# Independent Private Psychiatrists Group: Submission to the Royal Commission into Mental Health.

## OVERVIEW

### Private Mental Health Care: Something Positive in Mental Health.

Private mental health care is one of the only areas mentioned by consumers in the Royal Commission's community consultations, which is described as a positive area of success. There are much fewer stories of unhappiness about care occurring in the private sector, as compared to the public sector. So how can this positive model of care be shared, so that all of mental health can succeed, and help consumers thrive.

The key positive elements of private sector treatment are as follows:

Psychiatrist led treatment and care.

Person centred and holistic care.

Focus on Significant mental illness

Long-term Ongoing Treatment for those suffering ongoing and recurrent significant mental illnesses.

Flexible and long-term collaborative multi-disciplinary working model, with general practice and allied health professionals in the community.

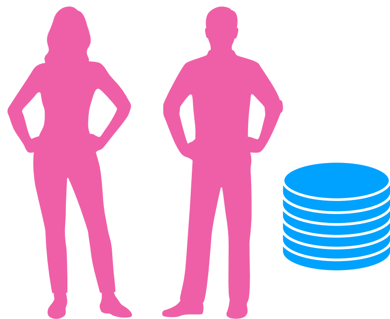
## WHERE PRIVATE MENTAL HEALTH FITS IN THE WHOLE MENTAL HEALTH SYSTEM

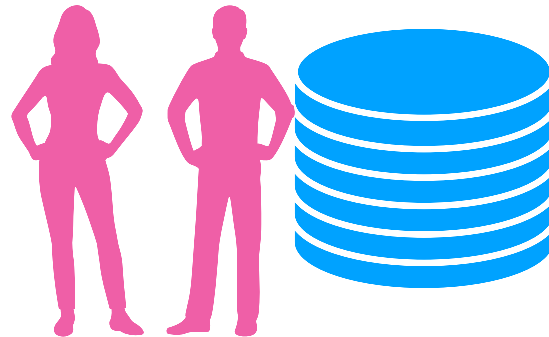
Private Psychiatrists lead the Private Mental Health delivery system in Australia, but work together with general practitioners, private psychiatric hospitals and the private health funds, and also work with mental health nurses, psychologists and other allied health workers. This is a network of specialist psychiatric care delivery which has been ignored in most previous inquiries, and which delivers around half of all specialist mental health care in Australia, for an expenditure of 13% of the cost of State and Territory Governments' mental health care delivery.

Private psychiatrists assess or treat 386,268 Australians every year. State and Territory funded public mental health care is said to contact 420,000 Australians each year (AIHW

2018). Some of these contacts are telephone contacts, and so the number of people seen in person in the public sector, is unknown; as is the number assessed by psychiatrists.

**Private Sector Specialist MH** **Public Sector Specialist MH**





The cost of private psychiatrists seeing their half of the specialist mental health care delivery system in Australia is $349Mill. We would estimate that the total cost of care delivery for these Australians, seen by the whole private mental health care system network, is around $800,Mill per year. The State and Territory funded public mental health care system costs $5.9 billion per year (AIHW 2018). Appropriate investments and development of the private mental health care system is likely to deliver the most cost-effective improvements in mental health care in Australia.

Outcome measurement, using the Health of the Nation Outcome Score (HoNOS) score is on average, 13.8 on admission to Public Mental Health hospitals, and 6.3 on discharge (lower scores representing improvement) (AMHOCN 2016). Mean HoNOS outcome measurement scores for those admitted to private psychiatric hospitals is 13.0 on admission, and 5.7 on discharge (lower scores indicating improvement) (AMHOCN 2016). Consumers presenting to hospital in both the public and private specialist mental health systems are suffering similar levels of acuity. For five years, Private Psychiatric Hospitals have collected data using a consumer and carer perceptions of care instrument. The patient perceptions of their psychiatrist's treatment is around 90% satisfaction on average.

63% of admissions into private psychiatric hospitals are women. 20% of admissions to public psychiatric hospitals are women. The private mental health sector is vital for adequate treatment of women suffering significant mental illnesses.

An assumption contained in the KPMG review ("Paving the Way", for the National Mental Health Commission, November 2014) was that private sector patients would be well off financially, because they could afford to pay Private Health Insurance premiums. A survey of private psychiatrists in 2012 revealed that 20% of their consumers were on a Government pension, and 45% were not working. So, the evidence that is available, indicates that the private sector is vital in dealing with consumers suffering significant mental illness, including those that are financially disadvantaged. To ignore the role of the Private Psychiatrist sector, which treats half of the seriously mentally ill Australians, would cause a

grave systemic modelling error in the development of mental health services to occur, disadvantaging seriously ill and financially disadvantaged consumers, and introducing large scale econometric errors into the modelling. Such a large modelling error will also add enormous extra cost to any funded mental health treatment solutions planned by Governments, and based on false assumptions used by KPMG in their paper.

## EXECUTIVE SUMMARY:

### Addressing the Royal Commission's Questions.

**Q1 Understanding mental illness, stigma and discrimination**
**See Appendix A (Page 11)**

Renewed public education about longer term mental illnesses, and how the community can support people living with those illnesses.

A new focus on discrimination directed at those people suffering significant mental illnesses.

**Q2 What works well in early intervention and treatment?**
**See Appendix E (Page 27)**

Early identification of significant mental illness by the GP, followed by early psychiatrist assessment for a comprehensive management plan, when the GP decides that a psychiatrist's help is required.

Long-term ongoing treatment (LTOT, described below) is one of the mechanisms of preventing suicide in particular, but also decreasing episodes of severe mental illness.

Person-centred holistic treatment - not just support without treatment.

**Q3 Improved Suicide Prevention.**
**See Appendix F (Page 30)**

Long-term ongoing treatment (LTOT, described below) is one of the mechanisms of preventing suicide, which has been ignored for too long - it already occurs in private psychiatry practice, but can be extended through flexible community located multi-disciplinary teams, led by psychiatrists, and focussed on those suffering significant mental illness.

The second major preventive strategy that has been ignored, is provision of high intensity family directed services, to families that are socio-economically disadvantaged, undergoing severe stresses (such as homelessness, drug addiction, or domestic violence), and in which there are quite young children developing. Such families can often be identified through existing institutions such as at-risk antenatal clinics, and the justice system.

**Q4 How can good mental health care be delivered to communities with unmet needs - especially communities with co-morbid problems, or suffering discrimination? Access, Treatment, Support and Linkage.**
**See Appendix C (Page 14) and G (Page 31)**

Better access and navigation of the system will be improved by the wider introduction of LTOT. The consumer then has a personal clinical guide through the mental health system.

Best practice treatment and care, which produces safe care and more person-centred care, can be delivered through LTOT, which will use recognised evidence based treatment techniques.

Strong pathways through to care will occur where LTOT is implemented, and in which that therapy includes strong rules about clinical governance and scope-of-practice.

Improved mental health planning will occur when the private mental health sector is included in the planning stages of mental health policy development. Secure and safe mental health planning will also include clear clinical governance and scope-of-practice rules, in order to produce a cohesive mental health structure.

Improving data collection is a vital element, that is very difficult to achieve. It may help to actually use the outcome measures already collected, so that mental health workers can receive adequate feedback about outcomes. Prior to the initiation of further outcome measurement collection, there should be careful planning and costing of appropriate mechanisms of data collection. Note also that widespread implementation of LTOT will have an effect of informing mental health workers more intuitively, concerning what interventions help to produce true recovery in consumers.

**Co-morbidity and Discrimination**

improving mental health outcomes in those with higher risks due to comorbidity is an important and previously ignored area of development.

ATSIC services will need to be developed in consultation with those communities, and be culturally informed and appropriate (but should involve LTOT, with psychiatrist input).

Co-morbid physical illness is an often unseen problem associated with mental illness, and Western Australian studies have shown the extent of that comorbidity. The implementation of the modified CLIPP model of psychiatrist/GP interaction, will strengthen the physical illness care of consumers, through a combined LTOT approach.

Specific Consultation-Liaison Psychiatry services in general hospitals have been chronically under-developed. Increasing such services, to assist people with significant mental illnesses during episodes of physical illness, allows targeted interventions to improve both physical and mental well-being in those people.

Rural and regional consumers and carers have been ignored for too long, and very much increased financial input will be needed, to truly provide the same level of service to rural and regional areas, as is provided in metropolitan areas. Many people suffering multiple disabilities (including mental illness) have moved to country towns, due to lower living costs. Assertive family care as a preventive approach for young children, is vital. Older long term rural General Practitioners are retiring, and the system used to replace them (coercing overseas trained doctors to work in rural areas for ten years) is collapsing. This will lead to a catastrophic collapse of health care to rural areas, quite soon - and will include mental health care.

The forensic and justice system must be appropriately supported. This will include innovative joint strategies led by Law and Psychiatry, working together.

Mental illness and alcohol and drug use problems are commonly co-existing. Besides significant evidence based treatments being provided more widely and with increased funding, the concept of involuntary treatment should be discussed, for consumers where there is an imminent risk of death.

**Q5 Some community drivers of poorer mental health.**
**See Appendix B (Page 13) and G (Page 31)**

There are some social determinants of poorer mental health which can be separately addressed, as usually, such determinants affect all health care status, not just mental health. Low levels of education, socio-economic disadvantage, minority group status, indigenous status and rurality are just some of the factors that diminish all health outcomes, and require a whole of Government approach.

**Q6 Family and carer support needs.**

Improving support for family members and carers is a vital necessity. LTOT will have a significant positive effect on families and carers, because there will be clear responsibility for the consumer's care, and they will often be able to participate in joint consultations. Where that is not possible, due you to consumer preferences, it is important to provide family directed services separately, either through the public system or Medicare mechanisms.

Specific training of some mental health workers, in family-oriented treatment techniques, will be required to facilitate this.

See also the important resource: "Practical Guide for Working with Carers of People with a Mental Illness", at http://pmhccn.com.au/Resources

**Q7 Mental health workforce needs.**
**See Appendix C (Page 14) and E (Page 27)**

Strengthening mental health workforce will be improved by the implementation of LTOT, where mental health workers are able to follow consumers in the longer term, understand the various stages of illness, and the best way to intervene in the stages. The workers concerned can experience a true understanding of what the stages of illness may be; and what recovery means for a consumer, and how to be instrumental in producing that. That type of work practice is effective for the consumer, and satisfying for the worker: ensuring the retention of workers trained in that way.

**Q8 Improving Social and Economic participation.**
**See Appendix H (Page 32)**

Improving the NDIS functioning for those suffering ongoing or recurrent mental illnesses will create options towards greater recovery. GPs and Psychiatrists should be able to help direct NDIS services to those people, in close collaboration with the consumer.

Diminishing stigma and workplace barriers towards people suffering ongoing or recurrent mental illnesses, will open up more employment opportunities.

**Q9 Priorities for Change: Vision of a New System**

Realistically, it will be hard for this Royal Commission to achieve more than a number of previous inquiries into Mental Health Care, but we certainly hope that some improvements can be achieved. If it were possible for this Royal Commission to suggest improvement strategies which all sectors can implement in unison, then consumers lives could be greatly improved.

**Q10 How to support and Implement Change?**

Focus on the significant ongoing and recurrent mental illnesses.

Include the private mental health sector in "top table" decision-making, along with the consumers and carers from that sector.

Survey and include the opinions of actively working full time treating Psychiatrists (for the first time) in the planning process, rather than just the opinions of a few consultants - just as would be done with other medical specialties, for other medical conditions. If this is not done, there should be a clear evidence based justification.

**Q11 Other Matters**
**See Appendix H (Page 32)**

NDIS reforms to match reforms in Primary care, Public and private mental health.

## A STRATEGY for MENTAL HEALTH ACTION

## THREE Principles of Action

Focus on significant mental illness

Mandate Long term Ongoing Treatment for significant mental illness

Ideally, the Royal Commission will make recommendations that will ensure that all sectors (Private, Public Primary Care and NDIS) of Mental health treatment and care delivery can be improved in unison - finally making good recovery from mental disorders a commonplace experience in Victoria and Australia.

## SEVEN Key Actions for Improved Mental Health Treatment in Australia, based on Private Sector success.

A prime future focus on “Significant Mental Illness” (see explanation below) in all areas of mental health improvement.

Psychiatrist led assessment and treatment of significant mental illnesses.

Long-term ongoing treatment.

Flexible community-based multidisciplinary teams with adequate clinical governance and scope of practice rules.

The implementation of a modified CLIPP model of interaction between psychiatrists and general practitioners. This model can be used in both the Medicare-based private mental health system, and in the public system.

Adequate funding models to support the changes (though these funds do not need to be massive, in budgetary terms, as explained below).

Inclusion of GPs and Psychiatrists, with consumers and carers, in determining NDIS plan formation. Review of the role of psychologists under NDIS for mental health conditions.

## Significant Mental Illness Focus

Even amongst psychiatrists, there is some reticence about using the term “serious” in relation to mental illness. Around 1993, the term “serious mental illness” was used by Government bureaucracy to try to limit the provision of State and Territory psychiatry services to those suffering schizophrenia and other psychoses. This was perceived by doctors to be related to a mechanism of limitation of funding to mental health overall. Psychiatrists advocated for their patients, and the policy did not proceed (although in light of current public sector mental health

provision, one could argue that it subsequently was implemented by stealth). The term is used without that political baggage by researchers overseas; but in this paper, we have mainly referred to “significant mental illness” This is because many other conditions can have serious consequences. Many people living with schizophrenia or recurrent mood disorder would be considered to suffer serious mental illnesses. However, some people suffering moderate but chronic depression or anxiety disorders, can have significantly serious ongoing consequences from their disorders, including higher mortality. The presence of co-morbidity, in consumers suffering physical illnesses, intellectual disability, autism spectrum disorders and drug use disorders, commonly propels an already moderately concerning disorder into a significant one. We estimate that there are at least 1,200,000 Australians suffering significant mental illness, and deserving of psychiatric service from public or private sectors.

We believe the emphasis of any new improvements in mental health policy should be directed to those suffering these significant mental illnesses. These people are at much greater risk of dying by suicide. They have been neglected by Government policy till now. Improving treatment, not just support, for these people will have major positive health, moral and economic implications for Australia.

# Psychiatrist Led Treatment

There is a difference between treatment and support provided to people who suffer from significant mental illnesses. In an active treatment approach, there is a continual seeking of further improvement in the symptoms and disabilities associated with a person’s mental health condition. There is a grave moral risk in an inadequately funded mental health system, that support will be provided to consumers rather than active treatment. This makes it look like action is being taken to improve a person’s well-being, but if their underlying conditions are not being actively treated, then there is the possibility of severe decline and even suicide, as a result of that inadequate treatment approach. Amazingly, psychiatrists working most directly with consumers in the community, have largely NOT been consulted in relation to development of the mental health system in recent years. This is particularly reflected in the lack of consultation with private psychiatrists.

It is time to turn this situation around. Development of policy for any other medical condition would involve consultation with actively practising medical specialists, working with consumers suffering those conditions. It is about time such consultation started to occur, and it is important that active psychiatrist lead treatment of consumers is given the highest priority. Instead of a psychiatrist lead system of mental health treatment, the development of more and more different mental health care workers in the community over the last twenty years, with NO requirement to liaise with the treating psychiatrist, has led to extreme fragmentation of care, and increased chance for adverse outcomes. When it comes to the mental illnesses that should be the focus of new developments in mental health care, significant medical conditions are the  likely basis for those mental illnesses, and a medical model should be at the forefront of treatment for those people, because of the almost certain biological contribution to those conditions.

## Long Term Ongoing Treatment (LTOT)

Long term ongoing treatment is one of the hallmarks of successful private psychiatric treatment. Consumers who suffer from significant mental illnesses that are likely to be ongoing or recurrent, are provided with longer term follow-up, over years if necessary, in order to further improve control of their conditions, and to achieve meaningful recovery and well-being. Unfortunately, whilst this approach was commonplace in public sector psychiatry 30 years ago, it now no longer appears to be practised there. In the public sector, an episodic treatment model has been implemented, and consumers are discharged from that system at the earliest opportunity, when any small degree of well-being seems to occur. No account is taken of whether a consumer’s condition is likely to be ongoing or recurrent.

One of our key suggestions for improvement in mental health care delivery, is the adoption throughout the mental health system, of a long-term ongoing treatment model. We believe that there are a number of significant advantages to such a model of treatment. Psychiatrists and

other mental health workers that work within such a model, develop significant knowledge and skills about the long-term trajectory of a number of different significant mental health conditions. Those skills can be applied to gradually work with the consumer, to develop greater and greater levels of well-being; with a focus on symptom reduction, followed by disability reduction through community participation. There is some tentative evidence that this long-term treatment approach can decrease hospital admissions, and maybe decrease suicides. Greater levels of well being and recovery from illness can be achieved. Mental health workers using such a model of treatment will typically enjoy their work more fully, because consumers are seen to be benefiting so clearly. Retention of the mental health workforce will be a likely side benefit of this model of treatment.

## Flexible community-based collaborative teams

The scientific evidence for the value of multidisciplinary care in mental health is far from complete. This relates to the fact that multidisciplinary care models vary considerably across the world, so studies of one model do not necessarily translate to another type of model. Whilst there appears to be an acceptance that multidisciplinary care is valuable quite frequently, there is no evidence to help us to decide how many people should be part of the team, which particular participants should be part of the team, and for an ongoing condition in a person, there is no evidence about how many time periods should include a multidisciplinary team focus, and the dynamics of teams working in the community.

We consider that it is time to reconsider what is required for community mental health treatment, in terms of a new collaborative multidisciplinary team model, similar to the one used in private mental health. This new multidisciplinary team model works within the long-term ongoing treatment approach. It would appear to be very wasteful of resources, for every member of a multidisciplinary team to be constantly working around the needs of a particular consumer, and for that team to have regular team meetings related to that treatment over a period of years. Such treatment could extend over twenty or more years. Multidisciplinary teams developed in a facility-based institutional setting are almost certainly inappropriate for such long term community-based care.

We suggest a model of multidisciplinary collaboration which is more flexible, and is able to extend over the longer term. In such a model, there would be a clear clinical governance structure, and scope-of-practice rules. The consumer's GP would request such treatment supervision from a psychiatrist. The psychiatrist involved in the team would lead the complex treatment required for the consumer. At an appropriate stage in treatment, the ongoing care would be handed over to another team member, who could be the GP, a mental health nurse, a psychologist, or other allied health worker - but with ongoing input via consultations for the consumer, with the psychiatrist. At times, two or three members of the multidisciplinary team may be actively consulting with the consumer. But mostly, the consumer would see just one team member predominantly. These teams would be bound together with local ties of trust from working with each other over time, and by regular consumer focused team meetings, but on a less frequent schedule than in institutional teams.

The problem currently is that private psychiatrists do not have enough adequately trained and skilled health workers to be able to refer to, for consumers who have attained good recovery, but need a long term ongoing treatment approach, to remain well, and to progress. This leads to "access block" to the care of private psychiatrists, because those psychiatrists must treat their significantly ill patients themselves, in many cases. The model above has the benefit of training mental health workers whilst treatment is provided.

## 100,000 more people with Significant Mental Illness can be treated with a Modified Meadows CLIPP Model, in the private sector

We propose here, that appropriate investment, 100,000 more people with significant mental Illness could be treated by the private mental health sector, within a period of two years. The

private mental health sector is under the effective control of one Government: the Federal Government. This eliminates the cost shifting and other political problems encountered with inter-governmental agreements. GPs and private psychiatrists are capable of responding quickly, once a framework has been developed through an intensive consultative process involving the AMA, RANZCP, RACGP, and with deliberate input of actively practising private psychiatrists. Over subsequent years, many more people suffering significant mental illness could be accommodated, as skills build in the GPs and allied health workers supervised by private psychiatrists. The same type of model could be extended to those treated in the public mental health sector, but that would require COAG negotiation, and would take longer to implement.

The model is explained in more detail in Appendix C. The model of treatment is activated by a significant and complex case referral from a GP to a psychiatrist. If the psychiatrist accepts the referral, all professional participants in the model could trigger increased Medicare rebates for the consumer, for the services required. The psychiatrist would take on considerably extended medico-legal responsibility for the consumer, and also undertake case meeting and educational responsibilities for the team. A suggested format for such meetings would be a peer review model, where the professionals involved would gather to learn about how best to manage each individual consumer. Such meetings would satisfy the Consultation-Liaison component of the CLIPP model, but with an increased educational component. The aim would be to develop a much larger cohort of professionals in the community, capable of managing people suffering significant mental illnesses in the community, and under the medico-legal supervision of the psychiatrist.

Prof Graham Meadows developed his Consultation-Liaison psychiatry In Primary-care Psychiatry (CLIPP) model of care, some 20 years ago (Meadows 2007). Our model above, is based on some of the principles that Graham developed. The CLIPP model emphasised consultation-liaison and education between psychiatrists and GPs, followed by collaborative care with the GP, with ongoing input and supervision by the psychiatrist. This exactly matches the key elements of the model outlined above. Unfortunately, the CLIPP model did not receive ongoing State Government funding support, possibly because of the dominance of episodic care management, and also because the Meadows model crossed Federal Government and State Government funding boundaries. An advantage of our suggested model is that it is contained within the Federal Government funding administration. Meadows suggested that his model should be a best practice model in mental health.

## Adequate Funding Models

It has often been stated that compared to the burden of disease caused by mental illness, funding for mental health has been inadequate. Part of that problem is due to the divide in Federal Government and State and Territory Government funding, with the inherent risk of cost shifting and blame shifting. The Royal Commission could be a good opportunity to bring this problem to public attention .

Note also that the Federal Government funding of Medicare over 35 years (under a number of Governments and parties), has deliberately allowed rebates to patients for medical services to fall, compared to CPI inflation. Now consumers cannot afford out of pocket costs for doctors who are trying hard to maintain high quality practice. Consumers suffering significant mental illnesses are typically financially disadvantaged, and such out of pocket costs hit them harder. The Federal Government, as underwriter of Medicare, should immediately correct this gross aberration, for people suffering mental illness.

## NDIS Reform

Medical involvement is required in NDIS decision-making. The artificial divide between medical treatment and disability care needs to be repaired. The NDIS rules already allow some mental health treatment; just not medical treatment. Much waste of tax payer monies is occurring, and mental health consumers are missing out on NDIS packages they need. Having the GP and Psychiatrist able to monitor and input meaningfully to the packages, will add to good financial

governance for the NDIS system, and better directed care for consumers. More adequate mental health training for all NDIS workers, will facilitate the process. (See Appendix H)

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# Appendix A

## COMMUNITY ATTITUDES TO MENTAL HEALTH AND MENTAL ILLNESS

Community attitudes to Mental Illness are important for shaping mental health policy, because they are shared by most of our population, including politicians and bureaucrats. Since around 2006, there appears to be a greater community awareness of mental health issues in the Australian community. This may be a result of at least two major developments. There have been specific community information campaigns, led by Government, and even the media itself (eg ABC mental health programmes). In 2006, a primary mental health campaign was launched, empowering GPs and introducing psychologist services to the Medicare Benefits Schedule. Australians have been more exposed to psychological treatments for high prevalence disorders in the community through those initiatives, thus decreasing some mental health stigma.

### Origins of Persistent Stigma

Much progress has been made regarding mental health stigma, but some serious gaps remain, which also adversely affect mental health policy. It is worth trying to understand why psychiatric treatment resourcing should have been left out of the 2006 mental health policy initiatives. Psychiatrists observe that community attitudes may have changed for less serious mental illness, but remain more ignorant and negative in relation to more serious mental illnesses. How otherwise could it be, that you now hear commentators in the media saying that someone had “suffered from mental health”, and the words “mental illness” are avoided by commentators as much as possible! We believe there is still significant community denial and misunderstanding regarding more serious mental illness.

The brain (and therefore mind) is probably the last “sacred” organ in the body. Many people feel that the essence of them as a person, is contained in their brain; in terms of the brain determining their thoughts, feelings and actions. It feels like the brain encapsulates all that is particular about us. It stands to reason that we do not want anything bad to happen to our brains. It is therefore very confronting for us to encounter serious mental illnesses, because the same thing could happen to any of us. Less severe mental illnesses can be tolerated by people more easily, because the essence of the person’s behaviour still appears to some extent intact. So, mild, and even moderate depressions can be tolerated. The less severe anxiety disorders also can be tolerated; and they seem almost to be an extension of normal “everyday” anxiety.

The brain is a difficult organ to scientifically explore. It is very difficult or may be unethical to experiment on the brain of a live human, and therefore, scientific knowledge about

mental illnesses has been slower to emerge. Unfortunately, the brain can suffer disease, like any bodily organ, so, blood vessel blockages or bursts, and infections can all occur in the brain. There are also biochemical or physiological disorders that can occur (as they can occur in any organ), but the underlying pathology of these disorders has been slower to emerge from neuroscience. These disorders include the psychotic disorders (such as schizophrenia, delusional disorders, drug induced psychosis), the recurrent mood disorders (like bipolar disorder), attention deficit conditions, and many other conditions. There is good scientific evidence for a large biological contribution to the cause of these disorders, from family history and twin studies, population studies, and most recently from genetic studies. An unfortunate corollary to the lack of more robust concrete pathologic evidence of the significant psychiatric disorders, is the mistaken belief that Psychiatry is fake, or it is "just commonsense dressed up", and that any person can do it, without any particular training. This is a particularly empty stigma-based assumption, which can even affect policy-makers.

Complicating understanding of these disorders is the interaction of genetics with emotional trauma, which can increase the risk of emergence of an underlying genetic vulnerability. Furthermore, trauma may induce severe mental illness by itself (such as post-traumatic stress disorder - PTSD), even in people without pre-existing, known vulnerabilities. Prior emotional trauma experienced as a child during upbringing, including trauma from attachment difficulties, has been shown to produce long term vulnerability to mental illness. Hence, most psychiatrists consider mental disorders and illnesses to be the result of a complex interaction of biological, psychological and social factors. Because psychiatrists have been inadequately consulted to assist with community education campaigns, this model has unfortunately not been utilised in education campaigns. This increases the ignorance about the more severe mental disorders.

The community finds it harder to confront these illnesses, and this may be partly because the personal outcomes for those people are not always good, even with very effective treatment. This is little different than the situation for people suffering severe auto-immune, heart or cancer illnesses, but appears to be harder for the community to accept, in relation to the brain. The community therefore tends to ignore the needs of people suffering more serious mental illness, as a way of denying that they or their family could easily suffer one of these illnesses. Public education campaigns have so far failed to educate the community about these illnesses in a realistic way. The outcome for most of these people, with adequate psychiatric treatment, can be really good; but there will be some who will struggle over a lifetime with a significant mental illness, and it would be helpful if their needs were understood, as much as the needs of those suffering rheumatoid arthritis for a lifetime, might be understood. Community awareness and education must educate about the significant mental illnesses, and how they are helped by the Biopsychosocial, wholistic approach, employed by psychiatrists and their collaborating professionals (when available).

Greater community awareness of the more serious mental illnesses might also lead to an awareness of the active long-term treatment needs of these Australians, the need for

adequate treatment resourcing, and the economic savings for the community if such treatment is available to all who need it.

## Appendix B

## WHY IGNORE THE PRIVATE SECTOR?

Private psychiatrists are rarely at the mental health planning top table when reforms and inquiries are conducted. This is a severe blindspot of all Government policy work, that it is hard to understand, because it would not be true of any other medical specialty. Perhaps psychiatrists share their consumers' stigma within the elite level of mental health administrators and Government?

In the past, the private sector was dismissed because it was pejoratively stated that private psychiatrists treat the "worried well". In fact, Private Psychiatrists see 386,000 Australians each year. To the present day, since 1993, Governments do not know how many Australians are seen by the public sector each year (let alone the number assessed by a psychiatrist), but it is estimated that they may "contact" 420,000 Australians. Outcome measurement data has been collected for 15 years, in both public and private hospitals. The severity on the HoNOS measure of consumers entering public hospitals is 13.8; and for consumers entering private hospital, it is 13.1 - very little different in illness severity. This demolishes the pejorative argument.

It is partly due to a lack of overall mental health system evaluation and measurement, that the private mental health sector has been ignored so completely, for so long. Whilst outcome measures have been collected for around 15 years, unfortunately, no significant use has been made of that outcome measurement data, since its inception. Useful data is available in those databases, and is available to both the Commonwealth and State and Territory governments, which could guide the type of service systems that need to be developed and implemented.

Private care is often dismissed as being for the rich people in society. This ignores the fact that many psychiatrists see people without private health insurance, and will discount their fees for those in financial difficulty. A survey in 2012 showed that 45% of private psychiatrists' consumers are unemployed, and at least 20% receive Government pensions. It should be noted that the significant out-of-pocket costs associated with private psychiatry are amongst the lowest out-of-pocket costs for any medical specialists in Australia. Note that these excess costs are almost completely related to the deliberate Federal Government Medicare policy, of limiting rebates available to patients under the Medicare system for 35 years.

Mental health leaders do not understand that private care is cost-effective, because it is allegedly predominantly utilising the most expensive mental health workers in the community: psychiatrists. There is clearly an economic advantage to having expert care delivered in the community, directly to consumers, because the total cost of private mental health care is $800Million, whereas, for public sector care, it is $5.9Billion (for a similar number of consumers).

Private care is often dismissed because it is perceived that private psychiatrists are largely working on their own, not in multidisciplinary teams, and therefore cannot achieve very much progress for their patients. This is a gross denial of the intensive collaborative work that goes on between private psychiatrists and a small group of general practitioners, psychologists and mental health nurses that collaborate on a flexible basis within the community.

Finally, little consideration is given to the fact that mental health care in Australia might well be much worse than it currently is, if it were not for the fact that there are two different major systems treating people with serious mental illnesses in the Australian community; and each seeing the same number of serious cases. Governments often bemoan their lack of control through management, over private psychiatric care. We contend that it is **only** because direct Government control has not extended to the private sector in Australia, that we still have at least one viable system delivering high-quality care to consumers with serious mental illnesses.

# Appendix C

# THE MENTAL HEALTH SYTEM AND ITS FUNDING

## What is the Range of Mental Illness in the Community?

Mental conditions affecting Australians can range from normal emotional reactions to life's stresses, through to the conditions that have more serious symptoms and impairments, which are generally those conditions considered by psychiatrists to be caused by brain disorders of a physical, biochemical or physiological nature, such as schizophrenia, recurrent mood disorders, many substance use disorders, attention deficit conditions, intellectual disability, the autism spectrum disorders, eating disorders and traumatic brain injuries. It is generally these latter conditions that have the greatest economic consequences to our community – both direct in terms of treatment, but also indirect in terms of various supports, and through impairment of work ability. The proportion of our population suffering these serious disorders is around 6%. With current limited resourcing, Australian psychiatrists are only able to treat about 45% of these significantly mentally ill people.

The so-called high prevalence disorders are largely comprised of normal reactions to stressors, milder anxiety conditions, mild to moderate depressions, milder substance use disorders and grief. At any one time, these conditions occur in around 20% of the Australian community. These conditions can be for the most part treated adequately in primary care, under the lead coordination of the GP, but with input at times from mental health nurses, psychologists, social workers, and other allied health professionals. It is important to treat these conditions quickly and adequately, because, whilst the level of symptoms and impairment might be lower, the large number of people involved, with less severe, but short-lasting significant symptoms, can have a large adverse economic effect, if they are not treated expertly. The GP needs to be in a strong position to coordinate care, and allocate which professionals should be involved, and for how long. GPs should have the remunerated time to adequately assess and treat these people, and a system where the GP can call on a number of allied health professionals to assist them. When the GP believes that the patient needs psychiatric assistance, despite the initial milder appearance of the

person's condition, they should be able to readily access psychiatric assessment and conjoint treatment.

Even amongst psychiatrists, there is some reticence about using the term "serious" in relation to mental illness. Around 1993, the term "serious mental illness" was used by Government bureaucracy to try to limit the provision of State and Territory psychiatry services to those suffering schizophrenia and other psychoses. This was perceived by doctors to be related to a mechanism of limitation of funding to mental health overall. Psychiatrists advocated for their patients, and the policy did not proceed. The term is used without that political baggage by researchers overseas, and in this paper, we have mainly referred to "significant mental illness" This is because many other conditions can have serious consequences. Many people living with schizophrenia or recurrent mood disorder would be considered to suffer serious mental illnesses. However, some people suffering moderate but chronic depression or anxiety disorders, can have significantly serious ongoing consequences from their disorders, including higher mortality.

Over the last ten years, more policy effort has been applied to the treatment of the high prevalence disorders. From 2006, the Federal Government directed significant resources to the introduction of psychologists to the CMBS Medicare system, as well as some benefits for encouraging GP's to coordinate with the psychologists and mental health nurses. That strategy made a significant difference to the level of stigma associated with mental illness, as it was also combined with media communication strategies concerning decreased stigma. The community, including politicians, have been puzzled as to why there remain significant complaints still, about the mental health system, given the large contribution of resources to the sector. Because some "high prevalence cases" turn out to be suffering significant mental illnesses after all, more serious cases will be identified. The AMA warned the Federal Government in 2006, that if it went ahead with its initiative, but did not combine it with a strategy for better resourcing psychiatric services, then there would be more of the serious cases identified by GP's and psychologists, but there would be no resources available to adequately treat them. We have indeed had a time of increased serious mental illness case identification, without any available resources for psychiatrists to treat these Australians. Hence, the complaints multiply, from the community of those affected by significant mental illnesses.

Psychiatrists generally treat the significant or serious end of the mental illness spectrum. Because of the lack of resourcing for psychiatric treatment, due to the factors already alluded to, we now face a crisis of treatment for the most significant mental illnesses suffered by Australians. The lack of resourcing, leading to unacceptable compromises forced on psychiatrists in the care of their patients, has led to psychiatry not being a popular medical specialty to enter. We now have a workforce issue, of inadequate numbers of psychiatrists available for the needs of the population.

Even if we start to correct that, psychiatrists on their own, will not be able to adequately treat the significant end of the mental illness spectrum by themselves. GP's are the

professionals in the middle, identifying people with significant mental illnesses, that are too complex for them to treat without psychiatrist assistance, but with little psychiatrist availability to treat these identified consumers. To fix this, psychiatrists will need to work with adequately trained GPs, who are also remunerated appropriately for longer consultations with mentally ill patients. Psychiatrists will also need to be able to access mental health nurses in the community, and the small number of psychologists who are adequately trained to deal with patients with more significant conditions than those normally treated by psychologists. Other allied health will be needed, especially social workers, and at times other allied health practitioners. (See the GP Complex Case Referral Model below.)

It is the significant end of the mental illness spectrum which accounts for the largest economic burden to the community, as they suffer the greatest degree of functional disability for the longest periods of time; especially those with chronic illness courses, rather than episodic self-limited patterns of acute high prevalence disorder. Our aim should primarily be the alleviation of suffering for these people, who in the majority of cases can be treated sufficiently to have vibrant and fulsome lives (sometimes called "recovery"). However, in the process we will save the community billions of dollars in wasted inadequate treatment, and in less overall community support costs.

## Brief Outline of the Current Mental Health TREATMENT System

Looking at the range of mental illnesses treated in the community, and identified above, who has responsibility for treating these people, who are the gatekeepers for the system, and where are the barriers to treatment access?

Firstly, the high prevalence disorders are usually initially identified, and often adequately treated by their GPs. This is still the case in our Australian community, even though consumer behaviour has probably slightly changed, in that some consumers do not see one consistent GP. Once seen with a high prevalence disorder, however, most GPs are capable of providing the necessary counselling and advice to deal with what is usually a short-term condition. These patients are likely to be employed in the same proportion as the societal average. If these patients need more counselling than a GP can provide, the GP will often refer the patient to a psychologist. Some of these patients will seek help from a psychologist without initial consultation with a GP, and many of them, who are working, can readily afford such care as an out-of-pocket cost. The Government initiative which included psychologists on the CMBS Medicare system, was intended to give some Government subsidy for psychological services, and perhaps allow some people who were financially disadvantaged, to obtain such services.

There is one key area of mental health service provision, the so-called "community-based sector" (previously Non-Government Organisations), that requires role-clarification, in

terms of the role it might play in mental health service delivery. Over the last 10 years, Federal funding to the sector has dramatically increased, to a level of approximately $500 million a year. Now the NDIS appears to be taking over those activities. It is quite unclear whether this sector should provide services for people with the high prevalence disorders, or for people suffering the more significant types of mental illnesses. There are two key reasons that their role in mental health service delivery needs clarifying. First of all, many services that have previously been provided by the so-called community-based sector, now will have those services delivered under the NDIS system. There has been a lack of proper integration of the community-based sector within the NDIS system at this stage, and such integration may have been the best policy solution.

Secondly, the community-based sector organisations have generally prided themselves in not being profession-based, and often are critical of the “medical model”. However, if they are to work collaboratively and effectively with other professional mental health treatment providers, under an appropriate clinical governance hierarchy, they must be required to further professionalise and train, to gain insight into the importance of the biologically related disorders, and the use of the medical model in treating these disorders. This understanding is needed for them to understand the nature of more severe illnesses suffered by people to whom, they may be providing services. They must understand who they should be contacting when a patient’s condition is deteriorating, and have the training to allow them to recognise such deterioration. These issues must be properly clarified by both State/Territory and Federal governments, who have had roles in funding the community-based sector for some time now. Many psychiatrists have had the experience of NGO workers telling their patients to cease psychotropic medications, because it will damage them – which could easily lead to patient suicide. Training is also needed for NDIS workers engaging with the severe end of the mental health spectrum (which would likely be the case), because similar problems of role definition seem to arise.

The more significant or serious mental illnesses typically have an ongoing or recurrent pattern of illness, and are associated with higher levels of disability, and with much higher risk of suicide. The symptoms and disabilities these people suffer, commonly leads to an unemployed state, and associated financial disadvantage. Once again, GPs are the frontline health professionals with sufficient knowledge of psychiatry to identify these more severe disorders. Psychologists usually do not have the training or experience to identify these mental illnesses. Doctors have frequently found cases of people suffering such significant mental illnesses, who have been assessed and treated by psychologists or counsellors in the community for some months, and the severity of their condition has not been obvious to the therapist. Often the ill person comes to notice after a suicide attempt. GP’s must remain the frontline identifiers of significant mental illness, because their training and experience allows them to accurately identify such illnesses.

If the GP does not have the expertise to treat these cases by themselves, they will need a Psychiatrist to work with them, or to take over the majority of care. A Psychiatrist’s expertise lies in the treatment of more significant or complex mental illness, using biological treatments, or more highly targeted psychotherapy. Lately, GP’s have complained

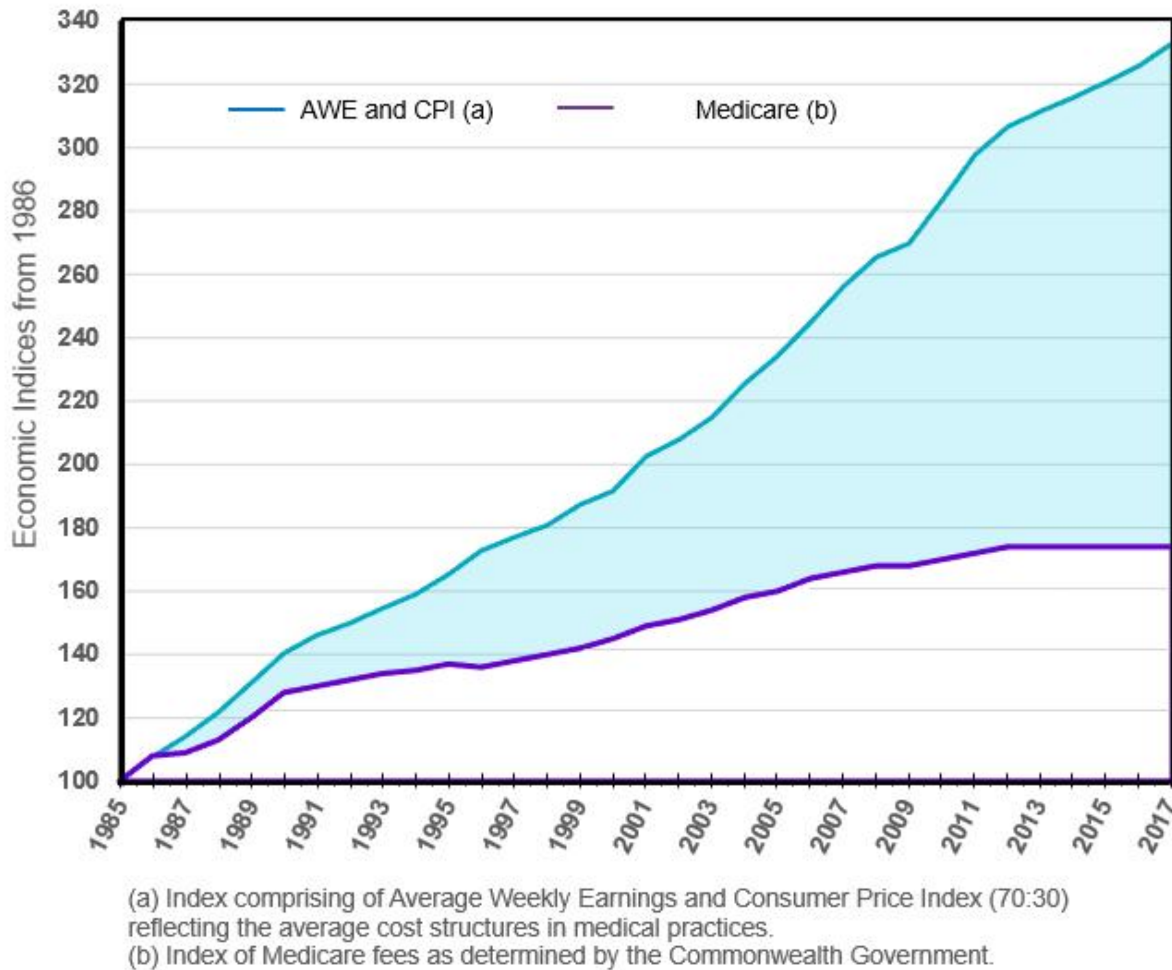
that it is becoming more difficult for them to access the services of Psychiatrists, after they have identified significantly mentally ill patients. In Australia, there are two main paths to obtaining Psychiatric services. One is through the public mental health system (the State and Territory funded services), the other is through assessment by a Private Psychiatrist. Private Psychiatrists see people with and without Private Health Insurance, and usually under the Medicare system. But, as Medicare rebates have consistently failed to match CPI inflation over 35 years, more and more Australians cannot afford the necessary out-of-pocket costs of Private Psychiatrist treatment. Public psychiatric services do not usually discriminate against people with Private Health Insurance either, but the services provided are almost exclusively directed to those people who are acutely suicidal, and those with acute psychoses. GPs know when it is unlikely that they will get a patient into public mental health care, and then, tend to turn to Private Psychiatrists, often in some desperation.

It is unusual in medical specialties within Australia for there to be as much differentiation of services between public and private sectors. Usually, public health services are intended to be available to all Australians suffering particular conditions, and fairly uniformly available. The State and Territory (public) mental health services have drifted over the last thirty years, from being available to most Australians, to being available only to a minority of those suffering significant mental illness. Services in the public sector tend to be provided on an episodic treatment basis, rather than a long-term treatment and follow up basis. This, despite the fact that most people using public mental health services will suffer ongoing or recurrent mental illnesses. The cost of State and Territory Government funded mental health care in Australia is around $5.9Billion, and with this, approximately 420,000 Australians each year are assessed at least once (the exact number of people assessed in public mental health is still not able to be determined, after 25 years of national data collection).

Outcome measurement, using the Health of the Nation Outcome Score (HoNOS) score is on average, 13.8 on admission to Public Mental Health hospitals, and 6.3 on discharge (lower scores representing improvement) (AMHOCN 2016). The opinions of consumers concerning their care in public mental health tend to vary. Some consumers have rather tragic tales to tell, of their experiences receiving treatment. However, many other consumers complain that they have not been able to receive the services provided by this sector.

Private Psychiatrists operate in the community, and their services are underwritten, like GPs and other medical specialists, by the Commonwealth Medical Benefits Schedule. When a patient receives a consultation from a Private Psychiatrist, they can claim a rebate from Medicare. Federal Governments have chosen, over 35 years now, not to increase rebates for patients in line with CPI or AWE inflation. More recently we have experienced Federal Government determined "rebate freezes", which were slightly relieved for GPs, but only recently, and partially, for other medical specialists. The long- lasting rebate limitation policy may have saved Government much money, but for the significantly mentally ill patient group, which is frequently financially disadvantaged due to their illnesses, it becomes much harder to afford the additional fee costs charged by Private Psychiatrists, in order to maintain a basically adequate service. GP rebates have been affected by the "rebate

freezes", but Private Psychiatrist rebates have been affected more, because psychiatrists are lumped in with surgical and procedural specialties, for greater rebate stasis.



(a) Index comprising of Average Weekly Earnings and Consumer Price Index (70:30) reflecting the average cost structures in medical practices.
(b) Index of Medicare fees as determined by the Commonwealth Government.

(AMA 2018)

Private Psychiatrists consult on 386,268 Australians each year, all of whom suffer significant mental illnesses. Inpatient hospital admission is required for around 7.7% of them(AIHW 2017). The predominant model of treatment by Private psychiatrists is long term community treatment and follow up, for those with ongoing and recurrent significant mental illnesses. The cost to the Federal Government, for treating these people is $349Million. Psychiatric hospitalisations in private psychiatric hospitals, cost Private Health Insurers about $400Million(AIHW 2018). Mean HoNOS outcome measurement scores for those admitted to private psychiatric hospitals is 13.0 on admission, and 5.7 on discharge (lower scores indicating improvement) (AMHOCN 2016). For five years, Private Psychiatric Hospitals have collected data using a consumer and carer perceptions of care instrument. The patient perceptions of their psychiatrist's treatment is around 90% satisfaction on average.

These figures show that a similar number of Australians are seen each year by Private Psychiatrists, for a cost to Government of close to one tenth of the public sector cost, and with a high level of consumer satisfaction. It may be that comparatively more Australians are treated each year in the private sector (versus the public sector), because some of the 420,000 "patient contacts" may not include psychiatric assessment or treatment. Note also, that the level of patient severity from the HoNOS score, measured at patient admission, when people are most ill, is not much less than the score level for patients entering Public Mental Health hospitals, indicating an insignificant difference in illness severity between private and public sectors, on patient admission to hospital. So, Private Psychiatrists are not treating the "worried well", as is so frequently pejoratively conjectured (and contained as an assumption in the KPMG review of mental health, published as part of the National Mental Health Commission report of 2014) (KPMG 2014).

"the private system predominantly supports people with more common mental illnesses such as affective disorders. People who have a severe mental illness tend to be treated within the public system given the challenges of maintaining private health insurance over a lifetime. "

Page 22 of "Paving the Way", KPMG, for the National Mental Health Commission, November 2014

(a central assumption error in KPMG modelling)

The other assumption contained in the KPMG review was that private sector patients would be well off financially, because they could afford to pay Private Health Insurance premiums. A survey of private psychiatrists in 2012 revealed that 20% of their consumers were on a Government pension, and 45% were not working. So, the evidence that is available, indicates that the private sector is vital in dealing with consumers suffering significant mental illness, including those that are financially disadvantaged. To ignore the role of the Private Psychiatrist sector which treats half of the seriously mentally ill Australians, will cause a grave systemic modelling error in the development of mental health services to occur, disadvantaging seriously ill and financially disadvantaged consumers, and introducing large scale econometric errors into the modelling. Such a large modelling error will also add enormous extra cost to any funded mental health treatment solutions planned by Governments, and based on false assumptions used by KPMG in their paper.

We would note that there is some overlap in the numbers of people seen by the private and public sectors. The people who private psychiatrists treat in the community, and who do not hold Private Health Insurance, must be referred to public sector psychiatric services

when hospital admission is warranted. The degree of overlap is not known, partly related to inadequate public sector statistics, but also related to a lack of research on this overlap. This would appear to be a serious absence in information vital to determining mental health service provision in Australia – and may be related to widespread pejorative prejudices about private psychiatry services, as expressed by KPMG in their report (possibly because their informants held this prejudice).

It would appear that public and private sectors consult on around 700,000 Australians suffering from significant mental illnesses, causing the majority of suffering and economic cost to the community. We estimate that around 1,200,000 Australians require psychiatric care, which is consistent with the figures used by the Productivity Commission issues paper. Mostly, private and public services have worked very collaboratively over the longer term, but in recent years it has become harder for private psychiatrists to take on consumers lacking private health insurance, referred from the public sector, because public sector follow up services are either not available, or not provided to these people. We need policies which leverage psychiatric expertise, by involving GPs and other mental health care workers to work in more active collaboration with psychiatrists.

## Appendix D

## OVERALL MENTAL HEALTH FUNDING IN AUSTRALIA

We would highlight the urgent need to address the gap in per capita spending on mental health, with significant investment at the Commonwealth and State level to reduce the deficits in care, fragmentation, poor coordination and access to effective care. It is generally acknowledged that there are significant deficits in mental health funding. In 2014-15, mental health received around 5.25 per cent of the overall health budget while representing 12 per cent of the total burden of disease(AIHW 2018). It is essential that properly funded community–based mental health, active treatment services are in place for people with mental illness and disability, as this will reduce the need for hospital admissions and re–admissions, has the capacity to diminish the severity of illness and its consequences over time, and should have significant economic benefits.

It has become clear that the current crisis in mental health care is being experienced throughout the Australian community. It is the whole community-based mental health treatment delivery system that is under strain. This includes General Practice, State and Territory funded community mental health centres, private psychiatrists, psychologists, mental health nurses and the non-government organisations (who have taken to calling themselves the “community-based sector”). When de-institutionalisation of mental health services was undertaken, from the late 1960s through to the early 1990s, a catch cry of Governments at the time was: that the dollars for mental health care would follow the patient into the community.

Unfortunately, as evidenced by the gap between the burden of mental illness, and actual mental health care funding, the dollars did not follow the patients into the community sufficiently. This is the central Governmental mistake that has occurred in mental health treatment delivery. In addition, at the time of deinstitutionalization, Governments were told by the AMA that community-based treatment would actually cost more than institutional hospital-based treatment, because there had been economies of scale in providing hotel-type services, to large numbers of people suffering mental illness in the hospital-based system. Understanding this, has never been properly integrated into Government policy, at either level of government.

Preventing hospital admissions is best achieved through building up flexibly integrated, but properly clinically governed, community-based mental health services (including psychiatrists, GPs, psycho-geriatricians, mental health nurses, psychologists, other allied health, paediatricians, drug, alcohol and gambling support staff, and consumer and carer representatives).

## The Governmental Funding Split

The bulk of Health funding in Australia is provided by the two highest levels of government, the Federal Government and the State and Territory Governments. The Federal Government contributes around $3 billion per year to mental health funding, and State and Territory Governments contribute another $5.9 billion per year to mental health funding. No level of Government exercises complete control or responsibility for Health care, and this appears to be a particular problem with Mental Health care. There can be a shifting of responsibility from one level of Government to the other for the care provided in the community; and at times, there has been outright cost shifting between the two levels of Government. There is an inherent problem in this lack of direct responsibility, for either level of Government, but unfortunately, this state of affairs is likely to continue into the future.

The only way these problems can be worked through is through the Council of Australian Governments processes. We would suggest that both levels of Government should be given instructions from this commission to be directed to clarify roles and responsibilities of the different levels of Government, and also clarify the funding involved, and the accounting for that funding.

Based on the long-term underfunding of mental health service delivery, it is necessary for both levels of Government to commit more funding to mental health services, particularly for long-term treatment of those with ongoing and recurrent mental illnesses of a significant or serious type. However, both levels of Government need to consider carefully how extra funding may be spent. There is a great risk that funds will be committed to mental health services, and no alleviation of suffering or improvement of the lives, of those with the significant mental illnesses may occur. We would suggest that both levels of

Government should look at how they can support the private mental health system, led by GPs and private psychiatrists, and including other allied health personnel, who could provide more services for the seriously ill in a relatively short time frame. We would suggest that investment in that particular sector in the first instance, is likely to achieve the greatest improvements in the shortest possible time.

## Federal Government Funding

The AIHW report for 2018 lays out the expenditure items financed by the Federal Government (AIHW 2018). Figures in that report show the proportion of spending on different items. A significant proportion of spending is related to expenditure under the Commonwealth Medicare Benefits Schedule. This expenditure covers psychiatrists, GPs and psychologists predominantly. Another long-term recurrent Federal expenditure is in relation to mental health programs for Armed Service personal and veterans under the Department of Veterans Affairs. Around $400 million dollars a year are spent on Federal Government mental illness prevention programs, including suicide prevention programs.

Please note that the amount of CMBS funds spent on private psychiatrists per year is $349 million. The amount spent on GPs for mental health specific services is $285 million per year. Not all GP services will have been devoted to those suffering the significant or serious end of the mental illness spectrum, but a number of the GP services will have been devoted to that particular cohort. It is suggested that very few of the funds ($517 million) devoted to psychology services are expended for patients suffering the significant or serious end of the mental illness spectrum. Private psychiatrists would note that they rarely are able to access the services of psychologists under Medicare, for patients with the serious type of mental illnesses. A recent suggestion by psychologists advocating for more consultations per year to be available to patients under the CMBS, would mean more services for the high prevalence disorders, and make very little difference to the consumers suffering significant mental illnesses.

## State and Territory Mental Health Funding

The funding from this level of Government is the largest amount of mental health funding provided by Government each year. It is largely directed to funding in the public sector mental health services. Approximately half the funding is devoted to in-hospital treatment of patients, and a similar amount is provided for ambulant out of hospital treatment of patients. As noted previously, most of these patients do suffer from significant or serious mental illnesses, commonly with a likely biological causation for their illnesses. Unfortunately, as previously noted, these services in most jurisdictions, are only available to those people who present an imminent risk of suicide, or harm to other people, or who may be suffering from very chaotic psychotic symptoms.

One problem with this level of Government funding is that the amount spent per capita by different States and Territories can vary enormously. Sometimes the expenditure can vary significantly over longer time periods, as well. It is worth noting that Victorian Government spending on mental health was quite high per capita, some 10 to 15 years ago, but in recent

years, seems to have decreased markedly, to be one of the least well-funded public mental health systems in Australia.

A recently increasing expenditure is that used to support the community-based sector, and the amount of support for the sector is now $466 million a year. This sector has been involved in residential support services, and originally, in what was called psycho-social rehabilitation services. The sector has expanded in recent times, but the exact role of this sector can at times be difficult to determine. With the advent of the NDIS, many of the roles of this sector could be subsumed under that structure. It is important for Government, which funds these services, to step forward and determine how much actual therapeutic work is meant to be performed by this sector, under what clinical governance does it work, and how much their work is social and disability support.

Another feature of this level of Government expenditure is the funds that are devoted to administrative services. Nearly $1 billion per year is spent on administration of the State and Territory mental health service delivery system. It is not entirely clear why such high levels of administrative management funding are required for a system which largely rests on clinical governance.

## Private Health Insurance Funds

Private Health Insurance (PHI) funds help to finance hospitalisations and some day-patient programmes run by private psychiatric hospitals, and available to those people suffering mental illnesses, who also have such Private Health Insurance. The proportion of the Australian population having private health insurance is currently around 40%. Rates of insured people in our population have been declining recently in relation to the very high premiums that must be paid. Only around 7% of Private Psychiatrists services are provided in hospital, reflecting the predominant community focus of these Psychiatrists.

Private psychiatrists are concerned by what amounts to managed care interventions by PHI funds, through "hidden rules" such as restrictions on day programme participation by consumers, and step down rules applied to some of the most ill consumers. These rules are relatively hidden because they are applied to hospitals through commercial-in-confidence contracts with hospitals, and are generally not available for consumer review. Whilst private psychiatric hospitals try not to let these hidden rules affect patient experiences of care, they can have an inhibitory affect on the treatment of the more severely ill consumers.

Mental Health Service provision is a relatively small part of private mental health insurers expenditure, but over the years PHIs have focused very strongly on this sector, in an attempt to decrease their expenditure. In the early 1990s, and at a Productivity Commission inquiry, PHIs tried to obtain the ability NOT to fund psychiatry services, rehabilitation services, or palliative care services. In the end, that Health policy was not implemented, and for nearly 20 years there was a more stable funding arrangement with the PHIs in mental health. This stability was associated with the formation of a strategic group that had been formed in 1994, called the Private Mental Health Alliance. Unfortunately, that group ceased to exist some four years ago, and private psychiatrists have obtained the impression that the PHIs are striving once again, to inappropriately limit their expenditure on patients with significant mental illnesses.

For many years the expenditure of PHIs was around $200 million dollars per year on mental health service provision. That figure has risen in the last five years particularly, to around $500 million dollars a year. A part of that increase in expenditure is related to a cynical cost shifting exercise exploited by State and Territory governments. Public psychiatric hospitals have encouraged patients who are admitted, to claim for their admission on their PHI. We would agree that this practice is most inappropriate. In this area, we thoroughly support the private health insurance funds. We do not believe that patients admitted to public psychiatric hospitals are able to see their own private psychiatrists in most cases, and are rarely able to see any other nominated psychiatrists for very long, most of the time. Such admissions are a travesty, and a blatant example of cost shifting from State and Territory governments to the private sector.

## UNDERWRITING FAILURE IN AUSTRALIAN HEALTH CARE

To us, there appear to be two main areas of underwriting failure in Australian Health Care.

### Medicare Underwriting Failure

The first is a threat to the sustainability of the Medicare system. The Medicare system is underwritten by the Federal Government. As the rebates available to patients under Medicare for doctors' services has not kept up with inflation, and has been impaired further by rebate freezes, doctors are forced to charge significant out-of-pocket payments to patients, in order to maintain a satisfactory level of practice that would satisfy the Medical Board of Australia. As the out-of-pocket expenses climb, some patients cannot afford to pay these gaps, and they are therefore put off obtaining medical care when they really could do with it. When consumers start putting off doctor visits when they are sick, they often get sicker, and then the suffering and economic cost is greater. The Medicare system then starts to fail as a Universal Health System. We believe that this system has gotten to a breaking point, where the Federal Government, of whatever type, must confront whether they want this system to remain universal, whether there will be a means test for some patient rebates, or whether the system may need a complete redesign.

In an example of how Medicare rebates are inappropriately low for consumers, it is instructive to look at private psychiatrist rebates. For a 45-75 minute outpatient consultation with a private psychiatrist, the Government's current preferred fee is $186.40, but the patient is able to claim $158.45 as a rebate for any fees charged by the doctor for this item. In order to maintain a practice which would satisfy the Medical Board of Australia, most private psychiatrists are now charging around $300-350 for this type of consultation. In 1995, the Federal Government spent $12Mill on the Relative Value Study (RVS): a process designed to determine the fair fee for a doctor to charge under Medicare. The Study was close to completion when the Government pulled out of the process. At the

time, the Government fee for the 45-75 minute consultation was set at around $130, but we believe the fair fee was found to be $170 for this item. If one increases this fee in line with CPI and AWE (see AMA website), then the fair fee, indexed appropriately for inflation should be around $296. Psychiatrists currently appear to be charging fairly, but successive Federal Governments have let rebates decline to a point where consumers find it difficult to access medical care – and Medicare is very sick!

Medicare cannot continue on as it is, and survive in a sustainable way. The health of the Australian community is likely to decline if the supposedly universal system is no longer properly universal. Medicare administrators and politicians appear to have failed to recognise that, when Medicare rebates remain close to the fair fee that a doctor should charge for their services, the doctors have a latitude in their fee-setting to discount some financially disadvantaged consumers, whilst charging some well off consumers a higher fee. In this way, there is a built-in economic management towards equity, which is exercised by most doctors, when given the capacity to do so. Referring GPs can easily identify specialists who fail to exercise this discretionary billing, and not refer to those specialists, unless they have particular skills. But when Medicare rebates drop far below the fair doctor's fee, then those doctors cannot afford to exercise that discretion in charging consumers.

## Private Health Insurance Underwriting Failure

The other area of underwriting failure is that of the private health insurance system. This system is meant to be community-rated, but many people do not take out this type of insurance cover when they are younger and relatively well. They may join up in later life when they have more disposable income, and when their medical needs become more apparent with ageing. Even though the government has imposed increased premiums for those who do not join up early in life, these differential premium rates do not seem to be having the required effect.

The result is that private health insurance premiums having increased markedly, to a point where fewer and fewer Australians can in fact, afford them. If a patient who has been a health fund member for 40 or 50 years, decides to drop their private health insurance cover, the huge premiums they have paid throughout their lives, do not count in any way, in terms of being able to retain the private health insurance benefits.

We would suggest that the private health insurance system needs extensive review, and perhaps a gradual generational replacement of the system with a different type of insurance model. Other models exist around the world. It would be possible to have a whole-of-life health insurance policy, which is taken out when the person first starts working, and if that person maintains that policy throughout their lifetime, the benefits would remain at a particular level selected near the beginning of their commitment to the product; and premiums would not need to rise so significantly. Singapore has developed a medical savings account system, which is very successful. In Singapore, patients actually pay the full fees (from their medical savings account) for the treatments that they require, and this allows some degree of significant competition in the marketplace. If they are unlucky enough to develop a severe illness when they are younger, there is accompanying catastrophic insurance provided, through government mandate. Other models also exist, but the point is that there is a significant need for a total revamp of our private health

insurance system. Any major changes may have to occur over a period of a generation, so that the existing system will last for those that joined earlier, but the new system will emerge over a period of perhaps 25 years.

## Appendix E

## A GP "COMPLEX CASE REFERRAL" COMMUNITY MENTAL HEALTH MODEL

We outline here, an alternative model utilising the CMBS private system to extend services rapidly and cost effectively to more people suffering significant mental illness.

Private Psychiatrists do not work alone in the community. A small number of GPs, Private Psychiatric Hospital mental health workers, mental health nurses and psychologists work actively with us in the treatment of our patients. To try to give the Productivity Commission an estimate of the total cost of the private specialist mental health treatment sector, treating the significant end of the mental illness consumers, we have made some estimates of the proportion of the other workers, who work in collaboration with Private Psychiatrists. By apportioning a financial amount to the proportion of a particular kind of worker, one can obtain a rough estimate of the total cost of this private mental health treatment. The estimates are from a brief survey of private psychiatrists, and whilst the estimates are not scientifically corroborated, no other estimates based on any credible methodology exist.

Any model which attempts to extend the number of patients that private psychiatrists can supervise in their multi-disciplinary teams should be consonant with the private practice business model. Primary Healthcare Networks, which use a different business model, do not seem to work seamlessly with Private Psychiatry practice, which has been a large contributor to their failure in the mental health space. Hence, the model we outline below relies on a method of enhancing what a Private psychiatrist can do, in looking after more patients, based on changes to the CMBS system. One of the advantages of working WITH the business model used by Private Psychiatrists is that the administration costs are contained within the practices involved (and within the CMBS costs expended by Government), and tend to be much lower than Public Sector administration costs. Governments also gain advantage from the work flexibility of private sector workers, and benefit from the micro-management of cost structures for patients, based on the practitioner's ability to target discounts appropriately.

These community based multidisciplinary teams are very flexible and responsive, and depend on trust between the members, formed over time, and reinforced by a clinical governance that recognises the limits of practitioners' scope of practice, and depends on

individual responsiveness, both to the consumer, and each other. These small teams often work with the consumer over a considerable time. Often the psychiatrist can take a less prominent role because another practitioner can attend to most of the long term follow up; but the psychiatrist knows that they will be contacted if trouble occurs. This latter feature is absolutely vital, because in the community, when a psychiatrist remains involved longer term, the psychiatrist takes the greatest amount of medico-legal responsibility (and risk), in case any harm comes to the consumer.

Consider carefully that private psychiatrists looking after significantly ill people in the community, are often looking after people, which, if they suffered physical illness, would be considered for ICU admission! It is often denied by our community, that if we want to keep people with severe mental illness out of hospital as much as apparently is desired, then we are looking after intensive care cases in their homes. No other specialty does this. It is not often realised that private psychiatrists remain on call, to respond to patient need, 24 hours a day. Governments do not have to separately pay for this enormous advantage for care security.

We estimate that around 15% of GPs actively work with us, in terms of taking over the bulk of long term follow up. Unfortunately, because of a dearth of mental health trained nurses in the community, there are very few actively working with psychiatrists. We estimate that only 5% of psychologists are adequately trained, or willing, to take on a long-term treatment role in collaboration with psychiatrists. Private psychiatric hospital day programme staff and outreach teams do routinely work with private psychiatrists in the community, but the costs of that work are included in health fund expenses.

The total cost of multidisciplinary treatment work performed in collaboration with private psychiatrists in the community, to treat the most significantly unwell people living with mental illness, is likely to be represented by the following table:

| | |
|---|---|
| Private psychiatrist CMBS rebates: | $354 Mill |
| Private Health Fund expenses for psychiatry: | $400Mill |
| 15% of GP mental health CMBS rebates: | $43Mill |
| 5% of psychologist CMBS rebates: | $26Mill |
| TOTAL cost: | $819Mill |

(estimated from AIHW 2018)

There may be a number of reasons for the huge discrepancy of cost, for specialist public and private mental health services ($819Mill Private, $5.9Bill Public). It would be very good to know why, and it is about time we had health system research into the reasons for this discrepancy. It should be acknowledged that there are a few “Statewide” services provided by public sector funding; the most significant of which is Forensic Mental Health. However,

this does not account for the disparity. It may be that public mental health patients are less socially connected than private sector patients, but there are no studies on this. It may be that multi-disciplinary teams have become institutionalized in the public sector, whereas, private psychiatrists work with less organized, but more flexible, multi-disciplinary teams in the community, which may cost less. Multi-disciplinary teams are not required all the time, for all significantly mentally ill patients, if they are followed up consistently, long-term. We would suggest that, until more research is done, a long-term follow up model (rather than an episodic care model) for public mental health, would be worth considering implementation.

In our opinion, the productivity Commission should consider how the cost-effectiveness of the GP/Private Psychiatrist model could be applied to deal with more of the significantly mentally ill population, through leveraging this private model. A fresh look, through an AMA led Mental Health Medical Benefits task force should immediately be commenced, to examine how the Private model involving GPs and Private Psychiatrists, can be extended effectively, to include other allied mental health workers, and thereby extend services to a further 50-100,000 significantly mentally ill Australians. Our estimate of the cost of supporting another 100,000 Australians suffering significant mental illness is spelt out in the following table. Our estimates for such an enlarged service are based on the GP "Complex Case Referral" triggering triple Medicare rebates for patients of psychiatrists (under such a referral), and proper increased rebates for the GPs following up such patients using 30 minute or 45 minute consultations. This model would require a re-investment in mental health practice nurses in private psychiatrists' practices, and higher psychologist rebates for 10% of psychologists, who are able to work with psychiatrists long-term.

| | |
|---|---|
| Private psychiatrist CMBS rebates: | $500Mill |
| Private Health Fund expenses for Psychiatry: | $400Mill |
| GP mental health rebates: | $150Mill |
| Psychologist mental health rebates: | $50Mill |
| Practice Nurses for Psychiatrists: | $50Mill |
| TOTAL Costs: | $1.15Billion |

(estimated from AIHW 2018)

This same GP initiated "Complex Case Referral" could just as easily include the GP referring the patient to the public sector: a patient that required the expertise and range of treatment modalities of the public sector for a time. It would be crucial that the GP received feedback directly from the public sector psychiatrist, to allow the GP to take a greater role in the long term follow up. Indeed, this would not work unless the public system adopted a long term follow up model of care (rather than episodic). Note that the public sector psychiatrists should be funded through the State and Territory funding mechanisms, and this should be strictly enforced. If this is not done, inappropriate cost shifting will occur, and the public sector psychiatrists would not have the necessary security of tenure to work long term in such clinics if they were "privatised".

Incorporated into this model is the expectation that GPs, psychologists, mental health nurses and other allied health workers would be educated in an "apprenticeship" style model, to become more expert in long term care and "indicated prevention". To facilitate that, we would envisage a variation of current multi-disciplinary case conference MBS items, to allow more frequent group education processes centred around patient care.

### Relationship to the Meadows' CLIPP Model

Prof Graham Meadows developed his Consultation-Liaison psychiatry In Primary-Care Psychiatry (CLIPP) care model of care some 20 years ago (Meadows 2007). Our model above, is based on some of the principles that Graham developed. The CLIPP model emphasised consultation-liaison and education between psychiatrists and GPs, followed by collaborative care with the GP, with ongoing input and supervision by the psychiatrist. This exactly matches the key elements of the model outlined above. Unfortunately, the CLIPP model did not receive ongoing State Government funding support, possibly because of the dominance of episodic care management, and also because the Meadows model crossed Federal Government and State Government funding boundaries. An advantage of our suggested model is that it is mostly contained within the Federal Government funding administration. Meadows suggested that his model should be a best practice model in mental health.

## Appendix F

## PROBLEMS IN SUICIDE PREVENTION

Two methods of suicide prevention have been under-emphasised in mental health. There is good evidence that "Indicated Prevention" (in some cases, this is referred to as Secondary Prevention) can be effective to prevent suicide. "Indicated prevention" means that a person is identified as being at higher risk of suicide, and as a result, is followed up over a longer time, to try to prevent actual suicide. Such individuals are identified as a result of unsuccessful suicide attempts, or by the presence of significant disorders with a high risk of suicide; disorders such as schizophrenia, bipolar disorder, or recurrent major depression, especially when combined with substance use disorders. The longer-term follow-up approach to mental health care, recommended by this group, is an opportunity to implement high quality "Indicated Prevention", with little additional cost in most cases. (Mendelson 2018) (Page 30, WHO 2014)

In the mental illness prevention sphere, few resources have been devoted to early childhood intervention with families struggling with mental illness, substance use and socio-economic problems (often concomitantly). Children in these families can frequently suffer various forms of abuse, including physical, emotional and sexual abuse. There is good evidence that such early childhood abuse can lead to "hard-wired" long term neurological evidence of brain change associated with lifetime difficulty coping with stress, and with long term symptoms of PTSD. Positive intervention in such families can lead to changed

developmental trajectories, and often a number of children in the same family can be assisted together, along with their parent(s).

## Appendix G

## RURAL MENTAL HEALTH

It is not hyperbolic to suggest that rural mental health service provision is about to enter a catastrophic phase. We believe this is due to the number of factors. For many years GPs living and working in rural areas have had a strong presence. Many of those GPs who have been the cornerstone of adequate health care generally in rural areas, are now in a phase of approaching retirement. Unfortunately, younger medical practitioners have not been much inclined to enter rural general practice.

It is not often realised that Private Psychiatrists significantly support rural people suffering mental illnesses. A careful analysis of the only comprehensive paper on rural mental health, by Burgess (Burgess 2002), shows that public mental health and private mental health are skewed to city -based distribution of services, to a similar degree. If actual psychiatrist assessment is taken into account, Private psychiatrists may be consulting a similar number of consumers as the public sector (see Attachment 1, Burgess MH Popn Needs Graph).

In the last 20 years, our rural general practice system has been backed up by the employment of international medical graduates (IMGs) in rural areas as general practitioners, with them having to serve a conscripted ten year period in those country areas, before they can obtain Metropolitan provider numbers, and be able to work in metropolitan areas. That system, based on the direction of IMGs into rural areas, is now declining. Most of the IMGs seek to move to metropolitan areas after serving time in rural practice. Many rural areas have also suffered economic decline over the last 20 years, and so, many of the other services which might be available for doctors and their families to enjoy and utilise in rural areas, have also declined. As a result of all these factors, we are likely to see decimation of the rural GP workforce. There appears to be no planning to cope with this imminent catastrophe.

We suggest the convening of an AMA task force with Governmental representation, and with appropriate rural GP input, and the input of Psychiatrists delivering services to rural areas, either personally, or via videoconference.

# Appendix H

## NDIS Improvement

The implementation of NDIS for mental health has been quite problematic. It has been complicated by a number of factors. There has been a difficult to implement transition from the mental health community based sector, with a mixture of funding sources and models involved.

There is an inappropriate separation intrinsic to NDIS philosophy, it seems, between treatment and disability support. Doctors have not been involved adequately in NDIS planning, and one gathers that the medical model is anathema to disability services ideology. It appears that doctors are assumed to not understand disability - but this is certainly not true in mental health, where the division between treatment and disability improvement has never been large, and doctors are often fully aware of the disability suffering of their consumers, second only to the consumer's carers.

So, whilst a non-remunerated letter from a doctor is required to obtain NDIS funding, and whilst the exact requirements for the contents of this letter are not clearly defined, we note that a disability coordinator is able to determine what components of the package will be provided to a person, and they are well paid for doing this, and may refer people to services run by their own organisation. This is a recipe for corruption, with a lack of separation of functions. There appears to be little oversight of this system. Note also, that whilst doctors are non eligible for payment under the NDIS system, psychologists are allowed to b e employed - a clear crossover of treatment into the NDIS system.

We would suggest much greater oversight from GPs and psychiatrists of the NDIS system for mental health. It should be made clear by the Commonwealth Government, that doctors doing work on Medicare funded consultations, to guide consumers in NDIS options, are not committing fraud under Medicare rules. Doctor oversight of NDIS would provide a level of oversight for decisions about funded packages, to make sure such packages are useful, needed, and enhance treatment strategies. Doctors should, where their knowledge of the NDIS system is significant, be able to determine with the consumer, the modules of disability care that will help that consumer most. Over time, the doctors involved will obtain a contemporaneous understanding of the most outstanding disability support providers, and with the consumer, be able to refer accordingly - thus strengthening the NDIS system.

## 2019 Submission - Royal Commission into Victoria's Mental Health System

**Organisation Name**
N/A

**Name**
Dr Bill Pring

**What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?**
"Focus on Significant/Serious Mental Illness  Implement long term ongoing treatment model in all sectors, for those consumers suffering ongoing or recurrent mental illnesses.  Make recommendations for improvement for all sectors, that can be implemented in unison, for greatest effect (Private sector, Public sector, Primary care sector, NDIS support sector"

**What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?**
"Private Psychiatrist led Private Mental Health sector, providing treatment for those suffering significant and serious mental illnesses  Primary health sector, led by GPs, providing most of the care for the high prevalence disorders"

**What is already working well and what can be done better to prevent suicide?**
"More indicated or secondary prevention, as part of long term ongoing treatment model.  Family interventions  for young children in at risk families, in at risk socio-economic areas, which are well identified."

**What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.**
"Episodic public sector treatment model, rather than a long term ongoing treatment model. Underwriting failure of Medicare and Private Health Insurance. Under Medicare, people living with mental illness, who are often financially disadvantaged, are finding harder to afford out of pocket doctor costs for GP and private psychiatrist services, due to 35 years of Federal Government failure to index medical consultation costs to the CPI."

**What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?**
"Serious and significant mental illnesses are not adequately understood by the Australian community, so stigma and disadvantage is a constancy for those people.  Socio-Economic disadvantage.  See our paper"

**What are the needs of family members and carers and what can be done better to support them?**
Mental health worker experience with family and group dynamics training.

**What can be done to attract, retain and better support the mental health workforce, including peer support workers?**

"Wider implementation of long term ongoing treat meant model of care leads to greater consumer, carer and mental health worker satisfaction, making it a joy to work in mental health treatment and care. "

**What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?**

"The long term ongoing treatment model leads to long term clinical and disability improvement, leading to lives more fully lived by consumers."

**Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?**

"People feel ""held"" by their treating team in an ongoing way, through adversity, progressing to significant improvement (sometimes called recovery)."

**What can be done now to prepare for changes to Victorias mental health system and support improvements to last?**

"To make  these significant suggested changes in a relatively unified way across all sectors: Private psychiatrist led Private mental health, Public mental health, Primary care, and the NDIS sector."

**Is there anything else you would like to share with the Royal Commission?**

"Despite the undoubted best intentions of the Royal Commissioners, we point out that there have been many mental health inquiries over many years - without much success. Even some moderately successful changes, coming out of your Royal Commission, would be much appreciated. Deep consultation is needed to achieve this, and with all sectors included. Our sector has not been significantly included before."