National Association of Practising Psychiatrists

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

APRIL 2005

National Association of Practising Psychiatrists Inc
ARBN 076 781 854
PO Box 12 ARNCLIFFE NSW 2205
Telephone: 02 9556 2534 Facsimile: 02 9567 4681
E-mail: napp@milgate.net Web: www.napp.org.au

PREAMBLE

We respectfully submit the following information for the Senate's enquiry; it deals with that vast number of patients who are deemed to suffer from psychiatric illness but who are inadequately managed in the community due to lack of resources. In making this submission, the National Association of Practising Psychiatrists (NAPP) wishes to commend the Senate on undertaking what is arguably one of the most critical issues facing the Australian community – that of mental health.

Terms of Reference
This submission is in **two parts** in order to address particular terms of reference, viz

- (b). the adequacy of various modes of treatment
- (f). the special needs of groups such as children…and of people with complex conditions
- (h). the role of support for primary care givers
- (i). promoting recovery-focused care

The specific terms of reference are elaborated in the Executive Summary of this Submission.

The Decline of Public and Forensic Psychiatry
NAPP outlined the problems of public and forensic psychiatry in NSW in its submission to the NSW Legislative Council Select Committee on Mental Health 2002[1]. This submission comprehensive evidence of

1. **Chronic shortage of hospital beds** for patients with acute mental illness.
2. The linkage between **inability to obtain urgent treatment**, **early discharge and tragic outcomes** for patients with mental illness.
3. The advent of **gaols as the "new" institutions for the mentally ill**.

Sadly, since this submission was **made very little noticeable progress** has been made.

The second report of the NSW Mental Health Sentinel Events Review Committee (March 2005) states that **102 suspected suicide deaths had been reported as occurring within one month of discharge** from a NSW Mental Health facility and this may be an under-estimate[2].

Although NAPP has emphasised the problems in NSW in its previous submission, there is **no evidence to show that the situation is demonstrably better in any other state**.

All state governments have **progressively devalued public mental health assets** and have **not significantly invested in new public health infrastructure** designed to support patients with mental illness.

The **significant decline in public hospital beds for patients with mental illness is an established fact**. The results of this decline are now the subject of intense debate.

---

[1] www.napp.org.au
[2] NSW Mental Health Sentinel Events Review Committee (March 2005), Page v

Managed Competition - a failed strategy
NAPP is fully aware of the view that recent proposals to introduce elements of competition policy into health care can only exacerbate an already desperate situation. The introduction of US-style managed care that will follow will inevitably lead to less services and access, which are already critical problems.

NAPP supports reinvestment in public sector facilities and treatment modalities for patients with mental illness.

NAPP is fully aware of the many difficulties facing public sector psychiatry. These no doubt will have been outlined in numerous other submissions; NAPP supports any reforms of the public sector aimed at reinvesting in facilities and providers to facilitate the availability of a diverse range of treatment options.

Patients with mental illness struggling to cope in the community

NAPP strongly recommends that the Senate Committee consider recommendations that promote care for a vast number of Australians, children and adults, who struggle with mental illness while remaining in the community. These are patients with non-psychotic illnesses who are in danger of being overlooked by virtue of their seeming adaptation in the community. The cost to this community of neglecting this issue is large, in terms of reduced productivity, drains on other services and absenteeism

Labelling fallacies
The NSW Legislative Council Final Report entitled, "Inquiry into Mental Health Services, December 2002" made the key point that the non-psychotic illnesses are chronically debilitating and need more treatment options available for them. **The dichotomy between "serious and (presumably) non-serious" mental illness is completely false**. In the words of the Final Report,

> *The New South Wales mental health system seems to be geared towards people with recognised psychotic illnesses which respond to medication. We do not suggest it is inappropriate that these people be given high priority, but we suggest that there are other people with non-psychotic illnesses who also need help. For people…who are depressed, suicidal and in need of long-term psychotherapy, it seems that the mental health system has little to offer apart from 'band aid' measures such as a dose of medication.*
> *(Page 218 Final Report - December 2002)*

Restrictions on rebates for treatment add unnecessarily to patient hardship
NAPP feels that **restrictions currently in place on treating this group of patients**, a group where often all else has failed, **disadvantages them in serious ways.** Firstly, their suffering is inadequately treated. Secondly, they have a large safety net obligation to meet. Thirdly, despite Medicare Plus arrangements these patients are still left to pay 20% in gap fees that amount to a large sum per week (in total) for families who already struggle under the burden of mental illness.

Medicare Plus
Although Medicare Plus arrangements have helped some patients who have more savings to fall back on to pay gaps after their 80% out-of-pocket rebate, nevertheless there remains a group of patients described above who are **seriously disadvantaged even with current arrangements**. This just adds to the problems faced by patients from declining services.

Evidence based medicine
As a society of medical practitioners **NAPP supports the pursuit of scientifically validated medical treatment** where evidence is researched and presented to establish the efficacy of treatment modalities.

However, a lay Committee should be very mindful that the mantra of "evidence-based medicine" can be used and abused as a rationing device to exclude efficacious treatments for certain groups.

The **choice of evidence can be deliberately skewed** subjectively often with disastrous consequences, as in the MBS Item 319 issue. One of the consequences of just such an exercise has been to label non-psychotic patients with mental illness as having no serious mental illness. The problem of the misuse of evidence has been described in research, but it is patients who bear the consequences.

The NAPP submission is divided into **two sections** for ease of reference. Although each section is detailed, an Executive Summary for each is appended.

We urge the Senate Committee to recognise the very great need the community has for highly specialised skills in psychotherapeutic strategies – a large number of adults and children rely on this expertise being maintained rather than eroded as is happening

Increasingly, General Practitioners are also coming to find these skills are vital to their being supported in the role of primary care provision. Trials are currently under way aimed at providing this support through the networks of the Divisions of General Practice. **The community cannot afford to lose such expertise, gained often with years of great personal effort**.

Long Term Intensive Psychiatric Treatment: The Impact of Medicare Item 319 and Associated Restrictions on Patients, Psychiatrists and the Community

Part 1 of a submission prepared for the
Senate Select Committee on Mental Health
by the National Association of Practising Psychiatrists

April 2005

Contents

Executive Summary

- The **rationale** for review of Item 319 (and all associated Items, eg 316) is outlined - primarily the lack of evidence that its introduction has produced any specific advantages for patients, it has actually disadvantaged adult patients that don't neatly fit Item 319 criteria; access to psychiatrists has decreased rather than increased; and there is an economic case for review.

- The **Senate Committee** should consider this area in light of the following terms of reference: ***(ref a)*** the National Mental Health Plan completely overlooks this issue, in contravention of its own *The Statement of Rights and Responsibilities;* ***(ref b)*** this mode of care is increasingly unavailable to patients with comorbid and complex needs; ***(ref f)*** special groups like children and young adults can particularly benefit if availability is increased; (***ref g & h)*** the expertise put at risk by Item 319 restrictions is invaluable in supporting primary carers and GPs in providing quality care.

- The document outlines the need for long term, intensive psychiatric treatment, which is seen as a necessary **treatment** for a wide group of patients which span the *whole spectrum* of psychiatric morbidity. The treatment of this vast number of non-psychotic patients will increase well-being and thereby increase productivity and reduce demand for services ie there are cost-offsets

- Patient characteristics (for those accessing this mode of treatment) are outlined, demonstrating their high level of previous trauma (sexual/physical abuse or bereavement), and the frequency of this group having failed prior attempts at briefer treatments.

- Australian and international **research** to support the validity of long term intensive treatment is presented - included are studies that demonstrate **efficacy**, studies demonstrating *the need for high frequency of consultations*, and demonstrations of **cost effectiveness**, as well as *comparison studies*. Supporting biological and general research shows such treatment is generally seen as **safe**.

- The conclusion outlines broader detrimental impact on issues such as the disincentive Item 319 provides for future training in psychiatry (which goes against recent AMWAC recommendations), the detrimental impact on treatment which the WHO outlines as necessary to deal with an impending epidemic of Depressive Disorders, as well as the disincentive for useful partnerships to emerge in dealing with maldistribution (eg rural) problems.

- A revised consultation **descriptor** is proposed, with an appropriate **fee.**

- **Consultations** with associated organisations, and **consumer** views are outlined - and remedial **policy options** are outlined.

Introduction

Long term intensive psychiatric treatment is a necessary treatment for particular groups of patients who have frequently been highly traumatised, have often failed prior treatment, and who often have (co-morbid) disorders involving debilitating personality disturbances as well as a formal psychiatric disorder. These patients are the psychiatric equivalent of patients needing "intensive care" in medical units.

This paper examines long term intensive psychiatric treatment in the light of the effects of Medicare rebate restrictions (Item 319 and associated restrictions) placed on patients requiring this form or care. These restrictions , in our view, do not reflect the sentiments expressed in *The Statement of Rights and Responsibilities, A Guide for Carers and Providers 1991* which formed part of the first National Mental Health Strategy, and was ratified by the Australian Health Ministers' Advisory Committee, which emphasises the rights of patients to access quality care.

The rationale for changes sought by the National Association of Practising Psychiatrists (NAPP) is outlined together with supportive evidence, details of efficacy and cost-effectiveness, and consumer views on the need for change. It needs to be clearly understood that NAPP views recent distinctions drawn between "serious mental illness" and (implicitly) "other" as completely spurious. NAPP argues that ignoring the long term pervasive effects of personality disturbance (so called Axis II issues in the Diagnostic and Statistical Manual for Mental Disorders (DSM IV) as they influence psychiatric conditions and their treatment does not reflect clinical reality and is a serious policy omission.

Further, NAPP submits that there are fundamental principles that underlie our proposition that Item 319 and associated restrictions need to be reversed - ie the need to always combine an understanding of Axis II issues in any treatment plan, long or short-term. Therefore NAPP sees every consultation potentially as one where this expertise and judgement is brought to bear on management - every consultation therefore, should be rebated equally.

The 1996-97 Federal Budget arguably brought with it a change in fundamental tenets which previously had underpinned the Medicare Benefits Schedule - rationing of health care based on *clinical diagnosis*. This fundamental shift in health care policy has, unfortunately, impacted in a variety of negative ways on patient care.

The personal suffering of patients affected by this policy shift, specifically outlined in the case studies, is both distressing and a wake-up call to policy makers.

The case to review Item 319, would seem to rest on several key points:

- It is demonstrably true that it has *disadvantaged* many patients
- It has clearly *not* led to increased access to psychiatric services
- It has *not* influenced maldistribution issues
- It is *unclear* that any monies saved were derived from this measure
- Section A.15.3 of the Medicare Benefits Schedule (MBS) discriminates against the use of proper treatment *first and so adds to costs* as money has to be spent on other treatments which have to fail before the patient is eligible for Item 319.

- There is a clear *economic case* to support increased access to intensive treatment.
- That Item 319 was initially based on a perceived need to save money ignores the issue of *duty of care* towards patients – which in turn has legal implications
- Long term intensive treatment is widely considered to be "*clinically relevant*" (as defined in the MBS) and therefore its effectiveness should not be impaired
- In the face of mounting concerns at the explosion of *costs* accruing from the Pharmaceutical Benefits Scheme (PBS), it arguably makes no sense to restrict treatments based on consultations that produce, in many cases, equivalent or better outcomes.

The true clinical impact of the MBS changes cannot be appreciated without understanding the nature of the work that is now being denied to some patient groups, and how it forms a vital link in an overarching chain of available treatments for mental illness.

Given the above, this document details some of the salient points, against which the clinical issues can be considered.

The Item 319 issue encapsulates the problem of economic rationing of health versus ethical treatment of patients, with the medical practitioner caught between government dictates, and ethical and professional obligations to their patients.

Further, the impact of Item 319 regulations needs to be measured against the more recent development of enquiries into mental health services currently underway in at least two states (NSW and SA). As community concern grows at a perceived lack of treatment resources, NAPP argues that a review of relevant Items that limit access to treatment would be both timely and wise.

Item 319 revisited

What is Item 319?

Medicare Item 319 refers to an item number in the MBS which is described as follows:

> *"Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry where the patient is referred to him or her by a medical practitioner - an attendance of more than 45 minutes duration at consulting rooms, where the patient has: (a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance related disorder, somatoform disorder or a pervasive development disorder; and (b) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale - where that attendance and any other attendance to which items 300 to 308 apply do not exceed 160 attendances in a calendar year."*[3]

The fee indicated for this Item is $138.45.

Furthermore, explanatory Notes to this Item, in part, read as follows:

> *"A.15.2 It is not sufficient for the patient's illness to fall within the diagnostic criteria. It must be evident that a significant level of impairment exists which interferes with the patient's quality of life. For persons 18 years and over, the level of impairment must be within the range 1 to 50 of the Global Assessment of Functioning (GAF) Scale contained in the DSM-IV (ie the patient is displaying at least "serious" symptoms). The GAF score, incorporating the parameters which have led to the score, should be recorded at the time of commencement of the current course of treatment. Once a patient is identified as meeting the criteria of Item 319, he/she continues to be eligible under that item for the duration of the current course of treatment (provided that attendances under 300 to 308 and 319 do not exceed 160 in a calendar year). Where a patient commences a new course of treatment, the GAF score in relation to Item 319 is the patient's score as assessed during the new course of treatment.*
>
> *A.15.3 In addition to the above diagnostic criteria and level of functional impairment, it is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. It is expected that such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long term psychotherapy; pharmacological therapy; cognitive behaviour therapy.*
>
> *A.15.4 It is the responsibility of the psychiatrist to ensure that the patient meets these criteria. The Health Insurance Commission will be closely monitoring the use of Item 319.*

[3] Commonwealth Department of Health and Aged Care. Medicare Benefits Schedule. November 2001. pg 157.

> *A.15.5 When a patient who meets the criteria defined in Item 319 attends a psychiatrist on more than 160 occasions in 12 months such attendances would be covered by Items 310 to 318."*[4]

When did Item 319 and associated Items commence?

Item 319 and its associated restrictions took effect from 1 November 1996.

Why were Item 319 and its associated Items introduced?

Fiscal reasoning

Following the election of the Coalition in March 1996, the existence of a $10 billion Budgetary deficit came to light. As a result, not unexpectedly, the Budget of 1996-97 took steps to eliminate or reduce certain costs in relation to Medicare rebates.

The following brief summary places these intended reforms in context:

The 1996-97 Federal budget contained cuts in Medicare outlays over 4 years of:

- $341 million in Pathology
- $241 million in Radiology
- $226 million across the MBS in fee freeze
- $670 million through provider number limitation of access to Medicare
- as well as a number of other lesser initiatives including changes to rebates in excess of fifty consultations per year in psychiatry.

Reduction in Medicare Rebates for psychiatric consultations

The reduction in Medicare rebates for patients requiring over 50 consultations in any 12 month period was to contribute $14 million to the total proposed 'claw back' of some $1.7 billion over the quadrennium.[5]

From 1 November 1996 it was proposed that, where patients attend a psychiatrist in their consulting rooms on 50 or more occasions in any 12 month period, the Medicare rebate for consultations would be reduced by 50% for those additional attendances.

It was asserted that patients having more than 50 out of hospital psychiatric consultations in a year represented some 1% of patients but accounted for 16% of Medicare benefits paid for such consultations.[6]

No costings (eg hospital or general medical costs) were given if this group were to be left *untreated.*

In the words of one psychiatrist *"to prevent 1% of psychiatric patients being seen more than once weekly, this policy (Item 319) has endangered the clinical care of the rest of the suicidal psychiatric patients we treat, quite apart from the extra suffering imposed upon those who do not meet the criteria to be seen more than once a week"*.

---

[4] Commonwealth Department of Health and Aged Care. Medicare Benefits Schedule. November 2001. pg 30-31.

[5] Facts Sheet – Budget 96-97: *Medicare Benefits.* p. 3. (Attachment 14)

[6] Facts Sheet – Budget 96-97: *Medicare Benefits.* p. 3. (Attachment 14)

The expected savings from the Medicare rebate restrictions from this measure were $2 million in 1996-97; $4 million in 1997-98; $4 million in 1998-99 and $4 million in 1999-2000. A total of $14 million over the budgeted 4 years.

It is important to see this measure in its proper context. $14 million over the four years represents 0.008% of the proposed budget savings.

Item 319's portion of the health sector's contribution to the 'Budget Black Hole' was therefore insignificant. (As mentioned previously the total proposed Budgetary saving in health expenditure was approximately $1.732 billion). A fiscal reason for the existence of Item 319 and associated restrictions therefore cannot be reconciled with the purported savings.

Ministerial justification for Item 319 and associated restrictions

As previously indicated, given the dollar amounts involved in the Item 319 and associated restrictions, it is difficult to sustain that the rebate reductions related solely to the government's macro *economic* policy.

It was however indicated at that time that if the results of the Budget decision could be seen to be ineffective or damaging and a viable alternative was available the Minister was willing to reconsider the Budget decision. This has not happened.

In addition, on 27 November1996, Dr Michael Wooldridge, Minister for Health, in a statement to a public meeting organised by the Mental Illness Network Against Discrimination (MIND) indicated the following:

> *"By way of background, the Governments proposals have been based on the need for more equitable distribution of available resources. We are very concerned about the number of people, particularly those in rural areas, who presently have no access to psychiatric care.*
>
> *As a means of comparison, the funds the Government has been spending each year to allow 2,500 people to see a psychiatrist more than once a week would allow 50,000 people to each see a psychiatrist five times a year.*
>
> *At the individual level, by the time patients have had 50 psychiatric visits, they will have received over $6,000 in Medicare benefits, before benefits are reduced. This compares to Medicare benefits of about $2,000 for heart surgery and $3,000 to remove a brain tumour, highlighting one of the problems the government has in balancing how resources are used in different medical conditions."* [7]

As far as NAPP was / is concerned, the argument that some people's suffering was worse (and therefore more costly to remedy) than the suffering of others - or that some patients should reduce adequate treatment to allow others access - could never be ethically justified.

[7] Statement by the Minister for Health and Family Services. Public Meeting organised by MIND. 27 November, 1996. (Attachment 15)

Dr 747

The Dr 747 incident is perhaps now only of historical interest, but in 1996 this "issue" was raised as an important justification for the introduction of cuts to rebates for long term intensive treatment.

In essence the premise put to Parliament was that long term treatment was clearly open to abuse (as shown by the purported practice of "Dr 747", a practice which was investigated but which has never proceeded to prosecution) and in addition that "little evidence" existed to attest to its efficacy. (Attachment 10)

Both claims were / are demonstrably untrue, as NAPP has maintained the view that evidence of efficacy, safety and cost-effectiveness (put in this submission) does indeed exist, and further the Commonwealth has always had the power to take action against alleged abuses of the Medicare system. Therefore, on these grounds, the introduction of Item 319 was not justified.

Evidence vacuum

The introductions of Item 319 and associated restrictions appears to have been a clear misunderstanding, not necessarily deliberate, on the part of the Government in 1996, as to the special nature of and requirements for long term intensive psychiatric treatment compared with those of more general psychiatric practice.

This Departmental *evidence vacuum* led to the categorisation of such requirements as overservicing based on the differences from everyday medical practice. An arbitrary cut-off point of fifty, presumably roughly based on weeks in the year, became the conventional wisdom for the appropriate frequency for psychiatric attendances. This unfortunately reflects a misguided mindset that oversimplifies the complexity of mental illness.

No clinical data was presented to support such a cut-off point and experienced clinicians working in the field were not consulted as to likely adverse outcomes.

NAPP asserts that the Department, unaware of the clinical realities came to the view that there was a perceived significant mal-distribution of limited psychiatric resources.

The implication was that psychiatrists spent much of their time looking after the upper-middle class “worried well”.

This erroneous line of policy was further compounded with the concept of ‘unmet need in psychiatry’ where it was believed that some people were seeing a psychiatrist two or more times per week *at the expense of others* who were seen as equally needy with only minimal or no access. The Minister went on to state clearly the Government’s commitment to improved mental health services through the better targeting of available resources and through increasing access to services by people who presumably were going without. In fact, access to psychiatric services has decreased since the introduction of these MBS restrictions in 1996.

The figure of 2500 psychiatric patients (1810 females and 690 males) utilising more than 50 consultations was based on 1994-95 statistics. At the same time it is worth noting that there were 259,217 patients receiving from 1-50 consultations. The distribution of these

2500 patients were subsequently enshrined in the now famous "coloured maps" which set out the number of patients with >50 consultations, by electorate, based on postcodes.[8] (Attachment 1)

Any conclusions drawn from the "coloured maps" need to be tempered by experience in providing long term intensive treatment. NAPP maintains the view that it is vital to remember that this particular form of treatment is like any other - ie it will be suitable only for those meeting certain clinical requirements, which indicate that this treatment is appropriate. It would be a fallacy to equate access of this particular kind of treatment to, say, access to surgery for hernias - the latter only requires the patient to have a hernia needing repair while the former is more complex.

Revisions to Item 319

The NAPP has always held the view that Item 319 and associated restrictions interfere with high quality psychiatric care, particularly as they restrict adequate treatment for a group of severely emotionally ill patients. We have regarded them as stigmatising and discriminatory, and have consistently sought their repeal or comprehensive modification.

In support of this position, NAPP would emphasise that

- experience since 1996 has shown us that neither psychiatrists nor patients are satisfied with Item 319 measures. Indeed, NAPP came into existence partly because of this dissatisfaction.
- NAPP feels that the descriptor for Item 319 is unduly restrictive for patients needing to access this service.
- the GAF requirement is unworkable and seriously violates privacy concerns.
- the limit of 160 sessions limits the effectiveness of what can be offered to ill patients.

NAPP therefore represents a widespread view amongst psychiatrists that these restrictions have been tried, they have caused undue hardship and stigmatisation, and so the time is ripe for a review.

To repeat, the case for review can be summed up thus:

- It is demonstrably true that it has disadvantaged many patients;
- It has clearly not led to increased access to psychiatric services;
- It has not influenced mal=distribution issues more generally;
- It is unclear that any monies saved were derived from this measure only; and
- There's a clear economic case to support unlimited coverage of intensive treatment.

Human Rights and Equal Opportunity Commission (HREOC)

The perceived discriminatory nature of the Item 319 regulations was the impetus for NAPP to approach the HREOC in an attempt to review these provisions of the Medicare Benefits changes introduced on 1 November, 1997. They recommended:

> *"HREOC urges continued review of the operation of the relevant provisions, in consultation with consumers and the professional bodies concerned, to ensure that they operate in a manner which is non-discriminatory and which is consistent with*

[8] Geographic Distribution – by electorate – of people having more than 50 psychiatric consultations per year.

> *and promotes the right of people with psychiatric disability to equality with all members of the Australian community.*"[9]

In summary, the National Association of Practising Psychiatrists (NAPP) was of the view that Item 319 and related item structures remained discriminatory (be it not in the strict legal sense), were thus unable to appropriately promote the rights of equality of people with psychiatric disability, and remained a significant deterrent to appropriate psychiatric practice in some circumstances. A wide range of psychiatric patient rights groups, whose members have been demonstrably affected by that initiative, were completely supportive of that view.

A brief summary of these above-mentioned changes follows:

The situation brought about by the unilateral introduction of the 1996-97 Budget soon brought the realisation on the part of the Government that there were potential problems with the Disability Discrimination Act (DDA). The Human Rights and Equal Opportunity Commission (HREOC) supported the view that the restrictions[10] introduced on 1 November, 1996 would have a discriminatory effect on patients with psychiatric disability which was inconsistent with the provisions of the Act.

Early on, meetings were held involving the Medicare Benefits Branch, HIC, RANZCP and the AMA through the Medicare Benefits Consultative Committee (MBCC) which resulted in the introduction into the MBS of Item 319 – effective from 1 January, 1997. These changes[11] were incorporated in the 1 May, 1997 Supplement to the 1 November, 1996 MBS. (Attachment 3)

The pluses and minuses of the 1 January 1997 version of Item 319 failed to satisfy the HREOC, who at their meeting in February 1997, decided to further examine the new Regulation concerned in terms of consistency with the objects of the DDA under Section 67 (7) (i1) of the Act. In August 1997 the Disability Discrimination Commissioner circulated a 'draft report' for consideration by the interested parties. The 'draft report' made reference to evidence of emotional disadvantage being experienced or apprehended as a result of the restrictions imposed. It expressed the view that this disadvantage did not constitute discrimination as defined by the DDA but that the regulations *did not promote the objects* of the DDA. In other words the 1 January, 1997 modification to the relevant Regulation, with the introduction of Item 319, addressed some but not all of the original concerns. HREOC nevertheless did accept the view that a finding of indirect discrimination should not have been excluded in relation to the Regulation as originally issued and modified up to August, 1997.

In its response to the 'draft report' the DHFS emphasised in relation to the definition of a "clinically relevant" service that a particular treatment, which might be regarded as effective and be the treatment of choice by some patients and some practitioners, did not necessarily meet the definition of clinical relevance for medical treatment generally and for psychiatric treatment in particular. The DH&FS saw the item descriptor 319 as setting out the circumstances where the clinical need had been supported by scientific evidence and that it took account of all the circumstances where there was evidence that more than

---

[9] Disability Rights - *Medicare benefits for Psychiatric services.* Summary of findings. p. 1. (9 January, 2000).
[10] Attachment 2
[11] Attachment 3

50 out-of-hospital consultations might be required for effective treatment. NAPP disagrees that *all* circumstances were taken into account.

It should be noted that this all took place prior to the removal of Sections 11 and 12 from the Health Insurance Act, 1973 along with the partial replacement of the functions of the Medicare Benefits Advisory Committee (MBAC) with the Medicare Services Advisory Committee (MSAC).

Nevertheless there were continuing substantial concerns which included :

- Restricted range of causes of disorders
- Restricted range of disorders
- Loss of privacy
- History of failed treatment
- Required level of functional impairment

Of particular relevance to the current debate is the issue of 'Loss of privacy'.

Also, in its response to the 'draft report' the DHFS advised that "the working party has continued to meet and recently agreed on some modification to the description of Item 319, again based on evidence and expert opinion, to ensure that people in genuine need of intensive long term psychiatric care have access to such treatment without undue financial hardship, where there is evidence that such treatment is likely to be effective".

The DHFS went on to request more time to provide further information to HREOC. The Disability Discrimination Commissioner agreed to this request on 26 September, 1997 and on 15 October, 1997 HREOC received advice from the DHFS regarding a revision of Item 319 as foreshadowed which was to come into effect on 1 November, 1997. (Attachment 4)

These modifications were welcomed by HREOC and as a result the changes to the new Regulations were no longer seen as discriminatory nor inconsistent with the objects of the Disability Discrimination Act. The remaining restrictions were seen then as consistent with those which apply generally to the Medicare Benefits Schedule across a range of other areas of medical treatment.

In summary, it is interesting to contemplate what the Government achieved in this exercise.

- It achieved savings well in excess of (approximately twice) those set out in the 1996-97 Facts Sheets.

- It achieved a reduction in fees/benefits for more than 50 consultations per annum setting out what it regarded as a price signal to both psychiatrists and patients. It was subsequently forced to modify this achievement on the grounds of discrimination.

- The DHFS, then, had successfully covered itself against the charge of any form of discrimination from the HREOC which had as already mentioned above, gone on to urge a *continuing review of the operation of the relevant provisions* in consultation

with consumers and professional bodies concerned, to ensure that they operate in a manner which is non-discriminatory and which is consistent with and promotes the right of people with psychiatric disability to equality with all members of the Australian community.

In October, 1998 the DHFS reviewed its achievements in terms of its stated aim to redress the uneven distribution of scarce psychiatric services. It claimed that between 1995/96 and 1997/98 the following had occurred:

1. An **increase** in the number of patients having at least one consultation per year.
2. The number of patients having more than 50 consultations **declined steadily**.
3. There was **a reduction** in the number of patients having 20-49 consultations per year.
4. An **increase** in the number of patients having less than 20 consultations per year.

The data on which these claims were based appears to be **incorrect** and a corrected version was released.

The following is an equivalent superficial analysis of the corrected data from 1996/97 and 1998/99:

1. A **decrease** in the number of patients having at least one consultation per year.
2. The number of patients having more than 49 consultation has **declined steadily**.
3. There was **a reduction** in the number of patients having from 21-49 consultations per year.
4. There has been a **slight reduction** in the number of patients having less than 20 consultations per year.

The Government appears to have achieved a significant reduction in the number of patients having more than 49 consultations but there is little evidence of any significant redistribution. However, during the four years there has been a slight reduction in total psychiatric services. Clearly, a much more sophisticated statistical analysis is required.

One other statistic of interest is that there has been a steady fall in the overall number of attendances per patient from 8.1 1992/93 to 7.7 in 1997/98. This change is related more to the Capital cities with figures of 8.8 to 8.1. Other Metropolitan and Rest of State were relatively steady at 6.6 to 6.4 and 5.6 to 5.7 respectively. **This downward trend in Capital cities appears to have well and truly preceded the 1996-97 Budget.**

The charge of over-servicing remains *unsubstantiated*, and the following data relevant to the last ten year period is of some interest:

Between 1988/89 and 1997/98 the following changes in indicators have occurred over a ten year period.

Indicator	**1988/89**	**1995/96**	**1997/98**
Providers per 100,000	7.6	8.8	9.0
Patients per 100,000	1158	1582	1521
Psych Expenditure as % of Total MBS	3.2%	3.3%	3.0%
Psych Expenditure per capita ($)	6.56	10.79	10.16
Services per 100,000	9,296	12,344	11,676
Average Patients per provider	153	179	169
Average Services per provider	1231	1400	1299
Average Services per patient	8.0	7.8	7.7
Average Benefits paid per provider ($)	86,795.4	122,319.7	113,074.1

GAF or GAFFE?

Accessing treatment using Item 319 provisions requires certain criteria be met, the most contentious of which is the use of the General Assessment of Function (GAF) Scale.

As LeFeuvre points out, the GAF Scale is purported to be a measure of psychological, social and occupational functioning, and has the appearance of being "value – free". Nevertheless, it has implicit values centering on behavioural measures which therefore leaves it poorly placed to take into account highly subjective aspects of patients' lives (eg how does one measure friendship?) which it aims to quantify.

The GAF scale has been described elsewhere as "*widely used, but minimally researched*".

Further, LeFeuvre points out that;

> "*the GAF scale may have a place as a research tool, but to try to use it on an individual clinical basis in general and in the assessment of patients for long term psychiatric treatment in particular lacks any scientific basis*".[12]

It has been claimed, for example, that patients can have quite severe and debilitating Axis 1 disorders, such as Major Depressive Disorder or Bipolar Disorder, which tend to be recurrent illnesses costing the taxpayer significant amounts in medication and hospitalisation costs, and yet find it impossible to access Item 319 as they can fail GAF requirements if they present whilst in remission. (Attachment 5)

The inclusion of the GAF scale in the criteria for accessing rebates under Item 319 and associated restrictions represents, in our view, one of the most clinically inappropriate measures that patients and providers must now contend with.

[12] LeFeuvre, C. Managed Care and Medicare: Item 319, GAF or GAFFE? Australasian Psychiatry vol 6, no 3, June 1998

What is long term intensive psychiatric treatment?

Long term intensive psychiatric treatment uses treatment modalities appropriate to the particular patient's clinical requirement. It may include modalities such as intensive psychotherapy, pharmacotherapy, inpatient care, separately or in combination.

Long term intensive psychiatric treatment also rests on the notion that we have specific genetic constitutions, which interact with developmental histories and unique internal or imaginative responses to external events (Doidge 1998, Stern 1992).

Many of these internal responses become part of “the unconscious” - that part of one’s thinking that seems *automatically to influence* some behaviours and feelings, and of which the person seems unaware.

Long term intensive psychiatric treatment in those patients *for whom it is indicated*, therefore, consists *not only* in uncovering one’s personal past/history, but more specifically aims to elaborate how the patient unwittingly does things *in the present* to seemingly recreate the past difficulties - thus perpetuating problems / symptoms.

Having “exposed” these unknown patterns, old feelings can be “worked through” in the present and the patient then has more capacity to improve/change their life.

Treatment itself is more than just listening or empathy. It is a highly sophisticated interpersonal interaction where a very specific type of listening, followed by intervention/confrontation/clarification, aims to expose hitherto unknown issues. It will be shown below to be analogous to management concepts which invoke the notion of “emotional labour”.

Outcome, including incorporating gains of treatment, is fostered by the technical ability of the clinician (Luborsky 1993).

Outcome and treatment are intertwined, as treatment is necessarily long term for some patients (eg where chronicity is an indicator for treatment) in order to effect enduring changes. This can only happen in the context of a trusting, confidential relationship where “exposure” feels safe. Restricting or impairing this treatment modality inevitably reduces the effectiveness of psychiatrists dealing with these issues.

What are the characteristics of patients affected by Item 319?

Patients who use this particular treatment modality are often individuals who have severe disabling problems that are either not apparent or are overlooked, the cause of these being rooted in several factors

1. Patients can have psychiatric disability and severe personality difficulty (Axis I and II disorders), while hiding it from family or employer to avoid stigma/unemployment in a highly competitive society.

2. The type of patient who can most benefit from long term intensive psychiatric treatment is often exactly that patient who has had severe difficulty interpersonally (resulting in mood disorder/anxiety, suicidality, etc) but who uses achievement as a distraction until this breaks down. Hence, they are often mistaken as "well" based on external *appearances* and *not diagnosis*.

Diagnostically these types of people, also erroneously known as the "worried well" have been shown to have:

- failed attempts at brief treatments (82%); Doidge 1998
- high levels of previous traumata such as sexual abuse (23%), physical abuse (22%), or the death of a parent/sibling as children (21%).
- major mood disorders (32%)
- major anxiety disorders (32%)
- substance abuse disorders (12%)

It is important to note that these same patients, if treated, are also those who have a large capacity to *increase* their productivity if freed from emotional conflict, which rebounds to the benefit of the community at large.

Recent Australian research (Doidge (1998), comparing Australia with the USA and Canada, confirms the above but also finds that Australian psychiatrists deal with *more* severely disturbed personalities than their US counterparts, implying *value for money.*

The President Elect of the Royal Australasian and New Zealand College of Psychiatrists (RANZCP), Boyce, in a study in NSW found (inter alia) that;

> *"…patients seen by psychiatrists are significantly disabled and warrant treatment. Patients who were classified as the "worried well"…were not more likely than other patients to be receiving long term psychotherapy."*[13]

Patients who access this long term intensive psychiatric treatment are the equivalent of that medical group that use Intensive Care Unit facilities for acute trauma, or have organ failure and hence use high degrees of resources (such patients are not discriminated against for this). The difference, however, is that psychiatric patients *can recover*, (treatment is finite rather than life-long) and there are gains accruing from recovery (increased productivity / lower health expenditure). The resources used are, therefore, in the nature of an *investment* for the community at large.

[13] Boyce, P. & Harris, M. Psychiatric Caseload Project. Department of Human Service and Royal Australasian and New Zealand College of Psychiatrists. 1996

The fallacy that many patients undergoing long term intensive psychiatric treatment come from apparently wealthy ‘leafy suburbs’ is an issue rooted in some complexity. One confounding factor is that many areas typically identified as ‘well off’ are in fact a mixture of socio-economic groupings. The clinical reality is that patients do come from varying socio-economic groups but will all have a history of trauma in common. Some patients might be unable to maintain stable jobs or lifestyles, while others might maintain the *appearance* of stability even as they suffer due to relational failures or decline in productivity. This might be particularly the case in the so-called "leafy suburbs" due to societal and cultural factors. All the while they unwittingly transmit their difficulties onto their children, adding to the overall community burdens of illness if left untreated.

Conversely, treatment of such patients with young families represents an important and overlooked aspect of long term treatment - ie its preventative function for current and future generations.

What research supports the use of long term intensive psychiatric treatment?

Unless separately listed in References, research findings and authors are taken from the comprehensive review in Doidge N, *Standards and Guidelines for the Psychotherapies*, University of Toronto Press. 1998.

Psychiatric

It is important to note that there are thousands of case histories available in the psychiatric literature for scrutiny, and the idea that only studies of "groups" yield generalisable results is arguably flawed (Fonagy 1993 - in Doidge 1998). The research into long term intensive psychiatric treatment can be divided into several areas below for discussion purposes.

Cost

- Dewan (1999) found that the integrated biopsychosocial model practiced by psychiatry is both theoretically and economically the preferred model when combined treatment is needed
- Krupnick (1991) found significant physical co-morbidity in 47%. Krupnick further found unlimited cover for long term intensive treatment was correlated with decreased medical and surgical utilisation rates.
- Gabbard (1997) found 80% of trials showed reduction of total health costs if intensive treatment is covered.
- Sharfstein (1975) found unlimited cover does *not* lead to overuse of treatment.
- Dossman (1997) found 33% reduction in medical visits sustained at 2 year follow-up.
- Duehrssn (1972) found average hospital inpatient days per annum per head decreased by 30% after treatment (compared with normals) but decreased by 95% if pre- and post-treatment figures compared.
- Andrews (1989) compared Australia & New Zealand, and found that unlimited cover of long term intensive treatment in Australia correlated with less total mental health expenditure than in NZ (where limited cover applied) per 100,000 population, despite Australia having twice as many psychiatrists per head of population.

Efficacy

- an extensive literature review (Bachrach 1991) found that suitable patients were much improved (by 60-90%) as measured by effect size measurements.
- multi-centre studies show that positive outcome is correlated with length of treatment; treatment cannot be shortened without loss of effect.
- length of treatment is not so long if co-morbidity issues are taken into account.
- PENN study (Luborsky 1993) found a positive outcome in 92%, with significant reduction in physical and emotional symptoms which were maintained at 7 year follow-up.
- shorter treatments aim for symptom relief rather than being focused on Personality Disorder issues. Long term intensive psychiatric treatment aims also at the latter thus making it more adaptive and complementing the former (Doidge 1994).
- Smith (1980) found 85% of patients were better when treated compared with a "no treatment" group.
- Shapiro (1982) found a mean effect size of improvement was 1 standard deviation.
- Mansen (1995) found at 5 year follow-up that 68% lost their Personality Disorder diagnosis and 75% who had an Axis I diagnosis also lost that problem.

Comparative

- only long term intensive treatment deals with Axis II disorders, short term treatments do not.
- patients with Axis I and II co-morbidity have a poorer prognosis with short term treatment as the Axis II component cannot be dealt with (Gabbard (1994)).
- patients with Axis I and II co-morbidity are more likely to suffer from residual depression after shorter treatment (NIMH (1990)).
- NIMH study on Depression further found that although improvement with short term treatment could be measured, the relapse rate at 18 month follow-up was up to 50%.
- In Australia, Stevenson & Meares (1992) compared dynamically based treatment with shorter treatment for Borderline Personality Disorder patients and found decreased impulsivity, decreased suicidality, decreased affective instability after the former, and 30% lost their Personality Disorder diagnosis at follow-up (with dynamic, intensive treatment).
- Wilborg (1996) studied Panic Disorder and found that symptoms would reduce with medication only, but there was a 75% relapse rate. Intensive treatment *plus* medication was more efficacious at 9 month follow-up.

Frequency (dose)

- Target & Fonagy (1994) studied intensive treatment in children versus less frequent sessions. Improvement was greater in the intensive group irrespective of age/length of treatment.
- Bannon (1995) in a meta analysis found patients with Axis II disorder remit 4 times faster with increased intensity of sessions, symptoms remit at 11.5% per annum, and the Axis II diagnosis was lost at 8 year follow-up.
- Kopta (1994) found symptoms of distress remit faster than character difficulties, thus requiring increased frequency of sessions.
- Waldinger (1984) found outcome after intensive frequency better for Borderline Personality Disorder than less frequent sessions.
- Hogland (1993) found number of sessions correlates with positive outcome at 2 year follow-up, and that increased length of treatment correlates with outcome.

<u>Biological</u>

It is important to realise that there is an increasing body of “cutting-edge” research aimed at finding a correlation between biological changes (from advanced research methods such as Positron Emission Topography (PET) scans) and effects produced from long term intensive psychiatric treatment (Shore (1997)).

Kandel (1991) demonstrated, in Nobel Prize winning work, that mental experiences change the structure and function of neuronal synaptic transmission. He proposed that long term intensive treatment ultimately leads to synaptic change and altered gene expression.

Karasu (1992) argues that regulating gene expression requires the induction of protein kinase to alter synaptic function, which necessarily then needs a long treatment time.

Schwartz (1996) has demonstrated (using PET scans in OCD patients), that psychological treatment produced changes similar to medication in the thalamic area and caudate nucleus of the brain.

General

It is noteworthy that the work in long term intensive psychiatric treatment can be seen as conceptually analogous to the concept of "emotional labour", increasingly cited as an important issue in management training dispelling the notion that long term treatment is "mere listening" or that it is a self-serving way of making "easy money" from apparently "well" people in affluent areas.

Leading universities offer extensive research opportunities, in postgraduate management courses to explore the areas of work that require "*emotional labour*".[14]

> *"Emotional labour is defined as the effort, planning and control needed to express organisationally desired emotion during interpersonal transaction."*

In a wide-ranging review of the subject, Morris & Feldman explore the different dimensions of emotional labour. They write that:

> "*…clients are more likely to do business with an organisation when the affective bonds of liking, trust and respect have been established*".

The parallels with the business of psychiatry are clear.

Further, they state

> "*longer emotional displays require greater attention and emotional stamina*"

or,

> "*the greater the variety of emotion to be displayed, the greater the emotional labour of the role occupants*"

Again, the parallels with intensive treatment can be noted with interest.

The authors pay special attention to the issue of "emotional dissonance", a concept well known (but labelled "countertransference") to practising psychiatrists engaged in long term intensive treatment.

> "*What makes regulation of emotional expression more difficult, and thus more labour intensive, are exactly those situations in which there are conflicts between genuinely felt emotions and organisationally desired emotions*"

and

> "*The more the job requires face-to-face interaction, the greater will be the emotional dissonance*".

---

[14] Morris, JA., and Fieldman, DC. The dimensions, antecedents and consequences for emotional labour. Academy of Management Review. 1996. v21:4 pp 986-1010.

That psychiatrists regularly engage in difficult and intense emotional labour is often and severely underestimated.

Morris & Feldman go on to say that

> "*…caregivers are more likely to suffer from emotional exhaustion, because intense display of emotion is often required in their jobs"*

However, the authors state that emotional dissonance and its potential consequence of emotional exhaustion need *not* be an inevitable outcome. Rather, they observe that

> "*…individuals with high job autonomy suffered fewer negative effects of emotional labour than did those with low job autonomy*."

The implications for a robust psychiatric workforce, able to provide a meaningful and efficient service, are clear. It would seem to be imperative to preserve high levels of training and autonomy to ensure high standards of care in all treatment modalities.

Item 319 affects both the areas of clinical autonomy (by reducing decision-making on the basis of patient need) and training (by promoting less intensive, less efficacious treatments).

Other

Along term study[15] in the USA, of over 20 years, linking personality disorders (PD) in adolescence with violent behaviour in early adulthood, found that this group, with the one exception among the personality disorders of the antisocial PD., could be treated effectively with psychotherapy.

Further, a 15 year study[16] on successful intervention on youth suicide, from Western Australia, concluded that when a young person is admitted to accident and emergency departments following self harm behaviours, *"…there were gross deficiencies in the kind of care being provided, not adequate assessments being made and the follow up tended to be woeful"*. The report showed that we can successfully intervene and dramatically reduce the suicide risk if *" you actually take the trouble to spend enough time with the person to gain their confidence, take a good history and ensure that whatever treatment is provided is addressing some of their immediate needs. It was particularly important to improve the likelihood of decent follow up."* The existence of Item 319 regulations (et al) precludes full implementation of these findings to reduce spiralling incidents of youth suicides.

Additional articles that are relevant to the issues under review are also attached for information:

Grant Donald, C., *Fact and fiction about serious mental disorders.* Australasian Psychiatry. Vol 3. No 1. February 1995. p. 13. (Attachment 6)

---

[15] Johnson JG et al. *American Journal of Psychiatry 2000*; 157: 1406-1412.

[16] Interview with Prof. Sven Silburn, Centre for Developmental Health, Curtain University and the Institute for Child Health Research, Perth, W.A., Radio National, 4 February, 2002. Ref: Hillman SD et al. Suicide in Western Australia. Institute for Child Health Research UWA 2000.

Buckle, R.C., Grant, D.C., Sheehan, G.D., *Psychoanalysis today: patient characteristics, treatment outcome and cost-effectiveness.* Australian Psychiatry, Vol. 3, No. 2. April, 1995 p. 73. (Attachment 7)

Doidge, Norman., *Empirical Evidence for the Core Clinical Concepts and Efficacy of the Psychoanalytic Psychotherapies:* ***An Overview.*** (Attachment 8)
Doidge has written extensively stating that there is a wealth of empirical evidence supporting the efficacy of the psychoanalytic psychotherapies and the core concepts on which they are based. …. *Data supporting the correlation between length of treatment and good outcomes, and data on frequency of sessions and outcomes are examined.*

Clinical Impact and Anomalies

In light of the above, it can be seen that patients requiring long term intensive psychiatric treatment come from across the spectrum of psychiatric disorder and often have *a history of chronicity, and/or early trauma*.

It is also important to note that in clinical practice, patients will often not divulge the existence of such traumata until a *therapeutic alliance* is well established (which correlates with positive outcome, Luborsky 1993). This can take a considerable time.

Of equal importance is recent concern expressed at the validity of the GAF scale, concern that it has little scientific validity (being a hybrid of other scales) yet is being used to justify rationing of treatment (LeFeuvre 1998). The following concerns arise:

<u>Patients ineligible to access treatment under Item 319 restrictions</u>

(i.) As mentioned previously, patients who *seem* to function well, despite severe difficulties personal and emotional, will not access Item 319 as they will be disqualified by the GAF requirement. In effect, they are "punished" for trying to cope, or trying to save face.

(ii.) Patients can have quite severe and debilitating Axis I disorders, such as Major Depressive Disorder or Bipolar Disorder which tend to be recurrent illnesses, costing the taxpayer great amounts in medication/hospitalisation, and yet find it impossible to access treatment under Item 319 as they can fail the GAF requirements if they present for treatment whilst in remission. Also important here is the use of long term intensive psychiatric treatment synergistically with medical treatment, in disorders that the World Health Organisation (WHO) have identified as major public health problems).

(iii.) Similarly, patients who might have qualified for Item 319 have presented for short term treatment and improved marginally. If they are then referred on for more specialised long term intensive treatment, they will have lost their ability to qualify under the GAF requirements.

(iv.) Given that patients must meet the criteria for Item 319 *at the initial presentation*, it is clear that there will be a significant number of patients who will not divulge enough material to meet the diagnostic criteria.

(v.) It is self-evidently true that not all patients will fit into the criteria so neatly eg: a patient may have severe personality difficulty without qualifying for a formal Axis II disorder on operational criteria - they will then be excluded.

(vi.) Similar patients will then be forced to carry a financial burden in large gap payments if they are to have anywhere near adequate frequency of treatment, thus restricting availability and access, thus adding to their burdens.

(vii.) Patients have been known to present acutely with say, suicidal ideation without necessarily meeting the diagnostic criteria outlined for Item 319, though they *would* at that time meet GAF requirements; they are then obliged to have potentially less effective treatment. In other words, Item 319 makes the issue of "risk management" problematic.

(viii.) Item 319 particularly burdens patients who present at a young age, say in their twenties, an age when early intervention is likely to make the *most impact* but when patients are often *least likely* to be able to afford to subsidise their own treatment if they don't meet Item 319 diagnostic criteria. It is often imperative that this group be

treated before the transgenerational transmission of their difficulties affect their offspring. Treatment thus has an important preventative role (Osofsky (1995)).

(ix.) Situations have been reported by clinicians where patients have necessarily attended child psychiatrists in support of their children, only to later find their own rebates are "prematurely" or unexpectedly reduced as they've reached the 50 session limit much earlier than they anticipated. This places sudden financial burdens on families already struggling with personal difficulties.

Patients affected despite having access to Item 319

This refers to patients who either need more treatment (cf research on better outcomes correlating with length/frequency of treatment) or who have other issues relating to Item 319.

(i.) There is a significant group of patients with severe Axis II disorders (eg borderline Personality Disorder) who can only be maintained at a functioning level without recourse to expensive/recurrent hospitalisation if they are seen 4-5 times per week for long term treatment. It is important to recall here that this refers to dynamic psychiatric treatment rather than supportive, cognitively based behavior therapy though the latter too has its place. This equates to visits up to 245 per annum.

(ii.) The RANZCP has indicated in its Quality Assurance Projects that for patients with severe Axis II disorders, long term intensive treatment is the treatment of choice.

(iii.) Patients (particularly government officials) have refused, despite being eligible, to use Item 319 as they quite correctly know that the use of this item on an account actually divulges a great deal of very sensitive, stigmatising information which they fear might be accessed by third parties - more so with the advent of electronic databases.

(iv.) Patients who require more than 160 sessions now need to carry a financial burden, which unnecessarily creates a confounding variable in treatment. This either leads to delays, or even guilt that they need more than the Government "says is good".

(v.) The advent of Item 319 has created a culture where people inaccurately perceive the regulations to mean they "ought" only to have 160 sessions. This can actually impede the emergence of deep unconscious issues which is so necessary for working through early and forgotten traumata, due to the induction of guilt.

The Particular Problem of Children

The rights of the child must include those of emotional well being, or health and if this is not present for whatever reason, then these children have an inalienable right to have available to them the treatment that will most effectively benefit them. This is consistent with the sentiments expressed in *The Statement of Rights and Responsibilities, A Guide for Carers and Providers 1991*.

Emotional difficulties in a child can impede normal developmental processes and we know from clinical experience, as well as research, that many emotional and psychiatric problems in adulthood have their origins in childhood. A troubled child rarely tells us they are sad, depressed or worried. An anxious child may present with frequent stomach aches or headaches, wet the bed, appear hyperactive. A child who is depressed may be unable to play or demonstrate behaviour problems, show school failure and learning difficulties,

anti-social behaviour or aggressiveness with friends or family and is sometimes at risk for suicide. Many adolescents who take drugs are trying not to feel their depression or despair. Some troubled children withdraw into their own world of fantasy.

Children do not just grow out of significant emotional difficulties. If left untreated, their development is impeded, with significant consequences for their family, school and social relationships. Apart from the emotional cost, it is difficult to treat troubled children and to repair the emotional and often physical damage they inflict on themselves, society and their families.

Modern neuroanatomical and developmental research (Daniel Stern 1985) has confirmed that experience, in the first three years of life, is the architect of the brain. Children who are emotionally deprived or cannot play develop brains that are 20% to 30% smaller than normal for their age and one of the most common causes of such deprivation is a *mother who is significantly depressed for prolonged periods*. Other traumas may include death in a family, divorce, environmental disasters, emotional neglect and physical and sexual abuse.

Traumatic events for children often are made worse by lack of opportunity to make stable and secure emotional bonds to a parent or parent substitute in early childhood, or when these bonds are prematurely disrupted by death, separations, illness or abuse.

How do we best help our troubled children, those with emotional and behavioural problems?

Clinical experience is now backed up by research studies which tell us that anti-depressant medication is not very effective in childhood. Likewise, as more and more stimulant medication is being used to treat a whole range of child behaviour problems, more and more parents and psychiatrists are becoming aware of the very limited effectiveness of trying to dampen a symptom of a child's anxiety, which may be misdiagnosed and treated as attention deficit hyperactivity disorder (ADHD) without also treating the *cause* of the anxiety.

NAPP was asked to outline these views in a submission to the Social Development Standing Committee of the South Australian Parliament, enquiring into issues of overprescribing in ADHD. NAPP submitted, inter alia;

- *Long term intensive psychiatric treatment modalities including psychotherapeutic expertise are not available in the public health system and this leaves a hole in public education strategies. In the private system these strategies are difficult to access because of restrictive Commonwealth financial arrangements.*

- *Child psychotherapeutic expertise should be reinstated into a core component of assessment and possible treatment of alleged ADHD children and made more accessible, if needed, to those correctly diagnosed and, in addition, other allied conditions currently diagnosed as ADHD.*

To quote Professor Robert Adler[17]: *"To this day, psychoanalytic psychotherapy remains the most valued form of treatment in many child psychiatric settings"*. Part of the treatment involves *working with parents or guardians* to ensure that an overall approach to the problems is taken. It is different to family therapy in that a child's symptoms and troubling behaviour are understood as unconscious communications of some underlying difficulties. This therapy is a working relationship in the context of a predictable setting and regular, frequent sessions, where the individual child or adolescent (or parent/guardian) work together with the psychiatrist. The difficulties that troubled children and adolescents experience often begin in infancy or early childhood and influence their functioning in the present. These experiences are re-enacted in treatment through the expression of unconscious fantasies and fears, in verbal and non-verbal ways and through a child's play. The observation, understanding and interpretation of the child's communications are part of the unique nature of the therapeutic relationship and involves skills and techniques and theoretical understanding obtained from specialised training. This therapeutic relationship is very different to counselling or talking to a friend. Problems including conflict, disturbed relationships or behaviours, school refusal, eating problems, depression, anxiety etc are related to the inner world as well as to external events, to unconscious as well as conscious experiences and to the interaction between them. Studies have also shown that psychoanalytic psychotherapy can have profound beneficial effects on serious childhood medical conditions, eg diabetes. Children who are placed in foster care and whose placement breaks down because of their disturbance can often be stabilised when treated with long term intensive treatment.

The treatment may be required more than once a week to be most effective.

This treatment, often the only effective treatment for many problems seen in childhood and often necessary to achieve *lasting* changes, can rarely be obtained in the public health system. Unless parents or guardians are wealthy, they rely on Medicare funding to pay for intensive psychiatric treatment. This has virtually become an impossibility with the changes to Medicare funding.

The Medicare treatment arrangements under Item 319 then, are discriminatory against children insofar as they contravene their rights when we are no longer able to treat *depressed mothers who require intensive psychiatric treatment*. These infants of depressed mothers are both cognitively and emotionally disadvantaged. There is no provision to treat these mothers intensively since 1996 despite the very serious implications to their children of not doing so.

These women often do not respond to less intensive short term treatment or anti-depressant medication, even if breastfeeding didn't preclude them taking it. There are often strong unconscious forces acting in the postpartum period which contribute to the depression. This is a vital and often *effective* time to treat these people.

In the words of one author, speaking at a recent public meeting in Melbourne:

> *"… it highlights how we need to consider as a community what best creates the conditions for children's flourishing. It demands action on an individual and public level to recreate the tools for a convivial childhood. It will mean tackling adequate parental leave provisions, involving fathers as well as mothers in family life,*

[17] RANZCP. Bulletin of the Faculty of Child Psychiatry, May 1993

> *economic support for families, a reasonable work/family balance, and investment in early childcare."*[18]

Ethical and Privacy Considerations

Item 319's restrictions based on categorisation of patients on the basis of diagnosis and level of disability violates the RANZCP's Code of Ethics and traditional medical ethical principles such as confidentiality, the commitment to serve the best interests of the patient, and professional independence of physicians.

Confidentiality

The RANZCP Code of Ethics[19], Principle 4:

> "*Psychiatrists shall hold clinical information in confidence*".

By virtue of receiving a particular type of treatment patients are on a database as "seriously psychiatrically ill". In addition, Item 319 is defined by specifics of diagnosis (sexual abuse, personality disorder, anorexia etc), personal information in the public domain.

Patients have told psychiatrists that clerks at Medicare offices have made comments about their being "a 319". These patients may be instantly identified as being "seriously psychiatrically ill" by clerical staff, thus compounding their difficulties.

Private health funds have access to a doctor's billing practices, and access to HIC data on item numbers and what they mean.

Those in the field of assessing risk can abuse "319" which is a stigmatising label. This is more than a theoretical concern. Psychiatric patients are currently refused disability insurance once they have been treated for depression, despite the fact of their having overcome their problems with intensive psychiatric treatment and being in full time employment for many years.

Patients' privacy is by no means guaranteed as Electronic Health Records (EHR), are being developed at a national level. Also there is the potential for errors of coding in computer databases and EHR which could prejudice the patient in the future.

While the restrictions on children were eased when the legislation which cut funding for psychiatric services were reviewed, to access Medicare funding for intensive treatment the child is still a "319". This raises concern about the privacy issues of labelling children with psychiatric disorders, as children cannot give informed consent and this data will be on their record for years to come, with unknown consequences for them in the future.

There is a breach of professional confidentiality unless patients give informed consent that important diagnostic information is to be disclosed and the risk that such information may be misused. Diagnostic information has major implications for employment, insurance, superannuation prospects and socially.

---

[18] Manne. A. Setting the frame of the ADHD epidemic: Childhood under the new Capitalism. Presented at the Royal Children's Hospital, Melbourne, Australia. 18 November 2001.

[19] RANZCP. Code of Ethics. www.ranzcp.org

This legislation vastly complicates the doctor/patient relationship. Many clinicians have found it clinically unworkable to inform patients of these risks. To give the patient the choice places an undue burden on them – to refuse treatment because of the risks, and the shame, or to accept the necessary treatment with the risks involved. Many patients have refused treatment. Many patients have not been informed. This contravenes Principle 4

> *"Psychiatrists shall seek informed consent from their patients before undertaking any procedure or treatment."*

The Best Interests of The Patient

RANZCP Code of Ethics, Principle 3

> *"Psychiatrists shall provide the best possible psychiatric care for their patients."*
>
> *"3.1 Psychiatrists shall serve the best interests of their patients by engendering mutual trust and therapeutic partnership, avoiding intentional or foreseeable harm and treating patients under the best possible conditions."*

Psychiatrists are placed in an untenable ethical situation of having to refuse appropriate treatment, where no other treatment would be efficacious, because most patients do not fulfil the criteria of Item 319, and because they cannot afford to treat more than one or two, or no, patients at half the fee. Most patients cannot afford to pay half of the schedule fee if they receive intensive treatment because many psychiatric patients are vocationally and thereby financially disadvantaged. This legislation contravenes the mandate of Medicare of equity of access.

Psychiatric patients are doubly disadvantaged, both by their having a psychiatric illness and by being unable to access appropriate treatment without stigmatisation and loss of privacy when they can access treatment under "319", or by being unable to access appropriate treatment if they don't qualify.

Professional Independence

Since these restrictions, appropriate clinical decisions in psychiatry cannot be made by the doctor committed to acting in the patient's best interest when he or she becomes ill, because decision making is constrained by clinically inappropriate criteria.

Item 319 is a challenge to the obligation to give not only the best possible care, but sometimes the only appropriate care or treatment cannot be offered to patients.

De-identified clinical vignettes

Below is a selection of problems communicated to NAPP by concerned clinicians - *none are fictitious*.

Psychiatrist 1

These people do not have the capacity to fight the changes to the rebate system, or if they do, they do not want to be identified as patients.

In my practice, there have been a wide variety of effects to the change in item number. In the beginning when Item 319 was even more discriminatory, one of my patients refused to allow me to reduce my fees so that they could continue with twice weekly therapy. They were so furious, that after our session, they hit their car with their hand so hard that they sustained a fracture to the wrist. This required surgery and physiotherapy, and caused a lot of pain. It also meant that they were unable to work for 6 weeks. From a personal point of view it was a great problem. From a financial point of view it cost the government quite a lot of money.

I had another patient with Bipolar disorder. She did not qualify for Item 319. She was discharged early from hospital, when she was still actively suicidal. She would not allow me to reduce my fee, and agreed to come only once per week to sessions. She committed suicide 6 weeks later. With cuts to the hospital system, so that severely ill patients such as these are discharged prematurely, and cuts to outpatient care, so that they cannot be seen adequately, this kind of problem will probably recur. I note that the major psychiatric illnesses do not fit into the 319 category, and therefore, when the hospital system does not see its own outpatients, private psychiatrists often cannot see them frequently enough.

Psychiatrist 2

Unfortunately, as I am carrying a fairly heavy load of half-fee sessions, I have to discriminate against patients who are unable to make a reasonable financial contribution. I regularly see patients who need more than once a week therapy, and would probably be able to use it, but as I cannot afford to subsidise them all I offer is to see them once a week, and pretend I feel that is all that is needed, when often I know they need more.

Psychiatrist 3

I am extremely grateful for the opportunity to feedback on the outcome of the Item 319 issue. Although only in practice since early this year I already have one patient out of my half time case load who now, after trials of CBT, medication and less intensive psychodynamic therapy has been qualifying for the Item 319 but has only now wanted to proceed with billing at this item (after much time and discussion due to perceived stigma). I have several other current patients who have extremely long and complex psychiatric histories with long-term function that has been grossly affected by both Axis I and II pathology that cross-sectionally at time of assessment lay outside the GAF requirements and are therefore receiving less intensive treatment than they need or are about to begin carrying the burden of decreased rebate. I have another patient who is terminating partly because of the cost of proceeding beyond the 50 sessions despite both Axis I and Axis II pathology and being in her twenties, at an age when early intervention is likely to make the most impact, but when patients are often least likely to be able to afford to subsidise their own treatment.

Hence my experience based on this current 6 months of treating patients is that a high percentage of my case load are impacted on by this issue and discriminated against by virtue of the definition of the 319 'gate' by both diagnosis and GAF and by the resulting intensification of stigma that already mitigates against presentation for acceptance of treatment. Furthermore this is happening at a time when Community Health Centres are overloaded and the issues that might have normally been dealt with by case management such as accommodation, support of family and rehabilitation are not being picked up in the more severe patients. These issues are then left to be dealt with within a psychotherapy frame which is struggling to make headway in reduced sessions in any case. It is often seen that if these patients have a psychiatrist offering therapy then any more is "overservicing" when in reality some of these patients are being underserviced and are not receiving the biopsychosocial treatments that they require. In my current experience access to appropriate and necessary care is being compromised.

Trainee Psychiatrist

My name is XX. I would like to add to any other comments by trainees about this crucial issue. I would feel comfortable that I speak for many trainees by adding that we believe this 319 business is another example of the government trying to introduce a quasi-managed care type arrangement where it would appear that the patient's needs are prioritised behind his funding restrictions. This can only serve to jeopardise optimal patient care, something to which every person is entitled. The other grave concern I have is that the ever-imposing shadow of government interventions savages the autonomy of our profession and the restrictions on psychotherapy benefits merely lead to this area of practice becoming less appealing. I believe this may have detrimental effects on trainees electing to undertake further study in this important, and some may argue, already neglected field.

Commentary

It can be appreciated from the above, that the kinds of patients needing long term intensive treatment are severely disabled, but often do not meet the criteria for Item 319. They may or may not need more than 160 sessions per year depending on the severity of Axis I or II pathology, and medical co-morbidity.

Long term intensive psychiatric treatment not only has economic merit (Friedman et al (1998), Dewan (1999)), it provides a cost effective option for patients requiring both intensive treatment *and* medication (Dewan (1999)) and in addition it has an important *preventative* role (Osofsky (1995)) in that it has been shown to reduce transgenerational morbidity in the children of ill parents.

The burden on the community, of leaving patients inadequately treated by suboptimal practices, can be substantial if it leads to excessive reliance on medication (and hence the PBS), hospitalisation, unemployment and decreased productivity. An understanding of patients needs based on these treatment modalities also helps in devising effective strategies to minimise the impact of adverse developmental events which might otherwise result in people becoming violent, impulsive, or predisposed to frank illness.

Health and Training Issues

The World Health Organisation (WHO) has indicated that depression will be a major public health issue in the developed world. All treatment modalities that deal with

emotional disturbances then, need to be able to be appropriately accessed. Further, it needs to be said that the Item 319 issue represents for young psychiatrists, a disincentive to continue training (or to encourage others to apply) which directly goes against recent recommendations from an Australian Medical Workforce Advisory Committee (AMWAC) report which calls for greater numbers of trainees to be recruited to meet shortfalls.

Rural Issues

The removal of Item 319 restrictions might, in carefully selected cases, lead to more intensive treatment being able to be delivered in rural areas by way of increased use of telepsychiatry and/or supervision of treatment (if there was also an appropriate MBS item for this). There would appear to be no clear reason why long term treatment might not be delivered via audio/video links, but it would necessarily be offered to patients who would not meet Item 319 criteria for eligibility (to ensure their continued, safe functioning between "session" in remote areas). This might facilitate a reduction in maldistribution of access based on geographic considerations, whilst also improving the quality / training of primary care providers in eg rural districts - useful and novel partnerships might then emerge.

Consultation with Stakeholders

Consumer groups

NAPP is cognisant of the role of the mental health consumer advocacy movement in all its diversity. Some groups within this movement have a significant political orientation as well as deep concerns about patient welfare. Clearly there is an important place for the views of these various groups in ongoing discussions. (Attachment 12)

Association of Survivors of Child Abuse (ASCA)
We attach a letter from the Chair of ASCA supporting a review of Item 319 restrictions. Although dated August 2000, ongoing communication tells us that this support is current and unchanged.

"A Meeting of Like Minds" Inc.
Set up in early 1997 basically to raise public awareness of the perceived dangers of and the move to "managed care" medicine. In this context Item 319 is widely seen as a "managed care" initiative. One of "A Meeting of Like Mind's" stated aims is:

> *"To ensure that ALL PATIENTS are eligible for MEDICAL TREATMENT and PARAMEDICAL TREATMENT by clinically and ethically trained professionals."*

This particular body has been particularly active in lobbying parliamentarians, health bureaucrats and the medical profession producing a wide range of 'vignettes' indicating the nature of significant adverse effects on a wide range of psychiatric patients.

The importance of their role has been recognised by the AMA as demonstrated by a personal invitation from the Federal AMA President to the Chair of "A Meeting of Like Minds" Inc to address a meeting of representatives of the AMA, RANZCP and NAPP on the perceived problems of patients in relation to the 319 issue.
We attach a recent letter sent to NAPP by the Chair of "A Meeting of Like Minds", Ms H Spring, asking for information regarding our activities in this area.

The Royal Australian & New Zealand College of Psychiatrists

Whilst NAPP does not speak for the RANZCP, we feel it important to point out that the vast majority of NAPP members are also Fellows of the RANZCP. These members span the subspecialties of the College and, given that NAPP is a national organisation, this represents a widespread view of psychiatric practice.

We attach a copy of two letters to NAPP from the Chair of the AMA Section of Psychiatry (Victoria), Dr N Lewis, informing us that they too are Interested to see Item 319 and associated restrictions reversed on the basis of the excessive burden to psychiatrists and their patients created by its implementation.

In addition, a copy of a letter sent to the current CEO of the RANZCP, as well as NAPP, is tabled which outlines the feelings of a Senior Consultant in regard to the restrictions based on Item 319 regulations. NAPP is of the opinion that the feelings outlined in his letter represent views generally held amongst that peer group.

Australian Medical Association

As above, NAPP cannot speak for the Federal AMA. However we note that discussions in the recent past aimed at reviewing Item 319 were hosted by the AMA.

Divisions of General Practice

Important developments in the area of Peer Support for primary care givers (General Practitioners) and all clinicians are currently underway. This initiative involves psychoanalysts and psychotherapists trained in group work, supporting doctors with the difficult clinical and personal Issues that arise in the practice of their profession. This is being co-ordinated by the Professional Peer Support Programme Committee formed by Dr Raymond Martyres of the Royal Australian College of General Practitioners.

This task, it will be appreciated, provides invaluable help to an already strained workforce. It is an initiative that is developing quickly and it is being well received. This is a critical development in light of the following from the Medical Journal of Australia (MJA 2002 177 (1 Suppl): S19-S20)

"There is compelling evidence that doctors are an at-risk group. Their high rates of mental illness and stress-related illness are of particular concern, and are reflected in tragically high suicide rates, high levels of drug abuse, and decreased job satisfaction and "burnout". All of these are powerful indicators of poor self-care……We have a responsibility to care for JMOs, who appear to be more vulnerable to stress and its consequences. While we have focused on this group, our results can clearly be extrapolated to the medical profession as a whole. "(emphasis ours)

Remedial Policy Options

Repeal

Clearly then, NAPP seeks a complete repeal of these regulations and a reversion to pre-1996 arrangements that left clinical judgement/treatment in the hands of psychiatrists under a general consultation Item.

Description

If this were too problematic in the first instance a *comprehensive modification might serve to ease the burden on psychiatrists while allowing increased access for patients.*

In regard to the latter option, one could suggest that if **the descriptor** for Item 319 (and therefore associated Items) were changed to the following:

"An attendance of more than 45 minutes duration at consulting rooms, where the patient's condition clinically requires intensive care and where that attendance and any other attendance to which Item 300 to 308 apply do not exceed 245 attendances in a calendar year".

then many problems with the current arrangements would be modified as a consequence. The stigma from lack of privacy and unduly restrictive diagnostic criteria would be gone, and the GAF requirement could quietly go: the above would allow proper access by patients in need of long term intensive psychiatric care at a level of intensity dictated by clinical need. Items 310 - 318 would ensure excessive use would be discouraged over the 245 annual limit, and NAPP would expect these to be used in extreme and rare circumstances only.

Fee

The fee would remain that of a general consultation (> 45mins) item, and amended each November in the MBS – ie currently $138.45 (well below the recommended AMA fee of $220). NAPP is very clear that there should be no fee differentials between any psychiatric consultation items of similar duration, lest this lead to problematic practices rather than best clinical outcomes.

Other options

Given statistical evidence earlier in this paper that attendances at psychiatrists' rooms have been *in decline since before the 1996 budget* measures, NAPP feels that a review of Item 319 regulations would in all probability *not* lead to greater utilisation rates.

We should re-emphasise though, that *the ideal solution would be to review* the whole Item 319 regulation, say as part of the prerogative of government, and to then subsume it into a general psychiatric consultation item (eg item 306). *The latter would Facilitate best clinical and ethical practice.*Again as mentioned above, NAPP opposes proposals aimed at weighting initial consultations for higher rebates than subsequent visits as this would lead to negative outcomes.

The Government could still monitor its use via clinical practice profiles, as it does at present, and abuses could be dealt with through existing means.

Workforce impact

One might reiterate here that these restrictions, if left unmodified, will cause undue problems for future training of the psychiatric workforce and will make the AMWAC recommendations (to increase the numbers of psychiatrists) difficult to implement - ie this issue has wider repercussions other than direct patient care.

PBS impact

Further, for the Government to continue to curb access to this sophisticated treatment modality is arguably not in its interests if concerns in other areas, eg in rapidly escalating costs of the PBS, are taken into account.

Wider Remedial Policy Options

Although this submission concentrates on the problems caused by Item 319 regulations, NAPP is very cognisant of the wider issues faced by the Government in facilitating access to psychiatric services to the community and the financial issues involved.

NAPP therefore puts forward *the following suggestions* for consideration. Some points necessarily require a medium to long term perspective or "vision". All however, point the way to potential cost savings initiatives that would also benefit the community at large while allowing room for Item 319 regulations to be subsumed back into general consultation items:

- Allowing access to treatment by repeal (or modification) of Item 319 regulations does in fact save the community from more general medical and PBS costs, and would have an important preventative role in reducing future costs

- GPs complain of lack of access to psychiatrists. Consideration could be given to funding trials of “Balint” type groups between psychiatrists with suitable interest/training and GPs as a part of professional development. Previous trials (abandoned for lack of funding) in Victoria produced GPs who were more sophisticated as to the emotional needs of their patients, and more sophisticated in whether referral was actually necessary (Prytula). This has the potential for (a) cost savings by reducing unnecessary referrals, (b) lessening the problems of access to specialist psychiatrists by reducing need in the GP group and (c) supporting GPs in an increasingly complex medical environment. It would also serve as an adjunct to current initiatives aimed at training GPs in brief therapy.

- If it became policy to fund positions for Visiting Medical Officers (VMO) in the public sector then many of the psychiatry workforce issues would be partly resolved. At present the limited funding for psychiatry is used on cheaper professionals and it has become a circular argument that psychiatrists are not in the system. In fact most VMO's have been sacked from their positions and those wishing to have such positions do not find them readily available.

- Similarly, rural GPs are also faced with difficulty. Consideration could be given to the viability of funding interested Visiting Psychiatrists to accompany such initiatives as the “Royal Flying Doctor” service. This has the potential to effectively and efficiently bring psychiatric expertise to very remote areas at regular intervals to look at group as well as individual functioning. This would be in addition to current country Visiting arrangements as exist eg in South Australia

- Psychiatrists have become very much aware of the obvious and demonstrable deficiencies associated with the tyranny of distance in rural and remote Australia. They are also aware of the rapid rate of technological change. It could not have escaped the notice of the Department of Health and Aging (DHA) of the particular leadership already shown by psychiatrists in this area. Telepsychiatry, in the form of Video links and Email communication is now being widely used especially within the public sector.

- On a broader note, priority should be given to facilitating enquiry into issues of early childhood development (as is being reviewed by the Attorney- General's Department) and how that can best be helped. It is well known that early experiences and socio-economic factors play a significant part in morbidity. By attending to this, there is huge potential for cost savings by reducing the need for psychiatric care of future generations. Such initiatives would be in keeping with similar international trends eg: The Early Years Study (Canada), The Sure Start Programme White Paper (UK), and Health 21 (WHO).

- Similarly, savings in psychiatric expenditure are there to be achieved by attending to educational policies (understaffing, high class numbers, teacher stress, lack of support networks eg school counselling) that allow the behavioural problems often classed as “attention deficit hyperactivity disorder” to emerge. These latter problems are a cause of great concern to the community as well as a source of expenditure for DHA through use of MBS items in child psychiatric services.

- Equally, work practices may well contribute to the psychiatric costs incurred by the DHA. For example, how much does the rigid application of competition policy encourage absenteeism, stress leave and poor productivity which then triggers referral to private psychiatrists ? How much do lack of paid maternity leave, and shared job arrangements have similar outcomes ? Addressing these issues has the potential for large cost-offsets by reducing utilisation of medical services as well as by increasing productivity through job satisfaction.

- In order to facilitate consideration of the policy matters raised above, an important initiative might well lie in the formation of an “overarching” committee whose task it would be to identify areas across diverse portfolios that have an economic impact by virtue of their leading to higher medical costs (as described in the above examples). Remedial policies could then be more easily identified and possibly implemented.

Clearly then, NAPP is of the view that a broader approach to the problems of service provision has the potential to reduce costs at source so that cruder managerial tools that rely on price signalling and inequity of access (in effect, crisis management) to achieve their aims need not be resorted to. It is with this in mind that NAPP is calling for a repeal or complete modification of Item 319 regulations and their associated restrictions.

Conclusion

Whether it is accepted or not by all there has been recent change in the methods of the delivery of psychiatric care in Australia. In raising the Item 319 issue under consideration in the era of 'Evidence Based Medicine' the profession has demonstrated a willingness to subject itself to a level of scrutiny to which the Government was not subjected in its unprecedented and unilateral budgetary decision during 1996-97.

The time has come for a full and clear assessment of the particular features of Item 319 and related restrictions as well as an assessment of psychiatric outpatient care in order to see what it really represented – was it really just a compromise (the best deal we could get at the time) reached and agreed to under some duress at a time of the rapidly changing medico-political scene? It arrived on the scene at a time of increasing economic intrusion into medical practice but what is more important for patients are the issues of *safety, efficacy and cost effectiveness*.

If, as NAPP suggests, Item 319 and associated restrictions were subsumed back into a general psychiatric consultation item, the Government would be seen to be facilitating access and equity at a time of rising mental illness rates in our youth and our community more generally – and would be seen to be supporting treatments, in keeping with consumer sentiment, that are effective and not reliant on expenditure via the Pharmaceutical Benefits Scheme.

Problems of access will not be addressed by a profession diminishing in numbers, disillusioned by restrictions which lead to deskilling and alienation when an effective therapy, sometimes the only effective treatment, is increasingly under attack as part of the therapeutic armamentarium.

A deskilled profession has serious implications for the training of future psychiatrists, a point frequently overlooked.

NAPP believes that it is timely to review the operations of Item 319 (and all associated restrictions) regulations particularly in the current climate of enquiry into mental health service provision. Such a review would have the effect of bringing policy into line with the sentiments and objects expressed in *The Statement of Rights and Responsibilities, A Guide for Carers and Providers, 1991,* which formed part of the National Mental Health Strategy, and ratified by the Australian Health Ministers' Advisory Committee, as well as bringing policy in line with consumer sentiment.

References

Boyce P. & Harris M. Psychiatric Caseload Project. Department of Human Services and Royal Australian & New Zealand College of Psychiatrists. 1996.

Buckle, RC, Grant, DC, & Sheehan, GD. Psychoanalysis today: patient characteristics, treatment outcome and cost-effectiveness. *Australasian Psychiatry.* vol 3 no 2. April 1995. p 73.

Doidge, N. in *Standards and Guidelines for the Psychotherapies.* Eds: Cameron, Ennis, & Deadman. University of Toronto Press Inc. 1998.

Doidge, N., Simon, B., Gillies, LA., & Ruskin, R. Characteristics of Psychoanalytic Patients Under a Nationalized Health Plan: DSM-III-R Diagnoses, Previous Treatment and Childhood Trauma. *American Journal of Psychiatry*. 151:4. 586-590. 1998.

Dewan, M. Are Psychiatrists Cost-Effective? An Analysis of Integrated vs Split Treatment. *American Journal of Psychiatry*. 156. 324 – 326. February 1999.

Friedman, RC., Bucci, W., Christian, C., Drucker, D., & Garrison, WB. Private Psychotherapy Patients of Psychiatrist Psychoanalysts. *American Journal of Psychiatry*. 155: 1772-1774. December 1998.

Gabbard, GO. The Meninger Clinic; Psychotherapy, Cost-effectiveness and Cost Offset. American Psychiatric Association Conference. 1994.

Gabbard, GO., Lazar, SG., Hornberger, J., & Spiegel, D. Menninger Clinic: The economic impact of psychotherapy: a review. ; *American Journal of Psychiatry* 154:147-155. 1997.

Grant, Donald C., Fact and fiction about serious mental disorders. *Australasian Psychiatry*. vol 3 no 1. February 1995. p. 13.

Information booklet of the Victorian Association of Child Psychotherapists *Won't They Grow Out of It?*.

Inquiry into mental health services in New South Wales. Legislative Council, Select Committee on Mental Health [Sydney, N.S.W.] :The Committee, 2002. (Parliamentary paper ; no 368)

Johnson, JG. *American Journal of Psychiatry*. 157: 1406-1412. 2000.

Le Feuvre, C. Managed Care and Medicare: Item 319, GAF or GAFFE? *Australasian Psychiatry*. vol 6 no 3. June 1998.

Manne, A. *Setting the Frame of the ADHD Epidemic: Childhood under the new capitalism*. http://www.napp.org.au/index.php?path=oi/&filename=adhd_manne.txt

Morris, JA. & Feldman, DC. The dimensions, antecedents and consequences for emotional labour. *Academy of Management Review*. Vol 21 No 4 986-1010. 1996.

Marans, S. Psychoanalytic Psychotherapy with Children: Current research Trends and Challenges. *Journal American Academy Child and Adolescent Psychiatry*. 28:669-674. 1989.

NAPP Submission to Senate Hearing on Rights of Children.

Prytula, R. *A Post-Graduate Training Program for General Practitioners*. 1997.

Osofsky, JD. How Research with Infants and Adolescents at High Psychosocial Risk Informs Psychoanalysis in *Research in Psychoanalysis.* Eds Shapiro, T., Emde, RN. International University Press. 1995.

RANZCP. Bulletin of the Faculty of Child Psychiatry. May 1993.

Shore, AN. A century after Freud's project: is a rapprochment between psychoanalysis and neurobilogy at hand? *Journal of the American Psychoanalytic Association.* 45, 3: 807-840. 1997.

Stern, DN. *The Interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. Karnac Books. 1985.

Submission To The Social Development Standing Committee, South Australian Parliament. *NAPP*. August 2001

The Statement of Rights and Responsibilities, A Guide for Carers and Providers, 1991, National Mental Health Strategy, Australian Health Ministers' Advisory Committee.

Target, M. & Fonagy, P. The Efficacy of Psychoanalysis for Children: Prediction of Outcome – *Journal of the American Academy of Child and Adolescent Psychiatry.* 33:8;1134. 1994.

Time Magazine. 3 February 1997.

Curriculum Vitae of Authors

Dr Gil M Anaf

MB BS Adelaide University 1975
General Practice 1977 - 1980
Fellow, Royal Australian & New Zealand College of Psychiatrists 1988
Clinical Lecturer in Psychiatry, Adelaide University
Founding President, NAPP, 1996 - 2004
Member, Australian Psychoanalytic Society
Member, International Psychoanalytic Association
Secretary, Adelaide Institute of Psychoanalysis
Member, Australian Medical Association

Dr Rachel Falk

MB BS
Fellow of the Royal Australian and New Zealand College of Psychiatrists FRANZCP
Committee member, NSW Section of Psychotherapy of the RANZCP 1997-2001
Membership of the Psychoanalytic Psychotherapy Association of Australia (PPAA)
Australian and International Psychoanalytic Associations
Australian Medical Association, Member
Teaches in the Sydney Institute for Psychoanalysis, The New South Wales Institute of Psychoanalytic psychotherapy, the postgraduate program in Psychotherapy of the NSW branch of the RANZCP and in the training program for psychiatrists for the past 17 years until 2001.

Dr Shirley Prager

Dr Prager graduated with the degrees of Bachelor of Medicine and Bachelor of Surgery from the University of Melbourne in 1968. She gained her Membership of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in 1980 and became a Fellow of the RANZCP in 1983. She has been a member of the Faculty of Child and Adolescent Psychiatry of the RANZCP since the Faculty's foundation in 1988.

Her experience in child and family psychiatry began over thirty years ago when in 1970 she was a child psychiatry registrar at the Royal Children's Hospital, Melbourne. She has treated children and families ever since, first as a rural general practitioner with a special interest in psychiatry (Armidale, NSW, 1971-76), and then, having completed her specialist training in Melbourne in 1980, as a qualified psychiatrist and child psychiatrist.

She has held the positions of:

- Vice-President of the National Association of Practising Psychiatrists (NAPP)
- Chair of the RANZCP Section of Forensic Psychiatry (Victoria)
- Honorary Senior Lecturer, Department of Psychological Medicine, Monash University
- Member of Editorial Advisory Panel, Mental Health Research Institute Pharmabulletin
- Committee member of the AMA Section of Psychiatry (Victoria)
- Chair of the Victorian Branch of the RANZCP (1995-1997)
- Member of the Victorian Branch Committee of the RANZCP (1985-1998)
- AMA Councillor, Victorian Branch
- Member of Committee of Convocation, University of Melbourne
- Chair of the Ethics Committee of the Victorian Branch of the RANZCP
- Foundation Chair of the RANZCP Section of Psychotherapy (Victoria)
- Treasurer, Federal Section of Psychotherapy of the RANZCP
- Victorian Councillor on the General Council of the RANZCP (1993-1997)
- Committee member of the Faculty of Child and Adolescent Psychiatry of the RANZCP (Victoria) (1982-1984; 1985-1994)
- Member of the Quality Assurance Committee of the RANZCP (1991-1997)
- Corresponding member for Victoria on the RANZCP *Committee on the Role of Psychiatry in the Family Court* (1987- 1993)

Dr Richard Prytula

Dr Richard Prytula is a psychiatrist and psychoanalyst working in private practice with individuals and small groups. He teaches in the Melbourne Institute of Psychoanalysis, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Advanced Training Course in Psychotherapy and various other psychotherapy training courses for individuals and groups.

Qualifications:

MB BS, Monash University, 1970
DPM, Melbourne University, 1975
Member, RANZCP 1975
Fellow, RANZCP 1977
Associate Member, Australian Psychoanalytic Society and International Psychoanalytic Association, 1980
Member, Australian Psychoanalytic Society and International Psychoanalytic Association, 1982
Member, International Association of Group Psychotherapy, 1995
Member, Group Analytic Society (London), 1996
Member, Australian Association of Group Psychotherapists, 1996

Positions held in the past:

- Victorian Councillor, National Association of Medical Specialists (NAMS), 1976
- Vice President, NAMS, 1985-88
- President, NAMS, 1989-95
- Honorary Teaching Associate, Department of Psychiatry, University of
- Melbourne
- Committee Member, Victorian Branch, AMA Section of Psychiatry

He is on the Editorial Board and is a contributing author to She Wont Be Right, Mate - The impact of managed care on Australian psychiatry and the Australian community, (1997), and the sequel, She Still Wont be Right, Mate!, (1998), both books edited and published by The Psychiatrists Working Group

NAPP SUBMISSION ON ATTENTION DEFICIT HYPERACTIVITY DISORDER

Part 2 of a submission prepared for the
Senate Select Committee on Mental Health
by the National Association of Practising Psychiatrists

April 2005

Executive Summary

The ADHD debate is a paradigm of the systemic problems facing child psychiatry. The core of the problem is rising prescription rates of amphetamines. This is a problem because it appears at times to be the only treatment being made available to ADHD diagnosed children rather than understanding the causes of their distress. That in turn is a problem because:

1. The internationally recognized treatment[20] would appear to be inaccessible to many patients; and
2. The status of ADHD as a discrete diagnostic entity is controversial.

The result is that other conditions are being misdiagnosed as ADHD and that children are unnecessarily being given powerful drugs which can substantially affect their emotional development. The influence of the major drug companies in marketing strategies using professional publications is heavily underestimated.

Other important aspects of the problem are that:

1. Psychotherapeutic expertise is not available in the public health system and this leaves a hole in public education strategies. In the private system these strategies are difficult to access because of restrictive Commonwealth financial arrangements. This is part of a larger social justice issue; and
2. The fact that about 90% diagnosed ADHD children are male. This suggests that there may be an inappropriate cultural and/or educational element in diagnosis or misdiagnosis.
3. Parliaments in WA and SA have now begun addressing these issues.

SUGGESTED SOLUTIONS

- Child psychotherapeutic expertise should be reinstated into a core component of assessment and possible treatment of alleged ADHD children and made more accessible, if needed, to those correctly diagnosed and, in addition, other allied conditions currently diagnosed as ADHD;
- To this end, a transparent career path for child psychotherapeutic professionals should be created within the State Department of Human Services;
- Departments of Health should create a multi-disciplinary framework dedicated to the management and treatment of childhood disorders including but not limited to those within the education system and headed by professionals with multi-disciplinary specialist training. Those are likely to be child psychotherapeutic professionals because of their education and training;
- The Education Department should keep accurate statistics on the number of children required to attend focus rooms and whether or not these children are medicated with amphetamines.

A NOTE OF CAUTION

Amendment of the State *Equal Opportunity Act* to include ADHD diagnosed individuals may be counterproductive. Experience from overseas, where this has been done shows that the effect may well be to encourage inappropriate diagnosis of ADHD because of perverse financial incentives.

[20] The question of the exact nature of the internationally recognized treatment will be discussed in the body of our submission.

Preamble

The National Association of Practising Psychiatrists (NAPP) is of the view that this enquiry by the Senate Select Committee is to be commended in seeking to address issues that are vital to the welfare of our children. To quote from the Mental Health Statement of Rights and Responsibilities , *"supporting the community in improving the mental health of its members is a major investment in all aspects of community life.." (p vii).*

In seeking to address the Committee on the issue of Attention Deficit Hyperactivity Disorder (ADHD), we would respectfully ask that the Committee bear in mind that our organisation (NAPP) is comprised of *practising* psychiatrists. We speak from the position of *clinicians* who hold the interests of the patient to be paramount. We maintain that ADHD is a complex clinical, scientific and societal problem. We also hold, perhaps more importantly, that resolution of the issue of increasing rates of prescribing practice for ADHD will depend on an appreciation of the political and economic forces that are brought to bear on patients, their families, and service providers.

NAPP is aware that investigation into the complexities surrounding ADHD has already been reduced, in some quarters, to an overly simplistic notion of "doctors overprescribing". We feel it would be unfortunate if that were to become the "5 minute news grab" from this enquiry, as the truth is rather more complicated; scapegoating a profession for what is in essence a policy issue will not help families already in distress.

Healthy emotional development of children is the bedrock of our society and the requisites for this have been, and will remain, unchangeable. These are times of accelerated change and this is likely to increase, as are economic and political forces that threaten the notion of the importance of the individual. If we are to be advocates for children into the future, as we were in the past when we spoke for their needs in regard to separations in hospitals, child care and the family court, then it is imperative that the emotional needs of children are not forgotten.

In a society plagued with problems such as youth suicide and drug abuse, depression and antisocial behaviour, it is our responsibility to not forget what we already know - that children who have stable and secure relationships with their parents (Bowlby), and who can play, and thereby develop a strong sense of self and purpose, tend not to run into these problems.

A recent study of 12,000 adolescents from 80 high schools across the United States, has found that young people who indicated a strong sense of bonding, closeness and attachment to family, regardless of the nature of that family - single parent, dual parent, adoptive family, (and this was corrected for class and income), have lower levels of smoking, drinking, drug use, suicidal thinking and behaviour, risky sexual behaviour and exposure to violence. These adolescents also felt more closely connected with school and teachers (Resnick MD, Klein JD).

It follows then, that an appreciation of the importance of family attachments (what strengthens them and what weakens them, irrespective of the nature of the "family") and a thorough knowledge of the stages of normal development must underpin any assessment of children with any disorder - be it physical, emotional, behavioural or learning disorders.

We will detail an actual (de-identified) case study that illustrates the issues we face as clinicians - these necessarily inform the approach in our submission.

Case History - A Second Opinion.

Justin aged 11 sat calmly, withdrawn, during the first assessment meeting with his parents doing most of the talking. His parents reported that he had been an 'impulsive' and at times 'aggressive' child both at home and school. They told me that he was diagnosed with ADHD aged 6. His developmental paediatrician prescribed Ritalin, two tablets in the morning and half tablet at midday. After starting medication, Justin's behaviour had improved dramatically. Both parents, as well as Justin, were relieved.

Regular medical follow-up was arranged along with speech pathologist, paediatrician, occupational therapist, and optometrist. At school, special educational support was started.

After five years on medication, his aggression persisted, although he was less disruptive, but the parents were concerned with his struggle with school's educational demands and his relationships with siblings and parents. The parents reported that Justin did not want to do his homework because he was 'unmotivated', and that he was easily provoked to rage by siblings. A second opinion was then sought.

Second opinion

During the lengthy four session assessment, Justin's developmental history elicited the following relevant facts whose significance had been previously ignored. Justin was in fact not unmotivated, but he was clearly a stubborn, opinionated and defiant youngster. During the meetings it emerged that neither parent, based on their own traumatic and inhibited patterns of family relationships, had the capacity to recognize ordinary defiance, let alone have the psychological resources to respond appropriately to Justin's testing manner. The reasons for the parental sense of lack of confidence were complex, but the transgenerational history helped me understand and to explain to them the relevance of how they responded to Justin's immediate behavior.

First, mother was diagnosed and treated with psychotic depression after Justin's birth. Second, to support mother during her depressive illness, Justin had three live-in caretakers, each for a period of about 2-3 months. Third, aged 3 and starting kindergarten, Justin was noted to have speech delay. Fourth, the birth of a sibling around this time resulted in Justin becoming a 'bully'.

During my assessment sessions, I could see the stresses that Justin's parents lived under, stresses that were exacerbated by mother's depression. Although one could understand the need for her to obtain additional help to assist with parenting her baby, the family were never helped to lessen the impact on child development of both maternal depression and the legacy of early, multiple care-takers.

The parents were genuinely surprised when I pointed out how these experiences can affect their child's later capacity to develop secure relationships, in particular his risk to develop attachment disorders characterized by anxiety, or more serious disorganization

and disruption. Dr Isla Lonie, past president of the Australian Association of Infant Mental Health observed how many professionals also either are unaware or tend to ignore this link between early attachments and later psychological symptoms

At this point, a skeptic could misrepresent my second opinion as highlighting that with time, most families could disclose disruptive events in their children's early childhood that could be construed later to need psychiatric intervention. That would be a distortion of the clinical facts - facts which demonstrate the fundamental need to assess children with ADHD 'symptoms' in a family and developmental context.

Justin's history highlighted a series of experiences of deprivation of stable care. That deprivation resulted from the well-intentioned replacement of the unavailable maternal care (due to maternal depression) with a series of substitute transient carers. Those episodes of making and breaking of substitute attachments in infancy can result in later attachment disorders, whose symptoms of impulsivity, aggression and lack of focus and concentration may mimmick ADHD. In short, the symptoms can be seen as the child's protest at disruptions to his / her attachment bonds, and an attempt to reinstate stability.

The later symptoms of chronic disruptions in early phases of attachment (0-3 month is the phase of undiscriminating social responsiveness; 3-7 months, the phase of discriminating social responsiveness; 7 months to 3 years is the phase of active initiative in seeking proximity and contact) may result in the child's later difficulty in regulating his behaviour, mood and relationships, which the Hon. M J Elliott noted in his speech.'The pressures faced by families affected by ADHD, sometimes over successive generations, can threaten family affection, cohesion and survival.'

We are not of the opinion that such transfer of symptoms across the generations must be thought to occur <u>only</u> in the form of genetic transmission. Current studies that explore the 'infants' display of particular attachment patterns has deepened our understanding of the intergenerational transmission of attachment.' (Lyons-Ruth et al)

These views support concerns that pressures can, if left unattended or misdiagnosed by the professionals, be passed on from generation to generation. The reliance on medication in ADHD, as Justin's case highlights, in the short term may reduce problematic behaviours, but in the long term, initial misdiagnosis, overmedication or inappropriate medication may result in the pressures being compounded for the child and the family.

Justin's parents benefited greatly from discussions that facilitated increased empathic listening skills and patience - these discussions were <u>only</u> possible because they were able to be based on an understanding of why each parent had difficulties in this area, and this understanding was then able to be put to Justin's parents in a non-threatening way.

The end result was a marked decrease in Justin's aggressive outbursts.

We now turn to specific issues.

1. Recent stimulant medication prescription practices and trends.

The ADHD controversy is centered on the clinical, scientific and social phenomenon that has resulted in increasing numbers of younger children, some under the age of five years, being prescribed powerful mind-altering (psycho-stimulant) drugs. National figures reveal the dispensing of Ritalin (methylphenidate) throughout community pharmacies in the calendar years 1990-1998 (public hospital drug use figures are not included) rose from 24,335 to 345,868, while dexamphetamine jumped from 9,937 to 248,286**, a twenty-four-fold** increase . Prescribing rates differ from state to state, and within each state, from area to area. It seems that there is an over-representation of ADHD prescriptions in the northern and southern suburbs of Adelaide. The number of children being medicated for treatment of ADHD within South Australia is understood to be in the order of 5500.

Dexamphetamine PBS prescriptions, state by state. Methylphenidate is not on PBS

State	**NSW**	**Vic**	**Qld**	**SA**	**WA**	**Tas**	**ACT**	**NT**
1992-93	6253	1590	2555	2250	3450	191	190	80
1999-00	69312	35761	32290	22446	71510	8226	2891	960

The South Australian figures show a nearly tenfold increase from 1992/3-1999/2000.

2. Appropriate diagnosis and treatment protocols

Do these prescription rates represent a genuine increase in ADHD? What other explanations may account for the increase? And what exactly is ADHD? These important questions are addressed by an overview below that outlines areas of contention in this debate, and this is divided into *issues in diagnosis* and *issues in treatment.*

Issues in Diagnosis

Although ADHD is the most diagnosed childhood condition in the US, the prevalence of ADHD in Australian children is reported to be between 2.3 -6% (NH&MRC).

The impact of medication on symptoms is to reduce behavioural problems following medication with Ritalin or dexamphetamine. Yet major debate centres on the 'scientific' status of ADHD. The symptoms of ADHD include **inattention, impulsivity** and **hyperactivity** to a level that impairs social, academic and occupational function. But as Jureidini has noted "this symptom cluster can be reliably identified…but reliability of identification does not entail validity *as disease"* (italic ours). He adds further, that "there are no neuropathological correlates of ADHD" and that therefore, the diagnosis of ADHD must be a diagnosis of exclusion (given that there are many reasons why a child might be overactive, varying from the understandable and transient, to the entrenched and pathological).

ADHD is a disorder of unknown aetiology, with a number of theories as to the possible underlying pathology coming out of increased understanding of neurobiology.

The key principle of developmental neurobiology is that the brain develops and organises itself as a reflection of developmental experiences, organising in response to the pattern, intensity and nature of emotional, sensory and perceptual experience. The quality of the attachment bond (*see illustrated case)* between the primary caregiver and infant determines the maturation of the infant's brain, specifically the maturation of the structural connections within the areas that come to mediate both the interpersonal and intra psychic aspects of all the child's future social and emotional functioning (Shore). Perry of Baylor College of Medicine in Houston says: "experience is the chief architect of the brain", and it is via the experiences of the individual that genes exert their effect. His group found that children who don't play much or are rarely touched develop brains that are 20% to 30% smaller than normal for their age.

The experience of the traumatised child is fear, unpredictability, frustration and the traumatised child's template for brain organisation is the stress response. In the developing brain neurotransmitters play an important role in basic developmental processes. Young children, victimised by trauma are at risk for developing permanent vulnerabilities - changes in brain organisation- and these alterations in brain development have an impact on all aspects of emotional, cognitive and behavioural functioning (Perry)

There is overwhelming evidence suggesting sensitive, if not critical, periods for brain development and function associated with mental health - including attachment, modulation of feelings, anxiety regulation and behavioural impulsivity. The brain's greatest period of growth spurt draws to a close around the age of 10 years. This is critical in planning early intervention and preventative programs, for there is also compelling evidence that the brain is plastic and capable of great changes, under the influence of experience (*hence the imperative for appropriate treatment resources).*

One opinion of causation then, is that ADHD is caused by developmental delay in the regions of the brain that control self- regulation. Work in the United States by Rapaport and Yelich has confirmed that ADHD may be caused by developmental delay but has *dismissed the popular opinion that response to medication is proof* of the existence of ADHD. In fact, they found that *all children* respond to stimulant medication with increased self-control and attention. So, response to psychostimulants is not proof of a biological cause of ADHD.

The Committee will understand, therefore, that in NAPP's opinion the cause of ADHD is a complex interaction between the environment (family, peers, school etc), and the individual child's genetic vulnerability, temperament and so on. We take issue with views expressed in some quarters that seek to portray ADHD as a *purely physical* disorder; it is no more a purely physical disorder than say, depression. This view takes from the complexity of the issue, and protocols can only be developed from an understanding of this complexity.

It is for this reason that the Australian National Health and Medical Research Council's Attention Deficit Hyperactivity Disorder Report recommend a range of tests and treatments for ADHD, *and not the prescription of medication alone*. These tests centre on a checklist of behaviours [detailed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)] which must be exhibited in both the home and school environment. Due to the similarity of behaviours resulting from other disorders, there have been cases of misdiagnosis.

To underscore the difficulty in diagnosis, young children often display behavioural changes before they develop adequate language to communicate states of distress that accompanies anxiety, panic, terror or abuse and trauma, conditions which may mimick or coexist (comorbid) with ADHD. Behavioural changes can include disruptive or erratic, unfocused behaviour. From a simplistic perspective, such behaviours fulfill DSM IV criteria for ADHD. A number of psychological conditions in childhood share the symptoms of 'attention deficit' and 'hyperactivity'. Children's attention can be compromised in a number of settings in medical/psychological conditions such as 'minimal brain dysfunction' (a term used in the past to describe an immature state of the central nervous system); intense grief reactions; moderate or severe depression; post traumatic stress as occurs after physical or emotional abuse; and times of family crisis or chronic family dysfunction**.**

It is worthwhile reminding ourselves that DSM, in all its versions, was only ever intended to be a tool to enhance communication amongst researchers and clinicians. Yet, it has assumed a status where some professionals assume that its operational criteria define conditions as 'proven'. However this trend has been strongly challenged in the US. For example, the US National Institute of Health's ADHD consensus statement concludes that: the '*unproven*' status of the disorder (ADHD) *'should give pause to both researchers and clinicians who may have reified ADHD as a 'true entity'* (rather than a *working hypothesis* that serves scientific, communication, and clinical decision-making purposes) - (Jensen). The 'scientific' status of ADHD therefore seems to be 'on hold'. Yet, recent books and reviews persistently refer to ADHD as if it was 'proven'.

The current trend to diagnose a child by his behavior, *rather than the meaning of that behavior,* is a complicated issue that perhaps has its roots in a wish for simple explanations or perhaps has a basis in the understandable wish of parents / society to seek a "biological" explanation rather than a more comprehensive assessment of emotional development that would include a compassionate self-assessment of one's parenting style.

NAPP feels therefore, that diagnosis of ADHD must be by exclusion; must be accompanied by appropriate investigation to rule out other similar conditions; and must never be made by the "tick-a-box" method where there is no regard for developmental issues. Neither do we feel that ADHD is to be diagnosed by a "trial of medication" - improvement does not equate to diagnosis.

Issues in Treatment

In discussing treatment issues, we reiterate our clinical position that treatment must be based on sound fundamental knowledge of emotional development *(see case illustration).*

As we are living in times when the quick, cheap cure is increasingly becoming imbued with moral meaning, and there is ever more sophisticated pharmacology, we can not afford to forget that children and adults are different not merely in degree *but in kind*. This knowledge is a necessary precondition to treating children. Children, and many adolescents, cannot communicate complicated feelings directly, they cannot conceptualise complex or abstract ideas and express feelings at a verbal level. Children are brought to us most often because their behaviour is disruptive to an adult, sometimes they are brought because they have learning problems, and only rarely because someone thinks they are unhappy or unduly anxious. Disturbed behaviour or aggression, arousing alarm or anger in other people, restlessness, difficulty concentrating , may be the first indication that a

child is struggling with an emotional disorder - to upsetting life experiences past or present and to emotional turmoil.

When patients are ill, and especially so when they have psychological illness or emotional pain, feeling understood is often a precondition for the amelioration of symptoms, *even in those situations where medications are indicated.*

The current system - DSM- is a medical model based on the organic disease analogy for considering behavioural and emotional disturbance. This system fails to grasp the developmental significance of the attachment history, the role of experience is relatively neglected, as is early adaptation or processes of change in childhood. The repertoire of the developing child to express psychic pain and distress is limited - behavioural and emotional disturbance reflects a succession of adaptations that evolve over time, in the same way that occurs with normal development (Sroufe).

Research of Sroufe et al showed that changing support for caregivers and changing the relationship status of these children with caregivers were the most consistent predictors of change in child behaviour problems. As the primary caregiver's relationship stabilised or destabilised, the child's manifestation of attentional and hyperactivity problems changed.

On the other hand, NAPP is of the view that stimulants are not specific in their effect - indeed, Jureidini notes that research indicates that "the response of normal boys and men (to stimulants) did not differ importantly from those with ADHD". He further goes on to add that a marked behavioural rebound effect (on cessation of stimulants) is often confused with a re-emergence of symptoms thus leading to an escalating cycle of prescribing. Jureidini is quite clear that "a child with ADHD should never be treated with stimulants until there is an explanation for overactivity, or at least until all major pathology has been excluded" (p 202). NAPP holds then, that the prescription of stimulants should be a last resort, to be used in exceptional circumstance, though we acknowledge that there might be a role for judicious use as a "circuit breaker" in the context of other interventions.

So what are these "other" interventions, and on what are they based ?

There are many things we do know, and they have been known by many people for a long time: children grow up and develop, *and develop problems*, in the context of their significant relationships - parents initially, siblings, teachers and peers. If we want to help children with problems, we need to know what's going on in their lives at present, and their past history - what has contributed to their development, their personality and their symptoms. We need to know what's worrying them, and we won't often be told directly, we need to be able to interpret them. Treatment of disturbance, like development, becomes meaningful in the context of a relationship based on rapport and understanding and the experience of being understood makes the patient more accessible to whatever interventions we feel are appropriate or possible.

There's no doubt that powerful psychotropic drugs will influence a child's (and adult's) behaviour, and sometimes their mood. This neither confirms a diagnosis nor in many instances justifies their use. A child's brain, their mind and personality, is evolving and modifiable in structure and function, by experience for a long time.

If we can modify their environment, their relationships, and offer an opportunity for growth of the personality so they can think about problems that arise rather than just react to them, be helped to tolerate unpleasant affects and to develop a capacity to symbolise conflicts in words and play, they will be better prepared to face life in the future as adults.

As Jureidini states,"there is no stronger influence on children than the quality of their parenting". While he, and NAPP, acknowledge that there is a lot to be gained by reducing the burden on parents of unacceptable or overdeveloped guilt feelings in relation to parenting, nevertheless we must as clinicians understand that families are pivotal to a child and their emotions, just as schools are, or peer relations. To do otherwise is to delude ourselves and thereby betray the welfare of our children.

Treatment issues then, if they are to be truly effective and are to work in the interests of the child, need to include a broad range of options. Now this is not necessarily, in NAPP's opinion, what is referred to as "multi-modal treatment". If one looks closely, we find that "multi-modal treatment" has become something of a catch-cry, but what is defined as "multi-modal" is in reality an arguably constricted range of initiatives. According to the NH&MRC protocols, management is based on the following:

4 Medication

- 4.1 Rationale for use of medication
- 4.2 Stimulant medication
- 4.3 Non-stimulant medications
- 4.4 Medication compared to and combined with other treatments
- 4.5 Medication for ADHD in special populations and with other disorders
- 4.6 Monitoring of medication prescribing

5 Educational management

- 5.1 Educational problems encountered by ADHD children
- 5.2 Overcoming learning difficulties
- 5.3 Education policy issues

6 Behaviour management

- 6.1 Behaviour modification
- 6.2 Cognitive behaviour therapies
- 6.3 Anger management training
- 6.4 Family intervention

When we look more carefully at "Behavior Management" (6.1 - 6.4), NAPP finds very little intervention based on the developmental underpinnings as detailed in our submission. No mention is made of the invaluable role of child psychotherapeutic approaches, and this is unfortunately reflected in policy statements more generally.

NAPP openly acknowledges the value and effectiveness of behavioural and cognitive techniques in management. However they have arguably become an "all - or - nothing" approach, their appeal perhaps lying in a perception that they are quick or easy to introduce into most settings. NAPP however is mindful that entrenched problems in

children and their families can often require individual and / or family therapy. The NH&MRC protocol for family intervention amounts to little more than providing information and more behavioural training.

NAPP cannot state too strongly, in regard to treatment protocols, that not only must we re-establish understanding children as the cornerstone of treatment, but that policies must encourage an expansion of psychotherapeutically informed strategy. **To divorce behaviour from its meaning in children is to be "penny wise but pound foolish".**

Stimulant use has been around for long enough that we are seeing some of these treated patients in their early twenties. They are then being diagnosed as borderline, anxious, etc. Having been untreated (psychotherapeutically) for so long, it then becomes necessary for this new generation of patients to provide longer term intensive treatments at greater cost to the community at large and to the individual in particular.

A fundamental issue in providing what NAPP calls true "multi-disciplinary treatment" is that there should be, in policy and in effect, explicit respect for differing expertise in differing fields. NAPP feels very strongly that current policy is more about encouraging competitiveness, increased economies, and undermining the development of expertise. Competition policy has no place in medical practice, and the desirability of economic downsizing of the health sector is a matter for the community to debate in an informed manner.

True multi-disciplinary assessment of all children, with or without ADHD, should include protocols that facilitate discussion of the issues of individual patients between all the service providers (such as psychiatrists, paediatricians, psychologists, speech pathologists, teachers, occupational therapists, nurses, etc). Given NAPP's continuous emphasis on context and meaning in a child's life, on understanding and working through problems in the family or the child, we feel it is imperative that the devaluing of psychotherapeutic expertise in our child psychiatry training be reversed forthwith, and that this be supported in policy.

In practice, the provision of these services might range from having such experts train and work in our public hospital settings (eg consultant positions for child psychoanalysts might be seen as a necessary repository of expertise) or private settings, to their educating teachers and health professionals, right through to informing the various approaches and parenting assistance programmes that were once available through our child welfare agencies. To quote from the Mental Health Statement of Rights and Responsibilities , "the consumer has the right to expect that educators…and other non-health professionals will receive sufficient education to enable them to recognise and refer…".

We reiterate our position that behavior therapy is not all that should be available, and that expertise in other areas should be immediately reestablished as imperative in management strategies.

3. Accessibility of Multi-Modal Treatment

As noted above, NAPP feels that the issue of access to treatment omits the important point of *what* treatment is required by each individual child. We reiterate our view that "internationally recognised multi-modal treatment" is different to what clinicians at the coal-face think of as appropriate intervention.

Access to a range of treatment options that are informed by developmental understanding would seem to be self-evidently desirable - eg a clinician might well feel that many children and their families referred for "ADHD" might benefit from parenting support programmes of the kind that were once available, rather than opt for the prescription pad as a first option.

In essence, the definitions of "multi-modal treatment" seem to be talking about something that used to be called a "multi-disciplinary approach" which all professionals agreed with. This point is not a semantic one since, if one examines the operational views of the "multi-modal" approach one sees that there is a very heavy reliance on behavioural and cognitive strategies to the exclusion of understanding what is going on in the family and in the child. Many child psychiatrists in Adelaide feel, we believe, that there is an overemphasis on behavioural management and "information" - or that, pressed by desperate families in need of help, and knowing that alternatives are limited, they feel they must do something.

This might particularly affect paediatricians as a group, who might feel that the chronic lack of psychiatric services leads them into having to prescribe stimulants in order to feel they have helped in some way (Jureidini). NAPP does however acknowledge that cognitive / behavioural methods do have a rightful place in treatment as part of a range of possible strategies.

In short, and in regard to child psychotherapy, there is little or no access to this (recognised) form of treatment if a child (eg from financially disadvantaged families) requires it due to restrictive Commonwealth funding, and unclear career paths for such specialists which in turn discourages training in this vital area.

The importance of this point is made by the Hon M J Elliott in a Parliamentary address when, in arguing for an enquiry, he stated in the SA Parliament that when one child is affected by ADHD then there are also "collateral" patients in the form of parents, siblings, peers etc. This point has been repeated in the WA Parliament which held its own enquiry into the issue of ADHD. Providing access to all forms of treatment, indeed maintaining expertise, is vital if one is to reduce the overall reliance on medication. The Mental Health Statement of Rights and Responsibilities document states that "the consumer has the right to a co-ordinated and ongoing range of adequately resourced …treatment" and further that "the consumer has the right to be treated in the most facilitative environment with the least intrusive treatment "(p7). Medicating the minds of young children is nothing if not intrusive.

As the Hon M J Elliott noted in his address, public service delivery in this area has meant children have to wait in the order of one year for effective public intervention - unless the family can pay for private services. Not only has expertise in one particular field (therapy) been unavailable for selected cases, but those behavioural interventions sanctioned by policy makers are in effect unavailable - a year is a long time in a child's life, and for their

distressed parents, and a year is long enough to cement maladaptive patterns of behavior that might otherwise have been modified.

Again, to quote from The Mental Health Statement of Rights and Responsibilities document "the consumer has the right to obtain treatment at an early stage of their illness…" (p7). The Hon M J Elliott opines "the common theme of government responses has been reassurance to the public that all necessary services are available and reaching those in need. That simply is not the case." NAPP agrees completely.

Another factor limiting access to timely treatment, we believe, is what the Hon M J Elliott refers to in his speech on the matter as an "issue that does not settle anywhere and does not have any *ownership" (*italic ours). This confusion of ownership is reflected in the profusion of policy statement by the educational sector, who look to the health sector for guidance but find any input to be ad hoc, and poorly resourced.

NAPP would advocate that multi-disciplinary treatment, involving all relevant professionals under the auspices of those whose training is indeed multi-disciplinary in approach, might be a more useful long term strategy for definitive treatment. This would, we feel, place ownership of the problem in the child psychiatry sector (where we believe this would work best), would allow expertise to be developed and maintained in conjunction with paediatricians, and this in turn would allow the wider dissemination of educational and liaison strategies to reach areas most in contact with these children - eg teachers, welfare sector providers etc. Of necessity this demands a greater policy commitment to properly fund and resource this approach.

4 Any other related matters

Whilst NAPP is cognisant of not wanting to burden the committee with too much broad information, we do believe that ADHD presents a complex array of problems that span several disciplines, and cut across several Parliamentary portfolios.

For example, NAPP understands that consideration is being given to the proposal that amending the Equal Opportunity Act, by making it more inclusive and less restrictive, might then enhance access to treatment for children diagnosed with ADHD.

Whilst NAPP can see that this might be potentially useful if it were to lead to proper definitive treatment as described above, we are also cautious in that this might inadvertently *increase* the rate of diagnosis and therefore *increase* stimulant prescription rates. NAPP bases this on experience in the US where Perrin et al observed that when children receive income as part of a program of disability benefit for ADHD, the diagnosis can ‘reflect bias because providers tend to code conditions and procedures that are likely to be reimbursed. Thus, the diagnoses on claims may not accurately reflect the conditions that children have.’ This raises critical questions: could the culture of ‘cash benefits to a maximum of approximately $6000.00 per year per beneficiary’ under the Supplemental Security Income in the US be a contributing factor that *promotes the increase* in the rate of prescriptions for drugs used to treat ADHD?

That non-ADHD psychological and social factors may bias the prescribing habits of the medical profession to diagnose children with ADHD for eligibility to claim up to $6000 in disability payment (in the US) should at least be considered a part of the ‘wider forces’ that might influence the complexities of the condition.

NAPP is also mindful that professional information in regard to drug management is disseminated via articles in professional journals. There is increasing concern that these same articles that purport to set objective standards are indeed caught up in conflicts of interest, occasioned by the fact that drug companies often heavily influence the reported findings.

This was recently stated thus :
" NIMH effectiveness research clearly is the result of several forces that emerged in the early- to mid-1990s," said Michael Thase, M.D., of University of Pittsburgh, who co-chaired the symposium with Gary Sachs, M.D. "First, in the area of psychiatric therapeutics, it became abundantly clear that there was a large disconnect between what we knew from randomized clinical trials and what was done by practitioners on an everyday basis…. Secondly, it became clear that we were entirely dependent, in terms of our knowledge of new treatments and their relative merits, on the information funded by…the very companies that would serve to benefit from the information about the new treatments."(Kaplan).

Further, we also need to consider the wider political forces that impinge on this problem. NAPP will now table a book (*She Still Won't Be Right, Mate) *written by the Psychiatrists Working Group in 1999. We would like to draw the attention of the Committee to three chapters that we deem to be relevant to the issue of ADHD and its management :

- Fact and fiction about unmet need for mental health services - D Grant & G Anaf
- "Voltaire's bastards" and the rights of the child: the manufacture of epidemics - George Halasz
- Managerialism, psychiatric reform and the community - Gil Anaf

Fact & Fiction - In this chapter the authors argue that the notion of "unmet need" so often reported in policy documents in Australia is in fact an exaggeration of the truth. The development of this notion is traced back to flawed documents that have as their agenda the purpose of cost cutting and downsizing the health sector, in line with the American models of health care.

We quote from this chapter "In short, the talk is about financial policies that in one way or another can be referred to as managed care strategies. These same policies have been imported from the US where they have led to devastating reductions in the availability of adequate care for large sections of their community…" (p50)

NAPP believes it is not a coincidence that as our health system is "Americanised", so too will our diagnostic patterns closely follow US trends, as is the case with ADHD and the increasing lack of access to definitive treatment.

Voltaire's bastards - "As we enter the 21st Century, the paradigm shift in administrative practice called "managerialism" and the marketisation of health care is daily eroding valued aspects of the Australian health care delivery system and the values of ethical health care, including the right of the child to be heard" (p186).

In this chapter the author puts the view that market forces, and our reliance on them, erode what can be done to help children in need particularly since these same forces encourage stimulant use, thereby creating "the manufactured epidemic of ADHD". The author quotes from research into ADHD where particular comment is made on the lack of importance placed on psycho-social factors (the child's environment, parenting, schooling) as primary or secondary contributors ***to the emergence of ADHD.***

Managerialism, psychiatric reform and the community - Lastly, this chapter puts four key issues that beset our health policies that in turn rebound onto vulnerable members of our community eg children. First, the author describes the complexities of policy changes that drive health care further away from the notion of concern for the underprivileged - and closer to a competitive, exploitative system. Second, the view is put that to turn social services into defacto businesses only leads to ethical dilemmas we can ill afford - eg do we only treat ADHD with pills ? Third, we see how managerialist theory now underpins policy, so that the longer term interests of the community no longer become paramount. Finally, the author argues that the nett effect of the above has negative implications for the whole of medical practice and hence the community at large, such as increased alienation of families, social fragmentation and rising medical costs with less access (p69). The problem of ADHD is a timely example. The author concludes with the view that governments must not abandon their social obligations - this would extend to ensuring comprehensive treatments remain available, and that all interventions are to be made potentially available for those in need.

Lest the Committee feel that the issues addressed in the chapters noted above might be far removed from the local scene, and that US problems "can't / won't happen here", NAPP would like to draw the Committee's attention to the existence of Item 319 Legislation in the Medicare Benefit Schedules.

This legislation has been in force since 1997. Its explicit intent and effect is to reduce the number of outpatient visits in any one calendar year for a particularly vulnerable group of mental health patients who require long term intensive treatment. The rationale for its introduction was the saving of money, and to increase access to psychiatrists more generally - a bit like a surgeon giving a patient half an operation so that another patient might also have half an operation.

Some (little) money has been saved, but access has decreased rather than the reverse. The emotional cost on individual patients and their families of being deprived of proper treatment has been tragic and severe in some cases.

NAPP feels very strongly that this has been the direct result of policies based on the issues we describe above, and that the issue of ADHD is likely to fall into the same category. Further, one can easily imagine that if a distressed parent needed their own treatment in order to ameliorate the effect of a child with ADHD, how easily this might become problematic for no other reason than Commonwealth funding arrangements. An escalating cycle of illness within a family will then have been created, which might easily have been avoided.

5 Recommendations

5.1 Child psychotherapeutic expertise should be reinstated into a core component of assessment and treatment of alleged ADHD children and made more accessible to those correctly diagnosed and, in addition, other allied conditions currently diagnosed as ADHD;

5.2 To this end, a transparent career path for child psychotherapeutic professionals should be created within the State Department of Human Services;

5.3 The Department of Health should facilitate a multi-disciplinary framework dedicated to the management and treatment of childhood disorders including but not limited to those within the education system and headed by professionals with multi-disciplinary specialist training. Those are likely to be child psychotherapeutic professionals because of their education and training;

5.4 Education Departments should keep accurate statistics on the number of children required to attend focus rooms and whether or not these children are medicated with amphetamines or have a history of diagnosis of ADHD;

5.5 The standard of broader professional expertise for the diagnosis/management of ADHD can be increased by providing increased training at the level of school councellors and general practitioners, and at welfare agencies, - that is to the professionals who usually have first contact with the child displaying behavioural problems.

5.6 Where over prescribing is suspected, the Health Insurance Commission and Pharmaceutical Benefit Scheme already have processes for review based on patterns of prescription, (as occurs with pethidine) which would allow the under-usage of the multi-disciplinary approach to be more closely evaluated.

5.7 Lastly, given the critical role of adequate resourcing and funding of our stated initiatives and being cognisant of the need for reasonable accountability, NAPP would urge that a review of such funding be undertaken through the Estimates Committee to ensure that all reasonable funds are made available, so as to reduce the over-reliance on medication by increasing effective and timely interventions.

In conclusion, NAPP would respectfully urge that the issues detailed in this submission, which present an overview of the complex issue of ADHD and its management, be given serious consideration. We believe that if the overarching principles for assessment and treatment outlined in this document were fully adopted, then Australia would once more have taken the lead in an important area involving health and social justice issues for the vulnerable in our community and their children.

The inclusion and fostering of psychotherapeutic expertise in child and adolescent psychiatric services can potentially make Australia a world leader in reducing morbidity, and reducing health expenditure by using clinically proven and effective strategies.

NAPP wishes to gratefully acknowledge the valuable contribution made by Dr R Falk, in preparing this submission.

REFERENCES

Elliott MJ - Attention Deficit Hyperactivity Disorder - Legislative Council, Hansard, April 5, 2000.

Jensen P S. - Commentary: The NIH ADHD consensus statement: Win, Lose, or Draw? Journal American Academy Child and Adolescent Psychiatry 2000; 39:194-197

Jureidini J - Some reasons for concern about Attention Deficit Hyperactivity Disorder - J Paed Child Health 1996, 32, 201-203.

Kaplan A - Psychiatric Times August 2001 Vol. XVII Issue 8 ;Who Is Funding Comparative Drug Trials?

Klein JD - National Longitudinal Study on Adolescent Health: Preliminary Results, Great Expectations - JAMA 1997, 278.

Lonie I - (Unshrinking the Hippocampus: evidence based medicine ignore the meeting of neurobiology and psychodynamics. (In She STILL Won't be Right, Mate! Will managerialism destroy values based medicine? Your health care at risk! Halasz G, Borenstein R. et.al. (editors). Melbourne: Psychiatrists Working Group, 106-117, 1999.

Lyons-Ruth K, Jacobvitz D - Attachment disorganization; Unresolved loss, relational violence, and lapses in behavioural and attention strategies. P.527. - In Handbook of Attachment. Theory, Research and Clinical Applications. (eds) J Cassidy PR Shaver. New York: Guilford Press, 1999. P 520-554.

Mental Health Statement of Rights & Responsibilities - Report of the Mental Health Consumer Outcomes Task Force, March 1991.

National Health and Medical Research Council, Attention Deficit Hyperactivity Disorder (ADHD). Canberra: Commonwealth Department of Health and Family Services, 1996.

Perrin JM. Kuhlthau K. McLaughlin TJ. Ettner SL. Gortmaker SL. - Changing patterns of conditions among children receiving supplemental security income disability benefits. Pediatrics & Adolescent Medicine 1999;153:80-84.

Perry B - Neurodevelopment and the physiology of trauma - The Advisor, vol 6, 1993

Psychiatrists Working Group - She Still Won't Be Right Mate; Will Managerialism destroy values based medicine ? Your health care at risk. - 1999.

Resnick MD et al - Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health - JAMA 1997, 278.

Rapoport JL et al - Dextroamphetamine; Cognitive and behavioural effects in normal and hyperactive boys and men - Arch Gen Psych 1980, 37, 933.

Shore A - Opening keynote address, Faculty of Child & Adolescent Psychiatry, Oct 1998.

Sroufe A et al - Psychopathology as an outcome of development - Development and Psychopathology, 1997, 9.

.

Dr Gil Anaf
MBBS FRANZCP
Past President, National Association of Practising Psychiatrists
Psychiatrist in Private Practice

Dr George Halasz
MBBS BMed Sc MRCPych FRANZCP
Child & Adolescent Psychiatrist
Department of Psychological Medicine
Monash Medical Centre
Clayton, Victoria