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Dear Productivity Commission,

Please find comments from members of the Australian Medical Association (AMA) in response to your draft Inquiry into Mental Health.

These responses and comments are from individual AMA members (not the Association) and have been complied to respond to the relevant requests for additional information. The members comments have been de-identified on request.

Please contact me if I can be of further assistance or if you wish to discuss this information.

Yours sincerely

Simon Tatz
Director, Public Health
Australian Medical Association

Productivity Commission Inquiry into Mental Health

Request Responses January 2020

Info Request #	Request	Response
3.1	**Education activities that support mental health and wellbeing**	Education directed in the educational sphere concerning mental health would be best targeted at secondary students, but should be very pertinent to their own circumstances. Note that we do not agree with the suggested implementation of well-being officers in all levels of schooling unless there is a radical revamp in resourcing for Child and Adolescent Mental Health services. Otherwise, serious cases of mental ill-health will be discovered in large numbers by the well-being officers, and once again, as has occurred after previous inquiries, those cases will not be able to be adequately treated. The whole system then becomes counter-productive, and more complaints will occur about mental health. (The issue of serious case-identification in the absence of adequate psychiatric treatment resources.)
3.2	**Out-of-pocket costs for mental healthcare**	Availability of psychology appointments are the two key issues with current mental health care plans. There are not enough providers who bulk bill sessions under MHCP therefore patients are still significantly out of pocket for these sessions. In addition, wait times for psychologists are a significant barrier. The availability of psychiatrists for complex diagnosis or medication management is even more challenging for subacute patients. Patients wait up to 6 weeks for an urgent medication review in the public system. Funding is used for acute and very severe mental health patients, leaving support for GP's who manage subacute mental health with minimal access when needed. Out of pocket costs for psychiatrists are significant even with supported MBS item numbers.
		Cost to patients and their carers continue to rise especially in regional Australia. The group that continues to be disadvantaged are often lower income, health care card holders, children. These costs include - Out of pocket costs for GP consultations, most GPs will assist, however with the chronic underfunding of primary care some of these costs will be passed on to the patient - Out of pocket costs to psychology, anecdotally out of pocket costs for patients can be $100 and above. Similarly, 10

		psychology visits is not sufficient for many patients - Accessing psychiatric services in regional Australia is difficult, it is fortunate that telehealth item numbers are available, however this is not the case of psychology - Medications, there is an increased use/recommendation to utilise antipsychotics in mood disorders, given the significant price reductions, this is a good opportunity for PBAC to review these listings as they are off-patent. Whilst cost has reduced the difference between $7/month and $25/month for some common antipsychotics is significant and is the choice between psychology or medications.
		I do not know of any surveys but car expenses and public transport should be considered. MBS consultations are costing more as doctors expenses have increased but rebates have not increased for years.
		The key point here is the discrepancy between the CPI index and rebates under Medicare contributing the biggest proportion to out-of-pocket costs. The Productivity Commission should be extremely concerned about this because of the adverse effects this problem has on health behaviour of consumers. The second major problem concerning out-of-pocket costs is the situation for rural and remote consumers. Not only are there gross discrepancies between Medicare rebates and the CPI index over nearly 30 years now, but people in rural locations have significant extra expenses, such as travel costs and downtime from their occupations associated with that travel as well. The idea therefore of removing item 288 as an incentive to tele-psychiatry services is a severe error. The use of tele-health services should be encouraged not discouraged, as it makes a significant difference to out-of-pocket costs for travel, and due to the goodwill of existing private psychiatrists, has been providing an expert service to people who would not otherwise receive such services.
5.2	**Mental health treatment plans**	The paperwork is tedious and takes time away from managing the patient. Having a proforma or template is useless if the GP has done a thorough mental health consult. I agree with different MBS rebates for those that have trained vs those that have not. 10 sessions is plenty for some but not for others. A new plan every 12 months is a waste of MBS dollars. If we do an initial plan, then it would be ideal to keep reviewing multiple times with say 6 sessions per review (attracting a lower rebate) if we are treating the same problem. No need for a new plan with

		higher rebate. Allowing more sessions per calendar year would be useful.
		Mental Health Treatment Plans are a tool that does increase accountability for both patient and GP. However, patients who are pro-active at managing their mental health should not be disadvantaged at accessing Medicare Rebatable Psychology, especially if they don't meet the criteria for a DSM-V criterion for a mental illness. If patients accessed mental health services earlier, their potential cost to community will be significantly lower. A MHTP should not be mandatory to access Medicare subsidised psychology visits. Patients whom have obvious need to access psychology visits should not be mandated to return back to "complete a MHCP" to access psychology visits. A GP referral should be valid for a patient to access psychology visits. MHTP should continue to have the higher rebate, because it covers the time for non-face to face contact (in addition to the time spent in the consult) Follow up phone calls to patients, follow up calls to psychology.
		Additional threshold is whether consumer needs to be on medication and then whether psychological therapy is still necessary and which type of therapy is most appropriate. Consumers should continue to require a MHTP for therapy access if being referred by a GP. New clinical thresholds should be introduced on all points. Clinicians should be required to give consumers the complete and reviewed plan. GPs should continue to receive a higher rebate for MHTPs and MHTP reviews than for standard consultations.
		After a period of three months following a consumer receiving a mental health plan from a general practitioner, if the consumer is not significantly improving, and if extra psychological sessions are being considered, then the consumer should be properly psychiatrically assessed by a trained psychiatrist. Such a review may reveal extra nuances of complexity to the diagnosis and may discover better ways of managing that particular consumer. The psychiatrist could then agree with the general practitioner's view of adding more psychological sessions, or the psychiatrist may suggest other treatments be provided, or may suggest a change of the psychological therapy required for that patient.

		As private psychiatrists, we would welcome the development of general practitioners who undertake much more serious training in mental health treatment, under the supervision of psychiatrists, and preferably followed up in Balint-type groups, that include psychiatrists for ongoing supervision and training. Such groups could also be run via video conferencing services for rural and remote practitioners. The general practitioners that undertake greater training should be paid more as well as the psychiatrists who participate in such a scheme. Training of general practitioners should not be done in isolation from a psychiatrist led initiative. Otherwise, there will be more case identification of serious cases, and when the resources of treatment by the trained GPs has been exhausted, psychiatrists will be required to help them out more directly but may not be resourced to do so.
6.1	**Supported online treatment for culturally and linguistically diverse people.**	We need further information with regards to the definition of "Low Intensity Therapy Coach". With regards to utilisation of tax-funded treatment, this requires to be evidence based with appropriate qualifications. Greater funding needs to be placed in evidence based therapy.
		Information Request: Treatment is conducted better face to face with an interpreter. Online should only be used for those geographically isolated. Supported online treatment cost is effective if person not in a city or town. Constraints to be considered are appropriate…. Language or cultural group to be the focus either Chinese speaking or Arabic speaking etc.
		We agree with this initiative, but suggest that significant psychiatric expertise be obtained, particularly from institutes of transcultural psychiatry.
5.1	**Low-intensity**	New MBS item – changes to MBS item for Psychiatrists to provide "over the phone" advice to GP's for diagnosis and treatment

	therapy coaches as an alternative to psychological therapists.	for a patient who is being managed by a GP.
		Low intensity therapy coaches: Their use depends on their level of training and/or experience. What level of involvement would they have?
		We believe that this is not a good idea. The training of low intensity therapy coaches is not specified sufficiently and is likely to potentially cause harm to consumers. One presumes that such coaches would work under the supervision of a medical practitioner, but if the general practitioner is to be that supervising specialty of the practitioner, then such coaches should only be allowed to treat mild forms of anxiety and depression.
11.1	**Aboriginal and Torres Strait Islander health workers**	We agree with this initiative and suggest that such training should involve significant input by psychiatrists in particular. The involvement of psychiatrists would be beneficial for both sides in this process.
14.1	**Individual placement and support expansion options.**	**YES**, direct employment of IPS employment specialists by State and Territory Government community mental health services. This cold be supported by additional Australian government funding. **NO,** a new Australian Government-administered contract for IPS providers, based on fee or service compensation and subject to strict adherence to the IPS model (including that a partnership is in place with a Sate and Territory Government community mental health service).
		We would support the idea of trialling the two different models suggested in a number of locations as pilot programs in the first

		instance. Such programs should be intensively followed up for outcomes, both in mental health terms and employment terms. Such follow-up should be long-term over a period of five years. Only after those pilot trials have completed a term of 2 to 3 years with clear results, should either model be implemented more widely.
14.2	**Incentives for DSP recipients to work.**	Both of these appear appropriate. Currently there is a motivation from patients to access DSP. If there is any additional motivation to keep patients in the workplace, this will improve productivity and mental health. This brings up the other issue of many patients being on "New start". It is not clear, but whether the Productivity Commission has done the economics of costs of administering social security v a universal income?
		YES agreed: increasing the income threshold at which recipients begin to lose their payments and the value of the taper rate after that threshold **NO disagree:** increasing the weekly hour limit above which no DSP is payable from 30 hours to 38 hours (ordinary full time hours of work), but retaining the requirement that a person will lose eligibility for the DSP if they work for more than 30 hours per week for more than two years. This would motivate more people to seek work if physically and psychiatrically well enough.
		We would support the idea of trialling the two different models suggested in a number of locations as pilot programs in the first instance. Such programs should be intensively followed up for outcomes, both in mental health terms and employment terms. Such follow-up should be long-term over a period of five years. Only after those pilot trials have completed a term of 2 to 3 years with clear results, should either model be implemented more widely.
16.1	**Transition support for those with**	Would be of definite benefit. The extent depends on the severity of the condition and their receiving appropriate treatment.

	mental illness released from correctional facilities.	
		We agree with this suggestion but note the need to develop expertise in this area to a greater degree, and to involve psychiatric assessment as part of this process.
16.2	**Appropriate treatment for forensic patients**	There would be definite benefits.
		We strongly support this initiative.
17.1	**Funding the employment of wellbeing leaders in schools.**	As per "Low Intensity Therapy Coach" there are concerns with regards to this proposal on paper. We need further information with regards to the definition of "Well Being Leading". With regards to utilisation of tax-funded treatment, this requires to be evidence based with appropriate qualifications. • Greater funding needs to be placed in evidence based therapy
		I It has been suggested that it was better to have school psychologists funded for counselling services. Also, school wellbeing leaders should be for all students, every student, every day.
		We see a very major problem with this initiative, in that it is likely to identify many more cases of serious mental illness in children of school age, but unless child and adolescent mental health services are massively improved and resourced to a greater extent, then the identified cases will not be able to be treated. This will be a recipe for disillusion and complaint.

		We also note that the emphasis on generational reform involving younger people in a preventive approach is very important, but the age group that needs to be targeted is the ages between zero and five years old. Such involvement could still involve a large expansion of child and adolescent mental health services, but in the early age groups, the psychiatrist would liaise with a broad multidisciplinary team where social interventions and educational interventions for parents in particular, would be a major part of the initiative. The guidance of psychiatrists is vital in this process for accurate diagnosis and targeting of therapeutic implementation. But many other mental health workers will be needed as part of the teams involved. School mental health well-being does not need to be neglected. We would suggest that in each educational district there be at least two well-being leaders at the district level. One of the key tasks of those people would be to identify difficult cases and seek guidance from expert psychiatrists in child and adolescent mental health services. Their role would also be to document difficult cases identified, and document whether those cases were adequately dealt with by the child and that adolescent mental health services. As a result, those well-being officers would be able to provide feedback to the systems in the States and Territories, as to whether child and adolescent services had been expanded and upgraded to the required extent.
18.1	**Greater use of online services.**	Online services will be beneficial provided they are evidenced based, culturally appropriate.
		These should be freely available to all tertiary institutions and their student populations.
		We do not disagree with the greater use of online services, but such services in tertiary institutions should be combined with a mental health worker-based service, that is easily accessible. Once again, more severe cases are likely to be identified, and if there is no adequate treatment available for those cases, then disillusionment and complaint will result.
18.2	**What type of level of training should be provided to**	Potentially mandating mental health education to students into curriculum. Basic level of training to educations, especially recognition of struggling students

	educators?	
		The Zolay mental health first aid course.
		There should be a well thought out planning process which would bring together educators who could express their own needs in the mental health sphere, together with other mental health professionals, but including child and adolescent specialist psychiatrists, so that the type and level of training can be clearly delineated.
18.3	**International students access to mental health services.**	International students requiring suitable health insurance to cover both psychological and physical injury.
		They are currently assessed by student medical services and referred to private psychiatrists. However, everyone needs to be aware of the cultural stigma in some cultures.
		We agree that these individuals require much more seamless access to mental health services, and these people often suffer from increased levels of mental health distress. We agree with the methods suggested by the Commission.
19.1	**How should the treatment be funded?**	This is a multifaceted issue. Workers compensation claims need to have a maximum time to determine liability of claim. Greatest stressor for patient is often the delay of decision. Government can fund initially as per limits of Medicare, however extensions beyond this one would hope a decision has been made.
		Through Medicare with subsequent reimbursement of the government by insurance agencies.

		We believe that if a worker has been off work for three months for a mental health condition, and has not had a psychiatric assessment, then this should be required. The psychiatrist's assessment should nominate the time that treatment may be required, and this treatment time may be for more than six months.
19.2	**Personal care days for mental health.**	Personal leave (sick, carers, parental) can be taken without the need for medical certificate / evidence. Employees should not be required to differentiate and advise why the leave is required. If an employee utilises all their personal leave, they can choose to go on leave without pay or their annual leave. The need to "get a note from your doctor" is a huge cost to society.
		YES agreed: designating a number of days of existing personal leave as 'personal care' to enable employees to take time off without medical evidence to attend to their personal care and wellbeing improve workplace mental health and information on absenteeism due to mental ill-health. A certificate from their general practitioner, psychiatrist or other health worker would make this provision effective.
		We would disagree with this initiative. If there is a suggestion of introducing personal care days as part of some type of leave allocation, then this should not be restricted to mental health alone but should be provided for any type of health concern. There is a risk if we make too many rules which favour people with mental health conditions, then increased stigma and problems may occur in the community as a result. We would also note that people who need to take time off for health conditions should be required to obtain a medical certificate from a doctor, not any other health professional. That way, people will need to see their general practitioner, and are more likely to receive treatments or counselling that actually alleviates the problem and is likely to prevent it from recurring.

19.3	**Barriers to purchasing income protection insurance.**	We do not disagree with the possibility of employers being able to purchase income protection insurance for employees on a wholesale basis, but that this should not be an excuse for poor mental health conditions in the workplace. There would need to be a careful oversight of any such programmes, to ensure that this system was not having perverse outcomes.
22.1	**Governance arrangements for NMHC.**	They should use consultants and experts in various areas. They also need to make sure the quality of the research meets guidelines.
		As expressed previously, we have difficulties with the concept of governance being satisfied in some way by nominating a management entity supposedly in charge of a mental health system. There are already governmental authorities supposedly in charge of State and Territory systems, and under their stewardship, mental health services appear to have deteriorated. We have no greater confidence in the National Mental Health Commission. In particular, the National Mental Health Commission has failed to listen to inputs coming quite strongly from the private mental health sector. The reasons that the Commission has not listened are quite unclear to us. If the National Mental Health Commission is to continue to exist in the future, then it must have meaningful membership on its Board and in its advisory channels, from the private mental health sector, particularly including private psychiatrists. The continuing neglect of the sector that treats half of the seriously mentally ill by the National Mental Health Commission should not be allowed to continue.
23.1	**Architecture of the future mental health system.**	The current model of PHN funding is some regions is not ideal. There is often no transparency and accountability with regards to outcomes of programs. This is evidenced by Stepped Care of Mental Health - GPs have difficulty referring to the service - No data on outcomes - Produced fragmentation of care Recommendation

		- Mandate – measurable outcomes - Localise the program, i.e. a metropolitan program will not work in regional Australia
		Where does private psychiatry fit in and why is it never mentioned when it treats 50-60% of the mentally ill?
		We have already emphasised that we believe that the Productivity Commission should recommend a renovate and rebuild model. The rebuilding should occur for a State and Territory Government funded services and should draw on the successful capacities shown by the private mental health sector, led by private psychiatrists. That way, State and Territory mental health services are likely to show greater effectiveness and greater cost effectiveness. Renovation of the Medicare system as a whole is highly recommended by our group. Such renovation will not be cheap and should not be confined just to mental health Medicare rebates. At least some psychologists should remain under Medicare funding, but those psychologists should show a willingness and capacity to be able to work in the community together with private psychiatrists. At this stage, that group of psychologists is quite small in numbers. Private psychiatrists would also like to work together with community-based mental health nurses on a much wider scale. Previous mental health nurse initiatives have largely excluded the private psychiatric sector in terms of developing models that would work together with a private psychiatry business model. Consultation about this could achieve rapid results quite quickly.
24.1	**Regional funding pools.**	**See 22.1**
		We see great problems with the regional funding pools suggested. At this stage it is suggested that these should only apply to Allied mental health care, provided under Medicare rebates. However, we can see such ideas being extended to actual medical Medicare rebates. Doing so would be disastrous for health care in general, and mental health care in particular. We believe that this suggested initiative should be very carefully re-examined, and consultation should occur with our group, in order to see whether there are any possible compromise solutions. One major problem with the production of such funding pools, is the possibility that psychologists and mental health nurses will not be readily available to the private sector in the community. That would see a further deterioration of the present situation. It would limit the effectiveness of private psychiatrists in their roles in the community, and would decrease services for consumers, rather than improving them.

25.1	**Under-utilised datasets.**	The Productivity Commission has not appeared to have identified the full extent of difficulties in underutilised data. Before new outcome measures and quantitative monitoring programs are suggested, we would strongly support the idea of actually using the data that is already available. We note as a starting point, that there is still no exact number for consumers treated in the public system in Australia. On the contrary, there is an exact number of Australians being treated by the private sector which is well known and has been documented for years. This problem should immediately be corrected, but we would suggest that the numbers so identified should have an indication of how many consumers have been assessed properly by a psychiatrist in the public sector. This may reveal some very interesting information about effectiveness and productivity. There is an ongoing collection of data from the private sector which is now more than 15 years old, and has been collected at a level of response of 80 to 90% during that time. Extremely valuable information could be extracted from that data, if resources were devoted to research to be able to analyse the data in more detail. We believe that there has been a study conducted by Queensland Mental Health approximately 5 years ago, which showed the differential suicide rates of the public sector and the private sector. We believe that information should be published and available to Australians, so that we can get some idea about suicide risk in the different sectors. We also suggest that in the upcoming National Mental Health and Well-being Survey, specific questions are included to be able to differentiate the degree of overlap between the public and the private specialist mental health services. This would provide very valuable information for overall Australian mental health care planning. These issues as listed above are crucial before further extension of data collection is envisaged.
25.2	**Proposed indicators to monitor progress against contributing**	As previously mentioned, including in the last item, we believe that no additional indicators should be considered until the existing information and indicators are properly assessed and fully researched. It would seem pointless to add further additional indicators, if they are also to be inadequately evaluated or researched.

	life outcomes.	
25.3	**Data sharing mechanisms to support monitoring.**	Formal mechanisms would definitely be required. Mechanisms would need all staff to record all contacts.
		Given the significant privacy concerns revealed regularly from both Australian and international Government sources, we would urge caution in expanding data sharing mechanisms beyond the sort of mechanisms that already exist. In the last 10 years, significant expansion of the possibility of sharing information has been undertaken at the national level. We suggest a further 10 years is required to make sure that that data can be held safely and securely to protect privacy, but also so that the information that is being collected can be proven to actually be evaluated usefully, and in ways that benefit the Australian population. We believe there is very little evidence of this latter useful use of already existing data that has been shared.

Additional Comments

Subject	Response
1. Overview of economic perspectives on mental health	The Productivity Commission's draft report highlights the economic cost of mental health problems, while also demonstrating the benefits and risks of an economic approach to mental healthcare in Australia. Some of the broader systemic recommendations are uncontroversial such as the need for stepped care, coordinated crisis management and the important role of welfare, housing and the workplace in improving mental health. However, there are several major areas of concern, particularly for public mental healthcare, three of which we highlight here. One is a disproportionate emphasis on prevention and intervention in the early years of life for strategies where evidence for effectiveness is limited. The other is the introduction of market-based approaches such as shadow billing or a commissioner/ provider split to the funding of mental health services across Australia. Similar arrangements have been either unevaluated or abandoned in other jurisdictions. Among the numerous problems of such market-driven approaches are the increased costs of additional bureaucracy and the lack of commissioner expertise in planning services or evidence-based practice. Although there is a need for effective reform of governance, this should be achieved without increasing administrative complexity. As the Report is the latest in over 30 years of review of mental healthcare in Australia without effective reform, we ask when will significant improvements in mental healthcare occur? **Introduction:** In 2018, the Australian Government instructed the Productivity Commission (hereinafter the Commission) to examine the effect of mental health on economic participation and productivity. The Commission is an independent

governmental advisory body for a range of economic, social and environmental issues in the country. The draft mental health report (hereinafter, the Report) was released for comment in November 2019, with recommendations to be finalised six months later (Productivity Commission, 2019).

The Report identified that mental illness and suicide cost Australia an estimated $500 million a day, and up to $180 billion a year. The Commission documented long-standing systemic problems including under-investment in prevention programs, an over-reliance on clinical services, difficulties in accessing support, and a lack of clarity between governments about their roles and responsibilities. As a result, the Commission recommended major reforms that appropriately extended beyond health, to address social determinants of mental health including welfare, schools, workplaces, housing and criminal justice.

The Report strongly emphasises prevention and early intervention (Productivity Commission, 2019). For instance, the Commission proposes that existing physical examinations of infants be expanded to include social and emotional wellbeing checks, as well as the appointment of a full-time teacher for "mental health and wellbeing" in every school at a cost of almost $1b a year. However, the evidence of efficacy of prevention and intervention, while promising, appears to be lacking, especially with respect to the characteristics of effective interventions applicable to different age groups.

The Report advocates a system of “stepped care” of five levels (Productivity Commission, 2019). These range from resources for self-management, that might be used by approximately a quarter of the population, through treatment in primary care or online, then Medicare-funded psychological services, and next to high-intensity care primarily delivered¬ by a psychiatrist. The report highlights the dilemma of the “missing middle”; those who don’t need inpatient care but are unable to access private psychiatric care because of cost or unavailability. At the highest level is complex care with a mix of inpatient services and case management in the community.

Perhaps the assumptions that frame the Report indicate both benefits and risks. The focus of the Productivity Commission is through: “the lens of participation and contribution … how people with or at-risk of mental ill-health can be enabled to reach their potential in life, have purpose and meaning, and contribute to the lives of others.” (Overview, p. 4, Productivity Commission, 2019). The emphases on participation and contribution are arguably founded on economic principles of utility and value, and therefore, self-admittedly determine the scope and nature of the Commission’s recommendations, which we believe are flawed in some areas. While some of the recommendations do address important social determinants of mental health by more successfully broadening the view to systemic issues, a few raise considerable concern for effective mental healthcare, which we discuss here.

The benefits: mental health care extends beyond specialist psychiatric services: Some of the recommendations are uncontroversial. For instance, one recommendation is to lessen demand on emergency departments by better integration of after-hours and mobile crisis services, as well as formalising follow-up after suicide attempts. Another is to highlight the role that welfare, housing and the workplace can play in improving mental health. For instance, the Commonwealth government could broaden the requirements for both the Carer Allowance and Carer Payment and increase funding for State and Territory government-provided housing and homelessness services. In addition, the National Disability Insurance Agency should include

	those with psychosocial disability when funding supported accommodation. Given recent debates on the efficacy of Headspace, we welcome the recommendation that the Department of Health should cease directing agencies such as Primary Health Networks (PHNs) to fund Headspace centres or other specific service providers (Looi et al., 2019). Rather, they should have the discretion to redirect funds to areas they feel better meet the needs of their local areas. The Report discusses in detail some of the failings of Better Access while (oddly) simultaneously recommending that funded sessions be increased in some cases. However, there are at least two major areas of concern, particularly for public mental health services, which in part arise from the economic focus inherent in the Report. **The risks: a disproportionate emphasis on the early years of life** The Report falls into the familiar refrain that mental illness is a young person's condition, when illness occurs across the lifespan. Through a strictly economic lens, this could be understood as maximising the utility of life through early prevention, although the reality is more complex. The Report cites 15 year-old data from the United States indicating that one half of those who develop mental illness experience mental illness before the age of 14 years, and 75% by the age 24 years (Kessler et al., 2005). However, this information was based on a retrospective survey of adults including seniors and so is particularly vulnerable to recall bias. Moreover, although the median age of onset for anxiety and impulse-control disorders was 11 years old, it was 30 years for mood disorders. More recent prospective data cited by the Commission show that much of the increased prevalence in younger ages is due to substance use disorders, not anxiety, depression or psychosis (Productivity Commission, 2019). This is mirrored by other data that show that many new cases of schizophrenia occur after the age of 25 (Allison, et al., 2019), as well as service use data from the Australian institute of Health and Welfare (Figure 1) (Australian Institute of Health and Welfare, 2016). As a result of this focus, there is a strong emphasis on interventions that are directed at children and youth even though the report presents very limited evidence of effectiveness for its recommendations 17.1-17.6 (Productivity Commission, 2019). These includes the expensive checks of infant social and emotional wellbeing covered previously. Often mentioned is the need for more data, or the fact that there have been inadequate resources for evaluation in the past (Productivity Commission, 2019). The focus on children and youth mental health may potentially detract from appropriate attention to mature and older adult mental health, especially in light of the preliminary findings on mental health in the Aged Care Royal Commission (Royal Commission into Aged Care Quality and Safety, 2019). **Further risks: Unproven market-based funding models** The second major area of concern is a proposal for market-driven “pooled funding” to address the current division of financial responsibilities between Commonwealth and State/Territory governments (Recommendations 23.1-23.3; 24.1-24.2, Productivity Commission, 2019). However, the problems with disorganisation and inefficiencies of existing public mental health services are not merely economic, they relate to specific governance, policy, planning, implementation and lack of evaluation of service provision. For example, the Report recommends that the Commonwealth, States and Territories identify and pool their resources to improve access to a wider range of services such as social workers, occupational therapists, mental health nurses and counsellors. The level of these 'pooled' funds would be linked to existing MBS rebate data for allied health professionals, which

could perpetuate existing inequities in under-serviced areas, but not GPs or private psychiatrists.

The Report proposes two market-driven options. One is the Renovate Model. Agencies such as PHNs would have greater flexibility in funding services, including employment and psychosocial supports outside of the NDIS, while public hospital and community mental health services would remain the responsibility of State and Territory Governments. However a major change would be to extend activity-based funding to community-based services as the Commission asserts that the current system is inefficient. This is on the basis of a single guestimate from unpublished data that only 29% of clinical staff time was spent on activities related to people with mental illness in community mental healthcare services across Australia — 21% with the individual present and 8% without them present (Productivity Commission, 2019). If true, this is certainly of concern, but much depends on how this is defined. The report is inconsistent – in one sentence relevant activities include face to face care, writing notes, individual care planning and liaison, while in another this is restricted to only face-to face contact, to the exclusion of even telephone calls. Following the admission that no adequate activity-based funding classification for community care exists, it advocates the market-driven solution of shadow-billing based on an unevaluated model from Victoria. By this approach, the Commission clings to a rather dated concept of individual clinician-based treatment, rather than multi-disciplinary care, so that only face to face time is billed at the full rate. The Commission fails to consider that multidisciplinary care also involves collaboration with other agencies, travelling to meet people in their homes, contacting them by phone etc. It is not a model where a clinician sits in their office and "bills" Medicare for appointments. Shadow billing for a limited range of services also does take into account that specialist mental health services also have responsibilities for teaching and research.

The second option is the Rebuild model where federal and state funding for all mental healthcare (inpatient and community care), as well as psychosocial and carer supports, would be administered by Regional Commissioning Authorities (RCAs). This would include funds currently channeled through PHNs, or other routes, with the exception of NDIS funding. RCAs would then buy, or commission, all services in the geographical area, for which they were responsible. This proposal vastly expands the very limited role that PHNs currently play, given that practically all mental health care would be included. Disappointingly, the Commission makes no recommendations on the precise number of required beds in spite of persistent concerns about the safety of current provision, leaving this to local commissioners.

The overall proposal to introduce a commissioner/provider split to the funding of virtually all of mental health services across Australia is deeply concerning, and risks repeating the errors already made in other jurisdictions of re-disorganisation. In the United Kingdom, a similar approach merely added a further bureaucratic layer of unclear utility in the planning of mental health services. Among the numerous issues were increased administrative costs and the lack of expertise in planning services or evidence-based practice (Health Care Commissioning, 2018), especially in areas of specialisation such as eating disorder. Commissioning was also difficult because of the complex nature of healthcare and further limited by the scarcity of relevant technical and managerial skills, as well as information asymmetries between commissioners and providers (Health Care Commissioning, 2018). In particular, commissioners lacked capacity and capability in needs assessment, risk profiling and budget management (Health Care Commissioning, 2018; Miller & Rees, 2014). The concept failed to gain legitimacy in the eyes of the public. Transactional problems included keeping to agreed deadlines for tenders, maintaining records and paying bills (Miller & Rees, 2014). There have also been concerns that outcomes set by commissioners/ purchasers did not fully reflect the clinical work

	that was being done (Ritz, 2014). Furthermore, consultation-liaison services often faced uncertainty as it was unclear whether funding should come from mental health services or the general hospital where they were located. Following Scottish and Welsh devolution, both countries abolished the commissioner/provider split in 2009 and reintroduced integrated health boards responsible for both planning and running services within defined geographical areas (Health Care Commissioning, 2018). The report fails to consider any of these issues; indeed it does not even mention what size of population the proposed RCAs would cover. Finally, the issue of proposed RCAs leads into the Report's recommendations on governance of mental health services (Recommendations 22.1-22.2; Productivity Commission, 2019). While we agree that a whole-of-government strategy to mental healthcare is necessary, it is important that governance reforms do not introduce further layers of administrative complexity (e.g. RCAs etc.) and thus detract from effective implementation of needed reforms. **Conclusions** The Commission's Draft Report follows a series of reviews, inquiries and similar processes that are short on evidence but long on radical ideas based on unclear evidence. Indeed, some of the recommendations on mental health services echo those from the National Mental Health Commission's 2014 Review that thankfully were never implemented (National Mental Health Commission, 2014; Kisely, 2016). Mental health deserves better than serving as a laboratory for the latest '*idée de jour'*. The Report may not only be an opportunity, but potentially a threat unless recommendations are subject to sustained critical review of the policy and practical implications.
2.	With my population health lens I would suggest some research into root cause of mental health issues in workplaces and young people particularly. Prevention is almost always less costly than cure in almost any health matter once causation /risk factors are established. This is true from infections to road trauma to natural disasters where there are known risk multipliers and risk mitigators pre, during and post event.
3.	Beyond Blue has identified that a significant number of people who successfully complete suicide has sought medical (e.g. hospital based emergency medical) care in the weeks prior. I wonder if consideration might be given to piloting/funding a risk assessment tool with evidenced based triage and interventions. This was being put into use in London a decade ago. I am not sure re coaching evidence but will ask around.