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

Organisation Name
N/A

Name
Miss Christen Velevski

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Make information about mental illness and comorbid disorders/illnesses (i.e. Migraine) more accessible, in order for people to understand how such disorders may cause mental illness or vice versa. "

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?
"The stigma around mental illness is beginning to become less negative as there are many mental health services that are readily available to individuals who require them. I also think that individuals with illnesses that may be risk factors for mental illness (i.e. Migraine) should be required to have free, regular mental health checks provided by a psychologist in order to identify/prevent any possible mental illnesses in the early stages. "

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

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?
N/A

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?
N/A

Recommendations Regarding the Provision of Services for Individuals Affected by Migraine

Christen Velevski

La Trobe University

Bundoora

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Recommendations Regarding the Provision of Services for Individuals Affected by Migraine

Migraine negatively impacts on the mental health of individuals suffering from it, as well as impacting on their families and communities. Migraine currently affects 4.9 million people in Australia (Deloitte Access Economics, 2018), it is a debilitating headache disorder, characterised by recurrent attacks lasting between 4-72 hours (The International Classification of Headache Disorders, 3rd edition (beta version), (ICHD-3), 2013). During migraine, individuals experience moderate or severe pain, unilateral location and pulsating quality, along with nausea, vomiting, photophobia and phonophobia (ICHD-3, 2013). This is known as migraine without aura. Migraine with aura is a migraine in which individuals experience additional sensory disturbances (ICHD-3, 2013). Chronic migraine is characterized by headache occurring on more than 15 days in a month, for three months (ICHD-3, 2013). There is extensive evidence to suggest that migraine negatively impacts mental health and is comorbid with depression and anxiety. Depression is characterised by a low mood, loss in pleasure and usual interests and an overall lack of energy (Breedlove & Watson, 2017). Anxiety causes fear, worry and panic in an individual, even when it is unwarranted (Craske & Stein, 2016). This policy document will outline the relationship between migraine and both depression and anxiety, current treatment and management options, as well as long term recommendations. This will be done to justify why migraine should be considered by the current Victorian Government Royal Commission into Mental Health.

Effects of Migraine

Studies show that there is a strong, bidirectional relationship between migraine and psychiatric disorders such as depression and anxiety (Baskin & Smitherman, 2009). Studies suggest that serotonergic (5-HT) dysfunction is the neurochemical mechanism responsible for

the comorbidity of migraine with these disorders (Smitherman, Rains & Penzien, 2009). During migraine attacks, there is an increase in concentration of 5-HT, and a decrease between attacks (Smitherman, Rains & Penzien, 2009). This altered serotonin concentration suggests that migraine is a result of reduced serotonergic transmission that originates from the brainstem raphe nucleus (Smitherman, Rains & Penzien, 2009). This serotonergic dysfunction may lead to an increase of cortical spreading depression (CSD). CSD then increases trigeminovascular pain pathway sensitivity, producing the pain experienced in migraine (Smitherman, Rains & Penzien, 2009).

Depression and anxiety have also been historically linked to serotonergic dysfunction (Smitherman, Rains & Penzien, 2009). The high level of comorbidity between migraine and both depression and anxiety is thought to be due to the fact that all of these disorders are characterised by serotonergic dysfunction (Smitherman, Rains & Penzien, 2009). The comorbidity of migraine with psychiatric disorders can have detrimental effects on an individual's life and mental health. It has been shown that individuals who suffer from both migraine and depression have higher suicide and attempted suicide rates than those with depression alone (Breslau, Davis & Andreski, 1991). Anxiety in those with migraine impacts on their satisfaction and perceived efficacy of treatment (Lantéri-Minet, Radat, Chautard & Lucas, 2005) and also acts as a risk factor for depression (Breslau, Davis & Andreski, 1991).

There are a multitude of societal effects of migraine. Migraineurs are more likely to be unemployed (Blumenfeld et al., 2010), due to frequent absence from work or difficulty in finding a job (Deloitte Access Economics, 2018). Migraine also impacts on an individual's ability to carry out day-to-day tasks such as household work, exercise, social and educational responsibilities (Blumenfeld et al., 2010). The disability caused by migraine not only affects the

migraineur, but also their friends and family (Deloitte Access Economics, 2018), as they may have to provide informal care for the sufferer, which can place a burden on their own well being as it may affect their ability to carry out their own duties (Deloitte Access Economics, 2018). Migraine has also shown to have a significant impact on the broader community with the total economic costs of migraine in 2018 being an estimated total of $35.7 billion (Deloitte Access Economics, 2018). The effects of migraine are harmful to the migraineur, their family and friends and the wider community, which highlights the need for the addition of migraine to the issues that out health system should be accommodating.

Management and Treatment

There are a variety of both pharmacological (Snow, Weiss, Wall &Mottur-Pilson, 2002) and psychological (Holroyd & Drew, 2006) treatments available for the short-term management of migraine. Triptans, also known as serotonin agonists, are one of the most common pharmacological treatments used in the management of migraines (Snow, Weiss, Wall &Mottur-Pilson, 2002). In several studies, triptans are shown to have reduced moderate or severe migraine headache to mild or no headache after only two hours (Loder, 2010). Research from Ferrari, Roon, Lipton and Goadsby (2001) supports the efficacy of triptans in the treatment of migraine, they found that all seven of the different types of triptans were effective in the reduction of migraine headache pain. However, triptans are not reported to have an effect on depression and anxiety.

One of the most common forms of psychological treatment in migraine is behavioural interventions. The types of behavioural interventions commonly used in the treatment of migraine are relaxation training and cognitive-behavioural therapy (CBT). Relaxation training is

used to increase the amount of control an individual has over physiological responses related to headache through muscle relaxation, breathing techniques and relaxation imagery (Andrasik, Buse & Grazzi , 2009). CBT is used to assist patients in recognizing their thoughts and behaviours that may be counterproductive in the treatment of and recovery from migraine, which may be causing stress-related headaches or stress in general (Holroyd & Drew, 2006). A multitude of studies support the efficacy of these psychological treatments for the management of migraine (Blanchard,1992).

Behavioural interventions such as CBT are also commonly used in treating depression and anxiety. A study conducted by Oei and McAlinden (2014), as well as other research (Blanchard, 1992), found that CBT significantly improved overall quality of life in patients and decreased both depression and anxiety symptoms. This provides evidence to suggest that behavioural intervention such as CBT can simultaneously address migraine and its comorbid psychiatric disorders.

Long-Term Actions & Recommendations

When considering the long-term treatment of migraine, it is important to also consider the simultaneous treatment of the comorbid psychiatric conditions. Studies have shown that there is a very strong, bidirectional relationship between migraine and both anxiety and depression (Baskin & Smitherman, 2009). Therefore, it is important that all of these issues are addressed simultaneously in long-term treatment in order to avoid relapse and prevent future migraine headaches.

Education is an important aspect of treatment and management of migraine (Andrasik, Buse & Grazzi, 2009). Patient education is important, as the migraineur is the person ultimately making decisions about when and how to treat attacks and which attacks need treating (Rains, Penzien & Lipchik, 2006). Cady, Farmer, Beach and Tarrasch (2008) found that patients felt an increase in confidence to manage migraine after being educated on it. Additionally, Rothrock et al. (2006) found that migraineurs who received education on migraine experienced a reduction in frequency and severity of migraine headache. Many studies have also shown that patient education improves comorbid conditions such as depression, anxiety and increases quality of life (Andrasik, Buse & Grazzi, 2009). Studies suggest that the use of patient education, paired with behavioural therapies such as CBT are extremely effective in the treatment of migraine and its comorbid diseases of depression and anxiety, as well as preventing relapse (Andrasik, Buse & Grazzi, 2009). Considering the high prevalence of migraine, education on the disorder should also be readily available at a community level. This will allow people to identify symptoms in themselves and possibly in others. It also provides family and friends of those with migraine information on the disorder, which allows them to better understand it and care for an individual suffering from it. Providing migraineurs with education on the disorder, aids in recovery, prevention and avoidance of relapse (Rains, Penzien & Lipchik, 2006), which in turn may also relieve informal carers such as family, of the personal burdens that come with caring for a migraine sufferer.

Social support is also an imperative part of migraine treatment and management. Since individuals who suffer from migraine experience disability which prevents them from undertaking daily self-care tasks, household tasks and work (Blumenfeld et al., 2010), they may need a family member or friend to care for them and assist them in carrying out such tasks.

Studies have also shown that social support decreases symptoms of depression and anxiety (Ross, Mirowsky & Goldsteen, 1990).

Migraine negatively impacts the life and mental health of migraineurs as it has high comorbidity with depression and anxiety. Migraine also effects friends and family of the migraineur, since individuals suffering from migraine require extra care, as well as effecting the wider community, due to the enormous economic costs migraine causes. Short term treatment for migraine includes triptans and behavioural interventions, however long-term treatments should focus on education on migraine at an individual and community level, as well as social support from family and friends. In sum, migraine should be an issue that our health system accommodates.

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