

SUBMISSION TO THE PRODUCTIVITY COMMISSION
IN REGARD TO ITS PAPER
“**THE SOCIAL AND ECONOMIC BENEFITS
OF IMPROVING MENTAL HEALTH**”

January, 2019

This submission is made by a retired Psychiatrist with over 40 years of clinical experience, having worked in the public mental health system from 1969 to 1978 and in the private mental health system from 1979 to 2015 – while retaining links with the public sector as a clinical supervisor for much of that time.

I commend the amount of work which has gone into preparing this comprehensive Issues Paper.

The seriousness of the issue itself will have driven the need for The Productivity Commission to prepare this comprehensive paper – and its detailed and searching questions attest to the fact that **the current “system” must be failing to achieve an appropriate level of “benefits” given the very considerable investment in both money and personnel made by federal and State Governments.**

The “outcomes” must be falling far short of those expected to justify this enquiry requested of The Productivity Commission by the Treasurer, the Hon. Josh Frydenberg.

I would agree that they are.

From the Treasurer’s Terms of Reference:

Mental health is a key driver of economic participation and productivity in Australia, and hence has the potential to impact incomes and living standards and social engagement and connectedness. Improved population mental health could also help to reduce costs to the economy over the long term.

Scope

The Commission should consider the role of mental health in supporting economic participation, enhancing productivity and economic growth. It should make recommendations, as necessary, to improve population mental health, so as to realise economic and social participation and productivity benefits over the long term.

Without limiting related matters on which the Commission may report, the Commission should: [this submission will highlight just two]

- examine the effect of supporting mental health on economic and social participation, productivity and the Australian economy;
- assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy;

MY MAIN SUBMISSION IS THAT THE WHOLE TENOR OF THIS ISSUES PAPER IS THAT *ECONOMIC CONSIDERATIONS* “COME FIRST” – AHEAD OF THE INDIVIDUAL’S MENTAL HEALTH AND THAT OF THEIR FAMILY.

That is, the individual appears to be seen as an ‘*economic entity*’ whose improved mental health brings economic benefits to Society. This is, of course, in an important sense, true.

However, optimal mental health development rests on an individual being able to grow in an atmosphere of not feeling ‘beholden’ to the needs of others (parents, school, society) and to be able to ‘actualise’ their true self. [I will hope to further explain this assertion later].

The tenor of this Issues Paper appears to rank individual mental health needs as *secondary* to socio-economic benefits – whereas making individual mental health the *primary concern*, will provide the economically and socially desired benefits as an inevitable consequence.

A simplified version of the psychoanalytic concept of ‘optimal mental health’ asserts that a capacity for “**love, work and play**” permits the individual to have satisfying personal relationships, economically support themselves and those dependent on them – and be able to enjoy leisure activities.

Thus (coincidentally for the purposes of this submission!) “work” is nestled *between* “love” and “play”.

The optimal capacity for “WORK” can only be attained in the context of a fully rounded personality capable of loving relationships and a balanced life including leisure activities.

While this submission in no way wishes to diminish the importance of the capacity to work, it asserts that by focussing so heavily on the “economic

questions”, the Issues Paper relegates the two other pillars of optimal mental health to a secondary place.

I wish to comment further on the Issues Paper from the perspective of my 45 years of working as a medical practitioner, psychiatrist and psychoanalyst in the NSW health system. I will confine my comments only to those aspects of working within the health system about which I can claim any significant clinical experience.

This submission will now highlight some parts of the Issues Paper where the individual DOES come into focus:

“Despite a plethora of past reviews and inquiries into mental health in Australia, and positive reforms in services and their delivery, many people are still not getting the support they need to maintain good mental health or recover from episodes of mental ill-health. Mental health in Australia is characterised by:

- **more than 3 100 deaths from suicide in 2017, an average of almost 9 deaths per day, and a suicide rate for Indigenous Australians that is much higher than for other Australians (ABS 2018)**
- **for those living with a mental illness, lower average life expectancy than the general population with significant comorbidity issues** — most early deaths of psychiatric patients are due to physical health conditions
- **significant stigma and discrimination around mental ill-health**, particularly compared with physical illness.”
- Suicide (especially among young indigenous people!), reduced life expectancy and the stigma of mental illness are all issues which have attracted considerable attention and considerable funding for less-than-hoped for benefits.
- I submit that less-than-adequate assessment of presentations of depressive symptoms and too-ready deployment of medications are the result of insufficient respect for what may be termed an “inner world”.
- A comprehensive assessment of troubled individuals at presentation requires that “the mental health system” respects individual experience, enquires deeply into personal history and allows sufficient time for all this.

Our mental health system is too burdened at present to provide what is required.

FIGURE 1 on page 3 is excellent in its scope and coverage of relevant issues !

However, the small section headed “Personal History”, almost disappears as, “graphically”, prominence is accorded to the THREE other areas of Figure 1 which are larger and more colourful !

I contend, again, that this “tone” in the Issues Paper itself reflects a major part of the problem in our Mental Health System: that the basic ‘design’ of the mental health system “puts the cart before the horse” ... that it does not allocate sufficient “primacy” to the inner world of the individual and rather sees the individual as a “secondary cog” in a larger wheel. An individual with adequately developed mental health capacities satisfactorily accomplishes all the other aspects of satisfactory socio-economic activity depicted in Figure 1 without any need for government intervention!

Regrettably, there is considerable social stigma attached to sufferers of mental illness and mental disorder. This in turn is reflected in a form of “intolerance” of mental suffering and a general “wish’ to distance from these painful issues in others – lest they “stir up” similar anxieties in oneself.

Thus the very disturbing issues of suicide are not as comprehensively explored (by clinicians) as they might be – and deserve to be; relationships between physical illness and psychological issues are avoided; and decreased life expectancy among those with mental illness and mental disorder are ignored.

To select again from the Issues Paper:

“To give the inquiry focus, we intend to give greatest consideration to where there are the largest potential improvements in population mental health, participation and contribution over the long term. From the Commission’s initial consultations, this seems likely to include:

- people with a mild or moderate mental illness (such as anxiety and depressive disorders) because they account for the vast majority of Australians with a mental disorder (figure 2)
- young people, because mental illness at a young age can affect schooling and other factors which influence opportunities over a person’s lifetime — moreover, most mental illnesses experienced in adult life have their onset in childhood or adolescence (McGorry et al. 2011)
- disadvantaged groups, such as individuals from very low socioeconomic backgrounds and people residing in remote areas because they may have more difficulty in accessing services which could improve their mental health (AIHW 2018d; Harris et al. 2010; Meadows et al. 2015)
- suicide prevention, because the years of additional life lived, and associated social and economic participation and productivity years into the future, can be significant.”

I strongly support this approach.

Each of the issues addressed by the Issues Paper (above highlighted in red) are more amenable to “earlier intervention” than has hitherto been the case.

More comprehensive assessment at the time of first presentation than is nowadays the case should permit more appropriate interventions with better outcomes.

- HOWEVER – and REGRETTABLY – this last sentence highlighted (in red) above: “suicide prevention, because the years of additional life lived, and associated social and economic participation and productivity years into the future, can be significant” is, perhaps, the worst instance of my main criticism of this Issues Paper in that it mentions “associated social and economic participation” together with “productivity years into the

future” – while **relief of psychic pain and despair** and **return to personal well-being and fulfilment** are not even mentioned !

ISSUES PAPER – page 14:

Suicide prevention

□

Suicides are not just the loss of an individual and their future, but the loss of a member of a family and community. Beyond the social costs of suicide, there can also be large financial costs to the whole community, with one estimate valuing lost economic participation; provision of coronial, police and ambulance services; and counselling support for family and friends at \$1.7 billion annually (KPMG 2013). An associated concern is the number of people who are hospitalised due to self-harm, which is more than twenty times the number who lose their life to suicide (COAG Health Council 2017b).

There has been no significant reduction in the death rate from suicide over the last decade, despite ongoing efforts to make suicide prevention policies more effective (figure 6). In light of this, governments recently made suicide prevention a focus for cross-jurisdiction coordination under the Fifth National Mental Health and Suicide Prevention Plan. This includes a commitment to develop a national implementation strategy, which will set the direction for future planning and investment, and is expected to be released in 2020 (NMHC 2018b). Moreover, individual jurisdictions have already committed to funding various trials and other interventions to prevent suicides.

As acknowledged in the Issues Paper (above):

Much effort and money has been invested in recent years into dealing with the suicide crisis. Regrettably, positive outcomes have not been achieved in keeping with the large efforts expended.

It is contended here that a greater focus on personal history of trauma and family psychodynamics is required in order for those with serious suicidal ideation to feel adequately understood by the assessing mental health workers – and not to be thrust into deeper despair by not feeling that their personal *psychic pain* has been adequately addressed.

This requires high levels of training of mental health professionals at all levels – together with adequate supervision by experienced senior staff. Dealing with threatened suicide is harrowing and requires high levels of clinical supervision and support from senior clinicians.

- *Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?*

This is a very important question !

I contend that there is insufficient clarity between what is considered a “mental illness” and a “mental disorder”. Healthcare Systems need to respond differently to these two categories of “mental health issues”.

“**Mental Illness**” should be reserved for severe psychotic illness episodes (which may become chronic) and severe mood disorders (which also may be acute or chronic).

“Mental Illness” is best managed with comprehensive assessment and appropriate medication – together with appropriate psycho-social support.

For ‘Mental Illness’, no effective forms of “**Primary Prevention**” are, as yet, available. But effective “**Secondary Prevention**” [i.e. treatment of first presentations of an already established illness. “Headspace” endeavours to this.] can be effective and is vital to minimise further ‘recurrences’. “**Tertiary Prevention**” [i.e management of established (and often chronic) mental illness] comprises the majority of services required by this group.

“**Mental Disorder**” has to do with ‘non-physical’ psychological disorders and refer to ‘Anxiety Disorders’, ‘Reactive Mood Disorders’, ‘Eating Disorders’, ‘Addictive Disorders’, ‘Autism Spectrum Disorders’, a range of childhood behavioural disorders (e.g. ADHD) and ‘Personality Disorders’ (of varying severity).

“Mental Disorders” comprise by far the larger group of ‘mental health’ presentations to the healthcare system.

All these mental disorders have in common that their ‘aetiology’ is in early infancy and early childhood. Comprehensive assessment by well-trained mental health care professionals is required for appropriate management decisions to be made and implemented.

For “Mental Disorder”, “**Primary Prevention**” would be the ideal approach. This necessitates an adequate understanding of childhood mental development – especially those childhood experiences which go toward developing a healthy mind, together with an understanding of those (many!) childhood experiences which impair optimal development.

Thus fostering of beneficial experiences and minimising harmful experiences in young families would be an ideal ‘program’ for fostering mental health in any community.

“**Secondary Prevention**” of mental disorders is likely where the major cost-benefits are to be obtained. Here, again, comprehensive assessment via sensitive history taking (individual and family where relevant) is essential before management options are decided upon.

The majority of instances of ‘mental disorder’ are a result of a mixture of early childhood trauma (of a wide variety of kinds) and what ‘meaning’ each individual has ascribed to those traumata. If appropriate psychotherapeutic interventions are deployed in early presentations, satisfactory ‘resolution’ is likely to be achieved.

Regrettably, this approach is the most ‘labour intensive’ and potentially costly aspect of an ideal mental health care system. Yet, all other approaches risk being ‘superficial’ and the patient/client will likely not feel understood – and the ‘issues’ will ‘go underground’ and will likely re-emerge at a future presentation.

“**Tertiary Prevention**” of ‘entrenched’ mental disorder will necessitate even more ‘labour intensive’ managements. Such managements need to be patient/client centred and not ‘system centred’.

All-in-all, improved training, increased staff numbers, enhanced mental health treatment facilities (community and hospital) and appropriate supervision are required if those vulnerable to mental disorder and mental illness are to be better served BY the health services – rather than needing to ‘get better’ FOR the economy.

Mental health promotion, prevention and early intervention [Issues Paper p.14]

An important issue for this inquiry will be how, and to what extent, can the prevalence and severity of mental ill-health be reduced through more effective mental health promotion (equipping the population to maintain good mental health), identification and prevention (such as interventions targeted at people with a high-risk of mental illness, including to prevent relapse) and early intervention (care provided soon after an episode of illness becomes evident).

This all-important question has been, to some extent, addressed in the paragraphs above. While earliest possible ‘preventive interventions’ are the most ideal investment of resources in a caring society, it will necessarily be costly and require the best utilisation of the considerable amount of ‘existing knowledge’ about childhood psychological development and associated family dynamics – and how these relate to the potential development of mental disorders.

Suicide prevention [Issues Paper p.14]

Suicides are not just the loss of an individual and their future, but the loss of a member of a family and community

And ...

There has been no significant reduction in the death rate from suicide over the last decade, despite ongoing efforts to make suicide prevention policies more effective (figure 6).

To state again, these two statements reflect the sad fact that despite investment of considerable money and effort, completed suicide remains both a personal tragedy and a loss to the family – as well as (secondarily), a loss to society of an economically productive member.

A suicide researcher, Edwin Schneidman coined the term “**Psychache**” to encapsulate the unbearable ‘psychic pain’ suffered by anyone considering committing suicide.

[“**Psychache**” is a term used to refer to *psychological pain* that has become unbearable. The pain is deeper and more vicious than depression, although depression may be present as well. ...**Psychache** is every bit as agonizing as physical pain, and often much harder to deal with.]

There is a considerable literature surrounding this evocative term – yet I would assert that this literature is not as widely known as it deserves to be.

More ready recognition of “psychache” would inform more sensitive assessments and would accord suicide (‘psychache’) a recognition of the *actual pain* involved and the person’s desperation to escape from this pain.

Issues Paper p.23

Justice and child protection

For some parts of Australia’s social frameworks — such as the justice system and child protection system — mental ill-health may be a factor that raises the likelihood of people interacting with these systems, but may also necessitate particular consideration in program and support delivery. You are invited to comment on what changes could be made in Australia’s justice and child protection systems that could improve mental health and have flow-on benefits to individuals’ economic or social participation and contribution in the short or longer term.

This is an extremely important issue: children becoming ‘involved’ with the justice system is a reflection of family dysfunction and (likely) neglect. Children entering the justice system are at extreme risk of becoming involved in a ‘revolving door’ phenomenon and risk further deterioration in their mental and social well-being.

Maximum efforts at rehabilitation should be deployed taking into account the high costs to society of failure to achieve some degree of rehabilitation. Again, these efforts need to be primarily ‘child-centred’ in order to seek maximum improvements in the individual child’s self-esteem – which is inevitable impaired in circumstances leading to detention in the justice system.

Issues Paper p. 24

Child safety

Mental ill-health is widespread among children and young people who are in contact with the child protection system. In particular, there are sharply elevated rates of mental illness among young people that child protection authorities have placed in out-of-home care (OOHC) and young people that have left out of home care — a consequence of factors such as trauma

associated with family circumstances prior to entering care, negative experiences (such as placement instability, disrupted attachments or sexual abuse) while in care and lack of support after leaving care. The prevalence of mental illness is especially high among the 5% of children in OOHC that live in residential care facilities, rather than home-based care with relatives or foster carers (AIHW 2018a; Rahamim and Mendes 2016).

In addition to the devastating impact on the mental health and development of children, child maltreatment generates significant economic costs that are borne by both the child and by society more broadly.

This group of at-risk children are indeed vulnerable to the whole range of mental disorders.

As acknowledged in the paragraph from the Issues Paper, the development of mental issues is primarily *as a consequence* of the prior reasons that any child needs to be placed in out-of-home-care. Such reasons need to be urgently addressed by well-trained mental health staff.

HOWEVER, regrettably, psychological problems can be compounded by issues arising in the out-of-home-care setting itself. High levels of appropriate support need to be made available to the out-of-home carers themselves in coping with already traumatised children. In addition, too often, such carers can themselves further traumatise those in their care if their own 'issues' intrude into the fostering setting.

While these circumstances are by no means confined to the indigenous community, there are special cultural considerations involved where indigenous children are involved. The need to be highly sensitively managed while maintaining the child's best interests at the centre of management planning.

SUMMARY of this SUBMISSION

The breadth and depth of the Productivity Commission's Issues Paper is acknowledged. However, this submission has repeatedly asserted that making 'economic considerations' the primary focus of the paper, risks losing a necessary understanding that optimal psychological development of individuals requires that their development be 'for their own sake' – and not that of others, nor (primarily) for the sake of society's economic interests.

All the desired benefits to society, in terms of an individual's "capacity to love, work and play" will flow from optimal psychological development. Such individuals will prove to be self-reliant, will support their dependants and will adapt well enough to most circumstances which they will encounter through life. Thus, they will be minimally dependent on public monies.

Nevertheless, many people (too many) are not so fortunate to have the kind of early 'environment' which leads to optimal psychological development.

Where possible, those vulnerable to adverse development circumstances should be identified and offered appropriate interventions, while those who have already developed sufficiently recognisable conditions should also be identified as early as possible – usually by their presentation to the relevant mental health care facilities.

At many points in this submission, the need for improved training to secure sensitive comprehensive assessment of each individual's needs has been highlighted.

Support of junior staff by experienced senior clinicians is even more essential in the mental health field than in other areas of physical health care.

It is acknowledged that all this is necessarily 'labour intensive' – and, consequently, costly !

The only 'initiative' I can propose is outlined in an Appendix to this submission.

It in essence recommends the establishment of a panel of senior clinicians with expertise in psychodynamically-oriented approaches to childhood psychological development and the treatment of mental disorders. This panel should be consulted by the range of government departments responsible for the design and implementation of mental health programs in order to ensure that adequate understanding of individual psychopathology and its aetiology is incorporated in such programs – and that adequate training in assessment and treatment is available for mental health workers in these programs. The provision of adequate supervision and support by senior clinicians is essential if these programs are to be maximally effective.

APPENDIX

Dr . Ron SPIELMAN

A PROPOSAL TO ADDRESS THE UNDERLYING PROCESSES WHICH A LARGE RANGE OF SERIOUS PSYCHO-SOCIAL PROBLEMS HAVE IN COMMON.

Among the serious problems which affect our Society and with which Governments have to attempt to deal are:

Child Sexual and Physical Abuse and Neglect

Domestic Violence

Child Behavioural Disorders, such as so-called Attention Deficit Disorders and Autism Spectrum Disorders

Alcohol and Drug abuse

Eating Disorders

Suicide – especially among adolescents and within the indigenous community

Gender dysphoria (a modern epidemic)

... and a range of Anxiety and Depressive Disorders

Each of these is very costly to individuals, their families and the community.

What this apparently unconnected group of issues have in common is that **they each have significant personality disorder problems at their core.**

Some harm themselves (the suicidally depressed and the eating disordered ones); some harm others (the domestically violent and the child abusers); while alcohol and drug abusers harm both themselves and others. Children are at all times the victims of their families' difficulties. **All pose heavy costs in health care, welfare support and loss of productivity in one way or another.**

Many would like to assert that some of these problems are the result of “diseases”: e.g. alcoholism is a disease, depression is a “mental illness”.

However, all of these problems are the result of individuals' personality problems: problems in individuals who have sadly suffered trauma (family dysfunction and psychological traumas of various kinds) during their childhood development. As a result they have difficulty in “regulating” their emotional life without either self-harming or externalising their “issues” onto others.

Understanding of childhood psychological developmental processes together with understanding of adult mental processes and defence mechanisms permits an appreciation of the underlying psychological issues which contribute to each of these serious “psycho-social problems”.

Programs intended to address these problems must be based on **comprehensive assessment** of the individuals and families involved.

Many of the psycho-social problems addressed above are suffered disproportionately by Indigenous Communities. The kind of approaches which are informed by deeper understanding of personality development issues could result in more effective programs aimed at reducing the toll these disorders take.

Comprehensive assessment, of course, is dependent on competent training in the understanding of the development of personality in our society and in understanding the onset and development of this range of psychological disorders.

Further, competent management and treatment are dependent on clinical supervision by senior clinicians passing on their experience and understanding to junior mental health workers.

Much so-called “burn-out” can be avoided in these stressful mental health fields by psychodynamically-informed supervision and teaching. Burn-out is costly to the mental health systems in necessitating replacement of already trained staff with new staff needing training.

PROPOSAL

The establishment of a **“Psychodynamic Consultancy Panel”** which could offer input to health and welfare planning bodies in order to deepen the understanding of the psycho-social problems being faced in many sectors of our society.

The panel should be composed of mental health workers with special training and experience in psychoanalytically-informed psycho-dynamic treatments.

The panel’s input should be sought by health and welfare planning bodies as well as institutions responsible for the training of mental health professionals in a range of disciplines.

Major Reference paper:

Shedler, Jonathan (2010) *American Psychologist*, The Efficacy of Psychodynamic Therapy, [February-March pp. 98-109]

SUMMARY

Empirical evidence supports the efficacy of psychodynamic therapy.

Effect sizes for psychodynamic therapy are as large as those reported for other therapies that have been actively promoted as “empirically supported” and “evidence based.”

In addition, patients who receive psychodynamic therapy maintain therapeutic gains and appear to continue to improve after treatment ends.

Finally, non-psychodynamic therapies may be effective in part because the more skilled practitioners utilize techniques that have long been central to psychodynamic theory and practice. The perception that psychodynamic approaches lack empirical support does not accord with available scientific evidence and may reflect selective dissemination of research findings.