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Senate Select Committee on Mental Health

In making this submission to the Committee, I do so as someone who faces the difficulty patients face gaining full treatment, on a daily basis. I work as a private psychiatrist and qualified psychoanalyst, and teach at the University of Adelaide.

The main points I describe speak to the following terms of reference:

- the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care
- the special needs of groups such as children, adolescents….and people with complex and co-morbid conditions
- the role of primary health care in promotion, prevention

The thrust of my submission is to emphasise the very great need for retaining, and indeed cultivating, expertise in psychotherapeutic techniques both in the public and private sectors. These can be used alone or as an adjunct to other treatments.

The Committee needs to understand that there has been consistent misinformation put about regarding the lack of efficacy of long term therapy, and worse the unjustified costs involved because they are so labour-intensive.

This misinformation has systematically ignored evidence of a local and international nature that attests to the **efficacy, safety and cost-effectiveness** of providing timely therapy. It has systematically downplayed the cost-offsets to be gained in reducing absenteeism, reducing general medical costs and increasing productivity. These are all borne out by research which is readily available. This too is ignored.

The main way by which this misinformation has sought to gain legitimacy has been by the use (or misuse) of the concept of “evidence based medicine”. In short, opponents in policy circles claim (mistakenly) that there is no evidence base. This is wrong.

I am strongly of the view that any "evidence base" should be kept in perspective, rather than becoming the justification for what seem to be ideological agendas to transform health services. Evidence should facilitate clinical work rather than limit treatment options to patients and their carers (MBS Item 319 restrictions are a case in point).

In a thorough critique of evidence-based policy making, Marston & Watts examine the enthusiasm for "evidence-based policy" in Australia, and in so doing ask the fundamental question of *what kind of evidence* (p2) is being advocated. They note too, that the push for EBM and policies based on this are attempts to modernise policy-making in an attempt to make it <u>appear</u> scientific and rational.

However they add, and I agree, that such "evidence" is *assumed to be neutral and value free,* which in turn ignores the influence of hierarchies in policy communities and the influence of "policy elites". The latter, especially if speaking with seeming authority, necessarily adds weight to any evidence presented; hence it becomes impossible to draw simple relationships between "evidence" and "policy" (p3).

Another critical issue arising from the convergence of managerialism and evidence based policy is the rise of technocratic logic, concerned with "procedural competence rather than substantive output" (p4) – ie it’s more about bean-counting than adequate clinical care. Nowhere is this more evident than in policies whose effect is to push for medication of psychiatric disorders rather than the additional time required to understand the social context in which a disorder has arisen.

Thus, these authors note that the effect of "outcome based funding" is to make (supposed) efficiency a primary value rather than discussions of justice and interest (in essence here, the best interest of the patient) (p5).

Marston & Watts add that "evidence based policy is no guarantee that good policy or good research will automatically eventuate" (p17).

Importantly, the authors contend that there is "a risk that evidence based policy will become a means for policy elites to increase their strategic control over what constitutes knowledge…***in a way that devalues tacit forms of knowledge, practice based wisdom and professional judgement*"** (p17).

As mentioned above, I am most interested to reverse an ill-informed push that aims to reduce access to long term therapy services, and that aims to only promote medication and quick-fix therapies as the main rebatable treatments.

To return to the Terms of Reference above, destroying the expertise of long term therapists by limiting rebates which in turn reduces the patients available to maintain clinical skills will disadvantage the community in the long run (as it is doing now).

- Clearly, limiting therapist skills by limiting patient access will do nothing to enhance early intervention and acute care that is well informed about the particular patient’s circumstances
- The special needs of groups such as children, adolescents….and people with complex and co-morbid conditions, most especially when they require psychotherapy because all else has failed to help, will be increasingly untreated

Lastly, I feel very strongly that some common sense needs to be brought to bear on the issue of training primary care givers such as GPs in mental health issues. No-one would suggest that more training wouldn’t be valuable. I strongly believe though that GPs lack the time required in many cases to adequately listen, understand and then appropriately treat complex patients.

A long consult with a GP might be 20 minutes, while a standard consult with a psychiatrist is 50 minutes.They have little time, and limited expertise that will not be remedied by a two month module in cognitive behaviour strategies. The latter may work for some, but not for all and certainly not for those most ill who have failed previous treatments. Training GPs, worthwhile as it is, I fear is going to become a defacto way of rationing access to specialist skills, merely to reduce costs at the patient’s expense. And psychotherapy skills will suffer the most from this strategy.

I strongly urge the Senate Committee to address this looming problem ie the impending decline and loss of expertise in long term psychotherapy as brought about by the current government’s policies. Item 319 restrictions in the Medicare Benefits Schedule are an example of these ill-advised policies. Another example is that no psychotherapy services are routinely available in the public system.

I urge the Senate to recommend an immediate review of MBS Item 319 restrictions, and to recommend that the Dept of Health and Ageing reverse its ill-considered policy of refusing to consider the matter. I deal with the consequences of their refusal, as I said, on a daily basis because it is patients who suffer rather than the policy advisors.

I thank the Senate Committee for its patience in considering these issues, and would be more than happy to appear before the Committee to elaborate on these problems should the Committee so choose.

Yours Sincerely,

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