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

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N/A

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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"The stigma is perpetuated by two key systems: 1) media - language use which is stigmatizing (e.g., schizophrenic) and blaming, such as linking of violence and crime to mental illness in simplified ways which does not get at the complexity of the issues. There needs to be tightened regulations around media reporting and the fact that mental health services are not meeting the needs of people within the messaging. 2) services and research funding are not fairly distributed based on need - I see 'physical' health conditions such as cancer receiving disproportionately larger funding and world-class health services, when the need is much greater for mental health. The stigma is top-down and until the Government leads by showing parity and fairness, the people with mental illness will feel stigmatized. Until the message that mental health IS health, then we are never going to reduce stigma."

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?
"It's hard to tell because the system is so fragmented. I think people who have money are able to access good care privately. I also believe mental health service providers in the public system are extremely dedicated and highly skilled, but due to significant resource constraints and stressful working conditions (due to demand and client complexity being much greater than what they are able to meet) that they cannot provide evidence-based world class treatment. This results in staff burnout, staff turnover and sub-optimal care for service users. headspace is a great model, but even it cannot meet the need and complexity. Many young people fall through the gaps because they are either too unwell for headspace or not unwell enough for the tertiary mental health services. Pressure is placed on emergency departments which are not well equipped for mental health crises."

What is already working well and what can be done better to prevent suicide?
"Detection of suicide risk needs to be happening at front-line services, including primary care and emergency departments, but also in schools. Risk of suicide is also increased post hospital discharge so there needs to be increased resourcing for aftercare support. "

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.
"Social determinants are a HUGE factor and too many to name, but include poverty, inter-generational trauma, being minority, unemployment, poor education. Prevention and early intervention is key. Schools need to be much better supported to provide programs for supporting student mental health and to assess and intervene early when problems arise. The mental health service system needs to be better integrated - at present it is too fragmented. A streamlined

referral system, such as a single state-wide triage service is needed to help people navigate help-seeking. There are examples of this overseas (e.g., NYC Well). Also see ACCESS Open Minds in Canada, which involves service users in the process of research and improving mental health services across Canada. Multi-disciplinary approach to care, such that individuals receive tailored care to meet need - e.g., social work, psychiatrist, OT, clinical psychologist, clinical neuropsychologist, drug and alcohol worker, vocational support, etc. All mental health services should have the best available interventions ranging from medication, exercise, cognitive rehabilitation, speech therapy, psychosocial programs, vocational (education and employment) services, and so on."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"Rural and remote communities have poorer access simply because there are fewer services and health professionals tend to be more generalist rather than expert in a particular domain. Increased access through tele-health may help as well as government funding to cover travel when distance and financial hardship is an issue. Poverty, social disadvantage, minority status, poor education, exposure to trauma are all determinants of poor mental health. Even things like a higher proportion of fast food chains and poker machine venues in outer suburban areas and less access to high quality fresh produce, bike paths, recreational facilities can impact mental health. Green space is really important too. "

What are the needs of family members and carers and what can be done better to support them?
Inclusive mental health care practices that always seek to involve family and caregivers whenever possible. Respite for family and caregivers.

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"Salary bonuses or attractive re-location packages for psychiatrists, psychologists, etc. who choose to work in rural and remote communities. Staff turnover or leaving often occurs due to burnout, which is associated with having a highly stressful and demanding job. Staff-to-service user ratios need to be much higher (in inpatient, residential and outpatient settings) - services need to be better resourced to meet the demand so that the mental health work force can do their job properly and happily without undue stress. Much more research into the best way to incorporate peer support workers into the mental health system is needed as we still do not know what is the best way to incorporate peer support effectively and in a way that benefits both service users and peer supporters."

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?
"Evidenced based supported employment and education needs to be a core part of EVERY public mental health service. However, we need workforce development to be able to deliver this also. The evidence suggests this is much more effective than disability employment services because it is INTEGRATED within the mental health system. "

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?
"A streamlined pathway to care and integration of services, rather than the fragmented system that exists presently. More research funding to inform best systems of care."

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"Routine data collection, including key outcome data that is identical across services, centralized/integrated and harmonized."

Is there anything else you would like to share with the Royal Commission?
"I am a clinical neuropsychologist with expertise in youth mental health, so would like to argue the case for increased access to clinical neuropsychological services, both assessment and intervention within the mental health system. A major stream of my research has focused on establishing empirical evidence for the value and need of neuropsychological services within the youth mental health sector, particularly within Australia [1-5]. I strongly argue for the inclusion of clinical neuropsychological assessment, report writing and feedback within the Medicare Benefits Schedule (MBS) and more broadly within mental health services. Mental illness is the greatest health issue facing young people in Australia and globally, responsible for 45% of the overall disease burden in those aged 10-24 years [6]. In a 12-month period, 25% of Australians under the age of 25 experience mental ill health, compared to 20% of the general population [7]. Australians aged 16-25 years seeking help for mental health problems are almost twice as likely to be Not in Education, Employment or Training' as peers in the general population [8]. This places them at high risk of never entering the labour market and, instead, of moving onto disability benefits early [9]. In people aged 16-34, almost 50% of new granted disability benefit claims are due to mental illness [10]. The economic ramifications are huge, with the cost of youth mental illness to Australia's economy estimated to be up to $10 billion per year [11, 12]. These costs include direct health care service use, productivity losses, imprisonment and premature mortality. If not properly assessed and treated early, mental health disorders endure and are associated with lower levels of education, workforce participation, income and living standards later in life [13, 14]. Comprehensive meta-analyses show that significant neuropsychological impairments (e.g., in concentration, learning, memory, thinking speed, problem solving) emerge early in the course of mental illnesses, including psychosis [15], bipolar disorder [16], eating disorders [17] and depression [18]. Impairments are also present in young people seeking help for mental ill health who do not meet full diagnostic criteria for mental disorder [19-21]. The average cognitive performance of Australians aged 18-30 presenting for mental health treatment is significantly lower than healthy peers [20]. Cognitive impairment often persists, even with improvements in mental health [22, 23]. Neuropsychological impairment is also a core stable symptom of pervasive neurodevelopmental disorders; disorders that emerge during childhood, including intellectual disability, communication disorders, autism spectrum disorder, attention-deficit/hyperactivity disorder, and specific learning disorders [24]. Neurodevelopmental disorders are more common in youth with mental illness than the general population [24-26]. Neurodevelopmental disorders pose an increased challenge to correct diagnosis and effective treatment [26]. We have found that youth referred for neuropsychological assessment with both mental illness and a history of developmental delays and learning difficulties were the most complex cases in the mental health service [27]. Unsurprisingly then, holistic and timely assessment is viewed as an important and potentially cost-effective attribute of youth mental health services [28]. Neuropsychological assessment is internationally recognised as important to youth mental health care [29].

Neuropsychological assessment is the most comprehensive and reliable means to assess cognitive functioning in individuals [30-33]. In young people, in addition to comprehensively assessing cognitive domains, neuropsychological assessment often includes academic achievement and behaviour testing, to diagnose neurodevelopmental disorders and help understand current school functioning, tertiary study and employment capacity. In their Review of Mental Health Programs and Services, Australia's National Mental Health Commission identified a specific gap in clinical neuropsychology service provision. Accordingly, they recommended that neuropsychological assessment should be included in the MBS as part of the Better Access to Mental Health Care initiative [9]. Currently, however, neuropsychological assessment is not routinely available in public mental health services [4, 5], nor through the MBS. While the frequency and uptake of private referrals for young people with mental ill health is unknown, it is suspected to be low given the high cost of private neuropsychological assessment [34, 35] and minimal reimbursement through private health insurance. Our research and the work of others internationally has consistently shown that clinical neuropsychological assessment yields rich information, including: (1) describing the presence and nature of cognitive impairments and strengths; (2) confirming, refuting or modifying diagnoses; (3) identifying treatment needs and guiding therapeutic approaches; and (4) monitoring treatment effects and changes in functioning over time [1, 3, 4, 30, 36]. To facilitate clinical practice and client outcomes, a written report and verbal feedback is standard practice [2, 36, 37], and thus, should also be included within neuropsychological service provision. headspace was established in 2006 and is Australia's federally-funded primary care service that provides early intervention and integrated support to people aged 12-25 years with mental health concerns [38, 39]. The headspace Youth Early Psychosis Programs (hYEPP) were established in 2014 and offer specialist early intervention to 12-25 year-olds experiencing or identified as being at risk of psychosis [40]. headspace aims to address the concerning mismatch between level of need and amount of mental health service use among adolescents and young adults. The headspace model of care is predicated on early and easy to access stepped-mental health care that effectively addresses the presenting concerns and needs of young people seeking help for mental health care. Our recently published nationwide survey of 532 headspace service providers [5], found that neuropsychological assessment was believed to be beneficial for 35% of headspace clients on average, but 86% of service providers reported that neuropsychological assessment was unavailable. Only 12% of clients were estimated to have received a neuropsychological assessment when it was needed. On average, 36% of headspace clients were estimated to present with cognitive impairment and 38% were described as diagnostically complex (e.g., comorbid medical, developmental, substance use, trauma presentations). A mean of 27% were described as having a suspected or diagnosed developmental condition (e.g., Intellectual Disability, Learning Disorder, Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder). Thus, we found a critical unmet need for neuropsychological assessment in Australia's primary youth mental health care system. Our research also suggests that this substantial gap in neuropsychological services extends to secondary youth mental health care (e.g., child and adolescent/youth mental health services) in Australia [4]. Thematic analysis of qualitative data from our survey (under review for publication) indicated that the most prominent theme in relation to neuropsychology was barriers in access to neuropsychological assessments', with by far the greatest barrier being high cost (e.g., Most significant barrier I have found for families and youth is cost. They are only able to access these privately and these [are] costly; Cost and wait times are the biggest issues. Whilst the universities offer cognitive assessments for a lower rate, the time between referring and obtaining results can be greater than 6 months). headspace clinicians estimated that they would refer approximately 4 clients per month for neuropsychological assessment if it was available freely or under the

Medicare Benefits Schedule [5]. Our findings strongly support the recognised lack of access to neuropsychological assessment for Australian youth seeking help for mental health care. There are now well over 100 headspace centres Australia-wide, with 115,000 adolescents and young adults visiting a headspace centre or using its online and telephone services between July 2016 and June 2017 [41]. Yet, only 12% of young people in need of neuropsychological assessment can access it. This suggests that a significant proportion of Australian youth presenting for mental health care are at risk of having a delayed or incorrect diagnosis and receiving suboptimal or inappropriate treatment. Cognitive impairments and neurodevelopmental difficulties affect one's functioning and health, and unless treated early impede the chances of a full functional recovery. Ultimately, this reduces productivity and causes a substantial economic burden [6]. Given this, it appears crucial to increase the availability of neuropsychological assessment and intervention for youth seeking mental health care through direct funding. References 1.Proffitt TM, Brewer WJ, Parrish EM, McGorry PD, Allott KA: Reasons for Referral and Findings of Clinical Neuropsychological Assessment in Youth with Mental Illness: A Clinical File Audit. Applied Neuropsychology: Child. 2018;7(2):164-174. 2.Allott K, Brewer W, McGorry PD, Proffitt TM: Referrers' perceived utility and outcomes of clinical neuropsychological assessment in an adolescent and young adult public mental health service. Australian Psychologist. 2011;46:15-24. 3.Allott K, Proffitt T-M, McGorry PD, Pantelis C, Wood SJ, Cumner M et al.: Clinical neuropsychology within adolescent and young-adult psychiatry: Conceptualizing theory and practice. Applied Neuropsychology: Child. 2013;2(1):47-63. 4.Fisher CA, Hetrick SE, Merrett Z, Parrish EM, Allott K: Neuropsychology and Youth Mental Health in Victoria: The Results of a Clinical Service Audit. Australian Psychologist. 2017;52(6):453-460. 5.Allott K, van-der-EL K, Bryce S, Hamilton M, Adams S, Burgat L et al.: Need for clinical neuropsychological assessment in headspace youth mental health services: A national survey of providers. Australian Journal of Psychology. 2018. 6.Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C et al.: Global burden of disease in young people aged 10-24 years: a systematic analysis. Lancet. 2011;377(9783):2093-2102. 7.Slade T, Johnston A, Teesson M, Whiteford H, Burgess P, Pirkis J et al.: The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. In. Canberra: Department of Health and Ageing; 2009. 8.O'Dea B, Glozier N, Purcell R, McGorry PD, Scott J, Feilds KL et al.: A cross-sectional exploration of the clinical characteristics of disengaged (NEET) young people in primary mental healthcare. BMJ open. 2014;4(12):e006378. 9.National Mental Health Commission: The National Review of Mental Health Programmes and Services. In. Sydney: National Mental Health Commission; 2014. 10.OECD: Mental Health and Work: Australia. Paris: OECD Publishing; 2015. 11.Access Economics: The economic impact of youth mental illness and the cost effectiveness of early intervention. In. Melbourne: Access Economics Pty Limited; 2009. 12.Hosie A, Vogl G, Carden J, Hoddinott J, Lim S: A WAY FORWARD: Equipping Australia's Mental Health System for the Next Generation. In. Australia: ReachOut Australia; 2015. 13.Patton GC, Coffey C, Romaniuk H, Mackinnon A, Carlin JB, Degenhardt L et al.: The prognosis of common mental disorders in adolescents: a 14-year prospective cohort study. Lancet. 2014;383(9926):1404-1411. 14.Gibb SJ, Fergusson DM, Horwood LJ: Burden of psychiatric disorder in young adulthood and life outcomes at age 30. British Journal of Psychiatry. 2010;197(2):122-127. 15.Mesholam-Gately R, Giuliano AJ, Faraone SV, Goff KP, Seidman LJ: Neurocognition in first-episode schizophrenia: A meta-analytic review. Neuropsychology. 2009;23(3):315-336. 16.Lee RS, Hermens DF, Scott J, Redoblado-Hodge MA, Naismith SL, Lagopoulos J et al.: A meta-analysis of neuropsychological functioning in first-episode bipolar disorders. Journal of Psychiatric Research. 2014;57:1-11. 17.Zakzanis KK, Campbell Z, Polsinelli A: Quantitative evidence for distinct cognitive impairment in anorexia nervosa and bulimia nervosa. Journal of Neuropsychology. 2010;4(Pt 1):89-106.

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