Submission to Productivity Commission enquiry

9th March 2019

I am a private citizen with no professional involvement in healthcare services. The basis of my remarks is the experience I shared with my wife, who suffered severe and almost unremitting mental anguish over a three-year period (2015-2019). Although we had been separated already for five years, I became her sole carer, as I was for our two young children. During that three-year period my wife underwent seven stints of treatment in various hospitals, public and private, lasting in one instance more than three months; and she had numerous consultations with psychiatrists, psychologists and psychotherapists, at various clinics and at the Emergency Department of a public hospital.

This experience might be considered unusual because the nature of my wife's condition was obscure (diagnoses at various times included bipolar disorder, personality disorder, addiction to pharmaceutical drugs, depression, PTSD, parathyroid malfunction, and rhinitis). Yet I suggest that the mental health services system ought to be competent in handling complex cases like these, not merely the "low-hanging fruit" such as treatable depression. I suggest also that while the Issues Paper is concerned primarily with high-level economic issues, any consideration of the effectiveness of the mental health care system demands attention to the details of its operation.

My remarks are concerned especially, but not exclusively, with Government programs and professional services relevant to patients whose condition is severe and for which diagnosis and treatment are uncertain. Suggestions made here may be classified broadly as follows.

- Improvements are needed in the design and delivery of Government services to allow for financial and other disadvantages suffered by patients suffering from mental illness.

- Greater continuity of care is needed across the different phases of illness and treatment, especially in complex cases.

- All potentially useful forms of treatment should be available to patients, and their delivery should be coordinated effectively among the medical and other practitioners.

1. Economic impacts

1.1. **Employment and employment support**. The Commission's focus on economic impacts naturally tends to highlight the importance of individuals' participation in the workforce. A similar emphasis is evident in the very strict reporting and work-seeking requirements of Newstart. It appears however that for persons with serious mental health problems, there is often little reasonable prospect of employment, even in the medium-term; and that this is not recognized in the rules applied by the main public service agencies.

It should be recognized in particular that mental illness often leads to escalating financial difficulties, culminating in loss of employment and lapsing of family support, even indigence and homelessness. In addition, the stringency of the rules and the complexity of paperwork imposed by Government agencies are inappropriate to people afflicted in this way. Even with the assistance of doctors or social workers, applying for public support (e.g. Newstart, DSP, or NDIS) is a demanding task, for which the applicant is ultimately held responsible, and inadvertent errors or omissions can easily lead to crippling Centrelink debts, which can be detrimental to any hope of recovery or future employment.

I suggest that a more realistic and humane approach lies in more direct financial or material support for persons with established mental health problems. Possibly this should be in the form of needs-based assistance, such as management of household bills when someone is hospitalised. Alternatively, it might be in the form of streamlined access to allowances such as Newstart, with similar simplification with respect to dealings with the ATO and other agencies, and with less severity in requirements for the return of payments received in error.

1.2. **Unproductive time**. The complexity of navigating the system and reporting to agencies imposes a major burden on the time and attention of all those concerned. This burden constitutes a cost imposed on patients and unpaid carers, and is not reflected in conventional economic measures. The burden is large in individual cases, and very likely also in aggregate.

The same type of burden is carried by professionals (social workers, doctors, and others), who expend substantial effort and time in referring patients to relevant services and in assisting them with various kinds of paperwork. This can involve an inefficient use of resources, and a distraction from the vocational focus of the individuals concerned. Some of this effort probably is unavoidable, given that patients themselves are often unable to navigate the system for themselves; even so, improvement ought to be possible, through both attention to system design (see §2.1 below), and careful review of case-management arrangements (see §2.2 below).

2. Service system design

2.1. **The services landscape**. The complexity of the mental health services system gives rise to serious inefficiencies. Services seem to have proliferated with very little attention to the point of view of the potential clients of those services; furthermore, it appears that many of those potential clients are incapable of finding relevant services and assistance on their own.

This complexity seems to have arisen from a tendency to create a new Government program to meet each new problem as it is identified. In addition, mental health services and programs available from various state government agencies intersect in arbitrary ways with the provisions of other programs such as Medicare, PBS, Newstart, NDIS and DSP, and of non-government institutions such as insurance companies and the various community organizations and charities.

I suggest that a wide-ranging review of mental health service delivery is needed, covering all relevant institutions, and concerned particularly with the roles and interactions amongst those institutions. In this respect I support the development of an integrated policy framework, as canvassed in the Issues Paper (Section 4).

2.2. **Case management and patient history**. Under current arrangements it appears there is little more than a "passing the baton" as patients move between different phases of care. A case management role is played sometimes by social workers, paramedical teams, GPs, psychiatrists, and even by volunteers working for community agencies; but the range of oversight and responsibility at any stage is incomplete and is not effectively communicated to patients or their carers.

A more comprehensive oversight function would cover – of course with the consent of the patient – all relevant doctors, hospitals, outpatient services, and the patient's life at home and in the workplace. For this purpose it would be useful to formally identify a single responsible individual or agency, especially in clinically difficult cases and where home support is inadequate. The role of the case manager would be to monitor the patient's welfare and circumstances over time, so as to develop a better understanding of the history of the case, better navigation of available clinical services, and more effective treatment and assistance for the patient.

Presumably many cases require no coordination at all, as illustrated by mental problems diagnosed by a GP or psychiatrist, and resolved through medication. Where the condition is less amenable to treatment, the intractability of the case may not be initially apparent, emerging only gradually as it becomes apparent that the illness is not yielding to treatment.

The challenge then is to design a case management framework that can accommodate all cases effectively and efficiently: it would be applied initially in response to a well-defined trigger (e.g. initial hospitalisation), and then adjusted in response to the patient's clinical and other circumstances. A particularly important function would be to ensure that decisions regarding treatment and discharge from hospital take full account of the patient's clinical history (see §4.2 below).

It is clear that the duties of a case manager may include both clinical overview and coordination of the contributions of various service providers. I suggest that these duties should be performed by a single individual, preferably a social worker or GP. This would allow clinical flexibility (e.g. in obtaining second opinions), and would facilitate the obtaining of other services (see §3 below). The case manager's authority must be clearly defined in relation to others with similar responsibilities (e.g. hospital social workers and outpatient support teams).

Whether or not a formal case-management role is adopted, there is a need for better continuity in all front-line roles (e.g. effective deputising whenever a social worker is unwell or goes on leave); and a more collegial relationship amongst all the professionals concerned (see also §3.2 below).

Related to the above, longitudinal research covering the trajectory of patients' welfare over all phases of their illness could yield insights that would be very valuable in further redesign or improvements to the system.

3. Clinical services

3.1. **Outpatient support**. There is a major gap in continuity of management of patients as they leave and enter hospital. An in-house social worker normally writes a discharge plan for the patient; once out, however, the patient is in uncertain hands of her family (if any), and of a team of people she has probably never met before, whose role she may not grasp clearly. And while it may be inevitable that the level of outpatient support is lower than what can be provided in hospital, it is not obvious why the two kinds of support should be fundamentally different.

For a better balance, I suggest that an effort should be made to ensure continuity in kind between in-hospital and outpatient services; for example, a uniform program of seminars or even group therapy might be available in both contexts, avoiding the need for patients to switch over on discharge or hospital entry. The transition could be improved also by instituting a hand-over conference with the outpatient team before release from hospital. Halfway houses are relevant here, as another way of smoothing the gap between hospital and home (see §4.2 below).

3.2. **Psychiatrists, in and out of hospital**. Another gap arises with respect to the roles of psychiatrists inside and outside hospital. As I understand it, once a patient is admitted to hospital, her referring psychiatrist (if any) is superseded by the in-house psychiatric team, who must then stand back again when she is discharged. This is in contrast with non-psychiatric medical services, where a private specialist normally continues to treat the patient when she enters hospital.

Perhaps that sort of continuity would not be practicable in psychiatric treatment. Even so, the sharpness of the divide between in-house and private specialist seems unfortunate. For one thing, it can be confusing to the patient; and for another, it discourages the sort of collaborative approach which surely is very important when it comes to mental health care and treatment.

3.3. **Psychiatry and other therapies**. A similar concern applies to relations between psychiatric and non-medical forms of treatment, notably those offered by clinical psychologists and psychotherapists. Out of about twelve psychiatrists whom I have met in recent years, most appear to have little knowledge of these other treatments, and rather than pursuing an integrated approach, tend to downplay their value. This is typified by slighting remarks such as "Yes, that might help – and you can get ten sessions free on Medicare". I suggest that this lack of guidance, and frequent scepticism, is unhelpful and unsatisfactory, given that the psychiatrist tends to be regarded by patients and carers as a clinical leader.

Talking therapies (psychoanalysis, psychodynamic therapy, etc.) are regarded by many psychologists and psychiatrists as ineffective, wasteful and even self-indulgent, by contrast with "evidence-based" therapies such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT). Indeed, clinical studies indicating the apparent effectiveness of CBT and DBT have won for them official approval in the form of coverage under Medicare. I would like to express here a little scepticism about some aspects of this situation.

First, in my observation, CBT and related therapies are often applied in a mechanical way, without apparent empathy, and without eliciting cooperation on the part of the patient. I note also that the efficacy of these therapies has been questioned (e.g. see Wikipedia article on CBT).

Second, I have observed that some experienced psychiatrists and clinical psychologists offer what is really a form of talking therapy (i.e. a régime they have developed themselves, or a recognized approach such as Conversational Therapy). My impression is that these doctors seek a more balanced understanding of their patients than some of their more conventional peers, whose medical preoccupation may risk ignoring important psychic aspects of a patient's condition.

Third, and related to the above, is that a talking therapy provided by a psychiatrist can attract Medicare or insurance benefits, unlike similar treatments such as psychodynamic therapy. I suggest that this ignores the possible contributions of practitioners with non-medical training, and involves a substantial inefficiency, in that that the fees charged by those practitioners are considerably less than those charged by psychiatrists.

A more efficient tableau of services could be conceived, involving recognition by Medicare and private insurers of the value of alternative therapies over the medium term, and with careful attention to issues of accreditation. Along with this, there would need to be a more widespread appreciation within the psychiatric profession of the value of those therapies in certain kinds of disorders, and the development of procedures for collaboration between alternative practitioners and others in the established mainstream.

4. Mental health in the community

4.1. **Suicide prevention**. A large amount of time is spent by social workers, nurses and other service providers, in and out of hospital, in checking for suicidal intent. An individual's repeated vocal assertion that she can't go on living obviously must not be ignored, yet the attention given to such an assertion distracts from any search for its cause, distorts the role of outpatient teams, and may lead to unnecessary hospitalisation. The problems here may include a lack of skill at helping a patient to calm down, and even evasion of professional responsibility.

The situation described above would be improved by better resourcing for outpatient teams, possibly including better training in the assessment and treatment of suicidality. In addition, costs might be reduced if private hospitals were no longer permitted to pass on suicidal or otherwise hard-to-manage cases to the public system.

4.2. **Discharge from hospital**. The policy imperative regarding return of patients from hospital to "the community" or "the family" may be justified by the need for patients to move back to a socially normal setting, resume employment, and otherwise get on with their lives. In my observation, this imperative seems to be underpinned by an ethic of "tough love" which favours throwing the patient in at the deep end, in the hope so as to help her avoid becoming too dependent on public care.

This attitude, and a desire for medical closure, can lead to unrealistic optimism attending the moment of discharge – the assumption that the patient will be in safe hands and that the danger of relapse is remote. A question that arises here concerns accountability for the discharge decision. If a patient is discharged from hospital only to show up again at the Emergency Department a few weeks later in an abject state, surely an error has been made? Are those responsible for discharge even aware that the discharge has failed in human terms?

I would go so far as to suggest that in some circumstances a hospital of some kind may really be the best place for a patient, who may be less competent than she thinks she is at managing on her own, and for whom a return home may be quite damaging to herself and her family. Impartial assessment of these factors by hospital staff is easily compromised by resourcing pressures, and by uncertainty over prospects for treatment (apparently in the absence of danger to the patient or others, hospitalisation requires a treatment plan with definite prospects of success). Patients themselves will often be anxious to return home, for reasons which may well be unrealistic (e.g. desire to resume the role of family carer, to resume employment, or to put a distance between themselves and the suffering which they may associate with their stay in hospital).

Short of a return to the old concept of the mental asylum as a place of long-term care, I suggest at least that more attention should be given to the design and provision of adequately resourced halfway house rehabilitation services.