flexibility is required.

Patients complain more now of being passed from pillar to post in so called wrap around teams, than ever before. They anecdotally report feeling alienated. They want to avoid these services because they feel alienated and disconnected. It is agreed that a standard referral would be an improvement on the waste of time and money in making mental health care plans.

The Commission reported that there should be more mental health nurses and no more psychologists on the basis that Australia has one of the highest number of psychologists per

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population ratios in the world. That is not a rationale for lack of support for more psychologists. The uptake in the Australian community of Better Access suggests that psychologists services are highly valued. The evidence from countries such as the UK, is that psychologists there are not coping with workloads and lack of resources. Appealing to International ratios that are not working is not a valid response to the situation in Australia. We say put forth evidence that supports effectiveness of mental health nurses in reducing the incidence of mental health in communities, before suggesting a model of training them to fill gaps in regional and rural areas.

3. Improving peoples' experience with services beyond the health system

Start now	Start later
Govts to commit to no discharges from care into homelessness	Mental health training and expanded tenancy support services for frontline housing tenancy workers
Additional supported housing places for people needing care on a regular basis	Develop disability justice strategies to ensure rights of people with psychosocial disabilities are protected during their interactions with justice system
Work toward meeting the gap in long term housing for people with mental illness who are persistently homeless	Improve rigor of mental health screening in correctional facilities and actively plan for care continuity post-release
Standards of care in correctional facilities to be equivalent to care in community	Ensure legal representation & non-legal advocacy services for those subject to involuntary mental healthcare
Ensure culturally capable mental healthcare for Aboriginal and Torres Strait Islanders in correctional facilities	
Funding cycles for all psychosocial services to be at least 5 years	
Improve eligibility requirements, availability & suitability of psychosocial supports	

AAPI supports psychosocial measures to improve conditions for people with mental health concerns.

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4. Increasing the participation of people with mental illness in education and work

Start now	Start later
<p>Effective outreach for disengaged school students</p> <p>Tertiary education institution registration linked to having effective student mental health & wellbeing strategy</p> <p>Improve employment support program assessment tools for people with mental illness</p> <p>Increase the appropriateness of job plans for those people with mental illness who are using employment services</p> <p>Amend model WHS laws to elevate the importance of psychological health & safety</p> <p>Develop codes of practice to assist employers to better manage psychological risks in their workplace</p> <p>Provision of no-liability clinical treatment for mental health related workers compensation claims</p> <p>Review insurance industry practices for people with mental illness</p>	<p>Staged rollout of Individual Placement & Support programs to job seekers with mental illness</p> <p>Eligibility criteria for Carer Payment and Carer Allowance that account for the differences between mental and physical illness</p> <p>WHS agencies to work with employers to collect & disseminate information on effectiveness of workplace programs & interventions</p>

AAPI supports measures to improve psychological well-being in workforces and to change a bullying culture in workcover investigations.

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5. Reforming the funding and commissioning of services and supports

Start now	Start later
<p>Include consumers and carers in all mental health program development</p> <p>COAG to develop a new National Mental Health & Suicide Prevention Agreement that</p> <ul style="list-style-type: none"> establishes clear funding, data sharing and service delivery responsibilities creates RCA governance arrangements (if adopted) <p>Expedite National Strategic Framework for Aboriginal & Torres Strait Islander Peoples' Mental Health & Social & Emotional Wellbeing</p> <p>Determine targets for key outcomes, & set data collection, monitoring & evaluation arrangements consistent with targets</p> <p>COAG to develop new whole-of-govt strategy to align health and non-health sectors on improving mental health outcomes</p> <p>Review regulations preventing insurers from funding community mental health care</p> <p>Review proposed activity-based funding classification for mental healthcare</p>	<p>Link regional mental health funding to volume of regional MBS rebates for allied mental healthcare</p> <p>NMHC to be given statutory authority</p> <p>Strengthen national leadership, guidance and the coordination of mental health program evaluations and research</p> <p>Use data collections to evaluate what works well, encourage continuous improvement and inform funding decisions and consumer choices</p> <p>Responsibility for all (non-NDIS) psychosocial & carer supports to be with states and territories</p>

Under Reform 5, the report talks about system reform; this has all been repeatedly discussed. What is not acknowledged is the difficulty in treating a mental health concern. Mental health concerns cannot be seen and the people experiencing them are often unsure about why they are occurring and what can work. Our government treatment services are overburdened with people who will largely remain unwell for much of their lives, according to medical model diagnoses. Perhaps it is a fact there will always be people who will require this level of ongoing care, although there are sectors of the international mental health research community who challenge the numbers so diagnosed¹.

¹ Grof, C., & Grof, S (2017). Spiritual emergency: "The understanding and treatment of transpersonal crises. *International Journal of Transpersonal Studies*, 36 (2)

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The AAPI supports only evidence- based opinion. The report suggests that the care people receive is well below best practice and provides no reference for this opinion. A critique of current standards of care needs to be openly and informatively debated. We do not support a mantra about best practice in a public productivity report, when the referencing for such a statement is absent.

We support 'cost effective delivery', in the same manner that we support environmental sustainability. That is, a longer term investment, if that is needed, in supporting clients to have an ongoing relationship with a practitioner of their choice. Short term solutions, we submit, generally lead to relapse and lifelong but perhaps episodic need for care.

Information request 3.1 Education activities that support mental health and wellbeing

AAPI supports the funding of psychologists in all schools and suggest that they be the lead practitioners of mental wellbeing in schools.

PART II Reorienting health services to consumers

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)?

Consumers should be allowed to complete whatever treatment they require without breaks or barriers to treatment. A simple referral with a brief mental health screen would suffice for an initial referral and communication between Mental Health Clinician and GP should also suffice for the continuation of treatment until the Consumer and the treating practitioner agree that treatment is completed. Putting a halt to treatment due to rebated sessions running out is not supportive of long-term recovery and increases the chances of relapse into mental ill health. What should be added to the MHTP or MHTP Review to encourage best-practice care?

It should be reduced not added to. The administrative burden exceeds the benefit. There is an assumption that mental health professionals are not motivated to provide best-practice care. No

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evidence supports that assumption. It would be more cost effective to prosecute those who fail than to act on an assumption that mental health care professionals do not take their practice seriously and are motivated to provide the best care research can suggest.

Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?

Diagnosis. A GP is not qualified to make a formal diagnosis of a mental illness. Distress and need for treatment should be enough to warrant the referral for treatment. All registered psychologists are qualified to assess, diagnose and treat (according to their training both tertiary and professionally).

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?

No, it should be the consumers choice who they access for treatment. These two terms are an artefact in the imaginations of a self -serving group. They are not terms referred to in the vast literature on 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)?

Consumers should be allowed to complete whatever treatment they require without breaks or barriers to treatment. A simple referral with a brief mental health screen would suffice for an initial referral and communication between Mental Health Clinician and GP should also suffice for the continuation of treatment until the Consumer and the treating practitioner agree that treatment is completed. Putting a halt to treatment due to rebated sessions running out is not supportive of long-term recovery and increases the chances of relapse into mental ill health.

What should be added to the MHTP or MHTP Review to encourage best-practice care?

It should be reduced not added to. The administrative burden exceeds the benefit. There is an assumption that mental health professionals are not motivated to provide best-practice care. No evidence supports that assumption. It would be more cost effective to prosecute those who fail than to act on an assumption that mental health care professionals do not take their practice seriously and are motivated to provide the best care research can suggest.

Are there current unnecessary aspects of the MHTP or MHTP Review that should be removed?

Diagnosis. A GP is not qualified to make a formal diagnosis of a mental illness. Distress and need for treatment should be enough to warrant the referral for treatment. All registered psychologists are qualified to assess, diagnose and treat (according to their training both tertiary and professionally).

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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?

No, it should be the consumers choice who they access for treatment. These two terms are an artefact in the imaginations of a self-serving group. They are not terms referred to in the vast literature on therapeutic effectiveness. Focussed Psychological Strategies are not trainings referred to anywhere in the professional training of psychologists.

Should consumers continue to require a MHTP for therapy access if being referred by a GP?

No. They should simply require a referral.

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?

No. Placing more barriers to treatment will ensure people do not access the support they need.

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?

We support only consumer choice as paramount. Current anecdotal evidence from clients of our members suggests they are alienated by a system of being sent from practitioner and team to another practitioner or team and they prefer to form a relationship with a primary therapist, and to collaborate with that therapist about any further care they may or may not require. Perhaps this is an area of research that would be profitable in setting up funding to support treatments and reduce barriers. That is, research consumers experiences of stepped care to date.

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?

A client has a right to their information if they request it. It should be based on consumer choice.

Should GPs continue to receive a higher rebate for MHTPs and MHTP Reviews than for standard consultations?

Yes

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Information 5.1 Low-intensity therapy coaches as an alternative to psychological therapists

We support the involvement of any practitioners where gains are made for mental health which are cost effective. However, in our collective experience, there are very few people who seek psychological therapists that would be better assisted by therapy coaches. If such professionals were available psychologists would be more than capable of referring to such services.

Information request 7.1 Freeing up psychiatrists for people who need them most

There needs to be an evidence base for the effectiveness of psychiatry before more support should be given to increasing the number of consultations involving new patients. If psychiatrists are effectively providing therapy, then they should continue. We support consumer choice.

Information request 17.1 — funding the employment of wellbeing leaders in schools

We support the funding of psychologists in schools as wellbeing leaders in schools. They are already qualified for the role.

Information request 18.1 — greater use of online services

Students as consumers should have choice. It is a known fact that tertiary student counselling services are and always have been in high demand. These services already provide online courses and approaches. Students who are tech savvy are likely to take up those options if they work. However, if students continue to seek face to face services perhaps that is the evidence that it is actually common factors that work, and not placebo type programs. See research referred to elsewhere in this report.

Information request 19.2 — personal care days for mental health

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We believe allowing and encouraging employees to take mental wellbeing days from existing personal leave would support their wellbeing. The evidence from some European cultures (Nordic) about reduced working hours and the productivity benefits might be more fruitful.

Information request 23.1 — architecture of the future mental health system

The model preferred by AAPI is the model allowing consumers greatest choice. We do not support large centralised purses, for reasons explained elsewhere. They are insufficiently flexible.

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¹ <https://aeon.co/essays/how-attachment-theory-works-in-the-therapeutic-relationship>

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