Independent Private Psychiatrists Group: Further Submission in Response to the Productivity Commission's Interim Report

Overview

Private psychiatrists want to contribute fully to the improvement of mental health and wellbeing of Australians. We believe that the Productivity Commission could benefit from listening, for the first time in the history of mental health inquiries, to the views of private psychiatrists. Mental health services have tended to disintegrate over recent years, providing less service for people over time, rather than improved services. This is a paradox when we have had so many formal inquiries and reports into mental health. No one has bothered to do research on the reforms that have been suggested by inquiries over many years, and whether reforms implemented have been effective or not.

Another very respected economist, Ross Garnaut, talking about climate issues in his latest book, "Superpower", said: "But today, policy based on marshalling knowledge through research and analysis, and then nurturing public understanding of the issues, seems a distant dream.That it is not contemporary reality is the essential problem behind the tragedies of the Murray-Darling Basin and of policy on climate change and energy transition." His analysis as to cause applies to the tragedies in mental health systemic failure. Psychiatrists have the largest scientific evidence base on which they base their treatments. Yet psychiatrists at the coal face are not being heard - especially private psychiatrists. Now is the time to listen, and to jointly (together with Lived Experience Australia) develop the huge opportunities available through your Inquiry, to improve and save lives, and to improve cost-effectiveness in this field - similar to the Garnaut vision on climate and energy.

Stephen King says in his article in the Australian, of January 1, 2020: "Today's system is often clinician focussed", and indicates in that paragraph that that is a part of the problem in mental health. We do not believe this is true in terms of psychiatry. Instead of Governments or Inquiries listening to expert psychiatric clinicians at the coal face, they have: listened to "celebrity" psychiatrists; increased funding significantly to psychologists on Medicare, preventive strategies and community based organisations with a predominant social emphasis. Mental Health care has continued to deteriorate. No significant increased funding has been applied to psychiatric treatment of serious mental illnesses, especially not to encouraging increasing the productive success of private psychiatrists. More serious cases have been discovered by the extra mental health workers employed in the community, but psychiatrists have not been resourced to treat these suffering and deserving people so identified. The psychiatrist clinicians are not generally at fault. The systems, the Governments and many Inquires have been faulty.

Who does the Productivity Commission wish to assist? People with less severe mental ill health are generally well served by GPs and psychologists, and others in primary health care in the community. The group you have identified who require a new focus is the more seriously mentally ill, and the complex cases at the serious end of the mental ill-health spectrum - who

actually are serious cases, and often require psychiatric assessment to define the complexity of their conditions. Now is the time for a Commission looking into the economics of mental health, to listen to the area of practice that treats half of Australians suffering severe illness in the community, and does so for one tenth the cost of the public sector. If the Productivity Commission is looking for cost effectiveness of treatment, then it must examine in some detail the cost effectiveness of the private sector in treating its half of the seriously mentally ill consumers. At least some enquiry into how such productivity is achieved seems warranted, and very pertinent to an economic assessment of mental health services, their effectiveness and cost, and the economic savings to be made.

Our College (RANZCP) represents the broad interests of the many types of psychiatric practice occurring throughout Australia, and our perception is that the College's recommendations in the past have barely been considered. Psychiatrists should not be listened to simply because of their training and experience over long periods of time, treating people with severe conditions and recurrent conditions, but also because our training is truly holistic, being biopsychosocial in the true sense, and at a deep level of understanding. We also know the trajectories of mental health conditions suffered by consumers that we treat. In the private sector our connection with consumers and carers is very close, and perhaps that is what is reflected in the fact that there appear to be less complaints about private sector practice than public sector practice.

If this Inquiry was occurring into any other area of healthcare, then we are sure that the medical experts in that area would be deeply consulted in relation to the types of treatment that should be provided, and the likely costs and benefits of such treatments, and from their knowledge of the conditions that they understand very deeply. Consumer and carer complaints would be analysed to find the areas and issues of concern, and the medical specialists would be engaged together with consumers to develop the answers.

The Medical Model and Mental Health

On page 2 of Volume One of your draft report, the Commission undertakes an interesting analysis of how mental health conditions may be different in some ways from physical health conditions. Whilst the analysis in your paper is somewhat ambiguous, there appears to be a justification in this analysis that mental health conditions are in some ways very different from physical health conditions. We would note that this is potentially an inaccurate premise for the Commission's analysis, and that many of the more severe mental illnesses actually are likely to be found to have a very significant biological basis, which must be addressed if any significant positive change is to occur for those consumers. Your analysis indicates that mental health has not fitted very well into the overall health care system. That is probably true, and has a lot to do with historical Government structures in hospitals and healthcare generally, and also to do with a stigma about mental illness that is shared by medical and other health practitioners and managers. This is not a reason to separate mental health treatment and care away from the general health care system, but to double down on the proper integration of mental health care into overall healthcare.

We note that whilst your own graphs indicate a larger increase in prevalence of mental disorders in early life, this does not seem to include the disorder of dementia which would radically flatten the graph. Your analysis seems to infer that early life onset indicates more social or family causes of mental illness. Note that early life onset disorders do not indicate a non-biological or non-medical causation in their aetiology. Paediatrics is a specialty devoted to the treatment of biological disorders in children. As part of your further analysis, there is mention of decreased awareness of mental illness and vague pathways to care. Surely this is a reflection of poor health care provision by Governments, rather than an indication that there is any vagueness about the severity of the mental health conditions existing in our community. Our levels of suicide should abolish that type of thinking.

We do not argue against the fact that there are very significant psycho-social factors which particularly occur in the first five years of life, which almost certainly contribute to later mental health conditions in many cases, and interact to amplify underlying biological and genetic vulnerabilities. This surely indicates the need for preventive strategies in that early life period (first five years), which will need psychiatric leadership, but will involve many non-health forms of intervention for families, and including non-health interventions to do with housing, anger management, and social support. The fact that young people are strongly affected by mental illnesses is an important reason to intervene at an early stage, and there are undoubted benefits for better work participation for those young people if they have adequate treatment for their conditions at an early stage, and are given adequate support in their introduction to work.

We hear a lot of vague talk about preventing mental illness through social interventions in the community, especially for the “missing middle”. We are critical of this so-called “preventive approach”, unless it is applied to children in the first five years of life with psychiatrist leadership (and also to their families). The more serious disorders, which cost the community so much in pain and suffering, and in economic terms, will not be prevented by more generic and insufficiently trained psycho-social workers in the community. More severe and complex cases need to be identified in the community by psychiatrists, and then referred for expert treatment by psychiatrist-led resources, which should be the major focus for rebuilding. More child psychiatrists will need to be trained for this generational change initiative.

When we look at the Commission’s own definition of the nebulous concept of the “missing middle”, it appears to refer to serious or complex cases approaching the severe end of the spectrum of mental disorders, but not sufficiently identified or treated. At this time, psychiatrists are the only group of workers with the expertise to identify such difficult cases, and determine useful treatment. Social intervention without medical treatment is empty, and indeed cruel and unethical. It would be like NOT providing any active treatment of cancer patients, but supplying only social support, pain management support, hospice care or assisted death services to consumers, and grief counselling to families.

The Concept of Medico-legal Governance

In the modern concept of clinical governance, medico-legal governance has been de-emphasised, if not written out of existence. This may be acceptable within institutions, where

the leaders of teams are usually the most medico-legally qualified professionals. At this stage, Law Courts do not seem to have abandoned medico-legal responsibility for care. In the mental health sphere, if an adverse incident occurs, and a psychiatrist is part of the treating team, then they are usually held accountable. Private psychiatrists are direct targets for litigation for adverse events because they are clearly totally in charge of therapy for a specific consumer. Psychiatrists in the public sector multi-disciplinary teams may not be held so directly accountable, as the courts may recognise “systemic failures”.

Hence, when we are dealing with non-institutional multi-disciplinary teams in the community, led by private psychiatrists, the issue of medico-legal governance becomes paramount. Multi-disciplinary team members will still be valued for their individual inputs to the therapy of a patient, but must be aware of the medico-legal responsibilities held by the psychiatrist. This also has implications for the relationship between the GP and psychiatrist, after the GP refers a consumer for ongoing management. All the necessary aspects of medico-legal governance can be adequately expressed in referral procedures, and other legislated requirements under the Medicare system. Consultation regarding medico-legal governance with private psychiatrists will be necessary in developing more widely, innovative community-based models of therapy and care.

New Community Multi-Disciplinary Teams in Mental Health

Psychiatrists will not be able to satisfy the demand for treatment of serious mental health conditions by themselves. Indeed most private psychiatrists enjoy working with a truly cohesive multidisciplinary team. The psychiatrist’s expertise must be leveraged, so that other mental health workers share the care of serious cases in the community. There is actually little good research on multi-disciplinary teams in the community, partly because there are a plethora of models used. Many of these models remain institutional and expensive. So what model should be used in community mental health?

For many years, private psychiatrists have been used to working in community multi-disciplinary teams, which are looser, more flexibly patient oriented, and much less costly. (These teams appear to have been virtually invisible to politicians, bureaucrats and inquiries.) The team governance is based on medico-legal principles, mutual respect gained through working together over time, and trust built over time. The psychiatrist can delegate some of the medico-legal responsibility to other team members, knowing that the team member will ring them promptly if trouble is brewing. The psychiatrist is able to spend more time with other consumers if some of their patients are partly managed by other team members. The pay-off for other team members is the enjoyment of longer term engagement with consumers over time, and the much more satisfying results achieved through such engagement. This is the model which ideally should apply to public, as well as private mental health. Institutional models appear to be clumsy when translated to community-based practice.

The Serious Case Identification Problem from Past Inquiries – Will You Repeat That Problem?

Past inquiries have placed a heavy emphasis on enhancing primary care mental health provision. The idea was that primary care health workers would be able to initiate treatment for their consumers, and much of the more serious mental illness would be prevented. This started round 2006 when psychologists were added to Medicare, and GP mental health items and Better Mental Health Access strategies were initiated. Psychiatrists warned Government at the time that unless treatment resources for the severe cases were similarly increased through funding and policy, then more people suffering serious mental ill-health would be identified, but would not be able to be treated, leading to dissatisfaction, complaint, and potentially more suicides. That is exactly what has ensued. Many psychologists that private psychiatrists had worked with in the community, migrated to the primary care sector, where using Medicare rebates, they could deal with less severe cases (and refer on to psychiatrists theoretically, when the going got tough). Soon there will be a generation of psychologists who have no idea how to treat the more severely ill mental health consumers.

We trust that the Productivity Commission will heed this warning. Too many mental health policies are good at identifying serious cases (your own proposed school mental health and wellbeing officers are an example). If no listening to psychiatrists occurs, and no extra resourcing occurs for psychiatric treatment in public and private sectors, then this problem will certainly recur.

Renovate AND Rebuild

We would say that rather than the community having to choose between rebuilding and renovating the mental health care system, there is a need to **both** rebuild and to renovate this system. The State and Territory-based public sector system does require very significant rebuilding in order to become more effective and more cost-effective. There are system design clues from the private sector for how that may be achieved, if your Commission has an inclination to hear about this.

A central theme in **your** rebuilding strategy is that better governance will be represented by increased management of mental health overall. We believe this could be a severe error, because similar systems, particularly in the United Kingdom under the National Health Service, have been remarkably inefficient in producing better mental health treatment and care, and extremely expensive. There is a modern concept of complex systems analysis, and the area of mental health within Australia can certainly be recognised as a very complex system indeed. The answer to providing better governance and effectiveness within the public sector system is not necessarily to impose further levels of institutionalised governance, in the form of traditional management. It would be better to look quite differently at this complex system, and look at minimalist type of management interventions that may be much more effective, and may devolve responsibility down to a lower level than the regional level.

We know our public sector psychiatrist colleagues are working at the limits of their capacities, often frustrated by the levels of management governance strategies piled upon them, with no real consideration for the adverse effect this has had on consumer treatment delivery by psychiatrists. Their multidisciplinary teams are often very institutionally based, with many unproductive meetings, which still fail to generate good clinical governance. There is a

desperate need for many more psychiatric inpatient beds: right now. To prevent the need for excess psychiatric hospitalisation in the longer term, it will be necessary to enlarge public sector community based treatment, so that psychiatrist led teams in the community look after consumers who suffer serious or recurrent mental health conditions **over the longer term** - the trajectory of their illnesses. This will ensure that adequate TREATMENT is applied to consumers, which should ensure that the social improvement strategies your Commission proposes, will achieve success - on "fertile ground", so to speak. When those treatment structures have been set up in the community, a new cohort of GPs who have been trained specifically in long term management of serious and complex disorders (similar to your Commission's suggestions) will be able to share the task more adequately. Preferably, they will be able to engage in treatment team meetings with psychiatrists on a recurring basis.

A further very concerning implication contained in your rebuilding strategy is that Medicare will be abolished for the mentally ill. We realise that you have been very careful to indicate that in the first instance Medicare will be abolished for allied health services under Medicare, for the mentally ill. The implication however is that medical services will later be pooled as well. The money devoted to Medicare services for mental illnesses is, as we understand it, to be rolled up into State and Territory mental health budgets. This amount of money in the case of private psychiatry is $360 million. Such an amount of money in the overall economic budgeting of around $9billion will make no positive difference to the effectiveness of mental health care, and would in one act, abolish a sector that is managing to treat half of the seriously mentally ill cases in Australia. If Medicare were abolished for mental illness cases in Australia, this would be a disaster for those suffering from mental illness, and would also be a political disaster for any Australian government which was foolish enough to implement such a strategy.

There is no doubt that the Medicare-based system run by the Commonwealth Government requires renovation. We would argue that this is true, not just for mental illness, but in general practice care, and in fact across the whole spectrum of medical treatment. The reason for the need for such renovation is that the Medicare system has been neglected by successive Governments, and a deliberate strategy has been used to drive down patient rebates for all medical services under Medicare. That has saved the Federal Governments of various political descriptions quite a lot of money, but the consequence is that it is no longer practical or possible for medical practitioners to practice safely or effectively, if they were to try to build their practices on Medicare rebates only. Therefore, more and more practitioners are charging out of pocket costs, and they are tending in the first instance to allocate those extra costs to people who are earning higher incomes. But in this process the health seeking behaviour of citizens is being adversely shaped, so people are presenting later in their illnesses, where costs will escalate.

People who suffer from more severe mental illnesses tend to have problems being able to obtain and maintain work, as your Commission has clearly surmised. Therefore, many of our patients cannot afford the specialist gaps charged by private psychiatrists who try to maintain safe and effective practice. That is not a fault of the psychiatrists, but is a fault of funding by the Federal Government. It has been a deliberate fault built into the system for more than 30 years, and is leading to a breakdown in the whole Medicare system. That severe fault will need addressing for all areas of medicine, but particularly for those suffering from mental illness.

Anything less than a major renovation of the Medicare system is likely to fail. We have previously suggested that one mechanism to fix this could be to increase the Medicare levy, probably to around 5%, in order to accommodate the necessary increase in Medicare rebates to make the system viable, and also to pay for the NDIS system, which is unlikely to be able to be funded as it presently stands.

Generational Preventive Intervention in the First Five Years of Life

We do agree with the very important reform, which is described as a generational reform, and is an intervention in the early years of life, to try to prevent many of the severe and disabling mental illnesses. We agree with this, and the fact that it is likely to take a generation of very significant reform before huge differences will become apparent. However, those differences are likely to have wonderful beneficial effects for the whole of Australian society, and not just for mental illness, but also for the prevalence of many physical illnesses as well. Indeed some social ills are likely to be impacted, such as domestic violence and child abuse. We would simply emphasise two very important caveats.

The first is that we believe it is more important to intervene in the first five years, and not only during the school years. This could be more difficult, but it is vital to intervene much earlier than the school age group for full preventive effect. Many people with children at some risk can easily be identified at infant welfare centres, various other welfare institutions, preschool centres and by general practitioners. The intervention that is required will be broad and not just confined to psychiatric intervention. However our second caveat is that there should be psychiatrists deeply involved in these preventive reforms, and in directing the professionals working with these families at the local level. These interventions will largely be family interventions, and have the capacity of possibly helping multiple members in the one family, rather than just individual patients. The main workforce will not be of psychiatrists, and may require some quite specifically trained other professionals. But child psychiatrists will be needed to make adequate assessment and diagnosis of family problems, so that the interventions can be allocated appropriately and effectively.

Evidence, Evaluation and Data

On a number of occasions your Commission has noted the fact that the level of evidence for the effectiveness of various system level interventions is very low. The answer the Commission comes up with seems to be a policy of directing clinicians to measure outcomes on a wide scale. We do not totally argue against that, but note that such an intervention is extremely expensive to implement effectively, and must contain very effective feedback to the clinicians involved, if it is going to achieve anything useful. That has not been the actual result for implementation of outcome measurement systems in Australia thus far. The actual costs of such implementation are grossly under-estimated by Governments and others - similar to the economic debacle that has occurred in the development of the universal eHealth record.

Because the level of evidence for the effectiveness of systemic intervention is very low, we believe your Commission should be extremely conservative (not in the political sense) in how your systemic reforms are shaped. We would suggest that the measurement needs at the

moment should be less about broad scale outcome measurement, and more about targeted research looking at the system as it is at the moment, and trying to find the sort of factors that may be changed or managed to improve the system. Then, if a reform suggested by your Commission is implemented, more targeted research should be commissioned to assess the actual results, over a 3-4 year period. Such a research approach should not be frighteningly expensive, and might give good evidence within a period of 3 to 4 years, which would help produce better health care planning.

Echoing the comments quoted from Ross Garnaut, there is extensive evidence available for analysis already about the mental health system, and the initial focus should be to gain valuable insights from the information that has already been collected. The CDMS (Centralised Data Management Service) initiated in the private sector in 1996, and now providing 16 years of outcomes data from private psychiatric hospital admissions, with a data collection rate of 80-90% during that time, is available for analysis. Public and private sectors can be compared using similar data. Questions can be asked regarding the trajectories of illnesses over 16 years in the Australian population, and targeted studies can be performed to extract insights into best practice care.

We are not sure whether the Commission is aware of the fact that even at the present time, and since National Mental Health Reports commenced in 1993, there is no clear knowledge about how many consumers are actually treated in the public sector system. That is a basic sort of information item which should be obtained. We also note that in coming to some conclusion about the number of consumers treated in the public system, it would be pertinent to know how many of those consumers actually receive an assessment from a psychiatrist. Whilst psychiatrist direct assessment is not always required, when the conditions are more serious, and when they are more ongoing, then psychiatrist assessment is almost certainly essential. Some figures on that from the public sector would be very important to obtain (if possible).

We also would acknowledge that there is overlap between the public and the private mental health systems. Contrary to some common beliefs, many people are treated in the private system who do not actually have private health insurance. Those consumers, when they are more severely ill, will often be hospitalised in the public sector. There is therefore an element of overlap between the sectors, and a time limited incidence study looking at both sectors, and determining the degree of overlap between the sectors, would be very useful information to obtain. We believe there is a new National Mental Health and Wellbeing Survey being developed at the present time, and it would be possible to delineate that type of information about the overlap in treatment between the private and public sectors, from that very survey, if the appropriate questions were asked. We would urge your Commission to recommend such information to be collected in this upcoming survey.

Therefore, we recommend that your Commission encourage the analysis of existing data sets to produce knowledge that will help guide policy. The recommendation for outcome measurement across all services is a policy recommendation which is enormously expensive, likely to be difficult for existing Governments to implement (when they can't even count the number of consumers treated in the public sector each year), and likely not to lead to beneficial

changes as a result. We would recommend your Commission looking at the knowledge you need to obtain to guide policy, and suggest high quality research projects with a focus on those key areas. Areas you may recommend would be delineating the actual community mental health services involved with consumers at any one time, perhaps through the soon to be initiated National Mental Health and Wellbeing being Survey. Defining the degree of consumer and diagnostic overlap in public and private treatment, again through the same survey. Recommending research on 15 years of outcome measurement data already collected, to determine the trajectories of care required for different diagnostic groups, such as Bipolar disorder, Major Depression and Schizophrenia; and asking about the overlap between those conditions and substance use disorders, and physical comorbidity. Such a strategy would be less expensive, give more immediate and sure results, by the employment of the excellent research community we enjoy in Australia.

Removal of Medicare Item 288 – the Demise of Rural Mental Health Treatment

In 2000, before telepsychiatry Medicare Items existed, private psychiatrists assessed or treated 36% of rural mental health consumers (43,000 of 119,000 people assessed). You will have been told that private psychiatrists work mainly in metropolitan areas, but they do in fact assess and treat many rural consumers. Re-analysis of the Burgess paper statistics from 2002 confirms this (this being the last reliable paper on population mental health needs). The reach of the public sector into rural and remote areas is grossly over-estimated, especially if actual direct psychiatric assessment is considered. The reach of psychiatry into rural and remote areas is not good enough, but consideration of modern digital communication strategies could quickly and radically turn that around. This would be more quickly achieved initially by a focus on private psychiatrist initiatives.

We believe that the recommendation contained in your report of eliminating the Medicare Item 288 tele-psychiatry extra rebate is very counter-productive, if you are hoping in any way to improve rural psychiatric service delivery.

There appears to be a misunderstanding about the way private psychiatrists function, and their exposure to medico-legal risk when using tele-health services to assess consumers. Whilst many of us have been very willing to be helpful, partly because we understand the extreme needs that have developed in rural areas, we are also conscious of carrying a very significant medico-legal risk weight, on the basis of such tele-health assessments. Usually, our initiating of such arrangements is done with very clear prior knowledge about the capacity of the general practitioners that we are liaising with to be able to carry out the management plans that we might suggest. We also need to know that those general practitioners will contact us readily if they are having difficulties implementing plans that we have suggested. We also need to have made some enquiries about the services provided by the public sector locally, and we hopefully have liaised with those services to ensure that they understand our approach and our willingness to work in conjunction with them. All of these factors, but particularly the very severe medico-legal risk, means that such services cannot be delivered at a normal cost.

Additionally, bear in mind that many of the consumers that we are likely to see in rural areas tend to be even more financially disadvantaged than those in metropolitan areas. Bulk billing

arrangements or similar, often have to be organised for those patients, so there is very little extra gap payment to be able to be charged, over and above the Medicare rebate for those services. The Item 291 and other existing Medicare item numbers were supplemented by the item 288 extra Item, to add another 50% rebate for the consultation. This is barely enough to account for the need to assess and give a detailed report, and really does not adequately cover the medico-legal risk managed by these practitioners. A more realistic fee rebate would probably be in the range of $1000-$1500. However, for altruistic reasons, many private psychiatrists have been willing to conduct such tele-health consultations. Removing the item 288 additional rebate will likely cause many of us to consider that the risk is not worth taking for the remuneration that is being provided. A first glance at items on the Medicare schedule that are apparently destined to be used instead of the Item 288 additional rebate, appear to us to be grossly inadequate. The risk of medico-legal cost and damage to our reputation is not worth the remuneration that we are likely to receive for these services. Removal of Item 288 additional remuneration will lead to a dramatic decrease in rural psychiatry services unless the new item numbers are priced at a similar rebate level or preferably above.

Note that a number of our private colleagues who engage in such tele-health activities have found that they have had coronial enquiries in which some GPs have incorrectly suggested that their understanding of the service was that the psychiatrist was undertaking ongoing management. Whilst our documentation in these cases has proven that this was not the case, it just reflects the type of medico-legal risk that can be experienced when doing tele-health services. We also note that this element of medico-legal risk is also present in another suggestion that your commission makes concerning telephone advice to general practitioners.

Even greater medico-legal risk would be attached to such advice given over the phone and based apparently upon the history of the GP. Whilst a sensible psychiatrist in that setting would probably record the conversation with the general practitioner, and would prefer to provide such advice to GPs that they actually know and trust; nevertheless, there is a very significant medico-legal risk associated with that type of consultation. We understand that there was some evidence to suggest that those telephone advice assessments that occurred in the past may have attracted remuneration for the psychiatrist of $900 per service. That would probably be a more adequate remuneration if such a service was to be considered. We believe that the telephone advice to general practitioners system suggested by your Commission is not generally a viable option, and that very detailed discussion should occur with both private and public psychiatrists about the viability of such a mechanism, and the sort of remuneration being envisaged. There is also no mention made of the expectation or otherwise of some ongoing responsible relationship between the GP and the psychiatrist about the cases that have been discussed, and what remuneration would be available for both parties in those circumstances. As this recommendation currently stands, it would appear unworkable for psychiatrist shouldering the medico-legal risk.

Major Economic Rebuilding: Medicare, Private Health Insurance, NDIS

We hope your Commission will not shy away from the “elephant in the room”: the Moribund Medicare Universal Health system, Private Health Insurance unviability and an NDIS riven with corruption and excess expenditures - a disability system WITHOUT ANY integration of

treatment and disability care. These problems were highlighted in our original submission, but seem to have been ignored by you. It is probably difficult for your Commission to address these issues, and you may have to be very brave - but to ignore them is like “shifting the deckchairs on the Titanic”.

We have made useful and concrete suggestions regarding these core deficiencies. Please consider our suggestions, or suggest other strategies that may be effective.

Medicare rebates have been deliberately held low for 30 years, so now, people feel they cannot afford medical gap payments (and certainly rarely budget for them as they did in the past). The result is that citizens are putting off attending the doctor when ill, which leads to much greater medical expense later, which public hospitals often have to attend to, costing Government dearly, and impairing people’s lives unnecessarily. Rebates should be brought back to the level determined from the results of the Relative Value Study of 1995-6, but adjusted for CPI increases since then. Inaction on this problem will likely consign Australia to third world health status.

Private Health Insurance is in a death spiral. Citizens are quitting this insurance in large numbers currently. The public hospital system would not be able to cope with a large scale exodus from Private Insurance. Government would have to pay for this result. Health standards would decrease. Strangely, private psychiatrist treatment under Private Health Insurance is one of the key benefits of such insurance, because people cannot receive similar personalised care in the public sector (not since the 1960’s and 1970’s has this been available. Health Insurance Funds try to limit private psychiatrist care in order to save money, even though these costs are minimal compared to other conditions treated. Doctors are blamed as the industry descends in this death spiral, insurance premiums increase, but the same funds have not tried to reinvent their offering, by investigating and discussing new innovative insurance models. We have suggested that Medical Savings Accounts similar to the Singapore system could be a great alternative solution. Alternatively, whole of life health insurance products could be offered by the funds with Federal Government agreement, where an individual would effectively underwrite their own health care through their lives (with necessary catastrophic insurance offered as a part of the product, for the early years of contribution).

The NDIS has mostly been a disaster for people living in the community with mental illness. Psychiatrists have pointed out a number of faults from the beginning. The system has been constructed to be very much open to corruption from the beginning. The artificial separation of treatment from disability services created deliberately from its inception is illogical, and has been very damaging in mental health. We note that many competent mental health care workers in the community have been excluded from NDIS services. This has been a particular disaster in rural areas, where we have lost years of competent experience as mental health workers have had to retrain in other jobs. The waste of NDIS funds, as seen by private psychiatrists is truly amazing. This level of wasteful spending is not sustainable. Costs will blow out, but political commitment has been high for this system - but eventually taxpayers may rebel.

To fund the necessary transitional arrangements whilst these major necessary changes are implemented we have suggested raising the “Medicare Levy” to 5% - anything less will not be sufficient.

Listed below are brief responses to a number of other specific information requests in your interim report.

Requests for information about specific suggestions made by the Commission.

Information Request 3.1. Educational materials for schools

We believe that mental health education directed to the educational sphere concerning mental health would be best primarily targeted at secondary students, but should be very pertinent to their own circumstances. Mental wellbeing training in primary school is also worthwhile. 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 is about serious case-identification in the absence of adequate psychiatric treatment resources.)

Information Request 3.2. Out-of-Pocket Costs

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.

Information Request 5.2 On mental health plans.

We would suggest that after a period of three months following a consumer receiving a mental health plan from a general practitioner, if the consumer is not 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.

Information Request 6.1 CALD online support.

We agree with this initiative, but suggest that significant psychiatric expertise be obtained, particularly from institutes of transcultural psychiatry.

Information Request 5.1 Low intensity treatment coaches.

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 practitioner, then such coaches should only be allowed to treat mild forms of anxiety and depression.

Information request 11.18 ATSIC health worker.

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.

Information request 14.1 Individual placement and support expansion in workplace.

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.

Information request 14.2 Incentives for DSP recipients to work.

We would approve particularly the first suggestion of increasing the threshold before recipients lose payments. We would not disagree with the second suggested increase of a weekly hour limit, but noted that there may be some discrepancies in how people with mental health conditions are treated, as distinct from people with other types of disabilities.

Information request 16.1 Transition support after release 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.

Information request 16.2 Appropriate treatment for forensic patients.

We strongly support this initiative.

Information request 17.1 Funding the employment of well-being leaders in schools.

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 a programme would 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 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.

Information request 18.1 Greater use of online services.

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.

Information request 18.2 Mental health training for educators.

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.

Information request 18.3 International student access to mental health services..

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.

Information request 19.1 Treatment of workers and how it is funded.

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.

Information request 19.2 Personal care days for mental health.

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 actually 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 diagnosis and treatments or counselling that actually alleviates the problem, and is likely to prevent it from recurring.

Information request 19.3 Barriers to purchasing income 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.

Information request 22.1 Governance arrangements with the National Mental Health Commission.

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.

Information request 23.1 Architecture of the future mental health system.

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.

Information request 24.1 Regional funding Pools.

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 formation of such funding pools involving allied health, 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.

Information request 25.1 Underutilised datasets

The Productivity Commission does not appear to have identified the full extent of difficulties in underutilised outcomes 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 actually 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.

Information request 25.2 Indicators to monitor progress against contributing to life outcomes.

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.

Information request 25.3 Data Sharing mechanisms to support monitoring.

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 beneficial use of already existing data that has been shared.