2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
Prof Emeritus Anthony Jorm

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"I have separate comments on each of these areas: 1. Community's understanding of mental illness, and 2. Reduce stigma and discrimination. In relation to the community's understanding, we lack up-to-date data on this. The last national survey of mental health literacy in Australia (including Victoria) was carried out in 2011 (Reavley & Jorm, 2012). In general though, there has been a major improvement in public understanding since the first national survey on this topic in 1995 and it is likely that this has continued. Nevertheless, there are several areas that I think are a priority for improvement. The first is action on prevention. In contrast to the situation with chronic physical diseases, where the members of the public take often action to prevent these diseases in themselves and others (e.g. their children), there is a lack of public action on prevention of mental disorders, even though there is much that can be done, e.g. preventive parental behaviours (Yap et al., 2015) and self-help for mild symptoms of distress (Jorm & Morgan, 2009). The second area is in mental health first aid skills. The first line in early intervention for mental disorders are the family, friends and work colleagues in the affected person's social network. There is evidence that how people with mental health problems are treated by those around them can make a difference to their recovery (Jorm, 2012). We also know that mental health first aid skills can be improved through training (Morgan et al., 2018) and that members of the community who are trained can support that is equal in quality to that of health professionals, e.g. when supporting a person who is suicidal (Jorm et al., 2018). The third priority is in the area of professional help-seeking. We have been spectacularly successful in persuading the community to seek help, with massive increases in use of both pharmacological and psychological treatment services over recent decades. However, the evidence clearly shows that the mental health of the population has not improved despite these increases (Jorm, Patten, Brugha, Mojtabai, 2017). The problem is that much of this treatment does not meet minimal standards of adequacy. To improve this situation requires not only change in what professionals are doing, but also in public understanding of what good quality treatment involves. For example, too many people are receiving a prescription as their only treatment, which is not consistent with clinical practice guidelines. Also, most people receiving psychological treatment receive too few sessions to be effective (Jorm, 2015). This is an area where consumer knowledge and expectations need to be raised. In relation to stigma and discrimination, I have several comments. The first is that the priority needs to be on reducing stigma and discrimination towards people with severe mental illnesses like schizophrenia and borderline personality disorder. The evidence we have from a recent national survey on discrimination shows that the behaviours towards people with common mental disorders, like depression and anxiety disorders, are relatively positive (Reavley & Jorm, 2015). My second point is that the quality of evidence on what interventions reduce stigma and discrimination is poor (Morgan et al., 2018). While quite a bit of research has been done on interventions to change short-term response to attitude questionnaires, very little is known about what produces changes in behaviour (discrimination) and whether any intervention effects persist beyond the short term.

Despite the fact that Reducing stigma and discrimination' is one of the priorities under Australia's Fifth National Mental Health and Suicide Prevention Plan, we lack an adequate evidence base to take any informed action in this area. My final point is that a major barrier to reducing stigma and discrimination towards people with severe mental illness is the association between mental illness and crime. Although this association is often downplayed, there is clear evidence that it exists (Fazel et al., 2009). While most people with severe mental illness and not violent and few people will experience violence at the hands of a mentally ill person, media exposure of these events, which often have a bizarre newsworthy quality, means that they have a disproportionate effect. A recent Victorian example is the Bourke Street murders by a person who the media reported as having a diagnosis of schizophrenia. More work needs to be done to find out how media reporting of such events can be framed so as not to increase belief that mentally ill people are violent (Ross et al., 2019). Australia has national media guidelines and training of journalists on responsible reporting of suicide. This sort of approach needs to be extended to the reporting of crime and mental illness. However, again the research to support this sort of work is lacking. References Fazel S, Gulati G, Linsell L, Geddes JR, Grann M. Schizophrenia and violence: systematic review and meta-analysis, PLoS Med 2009; 6: e1000120. Jorm AF. Mental health literacy: empowering the community to take action for better mental health. Am Psychol 2012; 67: 231-243. Jorm AF. The quality gap in mental health treatment in Australia. Aust NZ J Psychiatry 2015; 49: 934-935. Jorm AF, Morgan AJ. Self-help strategies that are helpful for sub-threshold depression: a Delphi consensus study. J Affect Disord 2009; 115: 196-200. Jorm AF, Nicholas A, Pirkis J, Rossetto A, Reavley NJ. Associations of training to assist a suicidal person with subsequent quality of support: results form a national survey of the Australian public. BMC Psychiatry 2018; 18: 132. Jorm AF, Patten SB, Brugha TS, Mojtabai R. Has increased provision of treatment reduced the prevalence of common mental disorders, Review of evidence from four countries. World Psychiatry 2017; 16: 90-99. Morgan AJ, Reavley NJ, Ross A, Too LS, Jorm AF. Interventions to reduce stigma towards people with severe mental illness: Systematic review and meta-analysis. J Psychiatr Res 2018; 103: 120-133. Morgan AJ, Ross A, Reavley NJ. Systematic review and meta-analysis of Mental Health First Aid training: Effects on knowledge, stigma and helping behaviour. PLoS One 2018; 13: e0197102. Reavley NJ, Jorm AF. Public recognition of mental disorders and beliefs about treatment: changes in Australia over 16 years. Br J Psychiatry 2012; 200:419-425. Reavley NJ, Jorm AF. Experiences of discrimination and positive treatment in people with mental health problems: Findings from an Australian national survey. Aust NZ J Psychiatry 2015; 49: 906-913. Ross AM, Morgan AJ, Jorm AF, Reavley NJ. A systematic review of the impact of media reports of severe mental illness on stigma and discrimination, and interventions that aim to mitigate and adverse impact. Soc Psychiatry Psychiatr Epidemiol 2019; 54: 11-31. Yap MB, Fowler M, Reavley N, Jorm AF. Parenting strategies for reducing the risk of childhood depression and anxiety disorders: A Delphi consensus study. J Affect Disord 2015; 183: 330-338. "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

"Prevention is the area of greatest neglect in the mental health sector, in stark contrast to the situation with chronic physical diseases where there is a better balance between treatment and prevention. I have previously argued that the neglect of prevention is a major reason why the mental health of Australians (including Victorians) has not improved, despite large increases in resources given to treatment (Jorm, 2014). I have cited evidence that prevention is possible, that it makes economic sense, and that there are opportunities for prevention in multiple settings, including families, schools and workplaces. I have argued that this is an area that finds it difficult to compete for resources with the pressing need for services and that we need a specific National

Strategy on the Prevention of Mental Disorders. (In lieu of this, a Victorian Strategy would be a good start!). More recently, I have pointed out that the successful prevention of chronic physical diseases has involved reducing risk factors and that this approach needs to be extended to mental disorders (Jorm & Mulder, 2018). The major risk factors for mental disorders are adverse childhood experiences. These include physical, sexual and emotional abuse, neglect, poverty, loss of a parent, domestic violence, serious physical illness, and exposure to parental mental illness, substance misuse and criminal behaviour. Such adversities are common in the community, they increase risk across virtually all mental disorders (as well as affecting physical health) and they have an impact right across the life span from childhood to old age. While the evidence base on what can be done to reduce adverse childhood experiences is limited, there is evidence for a number of strategies, including strengthening economic supports to families, changing social norms to support parents and positive parenting, providing quality care and education early in life, enhancing parenting skills to promote healthy child development, intervening to lessen harms and prevent future risk, broadening public and professional understanding of the links between adverse childhood experiences and mental disorders, and training clinicians to routinely enquire about childhood experiences to inform treatment and avoid re-traumatization (Jorm & Mulder, 2018). We also need to begin national (and state) tracking of these risk factors, just as we do with physical disease risk factors like smoking and obesity, in order to bring public attention to their importance and to motivate action being taken to reduce them (Jorm, 2019). References Jorm AF. Why hasn't the mental health of Australians improved? The need for a national prevention strategy. Aust NZ J Psychiatry 2014; 48: 795-801. Jorm AF. The need for national tracking of major risk factors for mental disorders. Aust NZ J Psychiatry 2019, in press. Jorm AF, Mulder RT. Prevention of mental disorders requires action on adverse childhood experiences. Aust NZ J Psychiatry 2018; 52: 316-319. "

What is already working well and what can be done better to prevent suicide?

"Australia has made many efforts to reduce suicide, including having National Plans, increasing the availability of treatment for mental disorders, training of GPs, restricting means, raising public awareness and implementing media reporting guidelines. However, there is no indication that any of this has had any lasting impact. I refer the Commission to a graph I have published showing the suicide rate by year since 1991, with arrows indicating points where various interventions were implemented (Jorm, 2019). Despite these efforts, the current national suicide rate is very close to what it was in the early 1990s. One reason for this lack of impact is that many of the causes of suicide lie outside the domain of the mental health system, such as lack of social connectedness and economic hardship, and also that many people who die by suicide are not in contact with health services in the period preceding their death. Nevertheless, there are things that can be done. Members of a suicidal person's social network may be well placed to detect and act to reduce that person's risk. There are a wide range of actions that members of the public can take to reduce suicidal risk (Bond et al., 2019) and people who are trained in how to respond are more likely to take appropriate action, in particular to talk openly about suicide to a person in distress. In fact, lay people who are trained, for example in Mental Health First Aid, show a quality of support that is at the same level as people with professional training (Jorm et al., 2018). Currently, around 12% of the Australian adults have had some sort of training in how to support a suicidal person, so there is the possibility of considerably increasing public skills in this area. It is also possible to improve the skills of adolescents in supporting a suicidal peer. A randomized controlled trial of teen Mental Health First Aid' training with Victorian teenagers has shown that this training substantially increased supportive intentions to help a suicidal peer (Hart et al., unpublished). References Hart LM, Cropper P, Morgan AJ, Kelly CM, Jorm AF. Teen Mental Health First Aid as

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What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
N/A

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
N/A

What are the needs of family members and carers and what can be done better to support them?
N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"I would like the see the Commission to take a population mental health perspective. This involves thinking about the whole Victorian population, including those who have a mental disorder and are being treated, those who have an untreated mental disorder, those with mental health problems that fall short of a diagnosis, and those in various degrees of good mental health. It also involves thinking beyond mental health services and looking at how we can best help each of these groups, which may involve taking action in areas beyond health services, e.g. education, housing, family support, sport and recreation, and community norms. There is much to be learned from what has occurred with chronic physical diseases, where a population health approach is much stronger than it is with mental disorders."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
"I would like to draw the Royal Commission's attention to my submission to the Productivity

Commission Inquiry on Mental Health (https://www.pc.gov.au/__data/assets/pdf_file/0003/238800/sub045-mental-health.pdf), in particular the section of my submission concerning the evaluation of reforms before roll-out. Although this submission is written from a national perspective, it applies equally to the Victorian state level. I have reproduced the relevant section of the submission below: We Need Better Evaluation of Reforms Before National Rollout Another factor in the lack of progress in reducing prevalence is that mental health reforms are often rolled out nationally in advance of a full evaluation. Proposed reforms may have a sound rationale, but this does not mean that they work in practice. When an evaluation is carried out retrospectively, the reform may be found not to have the expected benefits, but by then it is very difficult to backtrack and explore other alternatives. Two examples of this in Australia are the Medicare Better Access scheme and headspace youth mental health services. The Better Access scheme was devised to provide greater access to GP and psychological services for people with mental disorders. The scheme has proved to be very popular with the Australian public and has cost much more than anticipated. The Australian Government commissioned an independent evaluation which found a number of benefits, but the evaluators were hampered by the inability to get a controlled comparison in a scheme that had been rolled out nationally. When population data on the prevalence of psychological distress were examined many years later, there was no detectable reduction in prevalence despite a massive increase in the use of Better Access services (Jorm, 2018, 2019). Given that the scheme is well established and very popular, it would be very difficult to redirect the resources in alternative ways that might produce greater benefit. Headspace provides early intervention services for youth and has a sound rationale: mental disorders often have first onset during youth, they can have an adverse effect on key developmental outcomes and many young people do not get treatment. Early intervention services would seem to be a good way to reduce the potential lifelong impact of mental disorders. However, when evaluation data became available, the benefits of headspace were found to be modest. A study carried out by headspace staff found that only 36% of headspace clients had significant improvement on symptoms and 37% had significant improvement on functioning, as against 13% and 20% respectively who showed significant deterioration in these areas (Rickwood et al., 2015). It was not clear whether these effects were any more than would occur with spontaneous remission. Subsequently, an independent evaluation commissioned by the Australian Government found that compared to a matched control group receiving no treatment, the effects of headspace were relatively weak (Hifferty et al., 2015). One of the reasons for these weak effects may be that few headspace clients are engaged in treatment beyond the short term, with 45% receiving only 1-2 sessions, which is far below the recommendations of clinical practice guidelines for psychological therapies (Jorm, 2016). Furthermore, headspace services have not fulfilled the aim of early intervention, with services typically received many years after the onset of a mental disorder (Jorm, 2018). Despite these concerning findings, the Australian Government continues to expand headspace services, at the expense of the opportunity to explore alternative approaches to improving youth mental health. What these examples illustrate is the need for a more cautious rollout of proposed reforms. It would have been preferable for Better Access and headspace to be trialed on a smaller regional scale with comparisons made with control regions, before a decision was made on national rollout. What we need is a more experimental approach to social and health policy. This sort of approach has been adopted in Finland where, according to Kangas et al. (2019): The Government also strives to promote a culture of experimentation as a part of representative democracy. The idea is that by trying out different new models for delivering social benefits and services on a small scale it is possible to obtain useful information about the way in which these new models can be implemented nationwide. An excellent example of this is the Finnish basic income experiment in

which a sample of citizens who were unemployed were randomly assigned to receive either a basic income or the current unemployment benefits. While the primary purpose of this experiment was to investigate the effects on employment and income, it is also notable that several indicators of mental health and well-being were also included as secondary outcomes. The experiment has not been completed, but the preliminary results show that the basic income group had higher scores on a number of the mental health and well-being indicators (Kangas et al., 2019). This is the type of experimental approach that Australia needs to adopt if it is to get effective social and health policy. A notable exception to the roll it out first, evaluate later' approach are the regional trials currently underway on suicide prevention, including the National Suicide Prevention Trial, the LifeSpan study by the Black Dog Institute and the Victorian Government place-based trials. This sort of experimental approach in a number of small localities with appropriate controls needs to be the standard for the future. Recommendation: Australia needs to adopt a more cautious experimental approach to mental health reform, with controlled trials in local areas carried out before any national rollout. "

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What is already working well and what can be done better to prevent suicide?
N/A

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What are the needs of family members and carers and what can be done better to support them?
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What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"I would like to draw the Royal Commission's attention to an article I have written on The case for fuzzy age boundaries in mental health services. I have attached a copy. To summarize, this article argues that while there are benefits to having age-focused services (e.g. for children and

adolescents, youth, adults and older persons), having rigid age criteria for use of these services is not in the best interests of patients. I propose instead that we have age-focused services with fuzzy', rather than rigid, age boundaries. This would allow, for example, a 19 year old to access a child and adolescent service or a 26 year old to access a youth service. The advantages are: (1) It overcomes the discrimination by age and gender that is inherent in early intervention services; (2) It recognizes that chronological age is an imperfect indicator of developmental stage; (3) It allows patients to stay with a service where they have an established relationship rather than being forced to move to another service because they cross an arbitrary age threshold; and (4) It allows patients to seek services that best suit their needs, irrespective of their age."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

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N/A

figures of 20th century poetry who had severe bipolar I disorder with multiple hospitalizations for psychotic mania (and multiple courses of electroconvulsive therapy (ECT) to treat his manias in the pre-lithium era). In the recent biography of Lowell, highlighting the complex interactions between his poetry and his bipolar disorder, Jamison (2017) describes some of Lowell's childhood traits-long before his first manic episode—as thuggish, restless, wild, brash, irritable, and contrary. In today's world, he might be described as having had oppositional defiant disorder (ODD). It is hard not to believe that his childhood mood dysregulation was unrelated to his later bipolar disorder. Yet equally clearly, these same traits are seen in the majority of ODD children who do not grow up to be bipolar.

Thus, for now, the predictors described in the paper by Pfennig et al. should be considered generic markers of psychopathology rather than specific antecedents of bipolar disorder.

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See Review by Pfennig et al., (2017) 51: 509–523.

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The case for fuzzy age boundaries in mental health services

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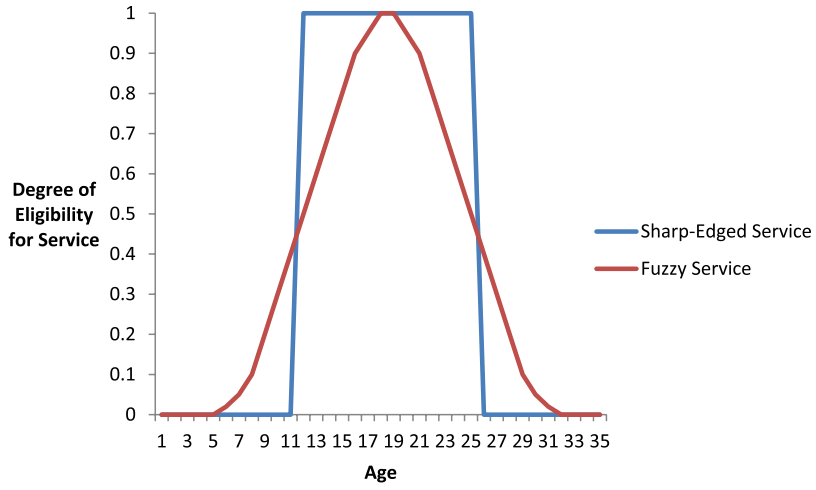
In a recent issue of the journal, Lappin et al. (2016) presented data on a 10-year follow-up of a cohort of first-episode psychosis patients. This cohort was from the United Kingdom in an era before the establishment of early intervention for psychosis services. They found that 58% of men and 71% of women had their first episode beyond the age of 25 years, which is the typical upper age limit for early intervention services in Australia. Similarly, 21% of men and 34% of women were outside the upper age limit of 35 years used by United Kingdom early intervention services. Lappin et al. (2016) concluded that current early intervention services are 'gender- and age-inequitable' and argued for the extension of early intervention services to first-episode patients of any age, not just youth.

McGorry (2016) responded to this article by arguing for the benefits of youth-specific early intervention services, including transdiagnostic services that recognize the arbitrary boundaries of emerging mental disorders in youth, coupled with specialized services for young people with psychosis and other more severe mental disorders. To support people with older onsets of psychosis, McGorry argued for the creation of a separate '*stream of care for genuine new onsets over 25 alongside people of the same age with illnesses whose onset was earlier but which have persisted or recurred*'. While essentially supporting the status quo in Australia, McGorry did concede that perhaps the upper age boundary could be increased to 'closer to 30' and that the age boundaries should be 'porous and fluid'.

Here, I propose an approach to age-entry criteria for mental health services that has the potential to overcome the inequities of fixed age limits, yet allows a specialization on a particular developmental period of life. The proposal involves what I will call 'fuzzy' age boundaries. The term 'fuzzy' comes from a concept in mathematics called a 'fuzzy set'. A traditional set is one with sharply defined boundaries, such as the set of people who are 'teenagers'. Any person who is aged 13–19 years is in the set and all others are out. A fuzzy set is one that has grades of membership rather than clear in-or-out membership. An example would be the set of people who are 'young'. A 10-year-old would be clearly in, a 30-year-old less so and a 60-year-old not at all.

Figure 1 represents how the concept would apply to age boundaries of a youth mental health service. It shows on a 0–1 scale how eligibility for a service of a person with a mental disorder varies by age. In a traditional youth service, there are sharp-edged age boundaries, whereas in the fuzzy service, there is a focus of specialization on a particular age group, but no sharp

Figure 1. Illustration of sharp-edged versus fuzzy age boundaries to a youth mental health service.



age-eligibility boundaries. People with mental disorders of any age would be eligible, but in practice, most would come from a limited age range. Similar fuzzy age boundaries could apply to child and adolescent services and to older person services.

Below are the advantages of a fuzzy service over a traditional sharp-edged one:

1. It overcomes the age- and gender-inequities noted by Lappin et al. (2016), while still allowing for developmental specialization.
2. It allows for the fact that chronological age is an imperfect indicator of developmental stage. For example, a mature 17-year-old may be suited to an adult service, while a less-mature young adult dependent on parental support might be better served by an adolescent service.
3. It allows patients with an established relationship with a particular service to stay with that service even if they cross an arbitrary upper age boundary. A person who has an episode that crosses an age boundary or who needs on-going support is unlikely to be helped by a forced move based on age criteria alone.
4. It allows patients to seek out services that best support their needs, irrespective of age. For example, a person with an early-onset dementia accompanied by behaviour problems may be best helped by an older person service, while a young adult with attention deficit hyperactivity disorder (ADHD) might find more specialized help in an adolescent service.

Could this work in practice? In fact, it already does. Australia has a dual system of private practice and public mental health services. The private practice system is already fuzzy, in that practitioners can have areas of developmental specialization, but are not rigidly constrained by specific age limits. It is only the public system that is sharp-edged.

Under a fuzzy system, there might be greater competition between services with overlapping developmental targets and a change in demand from some services to others. Obviously, funding would need to follow the patients. If the greater competition resulted in improved patient services, this would be an important bonus of a fuzzy system.

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