Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

2. 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?

Unlike cardiology, oncology and many other medical specialties, which provide and fund services on the basis of demand based funding, mental health is supply limited. Consequently, budgets for services are provided that are considerably below community demand. Public providers are forced to triage patients, increasingly based on risk rather than acuity or treatability. The public mental health system in Victoria therefore only provides treatment for a relatively restricted population of patients. Due to resourcing issues, treatment is predominately provided to patients with psychotic disorders such as schizophrenia along with only the most severely unwell patients with mood disorders, personality disorders or other conditions. Such treatment is largely crisis based, and chronic illness management is not provided, on the assumption that other sectors will provide these.

There are consequently extremely limited programs and services available for the vast majority of patients with high prevalence disorders such as major depression and severe anxiety or other severely disabling disorders such as obsessive compulsive disorder.

There is a gross disparity between the treatment available to patients with these disorders who have private health insurance and those who don't. Patients with private health insurance can access a broad range of services through private hospital providers including:

- intensive inpatient treatment,
- inpatient and outpatient electroconvulsive therapy (ECT),
- a broad range of inpatient and day patient therapy programs, including a range of psychotherapies and
- treatment with transcranial magnetic stimulation, a proven and increasingly used treatment for major depressive disorder.

There is extremely limited access to any of these therapies, other than ECT, in the public system. Even where ECT is provided within the public system, often the methods of administration used ensure that it is provided in the most rapidly effective way to limit bed stays but this can be

associated with a significantly higher rate of cognitive side-effects. Patients with insurance to access ECT with in the private sector are much more likely to receive ECT in a manner that may take longer to work but has a significantly lower rate of memory and cognitive side-effects.

Psychotherapies, cognitive behaviour therapy, mindfulness, social skills training and cognitive remediation therapy have proven efficacy especially when tailored to an individual's needs. Such therapies have been shown to improve the long-term outcomes, particularly psycho-social functioning. These treatments are rarely available in the public mental health system despite the current evidence-base.

In regards to transcranial magnetic stimulation, this is not provided at all on a therapeutic basis within the public sector. It is available widely through private hospitals and private providers on both an inpatient outpatient basis. This is a treatment that has a substantial evidence base for its efficacy and is now used widely around the world as an alternative treatment for patients with depression.

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

It is a well-established fact that the most effective suicide prevention strategy is effective treatment. The majority of individuals who successfully complete suicide have a significant mental illness at the time of their death. In many cases this is treated or untreated major depressive disorder. There has been a considerable emphasis in recent years on suicide prevention programs which treat suicide as a specific act that can be prevented or managed in isolation from understanding and treating the underlying mental health condition.

In reality, one of the primary and unrecognised problems we have with preventing suicide is the inadequacies of current treatments for significant mental health problems such as depression. Current first-line treatment for depression is cognitive behavioural therapy and antidepressant medications, predominately medications from the selective serotonin reuptake inhibitor group such as Prozac. Systematic research has demonstrated that at least 30% of patients will fail to respond to even the best evidence-based treatment protocols administering antidepressant treatments across a range of different classes. In clinical practice, there is even a much more restricted range of medications used and it is likely that the real-world outcomes are even worse than the 70% responses seen in clinical studies.

There is a large proportion of patients with depression who are really not helped in any way by existing therapies. This is compounded by the existence of a considerable proportion of patients who are just not able to tolerate antidepressant medications due to side-effects such as sexual dysfunction and a blunting of their emotional experience when taking these medications long-term.

Improving the treatment of depression requires investment in both research and the clinical provision of novel treatments such as transcranial magnetic stimulation which has been demonstrated to be an effective antidepressant treatment for a significant proportion of patients who otherwise fail to respond to medication interventions. We need a broader based research approach to address treatment resistance and develop better therapeutics to ensure a much broader range of patients recover from disabling mental health problems.

Individuals with Anorexia Nervosa have the highest mortality and morbidity of any mental health disorder, a substantial proportion of patients with this disorder committing suicide. A complex and multifactorial model of predisposing influences are believed to be behind the high suicide rate in Anorexia. A factor that cannot be ignored, however, is the paucity of understanding of this

condition in terms of a comprehensive biopsychosocial model. With our understanding of Anorexia falling significantly behind other mental health conditions. Substantial basic and clinical research is needed to untangle the puzzle that is Anorexia to ultimately develop an improved understanding and better interventions.

Mental health problems are chromic, and demand chronic illness management strategies to optimize outcomes and prevent relapse. Crisis based management models that do not have the resources to provide such ongoing care end up driving recurrence and crisis based hospital care that is the most expensive and inefficient mode of care.

The current triage system excludes most people with highly treatable disorders such as bipolar disorder, OCD, panic disorder and other high prevalence disorders.

4. 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.

There is a fundamental issue in the treatment of mental health disorders with the development of new and effective therapies. We have a variety of service level treatment delivery issues but fundamentally the treatments we have currently available are only of limited effectiveness when provided in either clinical trial form or within the real world.

For example, approximately one third of patients with schizophrenia fail to respond to the broad range of medications currently available for that disorder. At least 20 to 30% of patients with depression also fail to respond to standard medication treatments and psychotherapy. At least 50% of patients with Anorexia fail to respond to current interventions. There are a variety of research groups working to try and help develop novel treatments for mental health conditions in Victoria but there is a substantial lack of support for research into therapeutic innovation within the local mental health system.

A substantial reinvestment into therapeutic innovation and research is required to try and improve the outcomes of patients with mental health conditions going forward. We need to do this for several critical and interrelated reasons:

- We directly need to increase the innovation and research conducted to try and improve treatments to improve the mental health of patients currently within the system and who will access the system in the future. Early identification of mental illness and intervention is only of value if we are able to intervene with effective therapies and for many patients this is just not the case.

- The development of an innovation lead and academically integrated mental health system will help address issues around staff retention and recruitment. Currently there is substantial problems with burnout of clinicians within the public health system as they are treating extremely unwell patients and often see very little change or scope for future service development. The integration of research into clinical practice has the capacity to up skill a wide range of staff as well as provide motivation and incentive to remain working within the public mental health system. The development of academic leadership positions in mental services has been used locally in the past and widely internationally to develop an innovation focused and motivated mental health workforce that is now very much not the case in most services in Victoria.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
6. What are the needs of family members and carers and what can be done better to support them?

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?
8. 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?
9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

11. Is there anything else you would like to share with the Royal Commission?

Neurosciences Victoria Limited (NSV) is at the forefront of the neuroscience and mental health research ecosystem. Its mission is to drive collaborative research into neurological and mental illnesses and translate research into patient and health outcomes.

NSV has leading Victorian medical research organisations, all conducting invaluable research into mental illnesses, as its members. These include, University of Melbourne, Monash University, The Florey Institute of Neuroscience and Mental Health, Melbourne Health, Austin Health, Bionics Institute, Swinburne University of Technology, La Trobe University and Deakin University.

NSV has a well-established and respected Science Council made up of leading mental health and neuroscience experts, such as neurologists, neuroscientists, psychologists and psychiatrists, which set scientific priority research areas and provide guidance on areas of scientific strategic direction to the NSV Board. Mental Health is a strategic priority area for NSV and NSV has established a Mental Health Working Group to focus on key areas of need in mental health in Victoria. The Mental Health working group has taken the lead in developing responses to questions in this submission.

The Mental Health working group of the NSV Science Council, recommends that the Mental Health Royal Commission implement the following:

a. A fund for mental health research. This should be explicitly focussed on the development and testing of improved and novel interventions, which will ultimately inform mental health services.
b. The establishment of a Mental Health Clinical Trials Network.

These are key areas of need in mental health research. In the past, NSV has been involved in administering funds for mental illness research - Mental Illness Research Fund (MIRF) on behalf of the Victorian Government and would be delighted to discuss any or all the answers and recommendations raised in this submission further with the Mental Health Royal Commission.

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