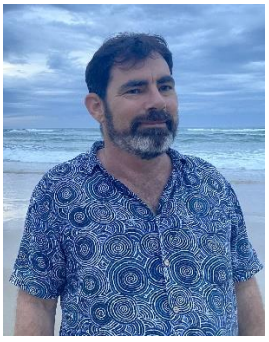
‘All animals are equal but some are more equal than others’: A discussion of guild capture of psychotherapy and the cost.

By Dr Richard Lakeman

Abstract

In 2021 the Australian Government announced the largest planned increase in investment in mental health services in the history of the Commonwealth. In the ‘Prevention, Compassion, Care’, National Mental Health and Suicide Prevention Plan (Commonwealth of Australia., 2021), ‘psychotherapy’ is not mentioned (or funded) at all (although ‘treatment’ is mentioned 14 times). Over half of committed expenditure is to extend existing initiatives in which the clinical work will primarily be provided through a small number of guilds at different rates of remuneration for the same work under the Medicare Benefits Schedule (MBS) scheme, *Better Access*. Meanwhile, the majority of Australians are unable to access a proper subsidised dose of the right therapy, at the right time from the most qualified person (often trained in psychotherapy). This paper discusses how professional guilds have appropriated ‘treatment’ as their own and how treatments provided by professional groups have become over-valued and unaffordable to those most in need. The call for action is for those most qualified to provide psychotherapy to clients most in need be enabled to access a subsidy through the MBS.

About the author



Richard Lakeman has worked in the mental health field for over 30 years as a mental health nurse, therapist, researcher and academic. He has a masters in psychotherapy, advanced training in EMDR and has written extensively about psychotherapy and more recently how MHN psychotherapists have been locked out of practising their craft. At the time of writing he coordinated the Southern Cross University, online postgraduate mental health programmes. He has been an advocate for extending Better Access to qualified psychotherapists. Please support this cause by visiting https://working4recovery.com/MHN/.

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In George Orwell’s Animal Farm, the government proclamation that “All animals are equal, but some animals are more equal than others” (Orwell, 1945, p.112) . This was a satirical comment about the hypocrisy of governments that proclaim the equality of the citizenry but confer power and privileges to a small elite. This is an apt metaphor for the treatment of psychotherapy and psychotherapists by Australian Governments. Since the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) which cemented medical hegemony over all matters to do with mental health (Lakeman & Cutcliffe, 2016), there have been few champions of psychotherapy within medicine or indeed from any other regulated profession in Australia. The rolling mental health crisis in Australia is framed by medicine, and it is medical doctors who prescribe ‘treatment’. The treatment for most mental health problems is psychotherapy, which is rarely available in State run mental health services and inaccessible to most in non-hospital settings due to the cost of access. Those most qualified and experienced in the provision of psychotherapy are excluded from being able to provide subsidised services under the MBS scheme, *Better Access*. Eligibility to do so has become a de-facto credential signalling competence in providing psychotherapy.

Even the traditional, conservative clinical practice guide for mood disorders produced by the Australian & New Zealand Journal of Psychiatry (Malhi et al., 2021, p. 42) concedes that there are many meta-analyses which conclude that there are no significant difference in the benefits of antidepressants compared to ‘psychological treatment’ of major depression. They go further by mandating lifestyle interventions and ‘psychological interventions’ for every person with depression. This foundational ‘treatment’ is rarely offered in tertiary services. I have been involved in numerous ‘complex case reviews’ where an individual has been receiving expensive frequent, lengthy and often unhelpful hospital care, and there is consensus that long term psychotherapy is the treatment of choice. However, never in my experience have tertiary services offered the treatment or even underwritten the cost of therapy (often a fraction of the cost of a hospital stay). There may of course be outstanding local examples of tertiary services offering therapeutic programmes or individual therapy. However, by and large if one attends hospital or the emergency department it is very unlikely one will receive treatment for those problems if treatment is psychotherapy.

Australia’s answer to the provision of subsidised psychotherapy is *Better Access* which is mediated through a ‘Mental Health Plan’ constructed by a general practitioner (GP) (a doctor in a tertiary service cannot make a referral although private psychiatrists can). In 2019-2020 the writing and review of mental health plans cost the taxpayer $281.5 million in subsidies (Australian Government., 2021). A further consequence of the medical framing of mental health issues and gatekeeping subsidised psychotherapeutic services is the over-valuing of somatic treatments and in particular medication and electroconvulsive therapy. Australia consistently rates as one of the highest consumers of psychotropic medications in the world. As illustrated in table one, Australians filled close to 14 million prescriptions for the nine most commonly prescribed antidepressants in 2019-2020 at a cost of $227 million.

Drug Name	Number of PBS Subsidised Prescriptions 2019-2020	Change in volume since 2018-2019	Total Cost
ESCITALOPRAM	2,089,633	+ 7.95%	$ 29,453,216
SERTRALINE	2,153,769	+ 6.25%	$ 29,704,027
VENLAFAXINE	1,739,256	+ 1.03%	$ 28,804,872
MIRTAZAPINE	2,037,113	+ 7.6%	$ 31,922,505
AMITRIPTYLINE	1,625,160	+ 4.38%	$ 23,600,589
DESVENLAFAXINE	1,171,599	- 0.98%	$ 31,072,104
FLUOXETINE	1,045,509	+ 6.74%	$ 19,242,242
DULOXETINE	1102516	+ 8.16%	$ 20,461,988
CITALOPRAM	963621	+ 1.01%	$ 12,831,903
Total	**13,928,176**	**5.3% increase**	**$ 227,093,446**

Table One: The cost of common antidepressant prescription in Australia. Source: Department of Health. (2021b)

In the last Federal Budget, Australia committed $200 million to provide transcranial magnetic stimulation (TMS) to those with treatment-resistant depression (Department of Health., 2021a). TMS has an effect size of approximately 0.39 (Sonmez et al., 2019). Even those who have taken a very critical review of the literature (often confining examination to randomised controlled trials) (Cuijpers et al., 2020; Cuijpers et al., 2010) find that psychotherapy has close to twice the effect size of TMS. However, how many people in Australia who have 'treatment-resistant depression' have ever had the experience of psychotherapy unsullied by a first parse as a medical problem and followed by prescription of drugs? Treatment resistance is defined as not responding to drugs (Malhi et al., 2021); not a poor response to psychotherapy. Drugs also have a lesser effect size than psychotherapy for conditions such as depression (Hengartner & Plöderl, 2018).

Our medico-centric system has not delivered improvements in the nation's mental health, despite increasing access to 'treatments'. Indeed, Australia has more years

lived with disability (YLD) due to depression than any other country in our region (see table two).

WHO Western Pacific Region

	PREVALENCE*				HEALTH LOSS / DISEASE BURDEN**			
	Depressive Disorders		Anxiety Disorders		Depressive Disorders		Anxiety Disorders	
COUNTRY	Total cases	% of population	Total cases	% of population	Total Years Lived with Disability (YLD)	% of total YLD	Total Years Lived with Disability (YLD)	% of total YLD
Australia	1 318 599	5,9%	1 548 120	7,0%	235 180	9,1%	142 603	5,5%
Brunei Darussalam	15 198	4,0%	13 431	3,6%	2 679	8,4%	1 256	3,9%
Cambodia	508 823	3,4%	479 469	3,2%	86 275	6,2%	44 575	3,2%
China	54 815 739	4,2%	40 954 022	3,1%	8 981 401	7,3%	3 804 591	3,1%
Fiji	30 568	3,5%	29 053	3,3%	5 040	5,6%	2 665	3,0%
Japan	5 058 124	4,2%	3 680 899	3,1%	850 351	6,7%	340 015	2,7%
Kiribati	3 452	3,1%	3 534	3,2%	574	5,4%	325	3,1%
Lao People's Democratic Republic	209 326	3,2%	204 147	3,1%	35 637	6,0%	19 030	3,2%
Malaysia	1 127 643	3,8%	1 461 481	4,9%	191 059	6,9%	135 638	4,9%
Micronesia (Federated States of)	3 182	3,1%	3 362	3,3%	536	6,2%	313	3,6%
Mongolia	117 436	4,2%	91 585	3,3%	20 864	8,6%	8 535	3,5%
New Zealand	221 338	5,4%	302 816	7,3%	37 989	8,1%	27 887	5,9%
Papua New Guinea	223 094	3,0%	237 578	3,2%	36 917	4,7%	21 730	2,8%
Philippines	3 298 652	3,3%	3 075 517	3,1%	554 100	6,2%	284 591	3,2%
Republic of Korea	1 904 645	4,1%	1 759 818	3,8%	325 944	7,3%	163 056	3,6%
Samoa	5 803	3,2%	5 975	3,3%	970	5,9%	554	3,4%
Singapore	162 203	4,6%	127 570	3,6%	28 675	9,0%	11 941	3,8%
Solomon Islands	16 535	2,9%	17 879	3,1%	2 780	5,6%	1 658	3,4%
Tonga	3 205	3,2%	3 333	3,3%	535	5,8%	309	3,3%
Vanuatu	7 917	3,1%	8 204	3,2%	1 328	6,0%	762	3,4%
Viet Nam	3 564 934	4,0%	1 941 166	2,2%	606 692	7,4%	180 920	2,2%

*Source: Global Burden of Disease study 2015 (*http://ghdx.healthdata.org/gbd-results-tool*)
Country data shown are crude prevalence rates (not age-standardized).
** Source: Global Health Estimates 2015 (*http://www.who.int/healthinfo/global_burden_disease/en/*)

Table Two: Reproduced from WHO (2017, p. 23)

Medicine has firmly established itself as the arbiter of what counts as mental illness, as well as the gatekeeper and prescriber of treatment. In Australia whichever guilds participate in *Better Access* effectively control psychotherapy. *Better Access* was established in 2006 with a view to providing 'focused psychological strategies' to those with mild to moderate problems. These strategies include CBT, problem-solving and more recently, Eye Movement Desensitisation and Reprogramming (EMDR). Costs have grown to close to $15 million per week in subsidies and while it has increased access to psychotherapy lite, critics note that it has not made any discernible difference to the overall mental health or wellbeing of the nation (Jorm, 2018). All eligible providers (GPs with specific training, psychologists, occupational therapists and social workers) apparently do the same thing, although there are different rates of remuneration for different guilds, (psychologists, social workers, occupational therapists and general practitioners) (See table three).

General Practitioner (Trained)			
DESCRIPTION	MBS ITEM	SUBSIDY	EXPENDITURE
30-40 mins	2721	$ 95.65	$ 427,588.00
30-40 mins (extra persons)	2723	$ 26.75	$ 6,102.00
At least 40 mins	2725	$ 136.85	$ 2,913,476.00
At least 40 mins (extra persons)	2727	$ 26.75	$ 34,434.00
Video 30-40 mins	2729	$ 95.65	$ 860.00
Video > 40 mins	2731	$ 136.85	$ 34,137.00
			$ 3,416,597.00
Clinical Psychologist			
DESCRIPTION	MBS ITEM	SUBSIDY	EXPENDITURE
30-50 mins	80000	$ 102.85	$ 1,123,223.00
30-50 mins (outside rooms)	80005	$ 128.55	$ 101,800.00
Group Therapy (> 60 mins) pp	80020	$ 38.35	$ 333,809.00
At least 50 mins	80010	$ 151.05	$ 278,302,762.00
At least 50 mins (outside rooms)	80015	$ 176.70	$ 4,611,124.00
Video at least 50 mins	80011	$ 151.05	$ 2,051,075.00
Group via video pp	80021	$ 38.35	$ 9,710.00
			$ 286,533,503.00
Psychologist			
DESCRIPTION	MBS ITEM	SUBSIDY	EXPENDITURE
20-50 mins	80100	$ 72.90	$ 1,410,056.00
20-50 mins (outside rooms)	80105	$ 99.15	$ 196,468.00
Group Therapy pp	80120	$ 26.25	$ 289,654.00
> 50 mins	80110	$ 102.85	$ 223,672,746.00
> 50 mins outside rooms	80115	$ 129.20	$ 12,016,976.00
Video 20-40 mins	80101	$ 72.90	$ 55,205.00
Video > 50 mins	80111	$ 102.85	$ 1,536,549.00
Group via video pp	80121	$ 26.25	$ 1,628.00
			$ 239,179,282.00
Occupational Therapist			
DESCRIPTION	MBS ITEM	SUBSIDY	EXPENDITURE
20-50 mins	80125	$ 64.20	$ 208,434.00
20-50 mins (outside rooms)	80130	$ 90.45	$ 35,922.00
Group Therapy pp	80145	$ 23.05	$ 24,462.00
> 50 mins	80135	$ 90.70	$ 3,715,308.00
> 50 mins outside rooms	80140	$ 116.90	$ 774,957.00
Video 20-40 mins	80126	$ 64.20	$ 646.00
Video > 50 mins	80136	$ 90.70	$ 34,385.00
Group via video pp	80146	$ 23.05	$ 97.00
			$ 4,794,211.00
Social Worker			
DESCRIPTION	MBS ITEM	SUBSIDY	EXPENDITURE
20-50 mins	80150	$ 64.20	$ 246,277.00

Table Three: MBS expenditure on Better Access in 2019-2020. Source: Australian Government. (2021)

There is no rationale for this disparity or an explanation why GPs can provide this service with 20 hours training, or how an undergraduate preparation focused on issues such as hand splinting, child protection or psychometric testing qualifies someone to provide psychotherapy. Some groups such as social workers may even qualify with a two year Masters degree. Why are these groups privileged to access subsidies to provide therapy? The disparity in rebates might be explained by concerted lobbying (as illustrated in figure one) in which a prominent psychologist suggested the then subsidy or $124.50 (now $151.05) was “pathetic” and out of step with the reported average charge per 50 minute hour of $260 Sapwell (2019).

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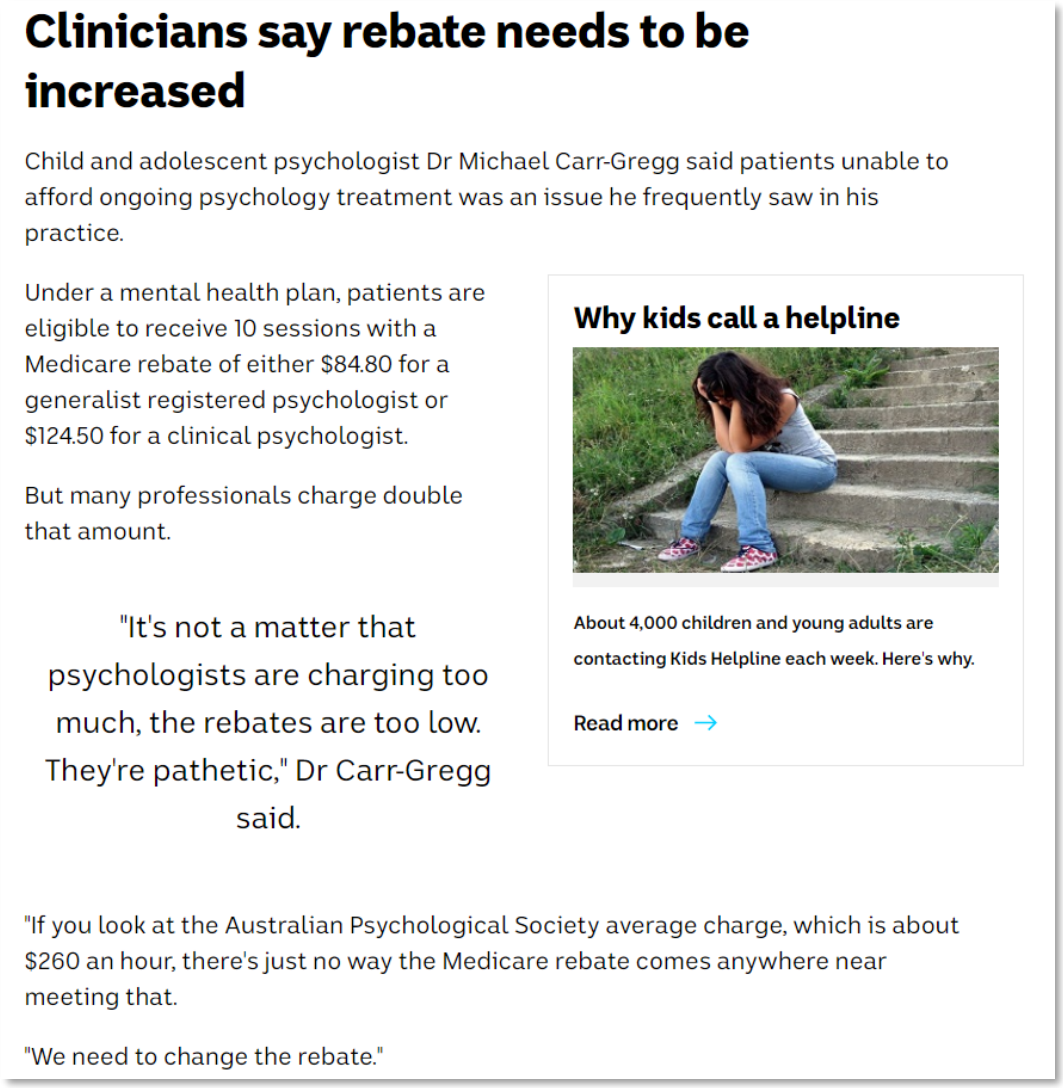

Clinicians say rebate needs to be increased

Child and adolescent psychologist Dr Michael Carr-Gregg said patients unable to afford ongoing psychology treatment was an issue he frequently saw in his practice.

Under a mental health plan, patients are eligible to receive 10 sessions with a Medicare rebate of either $84.80 for a generalist registered psychologist or $124.50 for a clinical psychologist.

But many professionals charge double that amount.

"It's not a matter that psychologists are charging too much, the rebates are too low. They're pathetic," Dr Carr-Gregg said.

Why kids call a helpline

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"If you look at the Australian Psychological Society average charge, which is about $260 an hour, there's just no way the Medicare rebate comes anywhere near meeting that.

"We need to change the rebate."

Figure One: Source Sapwell (2019)

Better Access has been disastrous for Mental Health Nurses (MHN) who opted instead for a now-defunct programme called the Mental Health Nurse Incentive programme where skilled nurse psychotherapists (myself included) often provided medium to long-term psychotherapy for those at risk of hospitalisation (Lakeman et al., 2020). In this survey of MHN psychotherapists, 86% of nurses had postgraduate qualifications specific to psychotherapy (in addition to graduate diplommas or equivalent in mental health nursing) and 95% had worked for over 10 years in the mental health field and had hundreds of hours of training in psychotherapy hospitalisation (Lakeman et al., 2020). Regardless of the skills, education or experience, MHNs (or anyone not belonging to the four guilds) cannot provide a subsidised service under *Better Access*.

Since the establishment of *Better Access* the number of psychologists in Australia has grown exponentially, and they now exceed nurses working in mental health and psychiatrists combined. The income of psychologists has also tracked steadily upward. As illustrated in figure two, psychologists claim 94% of *Better Access* and took home over $525 million in subsidies in 2019-2020.Therein lies another problem. In the spirit of the MBS providers can and do charge more than the subsidy. Given that the Government’s response to the escalating mental health crisis associated with COVID-19 was to double the number of sessions of *Better Access* (and allow video consultations) whilst not increasing supply of eligible practitioners, if the public wants ‘focused psychological strategies’ then they often must pay quite substantial gap fees and wait a long time (Rosenberg & Hickie, 2019). Meanwhile, groups who are highly skilled in providing sophisticated psychotherapy receive no rebate and often can’t compete in a market where a subsidy is expected, making them less able to assist those most in need who are unable to pay.

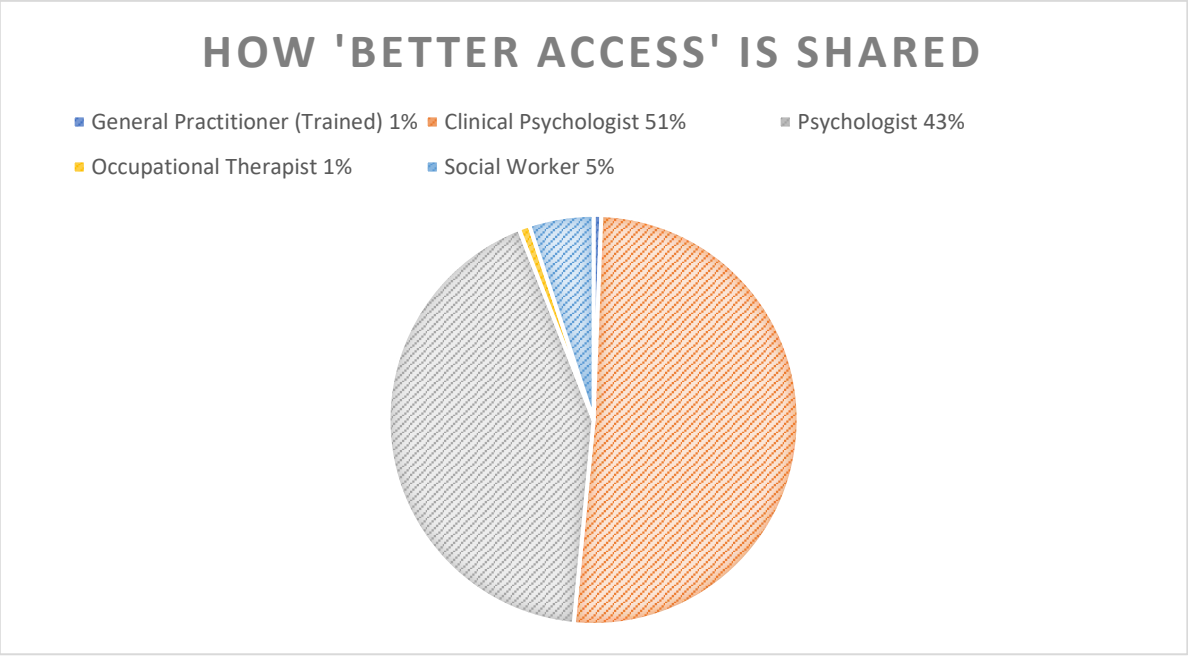

Figure Two: Who gets a slice of the Better Access pie.

There has for many years been a capped alternative to *Better Access* which was designed for a higher tier of service users who were unable to access *Better Access*. This programme called ‘ Access to Allied Psychological Services’ (ATAPs) had a higher rate of remuneration, allowed for a larger number of sessions and crucially was able to employ people who had skills in psychotherapy with at risk groups (rather than simply specify eligibility as membership of a guild). This programme was devolved to the Primary Health Networks to commission services for people who by and large can’t access *Better Access* because they can’t afford the gap fee charged by health professionals. The rate of pay (because a fee can’t be charged on top) was more than *Better Access*. Generally, ATAPs providers are also providers of *Better Access* and often the minimum rate charged for therapy is whatever the current rate of ATAPs is (usually $135~$150 per session). If people can’t afford the *Better Access* ‘gap’ then a GP can refer to the clinician by name under ATAPs. Other providers (including those not eligible for *Better Access*) are often unable to enter the programme.

If this doesn’t make it hard enough for competent psychotherapists to ply their craft in this anticompetitive and nepotistic environment, eligibility to *Better Access* is the benchmark for other psychotherapy MBS item numbers, most notably those to treat eating disorders. What the public perhaps don’t understand (and neither do most politicians) is that the $1.4 billion of extra funding announced in the federal budget to largely provide more headspace centres and adult equivalent services (Department of Health., 2021a) relies on quasi-private practitioners who have eligibility to provide *Better Access*. See for example a standing advertisement by Orygen (figure three) for practitioners to work at headspace who must be eligible to be registered with medicare to provide focused psychological strategies (and be prepared to ‘bulk-bill’ their services, an impediment to attracting a skilled workforce).

Sadly, in Australia, psychotherapy has been conflated with psychology and is rapidly losing a workforce of psychotherapists who can’t compete in a marketplace where their patients cannot receive a subsidised service (Hurley et al., 2020). In Australia, the dominant discourse around ‘stepped care’ is about the right dose of psychology and medicine (Anderson et al., 2020), whereas in Europe, the discourse is around the right dose of psychotherapy at the right time, and the conversation is with psychotherapists who are recognised as specialists (Maehder et al., 2020). Perhaps it is time to learn from the guilds, regulate psychotherapy, and strongly assert that the provision of psychotherapy is a specialist skillset and that people are best prepared to practice this craft by substantial training and supervision in psychotherapy not necessarily membership of particular guilds. The public deserves to get the right dose of the right therapy by the right therapist at the right time and for all appropriately trained practitioners in this craft to be considered and treated as equal.

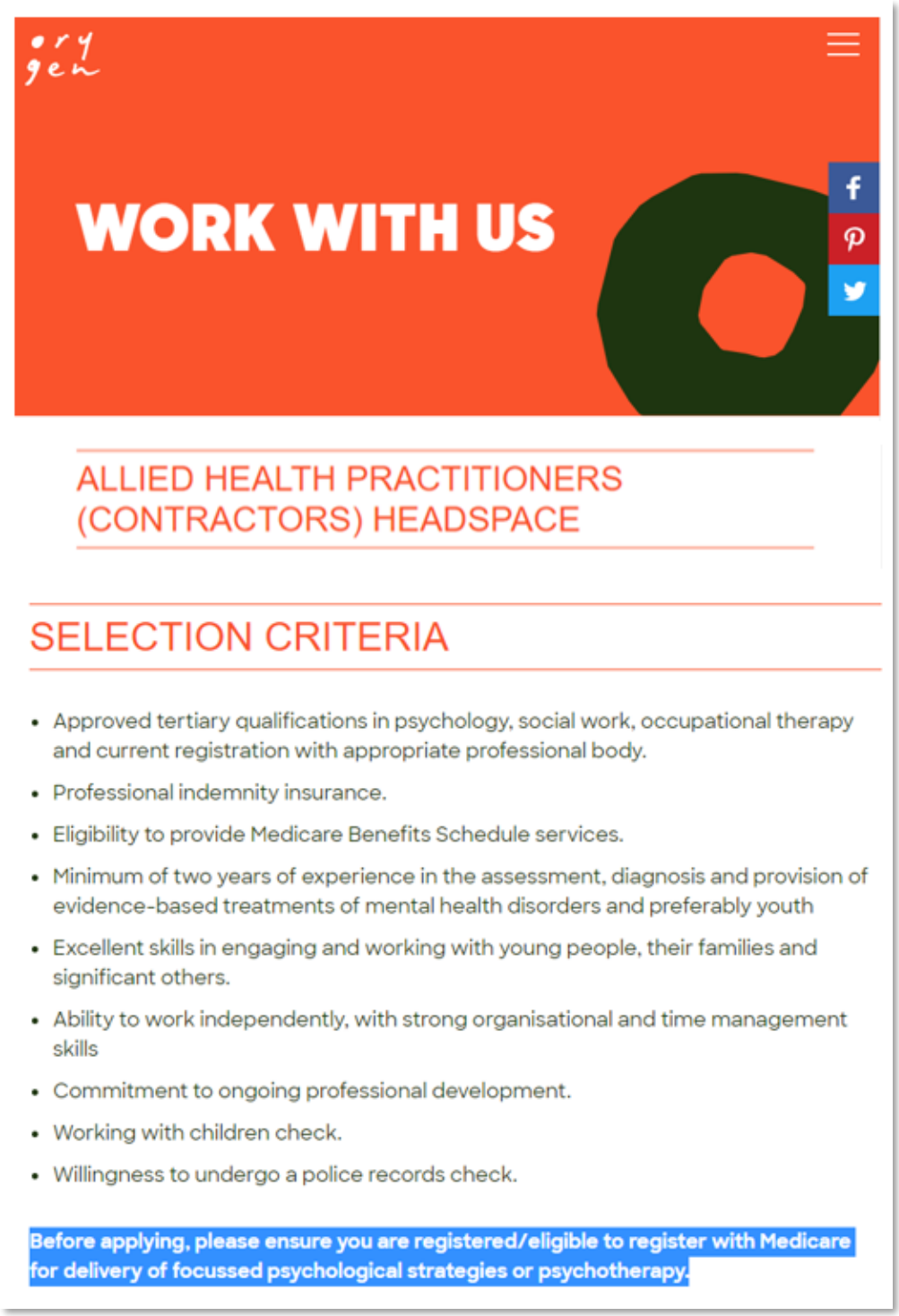

Figure three: An advertisement for a headspace practitioner on the Orygen web site

Source: https://www.orygen.org.au/About/Work-with-Us/Allied-Health-Practitioners-contractors-2017. Last Accessed 30/7/21

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