SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

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I have had the opportunity to read the wide-ranging submission of the Australian Medical Association (AMA) to this Senate Select Committee.

I largely endorse that comprehensive document, which addresses large scale demographic and psycho-socio-cultural issues.

What such a document must lack, however, is the perspective of the individual clinician who attempts to deal in depth with the severe problems of any given individual patient.

I would hope that this submission can be accepted form the viewpoint of an experienced clinician.

I became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1972 and worked in the public sector – both in-patient and community services – until undertaking further training as a psychoanalyst and entering private practice in 1979. My major public sector experience was in the diagnosis and management of severe personality disorder and alcohol and other drug abuse.

Consequent upon a further 25 years of clinical experience and further training and clinical experience as a Psychoanalyst, I wish to have the opportunity to input three relatively simple points of view:

(i) about the **regrettable decline in Mental Health Services** over these past two to three decades.

(ii) about the importance of psychodynamically-informed input into thinking about **complex case management** in a wide variety of disorders in mental health

(iii) about relatively **new early intervention possibilities** in mental health

1. THE LOSS OF SENIOR EXPERIENCED CLINICIANS FROM THE PUBLIC SECTOR

The progressive loss of relatively senior psychiatrist clinicians from the public health services has resulted in a decline of teaching and supervising for all staff disciplines in the public sector.

Senior, experienced clinicians play an essential role in teaching younger colleagues to adequately and competently assess all manner of disturbed behaviours, be they due to psychosis or severe personality disorder. The ability to calmly assess and think about complex clinical situations is a hard won skill and requires long experience and appropriate support from senior colleagues. (Newly qualified psychiatrists do not have the accumulated experience to offer this kind of leadership, and cannot "instantly" expect respect from public sector staff without it.)

The progressive loss of morale in the public sector is in great part due to the loss of supervision and teaching support for young staff faced with highly stressful clinical situations to manage.

I sincerely consider that the situation outlined above impinges directly upon nearly all the Terms of Reference of the Senate Inquiry:
(a) (b) (c) (d) (f) (g) (h) (i) (j) (k) (l) and even (p).
[i.e. ALL bar (e) (l) (m) (n) and (o)!!]

As a now senior psychiatrist myself, and having undertaken special training in psychoanalytic psychiatric treatment, I have had the opportunity - and privilege - to offer supervision and teaching to a variety of junior staff in many disciplines in the Drug and Alcohol Services of the Northern Metropolitan Region in Sydney over 25 years, which I believe was valued by the members of the groups which I supervised and taught.

In the latter years, I heard repeatedly about the stresses suffered - mainly by young Psychiatry Registrars - in having to cope with stressful clinical situations with inadequate supervision and teaching, together with progressively dwindling beds availability for admission of difficult cases.

Three years ago, my appointment was summarily terminated - due to cost considerations.

It was evident that the rate of "turnover" within the teams who had had such supervision and teaching was notably low and "burnout" and stress leave were not apparent. Since my being obliged to leave my VMO appointment, the clinical teams have largely fallen apart and relatively experienced staff have left due to lack of the support required in such high stress clinical areas.

Much lip-service is paid to the role of the Psychiatrist in having the broad "bio-psycho-social" training required to think about complex clinical cases. The reality is that as Psychiatrists we DO encompass these disciplines and are the professionals to whom - ultimately – "the buck passes".

I would summarise my first point as follows:

The vast majority of the TERMS OF REFERENCE would be benefited by the re-introduction (and valuing) of senior psychiatrist clinicians into the public sector to promote supervision and teaching of all the varied disciplines in the mental health field and consequently to raise both the competence and the morale of those working in highly stressful clinical situations.

A practice of discussing complex cases with senior consultants is an invaluable means of avoiding serious clinical error.

Also, high rates of "burn-out" and staff turnover can be avoided.

2. THE IMPORTANCE OF PSYCHO-DYNAMICALLY INFORMED THINKING IN COMPLEX CASE MANAGEMENT

As an extension of the general argument offered above, the specific relevance of psycho-dynamically informed thinking in a very wide variety of clinical disorders can be argued.

In depth understanding of the internal world and family dynamics of patients presenting with:

Borderline Personality Disorder (and other severe personality disorders)
Eating disorders
Alcohol and other drug presentations
Depressive disorders
Suicidal states
Severe anxiety states
Behaviour disorder in children (e.g. attention disorder and autistic states)

Together, these disorders are estimated to affect upwards of 10% of the population!

[see table 2, p.10 Australian Medical Association submission to this enquiry]

If these common disorders are adequately assessed at the earlier instances of presentation to health services, then appropriate management can avert subsequent costly – and often tragic – courses of illness presentation over following years.

Often competent assessment of families of such patients can benefit all concerned.

3. THE NEW POSSIBILITIES OF DELIVERING APPROPRIATE EARLY INTERVENTION PROGRAMS IN THE FIELD OF MENTAL HEALTH

Research deriving from the field of Attachment Theory shows that early intervention programs can be designed and delivered in a variety of early infant settings (Obstetric Clinics, Day Care Centers, Kindergartens, etc.) where early evidence of disordered attachment between mother and infant can be detected by reliable methods.

One of the major clinical advances in this field is the establishment of a link between a certain category of "insecure, disordered attachment" in infants [the so-called D-category] with later development of borderline-type personality disorders.

The possibility now exists of detecting vulnerability to development of these – and other – costly personality disorders earlier in life than before. Also, vulnerability to development of future depressive illnesses can be discerned by this new methodology.

RECOMMENDATIONS

1. Serious attention be given to means of attracting and adequately funding the return of senior psychiatrist clinicians into the public sector services in order to improve morale and raise standards of training in all associated mental health disciplines.
2. Recruit clinicians with specific expertise in psycho-dynamically informed and family-dynamic skills as consultants to those dealing with complex, co-morbid cases, to enhance standards of assessment and management by modeling competence in addressing complex disorders.
3. Specifically support a range of early intervention programs which have been developed via advances in research in attachment theory.

[References:

Due to the regrettable lateness of this submission, I can only offer to provide relevant references if requested.]