

To: community.affairs.sen@aph.gov.au

From: Mr. Peter Fox Clinical Psychologist

Submission to the Commonwealth Funding and Administration of Mental Health Services Senate Inquiry: Community Affairs References Committee.

Thank you for the opportunity to make this submission.

My expertise is in the areas of trauma and of intimate relationships. I have worked in the Mental Health field for 40 years as a Clinical Psychologist.

My specific interest in this submission is Mental Health Services for the householder couple¹ with moderate to severe mental disorder and co-morbid physical illness, unrelated to divorce², domestic violence or bereavement.

My typical client couple present with complex interacting physical and mental health problems affecting their 'marital' and family relationships.

They are all in long term committed unions, heterosexual and LGBTI, married or not, from the same and from different racial and religious backgrounds, with and without child or extended family dependents, living in urban and non-urban rural areas. All are in the work force public and private. About 20% operate their own businesses or are employed by their family company. They are a cross section of the Australian family but who have been quite specific in seeking out a Clinical Psychologist specializing in Couple's Therapy.

About 25% have found my service entirely through my content rich website³, which usually has helped them before they get to see me. Some couples reading my website are in rural or remote areas and some interstate and many report benefit from my⁴ and other evidence based marriage related web sites⁵.

The rest of my clients come referred through a combination of previous clients and other health practitioners in the region and interstate.

Apart from the chronic shortage of Clinical Psychologists, Clinical Social Workers and Psychiatrists expert in marriage and family services, one of the limits of providing or extending

¹ In the 2007 census there were 5.9 million family households in Australia, of whom 85% identify as couple led families. Couples with children made up 45 per cent of those families. In that year there were approximately 150,000 marriages and 50,000 divorces. [see http://www.peterfox.com.au/pre_marriage_ed1.html].

² The rate of divorce has been falling for decades. Twenty-five years ago, zero point six per cent (0.6%) of our population divorced. Today it is down to 0.26%. That is 2.6 Australian adults per thousand population divorced in 2007. The last-reported U.S. divorce rate for a calendar year is 0.38% divorces per capita per year, or 0.75% of the US population gets divorced each year.

³ <http://www.peterfox.com.au/index.html>

⁴ Email 23 July 2011

"Peter,

I have to say a big thank you.

I think I have learnt more about myself and my partner in one reading, than the past many years of conflict, and therapy sessions. I am in Perth, WA, so not able to visit your office but appreciate your information on your web site. The resource you provide is fantastic.

Cheers, M."

⁵ A particularly good example of evidence based, on line marriage counselling costing \$US18 a month is here: <http://poweroftwomarriage.com/>

mental health services to couples with complex interacting psychological and medical conditions is the fact that moderate to severe marital distress is not a recognized medical condition in our health system and particularly in the Better Access To Mental Health Scheme.

Evidence based Couple's Therapy is not a Medicare Item.

Yet chronic marital distress is no less important than other adverse impacts on physical health and life expectancy such as alcohol abuse, smoking or poor diet.

By contrast, secure relationship attachment soothes the brain. Those who undergo heart surgery recover faster when they are allowed visitors. People with congestive heart disease live two to three times longer if they have a happy relationship. Holding a partners hand when they are in pain reduces their experience of pain compared to one alone and without human contact. The happier the couple, the greater the relief ⁶.

Marital distress lights up the same areas in the brain (shown using an MRI) as a heart attack.

"Our attachments are so powerful that our brains code them as "safety." Any perceived distance or separation in our close relationships is interpreted as danger because losing the connection to a loved one jeopardizes our sense of security." ⁷

Marital distress has a significant adverse effect on recovery from illness and injury, for example in reduced speed of wound healing and increased difficulty in managing pain.

Marital distress is a powerful predictor of relapse from any kind of medical or psychological treatment.

I would speculate that only a few medical (and psychological) treatment protocols covered by Medicare include Clinical Psychology or Clinical Social Work assessment of, or concurrent treatment for high levels of marital distress.

Is the question even asked? Does the patient volunteer it?

The absence of this question, and of the assessment and treatment of high levels of marital distress in my patients journeys through the health system continues to surprise me given the increased risk of relapse in any kind of medical treatment.

It is a particularly concerning absence before, during and after infertility treatment of a couple with co-morbid physical illness and psychological disorders in one or both; after catastrophic childbirth such as an emergency cesarean with or without injury to the child; following life threatening accident or illness to one member of a couple, and in the medical treatment of debilitating physical illnesses that have a known impact on psycho-sexual functioning and/or increased probability of marital distress. These examples are regular occurrences and each has appeared at my door in the last twelve months.

I work with couples many years after the health system failed them in not providing an assessment of and a non-band aid treatment for marital distress during and after harrowing life saving medical interventions, a major health crisis, or life threatening accident or injury.

These couples have weathered high levels of resultant relationship conflict over many years with consequent relapse of illness and poor family adjustment in response to their changed physical health or loss of function.

⁶ http://www.youtube.com/watch?v=UCukN_8S124

⁷ <http://www.socialworktoday.com/archive/051109p18.shtml>

This failure must surely impact the cost of repeat health services on relapse, in lost work productivity and with school behavior problems where the couple have children.

In most of these cases the worsening marital distress could have been effectively treated at the outset with evidence based Couple's Therapy had the question been asked and the service available.

Like many of my Clinical Psychology colleagues my typical patient has complex presentations of many years duration, often without the benefit of prior Clinical Psychology or Clinical Social Work assessment or treatment.

Often one or both have moderate to severe psychological disorders (typically PTSD and other anxiety disorders; multi episode clinical depression; addiction; self-harm; suicidality; bi-polar and personality disorders) together with co-morbid serious physical illness.

In my practice during the last twelve months I have seen couples where one member has had insulin dependant Diabetes, Multiple Sclerosis, Parkinson's and Crohn's diseases, Asthma, sleep Apnea, debilitating Ulcerative Colitis, stroke and heart disease, early onset dementia, infertility and uro-genital complications of other medical conditions such as vertebral subluxation.

The side effects of their sometimes life saving medications e.g. cortisone, may exacerbate the psychological disorder and reciprocally increase marital distress.

Many have received prior non-specific counselling, individual or marital counselling or have been prescribed psychotropic drugs. At best these treatments are reported as short term band-aids to manage the immediate symptoms leaving the chronic underlying marital problem intact.

At worst they have received poorly executed relationship interventions in the absence of a Clinical Psychology, Clinical Social Work or Psychiatric assessment, which has threatened to damage their relationship further⁸.

Many come to my practice as a last resort⁹. Some of their previous health practitioners appear not to have had the benefit of post-graduate training in a mental health discipline. From some patient's report, previous practitioners have not demonstrated the clinical skills necessary for assessing the complex interactions of co-morbid medical and psychological conditions impacting on the patient's immediate family and their marital relationship.

This assessment takes time and the clinical expertise of Psychiatry, Clinical Psychology and Clinical Social Work.

Most of the GP's I work with who are aware of the reciprocal influences of marital distress, psychological disorder and physical illness, want simply to refer to a Clinical Psychologist or Clinical Social Worker expert in the field, as they would to any other medical specialist. And, they tell me, without filling out the diagnostically worthless, time consuming and intrusive Mental Health Treatment Plan Item 2710.

For those patients I see on a Mental Health Care Plan (MHCP) I have found the increased red

⁸ For an example of this occurrence please read this page on my website:
http://www.peterfox.com.au/how_to_choose_therapist2.htm

⁹ See a dis-identified case example at Section 1.1 on my website where for simplicity, I have deleted the complication of co-morbid psychological and physical illnesses present in a number of related cases: http://www.peterfox.com.au/how_to_mend_relationship1.html

tape and date driven reporting requirements inefficient and ineffective when a narrative letter from the GP, with follow up phone calls to them as required, and timely progress reports are quite sufficient. Prior to the Better Access Scheme that was all we ever did and it works well for the patient, whether privately insured or not.

I have had four couples in the last twelve months, with typical complex presentations, referred for Couple's Therapy by their GP, where both partners were on a Mental Health Care Plan, sometimes from different doctors. Each was also seeing individual therapists, some Medicare registered, for their separate quite serious mental health conditions.

Under the current Medicare arrangements I could not provide them with a receipt for Medicare refund as there is not a Medicare Item for evidence based Couple's Therapy.

In any event, each would have quickly reached the end of their 12 sessions in a year by claiming all their sessions with me and their other therapists¹⁰. For an effective Mental Health service with a low risk of relapse, the evidence suggests they needed between 20 and 40 sessions in that year, spread between their individual and couple therapists. That is outside of the current and proposed parameters of the Better Access Scheme.

Some of my patients do not always accurately recall how many sessions they have already had under their MHCP with other Medicare Mental Health providers during that year. As a consequence of the Medicare payments computer system not counting the number of MHCP sessions claimed and not restricting the refunds to 6, 12 or 18 sessions depending on their GP having done timely MHCP reviews, I am exposed to the risk of Medicare asking me to refund any overpayment subsequently discovered through a routine audit of my practice.

As a consequence of the administrative burden and the unknown but not insignificant financial risk above, I have ceased accepting new MHCP patients from August 1st this year.

I would have had to stop taking those referrals from November 1st 2011 anyway as it will likely be unethical for me to offer only 10 sessions to a patient whose condition usually requires 20 to 25 sessions and who could not afford my service without their Medicare rebate.

These difficulties in the Better Access to Mental Health Scheme stand in the way of getting robust recovery with a low risk of relapse to couples with complex interacting psychological disorders and medical illness.

Recommendations:

a) Require Medicare to ensure its computer payments system counts the number of sessions refunded for each patient on a Mental Health Care Plan and cease providing refunds when the annual limit for that Item has been reached.

b) Add Medicare item for evidence based Couple's Therapy to be provided by post-graduate trained Clinical Psychologists or Clinical Social Workers (minimum Clinical Master's level rising to Clinical Doctorate).

c) Increase the number of sessions available for Clinical Psychology and Clinical Social Work services to at least 20 and to 35 in exceptional circumstances, to reflect current research and findings from clinical practice. Research evidence should guide policy making on the number of

¹⁰ If they qualified for exceptional circumstances they could have claimed 18 in all but that would have still been insufficient. These dual trauma couples will require 20 to 40 sessions in a year for effective treatment by their chosen mix of practitioners.

sessions required for assessment, treatment and recovery from psychological disorders¹¹.

d) Simplify Medicare required referral processes to reduce unnecessary complexity and red tape for the patient, the referring GP and the Psychologist or Social Worker in the Better Access Scheme. Our patients' journeys to our offices are hard enough without having red tape frustrating their path and review visits to their GP just to continue qualifying for a Medicare refund.

As background to this submission, I am a Clinical Psychologist and foundation member of the Australian Clinical Psychology Association (recently resigned 40 year Member of the APS and 30 year member of its College of Clinical Psychology). I specialize in evidence based Couple's Therapy.

Treatment duration for the couple therapy protocol I employ ranges from 6 to 24 sessions. International research evidence of the methodology shows (a) 90% of couples using this approach felt their relationships had improved, and 70-73% felt that their marriage difficulties were solved after 10-30 sessions, (b) irrespective of the initial severity of the problem and level of distress, and significantly (c) with a low relapse rate - the treatment effect is retained at the two year follow up¹².

I first graduated in 1972 and have worked continuously since then as a Clinical Psychologist in a number of hospital and clinic settings with the full range of both patient populations and degrees of severity in mental health disorders. For the last 35 years I have worked in private practice servicing Canberra and surrounding rural areas.

Please do not hesitate to call me for questioning before the Committee should Senators so desire.

Ziji Peter-John Fox
Clinical Psychologist

¹¹ An Australian study found that 'The current (Government) policy appears to be suitable for only about one-third of clients who carry the burden of psychological illness'. The findings of the study, which are roughly consistent with those found elsewhere, suggest that a minimum benefit should be closer to 20 sessions. Another study conducted by the National Institute of Mental Health found that 16 weeks of specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission.

¹² There are three evidence-based couple's therapies that have proven high success and low relapse rates [see http://www.peterfox.com.au/how_to_mend_relationship2.html]. By contrast "the wide range of marital therapies based on conflict resolution share a very high relapse rate. In fact the best of this type of marital therapy has only a 35% success rate" [see http://www.peterfox.com.au/how_to_choose_therapist1.html].