**Allied Health Professions Australia and**

**the Australian Psychological Society**

**Submission regarding the**

**Development of the Australian Mental Health Care Classification:**

**Public Consultation Paper 1**

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**Introduction**

Allied Health Professions Australia (AHPA) appreciates the opportunity to comment on this consultation paper. AHPA represents over 30,000 allied health professionals in the professions of psychology, social work and occupational therapy many of whom provide services to people suffering from mental illnesses.

In responding to the 11 questions identified in the paper, it is recognised that, like the application of mental illness diagnostic categories, there is considerable overlap between the content of questions. They do not appear to be tightly discrete or independent. As a consequence, it was difficult to avoid repetition in responding to the questions. Some of the responses in this submission refer back to previous discussion or, where relevant, questions have been combined.

It is recognised that this is the first discussion paper in a process of public consultation and for that reason this submission adopts a broad and high level approach. It is anticipated that, as more detail emerges regarding the classification system being developed, the responses of AHPA will also be more detailed and specific. The submission identifies some fundamental issues that need to be recognised as a context for resolving some of the more detail-specific concerns that will emerge with time.

**Question One:** *What are the most important factors to draw from international experiences in classifying mental health care?*

One of the major concerns that is shared across the world with the classification of mental health disorders, and the intervention programs which respond to them, is the incomparability of mental health diagnostic systems with the other classifications of physical health systems. This is a fundamental consideration which alters the whole basis for judging and evaluating systems of classification.

This particular concern was highlighted in the recent review of the psychiatric ‘directory’ – Diagnostic and Statistical Manual of Mental Disorders (DSM) - and the subsequent debates and discussions regarding mental health diagnostic classifications. While there were many concerns about the DSM-5 with regard to specific disorders, one of the most cogent criticisms is that the DSM purports to be a set of diagnostic categories equivalent to those formulated and defended for physical illnesses. However, there are significant differences between the two types of classifications which raise considerable doubt about the equivalence of classifications for physical and mental illness.

The first version of the DSM came into being over 50 years ago and has been transformed considerably since that time. However, unlike medicine, where biological markers underlie an aetiological framework guiding diagnosis, for psychiatric diagnoses no generally clear aetiological structure has been identified. This is problematic because it means that current psychiatric diagnostic systems such as the DSM cannot provide an assured process for the proven identification of discrete psychiatric entities as found in the medical model. This is reflected in the large overlap of symptoms across diagnostic categories in the DSM and in the widespread finding of comorbidities. Many sets of criteria in the psychiatric diagnostic categories outlined in the various versions of the DSM have not as yet been validated through scientific evidence demonstrating causal pathways and an ability to predict trajectories. In many cases, proposed diagnostic categories are part of the ongoing review of strengths and weaknesses on the basis of rationale, scope of change, expected impact on clinical management of public health, strength of supporting research evidence, overall clarity and clinical utility. In this context, classification systems such as DSM provide a basis for ongoing research and an extension of knowledge in this area, but present a major dilemma for clinical practice.

There is an increasing number of critics who believe that it is unlikely that biological correlates will be found. It is fair to acknowledge that it does vary by disorder. For example, there is a larger genetic vulnerability for schizophrenia than depression. Coincidentally, many clinicians and academics are moving towards a very biological model of psychiatry. However, for many, it is the relational/environmental factors, not given much weight in the DSM, that are likely to provide increased understanding of pathways to, and distinctions between, psychopathology.

While it is acknowledged that Public Consultation Paper One has gone to considerable lengths to acknowledge the shortcomings of the diagnostic classification as a basis for meaningful costings categories, it remains a concern that the fundamental difficulties noted above are not sufficiently highlighted and stressed as important precursors and considerations in an exercise of this nature.

It is clear that the diagnosis of mental health disorders while including utilise clinical interviewing skills, psychometric tests, clinical case formulation also relies heavily on the phenomenological experiences of the sufferers, the behavioural reports often in the form of self-reports and the subjective interpretation of this information by the clinician. It is also acknowledged that the role of environmental and situational factors have much greater importance in many of the mental illness diagnoses than for many physical illnesses and, that despite this fact, they are not identified as critical in attempts to classify and differentiate the various conditions.

In much of the literature this is referred to as the bio-psycho-social approach where Not only do we look at each of these factors but also includes attempts to understand the predisposing, precipitating, perpetuating and protective factors implicit in each Bio, Psycho and Social factor. The complexity to the process of diagnosis that this introduces is totally acknowledged by the authors of this paper but it still has to be recognised in any attempt to develop a meaningful classification.

It is critical to consider the unique features of the mental illness diagnostic process because so much classification and costing in health has been driven by the development of Diagnostically Related Groups (DRGs). The natural tendency to place mental illness categories in a DRG framework will be hard to resist and should only be done with exceptional caution defended above.

It is with respect that it is acknowledged that this discussion paper has attempted to grapple with the failure of previous classification systems in accounting for costs in services and treatments. The concept of ‘phase of care’ therefore has considerable merit as another means of coming to terms with the very difficult-to-define differentiating features. What needs to be made very clear is that exploring phase of care as a possible differentiating mechanism is an investigative exercise (or fishing expedition) which has very little foundation in a conceptual framework that is both rigorous and defensible in terms of research.

**Question Two:** *What are the most important considerations in the national context ?*

The major implications of the shared and international concerns about mental health classification are as follows:

* the use of diagnosis as a means of classifying should never be regarded as similar or comparable to that used for physical illnesses;
* the complexity of mental health conditions makes any form of classification difficult to apply and problematic to rely on regardless of the means by which it is done;
* complexity in mental health refers to the fact that causation is always multifactorial and subject to considerable variation unlike the majority of physical illnesses. The psycho-social elements impact in ways much less common in physical illnesses;
* complexity also includes the high incidence of co-morbidity both within mental illnesses and between mental illness and physical disorders.

Even when very simplistic and broad classification, such as psychotic, non-psychotic and organic, are adopted (page 12, Public Consultation Paper 1) the overlap and individual variation is quite marked. For instance, the psychotic/non-psychotic overlap is considerable. Even people with depression (non-psychotic usually) can have psychotic episodes during acute episodes or at certain times.

Environmental, circumstantial or episodic influences (generally referred to as social and psychological) can also be an enormous source of variation. A person with depression who is still employed may have a very different recovery pathway to someone who is unemployed. Living circumstances, family support or therapeutic experiences can all impact on the trajectory of mental illness. So while *phase of illness* may provide a much more realistic basis for identifying/modelling costs and variations, the multitude of additional sources of variation and individual patient differences – and therefore costs - make predictability, reliability and even validity very uncertain.

Another factor which dominates much of acute psychiatric care, particularly in emergency departments and inpatient psychiatric units, is the issue of disturbance initiated by psychoactive drugs. To some extent this has become the *elephant in the room* with regard to mental illness planning and discussion. However, it is a dominant feature and influence in much of acute psychiatric care. The increasing utilisation of behaviourally disturbing drugs like ice and other amphetamines casts a significant shadow over pre-admission, admission and inpatient treatment services. While many of the features of drug-induced psychosis are similar to conventional psychosis, the dissociated behavioural and social factors can produce very different illness pathways and cost structures.

Finally, a feature that is particularly relevant in Australia as a multicultural society is the recognition and accommodation of cultural influences. These can be unique and critical for some individuals with strong cultural backgrounds and can have significant impact on both the effectiveness of treatment and preparedness to engage in service provision. As with the issue of drug taking noted above, cultural issues may significantly alter the standard trajectory for a particular disorder and as such may be a significant influence on costs.

The conclusion, then, it is not that costing mental health/illness services is impossible rather needs to be updated to match current clinical best practice to acknowledge the role of biological factors, psychological factors and social factors. This does not mean that the process of costing mental illness services should be abandoned. Instead, what must be enshrined in the classification process is a component of flexibility that enables the challenges in diagnosis to be accounted for rather than ignored.

**Questions Three and Four:** *Are there any other principles that should be considered in developing the AMHCC? Are there further dafter or other limitations of which the AMHCC should be aware?*

There are probably a number of additional issues that could be raised, particularly in light of the above, but one that is rarely raised and a vital issue when considering cost, is the issue of best practice versus current practice. Costing studies regularly record activities and services that are commonplace and routine with little attention paid to costing other, better or best practice endeavours.

It will always be argued that ‘we have to start somewhere’ or ‘it is not our business’ but the end result is the reinforcement of current practice and the serious inhibition of initiatives, enterprise or even just the adoption of new or best practice. This is particularly concerning for the mental health sector where there is considerable documented evidence of the lack of delivery of best practice in the treatment of mental illness (e.g. *Not for Service* report by the Mental Health Council of Australia). Failure to take the current poor practices into consideration will have severe negative impact on consumers

Classification, costing studies and environmental scans should accommodate opportunities to identify and cost best or novel practice to ensure mechanisms are in place for the delivery of effective and efficient services.

**Questions Five and Six:** *Are there any other key considerations that should be taken into account in developing the AMHCC? Are there other cost drivers that should be considered in the development of the AMHCC?*

As noted above, the influence of psycho-social factors in the characterisation and progression of mental illnesses is relatively immense when compared with physical illnesses. For this reason, it is vital to take account of at least some of the factors when attempting to classify and determine cost. For this reason, factors like physical home circumstances, social home circumstances and social engagement (work or community) would demand considerations as cost drivers. These are certainly not as simple to quantify or define as Phase of Illness, but clearly known to be major issues.

The International Classification of Functioning and Disability (ICF – WHO) has recognised these influences on all health conditions and has sought to remedy the general tendency for health systems to overlook these influences by building in both classification and measurement processes into its manual. Such a philosophy of health policy has adopted the term bio-psycho-social model to reflect the equal importance of all those factors. Mental illness above all needs to take account of all such influences.

**Questions Seven and Eight:** *Are there any further considerations in relation to the proposed architecture? Is there any further evidence that should be considered in testing the proposed architecture?*

In reviewing the proposed architecture, the points raised above regarding complexity, multifactorial causation and unique issues for mental illness classifications have ongoing relevance. Of particular concern where relying on Phase of Care are its insensitivity to the following:

* *best or improved practice*. As discussed above, this is a vital issue in a professional context where a ‘tailored approach’ - which introduces variability in intervention - and where the development of understanding and appropriate interventions is considerably dynamic. It is therefore critical that the measurement of organisational and professional activities takes account of the evidence and experience that supports or at least identifiers new or best practice;
* *psycho-social factors.* Once again, this has been discussed fully above but needs to be incorporated as an important dimension around which data needs to be collected within each phase of care;
* *age*. While the acknowledgement of Paediatric differences within the mental illness domain has been incorporated into phase of care, little consideration has been given to the significant differences in the presentation and pathway of mental illness among the aged. It may not be that age makes as significant a difference with regard to the type of mental illness but that the level of incidence for particular forms of mental illness do vary significantly and can have significant cost implications.

The latter point raises an interesting factor often not considered. The recent report by the Australian Institute of Health and Welfare (AIHW) indicated that over 50% of residents of residential aged care facilities (RACFs) experience moderate levels of depression. Other than the anecdotal reports that these conditions are largely treated by primary care physicians with medication, there is little data or analysis that treats this as a significant source of mental illness costs. Aside from the fact that medication alone is not best practice and a good example of the failure of the system to adopt and measure best practice, what it does highlight is the possible failure of the system to identify and manage untreated mental illness and the implications of this for both a meaningful data collection and a representation of cost. In other words, not only is their poor practice but huge amounts of “no treatment”. So costings need to give consideration to the current under-treatment of mental illness

**Question Nine:** *Which psychological interventions, if any, may be of significance in understanding the cost of care?*

It must be acknowledged that the meaning and purpose of this question is not clear. Whether it is discussing the implications of having appropriate staff to provide psychological interventions or whether it is questioning the role of psychological interventions in treating mental illness or understanding the cost of care remains unresolved. However an attempt to respond to the question is made.

With regard to the question of understanding the cost of care:

* The first issue is the limited if not absent use of psychological interventions in the majority of public mental health services. While the presence of clinical, neuropsychological and health psychology expertise exists in many hospitals and mental health units within public hospitals, psychological services are by no means uniform or sufficient to meet the demand for psychological interventions. Additionally, there are many instances of services meeting mental illness need outside of the tertiary institutions. Community-based services both public and private often accommodate provision of services for people with mental illness. For many of these the presence of personnel providing high quality psychological interventions is extremely limited.

A good example of this has been referred to above with regard to the incidence of mental illness in residential aged care facilities. While the AIHW report specifically referred to depression, we know that both anxiety and depression are commonly experienced by the aged and not always in combination. It is known that at least 45% of the aged community outside RACFs experience such disorders and, as noted above, this increases significantly when the aged are admitted to residential facilities. The presence of trained personnel and high quality services to provide psychological interventions within RACFs is almost non-existent. The crucial issue here that needs to be highlighted is that the research is very clear that psychological interventions for depression are as good as if not better than medication.

This is doubly important in RACF’s where residents commonly are already on a range of medications and the introduction of psychotropic substances can create major side-effects and the common problems of polypharmacy - the most common of which is the expensive admission to a tertiary hospital. So the issue of cost effectiveness is centre stage in such a discussion of practice and interventions.

* Apart from the absence of appropriate resources and trained personnel is the general cost of medication for mental illness interventions. For example, Australia has one of the highest rates for the prescription of anti-depressants in the world but the evidence for its efficacy is limited. Psychological interventions have been found to be more cost effective for treating depression;
* The third issue relating to the utilisation of psychological interventions and their contribution to cost effectiveness is the unfortunate tendency for many of these interventions to be administered by inadequately trained and inexperienced practitioners. This not only can inoculate the mental illness sufferer from future more effective interventions but weakens the cost-effective argument by the poor implementation and underuse of such effective interventions.

**Questions Ten and Eleven:** *Are there any further considerations that should be taken into account when developing the AMHCC?*

Most of these concerns and considerations have been dealt with above but just to reiterate, these are the factors and influences that need to be recognised and borne in mind when developing a mental health classification:

* the variability/fluidity of the diagnostic classification of mental illness;
* the failure of the mental health diagnostic classification for mental illness to be comparable to physical illnesses classifications and the DRGs which rely on the latter;
* the biopsychosocial nature of mental illness and the critical need to recognise all the components;
* the importance of other variables such as age, cultural background, drug-taking and co-morbidities;
* the need for a costing system to reward improved and best practice, and also account for the under-treatment of mental illness.