Submission to the Productivity Commission: Catts SV; 31 July 2025

At the heart of this submission is a list of recommendations. The most impactful one being item (2), which can be immediately implemented upon convening a proposed Working Party (item 1) as a number of federal block grants to state mental health services.

Setting the scene: Public Mental Health Services (MHS) are festering sores on the moral landscape of Australia.

Despite major increases in Federal mental health funding in recent decades, there is no evidence of improved mental health outcomes for those with serious mental illness (SMI) at a population level. Recovery rates are if anything getting worse, with more frequent comorbidities. Life expectancy is un-improved: rates of suicide, homelessness, and incarceration have worsened.

State-based MHS are reeling from an exodus of clinical staff, resulting in dysfunctional inpatient and community MHS teams. As well, Emergency Departments are overflowing dangerously due to access block to acute inpatient and older age care beds. No allowance has been made for the methamphetamine epidemic. My impression is that most psychiatrists in NSW are burnt-out, having been worn down by excessive bureaucratic oversight (a substitute for quality of care) and a lack of appreciation for their work and knowledge. Oppressive bureaucracy, especially in NSW, have locked in doctors as lackeys of the bureaucracy whose main role is to bear the medicolegal risk of a failing MHS, whilst doctors have to justify to patients the appalling quality of care they are forced to deliver. Opportunities for innovation and inspiring teaching have long gone. They work in sub-standard inpatient units which often have prison-like ward atmospheres, and in which nursing staff assault can be a daily occurrence. Much of the time of trainees is taken up finding an empty bed for a critically ill patient waiting in ED, which can often only be created by discharging another highly disturbed patient to what most consider negligent aftercare.

Looi and Robson (Australasian Psychiatry, 33:2; 232-234, 2025) epitomised the impact of the crisis by noting the appalling death rates of patients with schizophrenia in Australia. In 2023 when few ordinary Australians were dying of COVID-19, the odds of death from COVID infection for Australians with schizophrenia was 17-fold higher than that of the general population. Their human suffering is reflected in rates of attempted suicide, which continue to be almost 30 times higher than those of the Australian general population. Much of this misery is preventable with quality mental healthcare.

How can such a disgraceful situation exist in a wealthy democratic country, despite decades of reviews and national plans? What can Australian governments do to deliver on their unfulfilled promises? How can we build the foundations for quality of mental healthcare?

1. **Implement an unbiased advisory system for government that draws on the expertise of frontline clinical workers, combined with the knowledge of academics and lived experience: Think bottom up, not top down.**

With advice of bloated risk-despising bureaucracies and a handful of celebrity but politically-motivated academics, the Federal Government has systematically enacted a policy of non-assistance to State MHS and instead have funded programs that compete with state services and make their function more difficult through fragmentation. The Federal Government must stop building more stand-alone programs deliberately designed to be independent of State-based MHS. Federally funded programs compete for the same small pool of skilled clinicians that State MHS must recruit. This is hugely damaging because well-trained clinicians are drawn away from the thankless stressful work in State MHS dealing with the most acutely ill patients by offers of Commonwealth-funded 9-to-5 jobs without obligation to see difficult cases, which they can refer on to State services. Some of these programs have no accountability. One of the recent Federal initiatives, *Head to Health,* did not list a single measurable outcome that might have offered a minimum degree of accountability. These processes are nothing short of scandalous, and for me nauseating.

The Federal Government must stop acting on advice of field leaders who have unavoidable conflicts of interest. This has resulted in a totally inappropriate top-down population-based bureaucratic approach to reform. Such advisors brush off the failure of past recommendations, and are ever ready with their next proposal, without the slightest embarrassment over past poor advice. Dedicated clinicians embedded in the State MHS are not politically sophisticated and are ignored. Rather than speak to the needs of the seriously mentally ill, field leaders demand extension of services to the "middle" and "low" impact disorders, hence diverting attention from the acutely ill and disabled "high" impact disorders. Attempting to broaden the scope of services that now cannot cope with patients waiting for a bed in ED will make things worse and diffuse clinical staff effort. There is no evidence that these population-based interventions prevent mental illness. Please try to stop these policy directions, at least until the workforce crisis has been addressed. Suicide prevention sounds wonderful, except that it would require massive staff numbers to mount an effective whole-of-community effort.

To contain the powerful advocacy of influential leaders, another simpler advisory mechanism must be created. The National Mental Health Commission might sound an obvious vehicle, but it isn't. It is far too ideologically driven, and a hot-house of political intrigue. Sadly, the organisations representing consumers now have a conflict of interest with State MHS because these consumer groups seek government funding for their own un-evaluated programs, in a desperate response to the parlous state of public services. Any advisory mechanism must be bottom-up and include knowledgeable and experienced front-line staff, who are provided access to the latest published research. The UK has an

organisation called the National Institute for Health and Care Excellence (NICE), a type of organisation that might be useful in Australia (though this would need examination). However, until a NICE-like or other model can be established, a simple working group could be convened immediately to give the department technical and implementation guidance. The priority for this working group must be the implementation of a series of federally funded block grants to state MHS (see the next item)

2. **Fund block grants to state MHS committed to evidence-based mental healthcare: This will deliver immediate improvements**

This is the most important recommendation in my submission. The brevity of my supporting text is related to this initiative having already been well-described by George et al. Only state MHS may apply for this type of federally funded block grants. This funding is made available after receipt of detailed submissions outlining an evidence-based service model. This type of federal funding has had a major impact on State-based MHS in the US (see attached George et al, 2022, Psychiatric Services, 73, 12, 1346-1351).

3. **Massive upscaling and national integration of state-based data collection infrastructure.**

Construction national registers for neuropsychiatric disorders must be part of government leadership and governance in mental health, as described in the WHO Comprehensive Mental Health Action Plan (2013-2030). For decades researchers have been calling for this type of infrastructure. It would be unthinkable not to have disease registers in oncology (currently this is auspiced by Cancer Australia) and cardiology. Of course, there will be nay says who will scream abuse of civil liberties. It's time to stop bowing down to these self-interested lobbies, and act on our responsibility to the seriously mentally ill. These registers are feasible, though you may receive conflicted advice that is contrary to this view.

4 **Execute a National Mental Health Act (MHA) that will be the default for all interstate patients currently under a State-based MHA, and standardise State-based MHA procedures across jurisdictions**.

Because many neuropsychiatric disorders, but especially psychotic disorders (e.g., schizophrenia, bipolar disorder) and the dementias are associated with a high prevalence of persistent illness unawareness (called in neurology anosognosia), legislation ensuring access to treatment when patients cannot provide consent, is essential. In NSW, the procedures are excessively burdensome because most patients must be presented to a Tribunal hearing of one sort or another. In contrast, in South Australia, few patients are formally presented at a Tribunal hearing. In South Australia the psychiatrist carries out the procedures whereas in NSW the registrar (trainee) carries out the procedures. At some

busy hospitals in NSW, registrars can be taken off-line from patient care for about one day per week preparing Tribunal reports. In South Australia, I estimate the MHA procedures take a psychiatrist at most about 30 minutes per patient. There is no evidence that the rights of patients in South Australia are less protected than those in NSW. There is a great deal of evidence that turning NSW registrars into lackeys of the legal bureaucracy diminishes the precious time registrars have with patients, focused on their patients' care, not a magistrate. A related issues is the last-century hybrid electronic and paper-based medical records system used in NSW, which involves over-the-top, difficult to follow, and time-consuming procedures, e.g. medication reconciliation and knowing which "box" information should be recorded in. The NSW bureaucratic approach is blind to the high cost in medical staff time that their excessively rule-bound procedures involve, whilst only providing staff with out-of-date technical eMR support. It is a nightmare working as a doctor in NSW: no wonder there have been mass resignations. The denigration of medical staff by the NSW Premier and Minister is simply disgraceful and costing patients' access to quality medical care.

4. **Establish a National Training Centre that can offer accessible world class knowledge in theory and practice.**

I recently reviewed medical and nursing training, and it is old-fashioned, uninspiring and inadequate. There is little attempt to convey depth of understanding that is necessary for routinely delivered skilful and safe practice. Neuropsychiatry is one of the most exciting fields in medicine, and teaching must reflect this. Any shift in service reform must aim to provide clinicians with the resources they need to do their work well. If a service reform does not explicitly provide specific support to nurses, doctors, and allied health staff do their job, then it should not be funded. Most of the variance in clinical outcomes of people presenting with a first episode psychosis is determined by what happens to the patient in the first six months after service entry. That is, what treatment they receive. Not surprisingly, as with other medical fields, the quality of mental healthcare delivered by the clinician is the most important determinant of outcome. The consumer co-design movement is grossly over-done. Staff are the end-users of technology, not patients. Consumer co-design was not needed to design the smart phone.

You may think organisations like HETI in NSW would be a model for the nation: it is not. The training is ideological more than knowledge-based, and of course as might be expected of the NSW Ministry, HETI resources are locked up as a private resource for staff only. I wanted to train myself using HETI materials before starting work in NSW but could not access them. Why? You needed to have a staff number to access them. Once I started work and had a staff number, there was no time for formal training. The NSW Ministry just do not get the damage their policies inflict on patient care.

Background of author (Stanley Catts)

I am a 78-year-old psychiatrist. I graduated as a doctor in Australia in 1972 and subsequently specialised in psychiatry. As a psychiatrist I have worked in clinical, research, and advocacy roles related to improving outcomes for people with serious mental illness, especially schizophrenia, bipolar disorder, major depressive disorder, and combat-related Post-Traumatic Stress Disorder (PTSD). My academic affiliations have been with the University of Queensland, the University of New South Wales, and briefly with the University of Sydney. Most of my clinical work has been in public mental health services (MHS) in Australia, namely at the Royal Brisbane & Women's Hospital, Herston QLD, the Prince of Wales Hospital, Randwick NSW, and the South Western Sydney Area Mental Health Service, Liverpool NSW. I have had clinical experience in early intervention programs, including headspace. After a pause in clinical work during the COVID pandemic, I have accepted contract work as a senior medical officer up to the present time. Post-COVID, I have been shocked by the constraints on delivery of quality healthcare I have observed in MHS, especially those in New South Wales (NSW). In my opinion NSW mental health services are nothing short of a horror story.

I grew up in an era when there was much to be proud of about Australia. No more. I continue to do contract work in public mental health services (MHS) and have been sickened by the standards of care in NSW services: so much so that I now refuse to work in them. I have recently worked in Adelaide, and despite similar funding constraints to those in NSW, the South Australian MHS are considerably better than those in NSW. My view is that some of the difference relates to the greater respect for the knowledge of medical staff, a more usable electronic medical record, and a mental health act (MHA) that is much less burdensome to medical staff time. The distrust of psychiatric opinion that the NSW system exudes is not lost on medical staff. This lack of trust is just another aspect of the belittling of psychiatric skill in NSW, only exceeded by the denigration of medical staff in NSW public MHS propagated by the Minister and the Premier.

I was once proud to be an Australian psychiatrist. Now each day it is a moral challenge to step onto a public psychiatric ward.

Yours sincerely

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