

# CHAPTER 5

## ADDRESSING THE DIVERSITY OF MENTAL ILLNESS AND TREATMENTS

### Introduction

5.1 'Mental illness' is a label that covers a wide variety of conditions. These conditions are as different from each other as are physical illnesses. Because they are so diverse, they can have very different treatments. And just as with many physical illnesses, a treatment that works for one person can be ineffective for another. Some physical illnesses are easily and effectively treated, such as minor bacterial infections, or appendicitis. Others are difficult to do anything for, such as the common cold, or some types of cancer. So it is with mental illness: treatment is more successful with some than others, and more is understood about some than others.

5.2 However, this diversity of illness and diversity of treatments both present some special challenges. Some mental illnesses get more resources than others, and some are taken more seriously than others. This inquiry, like others, heard accounts of people being refused effective treatment, or being unable to locate a service that could assist them. It should be a source of concern when some diagnoses lead to poorer quality care than others, and not just because there are fewer known treatments for particular conditions.

5.3 Of course, the seriousness of a medical condition should be a factor in prioritising treatment. Faced with a choice between treating someone with acute schizophrenia who has recently tried to take their own life, and someone with a moderate anxiety disorder who is unable to leave their home, but is living relatively safely within its confines, the person with schizophrenia gets priority. However, other factors appear also to be at work. In a system with limited resources, and which is dominated by a medical model of illness, there are hierarchies of care. Often only the most severe conditions get treatment at all, most of that treatment is pharmaceutical, and little effort is directed toward prevention. This chapter looks at how some illnesses, and some treatments, are being marginalised by a health system that has determined that some illnesses are more worthy of attention than others.

### Diversity of Mental Illness

5.4 What mainstream Australian society refers to as 'mental illness' or 'mental disorder' has not always been, and is not universally regarded as, a medical matter.<sup>1</sup> Mental illness has also been defined from a variety of cultural, social and legal points

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1 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 38.

of view. Similarly, the tendency to distinguish between the mental, physical and spiritual dimensions of mental health is not, and has not always been, shared by other societies.<sup>2</sup> Further, in recent years, psychiatry and psychology have sought to move away from the distinction between mental and physical aspects of mental illness. For example, the DSM-IV notes that the term 'mental disorder' in its title 'unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionist anachronism of mind/body dualism':

A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.<sup>3</sup>

5.5 The National Mental Health Plan 2003-08 (NMHP) explains that: 'mental health problems and mental illness refer to the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people'.<sup>4</sup> Mental illness specifically is 'a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities'.<sup>5</sup>

5.6 The diagnosis of mental illness is typically made with reference to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-IVR), and, the International Classification of diseases, Tenth Edition (ICD-10). The DSM-IVR covers a wide range of mental disorders and the ICD-10 makes reference to mental and physical disorders.<sup>6</sup>

5.7 The DSM-IVR classifies the following disorders:<sup>7</sup>

- Adjustment Disorders
- Anxiety Disorders
- Dissociative Disorders
- Eating Disorders

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2 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 38.

3 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders—DSM-IV-TM*, Fourth Edition Revised, Washington, 1997, p. xxi.

4 Australian Health Ministers, National Mental Health Plan 2003-2008: Australian Government, 2003, p. 5.

5 Australian Health Ministers, National Mental Health Plan 2003-2008: Australian Government, 2003, p. 5.

6 Australian Health Ministers, National Mental Health Plan 2003-2008: Australian Government, 2003, p. 5.

7 [http://allpsych.com/disorders/disorders\\_alpha.html](http://allpsych.com/disorders/disorders_alpha.html), (accessed April 2005).

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- Impulse-Control Disorders
  - Mood Disorders
  - Sexual Disorders
  - Sleep Disorders
  - Psychotic Disorders
  - Sexual Dysfunctions
  - Somatoform Disorders
  - Substance Disorders
  - Personality Disorders

5.8 In terms of mental disorders the ICD-10 covers:<sup>8</sup>

- Organic, including symptomatic, mental disorders
- Mental and behavioural disorders due to psychoactive substance use
- Schizophrenia, schizotypal and delusional disorders
- Mood [affective] disorders
- Neurotic, stress-related and somatoform disorders
- Behavioural syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behaviour
- Mental retardation
- Disorders of psychological development
- Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- Unspecified mental disorder

5.9 A broad description of the above disorders can be located at Appendix 1 to this report.

5.10 The committee heard evidence that not all disorders receive equal or sufficient attention in the current mental health system. The focus of the National Mental Health Strategy on 'serious' mental illness and stigma surrounding certain disorders were highlighted as the key drivers. The following sections discuss these concerns.

### ***Mental illness – a homogeneous group?***

5.11 The use of the expression 'mental illness' in public policy and popular discussion is in stark contrast to the term 'physical illness'. Typically, in the realm of

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8 [http://allpsych.com/disorders/disorders\\_alpha.html](http://allpsych.com/disorders/disorders_alpha.html), (accessed April 2005).

'physical illness', attention is paid to the specific illness or subset of illnesses and this is reflected in care settings – the oncology ward, the cardiology unit, the ear, throat and nose specialist, for example.

5.12 While emphasis on the umbrella term 'mental illness' has been driven by the need to raise the profile of a neglected area of health policy, bringing a range of marginalised mental health problems on to the policy agenda, grouping the diverse range of mental illnesses in this way is problematic. Professor Gavin Andrews noted:

It is difficult to think about 'mental illnesses' as a homogeneous group and any discussion of a generic mental disorder is obscuring important information, just as discussion of a generic physical disorder would do.<sup>9</sup>

5.13 Conceptualising 'mental illness' as one category of care, compared with the many recognised specialist epidemiologies of physical health, fails to recognise the breadth of service responses required:

Through our experience we have found the Mental Health System to be seriously flawed, not so much by any persons in particular but rather by serious systemic failures. Furthermore, we have found that these systemic failures basically stem from the incorrect assumption that "one hat fits all." Prima facie, the policies and protocols in relation to the delivery of mental health services may appear to be adequate but in reality they fall far short. They simply do not take into account the enormous depth, breadth and variances in mental illness. Nor do they take into account the individuality and complexities of the sufferers of mental illness.<sup>10</sup>

5.14 Not only is there a diverse range of mental illness groups, but illnesses and people's experience of illness vary within the broad illness groupings. For example, the Black Dog Institute argued that while the prevailing simple conceptualisation of 'depression' is useful for counteracting stigma and for encouraging people to seek assistance, it is limited in practice:

In reality, there are multiple depressive conditions, each with differing principal causes and benefiting from differing treatment priorities. However, there has been a general tendency to homogenize myriad depressive conditions into non-specific single diagnoses such as 'major depression' or 'clinical depression', and then initiating non-specific treatment.<sup>11</sup>

5.15 Focussing on 'mental illness' as one single area of health need, rather than a diverse range of needs requiring diverse responses, also supports the under-resourcing of mental health services. Distinct differences are evident in the services available for mental illnesses compared with specific physical illnesses:

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9 Professor Gavin Andrews, *Submission 176*, p. 1.

10 Break the Psyche, *Submission 183*, p. 1

11 Black Dog Institute, *Submission 170*, p. 1.

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Visit both the psychiatric acute care unit and the cancer care unit of your local area health service. Compare the adequacy and quality of buildings, staffing, service levels, furniture and fittings, culture and attitude. You will find chalk and cheese.<sup>12</sup>

5.16 Evidence to the inquiry shows that overall mental health services need increased resources to meet the needs of the community. However, the use of the broad term 'mental illness' masks the reality that service response for some illnesses is far less than for others.

### **The diversity of need**

5.17 Certain disorders do not receive adequate coverage within the current framework for mental health services. Two factors underling this are:

- a two-tiered system that fails to equally recognise or accommodate different illnesses; and
- certain disorders are not considered within the ambit of national and/or state mental health plans, for example, dementia is primarily dealt with under aged care.

### ***Hierarchies of care—the acute focus***

5.18 One of the greatest obstacles to addressing the diversity of mental health need is the incapacity of the present health system to deal with anything other than the most acute levels of need. Dr Ruth Vine, Director of Mental Health, Department of Human Services of Victoria, told the committee:

Public funding is directed towards those most vulnerable, those most in need, those who may require treatment under the protection of the Mental Health Act. The recognition that this area has been under increasing demand and does require expanding services is shown in the growth of the mental health budget that has occurred.<sup>13</sup>

5.19 The mental health legislation sets out certain priorities:

One of the challenges for public mental health policy is to strike a balance, and we have to strike lots of balances. One balance is between the issues of safety and autonomy, another is between the interests of the community and the interests of the individual, and another is between the individual's immediate safety and their longer term safety. That is why we have mental health legislation—to try to strike that balance and to try to take into account the different interests.<sup>14</sup>

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12 Mr Brian Haisman, *Submission 114* , p. 3.

13 Dr Ruth Vine, Director of Mental Health, Department of Human Services of Victoria, *Committee Hansard*, 7 July 2006, p. 37.

14 Dr Ruth Vine, Director of Mental Health, Department of Human Services of Victoria, *Committee Hansard* 7 July 2006, p. 35.

5.20 The NMHP interprets this to suggest that the right 'balance' involves prioritisation of care for people with severe mental health problems but also ensures that 'appropriate services are readily accessible to all Australians with mental health problems'. This means that implementation of early intervention and prevention strategies and other health and community services, such as housing, employment and income support, are also necessary.<sup>15</sup>

5.21 Under current funding levels, however, most jurisdictions have adopted the Mental Health-Clinical Care and Prevention (MH-CCP) model, where state and territory funds aim to address high need, severe illnesses, leaving the high prevalence disorders, such as anxiety and depression, to be carried by federal government initiatives. The NSW Government reported:

In broad terms the MH-CCP model accepts the current division in which specialist public mental health services operated by States and Territories provide the vast majority of care for people with severe illness, and especially those who currently consume 50 per cent of state resources, namely people who are so ill that they must be treated under the involuntary care provisions of mental health legislation. The other 50 per cent of State services extend as far towards moderate and mild levels of illness as resources permit. The "care packages" in the model assume an increasing role for non-specialist clinical services, especially in primary care, for the high prevalence by lower severity illnesses. Most of these would be expected to be provided under Medicare, though generalist community health services would also be involved, especially in rural and regional areas where – for example – private psychiatry is either non-existent or extremely scarce.<sup>16</sup>

5.22 In Victoria the result is that, as Dr Vine stated, 'the most in your face' level of need is prioritised, hence in Victoria the majority of funding goes to adult and youth services, at 60 to 70 per cent, aged care gets 20 per cent, and child and adolescent services only nine per cent.<sup>17</sup>

5.23 Medical health professionals argued that the focus needs revision; delivery models should be front end and preventative, and address the continuum of need across both high and low-prevalence disorders:

...greater focus on early intervention and illness prevention is needed across the board, in both low prevalence severe mental health disorders such as schizophrenia and other psychoses, and in the high prevalence problems of anxiety and depression.<sup>18</sup>

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15 NSW Health – NSW Government, *Submission 470*, pp. 13–14.

16 *Submission 470*, pp. 13–14.

17 Dr Ruth Vine, Director of Mental Health, Department of Human Services of Victoria, *Committee Hansard* 7 July 2006, p. 38.

18 SA Divisions of General Practice, *Submission 88*, p. 3; see also, Western Australia Section of the College of Clinical Psychologists – Australian Psychological Society, *Submission 101*, p. 1.

5.24 Professor Patrick McGorry of ORYGEN Research Centre agreed:

I am sure you have heard this from a number of submissions but what we see in mental health care in Australia is too little, too late. The services that are provided at the state level are tightly targeted at people with end stage illnesses, severe chronic illnesses or in very acute, high-risk situations—they may be acutely suicidal, aggressive or behaviourally disturbed. So the care is reserved, in a sense, at a state level for that group of patients. The whole concept is to intervene early and prevent people from getting to that high-conflict stage—where they almost have to force their way into care—which can be avoided, but the current model of care and resource levels at a state level are impeding that. There is a resistance to this mind-set.<sup>19</sup>

5.25 Given the substantial pressures of competing need within the system, it was argued that the onus is on the federal government to set up support and funding structures which will train service provision towards the goal of early intervention and preventative care across the spectrum of need:

...the failure to specify the priority populations for care has led to a debate in which the needs of those who were to be given priority under the National Mental Health Policy have been combined with the much larger number of people in need of primary care and relatively low levels of specialist care. This is a long-standing issue in mental health, and for the same reason: all mental illnesses that warrant a diagnosis are “serious”, but they are not all equally acute, disabling, or in need of the same kind of treatment.<sup>20</sup>

### *Caring for the most vulnerable*

5.26 At present the NMHP not only fails to articulate priorities, it also excludes a number of significant areas of urgent mental health need from its purview. In the main, those disorders neglected are complex conditions combining features which fall into disputed territories between mental health and other health treatment regimes. These people are arguably the most vulnerable consumers in the community. Failed by demarcated service regimes, they are falling through the cracks in the mental health framework.

5.27 As discussed above, psychiatry and psychology have sought to move away from the distinction between mental and physical aspects of mental illness, and this is reflected in the definition of mental illness applied within the NMHP. Unfortunately, the traditional service divisions between physical, mental and intellectual disability services are not so easily overcome. This is reflected in the way the NMHP ascribes responsibility for significant mental health problems to other service systems.

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19 Professor Patrick McGorry, Director, ORYGEN Research Centre, *Committee Hansard*, 7 July 2006, p. 2.

20 NSW Health – NSW Government, *Submission 470*, p. 21.

5.28 In particular, dual diagnosis, a growing problem among youth, is the domain of the drug and alcohol service system, and dementia, on the rise as the population ages, is primarily the responsibility of aged care services.<sup>21</sup> The fragmentation of service delivery for the people with dementia and for those with dual diagnosis, as discussed here and in other chapters of this report, is therefore underpinned by this approach, which establishes them as 'non core' responsibilities for mental health; related, but separate to the mainstream mental health agenda.

5.29 At the other end of the spectrum, people with comparatively rare but complex high need disorders, such as intellectual and developmental disabilities like autism are left outside any identifiable care framework. The mental health system does not own responsibility for oversight of targeted assistance, and nor does mainstream health services.<sup>22</sup> In this way there is a lack of impetus and a lack of flexibility in the system to address the diversity of need in the holistic way intended by the NMHS. Dementia, dual diagnosis, and autism as cases in point, are discussed in more detail below.

### *Dementia and mental illness*

5.30 As discussed in Chapter 15, the mental health of older Australians is not adequately catered for compared with other groups in the community. Although some developments in psychogeriatric services are occurring at state level,<sup>23</sup> there is a need for a comprehensive national plan:

Mental health policy is largely focused upon the needs of relatively robust adults, with more recent attention given to the needs of children and adolescents. The third National Mental Health Plan acknowledges the elderly as a priority group, which is welcomed. However, there needs to be an insertion of the effort and resources required to develop this recognition into a coherent plan for comprehensive mental health service provision to older people across the nation.<sup>24</sup>

5.31 The key policy document for older people, the Public Health Action Plan for an Ageing Australia (2003), is implemented by the Department of Health and Ageing, with some assistance from the Department of Families, Community Services and Indigenous Affairs.<sup>25</sup> However, the partnership with mental health services needed to produce the comprehensive approach required is poorly developed:

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21 Australian Health Ministers, *National Mental Health Plan 2003-2008*: 2003, p. 36.

22 See for example, Autism Aspergers Advocacy Australia, *Submission 92*.

23 See for example, Queensland Government, *Submission 377*, pp. 17–18; Victorian Minister for Health – Victorian Government, *Submission 445*, p. 1; Professor Henry Brodaty, *Committee Hansard*, 2 August 2004, p. 72.

24 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard 2* August 2006, p. 73.

25 Australian Government, *Submission 476*, p. 65.



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There appears to be disagreement at National, State and Area Health Service levels regarding the respective responsibilities of Mental Health versus Aged Care departments. This is then further exacerbated by disagreement regarding the respective responsibilities of different levels of government. The consequence of this is that, even when the need for such services is acknowledged, at all levels the funding of mental health services to older people appears to always be something that should be sought 'from someone else'. This problem is particularly evident in attempting to develop services for people with mental health disorders in Residential Aged Care Facilities; or who have Behavioural and Psychological Symptoms of Dementia (BPSD). BPSD is a term that has been developed to describe those people with dementia who develop associated mental health and behavioural disorders.<sup>26</sup>

5.32 The Australian Government acknowledged that people with dementia and their carers are experiencing serious access problems.<sup>27</sup> Significant government funding was committed to health care in this area:

Existing Australian Government programs that support people with dementia and their carers currently attract funding of more than \$2.6 billion annually. The government further extended this commitment in the recent budget by allocating funding of \$52.2 million over four years to assist people with dementia by making dementia a national health priority. This funding will increase support to people with dementia and their carers through a wide range of initiatives, including innovative care, assessment, hospitals, workforce, palliative care and GP initiatives that directly benefit people with dementia and their families.<sup>28</sup>

5.33 However, without a coherent plan to integrate approaches across the distinct silos of aged care and mental health services, people with complex presentations of dementia and mental illness are unlikely to receive the comprehensive assistance they need:

...if an older Australian develops mental illness this becomes an impediment to obtaining access to appropriate support services (ongoing or respite) in the community or within Residential Aged Care. This can be because services consider (officially or unofficially) that the presence of a mental illness makes the person 'outside their scope'; fear that the presence of mental illness (even depression) may make the person dangerous or inappropriate for the service; or because no services have been developed

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26 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 2 August 2006, p. 73.

27 Australian Government, *Submission 476*, p. 66.

28 *Submission 476*, p. 66.

for those who do require services with able to refocus upon people with ongoing mental illness.<sup>29</sup>

5.34 The Office of the Public Advocate Victoria concluded:

There is little evidence that the projected dramatic increase in the incidence of dementia ...is matched with preparedness in the mental health system in terms of infrastructure and expertise. There is potential for a considerable negative impact upon services already over-stretched and supported accommodation already in critical under-supply.<sup>30</sup>

*Dual diagnosis*

5.35 Dual diagnosis is the combination of mental health disorders with substance abuse. Dual diagnosis has increased most markedly among young people.<sup>31</sup> At the same time, self medication among all people with mental health disorders has increased to the degree that dual diagnosis has become more like the rule, rather than the exception, among consumers.<sup>32</sup> As noted above, the NMHP ascribes responsibility for people with dual diagnosis to drug and alcohol services and the National Drug Strategy provides the framework of care. In relation to illicit drugs, the overall focus is on control and regulation of supply, demand reduction strategies, including abstinence-focussed treatments and harm reduction strategies.<sup>33</sup>

5.36 In recent years the rising incidence of co-mordity, as it is also termed, has supported a substantial increase in the number of people with mental illness in gaol. Predominating among these are young men<sup>34</sup> and Indigenous people, a disproportionate number being women.<sup>35</sup> Submissions to this inquiry took the view that this trend is a direct consequence of the failure to adequately respond to the mental health needs of people with dual diagnosis, combined with an increased focus on law and order models to control perceived behavioural problems.<sup>36</sup>

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29 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [3].

30 Office of the Public Advocate, *Submission 172*, p. 11.

31 Australian Division of General Practice, *Submission 308*, p. 38.

32 Eastern Hume Dual Diagnosis Service, Statement in support of *Submission 374*, tabled Melbourne Public Hearing, 6 July 2005, p. 2.

33 Australian Government, *Submission 476*, Part 1

34 Probation and Community Corrections Officers' Association Incorporated, *Submission 503*, quoting NSW Health, 2000b, pp. 4, 15.

35 See for example, Department of Psychiatric Medicine, Children's Hospital Westmead and Tamworth (CAMHS), *Submission 99*, p. 1.

36 Fr Peter Norden, Policy Director, Jesuit Social Services, 'Prison Is Not A Healthy Place': ANEX Harm Reduction Conference, July 2004, quoted in Catholic Health Australia, *Submission 276*, p. 14.

5.37 The increased prevalence of dual diagnosis has highlighted a service gap for this group which has been growing for over twenty years:

At one time psychiatric illness and the problems of dependence (inebriation) were regarded as closely related and care was provided in the same institutions and through similar sets of services. Australian health care saw these two areas separate several decades ago. That was a positive change at the time, however, with the increasing recognition of the coexistence of mental health and substance use problems, this separation needs to be rethought, and new organisational and professional approaches devised to respond to this area of serious unmet need more appropriately.<sup>37</sup>

5.38 The Australian Medical Association judged the failure to integrate services for people with dual diagnosis as an exemplar of the inefficiencies of the mental health system overall, with its reactive focus on episodic and acute need:

The separation of some services results in significant inefficiency eg between mental health, drug and alcohol services, and there is scope to improve patient outcomes by integrating these services. Existing funding mechanisms favour defined episodes of care. However the mental health conditions that generate the highest burden of disease are chronic conditions and they require longitudinal care. The Commonwealth/State funding arrangements are dysfunctional, funds are wasted in duplication of administration and policy formulation while a silo mentality detracts from the continuum of care.<sup>38</sup>

5.39 The committee received evidence from stakeholders and many personal stories illustrating the limited access that people with dual diagnosis have to services which can provide assistance. Some state and territory governments have responded to the extent of unmet need, attempting to bridge the gaps. The Mental Health Legal Centre – Victoria reported:

Complex and co-morbid conditions and drug and alcohol dependence, affects many of our clients. Like many people with multiple needs this may mean being on the waiting list for a number of different specialist services, though never being a priority for any, each service expecting another ‘more appropriate’ service to act. These clients fall between the gaps between service silos. The Victorian Department of Human Services was perplexed by the plight of such clients and established new legislation for some such complex clients. It is envisaged that the complex care list will provide a range of services to those people deemed to be some of Victoria’s most difficult clients.<sup>39</sup>

5.40 The extent of the problem of dual diagnosis, and proposals for a ‘whole-of-government’ response are discussed in Chapter 14.

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37 Dr Ian Webster, *Submission 458*, p. 17

38 AMA, *Submission 167*, p. 1.

39 Mental Health Legal Centre – Victoria, *Submission 314*, p. 17.

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*Autism—intellectual and developmental disorders*

5.41 Between one and three per cent of people in the community have a developmental or intellectual impairment.<sup>40</sup> Many have coexisting mental health problems consequent to their disabilities, such as stress, anxiety, depression and sometimes psychosis.<sup>41</sup> Their situation exemplifies the very considerable diagnostic and service access problems for people with complex disorders:

They require constant support and assistance across the lifespan....yet they are a very diverse group— their needs are often very individualistic...in the UK and parts of the USA psychiatrists specialise in the treatment of this group – in Australia, they fall through the gaps in service provision because they don't neatly fit into eligibility criteria...they don't "fit" because of their cross agency, cross-professional needs....in Australia few psychiatrists have the inclination, the skills or the expertise to be involved, this is a huge unmet need, clinicians don't know how to help this group—how to serve their best interests.<sup>42</sup>

5.42 As the Burdekin Report noted, there is 'a huge number of intellectually disabled people who receive no treatment for their psychiatric disorder because there is none available'.<sup>43</sup> At the extreme end of the spectrum, is the situation of those with severe developmental or intellectual disability; in June 2005, the Senate Community Affairs Reference Committee reported on the distressing circumstance of affected young people relegated to aged care facilities.<sup>44</sup> The gravity of their situation and those of people with intellectual disability and mental health problems more generally, requires more specialised attention, and should perhaps the focus in a separate inquiry.

5.43 Autism Spectrum Disorder (ASD), including high functioning Autisms or Aspergers syndrome, is a developmental disability, although it is also classified as a mental illness under the diagnostic treatment manual.<sup>45</sup> Termed Pervasive Developmental Disorder by the mental health sector, ASD is not regarded as a treatable condition. Accordingly:

Policy in the mental health sector does not provide the resources or funding for the clinical treatment that people with autism need. Nor does any other section of government...existing policy excludes people with autism from the effects of the National Mental Health Strategy.<sup>46</sup>

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40 Queensland Centre for Intellectual and Developmental Disability Mater Hospital, *Submission 463*, p. 1, and see attachments.

41 Autism Aspersers Advocacy Australia, *Submission 92*, pp. 3–4.

42 *Submission 463*, p. 1, and see attachments.

43 *Submission 92*, p. 3.

44 See Chapter 4, *Quality and Equity in Aged Care*, Senate Community Affairs Reference Committee, June 2005.

45 *Submission 92*, p. 9.

46 *Submission 92*, p. 9.

5.44 Rather cruelly this exclusion extends to access of services under the Better Outcomes Initiative. A parent was advised by a mental health department official:

Can I explain at the outset that the Better Outcomes Initiative is designed to support GPs in the management of their patients with mental health conditions. The Initiative was mentioned in the correspondence to you as being one of the mainstream programs we have in the health portfolio which may be of interest to families of children with autism. The program itself does not extend to developmental disabilities and provides treatment which specifically targets mental health conditions.<sup>47</sup>

5.45 This has serious consequences for the up to one percent of children who will be diagnosed with (ASD) before leaving school.<sup>48</sup> Effectively, children with Autism cannot access early intervention and preventative treatments available to other children with mental health problems. This is despite recognition of the effectiveness of these for ASD in the diagnosis reference manual:

The DSM-IV [1], first published in 1994, formally recognised PDD (or ASD) as a family of clinical conditions, categorising them on Axis I with the other mental disorders. Internationally, recognition that ASD requires treatment resulted in improved early intervention and treatment regimes being provided for people with ASD.<sup>49</sup>

5.46 Autism Aspergers Advocacy Australia asked for urgent recognition of the validity of recovery-based models of care for children with autism and for implementation of affordable and evidence-based early intervention approaches by public health services.<sup>50</sup> A key mechanism is early identification by screening. Under identification of autism can have profoundly negative outcomes in adult life. Studies have found, for example, that a significant number of people diagnosed with schizophrenia or psychosis and unresponsive to treatment have undiagnosed ASD.<sup>51</sup>

### ***Marginalisation of some disorders – Borderline Personality Disorder***

5.47 Borderline Personality Disorder seems to be as much a recipe for marginalisation as it is a diagnosis:

My daughter is now thirty years old and still no closer to getting the help or support she as a human being deserves and should be able to expect.

A few of the diagnoses mentioned by the government authorities are: psychiatrically ill, post traumatic stress disorder; self harmer; suicidal; major depression and borderline personality disorder. The most recent

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47 Autism Aspersers Advocacy Australia, *Submission 92*, p. 8.

48 *Submission 92*, pp. 8–9.

49 *Submission 92*, pp. 8–9.

50 The key feature is the requirement for more one to one intensive interaction. See *Submission 92*, pp. 10–11.

51 *Submission 92*, p.5.

diagnosis I have was that there is nothing wrong with her. Is it any wonder one can not cope with life? ...

As a mother it has been and is a heart wrenching exercise to see a loved one go through what my daughter has been through and to hear and see the cries for help go unnoticed or dismissed as being 'attention seeking'. There is barely a patch of unmarked skin on her arms or neck where she has slashed herself or attempted hanging. ...

Borderline Personality Disorder (BPD) is as I understand, a difficult thing to diagnose, but it can be done and it can be treated according to a Psychiatrist in Victoria. He recommends psycho-therapy and a mild medication for depression and anxiety which is part of BPD. He also states that many mental health clinicians dismiss people with BPD as being 'trouble makers'. What a sad indictment on our society.<sup>52</sup>

5.48 The evaluation of the second National Mental Health Plan noted that the role of the mental health system in the treatment of personality disorders was a particularly poorly understood issue.<sup>53</sup> This remains the case. While personality disorders clearly fall within the domain of mental illness, as defined in the DSM-IVR and ICD-10, those experiencing these disorders find it particularly difficult to access services. The Victorian Office of the Public Advocate assessed that '[p]eople with personality disorders are often excluded from the system through clinical judgements'<sup>54</sup> and recommended that there be '[g]reater acceptance of responsibility by the mental health sector for the provision of services for people with diagnoses of personality disorder'.<sup>55</sup>

5.49 Submissions to this inquiry particularly highlighted the plight of those experiencing Borderline Personality Disorder (BPD).<sup>56</sup> A diagnosis of BPD closes the doors to already limited mental health services. It leads to social rejection and isolation. Sufferers are blamed for their illness, regarded as 'attention seekers' and 'trouble makers'. BPD is the diagnosis every patient wants to avoid.

5.50 The ICD-10 classifies BPD under 'Emotionally unstable personality disorders', which are characterised by:

...a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. There is a liability

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52 Name withheld, *Submission 418*, pp. 1-2.

53 Steering Committee for the Evaluation of the Second National Mental health Plan 1998-2003, *Evaluation of the Second National Mental Health Plan*, p. 17.

54 Victorian Office of the Public Advocate, *Submission 172*, p. 11.

55 *Submission 172*, p. 11.

56 See for example, Mental Health Community Coalition of the ACT Consumer and Carer Caucus, *Submission 214*, p. 7; Council to Homeless Persons, *Submission 315*, p. 20; Mental Illness Fellowship of Victoria, *Submission 388*, p 12; Ms Merinda Epstein, *Submission 207*; Australian Mental Health Consumer Network, *Submission 322*, p. 18.

to outbursts of emotion and an incapacity to control the behavioural explosions. There is a tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored.<sup>57</sup>

5.51 ICD-10 further notes that BPD is particularly characterised by 'disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicide gestures and attempts'.<sup>58</sup>

5.52 There is a strong link between BPD and experiences of childhood abuse,<sup>59</sup> but this is too often ignored in the targeting of service responses:

Many of our clients have childhood abuse and neglect histories. There appears to be a political blind spot in relation to childhood abuse in terms both of State policy and everyday practice, the National Mental Health Strategies are silent about it. People who have early experiences of child abuse and neglect often end up in the mental health system particularly but not exclusively with diagnosis of dissociative identity disorder, borderline personality disorder and other forms of personality disorders; there are many people who have the diagnosis of psychotic illness who have early experiences of abuse and neglect.<sup>60</sup>

5.53 The AMA report data that, although a decade old, put the prevalence of borderline personality disorder at 0.3 per cent of the population, around the same as schizophrenia (0.4 per cent).<sup>61</sup> However, the likelihood of obtaining appropriate treatment for BPD is markedly different:

For example, we know that if you have Borderline Personality Disorder (BPD) somewhere in your history you've probably got a very limited chance of attracting a service regardless of the seriousness of your pain or functioning. Alternatively, if you've managed to attract a diagnosis of Schizophrenia your chances improve markedly.<sup>62</sup>

5.54 BPD is marginalised within the community and within the mental health sector. There is a lack of recognition of the disorder as a mental illness and a lack of service response, let alone specialised treatment response. Discrimination is evident

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57 World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision*, <http://www3.who.int/icd/vol1htm2003/fr-icd.htm>, (accessed March 2006).

58 World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> Revision*, <http://www3.who.int/icd/vol1htm2003/fr-icd.htm>, (accessed March 2006).

59 Women and Mental Health Inc, *Submission 310*, p. 3; Australian Mental Health Consumer Network, *Submission 322*, p. 18.

60 Mental Health Care Legal Centre, *Submission 314*, pp. 7–8.

61 Australian Medical Association, *Submission 167*, p. 7.

62 Ms Merinda Epstein, *Submission 207*, p. 13.

and studies have reported negative attitudes and a perceived lack of training amongst clinical staff toward patients with BPD.<sup>63</sup>

Certain diagnoses seem to have greater and lesser status in the community and in mental health systems. This status is often contradictory. It seems that “proper mental illness” (psychosis) brings some status within mental health systems but is perhaps most vilified in the community. Alternatively, ‘nasty behaviour traits’ (e.g., Borderline Personality Disorder) does not carry the same burden as Schizophrenia in society but is a dreaded diagnosis within mental health services and often leads to clinical neglect and gross and unfair judgments by many clinicians.<sup>64</sup>

5.55 The marginalisation of BPD has its roots, at least partly, in the early focus of the Mental Health Strategy on ‘serious’ mental illness, without a clear concept of how this emphasis would be interpreted for service delivery:

...since the emergence of the First National Mental Health Strategy some groups (and I have referred specifically to people labelled as having Borderline Personality Disorder and people too often not recognised as having Dissociative Identity Disorder) have been so badly marginalised that it will take a reversal of policy and a radical retraining and reorientation of clinicians to overcome the systemic neglect at the State policy and local level.<sup>65</sup>

5.56 Even the labelling of the disorder is marginalising:

Derogatory labels such as Borderline Personality Disorder must be examined and new, more respectful, and more accurate terms such as Complex Post Traumatic Stress Disorder be considered. Consumers must decide how they would like their distress to be described.<sup>66</sup>

5.57 Clinicians too encounter the mental health sector's routine discrimination against people with BPD and are unable to secure appropriate treatment responses for their patients:

My patient had rapid, severe mood swings and a tendency to self-harm. She met the criteria for borderline personality disorder. There is increasing evidence that, rather than a wicked soul, dysfunction of the brain's limbic system underlies this condition. This dysfunction is often associated with past emotional trauma. Among my female patients, a history of childhood sexual abuse is common.

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63 C. Deans and E. Meocevic, 'Attitudes of Registered Psychiatric Nurses Towards Patients Diagnosed with Borderline Personality Disorder', *Contemporary Nurse*, 2006, vol. 21, no. 1, pp 43–49.

64 Australian Mental Health Consumer Network, *Submission 322*, p. 13.

65 Ms Merinda Epstein, *Submission 207*, p. 4.

66 *Submission 207*, p. 4.



This already disturbed young woman had problems dealing with the murder of a friend and I sought psychiatric help for her.

She told me that the community mental health service said she didn't have a mental illness. She was also assessed at a public hospital psychiatric unit and apparently told that she didn't need a psychiatrist. None of this surprised me, and I'm not blaming the clinicians who assessed her. Like most health care problems, the fault does not lie with individuals. They were merely following their training and, of course, to a degree restrained by the resources allocated to the public system. There was certainly nothing unique about the failure to achieve psychiatric support for this woman and I have been down this same path many times with many patients in many locations.<sup>67</sup>

5.58 There is a clear need for a change in service response for those experiencing BPD, including the provision of treatments appropriate for this disorder. As noted elsewhere, a 'one size fits all' response is inappropriate for 'mental illness', and this is exemplified by the experience of BPD. For example:

It has been known for many years now that inpatient settings are terrible places for people with who have Borderline Personality Disorders. Many get “*‘re-triggered’ into reliving their abuse experiences and sometimes self harm as a consequence.*” More than any other category of patient these women (usually) do really badly in hospital. Because of this most services now have a system where people with Borderline Personality Disorder are told they will only be admitted very briefly (no more than four days) and only once every two months for example. However, the triage system is often too clumsy to pick up people who have not been hospitalized with psychotic illness as being needy of case management. Unfortunately many people with this Borderline diagnosis (for example) lead a terrible life on the streets, cutting themselves regularly, perhaps picked up for a few days in an acute setting, told that what is happening to them isn't serious and sent out to deal with their lives themselves. This happens even when it is demonstrably shown that they can't do this on their own.<sup>68</sup>

5.59 Some of the most appropriate treatment responses for BPD are not available.<sup>69</sup>

Many people who have been diagnosed as having 'syndromes' like BPD or DID which need long term psychotherapy or Dialectical Behavioural Therapy (DBT) and more intensive interpersonal relationships with therapists over a longer period of time (rather than medical drugs) are now 'out of policy fashion'. Consumers recognise and are very concerned that since the publication of the First National Mental Health Strategy **public**

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67 Dr Andrew Gunn, *Submission 52*, p. 1.

68 Australian Mental Health Consumer Network, *Submission 322*, p. 18.

69 Ms Merinda Epstein, *Committee Hansard*, 5 July 2005, p. 36.

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**systems throughout Australia have lost a whole generation of psychotherapists.**<sup>70</sup> [emphasis in original]

5.60 Ms Merinda Epstein pointed out that the private sector is providing some of the best services for people with this disorder:

The irony is that some consumers who have been literally ejected from the public system have found very special private psychiatrists with an interest in BPD and DID and who use psychotherapeutic tools and ‘talking therapies’ either instead of or as an adjunct to drug therapy. Often, these clinicians are also refugees from the State system where they found their skills were no longer wanted.<sup>71</sup>

5.61 However, access to the private sector is an issue for many with mental illness, with few private psychiatrists' bulk billing for their services. Accessible, appropriate treatments for those experiencing BPD, and an end to marginalisation of the disorder within the community and the mental health sector, are urgently needed.

### *Need for specialist services for some disorders*

5.62 Given the diversity of mental illness, there is a need for specialist services that allow response to distinctive features of conditions. Whilst not an exhaustive exploration of the spectrum of mental illnesses, this section examines: eating disorders; anxiety; obsessive-compulsive disorder; and, post-traumatic stress disorder.

### *Eating Disorders*

5.63 Eating disorders – grouped into three broad categories in the DSM-IV; anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified (eg binge eating disorder) – are a common group of psychiatric disorders with a spectrum of severity, and can include significant levels of medical complications.<sup>72</sup> Anorexia nervosa has the highest rate of mortality of any psychiatric disorder.<sup>73</sup>

5.64 There are many obstacles to obtaining help for the treatment of eating disorders. The Centre for Eating and Dieting Disorders reported that generalist and mental health professionals have expressed 'a lack of knowledge and skills' on eating disorders, which leads to reluctance in their willingness to work with people presenting with such disorders. The Centre also highlighted the stigma that results from the misguided and damaging notion that eating disorders are 'self-induced' and that the consumer is in some way to blame for their illness, so treatment is denied.<sup>74</sup>

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70 Ms Merinda Epstein, *Submission 207*, p. 17.

71 *Submission 207*, p. 17.

72 Centre for Eating and Dieting Disorders, *Submission 307*, p. 1.

73 E. Harris, B. Barraclough, 'Excess mortality of mental disorder', *British Journal of Psychiatry*, 173, 1998.

74 Centre for Eating and Dieting Disorders, *Submission 307*, pp. 8–9.

5.65 The inadequacy of services for people with eating disorders was highlighted in a submission by a person with recurring bouts of anorexia nervosa. The submitter explained that the only long-term support available was through a private practitioner. Paying for this support required the selling of personal assets.<sup>75</sup>

5.66 The Centre for Eating and Dieting Disorders stated that recovery from eating disorders requires intervention from multiple health care providers, such as dietitians, psychologists and psychiatrists, as well as from organisations delivering social support and family therapy.<sup>76</sup> There is a need for more research into effective treatments for the specific nature of eating disorders and risk factors, and strategies for better targeting the needs of groups with a high risk of developing eating disorders, such as children, adolescents and young women.

5.67 Promoting heightened awareness of the medical management of eating disorders and treatment is also needed to assist health care workers to facilitate the diagnosis and referral of patients with eating disorders. However, this also relies upon an adequate level of specialised health care services for people with eating disorders in the community, including an increase in the number of dedicated eating disorder hospital beds for the management of acute stages of illness.

### *Anxiety*

5.68 Anxiety Disorders – or disorders of fear and stress show predominantly in the teenage years or earlier. It is estimated that 12.6 percent of the population suffers from an anxiety disorder,<sup>77</sup> yet it is very difficult to access help until the person is in such a poor state of mental health that they may be suicide.

5.69 A person with an anxiety disorder commented on the enormous difficulties in accessing help for this category of mental illness:

My search for help has been in four states of Australia, as well as living in London for three and a half years. It's only since arriving in Perth in 1985 I've finally managed to obtain proper help.<sup>78</sup>

5.70 A support group for people with anxiety recommended that a 'mood disorders clinic(s)' be established, offering services that address the specialised needs of people with anxiety disorders and depression:

... shorten treatment delays and reduce misunderstandings by practitioners, negative labelling and poor referral systems. This would offer an alternative service to acute psychiatric services and an opportunity for early

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75 Name withheld, *Submission 13*, p. 1.

76 Centre for Eating and Dieting Disorders, *Submission 307*, p. 10.

77 Anxiety and Depression Support Group – Albury-Wodonga, *Submission 151*, p. 10.

78 Name withheld, *Submission 499*, p. 4.

intervention. The service focus should also consider wellness with less emphasis on purely medical treatment.<sup>79</sup>

### *Obsessive-Compulsive Disorder (OCD)*

5.71 The diversity of mental illness and the suffering faced when the true nature of the illness is misdiagnosis, was recalled by a submitter living with OCD which produced obsessions with food and dieting:

At age 19 I was diagnosed by a local GP with anorexia and began treatment. A specialist physician confirmed the diagnosis and admitted me to hospital. Whilst in hospital a psychiatrist appeared once and prescribed pills. For the next 29 years I was misdiagnosed by nine psychiatrists who did no more than give me medication which often left me in a zombie state. In and out of various hospitals and not once given any program or recovery of indeed any hope of recovery, How could there be – none of them knew what was wrong with me.<sup>80</sup>

5.72 Submitters pointed out the inadequacy of the public mental health system in providing specialised care for people with a diversity of mental illnesses, such as OCD:

There is an attitudinal problem from the public mental health professionals. I was told, "**Beggars can't be Choosers**".<sup>81</sup>

It is essential that people with OCD and people with other anxiety disorders and depression are able to access psychological and medical treatments that are evidence-based and can be tailored to their particular symptoms and experienced.<sup>82</sup>

5.73 The Brisbane Obsessive Compulsive Disorder Support Group has called for vocational, rehabilitation and employment programmes targeting the specific needs of people with OCD, so as to 'keep (people with OCD) on track' and better support living in the community.<sup>83</sup>

### *Post-Traumatic Stress Disorder*

5.74 Post-traumatic stress disorder (PTSD) is a common disorder where a person has experienced abuse or trauma in their life. In evidence submitted to the inquiry, groups commonly reported to suffer from PTSD include women subjected to abuse throughout their lives,<sup>84</sup> and care leavers who endured childhoods of terrible abuse

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79 Anxiety & Depression Support Group – Albury Wodonga, *Submission 151, Attachment 1*, p. 7.

80 Name withheld, *Submission 162*, p. 4.

81 Name withheld, *Submission 196*, p. 1.

82 *Submission 162*, p. 5.

83 Brisbane Obsessive Compulsive Disorder Support Group, *Submission 197*, p. 2.

84 Women and Mental Health Inc, *Submission 310*, p. 3.

and neglect growing up in institutional care<sup>85</sup>. The committee also heard evidence of the high incidence of PTSD that occurs following the release from involuntary treatment for a mental illness of a different nature.

### ***Responding to the diversity of mental illness***

5.75 The committee thus heard about an enormous range of conditions, and about distinct needs for many of them: needs that are not adequately being met. Generalist and specialist health care providers must recognise and respond to the full range of mental illnesses, just as we do to the range of physical illnesses. The key to achieving this outcome is recognition of the diversity of health professionals in the management of mental illness, discussed in Chapter 6, acknowledging the broad-based biopsychosocial model of illness and diversity of treatment responses required.

### **Diversity of treatments**

#### ***A dominant medical model***

5.76 The section above focused attention on two aspects of the mental health framework that impact on the way in which certain illnesses are responded to in the current system: the priority given to low-prevalence disorders and the boundaries of the mental health framework, which precludes certain disorders. This section introduces a third feature, which limits the kinds of treatments available within the public health system, in turn limiting consumer access to different and, in some cases, more appropriate forms of treatment: the dominance of the medical model.

5.77 As the dominant paradigm governing the care and treatment of mental illness, the medical model emphasises pharmacological approaches that aim to cure mental disorders that find their genesis in bio-chemical disturbances. Less attention is given to the prevention of mental illness, to non-pharmacological treatments and to the psycho-social causes of mental health disorders:

[The medical model] stresses: individual rather than collective health; functional fitness rather than welfare; and cure rather than prevention. The central beliefs of this model saw physiological factors ('genes and germs') not psychosocial factors as the main causes of illness. It is a model, which, in policy terms, translates into a prime concern with the treatment and cure of individuals' ill health, especially in acute sector settings.<sup>86</sup>

5.78 The medical model underpins the division between high and low prevalence disorders and, to an extent, the stigma attached to certain disorders – for example, the idea that depression is 'all in the mind' or that borderline personality disorder reflects bad behaviour. The psychological and the behavioural fit less easily into a model that

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85 Broken Rites (Australia) Collective Inc, *Submission 340*, p. 5.

86 B. Hardy and R. Rhodes, 'Beliefs and Institutional Change: The UK National Health Service', in I. Holland and J. Fleming (eds.), *Government Reformed: Values and New Political Institutions*, 2003, Ashgate Publishing, England and USA, p. 71.

emphasises biological and specifically, bio-chemical disturbance. This is not to suggest that there is no bio-chemical basis to some forms of depression and other high-prevalence disorders, or that there are no psychological or behavioural dimensions to low-prevalence disorders. Rather, how certain disorders are culturally characterised and how they are attended to is, in part, influenced by the dominant paradigm of thought. Those disorders most responsive to medication are embraced by the model. Other disorders are, to varying degrees, marginalised.

5.79 While the National Mental Health Plan 2003-08 reports a shift in emphasis from a 'focus only on treatment to consideration of prevention, early intervention, rehabilitation and recovery'<sup>87</sup> and presents a vision of a 'holistic approach to improving mental health and well-being',<sup>88</sup> evidence suggests that in practice this vision is yet to be realised. The Office of the Public Advocate, Victoria, submitted that:

Proposed new directions in mental health policy reflect a departure from the dominant medical paradigm, within which mental health care has hitherto been situated, to a more individualistic and social model of mental health care. The Public Advocate observes that despite this clear direction of the previous two NMHPs, and the current NMHP 2003-2008, this policy is not reflected in the services provided. For example, people in non-acute phases of mental illness and people with high prevalence disorders continue to have difficulty accessing the public mental health system.<sup>89</sup>

5.80 This echoed a 2004 report jointly prepared by the Brain and Mind Research Institute and the Mental Health Council of Australia:

The Australian system is over-reliant on cost-inefficient specialist care systems and does not support its investment in effective medications with effective non-pharmacological treatments and recovery strategies.<sup>90</sup>

5.81 Insane australia summarised consumer needs for a more diverse set of treatments:

a very common call from consumers is for greater attention on and access to counselling services, psychotherapies, psychosocial services, peer support groups, nutritional and so called 'alternative' approaches such as natural therapies, yoga and meditation etc. Resources are unavailable to these much sought after services because the vast bulk of publicly funding

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87 Australian Health Ministers, National Mental Health Plan 2003-2008: 2003, p. 3.

88 Australian Health Ministers, National Mental Health Plan 2003-2008: 2003, p. 4.

89 Office of the Public Advocate, *Submission 172*, p. 7.

90 I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, December 2004, Brain & Mind Research Institute and Mental Health Council of Australia, p. 69.

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for mental health is consumed by services based on the medical model – hospital wards, subsidies for doctors fees and the drugs they prescribe etc.<sup>91</sup>

5.82 Several submitters noted the dominance of the medical model and raised concerns about its limitations. These limits include: an over-reliance on pharmacological treatments and correspondingly, limited investment in, or access to, non-pharmacological treatments; an inadequate mix of mental health professionals accessible to consumers; and limited support for research into alternative/complementary forms of treatment.

***A poor mix of pharmacological and non-pharmacological treatments***

5.83 The dominance of the medical model results in 'a poor mix of pharmacological vs non-pharmacological treatments',<sup>92</sup> with an over-reliance on pharmacological responses to mental health disorders. The Office of the Public Advocate, Victoria, drew attention to the dominance of drug treatments noting their 'concern about the pharmacological focus of the system and the lack of psychosocial interventions accessible to people in the public mental health system'.<sup>93</sup>

5.84 Dr Horton-Hausknecht outlined recent research, which argues that medical and biological models are too frequently applied to psychological disorders, in part influenced by the interests of powerful pharmaceutical companies:

Dr. John Read, Director of Clinical Psychology at the University of Auckland in NZ, co-authored a book titled “Models of Madness” (2004). This excellent book, which mostly focuses on schizophrenia but produces research and argument which apply to all areas of mental health, outlines the problems which occur when medical and biological psychiatry illness models are applied to psychological disorders. The book also focuses on the power of the pharmaceutical companies to manipulate research to promote the biological models of mental ill health and to promote their medications. He provides good evidence that the medical model of psychological disorders is not supported in research and argues for greater use of psychological therapies in the treatment of mental health problems.<sup>94</sup>

5.85 Dr Horton-Hausknecht argued that the situation needs to be redressed with non-drug therapies being used as the 'first line' of treatment – particularly for high

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91 insane australia, *Submission 2*, p.5.

92 I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, Brain & Mind Research Institute and Mental Health Council of Australia, December 2004, p. 69.

93 Victoria, Office of the Public Advocate, *Mental Health Services Community Visitors Annual Report 2003/04*, Office of the Public Advocate, October 2004, p. 3.

94 Dr Jillian Horton-Hausknecht, *Submission 337*, p. 16.

prevalence disorders such as depression and anxiety - and drug treatments being used as a 'last resort'.<sup>95</sup>

5.86 The Western Australia Section of the College of Clinical Psychologists – Australian Psychological Society pointed to research that argues that medications are over-prescribed by GPs for 'less-serious' mental illnesses, which adds to the costs of medical care. It was claimed that other forms of treatment could be as effective, or more effective.<sup>96</sup>

5.87 The Professional Psychotherapy Centre stated that:

A common consequence of the dominance of the medical approach to mental disorders is the encouragement of the sick role with its emphasis on medication as the treatment of choice.<sup>97</sup>

5.88 The Mental Health Foundation (ACT) highlighted the importance of using a range of treatments and services to enable consumers to manage their illnesses, arguing that a pharmacological response alone was not enough:

Consumers need access to interventions which are proven to be effective such as cognitive behavioural therapy not just crisis management.

It is widely acknowledged that it is not good enough, morally or ethically to solely prescribe medication and hand over a few jargon written pamphlets. People need to be educated, and guided to seek ways of managing their own mental health that works for them. We need to empower these individuals to take control over their own lives, and access a range of relevant services to heighten their quality of life.<sup>98</sup>

5.89 Controversy around the treatment of attention-deficit/hyperactivity disorder (ADHD) highlights some of the concerns regarding the balance of pharmacological and other treatments. The committee heard evidence on this in Western Australia, where prescription rates for ADHD medications are higher than in other parts of the country. The committee does not want to weigh into a clinical debate about the treatment of ADHD, and it also acknowledges the work of others in this area,

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95 Dr Jillian Horton-Hausknecht, *Submission 337*, p. 16.

96 Western Australia Section of the College of Clinical Psychologists – Australian Psychological Society, *Submission 101*, p. 3.

97 Professional Psychotherapy Centre, *Submission 30*, p. 2.

98 Mental Health Foundation (ACT) Inc, *Submission 112*, p. 4.



including the NHMRC,<sup>99</sup> the Western Australian Legislative Council<sup>100</sup> and the federal parliamentary Library.<sup>101</sup>

5.90 Concern centres on the dominant use of pharmaceutical treatments for a behavioural disorder, rather than 'simultaneous medication use, behaviour management, family counselling and support, educational management, and specific developmental issues.'<sup>102</sup>

5.91 Drug-Free Attention Deficit Support Inc (DFADS) argued...

Medicare payments are structured to encourage quick diagnosis and treatment after brief consultations. This pressure for quick diagnosis and treatment results in ADHD being diagnosed as a catchall condition with the underlying cause ignored...

Dexamphetamine is the only treatment option supported by the Commonwealth Government for ADHD. Dexamphetamine in low doses has an almost universal effect of temporarily sharpening focus and concentration.

The combined effect is that the pressure for quick diagnosis encourages the diagnosis of ADHD that is then treated with subsidised Dexamphetamine...<sup>103</sup>

5.92 The Learning & Attentional Disorders Society of WA (LADS) had a different view from DFADS, arguing that ADHD was if anything under-diagnosed and that medication was an important part of an effective treatment strategy. The two groups appeared to differ about the extent to which ADHD was a primary medical condition as well as the number of cases in which it should be thought to be a medical condition at all.

5.93 However, the committee notes that the most obvious point the groups had in common was a consensus around a lack of effective non-pharmacological treatment options. LADS supported a multi-faceted approach to treatment including medication as just one element. However, as they themselves pointed out, 'due to a lack of funding and resources, the multi-modal treatment stipulated in [WA Department of Health] policy is seldom accessible to families with AD/HD'.<sup>104</sup> These concerns,

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99 National Health and Medical Research Council, *Attention Deficit Hyperactivity Disorder*, NH&MRC, Canberra, 1997.

100 Western Australian Legislative Council, Education and Health Standing Committee, *Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder in Western Australia*, 2004.

101 L. Buckmaster, 'Medication for Attention Deficit/Hyperactivity Disorder (ADHD): an analysis by Federal Electorate', *Research Brief*, no. 2, 2004–05, Parliament House, Canberra.

102 National Health and Medical Research Council, *Attention Deficit Hyperactivity Disorder*, 1997, NH&MRC, Canberra.

103 DFADS, *Submission 334*, p. [2].

104 LADS, *Submission 202*, p. 3.

together with evidence of high and rising rates of prescription, strongly suggest that medication is becoming a dominant treatment option at the expense of other approaches.

***An inadequate mix of mental health professionals***

5.94 The dominance of the medical model manifests in the limited range of mental health professionals financially accessible to consumers. Unsurprisingly, with their ability to prescribe medications, GPs and psychiatrists are heavily represented in financially-accessible services. Psychologists, counsellors and psychotherapists play a distinctly secondary role. Submitters argued that a greater mix of health professionals and, correspondingly, a greater mix of treatments are required to adequately meet the needs of consumers. At the heart of these concerns is ongoing anxiety about the practice of psychiatry.

*The practice of psychiatry*

5.95 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) submitted that psychiatrists are trained to bring an integrated biopsychosocial approach to mental health problems, which includes treatment with medication (the biological component), psychological therapies, and social interventions:

Psychiatrists are medical practitioners with a recognised specialist qualification in psychiatry. By virtue of their specialist training they bring a comprehensive and integrated biopsychosocial and cultural approach to the diagnosis, assessment, treatment and prevention of psychiatric disorder and mental health problems. Psychiatrists are uniquely placed to integrate aspects of biological health and illness, psychological issues and the individual's social context.<sup>105</sup>

5.96 However, this holistic approach was not the prevailing experience of consumers or of other organisations. The practice of psychiatry came in for criticism during the course of the inquiry, primarily in relation to its reliance on a medical model of treatment of mental illness.<sup>106</sup> Some witnesses indicated that psychiatrists took an approach where they made an assessment of a patient, formed a diagnosis, and decided on a treatment. This process often happened too quickly, and the treatment determined was often medication and/or confinement. This approach was taken without treating the patient with respect and without taking into account the patient's perspective or broader needs.<sup>107</sup>

5.97 Mrs Pearl Bruhn, a submitter with personal experience of the mental health system, expressed frustration with the perfunctory treatment sometimes received:

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105 RANZCP, *Submission 323*, p. 2.

106 See for example, insane australia, *Submission 2* and attachments.

107 Dr Julie Johnstone, *Committee Hansard*, 5 August 2005, p. 18.

Psychiatrists, if you are lucky enough to see one, and not just a medical officer, spend only 15 minutes with each patient, with time only to discuss medication. There is no time to deal with the many other worries a patient is likely to have.<sup>108</sup>

5.98 Other personal experiences provided to the committee were similar:

...psychiatrists knew that mania was a possible side effect of many anti-depressant drugs but they weren't apparently on the alert for it, and they apparently did not know how to recognise it, or what questions to ask. Even after I crashed, they had no idea how to deal with the aftermath, or how to deal with the devastation caused except to write more prescriptions.<sup>109</sup>

5.99 Evidence of negative consumer experience echoed the findings of the Mental Health Council of Australia's *Not for Service* report:

In short, the available evidence suggests that persons with mental illness still struggle on a daily basis to access appropriate health care or be treated with respect or dignity when they do enter our health care systems.<sup>110</sup>

5.100 The Mental Health Foundation ACT was also critical, noting the propensity towards pharmacological solutions with little attention to the therapist-client interface:

Professionals, especially medical people, still hold power and authority in our society. Psychiatrists are mainly educated in the medical model of prescribing medication, but are not necessarily clued into the importance of the relationship between themselves and their client, although this is changing.<sup>111</sup>

5.101 Even some doctors found that aspects of the organisation of the health system could be contributing to these kinds of problems and argued that there was a focus on 'biological therapies'. The committee frequently heard how the pressure in public hospitals, and emergency departments in particular, contributed to what was seen as unsatisfactory psychiatric treatment:

Many trainees are now forced to work on crowded, busy acute adult inpatient units, where the disorders are generally restricted to three or four diagnoses. The patients are chronic and almost impossible to treat and the focus is mainly on the biological therapies.<sup>112</sup>

5.102 Obviously not all consumer experiences with psychiatric treatment are negative. The committee heard from a consumer advocate, Mr John Olsen, a person

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108 Ms Pearl Bruhn, *Submission 147*, p. 2.

109 Name withheld, *Submission 449*, p. 4.

110 Mental Health Council of Australia, *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia – Summary*, 2005, p. 13.

111 Mental Health Foundation ACT Inc., *Submission 112*, p. 4.

112 Health Services Union, *Submission 223*, p. 36

with schizophrenia, who described himself as 'one of the lucky ones' for whom medication worked. He told the committee of his gratitude to a psychiatrist (in a prison setting) who coerced him into taking medication, and established him on the road to a stable life.<sup>113</sup> Others referred to the positive experience of finding a 'wonderful psychiatrist' whose care greatly assisted them or family for whom they cared.<sup>114</sup> Nevertheless, rapidly rising levels of pharmaceutical prescriptions and persistent, widespread complaints about a lack of other therapy options suggest that such positive experiences are not as common as they should be.

5.103 The RANZCP responded to criticisms of psychiatry by saying that they were supportive of consumer and carer involvement when planning treatment. Dr Freidin of the RANZCP stated that:

In the clinical setting, the more information you can get about someone's social circumstances and social network and the involvement of their carers and their families and their own views, quite simply the better able you are to plan with them what needs to be done and then to implement a plan that will be successful and acceptable to them.<sup>115</sup>

5.104 Dr Freidin went on to say that in some stressful circumstances, involvement of the consumer was difficult:

We are also aware, though, that practically, in stressed, under-resourced services, when people do start having to act fast to make decisions more quickly than ideally they should—for a host of reasons—one of the things that slips by the wayside is the time that should be taken to consult in detail with family and with the patient before deciding on an ongoing management plan. It is a little easier in private practice because one is a bit more able to control the pace of things.<sup>116</sup>

5.105 The committee recognises that the stresses under which psychiatrists are working, particularly in settings such as public hospital emergency departments, can contribute to poor care outcomes, such as the use of medication ahead of other therapeutic options. These stresses have been outlined in Chapter 4, and are discussed further in Chapter 8. However, these stresses do not account for the under-use of psychologists in the health care system (particularly public health care) compared to psychiatrists.

#### *A greater role for psychologists*

5.106 As discussed in Chapter 6, psychologists are under-employed in both the public and private sectors of the mental health system. The Australian Psychological Society submitted:

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113 Mr John Olsen, *Committee Hansard*, 27 July 2005, pp. 59–60.

114 Name withheld, *Submission 131*, p.2.

115 Dr Julian Freidin, President, RANZCP, *Committee Hansard*, 6 July 2005, p. 90.

116 Dr Julian Freidin, *Committee Hansard*, 6 July 2005, p. 90.

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Psychologists are significantly under-utilised in the provision of mental health services due to limited federal/state funding for allied health in the public sector, and by affordable, government-supported access in the private sector.<sup>117</sup>

5.107 At the same time, evidence to this inquiry also suggests there is an unmet need for the kinds of treatments that psychologists can offer. The Australian Psychological Society argued that there is currently only limited use of evidence-based<sup>118</sup> psychological interventions despite their effectiveness in treating a range of mental health disorders. Cognitive behavioural therapy (CBT) was highlighted as a 'best practice' treatment for depression, anxiety, panic disorder and alcohol/drug use, and as a contributing therapy for schizophrenia:

CBT is a more effective (and cost-efficient) treatment for Major Depressive Disorder than anti-depressant medication (Selective Serotonin Reuptake Inhibitors [SSRIs]) in most cases, especially for youth. In anxiety, CBT is the most cost-effective treatment available for panic disorder and generalised anxiety disorder when compared with pharmacological interventions. Significant developments have occurred in the use of cognitive behavioural strategies for patients with schizophrenia. These interventions have been shown to have a significant impact on symptoms, behavioural responses and relapse incidence.<sup>119</sup>

5.108 An increased role for psychologists could achieve a greater balance between pharmacological and non-pharmacological therapies. For example, *beyondblue* argued that treatments such as cognitive behaviour therapy should be more accessible to consumers.<sup>120</sup> The failure of the health care system to respond to such evidence or to facilitate a diversity of treatment options reflects a narrow medical model which marginalises psychologists and the therapies they offer.

### *Psychotherapists and Counsellors*

5.109 A number of submissions expressed support for greater consumer access to counselling and psychotherapy services and highlighted the benefits of talking therapies.

5.110 The Psychotherapy and Counselling Federation of Australia (PACFA) outlined the form of treatment offered by psychotherapists and counsellors explaining that:

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117 The Australian Psychological Society, *Submission 50A*, p. 6.

118 'Evidence-based' practice refers to psychological interventions that have been identified through research evidence as the most effective for different conditions across a range of patient groups. Australian Psychological Society, *Submission 50A*, p. 15.

119 The Australian Psychological Society, *Submission 50A*, p. 15.

120 *beyondblue*, *Submission 363*, p. 2.

Counsellors and psychotherapists work within a clearly contracted, principled and collaborative relationship to enable their clients to explore and resolve a wide range of personal and relational issues.<sup>121</sup>

5.111 In distinction to psychiatrists and psychologists, the training of psychotherapists and counsellors places a far greater emphasis on interpersonal communication, clinical skills and experiential learning, with the therapeutic relationship forming the core of the clinical encounter. In turn, distinctions can be drawn between counselling, which tends to focus on 'specific problems' or 'changes in life adjustment', and psychotherapy, which generally involves intensive, long-term work on 'deeper issues' and/or with more 'deeply disturbed clients'. Both psychotherapists and counsellors receive clinical supervision, which supports the health professional and provides a quality assurance mechanism for consumers by ensuring 'competent and ethical practice'.<sup>122</sup>

5.112 PACFA submitted that counsellors and psychotherapists are under-utilised in current models of care. They argued that government resources need to be allocated across a broad range of services and a wider mix of health professionals.<sup>123</sup>

5.113 PACFA explained that the existing policy framework also limits the role of counsellors and psychotherapists in the non-government sector and consumer access to private services:

Current government policy provides barriers to employment of well trained counsellors and psychotherapists within the non-government sector and access of clients to private providers. The most important barrier is that the current GST legislation does not recognise counsellors and psychotherapists as approved providers of counselling services. The GST legislation provides for GST-exemption on counselling services provided by several other health professions such as psychiatry, psychology and social work, many of whom would not meet the minimum requirements for specialist training in counselling or psychotherapy, as defined by PACFA. This situation is inequitable. Government policy should provide the same funding to the various health professional groups who can provide counselling services.<sup>124</sup>

5.114 PACFA made a specific recommendation:

We recommend that Psychotherapists and Counsellors who are eligible for registration on the PACFA national Register for Psychotherapists and Counsellors be recognised in the GST legislation as a recognised provider of counselling services.<sup>125</sup>

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121 The Psychotherapy and Counselling Federation of Australia, *Submission 383*, p. 5.

122 *Submission 383*, p. 5.

123 *Submission 383*, p. 2.

124 *Submission 383*, pp 2-3.

125 *Submission 383*, p. 3.

5.115 The Australian Mental Health Consumer Network (AMHCN) argued in favour of bolstering resources for therapeutic 'talking therapies'. In particular, the AMHCN expressed concern that mental health problems arising from childhood abuse and neglect required early intervention, but that resources in the public health system for providing psychotherapeutic treatment were inadequate:

AMHCN hears frequently from members with histories of child abuse and neglect. Many consumers come from childhood backgrounds that were psychologically dangerous and damaging. This calls not only on interventions to protect children but also on supporting psychotherapeutic interventions early – before harmful adult mental health patterns are fully established. At the present time there is almost no psychotherapy available in public mental health systems in this country. Since the First National Mental Health Plan 1993-1998 pushed priorities away from 'talking therapies' there has been no investment in developing the capacity of mental health services to respond to people with abuse and neglect histories.<sup>126</sup>

### *Other forms of care and treatment*

5.116 While more and more resources are poured into pharmacological treatments and pharmaceutical research, talk therapies remain relatively hard to access, while other possible approaches to care are largely neglected.

#### *Support groups and consumer-driven recovery approaches*

5.117 Several submitters highlighted the importance of support groups in the management of mental illness. The evidence presented by the community-based organisation, GROW, exemplified these views.

5.118 GROW is a voluntary, non-government mental health organisation that operates 'mutual support groups' and provides training and social activities. GROW explained that at the support groups:

individuals who are experiencing the trauma of mental illness or seek to prevent mental illness, come together to support each other with the aid of GROW's 12 step Program (referred to by some Psychologists as "lay person's cognitive behavioural therapy"). Here members are able to share their difficulties, find commonality and learn to recover from their illnesses with the sustained assistance of a caring and sharing community environment.<sup>127</sup>

5.119 GROW argued that mutual support groups provide a valuable, complementary role in the prevention and recovery stages of mental illness. Based on self-conducted and independent research, GROW submitted that the support groups:

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126 AMHCN, *Submission 322*, p. 12.

127 GROW, *Submission 224*, p. 2.

- Significantly reduce the need for hospitalisation
- Decreased the incidence of suicidal thoughts
- Improve quality of life for consumers
- Facilitate development of life management and social skills<sup>128</sup>

5.120 A recent study on GROW support groups undertaken by Lizzie Finn and Dr Brian Bishop, School of Psychology, Curtin University, Western Australia, confirmed GROW's claims. The researchers argued for the recognition of the value of mutual help groups:

It is important for health professionals to realise the very real benefits which mutual help groups can offer, and to see them as being complementary to mainstream mental health services. Mutual help groups can be integrated with therapy where relevant. For some people, particularly those with the more severe diagnoses, mutual help can be a vital ingredient for maintenance within community and reduction of the risk of relapse.<sup>129</sup>

5.121 In a study undertaken by the Albury-Wodonga Anxiety and Depression Support Group, La Trobe University and the Anxiety Recovery Centre, Victoria, the need for 'more support to support groups' was identified. This included increased funding and improved referral sources – for example, through educating GPs about referral to the support group.<sup>130</sup>

5.122 The need for more support of support groups was reiterated by Patricia Minnar, Coordinator of the Brisbane Obsessive Compulsive Disorder Support Group (BOCDSG). She argued that the lack of substantial recurrent funding was inhibiting the capacity of this state-wide support group.<sup>131</sup>

5.123 The Centre for Psychiatric Nursing Research and Practice (CPNRP) highlighted the importance of recovery centres outside of acute hospital care settings, and consumer driven recovery approaches:

The Soteria houses set up by Dr Loren Mosher are an example of a recovery centre without forced treatments. There are other recovery centres in Europe and The US, where outcomes are at the least comparable, usually better, than for standard acute hospital care. As the current rhetoric moves toward the language of recovery, it is critical that it is consumers who define this most individual and personal journey. We need the resources to develop and articulate our own deepening and sophisticated thinking about

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128 GROW, *Submission 224*, pp. 13–14.

129 L. Finn and B. Bishop, *Mutual help: An important gateway to wellbeing and mental health*, [http://www.vicserv.org.au/publications/new\\_para/pdf/mhelp.htm](http://www.vicserv.org.au/publications/new_para/pdf/mhelp.htm) (accessed 23 March 2006).

130 Albury-Wodonga Anxiety and Depression Support Group, *Submission 151*, Attachment A, p. 13.

131 B OCD, *Submission 197*, p. 2.



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what works best for us, in terms of service provision, and in terms of our own well being and self care. Nobody else can do that for us, and no service or government can be confident of success without that knowledge, and without then directing resources to it.<sup>132</sup>

5.124 The CPNRP noted that consumer support services in Australia are significantly under-resourced and therefore under-developed in contrast to services in New Zealand, the United Kingdom, Europe and the United States:

We know that peer support and peer operated services work. ... Australia lags far behind New Zealand, the United Kingdom, Europe and the United States when it comes to resourcing consumer operated peer support and recovery services, so that it is not surprising to find there are almost **no such services** in the whole of the country, and therefore almost no current evaluative data. In fact, the money spent on consumer initiated projects and services is negligible. This is a serious gap, when we already know that these types of services work. If our National mental health plans are to be more than mere rhetoric, proper resources must be devoted to consumer initiated projects and services.<sup>133</sup>

5.125 The Centre recommended:

That funding be allocated to develop peer support programs, and consumer operated services in each state and territory, and that consumers define recovery and what approaches/resources should be used to facilitate recovery.<sup>134</sup>

5.126 Noting that support groups should be encouraged, Professor Gavin Andrews argued that these services should complement rather than stand in for professional treatment. In particular, he emphasised that consumer groups should not be expected to fill the current service-gap. Rather, this should be met by evidence-based therapies.<sup>135</sup> He explained:

During the sixties we had consumer groups taking responsibility for the treatment of people with early psychosis. This experiment failed – people with psychosis did need medication. There is professional knowledge, and for all disorders evidenced-based care is better than compassionate care. The age of moral treatment of the insane as the only therapy is past. Treatment should be expert and moral.<sup>136</sup>

5.127 It was clear from evidence received that support groups play a vital role in the management and recovery of mental illness. If adequately resourced and managed, support groups can contribute significantly to improving the quality of life of

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132 Centre for Psychiatric Nursing Research and Practice, *Submission 217*, p. 16.

133 *Submission 217*, p. 16.

134 *Submission 217*, p. 6.

135 Professor Gavin Andrews, *Submission 176*, p. 11.

136 *Submission 176*, p. 11.

consumers. In this way, they play an important, complementary role to professional therapies. Further, support groups can also ease the pressure on the broader public health system by reducing consumer need for hospitalisation. The committee encourages increased Government investment in support groups. At the same time, the committee believes that improved consumer access to appropriate forms of professional treatment is also vital. Support groups should operate as a complementary and not replacement form of care.

### *Nutrition-based approaches*

5.128 The committee received evidence on other, dietary-based approaches to the treatment of mental illnesses.

5.129 Bio-Balance Health Association argued that 'the focus on biological causes and pharmaceutical solutions' has inhibited the development of 'more refined approaches' that draw on recent scientific advances in the understanding of the biochemistry of brain functioning.<sup>137</sup>

5.130 Bio-Balance was set up in 1998 to:

promote, support and assist recovery from mental, behavioural and learning disorders through the identification of biochemical imbalances and treatment of such imbalances by complementary nutritional techniques.<sup>138</sup>

5.131 Bio-Balance submitted that there are limits to medication therapy, which they described as a 'blunt instrument':

The powerful antipsychotic, antidepressant and other psychoactive pharmaceutical medications currently used to treat mental illnesses produce some beneficial effects in most cases, but these benefits are usually partial in nature and the medications can often result in unwanted changes in behaviour and various other 'side-effects' which can be so intolerable as to undermine patient compliance with the prescribed medication.<sup>139</sup>

5.132 Bio-Balance put forward a complementary form of treatment: biochemical treatment. They explained that:

It is now clearly understood that schizophrenia, bipolar disorder, depression and other mental disorders are primarily caused by imbalances in brain neurotransmitters, the raw materials of which are amino acids, vitamins, minerals and other nutrients. The step-by-step processes by which these neurotransmitters are produced in the brain and how neurotransmitters function are also well understood.

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137 Bio-Balance Health Association, *Submission 378*, p. 1.

138 *Submission 378*, p. 3.

139 *Submission 378*, p. 2.

5.133 In order to remedy these biochemical imbalances Bio-Balance explained that the prescription of 'appropriate nutrients in appropriate dosages' can complement, and in some cases reduce the need for, psychiatric medication therapy.<sup>140</sup>

5.134 Bio-Balance concluded:

Given the limited effectiveness of present 'mainstream' psychiatric medications and the serious and widespread implications of these limitations for patient, family and community outlined above, any treatment which offers the potential for improvement towards recovery for a significant proportion of people with mental illness warrants serious consideration.<sup>141</sup>

5.135 Mr Douglas McIver, a consumer, submitted a personal account of his success with an alternative treatment – orthomolecular medicine - which enabled him to manage schizophrenia without the use of medication:

I was diagnosed with schizophrenia in early 1973 and prescribed psychiatric medication for 10 and half years. I had various side effects from my medication. Following research by my wife, Jan, I decided to use an intervention strategy which was a biochemical model endeavouring to reduce the symptoms of mental illness. It involved the effects of foods and chemicals on my health, and required fasting, single food challenges, allergy and sensitivity testing, dietary control, the use of micronutrients, and minimising exposure to toxic chemicals. And, certainly, exercise! The intervention was more than, but included, 'megavitamin therapy'.<sup>142</sup>

5.136 Mr McIver argued that the current paradigm, with its focus on pharmacological treatments, inhibits a full examination of other measures:

Medical research is stuck in the biochemical approach of the drug treatment paradigm. While this continues, safe and effective treatment regimes using nutrient and food and chemical avoidance regimes are not being fully investigated. The present system seems more interested in proving such treatments do not work than finding out how they do work when they work.<sup>143</sup>

5.137 He envisaged a much greater role for medical accrediting bodies and government in seriously investigating orthomolecular medicine and other alternative/complementary treatments:

I believe that medical accrediting bodies have a responsibility to give more priority to examining the positive claims that are made about the nutritional and environmental medicine issues in conjunction with advocates. And I feel that Governments can assist the process in various ways and that it is

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140 Bio-Balance Health Association, *Submission 378*, p. 3.

141 *Submission 378*, p. 4.

142 Mr Douglas McIver, *Submission 317*, p. 1.

143 *Submission 317*, p. 4.

their interests to do so. ... All that can be done should be done to encourage the medical accrediting bodies, medical researchers and Governments to more proactively assess its inclusion within the Medicare protocols and the NMHS.<sup>144</sup>

5.138 The committee is not advocating any particular approach to treatment of mental illness. It is aware that different treatments have their advocates and their detractors. Some treatments may only work for some people. Some complementary treatments may be effective on their own, while others may assist when used in conjunction with conventional therapies.<sup>145</sup> Some may not be effective at all.

5.139 The committee agrees with the general sentiment expressed by Mr McIver that more attention may need to be paid to researching and disseminating a broad range of therapeutic approaches to different mental illnesses. The committee shares the opinion of the Senate Standing Committee on Community Affairs, in its inquiry into services and treatment options for persons with cancer, that this may involve some broadening of research in the field of medicine. That committee recommended:

the National Health and Medical Research Council provide a dedicated funding stream for research into complementary therapies and medicines, to be allocated on a competitive basis.<sup>146</sup>

5.140 The Mental Health Committee notes that the NHMRC essentially rejected this recommendation, arguing that

funding of research into complementary therapies and medicines, like the funding of other health and medical research, must be on the basis of excellence as assessed by peer review. Any funding for research outside of existing schemes, such as Project Grants, would need to be based on identified need and met from external sources.<sup>147</sup>

5.141 While there can be debate about what mechanisms are best to fund a broader research base, the underlying concern remains that research is currently not as broad as it could be, and this appears to marginalised those therapies that do not fit easily with the dominant medical model. The committee hopes that the current dominance of both pharmacological treatment and pharmacological research will be corrected through a range of measures, including some recommended in other chapters of this report. It can also see a case for a broad-based review of the current state of research

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144 Mr Douglas McIver, *Submission 317*, pp 7-8.

145 V. Kotsirilos, 'Psychotic illness: Does complementary medicine have a role in management?', *Australian Family Physician*, vol. 35, no. 3, pp. 115–116, 2006.

146 Senate Standing Committee on Community Affairs, *Inquiry into services and treatment options for persons with cancer*, June 2005, Recommendation 22.

147 Senate Standing Committee on Community Affairs, Response to the recommendations directed to the National Health and Medical Research Council (NHMRC), [http://www.aph.gov.au/Senate/committee/clac\\_ctte/cancer/response.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/cancer/response.htm), (accessed March 2006).

in the area of mental health. This will help a transition toward a more balanced approach to care.

### *A balanced approach to care*

5.142 Dr Di Nicolantonio argued that the medical model was fundamentally flawed and suggested a 'new paradigm' of care:

Set up a completely new paradigm for the treatment of so called mental illness. There are just too many competing ideologies at the moment. This is understandable given that mental illness and its treatment is a relatively new academic construct. Organic brain diseases such as dementia, mental retardation and schizophrenia will probably always remain within the province of the medical profession. Psychosis is in a bit of grey area. However, for states such as depression, anxiety, eating disorders, borderline personality disorders and addictions, the “patient” should be placed in the primary care of a psychologist or (better still) a psychoanalyst. A consultant psychiatrist would also be assigned to act in a liaison capacity only.<sup>148</sup>

5.143 Similarly the Australian Mental Health Consumer Network (AMHCN) submitted that the range of services available to consumers can no longer afford to be constrained by the medical model:

[T]he variety and scope of available services [should] no longer be limited by institutional traditions or medical model understandings of what constitutes a health intervention.<sup>149</sup>

5.144 These views were reaffirmed by GROW:

The belief that assumes the majority of problems experienced by mental health consumers are solved solely via medication and/or hospitalization needs to be challenged. In nearly all forms of mental illness medication/hospitalisation is not sufficient for recovery.<sup>150</sup>

5.145 Dr Horton-Hausknecht recommended that:

Non-drug therapies should be supported and promoted as the first line of therapy for mental health problems such as depression and anxiety, with medications used as a last resort – not the other way around.<sup>151</sup>

5.146 Research shows that non-pharmacological interventions can be effective across a range of illnesses. While it is clear that a pharmacological approach is appropriate and, indeed, imperative for certain illnesses under certain conditions, the dominance of pharmacological intervention does not appear to be justified. In

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148 Dr Robert Di Nicolantonio, *Submission 526a*, p. 7.

149 AMHCN, *Submission 322*, p. 5.

150 GROW, *Submission 224*, p. 13.

151 Dr Jillian Horton-Hausknecht, *Submission 337*, p. 2.

economic terms, it has been argued that the efficiency of the system could be greatly enhanced through a mix of therapies and models of care:

[I]t has been estimated that the efficiency of the system (specifically when dealing with persons with common disorders such as depression or anxiety) could be doubled by improving the balance between primary and specialist care providers and the use of medications or psychological therapies.<sup>152</sup>

5.147 The research highlights an over-reliance on medications for immediate and long-term care and inadequate attention to early intervention, the use of non-pharmacological treatments and specialised recovery programs. The flow-on effects are great. For example, the research states that the numbers of people with enduring mental illness able to return to work or other forms of social participation in Australia is half that of people in other OECD countries.<sup>153</sup> As a result, it is argued that increased expenditure should be directed towards remedying this situation.<sup>154</sup>

5.148 The committee is concerned that the dominance of the medical model may colour assessments of alternative/complementary forms of treatment and inhibit research into these areas. As discussed in Chapter 8, it is clear that the system still emphasises cure and crisis management and not prevention and early intervention, with care concentrated in the hospital system.

5.149 Evidence to the inquiry suggests there would be both economic and therapeutic benefits to diversifying treatments. The form this would take is two-fold:

- supporting consumer access to psychologists and other non-medical practitioners through the public health system, and Medicare access to private sector health professionals
- investment in research on other treatments

## Conclusion

5.150 The committee was disappointed to hear that there is a considerable disjunction between the aspirations of the National Mental Health Plan to provide a 'holistic approach' to mental health care in Australia and the actual range of treatments available to consumers. The committee recognises the necessity of pharmacological interventions and supports ongoing research to improve and refine pharmacological

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152 I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, December 2004, Brain & Mind Research Institute and Mental Health Council of Australia, p. 69.

153 I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, December 2004, Brain & Mind Research Institute and Mental Health Council of Australia, p. 69.

154 I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, December 2004, Brain & Mind Research Institute and Mental Health Council of Australia, p. 73.

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options available to consumers. However, it is clear that a better balance between pharmacological and non-pharmacological treatments is urgently required.

5.151 Within the current paradigm consumers have limited choice in the kinds of treatments available to them – unless they can afford the luxury of choice. The form of treatment offered is determined by the prevailing approach rather than the treatment being tailored to meet the specific needs of the consumer. This problem is exacerbated by the tendency to view mental illnesses as a homogeneous group.

5.152 In some cases, access to treatment is extremely restricted. The current (inadequately resourced) system concentrates on low-prevalence disorders and acute and crisis cases. At the same time, the system and many health professionals appear to be ill-equipped to manage certain illnesses such as obsessive-compulsive disorder and some of the personality disorders.

5.153 The dominance of the medical model and the consequent dominance of psychiatric treatment have resulted in these limits. While the committee recognises that consumer experience of psychiatric treatment has in many cases been positive, evidence to this inquiry suggests an unacceptable level of dissatisfaction with the current paradigm of care. Further, positive experiences conveyed to the committee highlight the expertise, compassion and receptiveness of *individual* psychiatrists rather reflecting a systemic attitude or approach to psychiatric treatment.

5.154 The committee believes that all consumers should receive appropriate forms of support in a timely manner. To this end, the committee supports the diversifications of treatments available in the mental health system. This will require:

- An increased role for psychologists, psychotherapists and counsellors in the mental health system
- Improved access of consumers to these health professionals through a) more positions for these health professionals in the public sector and b) Medicare funded access to these health professionals
- Investment in research of alternative treatments

5.155 Whilst the committee appreciates that public resources are invariably limited and must be targeted accordingly, the under-resourcing of mental health in Australia and the resulting focus on low-prevalence disorders and crisis intervention produces false economies. This is compounded by the dominance of the medical model and an over-reliance on pharmacological approaches. Evidence suggests that the diversification and appropriate targeting of treatments could, in fact, produce savings as well as enhancing the mental health and well-being of consumers.

