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Submission to the Productivity Commission Inquiry into Mental Health

I have a role within the RANZCP but submit the following in an unofficial capacity, believing I have a unique perspective of the various fragmented pieces of the MH system, informed by various clinical and administrative roles since 1990, including public, private and NGO sectors.

I contributed to the RANZCP submission but I don't know which of my contributions made the cut. The College is a broad church, serving the interests of psychiatrists in varied settings, and it was inevitable that some of my points, which may have not been seen as representative of the broad membership, were deleted.

So, here are the major points that I anticipate didn't make the cut:

Only re-design of MH funding and service delivery will save it from further fragmentation. Any re-design needs only have equity, accessibility and effectiveness as its aims.

The Productivity Commission's challenge will be developing a set of real-world recommendations that cut through interest group priorities, and set an agenda that is guided by the basic principles of equity, accessibility, and effectiveness. Whatever comes from the Commission's inquiry, it should aim for recommendations that simplify rather than complicate an already chaotic delivery system.

Realpolitik: The Commission's inquiry is a unique opportunity to recommend true reform. The landscape can be considered a 'blank slate'. There is no single interest group in the mental healthcare sector with critical pull or influence. All struggle to be heard, and as a result, the mental healthcare landscape has developed **chaotically**, to wit: *The MH system in Australia has developed much as the road and transport system in Sydney: starting with narrow and crooked paths, with no pattern; then patterns trying to be super-imposed by main roads, which are tortuous and inefficient; public transport commences, trams come, then superseded by buses; trams go; then it is decided to try trams again, with painful adjustments. A more comprehensive train system evolves, but fails to meet demand, then 'metros', are introduced, trying to intersect with the other trains and buses and trams. Main roads get superseded by toll roads that are redundant as soon as they're commissioned. Attempts at integrating the disparate elements is extraordinarily time consuming and expensive...massive re-engineering, retro-fitting.* Whichever interest group grabs the attention of the government of the time, has a short-term win, gets a brief funding stream, and sustainable models tend not to develop.

There has also been little political will to systematically address the fundamental structural weaknesses, which have resulted in inequities and ineffectiveness **across the**

mental health system. Initiatives such as the establishment of state and commonwealth Mental Health Commissions, mental health ministers, mental health task forces, and other oversight groups, have been well-meaning, but in essence, are symptomatic of the lack of true resolve to develop a fair and comprehensive mental health sector. The sector wants to be “mainstreamed” but then ends up advocating for these bodies which, in fact, alienate it from mainstream health decision-making. The growth in the consumer/carer sector is, in part, a reaction to the appalling state of service structure and functioning. If good, reliable care was comprehensively available, there would be little to agitate about.

My view is that this broad-ranging inquiry, to be effective, must address the fundamental weaknesses in the current structures and funding arrangements, and recommend novel and bold solutions. **Providing a raft of recommendations to better fund the various arms of the current dysfunctional system, risks propagating dysfunction and inefficiency.** *The latest example of this is this week’s Budget announcement of funding for suicide prevention, where funds will be increased to various current programs (including ATSI suicide prevention initiatives, Headspace, Early Psychosis programs), but it is unclear how any of this increased funding will lead to reduced suicide rates.*

System redesign is critical and I see the inquiry as a potential watershed in mental health service delivery in this country. Only a national focus will bring about change, and it is time for the Commonwealth to “person-up” and take responsibility. Only the Commonwealth, by itself and through COAG, can chart a course out of this mess.

Governance

There are a number of major players in MH service delivery, of varied capacity, but who is responsible to whom and for what is not clearly defined, leaving much wriggle room and gaps everywhere.

This is what we’re told (by the PC) should be reasonably expected, but we’re not meeting these “aspirations”.

Mental health services aim to:

- promote mental health and wellbeing, and where possible prevent the development of mental health problems, mental illness and suicide, and
- when mental health problems and illness do occur, reduce the impact (including the effects of stigma and discrimination), promote recovery and physical health and encourage meaningful participation in society, by providing services that:
 - are high quality, safe and responsive to consumer and carer goals
 - facilitate early detection of mental health issues and mental illness, followed by appropriate intervention
 - are coordinated and provide continuity of care
 - are timely, affordable and readily available to those who need them
 - are sustainable.

Governments aim for mental health services to meet these objectives in an equitable and efficient manner.

Public hospitals aim to alleviate or manage illness and the effects of injury by providing acute, non and sub-acute care along with emergency and outpatient care that is:

- timely and accessible to all
- appropriate and responsive to the needs of individuals throughout their lifespan and communities
- high quality and safe
- well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required
- sustainable.

Governments aim for public hospital services to meet these objectives in an equitable and efficient manner.

The reasons these things aren't happening has as much to do with governance as any other factor.

From the Governance perspective, the Commonwealth/State divide creates particular difficulties for mental healthcare delivery, in ways that other branches of medicine are not so affected.

States used to provide a greater range of services: inpatient services, outpatient services, rehabilitation and disability support services. Over the last two decades, the range of state services has declined to become mainly hospital and acute community focused, and some (maldistributed) subspecialty services. In NSW, 60% of the mental healthcare budget is spent on inpatient services, and only 40% on community based services. Nationally, state services have remained static in delivering services to 1.8% of the population annually. Their Emergency Departments are overwhelmed by MH presentations, and their capacity for community follow-up is limited to those under the Mental Health Act, and, crisis assessments and telephone follow-up.

Commonwealth funded services have increased dramatically, starting with the introduction of Better Outcomes in the 1990's, then Better Access, plus the rise in PBS spending on antidepressants, the addition of funding for disability support and other specific programs through Medicare Locals (now PHNs), and targeted programs such as headspace. Private psychiatry MBS spending has remained fairly static, but around 9% of the population annually receive some commonwealth funded mental health intervention. ***The reality of funding is that, although states are commonly reported to provide 5/8 of all mental health funding, much of their funding comes from the Commonwealth through the National Health Reform Agreement (NHRA). When these funds are considered, the proportion of funding for mental health services, directly from the Commonwealth, is 5/8. Whether it likes it or not, the Commonwealth should be the major player.***

There are other governance issues:

Maldistribution or Dilution of intellectual capital: there is little ‘operational’ or ‘clinical’ intellectual capital in mental health management outside of state sector and private hospital sector mental health services. Clinical and corporate governance frameworks are well-developed in these sectors, and they have experienced operatives. Commonwealth funded services via the PHN’s are of questionable effectiveness and efficiency. We are told, *The role of PHNs is to lead mental health planning and integration with states and territory, non-government organisation, NDIS providers, private sector, Indigenous, drug and alcohol and other related services and organisations* (AIHW 2016). The commissioning model that has been adopted by the PHN’s has been critiqued (Monitoring Mental Health And Suicide Prevention Reform National Report, 2018), as follows, noting: *the need for more transparency in the competitive commissioning process; gaps in service provision – some successful new service providers have had delays in providing services because of the need to recruit staff, and at the same time unsuccessful providers have withdrawn their services; some established local providers being replaced by new large providers without local knowledge; loss of jobs, especially mental health nurses who worked with unsuccessful service providers (a number of examples in Victoria were cited) negative impacts on and, in some cases, probably irreparable harm to some existing relationships that were very well-established, particularly between general practice and mental health nurses* The NMHC acknowledges that some of these issues may be part of the transition to commissioning services using the stepped care model. However, some of these issues may be compounded by contract lengths for commissioned services.

A common complaint from my colleagues is that PHN commissioned and/or coordinated services, are leading to more fragmentation. Having regular meetings of stakeholders does not equal integration. With each roll-out of new, time limited funding streams, targeted at specific groups, the PHN’s might consult broadly about developing ‘local solutions’ (I have been to many of their “co-design” sessions, with broad stakeholder input, but, solutions are, realistically, very limited when the resources on offer are limited (in dollars and duration), and the target groups are pre-determined). The history of Mental Health service delivery is replete with projects and trials. Re-invention of the wheel isn’t required.

At present the PHN model lacks critical resources (including human capital) to lead mental health planning and integration.

Community Managed Organisations: NGO’s are an increasingly influential player in the sector, in response to states devolving disability support and rehabilitation services to them, and, more recently, with commonwealth funding streams for Partners in Recovery and Personal Helpers and Mentors programs and other disability support roles, but there is a plethora of players (many also starting to deliver clinical services via PHN commissions), clinical governance arrangements are limited and NGO’s have limited resources to invest in internal training, expert supervision and governance arrangements. Compounding these services’ problems is their lack of secure, ongoing funding, and the chaos surrounding the NDIS roll-out and transitioning to NDIA from previous schemes.

Private Hospitals: The role of the private hospital sector is formidable and under-appreciated. They provide significant inpatient services, ECT services (half of all ECT services in NSW) and, increasingly, day patient services, as insurers see benefits in cheaper

day services preventing inpatient admissions. Those that use these services have conditions of significant complexity, severity and chronicity (mainly being moderately-severely affected people with high prevalence disorders, and those with mood, personality and substance use disorders).

Private MBS supported Practice: When it comes to psychology, specifically, Better Access, the problems are obvious and well-documented. Hickie and Rosenberg (MJA 01/04/19) note the massive expansion of the system with little or no accountability, and that access has come at the expense of quality and effectiveness. Jorm (ANZJP, 2018, 52) has also noted the lack of significant positive outcomes from the program more broadly.

For the PC submission I attempted to collate data on private practice psychiatry, particularly the characteristics of patients who are treated in the sector, but data was limited to broad MBS and ABS statistics. The data does show a maldistribution of across all MBS funded items, which is well-known, with outer-metro, regional, rural and remote areas receiving less of this funding, because there are fewer clinicians in these areas.

What do private psychiatrists do? N=1: Currently, I'm a psychiatrist in outer-metropolitan private practice, attached to a private hospital. I see patients across the lifespan, bar children, and see all diagnostic groups, many treatment-resistant and unable to be managed in alternative settings. How do we measure severity and complexity? We don't, but the cohorts we see have complex and severe disorders, suffer significant morbidity, and mortality (due to medical co-morbidities and suicide). But, although I am confident I do valuable work, there is little evidence to support that notion. It is important that we have accurate data about the work of psychiatrists, to ensure the best deployment of their skills.

And, in any consideration of re-design to MH systems, the role of psychiatrist is crucial. Whatever models develop, psychiatrists have a key role as clinicians, working face to face with the most severely unwell and distressed people, as well as being clinical leaders, as the most highly trained of all mental health professionals. As I point out to registrars and colleagues, we are expected to carry the burdens of clinical risk in the MH systems, and are the natural leaders in the multidisciplinary settings that Hickie and Rosenberg propose.

To Conclude:

- Existing systems are failing, the gaps in the system are many, and these issues need to be acknowledged
- All sectors in the MH system say that their area is underfunded
- Pumping more money into flawed systems is not the answer
- Re-design is critical, with aims of equity, accessibility and effectiveness: as part of this, there must be distribution of resources based on populations, not clinician location
- The Commonwealth must take the lead: it is their responsibility
- Alternative funding and governance models must be trialed and evaluated: there is no perfect system, and probably not one system that will suit all regions, but options such as pooled funding, cashing out the MBS (referring to experience with coordinated care trials) are an obvious step. Wholly integrated systems could develop as follows:

regional fund-holders, with demonstrable clinical and corporate governance structures contracted to provide all mental health ambulatory care services; consortia would involve operatives with mental health service operational experience (perhaps comprising groups of clinicians, private sector organisations, public sector mental health services, and community managed organisations). They would have clear, simplified points of entry, accessible and sophisticated triage and assessment systems that provide timely and comprehensive assessments, and can make informed decisions about the type of service that is required, using the “stepped care” model, according to defined minimum standards of care, refer accordingly, then track and evaluate outcomes. They would be accountable to the Commonwealth (contracted to deliver mental health services to all affected groups).

- Psychiatry is ready and skilled to provide leadership

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