# LAST WORD

## by Richard Lakeman

# Psychology belongs to everyone, but what about psychotherapy? A discussion of the undervaluing and professional capture of psychotherapy in Australia.

**Introduction**

Australia has made a huge investment in mental health through subsidised medical and psychological services in primary care. However, subsidised psychotherapy of any degree of sophistication is rarely available in the right dose, at the right time, or delivered by people that have advanced training in psychotherapy. Indeed, in Australia, psychotherapy is not part of the public discourse about treatment and is often conflated with or presumed to be the same as psychology. This article discusses the Australian funding context and argues that psychotherapy needs to be valued at least as highly as medicines and assume its rightful position as essential 'treatment' commensurate with its evidence base.

**Psychotherapy**

Psychotherapy is, or ought to be, the first, and primary treatment for almost all high prevalence mental health problems. These often manifest in an emotional soup of feelings and behaviour such as depression, anxiety, guilt, shame, angst, anger, disgust and sadness, but are all too often reduced to a diagnosis of major depression or an anxiety disorder which most of us will experience at some point in our lives. Psychotherapy (albeit of more focused variety) is the treatment for trauma and the myriad of problems which arise from adverse childhood experiences. It is even the treatment for the archetypal psychiatric diagnosis of schizophrenia in some countries (Lakeman, 2014) or at the very least in the form of focused cognitive behavioural therapy or psychosocial interventions is a recommended adjunct to standard pharmacological treatment (Galletly et al., 2016), the limitations of which are now widely acknowledged (Nelson et al., 2020). For some very serious syndromes such as borderline personality disorder (BPD), psychotherapy or programmes such as dialectical behavioural therapy (DBT) is the only treatment (Cristea et al., 2017; Oud et al., 2018), notwithstanding that people so diagnosed often present acutely to health services for treatment of self-harm, suicidal behaviour or overdose of often prescribed medication. I feel confident in asserting this rather lightly referenced opening (especially to this audience), and of course can back up my assertions with reference to metanalysis and systematic

reviews. So why is psychotherapy (particularly in my country of residence, Australia) not valued as a treatment, not routinely delivered and conflated with clinical psychology?

For those that may be unaware, Australia leads the world in counting things (Lakeman, 2020). This is perhaps why if you look at the mental health atlas you probably get a better and more accurate picture of Australia than anywhere else (see: https://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/). We spend a lot on mental health. Australian is a federation of states. States are charged with funding and providing hospital care, tertiary services and community mental health services, and the Australian Government subsidises medical services and some allied health care, primarily through the *medicare benefit scheme* (MBS), and drugs through the *pharmaceutical benefit scheme* (PBS). Additionally, there is a *national disability insurance scheme* (NDIS) and incentives for people to hold private insurance.

We have some statistics to be proud of, such as a great life expectancy (unless you are indigenous or indeed diagnosed and treated for mental illness in which case there are huge disparities in life expectancy). However, look a little deeper and we have some of the highest rates of depression and anxiety in the world, escalating rates of suicide, high rates of coercive care (over 50% of mental health hospital

| | 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/*)

WHO report on depression and anxiety rates in Australia & surrounding region.
https://www.who.int/publications/i/item/depression-global-health-estimates

bed days in Australia are under coercion) and we are in the top 2-3 nations in the world in the consumption of psychotropic drugs (prescribed or otherwise). Most readers will appreciate that the effects of so called antidepressants are at best only marginally better at treating depression than placebo and then the differences are unlikely to be clinically significant (Moncrieff, 2018; Munkholm et al., 2019). However, in Australia as illustrated in table one they remain highly valued and highly prescribed. indeed $217 Million dollars of government subsidies were spent on just 9 drugs in 2018-2019.

State mental health services rarely offer psychotherapy at all, such is the dominance of the bio-medically driven, risk averse and reactive service models that prevail. However, in recent years we have seen an increase in evidence based programmes such as DBT offered in some places (R. Lakeman et al., 2020). When the first wave of COVID-19 arrived in Australia the practice of psychotherapy and in particular group programmes were immediately impacted and often ceased (Lakeman & Crighton, 2020). If treatment for BPD was a drug, and this was denied people who had benefitted from it, then this would have inevitably led to a public outcry. Imagine the furore if the Government ceased paying over $216 million dollars for drugs of dubious efficacy (as outlined in table one)? The general lack of comment or interest speaks volumes about the status of psychother-

**Table One: Community prescriptions for common antidepressants (in top 50 drugs) in the year 2018-2019 in Australia**

| Drug Name | PBS Subsidised Prescriptions | Under Co-Payment Prescriptions | Total Prescription Volume | Total Government Cost |
|---|---|---|---|---|
| ESCITALOPRAM | 1,935,627 | 2,516,726 | **4,452,353** | $26,998,978 |
| SERTRALINE | 2,026,922 | 2,250,902 | **4,277,824** | $27,625,763 |
| VENLAFAXINE | 1,684,569 | 1,376,351 | **3,060,920** | $27,691,488 |
| MIRTAZAPINE | 1,891,830 | 700,558 | **2,592,388** | $29,513,521 |
| AMITRIPTYLINE | 1,556,818 | 817,234 | **2,374,052** | $22,386,101 |
| DESVENLAFAXINE | 1,184,137 | 1,028,794 | **2,212,931** | $33,482,622 |
| FLUOXETINE | 979,432 | 1,085,817 | **2,065,249** | $17,853,874 |
| DULOXETINE | 1,019,192 | 725,754 | **1,744,946** | $18,774,779 |
| CITALOPRAM | 946,083 | 767,540 | **1,713,623** | $ 12,488,886 |
| **Total** | **13,224,610** | **11,269,676** | **24,494,286** | **$216,816,010** |

Note prescriptions under co-payment means those where the consumer pays and additional cost

Source: https://www.pbs.gov.au/info/statistics/expenditure-prescriptions/pbs-expenditure-and-prescriptions-report

apy in Australia and in part this is because it is not a medicine, generally practiced by medicine or even understood by medicine.

This has not always been the case of course. The modern notion of psychotherapy was invented by Freud and for decades, psychoanalysis was the exclusive domain of psychiatry in many parts of the world (Masson, 2013). Until the publication of the DSM-III (American Psychiatric Association., 1980) psychodynamic formulation was even the dominant paradigm and explanatory framework of psychiatry. However, psychiatry raised its standing and esteem by moving towards a mainstream bio-medical model whereby a specific disease has a specific treatment. This is quite a radical departure from how most schools of psychotherapy conceive of and treat problems (Wampold, 2001). Alfred Adler, one of the founding fathers of modern individual psychology and one of the first people who identified as a psychotherapist was quoted as saying "My psychology belongs to everyone", and of course psychology informs almost every discipline and understanding human behaviour is a universal interest. All health professionals study psychology, but what of psychotherapy and psychotherapeutic practice? Psychology is not and never has been psychotherapy.

In Australia, psychotherapy is not regulated (and there is no protected title, i.e. anyone can call themselves a psychotherapist or counsellor), whereas particular guilds, like medicine, nursing, clinical psychology, dentistry are regulated. Curiously, these groups are not treated equally, equitably or receive the same patronage and respect from the Government. The title for this paper could have just as easily had a title derived from Orwell's Animal Farm, "All animals are equal, but some animals are more equal than others". In the absence of psychotherapy being a regulated profession with minimum training requirements as it is in some countries, the regulated guilds are the only groups which can claim subsidies to provide psychotherapy or psychotherapeutic services through the MBS. If you desire psychoanalysis in Australia you need to reach into your pocket or have exceptional health insurance coverage, but a psychiatrist could receive a rebate to see you (regardless of training). Whereas, the patient of a mental health nurse with a Masters degree in psychotherapy or indeed seven years of psychanalytical training can claim nothing.

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**Better Access**

Australia's answer to publicly subsidised psychotherapy is a kind of "psychotherapy lite" via an MBS programme called 'Better Access' which enables a GP to write a subsidised mental health plan which includes a referral to offer focused psychological strategies. Quite different subsidies are available for the same service provided by social workers, occupational therapists, general practitioners and psychologists. Unfortunately, even this scheme which now costs over $15 million per week is inaccessible to many because many people in these guilds are able to and usually do charge a 'gap fee' of 25% or more of the subsidy (Rosenberg & Hickie, 2019). The threshold for eligibility to access provider numbers is variable, but the bar is very low (Richard Lakeman et al., 2020). Eligibility to provide 'Better Access' is also the benchmark to access MBS item numbers for more complex groups such as those with eating disorders, and very few people are actually trained or competent to provide this service (Lakeman & McIntosh, 2018). I and colleagues recently reported on the training and competency of a sample of mental health nurses founding that 95% had worked in the mental health field for over 10 years and 86% had formal post graduate qualifications in psychotherapy (in addition to mental health nursing) but all are excluded from accessing subsidies to provide the lowest tier of services in what has become known as stepped care (Richard Lakeman et al., 2020). This is also true of people whose only degrees are in psychotherapy or counselling and many of these nurses also had such undergraduate degrees and had previously worked as therapists in the United Kingdom. On arrival in Australia they


are officially deemed incompetent by being ineligible to be providers under 'Better Access' (but would be excessively qualified if only they were members of an eligible guild).

In Australia, psychotherapy is often conflated with psychology and is rapidly losing a skilled 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' (or how to address the psychotherapeutic needs of those who may need service, more than self-help but less than tertiary mental health services) is around 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). In Australia the conflation of psychotherapy with psychology, has been a boon to psychologists who since the conception of 'Better Access" have grown to outnumber nurses and psychiatrists who work in mental health services (combined).

In one sense the 'Better Access' programme has been hugely successful because despite access problems, more people in Australia than at

any time in history now go to their doctor, often receive a prescription and are referred for psychological services. There are however critics, quite aside from the eligible guilds who lobby for increased subsidies and numbers of sessions (Sapwell, 2019). Such is the scale of increased service use (and this includes prescription of medications) since 2006 one might also expect to see some improvement in the overall well-being of the nation. However there has been no discernible impact on rates of suicide or on measures of overall wellbeing in the Australian community (Jorm, 2018). Rosenberg and Hickie (2019) have repeatedly questioned whether the $3 billion or more dollars spent on sole practitioners is really the best way to fund mental health services which should emphasis cooperative practice. However, a more radical shift in the discourse needs to occur.

Psychotherapy needs to be valued as a treatment across the continuum of human problems for which it has been proven to work. Those that are demonstrably qualified and competent to practice psychotherapy of various kinds should be enabled to do so through eligibility to subsidies. The practice of psychotherapy itself may need to be regulated in Australia as it can no way be assumed that the professional guilds have mastery over all forms of psychotherapy. As it stands in Australia most people do not get the right dose of the right treatment at the right time delivered by the most qualified person. This might be a better explanation for why, despite such massive investment the overall wellbeing of Australians has not appeared to have improved at all over many years of better access.

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