

Submission to

Senate Community Affairs Committees Inquiry:
Commonwealth Funding and Administration of Mental Health Services

19th August 2011

1. Purpose of this submission

This will respond to a number of false claims about me and the Early Psychosis Prevention and Intervention Centre (EPPIC) and headspace models of youth mental health care in a submission that the Committee forward me on 5th August. This submission complements a submission that I made to the inquiry on the same date.

2. Inaccurate information and false claims

The inaccurate information and false claims contained in the submission referred to me by the Committee include:

- incorrect statement that “there is simply no demonstrated means of assessing who is likely to become psychotic”
- misleading statement that “an enormous amount of ‘false positives’ will result from intervention provided by EPPIC”
- false claim that “young people who are not likely to become psychotic will be assessed as being at risk, resulting with them being placed on brain damaging anti-psychotic drugs”
- inaccurate claim that 9/10 young people will be “falsely assessed” and “placed on anti-psychotic drugs”
- misleading implication that EPPIC centres will do “damage to a young person’s self concept”
- misleading claim that “international experts in psychiatry also reject the entire notion and enterprise of early identification and treatment of psychosis as it will produce many more problems (and neurological ill-health) than what it could possibly achieve”
- misleading claim that EPPIC is being funded by cuts to Better Access program
- false claim that I and other colleagues have “vested financial interests” in the advice we provide to Government
- false claim that I and others receive “massive amounts of funding from pharmaceutical companies for endorsing their drug products, as are the organisations they head”
- misleading claim that headspace centres are “advocates of treating young people with anti-depressants drugs”
- inaccurate claim that young people are at “higher risk of suicide as a result of going on antidepressants drugs”
- misleading claim that headspace advocates “the antidepressant drugging of depressed young people – in spite of the evidence”
- false claim that I have “mislead” the Australian Government and “over sold” the values of their programs

On a much more minor point, the submission wrongly titles EPPIC as the “early psychosis identification and intervention centres.”

I have only identified errors that relate to EPPIC, headspace and myself and make no comment about other claims made in the same submission.

3. Corrections

I welcome the opportunity that the Committee has afforded me to correct the inaccurate and misleading information that I have identified in the previous section. I will principally make these corrections by addressing three themes – identification of young people with a significant risk of developing a psychotic disorder, the policy of headspace regarding the use of SSRI anti-depressants to treat depression in young people and my own personal integrity.

3.1 Identification and treatment of young people at significant risk of developing a psychotic disorder

Criteria for the identification of young people at Ultra High Risk (UHR) of developing a psychotic disorder have been developed and validated [1-7]. Combining findings from a range of studies, the average rate of transition to full-threshold psychotic disorder within 12 months has been reported at 36.7% [8], a rate 400 times greater than the expected incidence rate for first-episode psychosis in the general population.

This group of young people typically have significant mental health problems, experiencing symptoms that include depressed mood, anxiety, irritability and aggressive behaviour, suicidal ideation and attempts, and substance use, as well as subtle subjective deficits including cognitive, affective as well as marked social disturbances. They also experience sub-threshold psychotic-like symptoms.

The goals of interventions for this group of young people are to:

- (i) minimise disability and adverse health and social impacts associated with this phase;
- (ii) enable recovery before symptoms and poor functioning become entrenched, and
- (iii) prevent, delay or ameliorate the onset of full-threshold psychotic disorders.

Collective evidence from a range of trials and file audits [9, 4, 5, 10-14, 15-20] indicates that it is possible to reduce symptomatology and delay or even prevent the onset of psychotic disorder in young people who are at ultra-high risk of psychosis.

The Australian Clinical Guidelines for Early Psychosis (to which all new EPPIC services are expected to adhere) specify that the recommended preventative interventions for achieving these goals are Cognitive Behavioural Therapy (CBT) and Omega 3 fatty acids. **These clinical guidelines explicitly prohibit the use of anti-psychotic**

medication as the first line or standard treatment for the UHR group. Recent research conducted by our group and others now supports this guideline.

Although research data have indicated a potential role for anti-psychotics in preventing or delaying transition to psychosis, the potentially serious side effects of these medications argue against their use as a standard treatment for the UHR group. Our guidelines state that only in “exceptional circumstances” (e.g. rapid worsening of psychotic symptoms, together with significant deterioration in functioning related to these symptoms as well as elevated risk to self or others) would a low dose atypical anti-psychotic be considered in conjunction with close monitoring and support and that even then the use of anti-psychotic medication would not be justified in most such situations [21].

One of the benefits of this focus is that the existence of a UHR service means that an additional 10% or more FEP cases are picked up much earlier than otherwise would be the case. Our clinical guidelines are clear that the clinical care needs of young people assessed as meeting UHR criteria must in no way be confounded with those young people with a diagnosis of a first episode of psychosis (FEP). To maintain strong boundaries between treatments for the UHR and FEP groups, Australia’s only current EPPIC service (for which I am clinical director, and which only provides treatment to FEP clients) refers all young people that are identified at assessment phase as meeting UHR criteria to a separate program called PACE.

New EPPIC services should similarly ensure that young people who present for an FEP assessment but are instead identified as at UHR of psychosis are referred to a linked but separate stream of care that is distinct from the FEP program and that is provided in low stigma youth appropriate settings in either EPPIC or headspace. Both EPPIC and headspace are low stigma approaches in contrast to standard adult care settings which are the status quo. The alternative to the EPPIC and UHR strategy essentially is to support high stigma and late intervention services which are manifestly inferior and inadequate least for this purpose. The international data is very clear on this issue.

Young people in the UHR group who despite the interventions offered transition to full-threshold psychosis should be immediately referred to EPPIC’s first episode of psychosis program. Provision of UHR care will thereby enable treatment to be initiated with minimal delay and without the trauma and disruption that is often associated with the onset of acute symptoms, since a therapeutic alliance has already been established between the young person, their carer(s) and the treatment team.

3.2 Policy of headspace regarding the use of SSRI anti-depressants to treat depression in young people

Headspace reviewed the evidence of the effectiveness of SSRI anti-depressants to treat depression in young people (which is generally modest) and concluded:

“Overall, a stepped model approach is recommended for the treatment of depression in young people, whereby clinicians consider commencing treatment with a psychological therapy, such as CBT or IPT. This is especially the case for young people with mild depression. In cases of moderate to severe depression, SSRI medication may be considered within the context of comprehensive management of the patient, which includes regular careful monitoring for the emergence of suicidal ideation or behaviour. Irrespective of the treatment chosen, it is essential that there is close monitoring of the young person’s symptoms, and any side effects if medication is prescribed.” [22]

Additionally, it is not correct to state that anti-depressant medication increases incidences of suicide. The evidence on SSRIs is that they do increase risk of suicidal thoughts, not that they increase the risk of completed suicide.

3.3 Personal integrity

I have no financial interest in any of the recommendations that I have made to Government, nor is my remuneration linked to the amount of Government investment that is secured for these recommendations.

I have always complied with financial disclosure policies in my work. My principal sources of income are my employment by Melbourne Health and the University of Melbourne. I have in the past received payments for consultancy that I have provided to a range of commercial pharmaceutical companies, but these payments currently constitute a minor part of my income. Pharmaceutical funding currently plays a minor role (less than 5%) in funding Orygen Youth Health Research Centre projects – all of which have been designed and conducted independently of pharmaceutical company input, with no restrictions placed on publishing results.

My advocacy has focused on models of care that provide extensive psycho-social supports rather than over reliance on medication. I have not advocated for the PBS listing of any drug. Furthermore, I have always been fully committed to evidence based medicine, and my policy recommendations arise out of both the over 400 papers I have published in peer-reviewed journals and reviews of the wider literature.

In addition to the points addressed above, I will add that linking the funding of EPPIC to cuts to Better Access is clearly misleading. Those cuts were announced in the context of the National Mental Health Reform investment package in its entirety and are not linked specifically to the EPPIC measure.

4. Further information and contact details.

This submission is made on behalf of Orygen Youth Health Research Centre and is authorised by Prof. Patrick McGorry, Executive Director. For further contact: Matthew Hamilton, Senior Policy Adviser, Orygen Youth Health Research Centre. Tel 0401772669. Email hamm@unimelb.edu.au

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