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## PRODUCTIVITY COMMISSION MENTAL HEALTH ENQUIRY

### **The homeless mentally ill**

About a third of the people who sleep in the open in Sydney have severe forms of mental illness, mainly schizophrenia. Furthermore, research in Australia and elsewhere shows that they generate as much as \$100,000 per person in health, criminal justice and other costs.

Our study of 2389 attenders at psychiatric clinics provided in homeless shelters in inner city Sydney found that a third had been released from prison to the homeless sector, and as many as 21% had lost a Housing Department tenancy, seen as the solution to homelessness.(1)

The best way to treat homelessness is with the right kind of home. "Housing first" policies in other countries, particularly Canada, have been shown to improve health outcomes, reduce substance use and reduce costs, especially health costs. We estimate that providing a modern studio with an individual bathroom and kitchenette in a small complex with carers during the day and visiting psychiatrists and mental health nurses would cost \$25,000 per person per annum, a potential return on investment of four dollars for every dollar spent. We estimate there are about 3000 people in Australia who need this type of supported housing.

### **Recommendation**

We recommend policies to encourage purpose built small scale long term supported accommodation for people with severe mental illness, with on site treatment, direction and protection from exploitation. They could be built by private investors for a fixed return and run by NGOs.

### **Mental illness and the criminal justice system**

Prisons are our new asylums. There are about 1600 psychiatric hospital beds in NSW and between 900 and 1000 people with schizophrenia in prison at any one time. Prisons are cheaper, but the length of stay is greater, and they are very inefficient places to provide care. Moreover, the imprisonment of people with schizophrenia is often due to the failure of community care, and the interface between prison and the community does little to stop the door from revolving.

### **Recommendation**

One suggestion that might work in NSW and nationally would be to establish "mental health prisons", similar to the Compulsory Drug Treatment Correctional Centre (CDTCC) at Parklea, to facilitate the more intensive treatment and early release from prison to secure accommodation and treatment arrangements or inmates with schizophrenia, saving prison costs and reducing recidivism.

## Acute mental health services

There is widespread dissatisfaction with the performance of acute mental health services, which are often overstretched and have low morale. Finding accommodation for severely disabled patients is a big cause of bed block and stress, see above. Another problem is the low productivity of community mental health centres. Case managers increasingly conduct reviews by telephone and spend only a small proportion of their time face to face with patients, in contrast to GPs and other private practitioners, who spend nearly all their work time with patients.

The idea of episodes of care for chronic forms of severe mental illness, with discharge to general practitioners of patients who will inevitably relapse has been a disaster. Optimal care of chronic mental illness is continuous care.(2)

### Recommendation

The motivation and productivity of public mental health services could be improved by the measurement and transparent comparison of performance data, some fee for service within the centres, funding that follows the client, to prevent the rejection or neglect of difficult clients. Private psychiatrists should be engaged to provide sessional services in community health centres, so that patients develop long term relationships with the one doctor rather than seeing a different trainee every visit. A trial of the privatisation of community mental health centres providing indefinite care for people with severe mental illness might also be considered.

## Funding of mental health services

We are always hearing claims that mental health services need more funding. However, there is usually very little data to support those claims, and there are some egregious examples of waste.

Take Headspace. Our experience, supported to some extent by the evaluation of outcomes achieved by Headspace centres, is that they are largely ineffective, and further dilute and fragment the service provided by community health centres and early psychosis services.

Another example has been the Better Access Scheme of Medicare subsidies for psychological counselling, for which little actual outcome data is available. The fee structure for psychiatrists and psychologists have been set on the assumption that most patients would not be charged. However, they (we) have taken it as a cue to add a large margin, effectively making the subsidy a form of middle class welfare, termed "the prostitution of friendship".

The NDIS was not meant to be for the severely mentally ill. However, people with severe forms of schizophrenia often meet all the criteria apart from being unable to walk, and there will inevitably be a tension between funding of mental health and disability services.

### Recommendation

Reform of the Medicare subsidy to reward not charging a gap fee (to a level previously offered by private health insurers), or offering a bonus for certain treatment outcomes. Face to face treatment of milder forms of anxiety and depression should only be available after completion of an assessment for internet delivered CBT. Underserved patients could be assisted by funding packages similar to the NDIS that follow complex and disabled patients, for example, those released from prison, to create an incentive for public health services to

care for them, rather than reject them in favour of the more compliant and agreeable. All mental health funding should be independently evaluated on outcome data.

Any request for funding for suicide prevention should be treated with suspicion, unless it is proposing community wide public health interventions. Only 25% of people who commit suicide are engaged with mental health services, and hence the only way to lower the suicide rate in Australia would be to further reduce the availability of lethal means, such as potent opioids, and raise the price of that great enabler, alcohol.

Happy to expand on any aspect of this polemic.

Yours sincerely

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1. Nielsen OB, Stone W, Jones NM, Challis S, Nielsen A, Elliott G, et al. Characteristics of people attending psychiatric clinics in inner Sydney homeless hostels. *The Medical journal of Australia*. 2018;208(4):169-73.
2. Nielsen O, McGorry P, Castle D, Galletly C. The RANZCP guidelines for Schizophrenia: Why is our practice so far short of our recommendations, and what can we do about it? *The Australian and New Zealand journal of psychiatry*. 2017:4867417708868.