OVERSERVICING IN PSYCHIATRY

This material is submitted on the basis that while the submission itself can be placed on the Commission's website, my name will not be made available to the public.

This is a brief summary of a complex matter that has been going on for years. I have a wealth of detail, including extensive material released under Freedom of Information, to justify every claim made in this submission and much more. As submissions to the Enquiry are not privileged, and I am not prepared to risk reprisals from the unnamed psychiatrists whose activities are exposed in this submission, this material is provided in anonymous format. It would most definitely be in the interest of the Commission of Enquiry if I could give evidence in person.

A word of warning: On the very few occasions I have tried to describe this to non-psychiatrists, they have completely failed to understand what it is about.

BACKGROUND:

Since graduating as a psychiatrist, I have worked in a variety of settings, in public and in private practice, in regional and in major urban centres, in Australia and overseas. Over the years, I have published a number of research papers and a monograph, as well as presenting original papers on my particular field of interest at international conferences. As part of my practice, more or less since I graduated, I have worked closely with a particular population of mentally-disturbed people and have contracted with a number of government departments and agencies to provide specific psychiatric services to their clientele. For a variety of reasons, the departments see their main service in the field of mental health as the provision of psychological and associated services. The psychiatric needs of this group are seen as an adjunct to or branch of the medical services, and are largely privatised.

This particular branch of psychiatry is both complex and heavily regulated, and is therefore not popular with mainstream psychiatrists. It is seen as very restrictive, the patients are often seen as difficult and demanding, potentially dangerous and, it has to be said, all too often as ungrateful. For ease of accounting, government departments require the accounts to show specific items, starting with the Medicare Medical Benefits Schedule. Every approved treatment gets an item number so, as long as the account shows approved item numbers, it will be paid without delay. By way of compensation, the funding agencies have set their fees at a higher rate than Medicare. As long as the psychiatrist charges according to the approved schedule, their total fees are never questioned.

If a psychiatrist says the patient should be admitted to hospital, or should have certain medication or a particular form of management, a CT scan or expensive drug screens, the department pays without demur. Essentially, the metric used to ascertain quality of service is money spent. That is, quantity replaces quality yet, as long as it doesn't make headlines, everybody from the minister down is happy, not least because nobody in the government knows anything about psychiatry. Even the psychologists tend to avoid anything that could be seen as intruding on the area of psychiatry (possibly because they don't want psychiatrists intruding on theirs). Thus we find that patients in this subpopulation are prescribed drugs at much higher rates than the general population, are admitted to hospital more often, for longer, and receive additional treatments such as CBT or ECT at higher rates than expected.

Compounding the matter, the private hospitals offer extra services, mostly run as day-, week- or month-long courses addressing a specific issue. For example, there may be a course run for people

named as victims of sexual abuse, or another directed at the spouses or children of the patient population. Courses have to be approved but, once registered on the schedule, it is a matter entirely for the treating psychiatrist whether the patients or their families attend. As long as the forms are completed and the course is approved, no questions will be asked. This is true of courses consisting, for example, of twenty days of six hours each, costing from $20,000 per attendee. Thus, a course with say eight people would yield the organisers at least $1300 per hour, possibly a lot more.

Clearly, the scope for the elegantly simple subterfuge of over-servicing, of doing something which looks impressive on paper but which will not alter the outcome, is limitless. All the hospitals need do is find a course or treatment that has been used elsewhere and they know it will be approved, e.g. ketamine infusions for chronic pain and for chronic depression. Once approved in one hospital, it will immediately spread to all others and quickly become cemented in the list of "standard psychiatric procedures." I cannot recall an approved treatment being deleted from the schedule. At the same time, the departments involved have no idea what happens in the clinic, and have even less interest because their main concern is to be able to say they are providing the best service for their charges.

MY EXPERIENCE:

In 2015, for family reasons, I moved back to the capital city and opened a private practice. As soon as practicable, I contacted the relevant government departments in order to start providing psychiatric services but there had been some changes. All medical services had been centralised under a single department, which had established its own medical section to provide general practice to its clientele. Specialist services, including psychiatry, were entirely privatised. Much later, I learned they had established a part-time post of supervising psychiatrist to oversee all psychiatric matters, and a well-known administrative psychiatrist had been appointed (even though I have the qualifications, the experience and the seniority, had I known of the job, I would not have applied as I have no interest in administration).

One other change was that all specialists were required to sign a contract such as meeting this or that standard, or providing reports in a particular format, etc. That is, medical specialists were now individual private contractors, and received a contractor's code number (same as tradesmen had always done). None of this was new to me, or unexpected, and I signed my contract after only a cursory glance.

As I was known by some of the GPs working in the department, I soon started to receive referrals. For the financial year 2015-16, I took 127 referrals, increasing the following year to about 185. These came from about fifty general practitioners and other specialists who were affiliated with the department throughout the state, either as employees or as contractors. It will be understood that this is a lot of referrals for an individual psychiatrist to receive in one year, and it was clearly the great bulk of the department's referrals in the state. Most psychiatrists do not manage these sorts of numbers, especially when each referral required a lengthy (2000 word) report to full forensic standard.

The reason I was so favoured by the GPs was that I knew the field very well, I understood just what the department required and, from long experience, I could quickly write a report which meshed directly into their unique administrative requirements. I also provided a very prompt service, seeing all of their referrals within the week, sometimes even on the same day, with the report on the referring doctor's screen when he or she logged in next morning. Several times, such as over the Christmas break, it was quicker for me to drive to one or other centre to see the patient rather than wait for the

logistical processes of obtaining orders to move the patient, bring in escorts on overtime, etc. I know that the harrassed administrators were singularly grateful for this, even though it hardly impacted on my day at all and I enjoyed the hour or two of driving through the peaceful countryside (I don't charge travelling time, which probably also contributed to the flow of referrals).

My costs were very low: over those two years, the average *total* cost to the department over about 312 cases was $1012.00 per patient. Bearing in mind that a day in hospital costs about $1500.00 plus the psychiatrist's fees, plus the many extras, and that admission to hospital for a course of twelve ECT costs about $57,000, my patients were getting the same outcome at barely a tenth of the average cost, weeks or even months sooner. Essentially, this is what private enterprise is all about: you provide the best service, you will get all the work.

On a particular date in 2017, my contract with this department was terminated. There was no warning, no audit and no reason given - and, I soon found out, under the new contract I had signed, no redress.

That day, I rang the senior administrator to see what was happening but was told the instructions had come from the department and she was not at liberty to release any information whatsoever. Four weeks later, I lodged a lengthy application under the relevant freedom of information legislation (FOI) to try to discover why I had been excluded from a field I enjoy, and in which I was led to believe I was providing an unrivalled service. Over the next five months, the FOI application went back and forth several times as the department attempted to avoid releasing any information. Finally, five months to the day after I submitted my application, I received 103 pages of heavily redacted material relating to my appointment and my termination. Some pages were completely blank.

The decidedly unpleasant task of sorting all the material into chronological order, and setting up a flow-chart of the posts mentioned, took several weeks. Bearing in mind that I regularly dealt with and spoke to about fifty medical practitioners employed by or contracted to the department, only one was involved in ending my contract. This was the chief medical officer in the department, whom I had met twice and spoken to by phone another two times. I was aware that he didn't refer many cases to me but I wasn't much concerned as I knew his patient load was quite small. In addition, twenty-three non-medical public servants were named and their posts given. The administration of the department is distant from the workplace so, as a specialist, I had never had to deal with them. My reports were directed to the referring GPs, who then dealt with the department themselves, so I had never met or heard of any of the two dozen people who played a part in my termination. In particular, in the two years, I had never once met the supervising psychiatrist nor had any correspondence in any form. In fact, I didn't even know his name at the time.

It soon became clear that at every point in the FOI material where one would expect the supervising psychiatrist to be mentioned by name or by the position, there was a note: "Redacted, S.X (y, z)" (under the Act, a name can be redacted if revealing it would place the person "at risk"). That is to say, the very serious matter of terminating a senior specialist psychiatrist's appointment, without an audit, without providing reasons and without referring it to the Medical Board, apparently took place without the involvement or, indeed, knowledge of the supervising psychiatrist.

Based on the FOI material, my reconstruction is as follows:

July 1st 2015: Commenced taking referrals from the department.

Late 2016: A group of psychiatrists from a named private hospital contacted the department, claiming they were unhappy about some of my published work (I know of these people but have never met

any of them). The background is that these psychiatrists and their private hospital had previously been taking a large number of referrals, providing treatment at an average cost of somewhere between $5,000-10,000 per patient, not including the many courses they ran each year (they do not release their figures). This meant they were taking at least $1million a year, probably a great deal more.
Shortly after, a senior administrative officer (AO.K) met them and read some of the material they claimed they didn't like. He then sent a report to the redacted person, asking for a response "in your role as a senior consultant psychiatrist." There is only one person in the department who could be thus addressed. Without seeing any of my publications himself, the unnamed person responded that my published opinions were not suitable for a psychiatrist contracted to or associated with the department. Some time later, an email from the CEO of the medical service to the unnamed person and to AO.K stated that there were no clinical grounds to terminate my contract. Presumably, all contact between the CEO and the other staff between those two times had been by phone or in person. Thereafter, the matter went quiet for some months.

Early 2017: Without knowing any of this, I approached the department with a proposition. I was interested in setting up a service to provide 24hr psychiatric cover for all their clientele in the state, in return for which they would need to send me all their referrals. I guaranteed it would not cost any more than they were spending at the time and probably very much less, and they would get a much quicker and more effective response to referrals. In particular, they would have full cover after hours and on weekends and public holidays, and would no longer have to send patients to the public hospitals, which required special escorts, approvals etc.

Four weeks later: I met the deputy to AO.K, call her AO.L, and handed over a two page outline of the proposed service. AO.L was polite but manifestly completely disinterested. She said she would take the submission to AO.K and, without asking any questions or even accepting the offer of a cup of tea, left my office.

One month later, 2017: The next contact I had with the department was the notice of termination of my contract.

I have since learned that the psychiatrists at the named private hospital were on very close terms with the supervising psychiatrist, and had set up their programs in accordance with his particular views on mental disorder. In brief, he was strongly in favour of sending the great bulk of patients to hospital where they would be prescribed heavy doses of drugs and ECT. After some weeks or months in hospital, they would be discharged but this was just the first step on the well-known path through the "revolving door" of the mental hospitals.

Following my arrival in the city, it took the group of psychiatrists some time to realise they weren't getting any new referrals. They then spoke to the senior medical officer, who told them where the referrals were going. He suggested they speak to the supervising psychiatrist, or they did it themselves as they apparently met him fairly regularly when he visited to see if their facilities satisfied his guidelines. The psychiatrist directed AO.K to meet the private psychiatrists and find some reason to end my contract. It should be understood that the supervising psychiatrist never once contacted me nor, at that stage, did I know he existed.

Thus armed, the psychiatrist and AO.K approached the CEO to say I should be dismissed as I did not meet the psychiatrist's "clinical standards" (meaning I didn't admit people to his friends' hospitals or prescribe the drugs he thought patients should get). They were rebuffed, so they did nothing until they heard of my proposal to take all referrals and, thereby, to exclude the private psychiatrists and their hospitals. They had to do something because if the department heard that I could provide a better

service at only 10-20% of the rates charged by their friends, that would be the end of their friendly arrangement. In a panic, they checked with the department's legal officers who had written the contract and learned that they didn't need to give a reason for terminating my services. Somehow, they managed to convince the CEO and the permanent head of the department that this should happen but there is no correspondence. I expect that it was all done by telephone and by informal meetings. As it happens, I know just what was said but can't prove it.

CONCLUSION:

I have never seen the department's position statement for their supervising psychiatrist but I am quite sure that containing costs is a significant part of the role. If the psychiatrist had learned that a practitioner could obtain the same or better results at 80-90% savings per case, he was duty-bound to tell the department and, after investigation, provide a report. Most emphatically, he did not do that. As mentioned, even though he regularly met the other private psychiatrists providing services to the department, to the extent of staying in the home of one of them when he visited that particular provincial city, he never once contacted me or asked me to attend any of their meetings or educational activities. I was not given any direction on how to manage their cases, and received no feedback except from the referring GPs and other managers who needed reports.

Perhaps I should have realised this earlier but, because of my somewhat unusual career, I am completely accustomed to working alone with no support whatsoever. It was only when going through the FOI material that I realised how I had been totally excluded from all departmental activities. There was only one person who could decide this, the supervising psychiatrist. It is my view that he didn't dare allow my figures to become known, otherwise all his hard work over many years in setting up these programs would have collapsed and he would have been out of his (lucrative and very undemanding) job.

I believe the supervising psychiatrist of this department, and the group of psychiatrists at the private hospital, acted together to terminate my contract just because they could not allow my offer to become public. They did this in order to safeguard their grossly inflated fees. Since then, I have been warned a number of times that any attempt to make this matter known to the public will result in legal action for defamation, and have been subjected to a number of other quite serious threats. While I am sure I would win a legal case, I know that defamation action in this country is designed to crush the defendant. I am a solo practitioner in the latter stages of my career, with limited resources. The other (wealthy) private psychiatrists are backed by the department's lawyers and by the deep pockets of the companies owning the private hospitals, who stand to lose very considerable sums of money if my figures and views become known. I have since found that this is going on around the nation. I estimate that it is costing the country a minimum of $10million a year, all of which is wasted and much of which goes toward making the patients' lives worse.

Such is the power of the psychiatric establishment, such is the grip they have on not just the public imagination but also the very machinery of government, that they can reach into the heart of the public service and, with a flick of an unseen finger, compel it to do their bidding; but, remarkably, it seems they don't even suspect that they ought not to do this, that this might be, if not frankly criminal, at least unprofessional, the sort of thing that educated people in positions of very great power don't do to the vulnerable and disadvantaged. Compounding the matter, they know they can get away with it because they have been doing it for years and see it as their right, yet they feel perfectly safe because only an insider would know that what they are doing is wrong. The great majority of psychiatrists in the country would have no idea what is going on but would automatically close ranks to protect them.

I am an insider, I do know what is happening, but I am not part of their closed group and believe it must be brought to an end.

There is one other point to raise here: when the supervising psychiatrist retires, on his very handsome government superannuation, he can expect to join the team of psychiatrist at one or other of the private hospitals and enjoy the same fees. However, because of his contacts and inside information, he can also expect to be appointed as "consultant" to the industry, advising the private hospitals on the best ways to make their "product" more attractive - and remunerative.

Cosgrove and Vaswani have published extensively on the processes by which the psychiatric profession has been suborned by the vast sums of money drug companies have at their disposal. Speaking generally of corruption, they stated [1]:

> In a democratic society, there are certain elements common to (a corrupt) interaction:
> (1) something specific is given or taken in exchange for something else ("quid pro quo"),
> (2) the parties involved know it to be morally wrong, and
> (3) it is illegal, and there will be negative consequences if the behavior is made public.
> As Harvard law professor Lawrence Lessig and philosopher Dennis Thompson make clear, such quid pro quo corruption is very different from institutional corruption. In the latter, the trouble is not with a few corrupt individuals hurting an organization whose integrity is basically intact. Unlike individual corruption, which occurs when "bent or bad souls" engage in clearly unethical and illegal behavior, institutional corruption results when an organization is no longer sufficiently independent to pursue its stated goals or mission effectively.... Whereas individual corruption is conscious and explicit – a bad apple problem – institutional corruption is about the "bad barrel".

Given this definition, I submit that the termination of my contract was corrupt. In the first place, the *quid pro quo* was that the private psychiatrists were guaranteed reinstatement of the massive incomes they had previously enjoyed - and regarded as their right. For the unnamed other party, who can only be the chief psychiatrist of the department, the "something specific" was the knowledge that all threats to the model of treatment he had espoused (in the sense 'to which he was wedded') were eliminated and *nobody in a position of authority would ever know those threats had existed*. His legacy, and thereby his future income, were safe.

Second, all parties involved knew it to be *morally* wrong. While the contract was written in such a way as to permit the department to end it without providing any justification, that is professionally unacceptable in medicine. The people involved went to great lengths to conceal their actions because they knew that, in psychiatry, there is considerable flexibility built into the system. At a clinical meeting some time after my termination, and even though he had all the figures to show my results were better than anything his methods had achieved, the chief psychiatrist actually *ordered* departmental medical personnel to follow the programs he had devised. They were explicitly forbidden to follow the methods I had developed because he did not dare let anybody see the figures. There was no information about what he told the CEO of the department but if it had anything to do with clinical standards, he was duty bound to report it to AHPRA and to the RANZCP, which he did not do. That is not just morally wrong but, given his position, a breach of his statutory responsibilities.

Third, I expect that it was illegal in the sense that there should be regulations requiring the chief psychiatrist to advise the department if and when substantial improvements in costs were possible, not to mention improvements in clinical practice and outcomes. Finally, while I have taken pains to keep this matter private, under direct threat of action for defamation, which I cannot risk, I do not

doubt that the public perception of this matter will be that it was underhand, devious and deceitful, and thereby unacceptable. When the patient community becomes aware that they have been mistreated all these years, just to enrich a small group of well-connected psychiatrists and the owners of private hospitals, I expect their response will be decisive.

In blunt terms, groups of enterprising psychiatrists and their associated private hospitals have learned to game the system under the guise of offering a rational, scientifically-based service. What I have reported here is only the tip of a very large and dirty iceberg. However, psychiatry lends itself to this, its weaknesses are systemic.

1. Cosgrove L, Vaswani A. (2019). The Influence of Pharmaceutical Companies and Restoring Integrity to Psychiatric Research and Practice https://doi.org/10.1007/978-3-030-02732-2_3