

My name is Dr Matthew Macfarlane. I work as a psychiatrist in the public sector in New South Wales, and am a Fellow of the Royal Australian and New Zealand College of Psychiatrists, but the opinions I express here are my own, and not representative of the RANZCP or my local health district.

There are a number of areas where the mental health service needs attention. This submission will focus on just one problem, albeit a big one – the fragmentation of services and the difficulties this causes in someone attempting to access and get consistent care within Australia's mental health system.

The fragmentation starts at the beginning of an individual's journey into the system, and is well-illustrated by the website for this very Inquiry (<https://www.pc.gov.au/inquiries/current/mental-health/make-submission#lodge>), where there are six different numbers offered for counselling. Why are there so many? The answer is that each one has a slightly different focus, and are run by different organisations with different funding models. This will be a theme throughout my submission, and I will highlight a number of areas where this fragmentation creates confusion and inefficiency.

Once a person seeks help for a mental illness or distress, there are a mix of public and private providers, provided by many Governmental and non-Governmental organisations. The major advantage of this large number of organisations is the provision of choice to the individual and I agree this model has some merit in the context of physical illness, where people can use private providers to get services that are beneficial but attract waiting lists in the public system (such as hip replacements). In the case of mental illness however, in many individuals the symptoms of the condition themselves can impair help-seeking and decision-making capabilities, meaning that this is precisely the wrong time to be offering an overwhelming number of choices.

There are a number of fault-lines in the provision of services in the mental health system, and I will only focus on a few of these, such as the public-'private' sector divide, transitions between services that have an age range in their criteria, and the mental health system's links with adjacent services such as addiction services, disability services and the wider health system.

The public and private sector divide is seen within almost all of the disciplines that provide mental health services, but I will focus on psychiatrists (with whom I am most familiar) and psychologists (with whom I frequently work closely).

The first point is that so-called private sector providers are almost never wholly independent practitioners – the bulk of their income is from Medicare rebates for their services. While practitioners also have the discretion to charge a gap fee, the major divide between public and private providers in community care is the State or Territory funds the former and the Federal Government funds the latter. This means that in Australia, for certain classes of practitioner such as psychiatrists and psychologists, we have two separate health systems, both substantially Government-funded, that duplicate many aspects of their services.

This system does have advantages. Aside from the benefit of choice mentioned above (sometimes useful, sometimes overwhelming), private sector practitioners can work within niches or provide specialist services that public sector services are unable or unwilling to provide.

Unfortunately there are other disadvantages in the private sector provision of services that can offset advantages. I will focus on the Better Access scheme (intended to improve psychological health through increasing access to clinical psychologists and psychotherapy in the private sector through Medicare rebates) as an example, although many of the same concerns likely apply to private psychiatrist practice. In Better Access, there have been evaluations showing that private providers disproportionately work in urban areas and in areas of socioeconomic advantage [1]. Also, there is no consistent policy on provision of evidence-based services, and there is no quality control nor enforceable guidelines. For instance, the current Better Access arrangement allows ten subsidised psychotherapy sessions per year, and almost all evidence-based psychotherapy assumes weekly sessions in the trials that prove its efficacy, but many psychologists and their clients 'stretch' the sessions to monthly to allow some psychology 'coverage' throughout the year. I would argue that this

dilutes the intervention, and it is no longer evidence-based or effective. There is no enforceable mechanism under Better Access to stop this from happening, or indeed for psychologists to use methodology that is not evidence-based as long as they maintain their qualification.

Other issues that have been identified with Better Access include difficulties in evaluating a Federal intervention that is delivered in a non-standard manner across individual psychologist's offices nationwide [2], and a recent recognition that many years after implementation, and billions of dollars, there is no appreciable population mental health impact [3].

Quite apart from the disparity in access and the divergence from evidence-based practice, the other concern with the public-private divide is that the system defaults to a de facto division between more mild illness (or moderate-severe illness in the context of good family support), managed in general practices, private providers or NGOs; and more severe illnesses, managed via a 'safety net' public mental health sector that is funded by individual states and is invariably underfunded for this purpose. In anyone's mental health journey, their circumstances can shift back and forth along a continuum of wellness and symptoms fluctuate and/or family supports suffer carer stress. Each time this occurs, there is a need for handover from one system to another.

For example, in someone who is taken care of in public sector settings, as they improve they become 'too well' to be followed up, are discharged, and have to take their chances with a number of independent providers who can set their own criteria of who they accept, meaning that many fall between the cracks. They can then decompensate and return to the public sector services, who start the process again. Meanwhile, people taken care of in the private system whose mental health is worsening are sent to public sector mental health services, with the attendant issues with handover and communication making planning subsequent care difficult. Each transition point is an opportunity for vital information to be lost, or for someone to drop out of care.

These issues persist in other transition points such as age transitions, with child and adolescent services (CAMHS), adult services and older adult services all providing care with different foci and frequently different entry criteria, so that someone can have intensive input through CAMHS, then have nothing equivalent available to them once they turn 18. In the youth mental health field, organisations such as Headspace have both an age transition and a bureaucratic divide with the state-run CAMHS – they have their own hierarchy, policies and mode of practice and vary in their ability to work with adjacent services as they hand individuals over to CAMHS when they become too complex, or to adult services once the individual 'ages out.' It's also worth noting that, despite the claims of proponents, engagement with the better-branded Headspace is not significantly better than state-run CAMHS services, and a number of concerns have been raised about its status as a 'silo' rather than integrated into other local services [4].

The ideal mental health system would be seamless, but everywhere an individual turns there are seams. NDIS is repeating the same basic ethos as Better Access, and it is becoming clearer that when individual non-Governmental disability organisations are allowed to tender and set their own criteria, people with complex mental health-related disability find that the system does not work with them in mind [5]. People with comorbid mental health and substance use disorders often need to go to two separate services that liaise with each other only imperfectly. Individuals with comorbid physical and mental health issues, intellectual disabilities, or with psychogenic/functional symptoms who frequently present to physical health services, all find themselves unwitting victims of gaps in our systems.

What can be done about this fragmentation? Large-scale overhaul of the system, and creation of a monolithic public health system for mental health, would be impractical. I would suggest a number of smaller (but still substantial) measures:

- More rigorous policing of evidence-based standards and 'cherry-picking' of clients within independent practitioners and NGOs, with the option to withhold funding if standards (or appropriate inclusion criteria) are not maintained

- Consideration of significant investment in a 'traffic direction service' such as the NSW Mental Health Line or Lifeline, providing a single port of call available 24 hours a day. Such a service needs substantive involvement and dialogue with all the different services someone with mental health needs could access (including their inclusion and exclusion criteria), and a way of completing a referral to the appropriate service that is as simple for the individual as possible. The aim would be for this service to be, if not the only, then the major resource for people to contact regardless of their mental health needs, with individuals being able to trust that they can have effective matchmaking with an appropriate service
- In the child and adolescent space, significant thought should be put into whether the current duplication of services between CAMHS and Headspace is benefiting either party, or the young people they are trying to serve. At the very least, there should be a clear Memorandum of Understanding between each local Headspace and their corresponding CAMHS service about how they communicate and work together

These measures could allow some of the strengths of a diverse system to be maintained, but with improved access and a reduction in the overwhelming nature of choice.

## References

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