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23 January 2020

Mr Michael Brennan
Chair
Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Dear Mr Brennan,

RE: AMA Victoria's response to the Productivity Commission Interim Report

AMA Victoria welcomes the opportunity to provide feedback to the interim report of the Productivity Commission. In this submission, we wish to highlight a number of key themes identified as important by our members that have not been as comprehensively explored in other documents.

National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) has been rapidly rolled out in recent years with packages often between $20,000 - $100,000 for psychosocial disability with the aim of client focused psychosocial intervention, whilst also having the opportunity to optimise social determinants.

Our practitioners however have largely noted the initial rollout has had limited or no interface with medical staff, apart from the usual initial request for a report to submit for access to the NDIS. AMA Victoria members have noted that in some cases this limited collaboration has contributed to some important needs of their clients not being met, sometimes with limited opportunity to work towards effectively addressing these areas.

The patient and family knowledge obtained by general practitioners and various other specialists often spans a lifetime, with a recognition of the individual patient's needs through various stages of their life and where the doctor has historically advocated for numerous challenges prior to the development of the NDIS.

Yet, a constructive approach to utilise this information and to help prioritise and work towards effective goals has not been consistently developed. Whilst activities can be found to complete a funding package, these may not be optimally prioritised to the needs of the individual at that time.

There has also been a significant NDIS workforce turnover resulting in the 'case-learning process' recommencing with different support workers. This is unfortunate particularly for a patient group which struggles with trust and certainty and benefits from consistency and continuity of care.

Whilst this Commission focuses on social determinants, an effectively utilised NDIS could optimise these factors for the most disabled in our community. Additionally, the ongoing limited integration of mental health and disability services at multiple levels is likely to develop departmental silos and entrench these separate cultures into the next generation. In many cases, it also develops unnecessarily duplicated service provision in healthcare and disability services.

AMA Victoria members have also highlighted their concerns that a number of patients who are most in need do not co-operate with the process due to their illness and experiences, and subsequently do not obtain access to NDIS funding and associated programs. Some of these patients were captured by programs prior to the introduction of the NDIS, but their cessation after the NDIS now leaves unfortunate cracks in the system.

Rebuild versus renovate challenges

Rather than the community having to choose between rebuilding and renovating the mental health care system, AMA Victoria members recommend that the system be both rebuilt and renovated. The private sector mental health system works alongside and at times in conjunction with the public sector mental health system. The state and territory-based public sector system does require very significant rebuilding in order to become more comprehensive and cost-effective. An example is Victoria where there is currently a Royal Commission into Mental Health.

Public sector psychiatrist colleagues are working at the limits of their capacities, often frustrated by the levels of management and governance strategies they must satisfy, with limited real recognition of the adverse effect this has had on consumer treatment delivery by psychiatrists and other practitioners. Whilst there is a hope that earlier intervention and adequate treatment will result in fewer acute or crisis cases, there is still the need for adequate resourcing in the care of moderately to severely unwell patients.

It has been recognised that there is a desperate and immediate need for many more psychiatric inpatient beds. The Victorian Royal Commission's interim report recommended 170 new beds, with innovative approaches, and additional beds may be further recommended in the final report. Similar acute care reviews are required in all states.

A central theme in the Productivity Commission's rebuilding strategy is that better governance will be represented by higher level structures with increased management of mental health overall. There is however no clarity that this will work as similar systems have been remarkably inefficient in producing better mental health treatment and care, and extremely expensive – for example, the United Kingdom under the National Health Service, which has been operational for decades.

The introduction of an additional system might be alluring but also brings with it the paperwork, administration and non-clinical time costs for clinicians without any guarantee or proof of benefits or solutions. Apart from the problems and challenges noted in other countries at a countrywide level, at a local level it takes scarce and much needed time and finances away from direct clinical care.

There is no doubt that the Medicare-based system run by the Commonwealth Government requires renovation. Many AMA Victoria members would argue that this is true, not just for mental illness, but in general practice care, and likely across a spectrum of medical treatment. The reason for the need for such renovation is that the Medicare system has been neglected by successive governments, and has driven down patient rebates for all medical services under Medicare for decades. This has saved the federal government considerable amounts 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.

As a consequence, 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. Yet in this process, the health-seeking behaviour of citizens is being adversely shaped, so people are presenting later in their illnesses, which will escalate morbidity and employment-related disability costs.

People who suffer from more severe mental illnesses tend to have problems obtaining and maintaining work, as the Productivity Commission has clearly surmised. Consequently, 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.

Solutions

For the public sector to prevent the need for excess psychiatric hospitalisation in the longer term, it will be necessary to broaden 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 rather than the current acute and episodic care that currently occurs.

Once stabilised, consumers are currently regularly discharged to primary care often with no support or follow-up to guide the general practitioner to provide optimal ongoing care. Optimised preventative support strategies and treatment to limit further deterioration or relapse in these cases should provide a foundation to ensure that the social improvement strategies the Productivity Commission proposes, will achieve success - on 'fertile ground', so to speak. A range of solutions to expanding services provided by public state based psychiatric services are explored in the AMA Victoria submission to the Victorian Royal Commission into Mental Health (2019). Apart from the historical public sector client groups, this submission also covers approaches to addressing the newly coined 'missing middle'.

For the private sector, the answer to providing better governance and effectiveness within the system is not necessarily to impose further levels of institutionalised governance, in the form of traditional management. There is a modern concept of complex systems analysis, and mental health within Australia can certainly be recognised as a very complex system. It would be better to look quite differently at this complex system, and look at minimalist types of management interventions and more effective devolution of responsibility down to adequately resourced clinical leadership, co-ordination and expertise at a patient level. These enhancements and requirements are organised at a case by case level, by the most experienced clinicians who can access the necessary supports around this, rather than an external third party organisation, often with case workers with lesser clinical skills, and the application of another level of administration.

With respect to the optimisation of workforce access and linkages between providers, our members would recommend the development of a constructive framework that builds on the existing structures and benefits of the Medicare MBS process rather than a destructive process that removes or abandons Medicare and the beneficial effects of this for an enormous array of patients. There have been attempts to utilise MBS items for teleconferencing and case meetings to enhance capacity and integration however these item numbers have been relatively basic additions to traditional face-to-face consultations. Medicare may also be utilised to provide other processes and clinical structures including supervision, mentoring, facilitating group discussion and approaches to upskilling local providers by trained specialists to enhance mental health coverage. The system can also be utilised to provide very easy departmental auditing, checks and balances whilst also maintaining the current indicators, evidence and benefits.

School Age Intervention

It is noted that the Productivity Commission interim report does not cover the 0-5 age group. With respect to children from conception to 12 years of age, the evidence that investing in people's mental health and development trajectories from very early in life is compelling - with potential to save billions of dollars if implemented systemically with integration across whole of government departments. The current system results in many people not reaching their potential and being harmed by the secondary effects of not having their needs met.

Taking a developmental lens and intervening whilst critical brain connections are forming is an ideal time to protect and enhance children's potential. Community based settings are well located to deliver place-based services as part of children's normal activities with an emphasis on family involvement. The interim report does emphasise the enormous savings of investing very early in life and how proportionate universalism to help people overcome multiple adversities – often in the context of intersectional discrimination - is the right thing to do. The focus could be on the eight per cent of all families who are most at risk with health services identifying children with more complex difficulties who are more at risk.

This approach would identify child neglect and maltreatment earlier and reduce the risk and impact. The Marmot Review will be released in February 2020 and will be an important reference to consult. Mental health services will be vastly more effective if the government decides to invest in ending child poverty and helping families overcome intergenerational adversity, rather than investing in 'tough-on-crime' policies such as child detention, incarcerating parents for minor offending and targeting youth offenders. Delaying early intervention means extra costs will occur later, given the consequences of untreated mental ill-health, the impact on all domains of development and health, and the loss of potential across the lifespan and subsequent generations.

Strategies to improve mental health very early in life (antenatal to 5 years):

It is positive that the interim report recommends screening socioemotional health at maternal child health nurse (MCHN) checks. In Victoria, many MCHNs have had access to additional training, reflective supervision and direct consultation with infant mental health professionals.

To develop additional interventions, a working group should be formed with representatives across interrelated sectors – including child psychiatrists, paediatricians, epidemiologists and general practitioners. They would need to consult with the group of clinicians that is being established for the child mental health strategy. Such services should integrate care for children with acute health, mental ill-health and neurodevelopmental differences. The system would benefit from greater shared care arrangements and regular secondary consultations between paediatricians, GPs and child psychiatrists.

The current siloed approach can place additional pressure on paediatricians to diagnose and medicate children with challenging behaviours who are not receiving comprehensive team-based interventions, which increases costs. Greater independent oversight is needed for children prescribed stimulant and psychotropic medications given the potential for harm. Child psychiatrists could consult to GPs and paediatricians early in the management to formulate what is happening and what needs to be done to improve the child's mental health, relationship security and development.

Models to consider:

An integrated system of care would involve funding for advice and consultation from tertiary services to secondary and primary services in the clusters of services where children already attend. This model is available in those pockets where tertiary hospitals have prioritised the funding. Examples of Australian models for potential consideration

by the Productivity Commission for wider use and local adaptation include the infant & preschool team service model at the Alfred Health Child and Youth Mental Health Service (CYMHS).

Additionally, the New Orleans Tulane model works closely with the child protection system and the courts. It offers convergence between various levels of care with capacity building and ready access to specialist mental health service involvement. https://medicine.tulane.edu/centres-institutes/tecc

The development of appropriate follow-up, databases and evaluation of any models utilised would also contribute to the literature in this area.

Primary school aged children:

Many of the points above are relevant to primary school aged children. It is misleading to say adolescence starts at 10 years of age. Children in latency years need family centred interventions and do not fit into a youth model, which from a child psychiatry perspective is best applied from 15 or 16 years onwards.

A focus on improving the mental health skill set of teachers is only one part of the investment needed. Children with 4 or more adverse child events (ACEs) often have impaired capacity to learn and regulate within any group setting and struggle with the demands of a classroom environment. Early identification in children will prevent them falling behind with learning and peer relationships. School based interventions would need an additional workforce given the level of existing demands and role stress already placed on teachers. Many children presenting to tertiary centres often have significant risk issues to self and others. Many require child-centred team-based family interventions over time, to a degree that could not be feasibly managed in school settings.

The CASEA program could be extended to provide secondary consultations to schools after a period of intervention to consolidate the skills they have acquired. In some situations reflective supervision by a psychiatrist could be undertaken by teleconferencing for teams in more remote areas where access is limited.

Specialised child psychiatry mentoring, supervision and potential for tertiary referral can limit unnecessary over-diagnosis and over-medicalisation contributed by the current silos, with at times limited expertise and awareness of the literature by practitioners working in less supported environments. The above approaches would also help to identify infants and very young children on a potentially very negative or destructive trajectory and ensure optimisation of support services for the infant and parents at a time where neuroplasticity and the opportunity for change is potentially very significant.

This submission has been developed in conjunction with a number of members with experience across the spectrum of mental health care who have explored approaches to addressing some of the abovementioned challenges. We would be happy to provide additional information if required.

Yours sincerely,

Dr Ajit Selvendra
CHAIR OF THE SECTION OF PSYCHIATRY
AMA VICTORIA