National Association of Practising Psychiatrists

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

A submission prepared for the
Medicare Benefits Consultative Committee
by the National Association of Practising Psychiatrists

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

Contents

Executive Summary

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

- The document outlines the need for long term, intensive psychiatric treatment, which is seen as a necessary **treatment** for a wide group of patients which span the *whole spectrum* of psychiatric morbidity. The skills involved offer economic synergies with other treatments and should not be constrained by Item 319 criteria as it reduces the capacity of psychiatrists to offer efficiencies within "best practice".

- Patient characteristics (for those accessing this mode of treatment) are outlined, demonstrating their high level of previous trauma (sexual/physical abuse or bereavement), and the frequency of this group having failed prior attempts at briefer treatments – *but failing the GAF criteria highlights that these same patients often fall well outside the current Item 319 criteria for eligibility.*

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

- Actual details of patients who are *clinically disadvantaged* by Item 319 regulations are outlined case by case - these are subdivided into (a) patients who are ineligible to access treatment under Item 319, and (b) patients who are adversely affected *despite* having access to treatment under Item 319 regulations.

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

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

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

- Remedial **policy options** are outlined.

Introduction

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

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

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

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

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

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

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

- It is demonstrably true that it has *disadvantaged* many patients
- It has clearly *not* led to increased access to psychiatric services
- It has *not* influenced maldistribution issues
- It is *unclear* that any monies saved were derived from this measure

- Section A.15.3 of the Medicare Benefits Schedule (MBS) discriminates against the use of proper treatment *first and so adds to costs* as money has to be spent on other treatments which have to fail before the patient is eligible for Item 319.
- There is a clear *economic case* to support increased access to intensive treatment.
- That Item 319 was initially based on a perceived need to save money ignores the issue of *duty of care* towards patients – which in turn has legal implications
- Long term intensive treatment is widely considered to be "*clinically relevant*" (as defined in the MBS) and therefore its effectiveness should not be impaired
- In the face of mounting concerns at the explosion of *costs* accruing from the Pharmaceutical Benefits Scheme (PBS), it arguably makes no sense to restrict treatments based on consultations that produce, in many cases, equivalent or better outcomes.

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

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

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

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

Item 319 revisited

What is Item 319?

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

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

The fee indicated for this Item is $138.45.

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

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

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

> *A.15.5 When a patient who meets the criteria defined in Item 319 attends a psychiatrist on more than 160 occasions in 12 months such attendances would be covered by Items 310 to 318."*[2]

When did Item 319 and associated Items commence?

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

Why were Item 319 and its associated Items introduced?

Fiscal reasoning

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

The following brief summary places these intended reforms in context:

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

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

Reduction in Medicare Rebates for psychiatric consultations

The reduction in Medicare rebates for patients requiring over 50 consultations in any 12 month period was to contribute $14 million to the total proposed 'claw back' of some $1.7 billion over the quadrennium.[3]

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

It was asserted that patients having more than 50 out of hospital psychiatric consultations in a year represented some 1% of patients but accounted for 16% of Medicare benefits paid for such consultations.[4]

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

In the words of one psychiatrist *"to prevent 1% of psychiatric patients being seen more than once weekly, this policy (Item 319) has endangered the clinical care of the*

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

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

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

rest of the suicidal psychiatric patients we treat, quite apart from the extra suffering imposed upon those who do not meet the criteria to be seen more than once a week".

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

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

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

Ministerial justification for Item 319 and associated restrictions

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

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

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

> *"By way of background, the Governments proposals have been based on the need for more equitable distribution of available resources. We are very concerned about the number of people, particularly those in rural areas, who presently have no access to psychiatric care.*
>
> *As a means of comparison, the funds the Government has been spending each year to allow 2,500 people to see a psychiatrist more than once a week would allow 50,000 people to each see a psychiatrist five times a year.*
>
> *At the individual level, by the time patients have had 50 psychiatric visits, they will have received over $6,000 in Medicare benefits, before benefits are reduced. This compares to Medicare benefits of about $2,000 for heart surgery and $3,000 to remove a brain tumour, highlighting one of the problems the government has in balancing how resources are used in different medical conditions."* [5]

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

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

Dr 747

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

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

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

Evidence vacuum

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

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

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

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

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

This erroneous line of policy was further compounded with the concept of ‘unmet need in psychiatry’ where it was believed that some people were seeing a psychiatrist two or more times per week *at the expense of others* who were seen as equally needy with only minimal or no access. The Minister went on to state clearly the Government’s commitment to improved mental health services through the better targeting of available resources and through increasing access to services by people

who presumably were going without. In fact, access to psychiatric services has decreased since the introduction of these MBS restrictions in 1996.

The figure of 2500 psychiatric patients (1810 females and 690 males) utilising more than 50 consultations was based on 1994-95 statistics. At the same time it is worth noting that there were 259,217 patients receiving from 1-50 consultations. The distribution of these 2500 patients were subsequently enshrined in the now famous "coloured maps" which set out the number of patients with >50 consultations, by electorate, based on postcodes.[6] (Attachment 1)

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

Revisions to Item 319

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

In support of this position, NAPP would emphasise that

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

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

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

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

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

Human Rights and Equal Opportunity Commission (HREOC)

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

> *"HREOC urges continued review of the operation of the relevant provisions, in consultation with consumers and the professional bodies concerned, to ensure that they operate in a manner which is non-discriminatory and which is consistent with and promotes the right of people with psychiatric disability to equality with all members of the Australian community."*[7]

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

A brief summary of these above-mentioned changes follows:

The situation brought about by the unilateral introduction of the 1996-97 Budget soon brought the realisation on the part of the Government that there were potential problems with the Disability Discrimination Act (DDA). The Human Rights and Equal Opportunity Commission (HREOC) supported the view that the restrictions[8] introduced on 1 November, 1996 would have a discriminatory effect on patients with psychiatric disability which was inconsistent with the provisions of the Act.

Early on, meetings were held involving the Medicare Benefits Branch, HIC, RANZCP and the AMA through the Medicare Benefits Consultative Committee (MBCC) which resulted in the introduction into the MBS of Item 319 – effective from 1 January, 1997. These changes[9] were incorporated in the 1 May, 1997 Supplement to the 1 November, 1996 MBS. (Attachment 3)

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

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[7] Disability Rights - *Medicare benefits for Psychiatric services*. Summary of findings. p. 1. (9 January, 2000).

[8] Attachment 2

[9] Attachment 3

excluded in relation to the Regulation as originally issued and modified up to August, 1997.

In its response to the 'draft report' the DHFS emphasised in relation to the definition of a "clinically relevant" service that a particular treatment, which might be regarded as effective and be the treatment of choice by some patients and some practitioners, did not necessarily meet the definition of clinical relevance for medical treatment generally and for psychiatric treatment in particular. The DH&FS saw the item descriptor 319 as setting out the circumstances where the clinical need had been supported by scientific evidence and that it took account of all the circumstances where there was evidence that more than 50 out-of-hospital consultations might be required for effective treatment. NAPP disagrees that *all* circumstances were taken into account.

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

Nevertheless there were continuing substantial concerns which included :

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

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

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

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

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

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

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

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

- The DHFS, then, had successfully covered itself against the charge of any form of discrimination from the HREOC which had as already mentioned above, gone on to urge a *continuing review of the operation of the relevant provisions* in consultation with consumers and professional bodies concerned, to ensure that they operate in a manner which is non-discriminatory and which is consistent with and promotes the right of people with psychiatric disability to equality with all members of the Australian community.

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

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

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

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

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

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

One other statistic of interest is that there has been a steady fall in the overall number of attendances per patient from 8.1 1992/93 to 7.7 in 1997/98. This change is related more to the Capital cities with figures of 8.8 to 8.1. Other Metropolitan and Rest of

State were relatively steady at 6.6 to 6.4 and 5.6 to 5.7 respectively. **This downward trend in Capital cities appears to have well and truly preceded the 1996-97 Budget.**

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

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

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

GAF or GAFFE?

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

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

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

Further, LeFeuvre points out that;

> "*the GAF scale may have a place as a research tool, but to try to use it on an individual clinical basis in general and in the assessment of patients for long term psychiatric treatment in particular lacks any scientific basis"*.[10]

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

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

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

What is long term intensive psychiatric treatment?

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

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

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

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

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

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

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

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

What are the characteristics of patients affected by Item 319?

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

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

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

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

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

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

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

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

> *"…patients seen by psychiatrists are significantly disabled and warrant treatment. Patients who were classified as the "worried well"…were not more likely than other patients to be receiving long term psychotherapy."*[11]

Patients who access this long term intensive psychiatric treatment are the equivalent of that medical group that use Intensive Care Unit facilities for acute trauma, or have organ failure and hence use high degrees of resources (such patients are not discriminated against for this). The difference, however, is that psychiatric patients *can recover,* (treatment is finite rather than life-long) and there are gains accruing

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

from recovery (increased productivity / lower health expenditure). The resources used are, therefore, in the nature of an *investment* for the community at large.

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

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

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

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

Psychiatric

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

Cost

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

Efficacy

- an extensive literature review (Bachrach 1991) found that suitable patients were much improved (by 60-90%) as measured by effect size measurements.
- multi-centre studies show that positive outcome is correlated with length of treatment; treatment cannot be shortened without loss of effect.
- length of treatment is not so long if co-morbidity issues are taken into account.
- PENN study (Luborsky 1993) found a positive outcome in 92%, with significant reduction in physical and emotional symptoms which were maintained at 7 year follow-up.
- shorter treatments aim for symptom relief rather than being focused on Personality Disorder issues. Long term intensive psychiatric treatment aims also at the latter thus making it more adaptive and complementing the former (Doidge 1994).

- Smith (1980) found 85% of patients were better when treated compared with a "no treatment" group.
- Shapiro (1982) found a mean effect size of improvement was 1 standard deviation.
- Mansen (1995) found at 5 year follow-up that 68% lost their Personality Disorder diagnosis and 75% who had an Axis I diagnosis also lost that problem.

Comparative

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

Frequency (dose)

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

<u>Biological</u>

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

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

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

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

General

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

Leading universities offer extensive research opportunities, in postgraduate management courses to explore the areas of work that require "*emotional labour"*. [12]

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

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

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

The parallels with the business of psychiatry are clear.

Further, they state

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

or,

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

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

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

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

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

and

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

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

Morris & Feldman go on to say that

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

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

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

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

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

Other

Along term study[13] in the USA, of over 20 years, linking personality disorders (PD) in adolescence with violent behaviour in early adulthood, found that this group, with the one exception among the personality disorders of the antisocial PD., could be treated effectively with psychotherapy.

Further, a 15 year study[14] on successful intervention on youth suicide, from Western Australia, concluded that when a young person is admitted to accident and emergency departments following self harm behaviours, *"…there were gross deficiencies in the kind of care being provided, not adequate assessments being made and the follow up tended to be woeful"*. The report showed that we can successfully intervene and dramatically reduce the suicide risk if *" you actually take the trouble to spend enough*

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

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

time with the person to gain their confidence, take a good history and ensure that whatever treatment is provided is addressing some of their immediate needs. It was particularly important to improve the likelihood of decent follow up." The existence of Item 319 regulations (et al) precludes full implementation of these findings to reduce spiralling incidents of youth suicides.

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

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

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

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

Clinical Impact and Anomalies

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

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

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

Patients ineligible to access treatment under Item 319 restrictions

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

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

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

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

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

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

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

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

difficulties affect their offspring. Treatment thus has an important preventative role (Osofsky (1995)).

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

Patients affected despite having access to Item 319

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

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

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

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

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

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

The Particular Problem of Children

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

Emotional difficulties in a child can impede normal developmental processes and we know from clinical experience, as well as research, that many emotional and psychiatric problems in adulthood have their origins in childhood. A troubled child rarely tells us they are sad, depressed or worried. An anxious child may present with frequent stomach aches or headaches, wet the bed, appear hyperactive. A child who is depressed may be unable to play or demonstrate behaviour problems, show school failure and learning difficulties, anti-social behaviour or aggressiveness with friends or family and is sometimes at risk for suicide. Many adolescents who take drugs are trying not to feel their depression or despair. Some troubled children withdraw into their own world of fantasy.

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

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

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

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

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

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

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

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

To quote Professor Robert Adler[15]: *"To this day, psychoanalytic psychotherapy remains the most valued form of treatment in many child psychiatric settings"*. Part of the treatment involves *working with parents or guardians* to ensure that an overall approach to the problems is taken. It is different to family therapy in that a child's symptoms and troubling behaviour are understood as unconscious communications of some underlying difficulties. This therapy is a working relationship in the context of a predictable setting and regular, frequent sessions, where the individual child or adolescent (or parent/guardian) work together with the psychiatrist. The difficulties that troubled children and adolescents experience often begin in infancy or early childhood and influence their functioning in the present. These experiences are re-enacted in treatment through the expression of unconscious fantasies and fears, in verbal and non-verbal ways and through a child's play. The observation, understanding and interpretation of the child's communications are part of the unique nature of the therapeutic relationship and involves skills and techniques and theoretical understanding obtained from specialised training. This therapeutic relationship is very different to counselling or talking to a friend. Problems including conflict, disturbed relationships or behaviours, school refusal, eating problems, depression, anxiety etc are related to the inner world as well as to external events, to unconscious as well as conscious experiences and to the interaction between them. Studies have also shown that psychoanalytic psychotherapy can have profound beneficial effects on serious childhood medical conditions, eg diabetes. Children who are placed in foster care and whose placement breaks down because of their disturbance can often be stabilised when treated with long term intensive treatment.

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

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

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

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

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

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

> *"… it highlights how we need to consider as a community what best creates the conditions for children's flourishing. It demands action on an individual and public level to recreate the tools for a convivial childhood. It will mean tackling adequate parental leave provisions, involving fathers as well as mothers in family life, economic support for families, a reasonable work/family balance, and investment in early childcare."*[16]

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

Ethical and Privacy Considerations

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

Confidentiality

The RANZCP Code of Ethics[17], Principle 4:

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

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

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

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

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

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

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

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

This legislation vastly complicates the doctor/patient relationship. Many clinicians have found it clinically unworkable to inform patients of these risks. To give the patient the choice places an undue burden on them – to refuse treatment because of

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

the risks, and the shame, or to accept the necessary treatment with the risks involved. Many patients have refused treatment. Many patients have not been informed. This contravenes Principle 4

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

The Best Interests of The Patient

RANZCP Code of Ethics, Principle 3

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

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

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

Professional Independence

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

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

De-identified clinical vignettes

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

Psychiatrist 1

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

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

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

Psychiatrist 2

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

Psychiatrist 3

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

age when early intervention is likely to make the most impact, but when patients are often least likely to be able to afford to subsidise their own treatment.

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

Trainee Psychiatrist

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

Commentary

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

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

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

which might otherwise result in people becoming violent, impulsive, or predisposed to frank illness.

Health and Training Issues

The World Health Organisation (WHO) has indicated that depression will be a major public health issue in the developed world. All treatment modalities that deal with emotional disturbances then, need to be able to be appropriately accessed. Further, it needs to be said that the Item 319 issue represents for young psychiatrists, a disincentive to continue training (or to encourage others to apply) which directly goes against recent recommendations from an Australian Medical Workforce Advisory Committee (AMWAC) report which calls for greater numbers of trainees to be recruited to meet shortfalls.

Rural Issues

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

Consultation with Stakeholders

Consumer groups

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

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

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

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

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

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

The Royal Australian & New Zealand College of Psychiatrists

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

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

In addition, a copy of a letter sent to the current CEO of the RANZCP, as well as NAPP, is tabled which outlines the feelings of a Senior Consultant in regard to the

restrictions based on Item 319 regulations. NAPP is of the opinion that the feelings outlined in his letter represent views generally held amongst that peer group.

Australian Medical Association

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

Remedial Policy Options

Repeal

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

Description

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

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

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

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

Fee

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

Other options

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

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

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

Workforce impact

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

PBS impact

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

Wider Remedial Policy Options

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

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

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

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

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

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

- Psychiatrists have become very much aware of the obvious and demonstrable deficiencies associated with the tyranny of distance in rural and remote Australia. They are also aware of the rapid rate of technological change. It could not have escaped the notice of the Department of Health and Aging (DHA) of the particular leadership already shown by psychiatrists in this area.

Telepsychiatry, in the form of Video links and Email communication is now being widely used especially within the public sector.

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

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

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

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

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

Conclusion

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

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

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

Problems of access will not be addressed by a profession diminishing in numbers, disillusioned by restrictions which lead to deskilling and alienation when an effective therapy, sometimes the only effective treatment, is increasingly under attack as part of the therapeutic armamentarium. A deskilled profession has serious implications for the training of future psychiatrists, a point frequently overlooked.

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

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Curriculum Vitae of Authors

Dr Gil M Anaf

MB BS Adelaide University 1975
General Practice 1977 - 1980
Fellow, Royal Australian & New Zealand College of Psychiatrists 1988
Clinical Lecturer in Psychiatry, Adelaide University
Founding President, NAPP, 1996 - 2002
Associate Member, Australian Psychoanalytic Society
Member, International Psychoanalytic Association
Secretary, Adelaide Institute of Psychoanalysis
Member, Australian Medical Association

Dr Rachel Falk

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

Dr Shirley Prager

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

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

She conducts a full-time private clinical and medico-legal practice in Child, Adolescent and Family Psychiatry in Melbourne.

She currently holds the positions of:

- Vice-President of the National Association of Practising Psychiatrists (NAPP)
- Chair of the RANZCP Section of Forensic Psychiatry (Victoria)
- Honorary Senior Lecturer, Department of Psychological Medicine, Monash University
- Member of Editorial Advisory Panel, Mental Health Research Institute Pharmabulletin
- Committee member of the AMA Section of Psychiatry (Victoria)

In the past she served as:

- Chair of the Victorian Branch of the RANZCP (1995-1997)
- Member of the Victorian Branch Committee of the RANZCP (1985-1998)
- AMA Councillor, Victorian Branch
- Member of Committee of Convocation, University of Melbourne
- Chair of the Ethics Committee of the Victorian Branch of the RANZCP
- Foundation Chair of the RANZCP Section of Psychotherapy (Victoria)
- Treasurer, Federal Section of Psychotherapy of the RANZCP
- Victorian Councillor on the General Council of the RANZCP (1993-1997)
- Committee member of the Faculty of Child and Adolescent Psychiatry of the RANZCP (Victoria) (1982-1984; 1985-1994)
- Member of the Quality Assurance Committee of the RANZCP (1991-1997)
- Corresponding member for Victoria on the RANZCP *Committee on the Role of Psychiatry in the Family Court* (1987- 1993)

Dr Richard Prytula

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

Qualifications:

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

Positions Currently held:

- Victorian Councillor, General Council, RANZCP
- Councillor co-opted to Binational Committee of Psychotherapy, RANZCP
- Member, Victorian Branch Committee, RANZCP with responsibilities for child
- and adolescent psychiatry, psychotherapy and general practice.
- Honorary Senior Lecturer, Department of Psychological Medicine, Monash
- University
- Training Group Analyst, Australian Association of Group Psychotherapists
- (AAGP)
- Member, Victorian Branch Committee, AAGP
- Chairman, Training Committee, AAGP
- Member Federal Management Committee, AAGP
- Member, Federal Training Committee, AAGP
- Member of the Board, European Group Analytic Training Institutions Network
- (EGATIN) representing Australia
- Individual Member, EGATIN
- Director & Member, Management Committee, Australian Doctors' Fund

Positions held in the past:

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

He is on the Editorial Board and is a contributing author to She Wont Be Right, Mate - The impact of managed care on Australian psychiatry and the Australian community, (1997), and the sequel, She Still Wont be Right, Mate!, (1998), both books edited and published by The Psychiatrists Working Group, a voluntary non-profit group of eight Victorian psychiatrists in private practice with the aim of raising awareness of the human factors in health care and the present and future threats to good health care from managerial for-profit businesses and organisations.

Attachments 1- 15