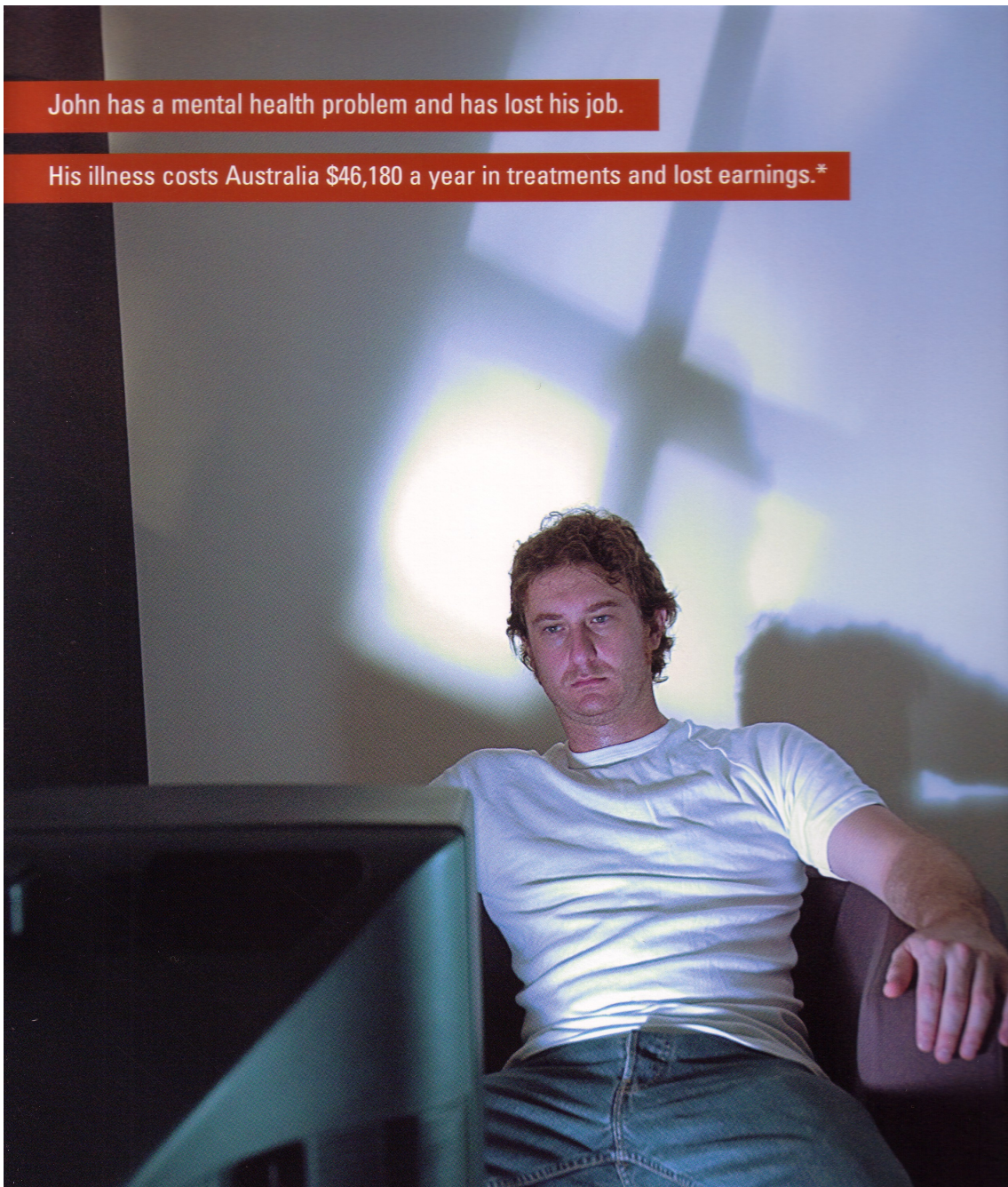


John has a mental health problem and has lost his job.

His illness costs Australia \$46,180 a year in treatments and lost earnings.\*



## Investing in Australia's future:

the personal, social and economic benefits of good mental health

December 2004

**Professor Ian Hickie**, Brain & Mind Research Institute, University of Sydney, NSW

**Dr Grace Groom**, Mental Health Council of Australia, ACT

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From cover: \*Carr *et al.* 2002



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## FOREWORD

The Mental Health Council of Australia (MHCA) has placed increasing emphasis on developing a solid base of medical, social and economic research to underpin its advocacy role. Currently, we are presented with daily stories of basic service failure and a wider lack of community support for ongoing reform. Governments of all persuasions have not backed the rhetoric of national mental health reform with real investment, real leadership or real accountability. The spectre of re-institutionalisation has now been raised as the media and State Governments pursue a 'law and order' rather than clinical care agenda. These undesirable outcomes reflect, in part, our collective failure to present a coherent strategy for increased national investment in mental health.

For too long we have accepted the argument that existing health funds will need to be redistributed to back new service or research developments. Additionally, we have relied heavily on personal, social or conventional medical advocacy. There is now a strong need to balance these approaches with sound economic arguments. Today, mental health more actively embraces the fields of health economics and health services research. We must emphasise the benefits that Australia would derive from moving to a cost-effective spectrum of mental health care and welfare reform. In this report, our goal is to provide key community and political leaders with the sound economic arguments that could underpin such reforms.

The community remains ill-informed about the successes that can be achieved in our field and that such advances can be delivered within a cost-effective system of care. While a small number of people do become actively involved in mental health advocacy (usually after a close relative or friend experiences the deficits in our system), the majority still believe that poor mental health only happens to others. As mental disorders affect more and more young people, and related alcohol and illicit substance misuse rises, demand for mental health services will continue to grow rapidly. Currently, every Australian family expects to use the medical care system for their physical health problems. In time, every Australian family will also need to access mental health care. Hopefully, we can now move rapidly to create a system where families do receive the effective mental health care they need and, consequently, our nation reaps the wider social and *financial* benefits.

Professor Ian Hickie  
Professor of Psychiatry and Executive Director  
Brain & Mind Research Institute  
University of Sydney, NSW  
December 2004



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## EXECUTIVE SUMMARY

*"I have seen numerous surveys of community priorities in health. They all tell very largely the same story. Whilst the community appreciates the important role of hospitals, they see mental health as today's top priority, followed by the health of children (particularly children subject to violence), and Aboriginal health. The community speaks very clearly and consistently on these issues, but they do not shape the priorities in spending. Insiders make the decisions."* John Menadue AO, 2003, p.368

Government leaders, health ministers and other politicians all have the potential to leave their mark on the national stage by delivering genuine health improvements. In Australia, there have been recent and notable achievements. These include restoration of child immunisation, reduction in adult smoking rates, declining deaths due to cardiovascular diseases and confinement of the spread of HIV infection. In mental health, there has been a 10.6% reduction in the national suicide rate since 1992. That success is likely to be due to a range of health and social factors but appears, at least in part, to be a consequence of rapidly expanding access to effective medical and psychological treatments for depression (Hall *et al.* 2003).

*Government leaders, health ministers and other politicians all have the potential to leave their mark on the national stage by delivering genuine health improvements.*

It is now time we set genuine national targets for mental health and placed a particular emphasis on the possible economic returns that could result from new investments. Independent analyses suggest that by Organisation for Economic Co-operation and Development (OECD) standards, Australia under invests in promoting good mental health or providing mental health services (Schizophrenia: costs, 2002). Australian health authorities dispute this claim arguing that such international comparisons are methodologically difficult and that Australia's overall level of expenditure on mental disorders (6.2%, excluding dementia or substance misuse) is comparable to the Netherlands (6.6%) and the United States (7.3%) (Australian Institute of Health and Welfare, 2003a). Importantly, frequently repeated claims that Australia spends 9.6% of health spending on mental health are not credible as they include the costs associated with treating persons with dementias including Alzheimer's disease, substance misuse disorders and intellectual disability (Table 1) (Australian Institute of Health and Welfare, 2003a).

**Table 1: Health expenditure in Australia, 1992-2003.**

	1992-93 <sup>a</sup>	2001-02 <sup>b</sup>	2002-03 <sup>b</sup>
<b>Total health expenditure</b>	\$35.1 billion	\$66.6 billion	\$72.2 billion
<b>Total health expenditure as percentage of GDP<sup>c</sup></b>	8.2%	9.3%	9.5%
<b>Total recurrent mental health expenditures (excluding dementias, substance misuse disorders and intellectual disability)</b>	6.2%	6.4%	Not yet available

<sup>a</sup>1992-93 figures (Australian Institute of Health and Welfare, 2003b); <sup>b</sup>2001-02 figures and 2002-03 figures (Australian Institute of Health and Welfare, 2003a); <sup>c</sup>GDP is gross domestic product.

*It is now time we set genuine national targets for mental health and placed a particular emphasis on the possible economic returns that could result from new investments.*

The patterns of health expenditure for each major health area (2000-01), and changes in those patterns over recent years, indicate that mental health does very poorly given its impact on overall health burden (Table 2). Although mental health is the third largest contributor to total health burden (13.2%) and the largest overall cause of disability (27.0%), it is only the seventh ranked disease area by expenditure (6.0%) (Australian Institute of Health and Welfare, 2004b). These figures for health burden do not include the additional contributions of suicide or self-inflicted injury (which are listed under the alternative illness category of 'injuries'). However, if these premature deaths and self-inflicted injuries are added, they result in a 2.3% increase bringing mental health to 15.5% of the total health burden. As the monies spent on suicide or self-inflicted injury are trivial (0.2%), the gap between expenditure and relative health burden is even more stark.

**Table 2: Key relative health expenditure and health burden statistics by illness category in Australia, 2000-01.**

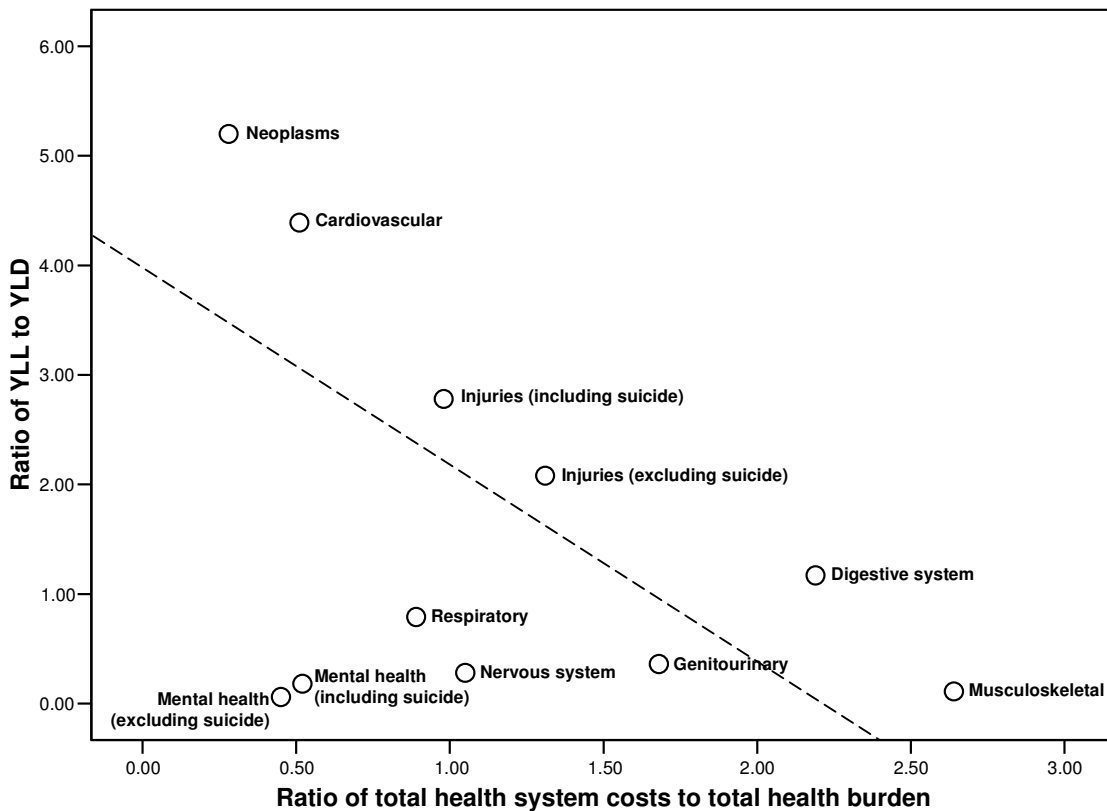
<b>DISEASE: Ranked by health expenditure</b>	<b>Total health system costs 2000-01<sup>a</sup></b>	<b>Total health burden<sup>b</sup></b>	<b>Ratio of health expenditure to health burden</b>	<b>Ratio of YLL to YLD<sup>c</sup></b>	<b>Total % of YLL (deaths)</b>	<b>Total % of YLD (disability)</b>
1. Cardiovascular	11.2%	21.9%	0.51	4.39	32.9%	8.8%
2. Nervous system (including dementia care)	9.9%	9.4%	1.05	0.28	3.6%	16.1%
3. Musculoskeletal	9.5%	3.6%	2.64	0.11	0.7%	7.1%
4a. Injuries	8.2%	8.4%	0.98	2.78	11.3%	5.0%
4b. Injuries (excluding suicide)	8.0%	6.1%	1.31	2.08	8.4%	4.95%
5. Respiratory	7.4%	8.3%	0.89	0.79	6.8%	10.1%
6. Oral health	6.9%	1.0%	6.90	-	-	2.1%
7a. Mental disorders	6.0%	13.2%	0.45	0.06	1.4%	27.0%
7b. Mental disorders (including suicide)	8.0%	15.5%	0.52	0.18	4.3%	27.05%
8. Digestive system	5.7%	2.6%	2.19	1.17	3.2%	2.1%
9. Neoplasms	5.5%	19.4%	0.28	5.20	29.5%	7.0%
10. Genitourinary	4.2%	2.5%	1.68	0.36	1.1%	4.1%

<sup>a</sup>Proportion of total allocated health expenditure (Australian Institute of Health and Welfare, 2004a); <sup>b</sup>Total health burden based on disability-adjusted life years (Mathers *et al.* 1999); <sup>c</sup>YLL is years of life lost due to premature mortality, YLD is 'healthy' years of life lost due to disability (Mathers *et al.* 1999).

The formal comparison with other relevant areas of health expenditure, such as nervous system diseases (9.4% health burden, 9.9% health expenditures) and musculoskeletal disorders (3.6% health burden, 9.5% health expenditures) is intriguing. The ratio of health expenditure to health burden generally increases for those disorders that result in disability rather than death. Hence, musculoskeletal disorders have the highest



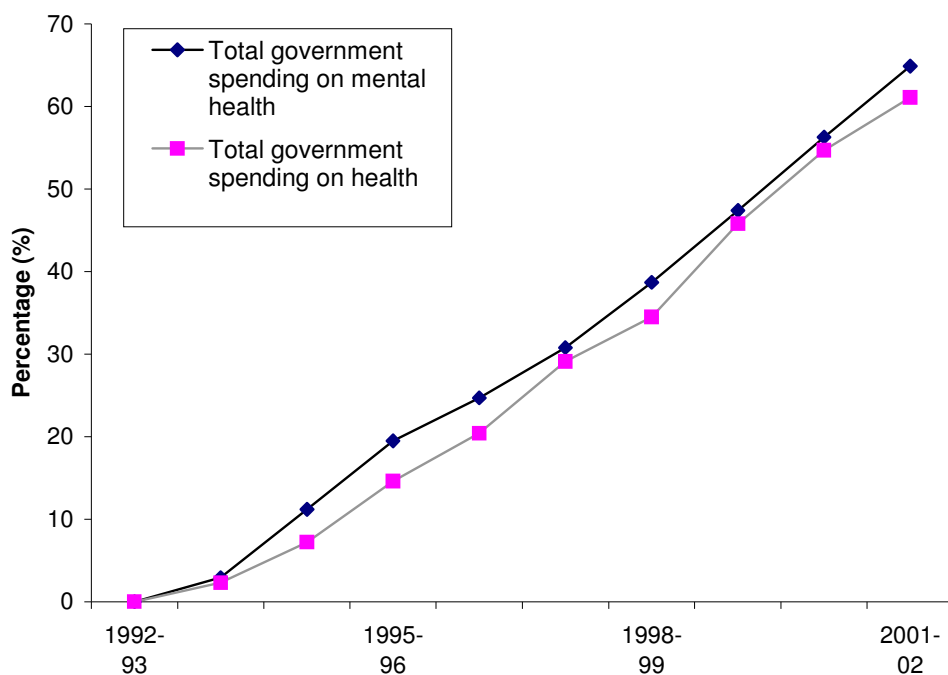
ratio at 2.64 while cancers (0.28) and cardiovascular diseases (0.51) are relatively low. There is a significant inverse and almost linear relationship across the major health areas in Australia (Figure 1). The major exception is mental health where the actual ratio is 0.45! (Table 2). That is, people with mental disorders are treated as if they had an acute or life-threatening disorder, or that they die shortly after onset of illness. In reality, they may require years or decades of episodic or ongoing medical care. Put another way, unlike persons with other well-recognised forms of chronic disability, they are denied access to appropriate and ongoing medical care.



**Figure 1: The inverse relationship between premature death and health expenditure in Australia.** The correlation between two key health ratios is depicted, namely the ratio of health expenditure to health burden (disability adjusted life years) and the ratio of years of life lost (YLL) to years lived with disability (YLD) (Australian Institute of Health and Welfare, 2004a; Mathers *et al.* 1999). The line represents the correlation between the two ratios when mental health is excluded ( $r=-0.72$ ).

By the end of 2002, national recurrent mental health spending was \$3.088 billion annually, up from \$1.908 billion in 1992-93, and reflecting 6.4% of total national *recurrent* health expenditure (Department of Health and Ageing, 2003). By contrast with other expenditure figures produced by the Australian Institute of Health and Welfare (AIHW; variously reported as 6.1% to 7.9% and either including or excluding community-base elements of care), the 2004 National Mental Health Report (Department of Health and Ageing, 2003) figures have been consistently tracked over a decade and include community aspects of health care (eg. preferential move away from hospital-based modes of care in mental health). Despite having had a National Mental Health Strategy in place for over a decade, the often-reported increase in expenditure in mental health (65%) was just ahead of the general rate of rise in total government recurrent expenditures on health

(61%) (Figure 2; Department of Health and Ageing, 2003). The 2004 National Mental Health Report figures can also be used to generate a national per capita expenditure rate (for 2002 AUS\$158.00; Department of Health and Ageing, 2003) which could then be used for more meaningful international comparisons.



**Figure 2: No real growth in government recurrent mental health expenditure as compared with general health expenditure since 1992-93 (Department of Health and Ageing, 2003).**

Further scrutiny of national recurrent expenditures highlight the poor performance of the states who reported only a 40% (or 26% per capita) increase in spending over a nine-year period of the National Mental Health Strategy. By contrast, the Australian Government's contribution increased 127%, though 66% of this increase was accounted for simply by the increase in expenditure on medications through the Pharmaceutical Benefits Scheme. While new medications play an important role in improving mental health outcomes, to achieve value for money they need to be backed by complementary psychological, social, informational and self-management strategies. To date, significant developments in these other areas have been promising but limited in scope or reach (Hickie *et al.* 2004) and now require more overt long-term support by the Australian Government. By 2002, the Australian Government accounted for 37% of total mental health spending compared with 27% in 1993 (Department of Health and Ageing, 2003).

It is important to note that national *health* spending continues to rise rapidly. By 2003, it had reached \$72.2 billion annually or 9.5% of gross domestic product (GDP; up from 8.4% in 1995-96) (Table 1; Australian Government Department of Health and Ageing, 2004). However, a significant proportion of that increased spending has supported provision of elective medical, dental and surgical services (underpinned by the private health insurance rebate) and ongoing support of the acute care and hospital sectors. Consequently, it is likely that overall mental health spending as a proportion of national health spending is now actually declining.

Despite a decade of policy initiatives, there is still no estimate available as to whether services provided to persons with mental disorders have actually increased in number or improved in quality. While there has been a very large increase in the number of persons employed in ambulatory care settings (109% greater than pre-1993), the 2004 National Mental Health Report notes that these figures “...do not tell us...levels required to meet priority community needs nor the amount of care actually provided” (Department of Health and Ageing, 2003, p.21). After a decade, our National Mental Health Strategy has still not even implemented the first round of key performance indicators for services or other proposed key quality or safety measures (eg. deaths of persons within three months, or 12 months, of presenting for mental health care). The 2004 National Mental Health Report notes that less than 50% of public mental health services have completed their review under the National Standards for Mental Health Services, even though this specific item was required under the 1998-2003 Australian Health Care Agreements (Department of Health and Ageing, 2003; New South Wales Health). With regard to actual systematic review of experiences of care, the only significant progress has been driven by the mental health advocacy sector (eg. [www.mhca.com.au/ConsumerCarerSurvey\\_000.html](http://www.mhca.com.au/ConsumerCarerSurvey_000.html)).

In this report, we present surveys of those who use care. The results highlight fundamental problems with our service systems. The majority of respondents (70%) did not have adequate access to services, with 19% being unable to find a health professional to talk to about their concerns. Forty-two percent of respondents said they were always or nearly always not treated with respect and dignity. Forty percent of participants felt they were given insufficient or no information about the condition or treatment. Of those who wanted information given to family and friends, 59% felt that not enough information was given. In situations where medication was prescribed, only 23% responded that the purpose, benefits and side-effects were fully explained. Over one-third (38%) did not feel they had enough say in decisions about care and treatment and 19% had not had the diagnosis discussed with them. Less than 10% had received a care plan, which is a document that outlines mental health needs and who will provide services. About one-third (34%) rated the health care received in the last 12 months as poor to very poor, 29% as fair to good, and 37% as very good to excellent.

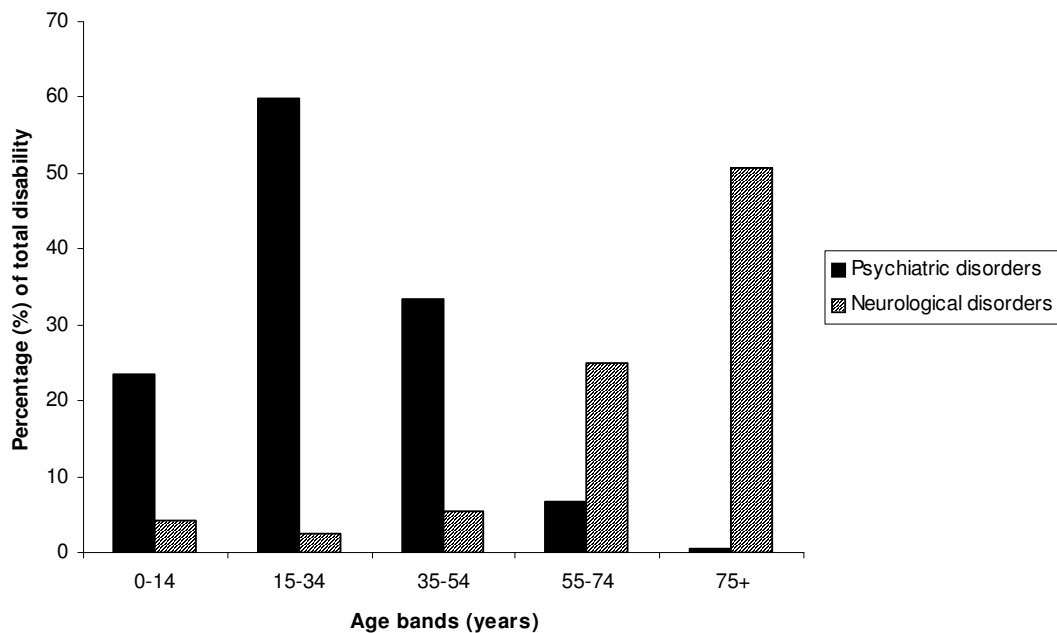
While poor mental health costs the economy directly through medical and social welfare costs, for each dollar spent directly on services, four more dollars are lost indirectly through poor education and training achievement, reduced workplace productivity, lost tax earnings and reduced participation by carers in the wider economy. Seventy-four per cent of major mental illnesses commence before 18 years of age (Tables 3 and 4; Kim-Cohen *et al.* 2003). Sixty percent of disability costs in 15 to 34 year olds are due to mental disorder (Figure 3; Mathers *et al.* 1999). Up to 60% of cases of alcohol or other substance misuse could be prevented by earlier treatment of common mental health problems (Kendall & Kessler, 2002). Less than 30% of people with psychological reasons for receiving the Disability Support Pension in Australia participate in the workforce (Table 5; Trewin, 2003). This contrasts with up to 60% in other comparable countries. Suicide rates are now highest among 25 to 44 year olds reflecting largely our previous neglect of the mental health problems that emerged rapidly in the teenagers of the 1980s and 1990s (Figures 4 and 5; Australian Bureau of Statistics, 2003a,b).

**Table 3: One-year prevalence of mental disorders in Australian children and adolescents aged six to 17 years (Sawyer *et al.* 2001).**

	PERCENTAGE (POPULATION ESTIMATE)			
	Males		Females	
	Percentage	Population Estimate	Percentage	Population Estimate
<b>Any depressive disorder</b>	3.2%	(52,000)	2.8%	(43,000)
<b>Any conduct disorder</b>	4.4%	(71,000)	1.6%	(24,000)
<b>Attention deficit hyperactivity disorder</b>	15.4%	(250,000)	6.8%	(105,000)

**Table 4: One-year prevalence of mental disorders in Australian adults (Andrews *et al.* 1999).**

	PERCENTAGE (POPULATION ESTIMATE)			
	Males		Females	
	Percentage	Population Estimate	Percentage	Population Estimate
<b>Any depressive disorder</b>	4.2%	(275,300)	7.4%	(503,300)
<b>Any anxiety disorder</b>	7.1%	(470,400)	12.0%	(829,600)
<b>Any substance use disorder</b>	11.1%	(734,300)	4.5%	(307,500)
<b>Any mental disorder</b>	17.4%	(1,151,600)	18.0%	(1,231,500)



**Figure 3: Common mental disorders and substance misuse rob the young of productive lives and cost our community through ongoing disability and income support (Mathers *et al.* 1999, p.53).**



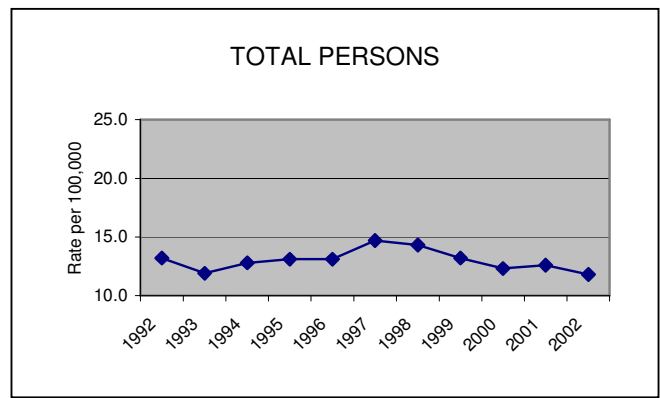
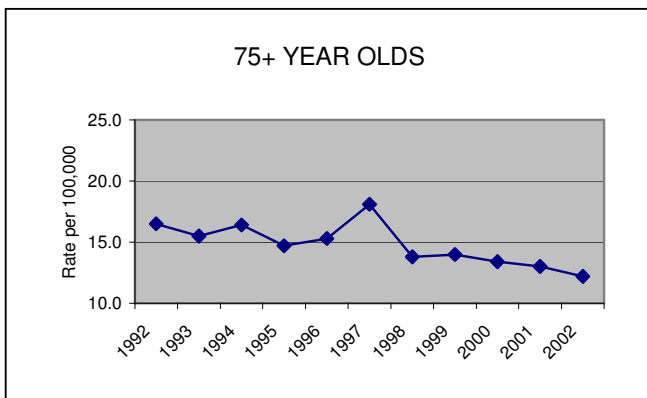
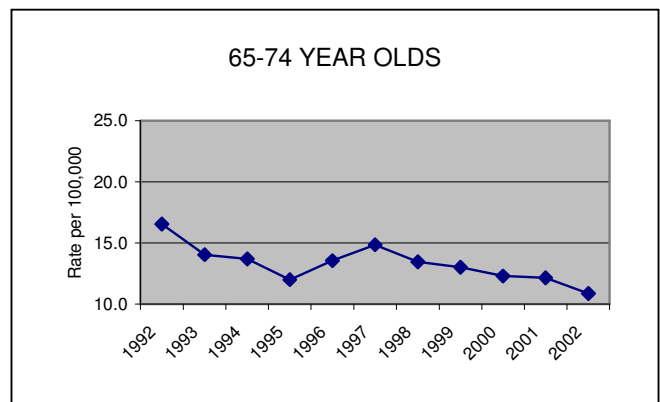
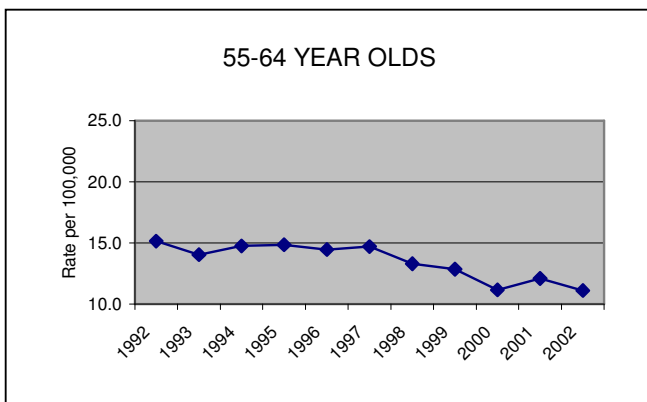
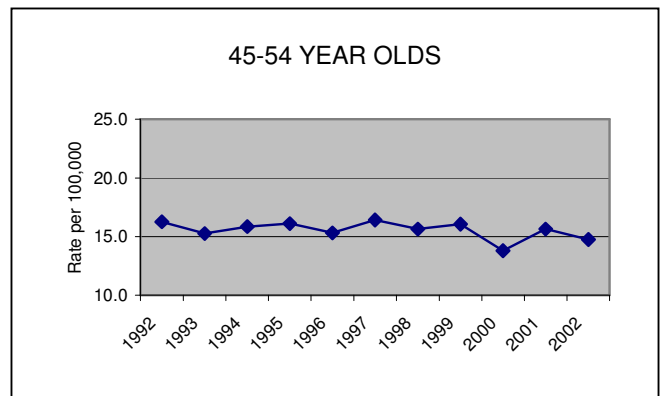
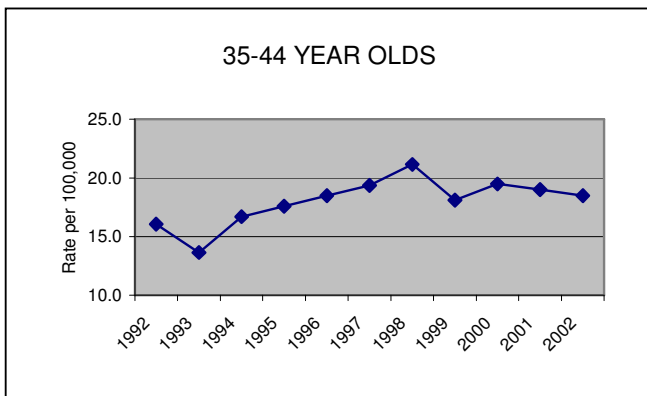
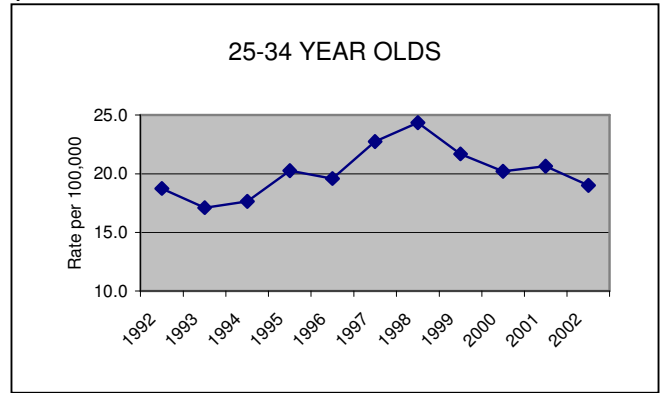
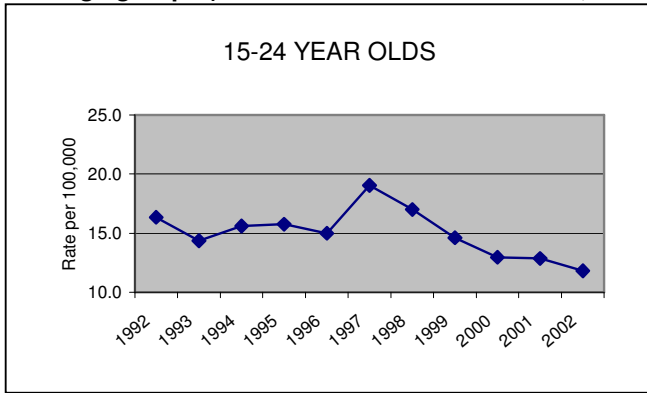
Less than 30% of people with psychological reasons for receiving the Disability Support Pension in Australia participate in the workforce. This contrasts with up to 60% in other comparable countries.

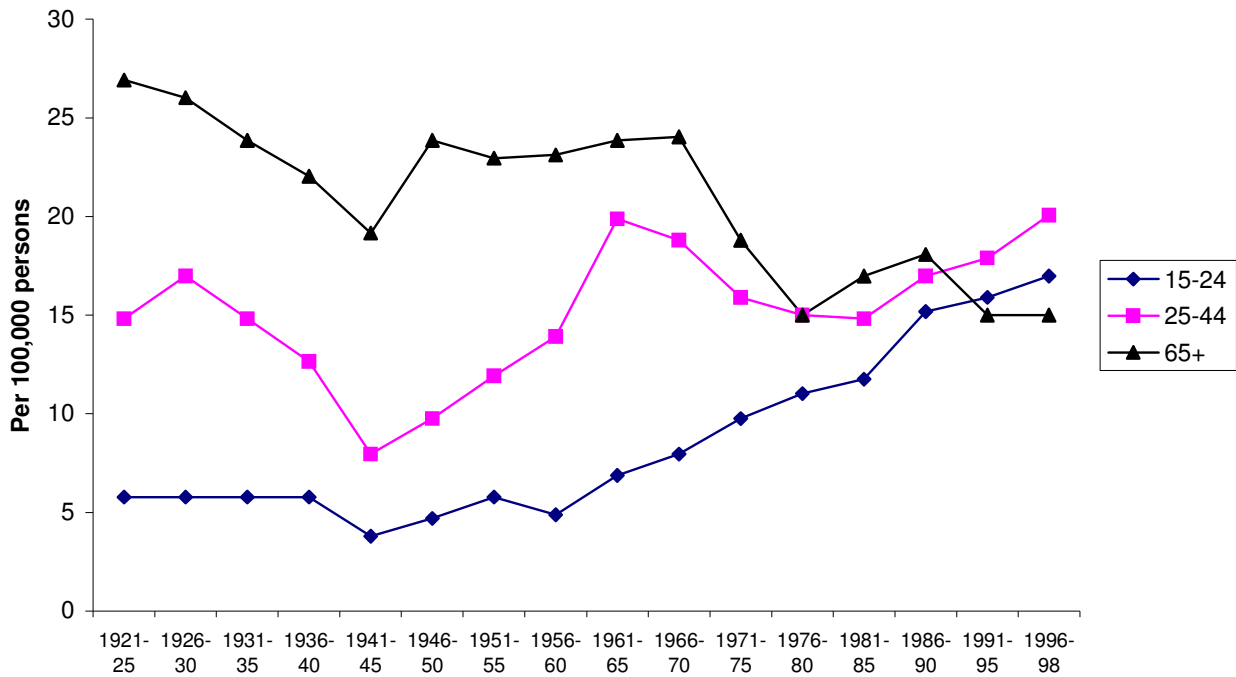
**Table 5: Less than 30% of people with disability<sup>a</sup> due to mental illness participate in the workforce (Trewin, 2003, p.260).**

	PERCENTAGE (%)						
	Psychol- -ogical	Intellect- -ual	Head injury, stroke or brain damage	Sensory or speech	Physical	All with a disability <sup>b</sup>	All persons <sup>b</sup>
Employed full-time	11.3%	17.1%	17.3%	37.2%	27.6%	31.0%	49.1%
Employed part-time	10.2%	12.8%	12.6%	13.9%	15.5%	16.1%	20.3%
Unemployed	7.2%	8.3%	6.6%	4.7%	6.0%	6.1%	6.3%
<i>Participation rate</i>	<i>28.7%</i>	<i>38.2%</i>	<i>36.5%</i>	<i>55.8%</i>	<i>49.1%</i>	<i>53.2%</i>	<i>75.7%</i>
Not in labour force	<b>71.3%</b>	61.8%	63.5%	44.2%	50.9%	46.8%	24.3%
Total <sup>c</sup>	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

<sup>a</sup>People aged 15 to 64 years and living in the community; <sup>b</sup>The sum of the components exceeds the total because a person can report more than one impairment; <sup>c</sup>Includes those for which the type(s) could not be determined.

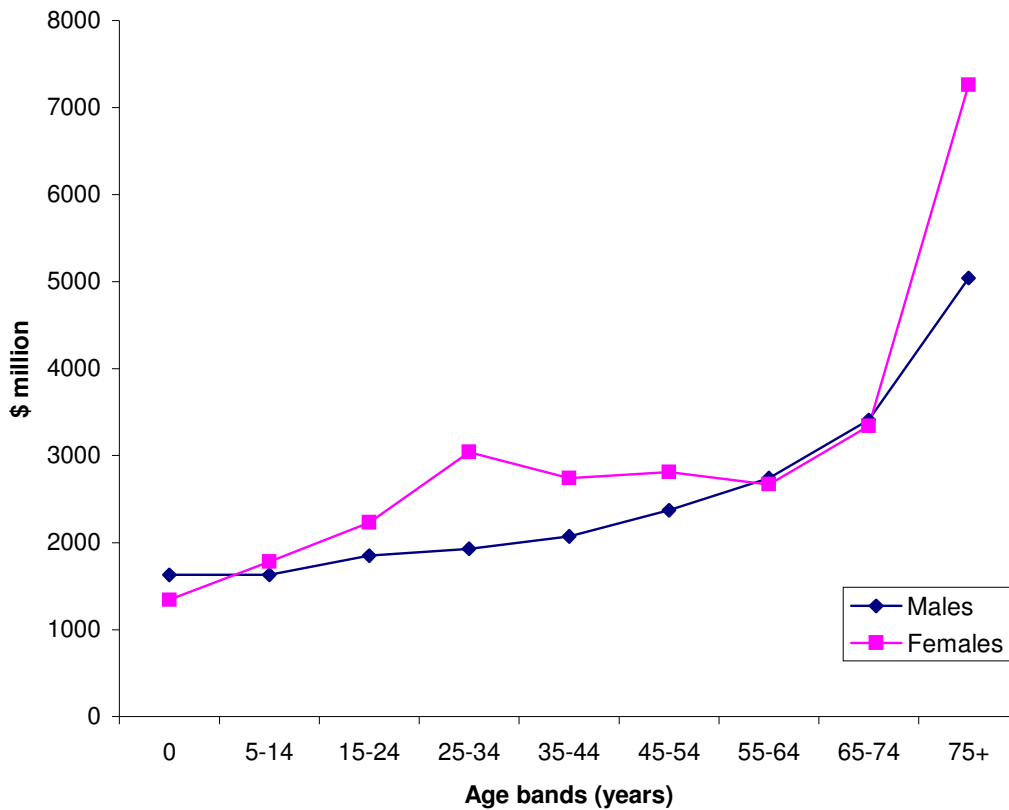
**Figure 4: Suicide death rates in Australia have decreased for older people but increased for younger age groups (Australian Bureau of Statistics, 2003a,b).**





**Figure 5: Suicide death rates by age, 1921-98 (Australian Bureau of Statistics, 2003a,b).**

In reality, health expenditures are not equitable. They track those who use the traditional health system, and particularly the acute care or surgical aspects of the hospital system. Health system costs are strongly linked to older age (Figure 6). As mental disorders commence mainly in younger age groups, are not treated extensively in the hospital sector and are more closely linked to ongoing welfare and income support, they contribute greatly to health burden rather than health expenditures. For the years 1999-2000 (Commonwealth Department of Health and Ageing, 2002), poor mental health (eg. for schizophrenia and bipolar disorder see Table 6) cost Australia at least \$13 billion annually (\$2.6 billion directly and \$10.4 billion indirectly). The efficient delivery of early intervention, effective treatment and positive return to work programs we estimate could have reduced this cost to \$9 billion annually (\$3 billion directly and \$6 billion indirectly).



**Figure 6: Total allocated health expenditure by age and sex, Australia 2000-01 (Australia Institute of Health and Welfare, 2004b, p.22).**

**Table 6: Access Economics reports show real, direct and indirect costs for schizophrenia and bipolar disorder exceed \$3.5 billion dollars annually.**

	Schizophrenia (2001) <sup>a</sup>	Bipolar disorder (2003) <sup>b</sup>
<b>Real financial costs</b>	\$1.85 billion	\$1.59 billion
<b>Direct health system costs</b>	\$661 million	\$298 million
<b>Real indirect costs</b>	\$722 million	\$833 million

<sup>a</sup>Schizophrenia figures (Schizophrenia: costs, 2002); <sup>b</sup>Bipolar disorder figures (Bipolar disorder: costs, 2003).

In response to these issues, we propose four key themes: promoting early intervention for all severe disorders among young people; providing effective pharmacological and psychological treatments in primary care; maximising returns to full social and economic participation; and investing in innovation, research and sustainability. To operationalise these themes we need to build a logical spectrum of community and hospital-based care.

Our explicit goals are to increase the workplace participation rate for those receiving disability support (due to psychological disorders) from 29% to 60% and reduce the suicide rate among 25 to 34 and 35 to 44 year olds from 19.0 and 18.5 respectively to 15 per 100,000 for each of these key age bands (Table 7). To achieve these goals, we will need to engage in both community-based initiatives and significant health



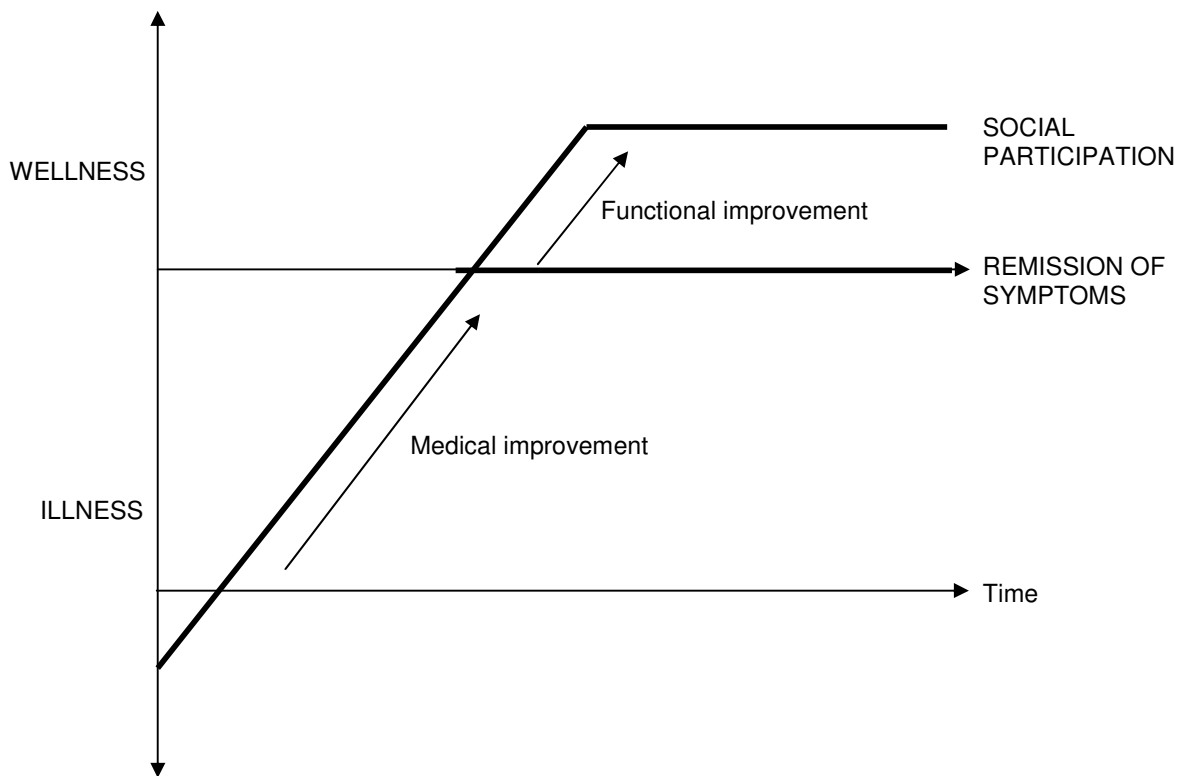
service reform (Figure 7). We will need to: reduce the duration of untreated illness among young people from five to 15 years to two to five years; reduce the rate of people untreated in primary care from 50% to 25%; and increase the provision of specific psychological treatments in primary care from 17% to 50%. For those with psychotic or more chronic mental disorders, and those more dependent on specialist services, we will need to increase access to specialist assessments, access to acute and emergency services and participation in targeted education and workplace-based rehabilitation and recovery services.

**Table 7: Comparison of 1992 and 2002 suicide rates in the Australian population (Australian Bureau of Statistics, 2003a,b).**

Age bands	1992 suicide rate <sup>a</sup>	2002 suicide rate <sup>b</sup>	Percentage change
15-24 years	16.4	11.8	- 28.0%
25-34 years	18.8	19.0	+ 1.1%
35-44 years	16.1	18.5	+ 13.0%
45-54 years	16.3	14.8	- 9.2%
55-64 years	15.2	11.1	- 27.0%
65-74 years	16.6	10.9	- 34.3%
75+ years	16.5	12.2	- 26.1%
All ages	13.2	11.8	- 10.6%

<sup>a</sup>Total rate per 100,000 is the standardised death rate per 100,000 of the mid-year 1991 total Australian population;

<sup>b</sup>Total rate per 100,000 is the standardised death rate per 100,000 of the mid-year 2001 total Australian population.



**Figure 7: The goal of good mental health is social and workforce participation.** Traditional high cost medical investments only return persons with mental illness to low levels of social participation. Investment in additional lower cost rehabilitation and workplace strategies is required to achieve social and workforce participation.

*Our explicit goals are to increase the workplace participation rate for those receiving disability support (due to psychological disorders) from 29% to 60%.*

This report focuses on the need to shift thinking, recognise new challenges and implement new ways forward. New thinking is increasingly backed by community support and emerging scientific evidence. We must be willing to move beyond broad statements of principle (see our National Mental Health Strategy of 1993 and National Mental Health Plan 2003-2008) to real programs of implementation. Leadership, investment, innovation and accountability lie at the heart of our concerns.

*New thinking is increasingly backed by community support and emerging scientific evidence. We must be willing to move beyond broad statements of principle to real programs of implementation.*

## FOUR KEY THEMES

*“While the aims of the Second (National Mental Health) Plan have been an appropriate guide to change, what has been lacking is effective implementation. The failures have not been due to lack of clear and appropriate directions, but rather to failures in investment and commitment.”*

Steering Committee for the Evaluation of the Second National Mental Health Plan (1998-2003), 2002, p.3.

Mental illnesses are increasingly recognised as a major health challenge in both developing and developed countries. As disorders such as depression, anxiety, alcohol or other substance misuse, schizophrenia and manic-depressive illness (bipolar disorder) are extremely common they now pose a significant threat to both social and economic development. In the next 20 years, the incidence of all these disorders is expected to rise as will the complication rates in terms of physical health problems, premature death and lifelong disability. The size and coherence of each nation's response will vary not only as a result of current economic and health status but also according to social attitudes and perceived opportunities for strategic investment. Good mental health is a key determinant of education and training achievement, workforce participation and family and social cohesion.

This report highlights four key themes for a new style of reform. These are: promoting early intervention for all severe disorders among young people; providing effective pharmacological and psychological treatments in primary care; maximising returns to full social and economic participation; and investing in innovation, research and sustainability. To operationalise these themes, we need to build a logical spectrum of community and hospital-based care. Here, we propose those changes of existing systems or major extensions of innovative programs that demand immediate attention.

### **THEME 1: Promoting early intervention for all severe disorders among young people**

- a. Adopting early intervention models for psychosis nationally;
- b. Emphasising early intervention for mood, anxiety and alcohol or other substance misuse disorders;
- c. Basing early intervention on new youth health networks and increased primary care detection, with interventions co-ordinated through the specialist service sector;
- d. Emphasising social recovery and completion of education and training rather than just workplace participation; and
- e. Establishing a national network of early intervention centres that share common clinical, research, education and family support structures.

**THEME 2: Providing effective pharmacological and psychological treatments in primary care**

- a. Expansion of general practitioner-based and allied health services (notably psychological treatments) under the *Better Outcomes in Mental Health Care* and related Australian Government initiatives;
- b. Introduction of quality use of medicines initiatives designed to maximise effective use of affordable pharmaceuticals, including linking prescribing rights to increased education, training and practice-organisation systems; and
- c. Maximising links between the general practice, specialist psychiatry and allied health sectors to ensure timely delivery of specialised assessments and interventions.

**THEME 3: Maximising returns to full social and economic participation**

A. Maintaining employment through:

- a. Workplace awareness programs;
- b. Workplace screening and intervention programs;
- c. Workplace treatment services; and
- d. Expansion of general practitioner-based and allied health services (notably psychological) under the *Better Outcomes in Mental Health Care* initiative.

B. Promoting treatment services and related income support through:

- a. Expanding current goals of treatment to include 'return to work' programs and not just a reduction of symptoms;
- b. Ensuring treatment goals include attention to the need for provision of access to stable and appropriately individualised, supported accommodation (not a return to institutionalised boarding homes); and
- c. Support through Job Network programs for those with chronic disability.

**THEME 4: Investing in innovation, research and sustainability**

- a. Researching predictors of transition to psychosis or other chronic and disabling mental disorders during the teenage years;
- b. Studying the effects of medical, social and psychological intervention strategies during the early stages of illness;
- c. Evaluating the benefits and costs associated with assertive completion of education and return to work programs for those with severe mental disorders;
- d. Researching the short and longer-term effects of alcohol or other substance misuse on our youth's cognitive and emotional functioning; and
- e. Establishing a national network of brain and mind research centres with a strong emphasis not only on the identification of the interplay of basic biomedical and social causative factors, but also on the support of families and communities at risk.



## KEY RECOMMENDATIONS AND URGENT RESPONSES

The MHCA and a wider coalition of health, community and social welfare groups, propose the following immediate actions. These actions are outlined below, with background arguments for each developed throughout the text. The immediate implementation of these actions by the Australian Government would send a clear signal to the community of an intention to restore confidence in our mental health service system and maximise the national benefits of increased investments in good mental health.

### 1. Implementation of an *annual and independent* reporting system

- a. This is most easily achieved through direct contractual arrangements with the MHCA. The estimated cost of this process is **\$300,000** per year and should be mandated for an initial five-year period. The MHCA should report to the Minister for Health on progress in national mental health reform and a formal report should be presented to the National Parliament annually.
- b. The governments of Australia should be required to continue their own yearly reporting of expenditures in mental health (which is surprisingly not included in the most recent National Mental Health Plan; Australian Health Ministers, 2003).
- c. Consideration should be given to increasing the powers of the Australian Human Rights and Equal Opportunity Commission to monitor human rights abuses and incidents of discrimination in employment, education or other Federal agencies related to people with mental disability. The Commissioner should also be further empowered to proactively liaise and work with appropriate state-based agencies and commissioners whose work may overlap.

### 2. Continuation of the *Better Outcomes in Mental Health Care* initiative beyond 2005

- a. This landmark program in integrated mental health services is considered to be a lapsing program of the Australian Government.
- b. The component of it devoted to allied health services (such as clinical psychology) should be immediately expanded (currently \$10-12 million in 2004) to provide reasonable access to non-pharmacological treatment services.
- c. A range of recently developed allied health service models is feasible, and they should reasonably be expected to attract **\$50 million per annum by 2008**.
- d. Urgent consideration should be given to reform of the Medicare Benefits Schedule rebate for psychiatrists to encourage better delivery of consultancy services. Current modelling suggests this could be achieved at low cost initially and could be cost neutral in the longer-term.

### 3. Direct support for novel workplace employment schemes

- a. Immediate implementation of specialised schemes for people on a Disability Support Pension to resume some work. Such schemes must include attention to the provision of stable, appropriately individualised supported accommodation (not a return to institutionalised boarding homes). An initial investment of **\$49 million annually** is required to produce a cost-neutral result.
- b. Support for trials of workplace mental health awareness, screening and implementation programs. This could be achieved through currently supported initiatives such as *beyondblue: the national*

*depression initiative* or contractors such as the MHCA, SANE Australia or the Centre for Mental Health Research (The Australian National University).

#### 4. Backing of innovation, research and sustainability

- a. National implementation of early intervention programs for psychosis. This should occur through direct funding models and not through state transfer models. A national network of early intervention centres should be established. The range of models available vary, but **\$30 million annually** is required to develop a sustainable system.
- b. Support research into early intervention models for youth-onset mood and alcohol or other substance misuse disorders.
- c. Support research for early intervention into later-life depressive and brain degenerative disorders.
- d. Immediate support for *Brain & Mind Australia* to evaluate the consequences of the Prime Minister's Science, Engineering and Innovation Council (PMSEIC) 'Neurosciences' development. The estimated cost of this is **\$250,000 for one year**.

## **PART ONE: INTERNATIONAL AND HISTORICAL CONTEXT OF MENTAL HEALTH REFORM**

*“In more ways than one, we make this simple point: we have the means and the scientific knowledge to help people with mental and brain disorders. Governments have been remiss, as has been the public health community. By accident or by design, we are all responsible for this situation. As the world’s leading public health agency, WHO [World Health Organization] has one, and only one option – to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason.”* Dr Gro Harlem Brundtland, Director-General, World Health Organization, 2001, p.x

The experiences of people with mental disorders have always been as closely tied to key social and economic movements as major medical advances. Developments in our understanding of the human brain, progress in medical and psychological treatments and increased identification of social factors that impart risk to mental illness now all offer hope for an improved quality of life. However, persistent negative attitudes towards mental illness in the wider community result in an ongoing reality of neglect, discrimination, lack of integration of mental health with general health services and lack of empathy for the personal and family costs of mental disorders. The international nature of such negative attitudes, and their considerable impact on health care policy, have been well summarised by the WHO (World Health Organization, 2001).

Psychotic illnesses such as schizophrenia, and major mood disorders such as bipolar affective disorder or manic-depressive illness, occur at similar rates in developed and developing nations – suggesting the role of common genetic and environmental risk factors. Interestingly, social outcomes appear to be as good for people in developing countries that utilise community-based rather than institutional services, despite their limited access to medical treatments (Cooper & Sartorius, 1977). This surprising finding highlights the protective effects of remaining within a *consistent and supportive social environment*. The personal experience of stigma – and its overt and covert consequences (eg. discrimination in employment, limited access to financial and insurance services, social exclusion) – is profound for someone who has experienced a psychotic illness (eg. Figure 8). In many places around the world, s/he is a source of shame to their family, and may still be considered evil, possessed or some other major threat to their local community.

Common mental disorders, such as depression, anxiety, alcohol or other substance misuse, are highest in communities subject to poverty, war, trauma, poor physical health and chronic social disadvantage. Rates of illness often increase during periods of rapid social and economic change. For example, suicide rates increased markedly in Eastern Europe in association with increased unemployment and social dislocation in the decade after the demise of the Soviet system. Internationally, rates of suicide are generally higher in men than women, but the very high rate among young women in rural China is believed to reflect particularly adverse personal and social circumstances. Rates of depression now appear to be falling in older people (between 50 and 75 years of age) in Western countries, largely as a result of improved physical health and reduced social barriers to social participation. Rates of suicide, however, remain high in older men who are physically-ill and socially isolated. Older women in Hong Kong experience surprisingly high rates of suicide, a phenomenon thought to reflect loss of valued social roles in a rapidly changing social system.

## Treat mental illness with more sensitivity

WE have come a long way since the term "lunatic" was applied to those suffering mental illness. Nor do we continue to segregate them in asylums where despair was often the daily companion of both inmates and staff.

That 800,000 Australians will suffer some form of mental illness each year is a sobering thought. And the controversy aroused by Assistant Treasurer Helen Coonan's well-intentioned but perhaps clumsy remarks could be useful in another appraisal of mental health problems, especially depression.

Senator Coonan's use of the word "malingering" was the catalyst for the torrent of criticism the senator has received. She has been quick to apologise for the misunderstanding her remarks have caused. It is easy to see what she might have had in mind. It is a problem when some people exaggerate or claim prolonged illness to seek financial reward or avoid their responsibilities. The way to tackle this problem is through close scrutiny of medical claims and reduced legal incentives to cheat. But Senator Coonan's approach verges on creating an environment in which anyone with a mental illness or symptoms of depression is under a cloud.

But even the diagnosis of depression is a challenge. Those who suffer its onslaught are often confused about what is wrong with them. Its effect on confidence can be devastating, and bring tensions at home and work which are hard to combat. A measure of shame inhibits many from

admitting they have a problem, and unfriendly assessments sometimes accuse sufferers of feigning what is an often serious illness. Being told to pull themselves together, as if simple effort could defeat depression, is useless. They lack the necessary resources.

Fortunately, those suffering depression are now more likely to find reassurance than in the past. People who have their mental illnesses diagnosed and treated can make important contributions through their work and family lives. Australians should consider the achievements of poet Les Murray and the late comic Spike Milligan before submitting to the easy option of stigmatising possible sufferers.

The more obvious symptoms of depression make some diagnoses simpler. It is the less obvious, who feel distressed and believe they are somehow failing, who need the most care. These are the people most susceptible to Senator Coonan's clumsy words, the ones who might react to the threat of being stigmatised, by keeping quiet about their concerns, rather than coming forward.

Depression costs the economy \$5 billion and is a factor in 2400 suicides each year. The availability of beds for those in greatest need is a mere 5000. A good many of the homeless are the pathetic victims of their own mental state. Sadly, those of us who have never suffered depression, or the debilitating effects of schizophrenia or epilepsy, may be less sympathetic than we ought to be.

**Figure 8: Newspaper editorial entitled "Treat mental illness with more sensitivity". Source: *The Australian*, Friday 4 October 2002, p.10 – reproduced with permission.**

In Western countries, rates of depression, anxiety, alcohol or other substance misuse and suicide have tended to rise among young people during the second half of the twentieth century (Table 8). These rises are thought to reflect changes in key factors in the social environment, such as reduced social connectedness, rather than changes in biomedical or psychological factors. A characteristic feature of both developed and developing countries is that the vast majority of people with common mental disorders do not present for professional assessment or treatments (Hickie *et al.* 2001a,b,c). The main explanatory factors appear to be a combination of stigma, shame and fear that the consequences of treatments are worse than living with the illness (McNair *et al.* 2002; Meadows *et al.* 2002). These consequences might be direct side-effects of treatment or indirect effects such as discrimination. Consequently, many people with disorders, and their families, live continuously with the personal and social effects of their chronic or recurring illness.

**Table 8: Burden of disease in DALYs<sup>a</sup> by neuropsychiatric disorders within the Western Pacific stratum, 2001 (World Health Organization, 2002).**

	TOTAL DALYS <sup>a</sup> ('000)	
	Very low child/ very low adult (includes Australia)	Low child/ low adult
<i>Population ('000)</i>	154,919	1,546,770
<b>Cause of death</b>		
Alcohol use disorders	480	5,456
Alzheimer and other dementias	530	1,719
Bipolar affective disorder	241	3,691
Drug use disorders	246	351
Obsessive-compulsive disorder	63	755
Panic disorder	127	1,679
Post-traumatic stress disorder	81	847
Schizophrenia	234	4,336
Unipolar depressive disorders	1,005	14,685
Other <sup>b</sup>	750	7,792
<b>Total neuropsychiatric disorders</b>	<b>3,757</b>	<b>41,311</b>

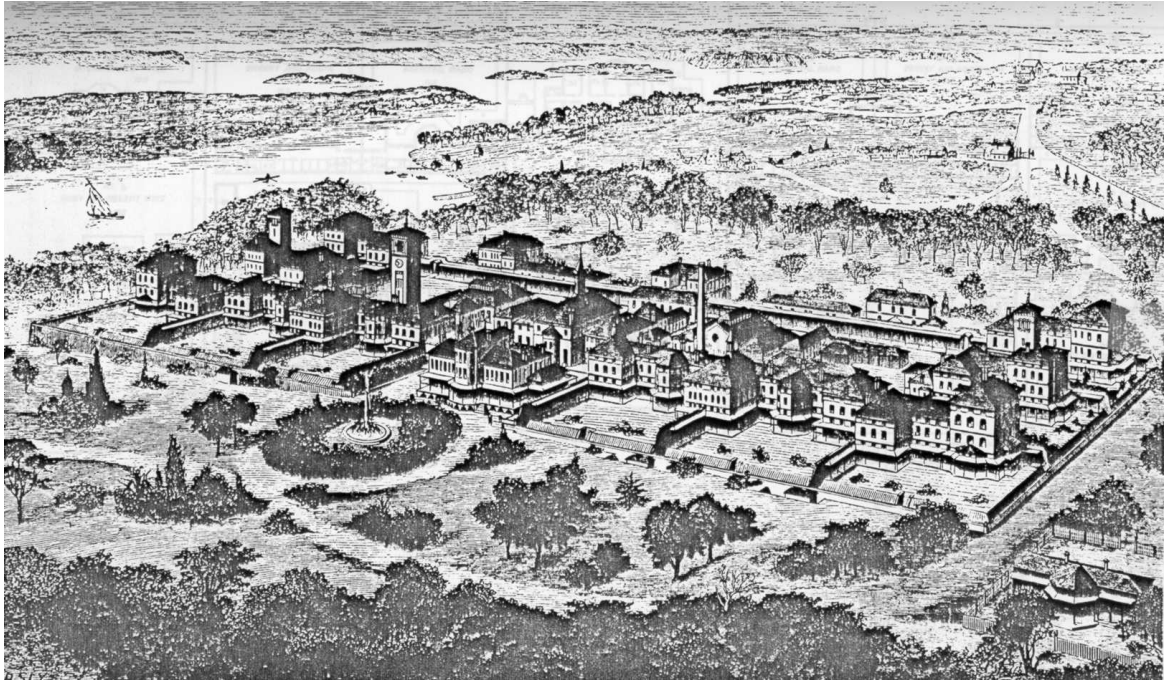
Note: These figures were produced by WHO using the best available evidence. They are not necessarily the official statistics of Member States. <sup>a</sup>DALYs = disability-adjusted life years; <sup>b</sup>Other includes: epilepsy, Parkinson disease, multiple sclerosis, insomnia (primary) and migraine.

By contrast with psychotic disorders, there is also widespread community belief that disorders such as depression, anxiety and alcohol or other substance misuse are trivial, are under voluntary control or are not genuine 'illnesses'. Many people do not believe that such problems require medical help (Highet *et al.* 2002). Such stereotypes are commonly re-inforced by insensitive or inaccurate media portrayals (Blood *et al.* 2003) or by media promotion of the notion that ordinary human sadness is being turned into a series of illnesses requiring pharmaceutical treatments (Moynihan, 1998). The lack of community understanding of common disorders such as depression has led to major national campaigns in the United States in the 1980s (eg. Depression/Awareness, Recognition and Treatment Campaign; Regier *et al.* 1988); in the United Kingdom in the mid-1990s (eg. Defeat Depression Campaign; Paykel *et al.* 1997) and late-1990s (eg. Changing Minds); and now in Australia through *beyondblue* (2001-05; Hickie, 2004b,c).

### 1.1 Industrialisation and the growth of institutionalism

Prior to the industrial revolution, the burden of care in the Western world for people with mental disorders fell on small family units and local communities. This is still the situation in most developing countries. During periods of industrialisation and rapid urbanisation, people with mental illness are highly likely to be unemployed, socially isolated and subject to abuse, exploitation and violence. As an enlightened and compassionate response, the asylum movement developed in Europe in the seventeenth century to provide basic care, housing and respite for people with mental disorders, as well as people with severe epilepsy, brain injury or developmental disability (or mental retardation). Although administered by benevolent organisations, asylums came to constitute the major service system for the social management of people

with mental illness (eg. Figure 9). The predominant view, which persisted well into the twentieth century, was that institutional care was the most humane response possible. Additionally, it provided the wider community with a sense of protection against the unpredictable behaviour of those with psychotic illnesses. Although institutional care has long been associated with neglect and abuse, these positive views about it persist in both developing and developed countries.

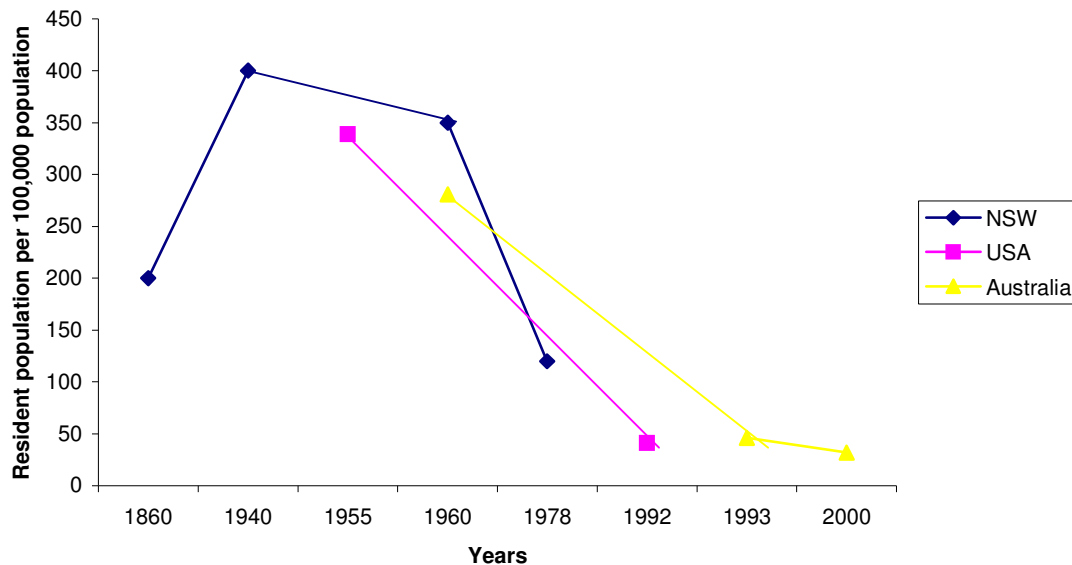


CALLAN PARK HOSPITAL FOR THE INSANE, SYDNEY.—MR. JAMES BARNET, ARCHITECT. Sept. 6, 1879 - THE BUILDER.  
(DIAGRAM 12)

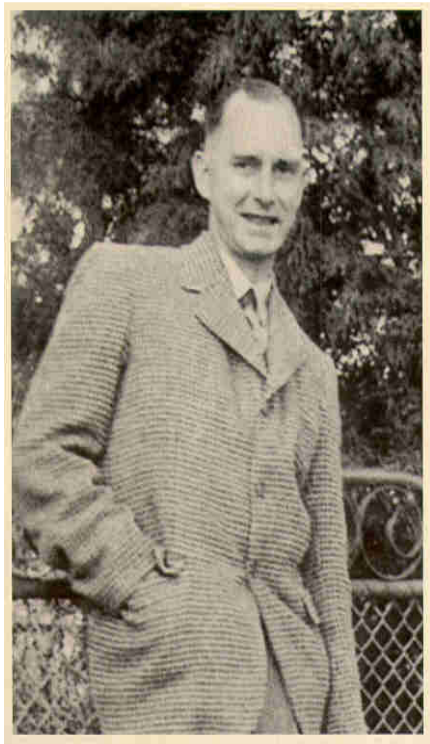
**Figure 9: Drawing of Callan Park Mental Hospital and caption as recorded in a thesis written for the Degree of Bachelor of Architecture, 1984. Source: The University of New South Wales – reproduced with permission (Leong, 1984).**

## 1.2 Decline of institutionalism

The asylum movement was established largely for people who were unresponsive to medical care and, consequently, unable to function in the wider community. From the 1950s, the number of people in institutional care began to decline internationally (Figure 10). A series of medical and social factors underpinned this decline long before any active government policy promoted community-based care. The first was the introduction of effective pharmacological treatments for schizophrenia (eg. chlorpromazine), bipolar affective disorder (or manic-depressive illness) and severe depression (eg. tricyclic antidepressants) and, anticonvulsant drugs for epilepsy. The description of the therapeutic effect of lithium carbonate for mania by John Cade was first reported in the *Medical Journal of Australia* in 1949 (Figures 11 and 12).



**Figure 10: Number of persons in institutional care from 1860-2000.** Data sources: for NSW (Public Health Division, 1996); for USA (Lamb, 1992); for Australia (Commonwealth Department of Health and Ageing, 2002; Whiteford *et al.* 1993). Figures: for NSW represent “resident population of institutions for the mentally ill per 100,000 population”; for USA represent “state hospital beds per 100,00 population”; and for Australia represent “total public sector inpatient beds per 100,000”.



**Figure 11 (left): Photograph of Dr John Cade from the front cover of the *Medical Journal of Australia*, 1999; 171(5). © Copyright 1999. The *Medical Journal of Australia* – reproduced with permission.**

**Figure 12 (right): First page of original article by Dr John Cade published in the *Medical Journal of Australia* in 1949. Source: Cade, JFJ. Lithium salts in the treatment of psychotic excitement. *Medical Journal of Australia* 1949; 2: 349-352. © Copyright 1949. The *Medical Journal of Australia* – reproduced with permission.**

LITHIUM SALTS IN THE TREATMENT OF PSYCHOTIC EXCITEMENT.

By JOHN F. J. CADE, M.D.,  
Senior Medical Officer, Victorian Department of Mental Hygiene.

LITHIUM SALTS enjoyed their hey-day in the latter half of last century when, commencing with their introduction by Garrod, they were vaunted as curative in gout, and so doubtless in a multitude of other so-called gouty manifestations. This followed the demonstration that lithium urate was the most soluble of the urates. It was shown that if pieces of cartilage with urate deposits were immersed in solutions of sodium, potassium and lithium carbonate, the urate was dissolved first from that piece immersed in the lithium carbonate solution.

As time went on and lithia tablets were consumed on an ever-increasing scale for an ever-increasing range of ailments, the toxic and depressant effects were more and more commonly seen.

Garrod (1859) wrote of lithium carbonate: "When given internally in doses of from one to four grains dissolved in water, two to three times a day, it produces no direct physiological symptom . . . their use does not appear to be attended with any injurious consequences." And certainly, in that dosage, there should never be any toxic symptoms.

But about fifty years later cases are reported "of cardiac depression and even dilatation, as a result of excessive and continued consumption of lithia tablets" (*The Practitioner*, 1907).

"Cardiac depression and even dilatation" was perhaps very vague physiology, but the note of warning was clear, also the statement in Squires's "Companion to the British Pharmacopoeia" that "lithia salts upset the stomach very easily" (*The Practitioner*, 1909).

What with the hypothetical cardiac depression and the actual mental depression, nausea and giddiness, the uselessness of lithium in most of the conditions for which it was prescribed, and the fact that there was other, more efficacious treatment in the only disease in which it had been shown to be of some value, it is not surprising that lithium salts have fallen into desuetude.

Culbreth (1927) says of lithium bromide that it is the most hypnotic of all bromides. The dosage stated there is the relatively enormous one of 10 to 30 grains. It is not stated how often this huge dose might be repeated each day, but one presumes the traditional two to three times. Squires, too, states that "in epilepsy it is the best of all bromides" and gives the dose more conservatively as five to 15 grains.

It is worth noting that the hypnotic action of lithium bromide was thought to be due to the fact that, the atomic weight of lithium being so small, weight for weight, lithium bromide must contain more bromide ion than any other bromide. There is no evidence that the lithium ion was recognized as having a marked sedative action superior in some respects to that of the bromide.

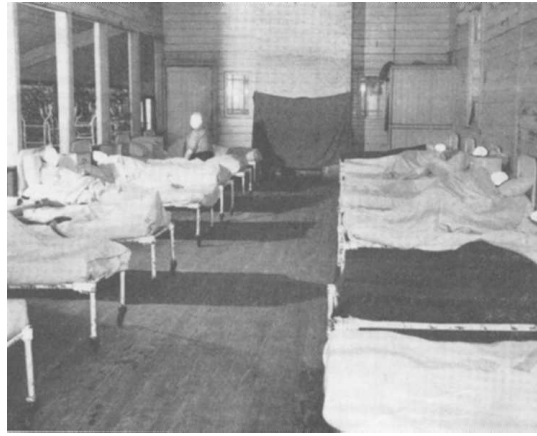


**Figure 13: Photograph of airing court and caption as recorded during the Royal Commission into Callan Park Mental Hospital, 1961. Source: New South Wales Royal Commission into Callan Park Mental Hospital, 1961, photograph 5, p.200 – reproduced with permission.**



The airing court between Male Ward 1 and Male Ward 2 may give some indication of the pathetic disinterest of patients who have nothing to do

**Figure 14: Photograph of a dormitory and caption as recorded during the Royal Commission into Callan Park Mental Hospital, 1961. Source: New South Wales Royal Commission into Callan Park Mental Hospital, 1961, photograph 2, p.198 – reproduced with permission.**



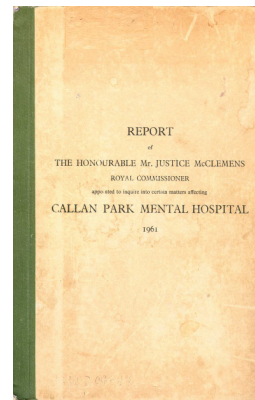
One of the dormitories in Male Ward 7, which ward is marked for demolition. This photograph shows patients who have been put to bed in broad daylight, all of whom were ambulatory

**Figure 15: Photograph of a bathroom and caption as recorded during the Royal Commission into Callan Park Mental Hospital, 1961. Source: New South Wales Royal Commission into Callan Park Mental Hospital, 1961, photograph 9, p.202 – reproduced with permission.**



The bathroom in Female Ward 4. It is not possible in a photograph to recapture the squalor of this and other bathrooms in the Female section at Callan Park

**Figure 16: Front cover of the Royal Commission into Callan Park Mental Hospital. Report of the Honourable Mr Justice McClemens, Royal Commissioner appointed to inquire into certain matters affecting Callan Park Mental Hospital, 1961. Source: New South Wales Royal Commission into Callan Park Mental Hospital, 1961 – reproduced with permission.**





Next, the very poor physical state of institutions (constructed largely in the early to mid-nineteenth century in Australia) and the associated patterns of systematic abuse and neglect were increasingly recognised (Figures 13-15, Box 1). A series of national enquiries (eg. Figure 16) and international reviews recommended major reforms and the development of general hospital and other non-institutional forms of care. A third development was the concept of community-based mental health care and the recognition of the wider mental health needs of the population. Both World Wars had given governments some insight into the prevalence of mental disorders in people in the community (making them unfit for military service at the time of recruitment) and the extent to which acute changes in mental function during military service could disable large numbers of people.

**Box 1: Professor Trethowan's views regarding the general defects of accommodation at Callan Park Mental Hospital as reported in the 1961 Royal Commission into Callan Park Mental Hospital (New South Wales, 1961, p.67).**

*The opinion of Professor Trethowan as to the general quality of the accommodation at Callan Park on the civil side is:*

“The accommodation is very variable in quality. A good deal of it is unsatisfactory, I would say, from the point of view of patient-accommodation, particularly the old Kirkbride buildings. Although attempts have been made in a number of cases to improve conditions in some of these wards, in many cases they are in a dilapidated condition in regard to paintwork and the general standard of decoration. In some cases there is not inconsiderable overcrowding. In others the bathroom and washing facilities appear to be inadequate and in need of replacement and repair. The toilet facilities are, as a whole, unsatisfactory, even where these have been renewed. For example, one finds the urinals and toilets in the dormitories right next to the patient's bed, with no air lock or proper provision in between. Lighting in some wards is unsatisfactory. There is an absence of storage for clothing and there is no adequate storage space for personal effects in many cases. Some of the pantry accommodation has been renewed and is satisfactory, but a good deal of it is outdated and without proper stoves. The contrast, for example, between the old Kirkbride buildings which have not been tackled and one of the female buildings which has been much improved is quite striking. As a whole, I think there is insufficient day room space in these wards.”

In Australia, the process of deinstitutionalisation has been depicted erroneously as the result of government policy changes that occurred at a much later period (Australian Health Ministers, 1992a,b; Commonwealth Department of Health and Aged Care, 2000a; Department of Health, 1983; Mental Health Consumer Outcomes Task Force, 1991). Such policies are frequently portrayed as ‘cost-cutting’ measures associated with an accompanying failure to fund comprehensive community services. More accurately, the 1980s saw an international movement to define what constituted comprehensive community care. Some Australian service innovations were acclaimed internationally (Hoult *et al.* 1983) and generated sound evidence for more humane and community-based care. In many less developed countries, there is still a strong reliance on institutional care, prolonged periods of treatment in other hospital settings and a relative lack of development of policies designed to meet the overall mental health needs of the population.

### 1.3 Increasing demand for quality care in non-institutional settings

For the last 50 years in most Western countries, mental health care has been provided largely within non-institutional settings such as family practice, general hospitals and outpatient and community-based care. By the end of the twentieth century, the contribution of specialist systems, let alone hospital-based systems of care, in countries like Australia was quite small (Andrews *et al.* 2001; Commonwealth Department of Health and Aged Care, 2000a). People with mental illness are now perceived as requiring finite periods of medical or psychological treatment. This change has been accompanied by an increased demand for more treatments, better quality treatments, more responsive services, more appropriate treatment settings, coordinated medical and psychological care and better support from related social welfare, housing and disability services (Figure 17). At the economic level, it is now clear that countries have more to lose by continuing to ignore the impact of mental disorders than by responding through a broad program of prevention, early intervention, and provision of the most effective treatment forms (Murray & Lopez, 1996; World Health Organization, 2001). The WHO has recently defined the priorities in mental health planning giving consideration to a country's capacity to afford quality health care (Box 2). For a country like Australia, with a relatively high level of resources, this translates to a call to action across a wide range of primary and secondary care services, associated social welfare and welfare systems, community education, consumer and carer empowerment and research innovations.



Figure 17: A series of newspaper special reports addressing the under-resourcing for people suffering from mental illness. Source: The Sunday Age, Sunday 12 December 2004, pp.1,6,7,16 – reproduced with permission.

*At the economic level, it is now clear that countries have more to lose by continuing to ignore the impact of mental disorders than by responding through a broad program of prevention, early intervention, and provision of the most effective treatment forms.*

**Box 2: Actions required for the improvement of mental health care in developed countries with a high level of resources (eg. Australia) based on overall recommendations made by WHO (World Health Organization, 2001, Table 5.1, p.114).**

<p><b>Recommendation 1: Mental health treatment to be provided in primary care</b></p> <ul style="list-style-type: none"> <li>• Effective management of mental disorders in primary care to be improved</li> <li>• Patterns of referral to be improved</li> </ul>
<p><b>Recommendation 2: Psychotropic drugs to be made available</b></p> <ul style="list-style-type: none"> <li>• Easier access to be provided to newer psychotropic drugs (under public or private treatment plans)</li> </ul>
<p><b>Recommendation 3: Care to be given in the community</b></p> <ul style="list-style-type: none"> <li>• Remaining custodial mental hospitals to be closed down</li> <li>• Alternative residential facilities to be developed</li> <li>• Community care facilities to be provided (100% coverage)</li> <li>• Individualised care to be given in the community to people with serious mental disorders</li> </ul>
<p><b>Recommendation 4: The public needs to be educated</b></p> <ul style="list-style-type: none"> <li>• Public campaigns to be launched for the recognition and treatment of common mental disorders</li> </ul>
<p><b>Recommendation 5: Communities, families and consumers to be involved</b></p> <ul style="list-style-type: none"> <li>• Advocacy initiatives to be fostered</li> </ul>
<p><b>Recommendation 6: National policies, programmes and legislation need to be established</b></p> <ul style="list-style-type: none"> <li>• Fairness in health care financing (including insurance) to be ensured</li> </ul>
<p><b>Recommendation 7: Human resources need to be developed</b></p> <ul style="list-style-type: none"> <li>• Specialists to be trained in advanced treatment skills</li> </ul>
<p><b>Recommendation 8: Other sectors need to be linked</b></p> <ul style="list-style-type: none"> <li>• Special facilities to be provided in schools and the workplace for people with mental disorders</li> <li>• Evidence-based mental health promotion programmes to be initiated in collaboration with other sectors</li> </ul>
<p><b>Recommendation 9: Community mental health needs to be monitored</b></p> <ul style="list-style-type: none"> <li>• Advanced mental health monitoring systems to be developed</li> <li>• Preventive programmes to be monitored for effectiveness</li> </ul>
<p><b>Recommendation 10: More research needs to be supported</b></p> <ul style="list-style-type: none"> <li>• Research on the causes of mental disorders to be extended</li> <li>• Research on service delivery to be carried out</li> <li>• Evidence on the prevention of mental disorders to be investigated</li> </ul>

Note: Actions accompanying each recommendation for countries with low and medium levels of resources for mental health care are described in the original report.

#### 1.4 Unforeseen consequences of community-based care

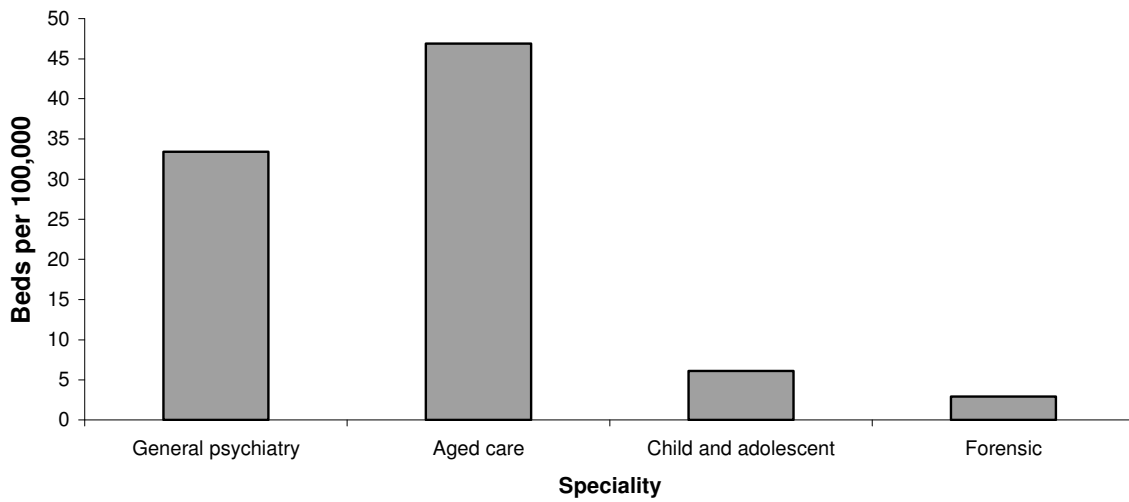
Providing treatments for finite periods in non-institutional care settings has strong support from consumers, family members and other carers and mental health advocates. However, it has given rise to a series of unforeseen difficulties. While some of these difficulties are a consequence of a failure to fund a full range of services, others reflect a wider lack of community acceptance of the rights of people with mental disorders, and a fundamental lack of empathy for the nature of their experiences (Hickie, 2004a). Recognition of the abuses associated with institutions was also unfortunately linked historically with the proposition that the institutions, or the treatments provided, were themselves the causes of mental illness (Szasz, 1961). In this model, and the associated anti-psychiatry movement of the 1960s and 1970s, advocates predicted that the removal of the institutions and the restriction of psychiatric services would result in a fall in demand for services. Some places (eg. California and Italy in the late 1970s and early 1980s) enacted radical changes with a variety of predicted and unpredicted consequences, but no resultant fall in the prevalence of mental illness or the need for services. The Italian experience led not only to gross neglect in some regions but, interestingly, the development of some of the more innovative models of genuine community-based care (Tansella & Thornicroft, 1998).

The progressive decline in the use of institutional care has simply resulted in an increased number of people with severe and enduring mental disorders living in community settings. Most of these people respond well to existing treatments and many with schizophrenia, bipolar disorder or severe depression or anxiety spend very little or no time in hospital-based care. A minority of these people, however, continue to exhibit confronting behaviours (that had been incorrectly attributed to institutional care or family dysfunction) and continue to have high levels of social disability. When there are pressures on accommodation services or social supports, these people are more likely to be incarcerated or found living among the homeless population. Another feature of low rates of utilisation of hospital-based care is that there are many young people with psychotic illness (often complicated by alcohol or other substance misuse, minor criminal offences, and periods of violence), who have never spent significant periods of their illness in institutional settings. They, and their family members, are more likely to experience great difficulties accessing medical care, as well as housing and welfare, despite deterioration in their capacity to reside in the community. While many of their needs are not met by current services, a return to institutional forms of care could simply expose these individuals to the overt abuse and covert neglect that characterised those services. Australian research has highlighted the ongoing traumatic effects when young people with these disorders are exposed even to our more permissive and time-limited forms of hospital-based care (McGorry *et al.* 1991).

While some countries, such as the United States, appear to tolerate these difficulties, others such as Australia are more disturbed by them (Figures 19-21). In the United Kingdom, there is currently debate about the potential *community* and consumer benefits of a return to institutional forms of care.

Some countries have responded even in recent years by building new institutions (eg. Figure 22). The significant expansion in 'forensic' psychiatry services in the United Kingdom is perceived by some as a covert return to a reliance on institutional models of care. Rapid transformations in the forms of care provided, and the implications for the people and families affected, let alone the wider community, have rarely been actively debated.

While mental health advocates emphasise there is “no going back” (Hickie, 2004a), others in the wider community are yet to be convinced. Among individuals with illness and their families, the debate about the location of care is less relevant than the more immediate demand for accessible, high quality and continuous forms of care. The current emphasis internationally is first on finding the right mix of locations of care (eg. acute and longer stay hospital care [Figure 18], community programs, rehabilitation and ‘return to work’ programs, supported accommodation in community settings) while also improving the mix and quality of treatments provided (eg. access to novel pharmacotherapies and cognitive-behavioural treatments and, participation in ‘return to work’ programs).



**Figure 18: Number of beds per 100,000 by speciality in Australia.**

## 1.5 Human rights agenda

*“It is now recognised that violation of human rights can be perpetrated both by neglecting the patient through discrimination, carelessness and lack of access to services, as well as by intrusive, restrictive and regressive interventions.”* World Health Organization, 2001, p.53

Progressively, over the last 30 years, attention has been paid to the basic human rights of people with mental disorders (Box 3). Various principles have been established and include: the need to limit periods when treatment can be administered without a patient’s consent; that periods of involuntary treatment should be limited to when someone poses a serious threat to themselves or others or is very likely to benefit from a specific medical treatment; that care should be provided in the least restrictive environment and as close as possible to his or her usual place of residence; and that people with mental disorders have similar rights to receive appropriate forms of medical and social care as those with other medical disorders. In developing countries, this has resulted in movements that link mental health services strongly with the development of local and regional primary care services (eg. Declaration of Caracas; Pan American Health Organization [PAHO], 1991). In developed countries, while this movement focused initially on the reform of mental health legislation, the removal of discrimination in other forms of legislation and the reduction of abuses within psychiatric hospital systems and other restrictive forms of care, it has increasingly focused on people’s rights to the best available treatments and active partnerships with consumers and carers in the formulation of all key aspects of mental health policy, service development and research.

This human rights movement was linked to wider social changes that expressed distrust of autocratic or paternalistic systems of care. Consequences of this movement included support for community-based care of people with mental disorders and, concurrently, those with developmental disability (or mental retardation). There is still considerable pressure internationally to close, or at least monitor, institutional forms of care, as they previously have been linked with political oppression and other human rights violations in the former Soviet Union, China and Central America. The movement towards non-institutional care in Australia was greatly assisted by the development of the national insurance scheme for outpatient medical care (i.e. 1973 – Medibank; 1983 – Medicare).

It is common elsewhere in the world for mental disorders to be excluded from medical insurance. Further, the development of regional models of care in Australia under the supervision of the states has assisted with providing reasonable access to at least emergency care and ongoing community-based ‘case-management’ within each health region. Each of these movements in Australia reflects the basic concept that people with mental disorders should be treated no differently to those people with other common general health problems.

Figure 19: A newspaper special report entitled "Community care fails mentally ill". Source: *The Australian*, Monday 29 April 2002, p.1 – reproduced with permission.



Figure 20: A newspaper special report entitled "The forgotten ones". Source: *The Australian*, Monday 29 April 2002, p.9 – reproduced with permission.



Figure 21: SANE Mental Health Report 2002-03. Source: SANE Australia, 2002 – reproduced with permission.



Figure 22: Photograph of Woodbridge Hospital in Singapore, 2004. Source: Institute of Mental Health, Woodbridge Hospital – reproduced with permission.







**Box 3: Principles 1, 3 and 7 of the *Principles for the Protection of People with Mental Illness and for the Improvement of Mental Healthcare* (United Nations, 1991).**

**Principle 1: FUNDAMENTAL FREEDOMS AND BASIC RIGHTS**

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
4. There shall be no discrimination on the grounds of mental illness. 'Discrimination' means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.
5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the *Universal Declaration of Human Rights*, the *International Covenant on Economic, Social and Cultural Rights*, the *International Covenant on Civil and Political Rights* and in other relevant instruments such as the *Declaration on the Rights of Disabled People* and the *Body of Principles for the Protection of All People Under Any Form of Detention or Imprisonment*.
6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is in issue shall be entitled to be represented by a counsel. If the person whose capacity is in issue does not himself or herself secure such representation it shall be made available without payment by that person to the extent that s/he does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is in issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is in issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.
7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.

**Principle 3: LIFE IN THE COMMUNITY**

Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

**Principle 7: ROLE OF COMMUNITY AND CULTURE**

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which s/he lives.
2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.
3. Every patient shall have the right to treatment suited to his or her cultural background.

### 1.6 Current global view

*"It is estimated that, in 2000, mental and neurological disorders accounted for 12% of the total disability-adjusted life years (DALYs) lost due to all diseases and injuries. By 2020, it is projected that the burden of these disorders will have increased 15%. Yet only a small minority of all those presently affected receive any treatment."* World Health Organization, 2001, p.xiv

Mental health is now recognised as one of the most serious public health challenges for the next 20 years, demanding increased population-based prevention and early intervention approaches as well as improved quality of existing services. Although proportional health expenditures remain relatively low (Australia spends 6.4% of total gross recurrent funds), 67% of countries spend less than 1% of total health expenditures (World Health Organization, 2001). While mental health is now on the health policy agenda of most developed countries, 40% of all countries still have no formal mental health policy, over 30% have no mental health program and over 90% have no specific policy for children and adolescents (World Health Organization, 2001).

*"The single most important barrier to overcome in the community is the stigma and associated discrimination towards people suffering from mental and behavioural disorders."* World Health Organization, 2001, p.98

One of the consequences of these difficulties has been that while very significant reforms are proposed, even in Australia the community remains relatively unaware of the size and scope of the problem (Highet *et al.* 2002) and continues to express fears and concerns that are detrimental to the lives of people with mental disorders (McNair *et al.* 2002). Even those who provide health services are commonly seen to reinforce the stigma associated with mental disorders (McNair *et al.* 2002). Professional organisations have been relatively slow to engage the wider community with their concerns, and active consumer and carer advocacy and mutual support organisations are recent phenomena. Current international priorities include: stigma reduction campaigns (Sartorius, 1997); recognition of the economic and social impacts of common disorders such as depression, anxiety and alcohol or other substance misuse (Sartorius, 2001); partnerships with consumers and carers; promotion of the human rights of people with mental disorders; reduction of wider social, financial and legislative barriers to full community participation (eg. discrimination in the workplace); expansion of effective pharmacological and psychological treatments into primary health care settings; and the pursuit of novel methods for delivering mental health information and services to disadvantaged populations (eg. via the Internet).

## **PART TWO: MENTAL HEALTH REFORM IN AUSTRALIA – RECENT HISTORY**

### **2.1 Introduction**

Mental disorders contribute substantially to the burden of disease in Australia. The AIHW reports that mental disorders account for 27% of non-fatal disease burden, and that mental health is third after heart disease and cancer in terms of disease burden (Mathers *et al.* 1999). Despite considerable advances in the mental health reform process over the last decade (such as the movement towards community-based care), much remains to be done to address the burden of mental health as identified in this Australian study and the 1996 *Global Burden of Disease Study* conducted by the WHO/ World Bank (Murray & Lopez, 1996).

The Australian *National Survey of Mental Health and Wellbeing* indicates that approximately 20% of the population experiences a mental health problem each year. These include depressive, anxiety and alcohol or other substance misuse disorders (McLennan, 1998). The prevalence of mental health problems in children and adolescents is 14% of the population (Sawyer *et al.* 2000). Three percent of Australian adults experience serious mental illness such as a psychotic disorder (Jablensky *et al.* 1999).

The stigma associated with mental illness is especially pervasive in the community, and society often deals with such fear and distress by alienating and segregating those with mental illness. The impact of stigma, discrimination and misunderstanding is often profound – becoming a part of the problem and affecting the life of the individual.

Services for people with mental illness are provided through a range of health and welfare programs funded by the Australian, State and Territory Governments, private health insurance and individual co-payments.

In the public sector, typical specialised mental health involves services being provided for a defined catchment population, with the service integrated across hospital and community settings. Inpatient services are provided in general hospitals and in separate psychiatric hospitals. Community-based services comprise a range, including clinic-based, mobile follow-up and treatment, and mobile crisis response services. Case management is often used to co-ordinate services provided in different settings. Housing, disability, support, employment and income support services are funded under other government programs.

*The stigma associated with mental illness is especially pervasive in the community, and society often deals with such fear and distress by alienating and segregating those with mental illness. The impact of stigma, discrimination and misunderstanding is often profound – becoming a part of the problem and affecting the life of the individual.*

### **2.2 Context**

The mental health of the Australian community has been a key policy area for the Australian, State and Territory Governments over the past decade.

## National Mental Health Strategy

The National Mental Health Strategy was agreed to by all Australian Health Ministers in 1992, initially for five years. The strategy provided – for the first time in Australia – a national agenda for mental health reform. The agreement defined a national direction and a framework for governments to work together to reform a system that was considered to be inadequate and neglected by policy makers.

The drive for reform had its origins in the convergent desire of mental health professionals, consumers and carers to see a better overall mental health service system in Australia and the release of the United Nations declaration *Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care* (United Nations, 1991). The 1993 *Report of the National Inquiry into the Human Rights of People with Mental Illness* (i.e. The Burdekin Report; Human Rights and Equal Opportunity Commission, 1993), highlighted the ongoing abuse and violation of the human rights of people with a mental illness. Inquiries in a number of states showed similar findings.

Broadly, the National Mental Health Strategy aims to:

- Promote the mental health of the Australian community and, where possible, prevent the development of mental health problems and mental disorders;
- Reduce the impact of mental disorders on individuals, families and the community; and
- Assure the rights of people with mental illness.

The National Mental Health Strategy comprises:

1. The *National Mental Health Policy* (Australian Health Ministers, 1992b) – outlines the approach to mental health reform, promoting a shift from institutional care to community care. The policy was endorsed by all Australian Health Ministers in 1992 and defined the broad aims and objectives to guide service re-development.
2. The *Mental Health: Statement of Rights and Responsibilities* (Mental Health Consumer Outcomes Task Force, 1999) – articulates the principles of United Nations Resolution 98B (*Resolution on the Protection of Rights of People with Mental Illness*). This document was agreed to by all Health Ministers in 1991 and outlined the philosophical foundations of the strategy regarding civil and human rights.
3. The *National Mental Health Plan* – since the commencement of the strategy in 1992, three consecutive five-year plans have been developed:
  - a. The First National Mental Health Plan (Australian Health Ministers, 1992a) provided priorities for reform for the period 1992-93 to 1997-98;
  - b. The Second National Mental Health Plan (Australian Health Ministers, 1998) improved and extended these directions for the period 1998 to 2003; and
  - c. The (Third) current National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003) provides an ongoing agenda for mental health reform and service delivery and outlines the priorities and 34 desired outcomes.
4. The *Medicare Agreements* (1992-93 to 1997-98) and the *Australian Health Care Agreements* (1998-99 to 2007-08).

The National Mental Health Strategy recognises the complementary but different roles of the Australian, State and Territory Governments. The Australian Government co-ordinates reform on a national basis, monitors the reform process, and disseminates information in annual reports on national progress in achieving the agreed outcomes. As well as providing additional mental health funding for the states and for national programs, the Australian Government has gradually increased access to nursing homes, emergency relief and accommodation, vocational rehabilitation, disability services and income support for people with mental illness and psychiatric disability (Whiteford *et al.* 2000). As documented in the body of this report, the findings of this evaluation suggest that much remains to be done in these areas. The State and Territory Governments, which are responsible for service delivery in Australia's public mental health system, are responsible for the bulk of public sector reform.

The implementation of the National Mental Health Strategy is undertaken in collaboration between the Australian Government, the governments of the states and territories (i.e. jurisdictions), and consumers, carers and mental health sector representatives through the Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group.

#### National Mental Health Strategy achievements

The main directions for reform under the strategy include the reduced reliance on stand-alone psychiatric hospitals and the expansion of community-based services and primary mental health care. Whilst progress with these goals has been made, improvements are uneven, the structural reform agenda has not been finished, and concerns about poor service quality and limited client outcomes have not been adequately addressed.

Some insight into how the strategy is progressing is provided via the *National Mental Health Report*, prepared and published bi-annually. The mandate for the report was provided by all Australian Health Ministers who agreed to monitor and report publicly on the progress of all jurisdictions.

Key achievements are reported in the most recent *National Mental Health Reports* (Commonwealth Department of Health and Ageing, 2002; Department of Health and Ageing, 2003) include:

- Continued increases in national spending on mental health, though only a rate parallel to increases in general health spending;
- Shift to a community-based system of care;
- Reduction in the size of psychiatric institutions;
- Reduced isolation of mental health services from the mainstream health system;
- Increased consumer participation in decision-making;
- Expansion of psychiatric disability support services; and
- Savings from the reduction in institutions redirected to new services.

It is also reported that all states and territories have amended their mental health laws to meet the strategy's requirements that all mental health legislation is consistent with the United Nations *Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care* (United Nations, 1991) and the *Mental Health: Statement of Rights and Responsibilities* (Mental Health Consumer Outcomes Task

Force, 2000). To facilitate this model, mental health legislation was developed and a 'Rights Analysis Instrument' was designed by the Federal Attorney-General's Department to evaluate the compliance of state and territory mental health legislation.

#### Impact of changes in psychiatric hospitalisation

The following information provides a national overview of changes in psychiatric hospitalisation. Central to the vision of the National Mental Health Strategy is the idea that an effective mental health service requires a core set of components, which place the locus of care in the community. The strategy has therefore advocated a fundamental shift in the service balance, away from the historical reliance on separate psychiatric hospitals to the development of local, comprehensive mental health services. These should be linked to form a single, integrated service system that emphasises continuity of care, both over time and across service boundaries and mainstreamed with the health system as a whole.

Stand-alone psychiatric institutions were central to Australia's mental health system at the commencement of the strategy, accounting for 49% of total mental health resources. By 1998 this reduced to 29% and total beds in institutions reduced by 42% (Commonwealth Department of Health and Ageing, 2002). At the commencement of the strategy, 55% of acute psychiatric beds were in specialist mental health units in general hospitals. By June 1998, this had increased to 73% as a result of a reduction in stand-alone acute services and a 34% growth in general hospital-based beds through the commissioning of new or expanded units (Commonwealth Department of Health and Ageing, 2002).

New models of care, and the shift away from institutional care towards community care, have challenged the attitudes and skills of mental health workers. Stigmatising attitudes to people with mental illness are still held by some clinicians and mental health professionals. It is important that practitioners acquire and maintain knowledge, skills and attitudes to provide quality services in this new service environment and ensure those with a mental illness play an active role in decisions about their treatment.

More people with mental illness are living in the community which means stigma from community members has a more direct impact on consumers. Consumer participation in community life, as well as in mental health services and policy development, is important for recovery and improved quality of life and citizenship. Ongoing efforts to reduce stigma and discrimination continue to be important.

#### Funding of mental health services

For the first 10 years of the National Mental Health Strategy, protection of the resource base for mental health reform was imposed by the Australian Government. Federal mental health funding was quarantined from general health funding provided to the states and territories which subsequently agreed to maintain their previous levels of mental health expenditure throughout the reform period. In addition, any savings arising from the downsizing of institutions were required to be directed back to new mental health service development. However, this arrangement changed under the current National Mental Health Plan, where separate funding for mental health was not earmarked under the Australian Health Care Agreements 2003-08.

The following information is an overview of mental health expenditure nationally. Australia spends 6.4% (\$3.088 billion) of its recurrent health budget on mental health (Department of Health and Ageing, 2003).

While comparisons with other health areas are problematic, mental health accounts for 13% of total disease burden due to death and disability (Mathers *et al.* 1999). If the contributions of suicide and self-inflicted injury are added, the proportion rises to over 15%. The costs of all health areas continue to increase due to increased population size (17.6 to 19.0 million Australians) and increased demand for new treatments, new technologies and more comprehensive services.

Despite the increased total expenditure in mental health over the last decade, *there is no evidence that the proportion of total health expenditure devoted to mental health has increased.* Increases in expenditure on mental health (65%) have simply mirrored increases in the costs of providing other forms of health care (61%).

The National Mental Health Strategy assumed that the proportion of health expenditure devoted to mental health would increase. While the Australian Government did increase its contribution significantly (by 128%), growth in state and territory expenditure was only 40% per capita (Department of Health and Ageing, 2003).

New South Wales and Victoria recorded very low increases – only 16% and 12% per capita respectively. While growth in Australian Government expenditure was significant, two-thirds of this was accounted for by the increase in pharmaceutical costs, rather than planned or appropriate expansion of service systems. The expansion in pharmaceutical costs is a result of the rapid growth in new products to treat brain-related disease, as well as the decline in the external purchasing power of the Australian dollar. There is no substantial investment in development of these products in Australia.

#### Community participation in, and integration of, mental health services

Consumers and carers have been included in national planning since the National Mental Health Strategy began. By 1998, 61% of service delivery organisations reported the establishment of formal mechanisms for consumer participation in local service issues (Commonwealth Department of Health and Ageing, 2002). However, recent reports highlight that consumers and carers are still not satisfied with the rate of progress of service reform (Groom *et al.* 2003). Service providers, particularly those working in the public sector, also report a deteriorating system of care (Rey *et al.* 2004). Interestingly, service administrators do not share the views of declining standards of care expressed by those who use or provide such services (Groom *et al.* 2003).

Integration advocates the bringing together of the elements that make up a mental health service into a cohesive program that promotes continuity of care. These elements include acute and non-acute inpatient services, residential services and psychiatric disability support services. Achieving a balance between mainstreaming and integration has presented a challenge for the states and territories.

This requires a balance between removing barriers that separate mental health services from the general health system and maintaining the identity and cohesion of the mental health service network. Monitoring

progress on the objectives of mainstreaming and integration is complex. Each state and territory runs its health services differently and there is, as yet, no nationally agreed method for measuring progress.

#### Quality control of mental health services

It is an objective of the National Mental Health Policy that all mental health services have a quality assurance program. In December 1996, the AHMAC National Mental Health Working Group endorsed the *National Standards for Mental Health Services* (Commonwealth of Australia, 1997) as an essential part of achieving high quality mental health services. Under the Australian Health Care Agreements all states and territories agreed to full implementation of the national standards in public sector mental health facilities by 2003. However, only 49% of services had implemented such services by June 2003 (Department of Health and Ageing, 2003)

There are three sections in the *National Standards for Mental Health Services*:

- Standards one to seven address universal issues including human rights, dignity, privacy and confidentiality and community acceptance;
- Standards eight to 10 relate to mental health service organisational structures, service integration and links between parts of the mental health sector; and
- Standard 11 has sub-components which describe the process of delivering care on a continuum, commencing with access to mental health services, exiting mental health services and types of treatment and support available.

The Australian Government is working with states and territories to support quality assurance through review and accreditation of services against the national standards. The states and territories are currently at varying stages of this work. The private and non-government sectors are also working to implement the standards.

Consumers and carers have consistently identified that many of their issues and concerns with mental health service delivery would be addressed, if effective implementation of the national standards was actually prioritised.

### **2.3 Out of Hospital, Out of Mind!**

After 10 years of this approach, the MHCA conducted a nationwide review to ask those who used, or provided, mental health care whether substantial change had been achieved. This consultation involved more than 400 organisations and individuals and was conducted between August and December 2002. It utilised appropriate qualitative and quantitative methodologies. The face-to-face consultations and the three-stage mailed surveys engaged a wide range of national bodies, representing consumers and carers, professional groups, non-government organisations and local service providers.

The major conclusion of the review was stark. Despite the efforts of many committed politicians, government officials, service providers and community advocates, we do not have a system of effective or accessible mental health care. At all levels of government, within some of the health professions and in the wider community, there is a perception of general apathy, lack of accountability and lack of commitment to real



change. While public understanding of mental health has begun to improve, the wider community remains relatively ignorant of the service crisis. Only when a family member is affected are they made aware of the gross deficits in care.

*The major conclusion of the review was stark. Despite the efforts of many committed politicians, government officials, service providers and community advocates, we do not have a system of effective or accessible mental health care.*

People with mental disorders, and their families, feel frustrated and let down by the system. Their goodwill, patience and support for the protracted nature of genuine health care reform have been dissipated. People whose lives have been affected are willing to back another five years of government national planning only if it is supported by genuine national leadership and commitment.

*People with mental disorders, and their families, feel frustrated and let down by the system. Their goodwill, patience and support for the protracted nature of...reform have been dissipated.*

While mental health reform is difficult, and needs to be seen as occurring over years rather than weeks or months, those in need of services today require an urgent and substantial improvement in our mental health care system. To simply continue with the current inadequate pace of reform, perpetuate the same inadequate resource base, utilise the same governance structures, and fail to invest in innovation and disease prevention, is to condemn many of the most disadvantaged and ill members of our community to many more years of abuse, neglect and very poor mental and physical health. It also puts at great risk the wellbeing of many other Australian families who are likely to require such services for the first time in future years.

*To simply continue with the current...pace of reform...is to condemn many of the most disadvantaged and ill members of our community to many more years of abuse, neglect and very poor mental and physical health.*

#### Key Themes of Out of Hospital, Out of Mind!

##### 1. Restricted access to existing services

- The experience of current consumers of mental health care is that they have severely limited access to primary care (exacerbated by current declines in bulk-billing rates), emergency care, specialist care and rehabilitation services.
- Current care systems are perceived to be chaotic, under-resourced and overly focused on providing brief periods of medicalised care, largely within acute care settings.
- Private psychiatric services are poorly distributed (Burgess *et al.* 2002) and involve large out-of-pocket costs, while access to specialist psychology and other allied services has been restricted by lack of government or private insurance support.
- The demands on the carers and families of people with mental illness, as a consequence of shortcomings in our community-based system, are increasing.

## 2. Ongoing human rights abuses and neglect

- While the locus of care under the National Mental Health Strategy has moved from institutional to community-based care (Commonwealth Department of Health and Ageing, 2002), no effective management system has evolved to provide either high quality care or the necessary supports for living productively within the wider community.
- People with mental illness report ongoing abuse within hospital forms of care, and abuse and neglect in the wider community. Overt abuse is reported to occur within emergency departments and other acute care settings of general hospitals.
- People with mental illness report ongoing discrimination in employment and insurance, and restricted access to basic welfare services and support (McNair *et al.* 2002).

## 3. Increasing demand for mental health care

- The future of mental health care will be one of increasing demand and increasing costs to health and welfare services.
- Increasing demand will be driven by the significant stress placed on Australian families from war, threat of terrorism, ongoing drought, more young people developing mental disorders, increasing numbers of people with current disorders presenting for care (as public awareness of these conditions increases), and increasing expectations that services will provide optimal and evidence-based care for whole episodes of illness.
- In the 2001 *National Health Survey* (Australian Institute of Health and Welfare, 2003c), 10% of adults reported they had a long-term mental or behavioural problem and 10% had taken a pharmaceutical medication in the last two weeks.
- People with disorders will expect treatments to be provided earlier in the course of their illness, in more specialised forms and for longer periods.
- Increased costs of care will occur when we import new pharmacological agents affecting the central nervous system.
- Increased public, business and professional awareness of the total societal burden and economic costs of untreated mental disorders (as described within the Global Burden of Disease framework; Murray & Lopez, 1996) will create increased expectations of a broad illness prevention approach across the population.
- Governments will be expected to fund not just basic services but also support mental health promotion and disease prevention campaigns for the whole population.

### 2.4 Other national and state reviews

The findings of this review resonate strongly with, and build on, the extensive nationwide research by SANE Australia in 2002-03. SANE's *Mental Health Report 2002-03* clearly showed that "... *mental health services are in disarray around the country, (and) operating in crisis mode...*". SANE also reported that "... *effective treatments ... are not routinely available ...*", and "... *untreated mental illness is a leading contributor to Australia's suicide rate ...*".

*"The weight of evidence presented to the Committee highlights that mental health services in NSW need revolutionary improvement. Deinstitutionalisation, without adequate community care,*

*has resulted in a new form of institutionalisation: homelessness and imprisonment.*" Honourable Dr Brian Pezzutti, Chair, NSW Select Committee on Mental Health, 2002, p.xv

A number of other independent state-based reports have highlighted the inadequacy of current mental health services. The *New South Wales Upper House Inquiry* (Select Committee on Mental Health, 2002) highlighted the inadequacy of community-based care systems while the report of the Victorian Auditor-General (Cameron, 2002) emphasised the poor performance of acute mental health services:

*"This audit identifies a range of concerns about the timeliness of service provision, the completion of key service delivery processes in compliance with relevant standards and guidelines, and the burdens placed upon carers and families. In making these findings, I do not wish to impugn the many dedicated professionals providing mental health services. It is clear that the service system is under significant stress, due to demand pressure, work force shortages and the increasing complexity of mental disorder in our society."* J. W. Cameron, Auditor-General, 2002, p.vii

When the states and territories most recently reported on their own performance in 2002 (Commonwealth Department of Health and Ageing, 2002), it was clear that some (notably South Australia, which had recently commissioned its own external review) had not made the substantial moves planned under the national strategy, while most had failed to implement the national mental health standards or report significant increases in funding in the last five years.

## **2.5 Conclusion**

This part of the report has provided the national context and a broad overview of the progress made in implementing the National Mental Health Strategy. It needs to be restated that the progress with mental health reform, as documented in the most recent National Mental Health Report (Department of Health and Ageing, 2003), does not fit with the 'felt reality' of people who use the system (Groom *et al.* 2003). Whilst progress has been made, it seems that much remains to be done to complete the structural reform of mental health services and improve the quality of life of mental health consumers and their carers.

## PART THREE: MENTAL HEALTH SERVICES IN AUSTRALIA FOR 2003-2008 – A REVIEW

### 3.1 Introduction

In April 2003, the MHCA launched its national review of mental health services in Australia: *Out of Hospital, Out of Mind!* (Groom *et al.* 2003). The report highlighted the obvious deficiencies in care (Figure 23) and developed community priorities for action. We still have insufficient data from government agencies about what really happens in mental health at local, regional and state/ territory levels. Consequently, the MHCA, with academic support from the *Brain & Mind Research Institute*, is undertaking a state-by-state review of services in 2004.

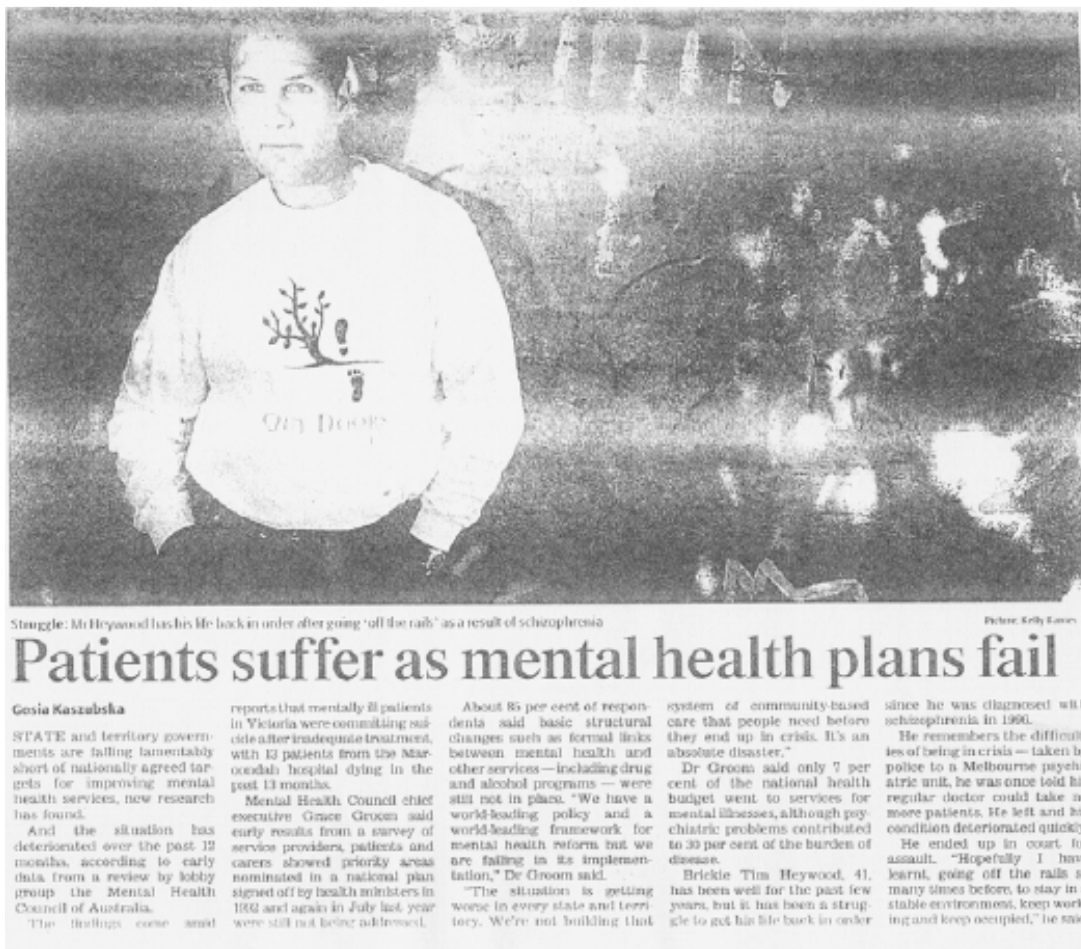


Figure 23: A newspaper special report entitled “Patients suffer as mental health plans fail”. Source: *The Australian*, Friday 20 February 2004 – reproduced with permission.

### 3.2 Methods

Two surveys have been developed. This first survey evaluates the extent to which national and community priorities have been implemented at the local and state level (Appendix 1). It is designed to be completed by both providers and users of mental health services. Our second survey assesses direct experiences of care against internationally developed benchmarks for quality health care (Appendix 2). We believe that these surveys provide a unique opportunity for genuine input from the broader mental health sector.

The first survey was divided into three sections:

- The first asked some demographic information about the respondent and the service they used.
- The second asked the respondent to rate how the national and community priorities have been implemented or supported within their *local* area.
- The third asked respondents to rate how the national and community priorities have been implemented or supported at a *state* level.

The second survey was divided into two sections:

- The first asks *consumers, carers and family members* about their experiences with mental health services as well as some demographic information. Its basic domains are drawn from those identified by the Picker Institute Europe as critical elements of quality health care.
- The second asks *consumers only* more specific questions about their experiences with mental health services. It is based on a current survey being undertaken also in the United Kingdom to evaluate consumers' direct experiences of care.

### 3.3 Preliminary results

#### Survey 1: national and community priorities

As of December 2004, 750 complete surveys have been received. This includes 596 (80%) respondents completing the survey as an individual and 149 (20%) completing the survey on behalf of an organisation. The majority of respondents describe their role in the mental health sector as public providers of specialist treatment (n=260, 35%). This is followed by consumers and carers (n=170, 23%) and then non-government community service providers (n=74, 10%). Across Australia, most respondents were located in New South Wales (Table 9).

**Table 9: Total number of respondents by state; N=750.**

State	Total number (%) of respondents
New South Wales	244 (33%)
Victoria	136 (18%)
Western Australia	111 (15%)
Queensland	98 (13%)
South Australia	72 (10%)
Australian Capital Territory	44 (6%)
Tasmania	27 (4%)
Northern Territory	9 (1%)

Respondents rated the extent to which the top four national priorities as identified in Out of Hospital, Out of Mind! have been implemented or supported in their *local* areas (Table 10).

**Table 10: Implementation or support for the top four priorities at a LOCAL level; N=750.**

	<b>Nearly complete or high level support PLUS fully implemented or full support</b>
1. Implementation of early intervention services	125 (17%)
2. Development of innovative services for people with mental health and alcohol or substance abuse disorders	81 (11%)
3. Development of a wider spectrum of acute and community-based care settings	88 (12%)
4. Implementation of the national standards for mental health services	115 (15%)

Respondents also rated a number of other priorities on the extent to which they have been implemented or supported in their *local* areas (Table 11).

**Table 11: Implementation or support of other priorities at a LOCAL level; N=750.**

	<b>Nearly complete or high level support PLUS fully implemented or full support</b>
1. More genuine consumer participation	120 (16%)
2. More genuine carer participation	130 (17%)
3. Support for enhanced role of non-government organisations in all aspects of care	73 (10%)
4. Clear accountability for expenditure of mental health strategy funds	84 (11%)

Next, respondents rated the extent to which priorities have been implemented or supported within their *state* (Table 12).

**Table 12: Implementation or support of priorities at a STATE level; N=750.**

	<b>Nearly complete or high level support PLUS fully implemented or full support</b>
1. Development of specific inter-governmental service agreements (eg. between health, education, housing, employment, and social security)	96 (13%)
2. Direct support for 'innovation', 'research' and 'service evaluation' in mental health	78 (10%)
3. Support for enhanced role of non-government organisations in all aspects of care	86 (12%)
4. Clear accountability for expenditure of mental health strategy funds	80 (11%)
5. Development of datasets for monitoring the quality of local services	105 (14%)

6.	Development of specific procedures for reporting Human Rights abuses or neglect	77 (10%)
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Finally, respondents living and/or working in regional, rural and poorly-resourced areas were asked to rate the extent to which such factors have been implemented or supported within their *state* (Table 13).

**Table 13: Implementation or support for regional or rural and poorly resourced areas.**

	n	Nearly complete or high level support PLUS fully implemented or full support
1. IN YOUR STATE, what is the level of support for service development in rural and regional areas?	392	27 (7%)
2. IN YOUR STATE, what is the level of support for service development in poorly resourced areas?	394	8 (2%)

Survey 2: direct experiences of care

As of December 2004, 241 complete surveys have been received, including 134 (56%) from consumers, 64 from carers (26%) and 43 (18%) from family members or close friends. All respondents had experience (either direct or indirect) with mental health services during the previous twelve months. Forty-two percent (n=101) had contact with public health services, 30% (n=72) with private health services, and the remaining 28% (n=68) a mixture of the two.

Eighty percent (n=193) of the sample was female with an average age of 41 years. The majority of respondents (66%) resided in major urban areas, with only 14% of the sample from rural areas with populations less than 10,000.

Forty-two percent (n=102) of respondents (mostly consumers and carers) said they were not treated with respect and dignity nearly always or always (Table 14).

**Table 14: The extent to which the consumer or someone close to them was treated with respect and dignity by health professionals; N=241.**

	Consumer	Carer	Family member or close friend
n	134	64	43
Always	32%	27%	16%
Nearly always	34%	30%	19%
Sometimes	19%	31%	42%
Not often	11%	12%	21%
Never	4%	0%	2%

The majority of respondents (70%) felt they did not have adequate access to services (Table 15), with 19% not being able to find a health professional to talk to about their concerns.

**Table 15: The extent to which access to adequate services for mental health problems was achieved; N=241.**

	Consumer	Carer	Family member or close friend
n	134	64	43
Always	13%	9%	0%
Nearly always	25%	17%	9%
Sometimes	27%	41%	26%
Not often	25%	25%	58%
Never	10%	8%	7%

Over one third (40%) of participants felt they were given insufficient or no information about the condition or treatment. Of those respondents who wanted information given to family and friends, more than half (103/174) felt that not enough information was given. In situations where medication was prescribed for the mental health problem, only 23% responded that the purpose, benefits and side-effects were fully explained (Table 16).

**Table 16: The extent to which medications prescribed for a mental health problem was explained in terms of purpose, benefits and/or side-effects; N=228.**

	Consumer	Carer	Family member or close friend
n	126	63	39
Yes, definitely	30%	19%	8%
Yes, to some extent	24%	24%	15%
Yes, a little	25%	25%	33%
No	21%	32%	44%

Approximately one third of the sample (34%) said that the health professionals involved agreed always or nearly always with one another. Over one third (38%) did not feel they had enough say in decisions about care and treatment (Table 17), and 19% had not had the diagnosis discussed with them (17% of consumers, 11% of carers and 37% of family members or close friends).

**Table 17: Whether the consumer, carer or family member/ close friend felt they had enough say in decisions about care and treatment; N=241.**

	Consumer	Carer	Family member or close friend
n	134	64	43
Yes, definitely	38%	19%	0%
Yes, to some extent	37%	34%	37%
No	25%	47%	63%



Ninety-two consumers answered more detailed questions regarding their care and treatment. The majority (86%) had seen a psychiatrist in the previous 12 months (see Table 18 for ratings), only 28% a community psychiatric nurse and 69% had seen some other mental health professional. All but six consumers had taken medications for mental health problems in the last 12 months and 65% had received a talking therapy. Half the consumers (50%) had an after hours contact in a mental health service, and of these people 62% had used this form of crisis care in the previous 12 months.

**Table 18: Consumer ratings of psychiatrists they had seen in the last 12 months; N=92.**

	<b>Psychiatrist listened carefully to you</b>	<b>You have trust and confidence in the psychiatrist</b>	<b>Psychiatrist treated you with respect and dignity</b>	<b>Given enough time to discuss condition and treatment</b>
Yes, definitely	55%	39%	54%	30%
Yes, to some extent	27%	30%	34%	31%
No	18%	31%	12%	39%

Only five consumers (5%) had received a care plan, which is a document that outlines mental health needs and who will provide services. About one third (34%) of consumers rated the health care received in the last 12 months as poor to very poor, 29% as fair to good, and 37% as very good to excellent.

### **3.4 Conclusions**

The responses of local providers of services, and many consumers, carers and non-government organisations, indicate clearly that the key community priorities for national mental health reform have not been implemented. The results are a sad commentary on our capacity to turn mental health rhetoric into real local action in Australia. Very basic structural issues of implementation of the national standards, accountability for funds, involvement of consumers and carers, and engagement and support of the non-government sector have not been attained. Real program development – such as implementation of early intervention strategies, management of concurrent alcohol or other substance misuse problems and development of a greater range of acute care settings – remain largely on the drawing board. Rural and regional areas and areas within states with low levels of other resources still appear to be neglected. The perceptions of the providers and users of services continue to reinforce the data originally described in *Out of Hospital, Out of Mind!* (Groom *et al.* 2003).

In our most recent surveys we have begun to place more emphasis on direct experiences of care by consumers and carers. Here again, we see a disturbing pattern of neglect of basic aspects of care including provision of adequate information for decision-making and clear planning of service interventions. Such surveys should rapidly become a central feature of quality improvement systems within regular health services.

## PART FOUR: WIDER PHYSICAL HEALTH AND SOCIAL IMPACTS

### 4.1 Related alcohol or other substance misuse problems

The intimate relationship between alcohol or other substance misuse and mental disorders is increasingly recognised. We now have good data on usage patterns (Tables 19 and 20), changing patterns of use, risk factor relationships between different substances and different patterns of mental disorders, and the types of treatments that need to be provided to reduce the long-term consequences of these combined problems. Historically, however, our medical services have responded very poorly to these common problems. By contrast, the community rates the management of comorbid mental health and alcohol or other substance misuse as the second top priority for immediate attention under any national mental health plan (Groom *et al.* 2003).

**Table 19: Alcohol use by the Australia population aged 14 years and over, 2001 (Australian Institute of Health and Welfare, 2002).**

	Males		Females		Persons	
	1998	2001	1998	2001	1998	2001
Daily	12.1%	11.1%	5.1%	5.6%	8.5%	8.3%
Weekly	47.3%	46.0%	33.0%	33.2%	40.1%	39.5%
Less than weekly	25.2%	28.8%	38.5%	40.3%	31.9%	34.6%
Ex-drinker	8.6%	6.8%	11.4%	9.2%	10.0%	8.0%
Never a full glass of alcohol	6.8%	7.4%	11.9%	11.7%	9.4%	9.6%

**Table 20: Cannabis (or marijuana) use by the Australian population aged 14 years and over, 2001 (Australian Institute of Health and Welfare, 2002).**

	Males	Females	Persons
14-19 years	26.6%	22.6%	24.6%
20-29 years	35.1%	23.2%	29.3%
30-39 years	20.8%	11.7%	16.1%
40-49 years	10.7%	6.6%	8.7%
50-59 years	4.5%	2.0%	3.3%
60+ years	0.7%	0.3%	0.5%
<b>All ages</b>	<b>15.8%</b>	<b>10.0%</b>	<b>12.9%</b>

Of greatest importance for the future of mental health in Australia are two unresolved issues. First, alcohol remains the most commonly used substance by people with common mental health problems. In fact, it remains the number one strategy used by people with depression to control their difficulties (Jorm *et al.* 1999). By contrast, seeking help from a family doctor ranks number nine. Second, the increasing use of alcohol and other illicit substances, most notably cannabis, by young people with emotional and behavioural difficulties poses clear threats for not only their current wellbeing but also their long-term physical and mental health (Table 21).

**Table 21: Proportion of the Australian population aged 14 years and over at risk of harm in the long-term, 2001 (Australian Institute of Health and Welfare, 2002).**

	<b>Abstainers</b>	<b>Low risk<sup>a</sup></b>	<b>Risky<sup>b</sup></b>	<b>High risk<sup>c</sup></b>
Males	14.1%	75.6%	6.7%	3.5%
Females	20.8%	69.8%	7.2%	2.2%
<b>Total</b>	<b>17.5%</b>	<b>72.7%</b>	<b>7.0%</b>	<b>2.9%</b>

<sup>a</sup>For males less than 28 standard drinks per week is considered 'low risk' while for females less than 14 standard drinks per week is considered 'low risk'; <sup>b</sup>For males 29 to 42 per week is considered 'risky' while for females 15 to 28 per week is considered 'risky'; <sup>c</sup>For males 43 or more per week is considered 'high risk' while for females 29 or more per week is considered 'high risk'.

Cannabis has clearly emerged as a major risk factor for the onset of psychosis and the increased severity of psychosis, as well as for relapse and poorer long-term outcomes (Arseneault *et al.* 2002; Patton *et al.* 2002; Rey & Tennant, 2002; Zammit *et al.* 2002). The risk appears to be increased particularly if regular exposure occurs before 15 years of age (Arseneault *et al.* 2002). Importantly, regular cannabis use has been identified as a risk factor in the onset of common disorders such as depression and anxiety in Australian youth (Patton *et al.* 2002). There is no clear consensus on the educational, social policy or population health measures that should be developed to deal with this rapidly emerging problem.

*Cannabis has clearly emerged as a major risk factor for the onset of psychosis and the increased severity of psychosis, as well as for relapse and poorer long-term outcomes.*

The longer-term cognitive, emotional, behavioural and neurological consequences of other forms of illicit substance use, notably of amphetamines, cocaine and other stimulants, is now hotly debated. There is an urgent need for further longitudinal research but the potential short and long-term adverse effects need to be more clearly communicated to young people.

*The potential short and long-term adverse effects [of amphetamines, cocaine and other stimulants] need to be more clearly communicated to young people.*

The WHO recently released (March 2004) a major report, *Neuroscience of Psychoactive Substance Use and Dependence*, which details the role of the brain in substance dependence (World Health Organization, 2004). It concludes that substance dependence is as much a disorder of the brain as any other neurological or psychiatric disorder. Advances in genetics, brain chemistry and brain imaging have all demonstrated the neurobiology of substance misuse, adverse effects on the brain and the strong overlap with mental disorders.

Australia's mental health, alcohol, drug and suicide prevention strategies have all paid too little attention to this major health issue across the population and do not reflect adequately the degree of community concern or the rapidly advancing basic and clinical sciences in this area. Most importantly, from a community perspective, it has been estimated that up to 60% of cases of alcohol or other substance misuse could be

prevented by earlier attention to causative mental health problems (Kendall & Kessler, 2002; McGorry & Jackson, 1999).

#### **4.2 Physical health impacts of mental illness**

In recent years, there have been two major developments in the understanding of the ways in which mental disorders impact on physical health. The first relates to the degree to which people with diagnosed mental disorders die prematurely – not only from suicide and accidental death, but also from other physical diseases. The second is the extent to which some specific mental health problems predispose to particular physical illnesses. The best recent example was the announcement by the National Heart Foundation in 2003 that it now recognises depression as a major risk factor to heart attack and that its size as a risk factor is similar to others such as smoking, high blood pressure and high blood fats (Bunker *et al.* 2003).

The adverse effects of mental illness on physical health have been elegantly demonstrated in Australia by a recent report from Western Australia (Lawrence *et al.* 2001). Linking hospital records from psychiatric and other medical hospitals, as well as death records, it is possible to see that people admitted to psychiatric hospitals have significantly increased premature death from heart disease and cancer. The rate of onset in heart disease is significantly increased and the rate of presentation for treatment is much lower than in the general population. People with psychiatric disorders continue to smoke at much higher rates (approximately 50% of those admitted to hospital) than the rest of the adult population (now under 20%). The rate of onset of cancer is not significantly higher, but people with psychiatric disorders come to treatment for cancer later and survive for shorter periods.

Much is now known about the ways in which common disorders like depression affect three of the body's most important self-protection mechanisms, namely the immune system (Hickie *et al.* 1993), the sympathetic nervous system (Gold & Chrousos, 1999) and the hormone system, particularly the cortisol system. Prolonged or severe depression will lead to significant perturbations in these systems and may account for the increased rate of heart attack in those with depressive disorders (Box 4; Bunker *et al.* 2003).

#### **Box 4: Some outcomes of the National Heart Foundation of Australia's Expert Working Group deliberations (Bunker *et al.* 2003).**

1. Depression, social isolation and lack of social support are significant risk factors for coronary heart disease. They are independent of conventional risk factors such as smoking, hypercholesterolaemia and hypertension and are of similar magnitude to these conventional risk factors.
2. Psychosocial risk factors may cluster together in a similar way to conventional risk factors. Psychosocial and conventional risk factors often coexist (eg. patients with depression are more likely to smoke and be physically inactive).

#### **4.3 Mental health impacts of physical illness**

Many physical illnesses are significant risk factors to the onset of mental disorders. The co-occurrence of mental and physical health problems often leads to greater disability; poorer long-term outcome from the physical illness; less willingness to treat the physical illness actively and comprehensively; and a poorer

quality of life. In older men specifically, the combination seems to be a particularly strong predictor for the onset of depression and suicidal behaviour.

Frequently, however, the medical significance of psychological disorders in people with physical illnesses is missed, dismissed or downplayed. Commonly, patients and doctors talk of the emotional problems as being an 'understandable' or 'predictable' psychological response to pain, disability or physical incapacity. Consequently, often very little is done to characterise or treat the problem. This notion of understandable causation is often flawed. Some medical problems that directly affect the brain, such as stroke, epilepsy or Parkinson's disease, are particularly likely to give rise to neuropsychiatric disorders (Table 22). Some drugs such as the cortico-steroids that are used to treat inflammation, arthritis, asthma and other chronic medical conditions are particularly likely to give rise to major mood disorders. Some hormonal conditions, notably those affecting the thyroid or adrenal glands, are particularly likely to induce psychiatric disorders.

There have been some significant developments in better psychosocial care of people with medical disorders, most notably in cancer management (National Breast Cancer Centre and National Cancer Control Initiative, 2003). However, this development was driven as much by consumer demand as by medical planning. While progress has been evident in some areas, such as breast cancer management, it remains largely ignored in other areas such as prostate, lung and bowel cancer.

Under the guidance of the National Health Priorities Action Council, there has finally been some significant movement in this very important area, especially given that it had largely been ignored by the National Mental Health Strategy (Box 5). Increasing emphasis on the role of the general practitioner in mental health is a key part of the way forward.

**Table 22: Standardised first-time hospitalisation rate ratios for selected infectious diseases, nutritional deficiencies, Parkinson's disease, circulatory system diseases, respiratory system disorders and digestive system disorders by principal psychiatric diagnosis (Lawrence *et al.* 2001).**

	Alcohol/ drug disorders RR <sup>a</sup> (95% CI)			Schizophrenia RR <sup>a</sup> (95% CI)			Depressive disorder RR <sup>a</sup> (95% CI)		
	Females	Males	All	Females	Males	All	Females	Males	All
Infectious diseases:									
• Tuberculosis			3.83 (2.62-5.60)			2.74 (1.56-4.80)			-
• Human immunodeficiency virus			4.71 (2.93-7.56)			2.42 (0.56-10.5)			-
• Viral hepatitis	30.57 (26.9-34.8)	18.20 (16.3-20.3)		4.93 (2.95-8.23)	3.58 (2.54-5.05)		2.17 (1.21-3.88)	2.17 (1.07-4.40)	
• Herpes Zoster (shingles)	1.68 (1.11-2.54)	1.04 (0.57-1.88)		-	-		2.19 (1.30-3.69)	2.56 (1.27-5.16)	
• Sexually transmissible diseases			4.27 (2.64-6.89)			1.34 (0.47-3.85)			-
Nutritional deficiencies	9.71 (7.47-12.6)	8.97 (6.23-12.9)		2.78 (0.74-10.5)	4.67 (2.51-8.69)		1.43 (0.59-3.45)	-	
Parkinson's disease	0.77 (0.31-1.86)	1.48 (1.01-2.15)		7.78 (4.68-12.9)	6.53 (4.48-9.53)		1.93 (1.14-3.27)	1.53 (0.68-3.44)	
Circulatory system diseases									
• Hypertensive disease	1.52 (1.22-1.90)	2.17 (1.84-2.56)		0.98 (0.68-1.41)	1.07 (0.72-1.57)		1.67 (1.32-2.12)	1.56 (1.05-2.29)	
• Stroke	1.69 (1.46-1.97)	1.43 (1.30-1.57)		0.86 (0.67-1.12)	0.82 (0.64-1.05)		1.52 (1.29-1.78)	1.53 (1.24-1.88)	
Respiratory system disorders									
• Pneumonia	2.93 (2.61-3.29)	2.75 (2.54-2.97)		1.19 (0.91-1.56)	1.23 (1.02-1.47)		1.64 (1.38-1.94)	1.43 (1.15-1.78)	
• Influenza	2.26 (1.68-3.04)	1.90 (1.38-2.61)		0.27 (0.12-0.60)	1.35 (0.80-2.29)		3.67 (2.69-5.01)	3.09 (1.85-5.15)	
• Chronic obstructive pulmonary disease	3.46 (3.00-3.98)	2.87 (2.63-3.13)		1.12 (0.81-1.55)	1.14 (0.89-1.46)		2.95 (2.44-3.57)	2.03 (1.57-2.62)	
Digestive system disorders									
• Chronic liver disease and cirrhosis	20.67 (17.6-24.2)	11.62 (10.4-12.9)		1.27 (0.68-2.38)	1.55 (0.98-2.46)		0.89 (0.48-1.67)	1.14 (0.59-2.21)	
• Diseases of the pancreas	8.45 (6.83-10.5)	8.08 (7.11-9.18)		1.41 (0.64-3.07)	1.49 (0.94-2.35)		1.82 (1.05-3.16)	2.36 (1.13-4.93)	
• Gastro-intestinal haemorrhage	4.55 (3.89-5.31)	4.57 (4.10-5.09)		1.46 (0.94-2.28)	1.66 (1.24-2.22)		2.32 (1.79-3.01)	1.59 (1.09-2.32)	

<sup>a</sup>Rate ratio (RR) = the ratio of the rate within the population of people in contact with mental health services to the rate in the entire Western Australian population.

**Box 5: Recommendations of the National Health Priorities Action Council, Advisory Group on Mental Health (National Health Priority Action Council, Advisory Group on Mental Health, 2003).**

Overarching recommendations

- The articulation of psychosocial care into national initiatives (such as the national service improvement frameworks, national action plans and the national chronic disease strategy);
- Information and education for health professionals, including a clinician kit for psychosocial care;
- Information and education for patients, carers, and families, including a 'psychosocial' self-care kit; and
- Quantity and quality of care including psycho-education, quality use of medicines and screening.

Condition-specific recommendations

*Cardiovascular diseases*

- Positive safety aspects of selective serotonin reuptake inhibitors, particularly following a myocardial infarction;
- Overt inclusion of psychosocial care in cardiac rehabilitation programs; and
- Psychosocial care as part of end of life care.

*Stroke*

- Ongoing six monthly assessment for two years post stroke; and
- Overt psychosocial care and cognitive function assessment in stroke rehabilitation.

*Diabetes*

- Diabetes education on the impact of depression in risk factor modification and on blood glucose levels; and
- Impact of depression on juveniles and younger adults with diabetes and transition to adult services.

*Asthma*

- Anxiety in patients with asthma, carers and their families, including impact of living with an episodic and potentially life threatening illness;
- Impact of depression/ anxiety on juveniles and younger adults with asthma, and transition to adult services; and
- Impact of beta agonists and corticosteroid medication.

*Cancer*

- Implementation of psychosocial care guidelines for adults with cancer;
- Psychosocial care while waiting for diagnosis and at time of diagnosis; and
- Psychosocial care during and following remission.

*Arthritis*

- Better active management of arthritis to reduce pain and sleep disturbance, as risk factors for depression.

**4.4 National suicide trends**

Many people are aware of the rapid increase in youth suicide in Australia in the last 50 to 60 years. Many who were teenagers last century are now in their 20s and 30s and among the group that has the highest suicide rate in the country, namely 25 to 44 year olds. For those over the age of 65, suicide rates have fallen

progressively over the last 50 years, largely reflecting improvements in physical health, mental health, and social and work participation. However, there is still a significant group of men over the age of 75 with high suicide rates, often occurring in the context of untreated depression, physical ill health or social isolation.

The national suicide prevention strategy initially placed great emphasis on reducing youth suicide and emphasised social and community-based interventions that may be of benefit. However, less emphasis was placed on the importance of treating those with diagnosable mental disorders such as depression and psychosis – who are actually at very high risk. Currently, the scope of the National Suicide Prevention Strategy has broadened right across the life cycle. As people age, the link between overt mental disorders and suicide strengthens such that greater emphasis needs to be placed on providing effective treatments as a major part of the suicide prevention framework. There is good evidence that expanded treatments for depression in primary care in Australia have already yielded significant benefits for those who reach care. That has meant that the benefits of effective treatments have been most evident in women and older people and least evident in young people or men (Hall *et al.* 2003).

#### **4.5 Impacts on crime and homelessness**

Much community and media attention focuses on the extent to which untreated mental illness, often in association with alcohol or other substance misuse, contributes to crime and homelessness. There is no doubt that mental disorders, particularly those complicated by substance misuse, lead to increased risks of some crimes, incarceration and homelessness. The important consideration, however, is that much of this increased morbidity and social harm is due to people with *untreated* rather than treated illness.

Additionally, Australia has had a crudely developed system of providing appropriate institutional or community-based care to people who commit serious crimes in association with their mental illness. Consequently, we are now very poorly placed in most states other than Victoria to respond to the increasing clinical and community pressures posed by these problems. The services developed by Victoria (Box 6, eg. Forensicare) should stand as a model for the rest of the nation, while those states and territories that continue to fail to invest in this key area should be roundly condemned. Community confidence in mental health services and the destigmatisation of those with serious mental illness are absolutely reliant on major advances in this area.

#### **Box 6: Clinical services including assessment and treatment in Victoria.**

##### ***Inpatient services***

- Thomas Embling Hospital

##### ***Prison services***

- Melbourne Assessment Prison
- Other State-run prisons

##### ***Community services***

Outpatient program:

- Mental Health Clinic (including forensic patients)
- Problematic behaviours
- Sex offenders
- Court liaison service



## **PART FIVE: NEW CHALLENGES**

### **5.1 Youth mental health**

The most profound challenge is the progressive deterioration in mental health among young people over the last 50 years. The deterioration is not simply a reporting phenomena. The rises in depression, anxiety, alcohol or other substance misuse and suicide in each successive generation since the end of the Second World War all give the same message: a range of social factors must be at play which are having their most important adverse effects on young people. These are likely to include: increased family and social disconnection; increased harmful use of alcohol or other substance use; increased uncertainty about access to education and employment; increased awareness of local and global notions of threat, terrorism and uncertainty; and other less overt factors such as exposure to trauma and violence via the global media.

Whatever the causes of these changes in patterns of youth mental health, clear consideration should be given to potential preventative, early intervention and treatment measures. In Australia, as elsewhere in the world, such services are poorly developed and relatively inaccessible to young people. While governments speak of focusing on the needs of younger people as the basis for investments in the future, the reality, particularly in health, is the opposite. The health debate in Australia, as with much of the economic debate, is focused on the current and future needs of those in the 40 to 70 year age range. But increasingly, people under 30 have marked mental health problems with consequently poor completion of education and low participation in the workforce. They do not use appropriate and/or sufficient health care and are not seen as a current health priority. By contrast, they are over-represented in the disability support and other income support and social security systems.

*While governments speak of focusing on the needs of younger people as the basis for investments in the future, the reality, particularly in health, is the opposite.*

Important universal approaches such as increased awareness of mental health in secondary school students (eg. MindMatters) are now underway in Australia. Large scale trials of other community and school-based psychological interventions and parenting programs are being conducted, particularly in association with *beyondblue*. Such investments, however, are at a very early stage and there has not yet been a clear commitment to transfer the findings to mainstream family support, education and health programs. For young people with more severe mental disorders, Australia has failed to adopt the most promising program of targeted and specialised early intervention programs. Although much of this development work was conducted in Melbourne (McGorry & Jackson, 1999), other countries such as the United Kingdom have now gone ahead and implemented it as a national system.

### **5.2 Alcohol and drug patterns of use and misuse**

As highlighted above, patterns of alcohol or other substance misuse in association with mental disorders represent some of the most obvious new challenges Australia faces. Such changing patterns are undoubtedly one of the social factors underpinning the increased demand for psychiatric services among young people as well as the increased rates of violence associated with acute mental disorders. The longer-

term effects of such changing patterns of misuse on brain function and social performance are yet to be determined.

The Victorian Adolescent Health Cohort Study showed that 59% of young people had used cannabis by the age of 20. Seven percent met the DSM-IV criteria for cannabis dependence within the past 12 months. One in five of all adolescent cannabis users became dependent by age 20, and one in three weekly users became dependent by age 20 (Coffey *et al.* 2003).

### **5.3 Family and community disconnection**

A range of social theories have been put forward about the increases in rates of depression, alcohol or other substance misuse and suicide among young people over the last 50 years. The most plausible explanation relates to the progressive degree of social disconnection between individuals in Western societies over that period. Key social phenomena have been well documented that reflect this change and include the increasing isolation of the nuclear family from other extended family and kin; the increasing number of single parent and single person households; and the decrease in participation in other formal social structures such as community groups, sporting and social clubs, and churches. Additionally, adults are more likely to work for multiple employers over their life span and to change residence in relation to work and educational opportunities. While this lower degree of reliance on formal social structures may have led to greater autonomy for many people, it may also have led to greater uncertainty and disconnection. It appears to be young people who are placed at the greatest risk by such uncertainty, disconnection and less access to a range of adult role models. This concept has become stereotyped in some countries, including Australia, into a sterile debate over the virtues of two-parent versus one-parent families or the value of a 'working' versus 'stay at home' mother. The clear message of research is that children and teenagers need access to a wide variety of adults who can provide consistency, care and practical support (Burns *et al.* 2002). That is, the community needs to reattach young people not just to their parents but grandparents, aunts, uncles, teachers, sporting coaches, community leaders and local residents.

### **5.4 Workplace difficulties (Department of Family and Community Services, 2003)**

As of June 2003 there were 673,334 people receiving the Disability Support Pension in Australia. The three main medical reasons for the pensions were musculoskeletal conditions (34%), psychological or psychiatric conditions (25%) and intellectual or learning difficulties (11%). The age distribution for musculoskeletal condition recipients is strongly skewed towards older age groups. However, while psychological and psychiatric condition recipients also show a high representation in the older age groups, there are substantial numbers in younger age groups. This leads to a more even distribution. Only a small percentage of Disability Support Pensioners have declared earnings related to work (9%). The majority of customers with earnings are in the lower income ranges (53% earn less than \$100 per week). Customers with psychological or psychiatric disabilities declared work earnings less often than the total disability population (8%). The majority of customers who were on the Disability Support Pension in June 2002 but were not on it in June 2003 moved onto the Age Pension (57%). Of the people who left the Disability Support Pension, only 21% left payments entirely. A substantial proportion of people who left the Disability Support Pension did so due to death (17%). In the United States, Canada, Sweden and Australia only 1% of disability benefit stock, leave

the rolls each year due to recovery or work resumption. The outflow rate is higher in the United Kingdom where 5% return to work/ recover each year.

We have rapidly growing data about two major aspects of employment difficulties for people with mental disorders. The first relates to the very poor prospects for those with psychotic disorders returning to workplace participation with current medical, work and social practices. The second is the extent to which those with depression, anxiety and related alcohol or other substance misuse lose their jobs as a consequence of untreated illness and are unlikely to return to full capacity due to a combination of inadequate treatment and ongoing discrimination. The end results of these factors is that while Australia provides potential access to expensive forms of medical treatment, it receives a relatively poor return on its investment in terms of affected people resuming income-generating work and genuine social participation.

The rate of workforce participation in Australia among people with mental illness is low (29%) compared with people with physical disability (49%; Trewin, 2003). Indeed, the relative employment rate of people with any disability (not just mental health) compared with those with no disability in Australia (0.55) is among the lowest for OECD countries (OECD average, 0.62; Canada, France and Norway, each, 0.72; Switzerland, 0.79; Organization for Economic Co-operation and Development, 2003). Furthermore, on average, only one in nine disability-benefit recipients in Australia are employed, compared with the OECD average of one in three (Organization for Economic Co-operation and Development, 2003).

For those with psychotic disorders such as schizophrenia and bipolar disorder (manic-depressive illness), treatment and welfare costs are high while workforce participation rates are low. Currently, 85% of people with psychotic illnesses in Australia are reliant on welfare benefits as their main source of income. Of these, 79% are disability pensions, 12% Newstart and 5% sickness allowance. Importantly, Australia would be likely to receive very large returns on relatively small investments from better and more sustained treatment options, and supported workforce participation programs.

*“...in some countries such programs (i.e. special employment programs for people with disabilities)...seem to make an important contribution to the employment of severely disabled people and of people with certain types of disabilities, such as intellectual and mental health disabilities.”* Organization for Economic Co-operation and Development, 2003

For those with more common mental disorders such as depression and anxiety, there are very disturbing patterns of low workforce and social participation, particularly given that these are very treatable conditions. Such problems are common in those who are unemployed or under-employed, but longitudinal analyses suggest that the mental disorder often leads to reduced employment rather than the reverse. Clearly, the goal needs to be identification and treatment in the workplace to prevent people moving from independent to supported income schemes.

### **5.5 Maximising education and training**

A major factor in maximising workplace and social participation is ensuring that all those who develop mental disorders have access and support to complete appropriate forms of education and training. Additionally,

given that most of the serious disorders develop during the teenage years, it is very important to ensure that these disorders, where possible, are detected and treated while the individual is still participating in education or training. As with older people who are already in the workforce, mental disorders in these years are often not detected or treated resulting in a failure to complete relevant courses. The longer-term implications of this loss for their later economic independence and development of other social structures (intimate relationships, family, social networks) is profound.

Most treatment services have poorly developed relationships with educational and training services. For young people with early onsets of mental disorders, a key strategy needs to be not just rapid resolution of symptoms but active support for continuation of educational and training activities. There is good evidence that those with psychotic disorders who are able to return to such activities within 12 months of beginning treatment are likely to achieve much better long-term outcomes (Thompson *et al.* 2003).

*For young people with early onsets of mental disorders, a key strategy needs to be not just rapid resolution of symptoms but active support for continuation of educational and training activities.*

Another crucial point is that those who have an onset of severe disorders between the ages of 15 and 19 years tend to have much worse social and economic outcomes than those who have an onset after the age of 25 years. While this may reflect, in part, simply the severity of illness, it also reflects the major disruption of education and training, and social and personal development that accompanies earlier onsets. It has become clear that the earlier effective treatments are provided, the more likely progression to more severe symptoms is delayed and hence, the more likely the individual is to complete education and training. That is, not only is prevention of the onset of more severe symptoms in people a goal of early intervention, but simply delay in progression may result in considerable later economic and social benefits for them.

## **5.6 Global fears: terrorism and globalisation**

There is evidence in children and early adolescents that levels of anxiety (which is often the precursor to depression or alcohol or other substance misuse) are higher in recent generations than earlier birth cohorts (Twenge, 2000). While a range of factors may be influencing this trend, there is increasing evidence that media portrayal of violence, terrorism and global conflict may be contributing factors. Additionally, there is now daily evidence of increased awareness of the threat of terrorism through the reporting of real and close events, such as the Bali bombing, as well as national terrorism awareness campaigns. While the longer-term effects of such increased exposure to perceived threat is unknown, the short-term effects are likely to be adverse and might be expected to contribute to the increased demand for mental health services.

## PART SIX: DETERMINING PRIORITIES

### 6.1 Economic perspective

A fundamental consideration is whether an appropriate mix of prevention, early intervention, rehabilitation and social recovery strategies can be instituted for mental disorders and whether such interventions can be delivered in a cost-effective manner. Our overall goals must be to have the maximum number of people in the 15 to 44 age group commence and complete education and training, participate fully or partially in the workforce and have the least number of people remain permanently on the Disability Support Pension or other forms of long-term income support. The goal of the mental health sector is the same as governments and other private third party insurers – namely, to have the maximum number of people return to full capacity with the minimum time possible out of normal role or out of the workforce.

There is an important perspective underpinning this consideration, namely to what extent can current treatments reduce illness burden as distinct from requiring new treatments to achieve genuine improvements in illness outcomes. These issues have been recently addressed by Andrews and colleagues (Andrews *et al.* 2003; Andrews *et al.* 2004; Issakidis *et al.* 2004; Vos *et al.* 2004). Some basic assumptions underpin these studies. First, overall it has been estimated that current disease burden can be halved by applying appropriate treatments. This leaves another 50% that cannot be currently changed, requiring investment in research to determine new treatments and new ways of delivering existing treatments. Second, the Australian Healthcare system is particularly inefficient in its mix of providers of treatments (generalists versus specialists) and pharmacological versus non-pharmacological treatments. For some disorders, such as depression, it has been estimated that changes in the mix of providers and appropriate use of pharmacological and non-pharmacological treatment could double the reduction in disability achieved with the same level of financial investment. Third, there is currently little investment in the rehabilitation, social recovery and reduction of social barrier strategies that might have further dramatic effects on disability reduction.

The economic argument in Australia tends to be restricted to a discussion of the increase in direct health costs that arises from increasing the number and scope of treatments provided. Currently, major direct health care cost increases are particularly likely to occur largely through the provision of new pharmaceuticals (Department of Health and Ageing, 2003). Actual national or state increases in other new non-pharmacological treatments has been minimal (Commonwealth Department of Health and Ageing, 2002; Department of Health and Ageing, 2003).

The extent to which the costs of new pharmaceuticals explain largely the Australian Government's increased expenditure in mental health over the last decade tends to evoke a rather negative response from both the wider community and health policy analysts (Hamilton, 2003). New neuroscience-related products will increasingly become available for a wide range of mental disorders and related forms of alcohol or other substance misuse. To date, there has been little sophisticated discussion of the ways in which new pharmaceuticals may:

- Offset other direct treatment costs such as repeated hospitalisation and acute care costs;
- Enhance the capacity to return to part or full-time workforce participation;

- Significantly improve quality of life through reduction of disabling side-effects;
- Be appropriately integrated (particularly sequentially) with appropriate non-pharmacological treatments;
- Be introduced in association with other educational, quality use of medicines and health service system reforms to maximise therapeutic benefits; and
- Significantly reduce premature death through reduced suicide and accidental injury.

The same principles apply with regard to other proposed increased investments in additional health care and social recovery processes. The introduction of genuine service enhancements that increase direct costs in the short-term may result in longer-term cost-offsets through:

- Reduction in hospitalisation and acute care costs via improved continuity of community-based care;
- Reduction in the percentage of people receiving Disability Support Pensions;
- Improved physical health care outcomes through better uptake of preventative and early intervention strategies for common physical disorders; and
- Cessation of historic but less effective service strategies (eg. day hospital programs, long-term inpatient treatments for substance misuse, generic case-management by mental health specialist staff).

Here we present a rather simple model, where the goal of intervention is not simply resolution of symptoms but rather maximising 'wellness' (Figure 7). The economic and social value of 'wellness' has been increasingly recognised at both the individual and national level. That is, there are strong correlations between 'wellness', workforce and social participation and cost-effectiveness of medical and social interventions. We need now to implement those new models that add appropriate social and workforce interventions to sustained and effective medical treatments (Crowther *et al.* 2001; Lehman *et al.* 2002; Mueser *et al.* 2004) and ensure that these interventions are delivered in a sustained fashion by proactive community-based service systems.

## **6.2 Community priorities**

Given the size of the gap between current mental health expenditure and current mental health needs, it is unrealistic to expect that this gap will be closed in the short-term by increased government expenditure. The situation is exacerbated by the historic low place of mental health funding in overall health funding models, negative community attitudes towards mental disorders, limited growth in total health spending in all developed countries and the fact that many people with mental disorders are not presenting to current health care systems. Consequently, during the surveys conducted in 2002-03 by the MHCA the mental health sector developed clear priorities for immediate action (Table 23).

**Table 23: Key national priorities for mental health reform.**

Priorities outlined	Percentage	Implemented
	in favour <sup>a</sup>	locally <sup>b</sup>
1. Implementation of early intervention strategies nationally	56%	17%
2. Innovative services for persons with mental health and alcohol or other substance misuse disorders	54%	11%
3. Develop wider spectrum of acute and community-based care settings	52%	12%
4. Support for service development in rural and regional areas	49%	7%
5. Implementation of national standards for mental health services	45%	15%

<sup>a</sup>Percentage in favour figures (Groom *et al.* 2003); <sup>b</sup>Implemented locally figures (Unpublished data, Mental Health Council of Australia, 2004).

In reality, there is a clear connection between the community's top priorities (early intervention, concurrent alcohol or other substance misuse problems, wider spectrum of care settings and implementation of national standards) and the priorities that would derive directly from a more pure economic or investment model. In any future government decision as to immediate areas for investment, consideration also needs to be given to those components of the prevention or service systems for which there is broader community support. For example, investment in the prevention of postnatal depression, maximising the welfare of children, ensuring the availability of appropriate forensic mental health services and rapid access to appropriate acute care services are all rated highly by the general public. Additionally, failure to deal with some of these key areas increases the community's fear of people with mental illness and reinforces the negative stereotypes and daily experiences of stigma that also contribute directly to illness burden estimates.

### 6.3 Enhanced care strategies

Development of enhanced care strategies not only lie at the heart of better clinical care and improved social recovery, but also at achieving better economic outcomes. Services are most cost-ineffective when they rely heavily on medical interventions combined with other non-specific clinical strategies (eg. generic case management, day hospital programs, institutional rehabilitation programs, institution-based treatment of substance misuse) being delivered intermittently by specialist service providers.

Enhanced care combines better use of a range of primary and secondary care service providers (eg. general practitioners, allied health professionals, medical specialists) and active partnerships with non-medical and non-government service providers (education, training, individualised rehabilitation, workplace-based support) to achieve a more diverse set of interconnecting goals. The goals can clearly be defined as:

- Maximum and sustained reduction of symptoms;
- Return to social and workplace participation;
- Enhanced physical health outcomes; and
- Promotion of personal recovery and enhanced quality of life.

#### **6.4 Promotion, prevention and early intervention**

All economic and social models proposed rely on a shift away from the traditional focus of providing specialist care late in the illness course. As in most other areas of medicine there is an urgent need to expand research and service innovation in the key areas of mental health promotion, illness prevention and early intervention. Importantly, these three domains do not simply lie along one dimension – as typically portrayed in most recent national mental health documentation. Each needs to be pursued in its own right!

For mental health promotion, there is a clear need to promote the economic, personal and social value to the wider society. The methods for achieving better mental health through broad community-based interventions as well as individually-based approaches needs to be clearly articulated and defined for governments, educators, employers and other major national organisations. Additionally, those with overt disorders are often ignored in this area. Consequently, service providers need to continue to provide information, support and resources that encourage those with illnesses to continue to strive for better health.

For illness prevention, we now have clearly articulated strategies for possible prevention of depression, anxiety and some forms of substance misuse. For the psychotic disorders we do not yet have clear evidence for primary prevention strategies. However, for all of those with mental disorders, the issue of secondary prevention of other mental disorders, substance misuse, self-destructive behaviour or adverse physical health outcomes is typically ignored by service providers. The cost-effectiveness of both primary and secondary prevention strategies requires more research, but given the very high costs of providing specialist services later in the course of illness, it is likely that cost-effective measures will emerge. Some of the most exciting and extremely cost-effective measures have recently been demonstrated in terms of e-health information and behavioural strategies delivered by the web (Christensen *et al.* 2004). We may now have the capacity and the technology to reach the very high numbers of people in need of at least the most basic levels of self-care and clinically-informed interventions.

For early intervention, we now have a considerable evidence base relating to efficacy and cost-effectiveness. While there will be continuing developments of both the clinical service models and the use of novel strategies (eg. e-health), there can be little argument in favour of our services continuing largely with their traditional emphasis on specialist care being confined to those with long-standing disorders. Changing the course of serious mental disorders through earlier identification, more specialised interventions and earlier promotion of full social, educational and workplace recovery needs to be accepted not only as a national goal but also as a measure of the success or failure of implementation of our National Mental Health Strategy.

#### **6.5 Community development**

As highlighted earlier, the degree of change in mental health has outstripped re-modelling of community attitudes or development of community or workforce capacity. Sustained efforts focusing on stigma reduction, reductions in key social barriers (eg. in insurance, workplace practices, access to education) and enhanced partnerships to promote better mental health need to be pursued alongside service reform.



## 6.6 Social and workplace participation

The common goal of maximising social and workplace participation is not widely understood by either mental health service providers or those funding systems that provide income support or ongoing disability payments. More than 85% of those with psychotic disorders receive government welfare payments as their main source of income. The Australian Government pays approximately 6% of all income and disability payments to people with psychosis and approximately three times that amount to people with non-psychotic disorders. The potential cost savings associated with moderate improvements in workforce participation by those with psychotic disorders has been extensively modeled (Carr *et al.* 2002). When only 10% of people with psychosis are able to achieve even a 10% reduction in disability, the cost saving to governments is estimated to be \$49 million per annum (Table 24). More significant reductions in disability, in higher proportions of patients with psychosis, would result in predictable multiples of that saving.

**Table 24: Societal cost projections based on a 10% reduction in disability for people with psychosis (Carr *et al.* 2002).**

Proportion of people with psychosis experiencing a 10% improvement	Average mental health cost per patient	Average total cost per patient	Total population cost	Savings across population
0%	\$19,443	\$48,085	\$2,345,778,640	-
<b>10%</b>	<b>\$18,941</b>	<b>\$47,080</b>	<b>\$2,296,705,720</b>	<b>\$49,072,920</b>
20%	\$18,448	\$46,079	\$2,247,917,936	\$97,860,704
30%	\$17,982	\$45,105	\$2,200,402,320	\$145,376,320

## 6.7 Innovation, research and sustainability

Australia's investment in mental health research is low, constituting only 3% of national research expenditure compared with 9% for cancer and 8% for new pharmaceuticals. On the back of our total national health-related research and development expenditure, which is also still low by international comparisons (0.10% of GDP vs 0.23% in the United States), it means we are poorly placed to reduce long-term mental illness costs by implementation of new research. A recent review of our national investments in mental health also indicated that the traditional investigator-driven grant systems, such as those supervised by the National Health and Medical Research Council, do not necessarily result in research that is of high community or economic priority (Jorm *et al.* 2002). While some Australian researchers in psychiatry and psychology are highly regarded internationally, collectively our mental health research sector performs less well than comparable systems in Canada or New Zealand (Hickie *et al.* 2004). Australia does have particular research strengths in clinical medicine and neurosciences which need to be integrated with mental health research at a national level to deliver better results (Hickie *et al.* 2004). Such integration also needs to be backed by targeted national resources that maximise the chance that key discoveries will be made in Australia or that such discoveries and associated technologies and health benefits are rapidly transferred to the Australian health care system. While there has been some recent national investments in neuroscience infrastructure (eg. National Neuroscience Facility), our current processes lack sufficient emphasis on building the basic national and international collaborations required to deliver real health benefits. While the importance of this agenda was recently highlighted by consideration of these issues by the PMSEIC (Read *et al.* 2003), to date, there have been no specific national commitments to real investments.

When Australia does develop major innovations in clinical services, typically we fail to make such advances readily available to the wider population. Two recent examples are relevant. First, the most promising clinical program internationally for early identification and management of young persons with recent-onset psychosis or other severe mental illness was developed in the 1990s in Melbourne by McGorry and colleagues. While national health planners in Australia go on debating the merits of its wider implementation, the United Kingdom has recently adopted its framework nationally and it now underpins other major reforms in Scandinavia, the United States and other European countries. Second, Australia has a world-leading program of primary-care based mental health reform (i.e. *Better Outcomes in Mental Health Care* initiative) initiated by the Australian Government in 2001 (Hickie & Groom, 2002; Hickie *et al.* 2004). By mid 2004, however, the other major components of this reform, namely increased access to clinical psychologists and other non-medical specialists and increased support by specialist psychiatrists had not been delivered nationally. Typically, we remain a nation of 'pilot' programs offering great promise rather than a country that quickly implements the most recent advances in mental health care.

### **6.8. Implementing a rational economic approach**

In 2002, the Australian Government reported spending \$3.088 billion annually on direct mental health services (Department of Health and Ageing, 2003). While mental health accounts for 27% of health-related disability costs, the 2002 data indicate that 6.4% of recurrent spending was spent on mental health services (Commonwealth Department of Health and Ageing, 2002). Although Australian Government agencies report that 9.6% of health expenditure is now allocated to mental health, and this is reinforced in media reporting (Contractor & Metherell, 2004), this includes expenditures related to dementias, substance misuse and intellectual disability. The sources of lost efficiency in Australian mental health care and the opportunities for greatest advances can be readily deduced from existing data sources. In summary these are:

1. 62% of persons with mental disorders receive no specific mental health care;
2. There are prolonged delays in presentation for treatment by younger persons with severe illness, and this particularly affects young men, those with comorbid alcohol or other substance misuse and those residing in regional and rural Australia;
3. There is a poor mix of primary and specialist care systems and a poor mix of pharmacological vs non-pharmacological treatments. The Australian system is over-reliant on cost-inefficient specialist care systems and does not support its investment in effective medications with effective non-pharmacological treatments and recovery strategies; and
4. Those with enduring mental illness return to work or social participation only half as often as persons with similar disorders residing in other OECD countries.

The indirect costs of mental disorders in Australia are, on average, four times the direct treatment costs. Based on modelling of the current patterns of medical utilisation and expenditures, it has been estimated that the efficiency of the system (specifically when dealing with persons with common disorders such as depression or anxiety) could be doubled by improving the balance between primary and specialist care providers and the use of medications or psychological therapies (Tables 25-27; Andrews *et al.* 2004). That is, we don't use primary care providers appropriately to detect disorders in their early phases or to co-manage those with chronic or recurrent disorders, and we over rely on medications for immediate and long-term care.

**Table 25: Cost-effectiveness of treatment given current coverage and mix of interventions (Andrews *et al.* 2004).**

	POPULATION BURDEN		BURDEN AVERTED				COST		EFFICIENCY	
	Prevalence	YLDs <sup>a</sup>	Coverage	Effective	YLDs Averted	Cost per case	Total cost	\$/YLD	95% CI	
				coverage						n
			%	%	n	%	AUD	AUD M	AUD	AUD
Any affective disorder	797,892	194,162	59.8	33.7	30,078	15	1,290	615.5	20,463	12,885 – 36,552
• Depression	648,375	143,018	60.2	31.7	22,559	16	1,239	483.7	21,442	11,434 – 40,433
• Bipolar disorder	71,308	13,363	66.1	46.2	2,536	19	1,779	70.8	14,217	6,157 – 36,536
Any anxiety disorder	1,086,331	201,547	35.2	19.7	26,059	13	1,035	395.7	15,184	12,934 – 19,031
Any alcohol use disorder	479,342	48,744	10.7	5.6	745	2	1,417	72.9	97,932	51,158 – 183,203
Schizophrenia	39,048	28,671	100	100	3774	13	18,949	739.9	196,070	123,827 – 297,516
<b>Any study mental disorder</b>	<b>2,402,613</b>	<b>473,123</b>	<b>39.5</b>	<b>22.8</b>	<b>60,655</b>	<b>13</b>	<b>1,920</b>	<b>1,824.0</b>	<b>30,072</b>	<b>25,424 – 38,303</b>

<sup>a</sup>YLD = Years lived with disability. Calculated as measured YLDs *plus* currently averted YLDs to give a baseline for the proportion of population burden averted.

**Table 26: Cost-effectiveness of treatment given current coverage and optimal treatment with evidence-based medicine (Andrews *et al.* 2004).**

	POPULATION BURDEN		BURDEN AVERTED				COST		EFFICIENCY	
	Prevalence	YLDs <sup>a</sup>	Coverage	Effective	YLDs Averted		Cost per case	Total cost	\$/YLD	95% CI
				coverage	n	%				
			%	%	n	%	AUD	AUD M	AUD	AUD
Any affective disorder	797,892	194,162	59.8	59.8	44,557	23	1,002	478.4	10,737	9,103 – 13,896
• Depression	648,375	143,018	60.2	60.2	32,583	23	874	341.3	10,475	8,283 – 14,049
• Bipolar disorder	71,308	13,363	66.1	66.1	4,529	34	2,301	108.4	23,934	14,785 – 38,298
Any anxiety disorder	1,086,331	201,547	35.2	35.2	40,101	20	957	366.1	9,130	7,965 – 11,161
Any alcohol use disorder	479,342	48,744	10.7	10.7	2,253	5	2,338	120.3	53,412	27,007 – 92,283
Schizophrenia	39,048	28,671	100	100	6,217	22	17,113	668.2	107,482	59,714 – 205,418
<b>Any study mental disorder</b>	<b>2,402,613</b>	<b>473,123</b>	<b>39.5</b>	<b>39.5</b>	<b>93,128</b>	<b>20</b>	<b>1,719</b>	<b>1,633.1</b>	<b>17,536</b>	<b>16,132 – 20,145</b>

<sup>a</sup>YLD = Years lived with disability. Calculated as measured YLDs *plus* currently averted YLDs to give a baseline for the proportion of population burden averted.

**Table 27: Cost-effectiveness of treatment given optimal coverage and optimal treatment with evidence-based medicine (Andrews *et al.* 2004).**

	POPULATION BURDEN		BURDEN AVERTED				COST		EFFICIENCY	
	Prevalence	YLDs <sup>a</sup>	Coverage	Effective coverage	YLDs Averted	Cost per case	Total cost	\$/YLD	95% CI	
			%	%	n					%
						AUD	AUD M	AUD	AUD	
Any affective disorder	797,892	194,162	70	70	52,176	27	941	525.7	10,075	797,892
• Depression	648,375	143,018	70	70	37,518	26	827	375.5	10,010	648,375
• Bipolar disorder	71,308	13,363	70	70	4,626	35	2,301	114.8	24,827	71,308
Any anxiety disorder	1,086,331	201,547	70	70	70,784	35	1,754	670.8	9,476	1,086,331
Any alcohol use disorder	479,342	48,744	51	51	5,597	11	1,054	257.8	46,064	479,342
Schizophrenia	39,048	28,671	100	100	6,217	22	17,113	668.2	107,482	39,048
<b>Any study mental disorder</b>	<b>2,402,613</b>	<b>473,123</b>	<b>67</b>	<b>67</b>	<b>134,774</b>	<b>28</b>	<b>1,324</b>	<b>2,122.5</b>	<b>15,748</b>	<b>2,402,613</b>

<sup>a</sup>YLD = Years lived with disability. Calculated as measured YLDs *plus* currently averted YLDs to give a baseline for the proportion of population burden averted.

Our proposed model, therefore, rests not only on increased expenditure but also increased efficiency of the system such that it would result in the style of real reductions in disability that are genuinely achievable. By contrast, we suggest the need to allocate financial and manpower resources at key points across the whole spectrum of care (Table 28). Importantly, not all these investments draw solely on government resources. In this model, only 25% of new funds would be devoted to expansion of acute hospital-based services, forensic or other restrictive loci of care. We argue that the majority of new spending (60%) needs to track primary and stepped care models as well as specialised recovery programs, while broad population measures and research and innovation also require specific allocations (15%).

The key assumptions are that:

1. National expenditure on mental health (excluding dementias, substance misuse and intellectual disability) increases from less than seven to 11% of recurrent health expenditure on a recurrent basis (\$5.4 billion in 2002 dollars).
2. Increased expenditure be devoted immediately to:
  - a. Enhanced early intervention;
  - b. Primary-care based systems;
  - c. Non-pharmacological treatments;
  - d. Workforce participation schemes; and
  - e. Innovation, research and sustainability.
3. Current expenditure on specialist medical and allied health workforces from Australian Government sources be maximised to provide early assessment of more cases and time-limited specialised interventions:
  - a. The Medicare Benefits Schedule for psychiatrists be reviewed to maximise consulting clinician behaviour and aim to reach levels of care approximating that of other specialist physicians; and
  - b. Access to services by non-medical mental health specialists will be widely expanded and work in close co-operation with general practitioners and other forms of primary and ongoing medical care.
4. Medical, psychological and alcohol and drug comorbidity will be managed collectively:
  - a. Much of the lost opportunity for cost-effective care in our community is lost through separation of closely aligned forms of medical and psychological morbidity.

**Table 28: Recommended percentage of new spending devoted to key mental health domains.**

Key mental health domains	Proportion of new spending
1. Broad population measures	10%
2. Primary care services	20%
3. Stepped care programs	20%
4. Acute care programs	20%
5. Specialised recovery programs	20%
6. Forensic and restrictive care	5%
7. Medical research and innovation	5%

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[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-tmhoa.htm/\\$FILE/mentalhealth.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-tmhoa.htm/$FILE/mentalhealth.pdf) (Accessed January 2005).

This is the second report emerging from the 1997 National Survey of Mental Health and Wellbeing, authored by representatives from the World Health Organization Collaborating Centre for Mental Health and Substance Abuse, the National Drug and Alcohol Research Centre, University of New South Wales and the National Health and Medical Research Council Psychiatric Epidemiology Research Centre, The Australian National University. Whilst the first report (see McLennan, 1998) provided details on the prevalence of mental disorders in the adult population, this report examines the affect of mental illness on the population.

Andrews G, Henderson S, Hall W. Prevalence, comorbidity, disability and service utilisation: an overview of the Australian National Mental Health Survey. *British Journal of Psychiatry* 2001; 178: 145-153. Available at: <http://bjp.rcpsych.org/cgi/reprint/178/2/145> (Accessed January 2005).

This paper presents the results of the Australian National Mental Health Survey on the prevalence of mental health disorders, related disability and use of services. In the sample of 10,641 adults, approximately one-quarter (23%) had experienced a mental health disorder in the previous year, and approximately one in seven (14%) people were experiencing a current disorder. Of the people with a diagnosis during the previous year, only 35% had consulted someone about the disorder, usually a general practitioner. People with more than one disorder had higher levels of disability and were less likely to have consulted someone. The authors conclude that more research is needed into barriers to mental healthcare.

Andrews G, Issakidis C, Sanderson K, et al. Utilising survey data to inform public policy: a comparison of the cost-effectiveness of treatment of ten mental disorders. *British Journal of Psychiatry* 2004; 184: 526-533.

Andrews and colleagues present estimates of the costs associated with current and 'optimal' treatments for a range of psychiatric disorders (affective, anxiety, alcohol use disorders and schizophrenia) as well as estimates of avoidable burden related to each disorder. Considering 10 psychiatric disorders, they calculated that current treatments reduced burden by 13% with an average cost of \$30,000 per years lived without disability. Optimal treatments, costing \$18,000 per years lived without disability, avoided 20% of the burden. The authors suggest that 40% of the burden of mental disorders could be prevented through use of more effective treatments.

Andrews G, Sanderson K, Corry J, et al. Cost-effectiveness of current and optimal treatment for schizophrenia. *British Journal of Psychiatry* 2003; 183: 427-435. Available at:

<http://bjp.rcpsych.org/cgi/content/full/183/5/427> (Accessed January 2005).

Epidemiological data on schizophrenia were used to estimate the cost-effectiveness of current and 'optimal' treatments for schizophrenia. The authors calculate that current interventions mean 13% of burden can be avoided, whereas optimal treatment results in 22% of burden avoided. Whilst the cost per years lived without disability was similar for standard and optimal treatments, the latter was estimated to increase the years lived without disability by two-thirds.

Arseneault L, Cannon M, Poulton R, et al. Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study. *BMJ* 2002; 325: 1212-1213. Available at: <http://bmi.bmjournals.com/cgi/reprint/325/7374/1212> (Accessed January 2005).

The authors present results from a longitudinal study of the relationship between adolescent cannabis use and adult schizophreniform disorder in a sample of over 1,000 adolescents born in New Zealand. They found that the experience of schizophreniform symptoms was more frequent in adolescents who had used cannabis by the age of 15 or 18 than the subjects who by age 26 had never used. The relationship remained after adjusting for childhood psychotic symptoms preceding cannabis use. There also appeared to be a relationship between age of cannabis use and risk, those subjects using by age 15 being four times more likely to be diagnosed with schizophreniform disorder at age 26 than subjects who had never used. However, this relationship was weakened once they accounted for experience of psychotic symptoms at age 11.

Australian Bureau of Statistics. Information paper: suicides, 2001. Canberra: Australian Bureau of Statistics, 2003a. (ABS Catalogue No. 3309.0.55.001). Available at: [http://www.ausstats.abs.gov.au/ausstats/free.nsf/Lookup/6599AF372AA8A2EFCA256CC50003AD8A/\\$File/3309055001\\_2001%20\(revised%20edition\).pdf](http://www.ausstats.abs.gov.au/ausstats/free.nsf/Lookup/6599AF372AA8A2EFCA256CC50003AD8A/$File/3309055001_2001%20(revised%20edition).pdf) (Accessed January 2005).

This paper contains summary statistics on deaths by year of registration and occurrence of death, where the underlying cause of death was determined by coronial inquiry as suicide.

Australian Bureau of Statistics. Suicides: recent trends, Australia. Canberra: Australian Bureau of Statistics, 2003b. (ABS Catalogue No. 3309.0.55.001). Available at: <http://www.abs.gov.au/Ausstats/abs@.nsf/Lookup/2880924588DBFDB8CA256EC00079888B> (Accessed January 2005).

This electronic publication details statistics regarding registered suicides in Australia during 2002. Data are presented by age and sex, method of suicide and by state/ territory of residence. Numbers of deaths and standardised death rates for 1992 to 2002 are also shown for comparison.

Australian Government Department of Health and Ageing. Australian health and ageing system: the concise factbook. Canberra: Commonwealth of Australia, 2004. Available at: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-statistics-november2004+-+introduction> (Accessed January 2005).

The Department of Health and Ageing publish quarterly statistical indicators including health expenditure and service utilisation. The diverse facts presented range from figures on the ageing population, the general practitioner workforce through to membership in private health insurance.

Australian Health Ministers. National mental health plan. Canberra: Australian Government Publishing Service, 1992a.

The first National Mental Health Plan provided specific strategies to assist in the implementation of the 1992 National Mental Health Policy on Australian health service reform. The broad aims of the Plan were: to encourage a national approach to mental health policy and service delivery; to strengthen the impetus for



reform of mental health services; and to provide a mechanism for addressing agreed priority issues over a five-year period.

Australian Health Ministers. National mental health policy. Canberra: Australian Government Publishing Service, 1992b. Available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-standards-nmhp.htm/\\$FILE/nmhp.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-standards-nmhp.htm/$FILE/nmhp.pdf) (Accessed January 2005).

The National Mental Health Policy is a document outlining the direction proposed by the Australian Health Ministers for reform of mental health services. The statement was developed in consultation with consumers, carers and service providers with the objective of providing access to appropriate care as well as mental health promotion, prevention, early intervention and primary care service provider education.

Australian Health Ministers. Second national mental health plan: 1998-2003. Canberra: Australian Government Publishing Service, 1998. Available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-nmhs-plan2.htm/\\$FILE/plan2.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-nmhs-plan2.htm/$FILE/plan2.pdf) (Accessed January 2005).

The Second National Mental Health Plan built on the progress made following implementation of the First Plan, whilst continuing to utilise the framework established by the 1992 National Mental Health Policy. In the Second Plan it was proposed to continue reform based on the First Plan, but additionally: to focus on mental health promotion and prevention; to develop partnerships between health, welfare, employment and income support services; and to improve the quality, range and access to mental health services especially for Indigenous and rural Australians and people from culturally diverse backgrounds. The Second Plan also recognised that many people with mental illness are treated within primary care or general practice settings.

Australian Health Ministers. National mental health plan 2003-2008. Canberra: Australian Government Publishing Service, 2003. Available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-nmhs-2003.htm/\\$FILE/mhplan.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-nmhs-2003.htm/$FILE/mhplan.pdf) (Accessed January 2005).

The National Mental Health Plan 2003-2008 is the third plan under the National Mental Health Strategy. It outlines four main priorities: promotion of good mental health and prevention of mental health problems; to improve access to all mental health and related services and enhance continuity of care for consumers, and increased support for carers; strengthening quality of care; and fostering research and innovation across the sector for sustainable programs and services.

Australian Institute of Health and Welfare [homepage on the Internet]. Canberra: Australian Institute of Health and Welfare. Available at: <http://www.aihw.gov.au> (Accessed January 2005).

The website for the Australian national health and welfare statistics and information organisation provides links to publications as well as to databases.

Australian Institute of Health and Welfare. Australia's health 2000: the seventh biennial health report of the Australian Institute of Health and Welfare. Canberra: Australian Institute of Health and Welfare, 2000. (AIHW Catalogue No. AUS-19). Available at: <http://www.aihw.gov.au/publications/index.cfm/title/5742> (Accessed January 2005).

The Australian Institute of Health and Welfare publish a biennial report containing reference material on patterns of illness, health service provision and utilisation and performance of the health system in Australia. The seventh report also presents information on changes in the health of Australians over the previous century.

Australian Institute of Health and Welfare. Health expenditure bulletin no. 17: Australia's health services expenditure to 1999-2000. Health and Welfare Expenditure Series no. 12. Canberra: Australian Institute of Health and Welfare, 2001. (AIHW Catalogue No. HWE-18). Available at:

<http://www.aihw.gov.au/publications/hwe/heb17/heb17-011026.pdf> (Accessed January 2005).

This bulletin is the 17th report on health expenditure released by the Australian Institute of Health and Welfare. Expenditure figures are presented by the source of funding and area of expenditure, and estimates of recurrent, capital and total expenditure are provided. Comparative data are provided for earlier time periods and for other OECD (Organisation for Economic Co-operation and Development) countries.

Australian Institute of Health and Welfare. 2001 National drug strategy household survey: detailed findings. Drug Statistics Series No. 11. Canberra: Australian Institute of Health and Welfare, 2002. (AIHW Catalogue No. PHE-41). Available at: <http://www.aihw.gov.au/publications/phe/ndshs01df/ndshs01df.pdf> (Accessed January 2005).

This report provides information on tobacco, alcohol and illicit drug use patterns, community perceptions of drug use, support for drug-related policy and legislation, and drug use among special population groups.

Australian Institute of Health and Welfare. Australian expenditure on mental disorders in comparison with expenditure in other countries. Canberra: Australian Institute of Health and Welfare, 2003a. (Resources Division Working Paper Series No. 1). Available at: <http://www.aihw.gov.au/publications/rwp/rwp01/rwp01.pdf> (Accessed January 2005).

This report compares the health expenditure for mental disorders of four countries – the Netherlands, United States, Canada and Australia. After adjustments for comparability, it is estimated that these four countries spend between 9.5% to 11.5% of their health expenditure on dementia, substance abuse disorders and other mental disorders. Specifically, the amount spent on mental disorders alone ranges from 6.2% (Australia) to 6.6% (the Netherlands) and 7.3% (United States).

Australian Institute of Health and Welfare. Health expenditure Australia 2001-02. Health and Welfare Expenditure Series no. 17. Canberra: Australian Institute of Health and Welfare, 2003b. (AIHW Catalogue No. HWE-24). Available at: <http://www.aihw.gov.au/publications/hwe/hea01-02/hea01-02.pdf> (Accessed January 2005).

This report continues the Australian Institute of Health and Welfare's series of reports on health expenditures, which have been produced annually since 1986. It presents the most recent estimates for Australia for the year 2001-02, plus time-series data covering the period from 1991-92 to 2000-01.

Australian Institute of Health and Welfare. Mental health services in Australia, 2000-01. Mental Health Series No. 4. Canberra: Australian Institute of Health and Welfare, 2003c. (AIHW Catalogue No. HSE-24). Available at: <http://www.aihw.gov.au/publications/index.cfm/title/8518> (Accessed January 2005).

This is the fourth annual report on mental health services released from the Australian Institute of Health and Welfare. It contains statistical details on all aspects of Australian mental health service provision, ranging from specialist and general health services, through to non-health sector support services. The data pertaining to mental healthcare services (community and specialist) are based on information collated in the National Minimum Data Sets for Mental Healthcare. Information is presented not only on service activity but also on service utilisation.

Australian Institute of Health and Welfare. Australia's health 2004: the ninth biennial health report of the Australian Institute of Health and Welfare. Canberra: Australian Institute of Health and Welfare, 2004a. (AIHW Catalogue No. AUS-44). Available at: <http://www.aihw.gov.au/publications/index.cfm/title/10014> (Accessed January 2005).

The Australian Institute of Health and Welfare publish a biennial report containing statistics on health and its determinants, health service provision and utilisation and performance of the health system in Australia. The ninth report also presents information on the health of older Australians.

Australian Institute of Health and Welfare. Health system expenditure on disease and injury in Australia, 2000-01. Canberra: Australian Institute of Health and Welfare, 2004b. (AIHW Catalogue No. HWE-26). Available at: <http://www.aihw.gov.au/publications/hwe/hsedia00-01/hsedia00-01.pdf> (Accessed January 2005).

This report presents estimates of health expenditure on disease and injury in Australia in 2000-01, classified by disease or injury group, age and sex.

*beyondblue: the national depression initiative* [homepage on the Internet]. Melbourne, *beyondblue*. Available at: <http://www.beyondblue.org.au> (Accessed January 2005).

The website aims to raise community awareness about and reduce stigma towards people with depression, anxiety and related substance misuse. Contained on the website are descriptions of common symptoms, fact sheets containing information about the causes and treatments of depression, anxiety and substance misuse, as well as links to other sites and materials on the Internet and other educational resources. Another aspect of the website are online discussion rooms or forums where people are encouraged to relate their personal experiences of living with depression or anxiety. Finally, the website contains information on events organised by *beyondblue* and other related organisations.

Bipolar disorder: costs. An analysis of the burden of bipolar disorder and related suicide in Australia. An Access Economics Report for SANE Australia. Melbourne: SANE Australia, 2003. Available at: [http://www.sane.org/images/assets/Research\\_reports\\_and\\_images/bipolar\\_costs.pdf](http://www.sane.org/images/assets/Research_reports_and_images/bipolar_costs.pdf) (Accessed January 2005).

This report details the direct and indirect costs of bipolar disorder and associated suicides. It makes the point that without immediate significant investment, health costs for bipolar disorder will approach \$400 million per annum while indirect costs will out number these costs four-fold.

Blood RW, Putnis P, Williams J, Turner B. Depression in the Australian news media. Canberra: University of Canberra, 2003.

This report examined the impact of the establishment of *beyondblue* on coverage of issues surrounding depressive illness during 2000-02 in major Australian metropolitan newspapers. The 'Blood Report' employed the Factiva and Newstext databases to identify prominent mentions of depression linked to *beyondblue* or its key staff.

Bunker SJ, Colquhoun DM, Esler MD, et al. "Stress" and coronary heart disease: psychosocial risk factors. National Heart Foundation of Australia position statement update. Medical Journal of Australia 2003; 178: 272-276. Available at: [http://www.mja.com.au/public/issues/178\\_06\\_170303/bun10421\\_fm.pdf](http://www.mja.com.au/public/issues/178_06_170303/bun10421_fm.pdf) (Accessed January 2005).

Bunker and colleagues report on the conclusions of an expert working group, working under the auspices of the National Heart Foundation of Australia, who reviewed research into the link between coronary heart disease (CHD) and psychosocial risk factors (as opposed to traditionally recognised risk factors such as smoking or hypertension). They found strong evidence for a link between CHD (and its outcome) and depression, social isolation and poor social support. However, the evidence linking CHD to stress, chronic life events, certain personality traits, anxiety or panic disorders, was weak and inconsistent.

Burgess P, Pirkis J, Buckingham B, et al. Mental health needs and expenditure in Australia, 2002. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing, 2002. Available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-needsexp.htm/\\$FILE/needsexp.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-needsexp.htm/$FILE/needsexp.pdf) (Accessed January 2005).

Consequent to the growing recognition of the burden associated with mental illness and endorsement of the National Mental Health Strategy, the need to examine whether the current funding of mental health services was adequately addressing needs became apparent. This publication presents the results from a national 'needs and expenditure project', instigated following the national surveys of Mental Health and Wellbeing and of Mental Health Services.

Burns JM, Andrews G, Szabo M. Depression in young people: what causes it and can we prevent it? Medical Journal of Australia 2002; 177 Suppl Oct 7: S93-S96. Available at: [http://www.mja.com.au/public/issues/177\\_07\\_071002/bur10371\\_fm.pdf](http://www.mja.com.au/public/issues/177_07_071002/bur10371_fm.pdf) (Accessed January 2005).

The authors review literature on the prevention of depression in young people, the identification of modifiable risk factors for depression in young people as well as protective factors and school-based programs designed to improve the school environment.

Cade JFJ. Lithium salts in the treatment of psychotic excitement. Medical Journal of Australia 1949; 2: 349-352.

This is a report on the discovery of the sedative effect of lithium salts for people with mania. It is a ground breaking paper, representing the first use of chemical or pharmacological treatments for psychiatric conditions.

Cameron JW (Auditor-General). Mental health services for people in crisis. Victoria: Government Printer for the State of Victoria, 2002.

This is a comprehensive report on mental health service provision in Victoria. The aims of the audit included assessment of the timeliness and appropriateness of services for adults with mental health problems who were experiencing or at risk of experiencing an illness related crisis, the impact of the mental health system on carers and families, the protection of rights for persons with community treatment orders or who had been involuntarily admitted to hospital, the distribution of mental health budget funds, and the adequacy of measures used to assess the efficacy of mental health crisis prevention and response. Some of the main findings were: 25% of urgent cases did not receive a face-to-face assessment by an area mental health service clinical staff member for seven or more days; documentation in client files was poor; carers and families found services for consumers and support for themselves were inadequate; and that, whilst distribution of funding was becoming more equitable, discrepancies remain.

Carr V, Neil A, Halpin S, Holmes S on behalf of the Low Prevalence Disorders Study Group. Costs of psychosis in urban Australia. Canberra: Commonwealth of Australia, 2002. Available at:

[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-costs.htm/\\$FILE/costs.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-costs.htm/$FILE/costs.pdf) (Accessed January 2005).

This publication presents findings from the Low Prevalence Disorders Study (LPDS), which was a part of the National Survey of Mental Health and Wellbeing. The main aims of the LPDS were to find out the prevalence of psychotic disorders in Australia, to describe demographic features of people with psychotic disorders (such as socioeconomic and domestic status) as well as service utilisation, unmet needs and burdens associated with the illness. The main findings were that despite low prevalence, treating psychoses is relatively expensive, partly due to the severe burden and disability caused by the disorder. While service utilisation was high, treatments were limited (i.e. few psychosocial interventions).

Changing Minds [homepage on the Internet]. London: The Royal College of Psychiatrists, 2004. Available at: <http://www.changingminds.co.uk> (Accessed January 2005).

This website details the Changing Minds campaign, a strategy designed to reduce stigma towards persons with mental illness, and specifically includes information about depression, anxiety, anorexia and bulimia, Alzheimer's and dementia, schizophrenia and alcohol or other substance misuse.

Christensen H, Griffiths KM, Jorm AF. Delivering interventions for depression by using the Internet: randomised controlled trial. *BMJ* 2004; 328: 265-269. Available at:

<http://bmj.bmjournals.com/cgi/reprint/328/7434/265> (Accessed January 2005).

In this paper the authors present results on a randomised controlled trial comparing the effectiveness of two Internet delivered interventions for people with symptoms of depression living in the community. The interventions included cognitive behaviour therapy (MoodGYM) and 'depression literacy' (BluePages). These two interventions were shown to be superior to a credible 'placebo' or control condition in terms of reducing symptoms of depression. In addition, the cognitive behaviour therapy intervention reduced dysfunctional thinking, and the depression literacy intervention improved knowledge about effective evidence-based treatments for depression.

Coffey C, Carlin JB, Lynskey M, et al. Adolescent precursors of cannabis dependence: findings from the Victorian Adolescent Health Cohort Study. *British Journal of Psychiatry* 2003; 182: 330-336. Available at:

<http://www.ukcia.org/research/AdolescentPrecursorsOfCannabisDependence/AdolescentPrecursorsOfCannabisDependence.pdf> (Accessed January 2005).

This is a report on a longitudinal study of 1,601 Victorian school students followed over a six-year period. The authors report that frequent use of cannabis in adolescence was associated with dependence as a young adult (20-21 years), particularly if adolescent use was weekly or more and if the adolescent was not a frequent alcohol user. Other predictors of cannabis dependence were being male, demonstrating persistent antisocial behaviour and cigarette smoking.

Commonwealth Department of Health and Aged Care. National mental health report 2000: sixth annual report. Changes in Australia's mental health services under the First National Mental Health Plan of the National Mental Health Strategy 1993-98. Canberra: Commonwealth Department of Health and Aged Care, 2000a. Available at: <http://www7.health.gov.au/hsdd/mentalhe/resources/reports/pdf/nmhr2000.pdf> (Accessed January 2005).

This is the sixth report on the progress of Australian mental health service reform since the National Mental Health Policy was proposed in 1992. Data in the report pertain largely to the 1997-98 financial year. The main changes to mental health service provision during 1993-98 were a shift from institutional to community, non-specialist or primary care (as evidenced by a reduction in number of beds in separate psychiatric institutions), and expansion of the range and improvements in quality of mental health services. This report also documents increases in national spending on mental health, increases in the number of acute psychiatric beds in hospitals, and increased consumer and carer participation in mental health service organisations.

Commonwealth Department of Health and Aged Care. Promotion, prevention and early intervention for mental health – a monograph. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000b. Available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-ppei-monograph.htm/\\$FILE/monograph.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-ppei-monograph.htm/$FILE/monograph.pdf) (Accessed January 2005).

This is a reference book in which the theories and evidence behind Action Plan 2000 are outlined. Action Plan 2000 is a document that outlines strategies proposed to address the goals identified in the Second National Mental Health Plan. More specifically, these goals included promoting better mental health, preventing the development of mental health problems by reducing risk and enhancing protective factors and providing early intervention.

Commonwealth Department of Health and Ageing. National mental health report 2002: seventh report. Changes in Australia's mental health services under the first two years of the second National Mental Health Plan 1998-2000. Canberra: Commonwealth of Australia, 2002. Available at: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-nmhrep2002.htm> (Accessed January 2005).

This is the seventh report on the progress of Australian mental health service reform following the 1992 proposal of the National Mental Health Policy. Data in the report pertain largely to the 1999-2000 financial year (the first two years of the Second National Mental Health Plan) and are contrasted against data from

1992-93. As well as national policy implementation, the report summarises the activities of consumer advisory groups, Commonwealth service provisions and private mental healthcare.

Commonwealth of Australia. National standards for mental health services. Canberra: Commonwealth of Australia, 1997. Available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-standards-nsmhs.htm/\\$FILE/standards.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-standards-nsmhs.htm/$FILE/standards.pdf) (Accessed January 2005).

This publication provides standards endorsed by the Australian Health Ministers' Advisory Council's National Mental Health Working Group for mental health services in Australia. The standards can be employed in many circumstances, from service development, to evaluation of service quality, to developing guidelines for consumers and carers about expected standards of care.

Contractor A, Metherell M. Rescue plan to aid struggling mental health system. The Sydney Morning Herald. Wednesday 18 August 2004: 9.

This newspaper article argues that Australia's faulting mental health system would benefit from a plan currently being considered by the Federal Government. The plan includes an expansion of counselling services (eg. Lifeline) and improved support for doctors and other health workers caring for mentally-ill patients.

Cooper JE, Sartorius N. Cultural and temporal variations in schizophrenia. British Journal of Psychiatry 1977; 30: 50-57.

This paper presents hypotheses on the relationship between schizophrenia and the impacts of industrialisation on families and society in general. The authors suggest that 'cultural' variations in schizophrenia make mirror societal changes such as the move from community care pre-industrialisation to institutionalisation during and post-industrialisation, and that more chronic forms of the disease may have been more apparent in the institutional settings. They propose that more attention should be given to historical changes in family and community structures and our conceptualisations of schizophrenia.

Crowther R, Marshall M, Bond G, Huxley P. Vocational rehabilitation for people with severe mental illness. Cochrane Database of Systematic Reviews 2001; 2: CD003080.

This study aims to assess the effects of pre-vocational training and supported employment for people with severe mental illness. It found supported employment is more effective than pre-vocational training when trying to obtain competitive employment. It also suggests that pre-vocational training is not effective at all.

Department of Family and Community Services. Characteristics of Disability Support Pension customers. Canberra: Australian Government, June 2003.

The Disability Support Pension (DSP) is paid to people who are unable to work for at least 30 hours per week, or be re-skilled for such work, for more than two years because of a disability. The DSP is intended to ensure that people with a disability have adequate levels of income and maximum opportunities to participate in society. This document describes the socio-demographics of people receiving the DSP in Australia during the financial year 2002-03.



Department of Health, NSW Division of Planning and Research. Inquiry into health services for the psychiatrically ill and developmentally disabled (Richmond Report). Summary of recommendations. Department of Health, NSW Division of Planning and Research; March, 1983.

This Inquiry recommended that people with a mental illness or people with a developmental disability be treated within a community setting, rather than institutionalised.

Department of Health and Ageing. National mental health report 2004: eight report – summary of changes in Australia's mental health services under the national mental health strategy 1993-2002. Canberra: Commonwealth of Australia, 2003. Available at:

[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-index.htm/\\$FILE/NMHR2004.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-index.htm/$FILE/NMHR2004.pdf) (Accessed January 2005).

This is the eight report on the progress of reforms to the mental healthcare system outlined in the National Mental Health Strategy. This report covers the period 1993-2002 and uses data collected in the annual National Survey of Mental Health Services conducted by the Department of Health and Ageing. The main findings were: growth in government mental health spending has paralleled growth in overall health expenditure; the proportion of funds allocated to community-based mental health services has risen from 29% in 1992-93 to 51% in 2001-02; the proportion of psychiatric beds in stand alone hospitals has dropped from 73% in 1993 to 39% in 2002; and the proportion of mental health service organisations with formal consumer participation mechanisms had risen from 33% in 1992-93 to 77% in 2001-02.

Forensicare [homepage on the Internet]. Victorian Institute of Forensic Mental Health. Available at: <http://www.forensicare.vic.gov.au/website.nsf/web/clinicalservices.html> (Accessed January 2005).

This site contains a wide range of information on the Victorian Institute of Forensic Mental Health and Forensicare, the agency responsible for the provision of adult forensic mental health services in Victoria.

Gold PW, Chrousos GP. The endocrinology of melancholic and atypical depression: relation to neurocircuitry and somatic consequences. *Proceedings of the Association of American Physicians* 1999; 111: 22-34. People with major depression with melancholic features often present with symptoms of sustained anxiety and dread for the future, along with physiological evidence of hyperarousal or activation of the stress system. It is believed that chronic experience of stress (experienced as part of depression), and the endocrine changes associated with this stress, could explain the link between depression and coronary artery disease, female susceptibility to depression, and help with understanding the mechanisms of action of antidepressant medicines.

Groom G, Hickie I, Davenport T. Out of hospital, Out of mind! A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008. Canberra: Mental Health Council of Australia, 2003. Available at:

[http://www.mhca.com.au/Public/PoliciesDocumentation/OutHospitalOutofMind\\_FinalReport.pdf](http://www.mhca.com.au/Public/PoliciesDocumentation/OutHospitalOutofMind_FinalReport.pdf) (Accessed January 2005).

This is a description of a nationwide review of the experiences of those who use and provide mental health services in Australia. The report documents that current community-based systems are failing to provide adequate services.



Hall WD, Mant A, Mitchell PB, et al. Association between antidepressant prescribing and suicide in Australia, 1991-2000: trend analysis. *BMJ* 2003; 326: 1008-1012. Available at: <http://bmi.bmjournals.com/cgi/reprint/326/7397/1008> (Accessed January 2005).

Hall and colleagues describe a study in which they explored the relationship between Australian national suicide rates and prescriptions for antidepressants during 1991 to 2000. They found that whilst overall suicide rates for adults did not change over this time period, rates in older age groups did decrease considerably. Significant relationships between exposure to antidepressant medication and decline in suicide rates were observed, especially in the older sub-sample.

Hamilton C. Comfortable, relaxed and drugged to the eye-balls. *The Australian Institute* 2003; 35: 1-2, 12. Available at: [http://www.tai.org.au/Newsletter\\_Files/Newsletters/NL35A.pdf](http://www.tai.org.au/Newsletter_Files/Newsletters/NL35A.pdf) (Accessed January 2005).

Drawing on unpublished data from the Australian Bureau of Statistics, Clive Hamilton concludes that nearly one third of adult Australians rely on medications, alcohol or illicit drugs for mental wellbeing. The report shows that men are more likely to seek refuge in alcohol while women are more likely to turn to pills.

Hickie I. A caring community would show the mentally-ill open doors, not closed minds. *The Sydney Morning Herald* 6 February 2004a: 11.

Professor Ian Hickie argues in this article that people with mental disorders still experience stigma, and that a failure to provide adequate services, combined with a lack of understanding about mental illness in the community and heightened fears about personal safety resulting from increased global terrorism, have contributed to Australian society adopting a more custodial approach to mental healthcare. The stigma associated with mental illness and a fear of being scheduled or held against one's will in an institution, are barriers to effective care. This article challenges community attitudes towards mental illness and apathy about the current state of the mental healthcare system and emphasises the right of persons with mental disorders to expect higher standards of care.

Hickie I. Reducing the burden of depression: are we making progress in Australia? *Medical Journal of Australia* 2004b; 181 Suppl Oct 4: S4-S5. Available at:

[http://www.mja.com.au/public/issues/181\\_07\\_041004/hic10389\\_fm.pdf](http://www.mja.com.au/public/issues/181_07_041004/hic10389_fm.pdf) (Accessed January 2005).

As the editorial of a special supplement entitled "Depression: reducing the burden" (published by *The Medical Journal of Australia*), this article outlines the coordinated population health response adopted by *beyondblue: the (Australian) national depression initiative*. The article and supplement go on to discuss the early achievements of *beyondblue* and its associated organisations. The author concludes that *beyondblue* appears to be achieving wide benefits and has successfully established a broad framework for more sustainable changes in community attitudes and health service reform.

Hickie I, on behalf of *beyondblue: the national depression initiative*. Can we reduce the burden of depression? The Australian experience with *beyondblue: the national depression initiative*. *Australasian Psychiatry* 2004c; 12 Suppl: S38-S46.

This article describes the development and early achievements of *beyondblue: the national depression initiative*. Specifically, the author lists its most important achievements to date as: the degree of national

recognition of *beyondblue*; size and scope of media impact; growth in website utilisation ([www.beyondblue.org.au](http://www.beyondblue.org.au)); increased reporting of the community's recognition of people with depression; genuine reforms in life insurance and income protection; development of a new national consumer and carer organisation; establishment of major population-based preventative and early intervention programs; system-wide reform of primary care-based mental health services; national educational program uptake by general practitioners; and development of key awareness and intervention programs for use in schools and the workplace.

Hickie IB, Christensen H, Davenport TA, Luscombe GM. Can we track the impact of Australian mental health research? *Australian and New Zealand Journal of Psychiatry* (in review 2004).

This article explores the measurement of academic performance in mental health research in Australia and New Zealand in the context of developing markers to guide allocation of research funding. The method proposed is the consideration of citation rates, i.e. the number of times a research paper published in a journal (or professional magazine) has been quoted in other journal articles. Citation rates were compared between countries, Australian states, institutions and individual researchers. Australia's performance in mental health research was poorer than in Canada or New Zealand. The papers written by Australian and New Zealand authors receiving the highest citations included subjects as diverse as [syndrome definition](#), epidemiology [and epidemiological methods](#), cognitive science [and](#) studies of prognosis.

Hickie IB, Davenport TA, Hadzi-Pavlovic D, et al. Development of a simple screening tool for common mental disorders in general practice. *Medical Journal of Australia* 2001a; 175 Suppl Jul 16: S10-S17.

This article describes the development of the 12-item short form of the self-report Somatic and Psychological HEalth REport (SPHERE) questionnaire. The SPHERE questionnaire was designed to address the inadequacies of other measures of mental disorder apparent when used in medical settings. More specifically, many screening instruments are restrictive, providing information on specific disorders rather than general psychological distress or subthreshold disorders, the latter of which are more commonly found in general practice settings. The SPHERE is a reliable instrument, able to provide information on both somatic (eg. headaches, pain) and psychological (eg. depression, anxiety) presentations of psychological distress.

Hickie IB, Davenport TA, Naismith SL, et al. Treatment of common mental disorders in Australian general practice. *Medical Journal of Australia* 2001b; 175 Suppl Jul 16: S25-S30.

This manuscript presents the results from a national audit of Australian general practices. General practitioners (GPs) enrolled in the audit screened all eligible patients over a one-week period using the SPHERE questionnaire (to detect common psychological disorders). Information was also collected on treatments provided for patients with common mental disorders. Just over a quarter (27%) of patients received some intervention, 21% non-pharmacological and 12% pharmacological. However, treatments that were apparently evidence-based were only provided to 12% of the sample. Approximately 10,000 patients were found to have severe psychological disorders using the SPHERE, and of these, only half received an intervention from their GP (38% non-pharmacological and 27% pharmacological). The authors concluded that GPs tended to provide non-specific, non-pharmacological treatments for patients with common psychological disorders.

Hickie IB, Davenport TA, Scott EM, et al. Unmet need for recognition of common mental disorders in Australian general practice. *Medical Journal of Australia* 2001c; 175 Suppl Jul 16: S18-S24.

This manuscript reports on the national audit of general practitioners (GPs) conducted as part of *SPHERE: a national depression project*. Using the 12-item version of the SPHERE questionnaire (which detects common mental disorders), the authors determined the rate of unmet need, i.e. the proportion of patients identified as having a mental disorder on the SPHERE but not by the GP, as 56%. The SPHERE identified cases that were least recognised by the GPs related to those patients presenting with predominantly somatic symptoms (76% unrecognised), followed by predominantly psychological symptoms (58%) and finally 46% of patients with more severe mental disorder (with both psychological and somatic presentations).

Hickie I, Groom G. Primary care-led mental health service reform: an outline of the *Better Outcomes in Mental Health Care* initiative. *Australasian Psychiatry* 2002; 10: 376-382.

The key features of the Government-funded *Better Outcomes in Mental Health Care* (BOiMHC) initiative are described in this paper. In 2001, the Federal Government budget dedicated \$120.4 million to a scheme to enhance the care provided by general practitioners (GPs) for patients with mental health problems. The main elements of the scheme are GP education, and promotion of better integration between primary and specialist care provision. More specifically, GPs are trained in mental health recognition and management, and have the opportunity to continue to train in focused psychological strategies. Part of management training involves close monitoring of individual consumer outcome. Systems have also been instigated to help facilitate GP referral to allied health professionals.

Hickie I, Hickie C, Lloyd A, et al. Impaired *in vivo* immune responses in patients with melancholia. *British Journal of Psychiatry* 1993; 162: 651-657.

Data from a case-control study suggest that impaired cell-mediated immunity *in vivo* may be limited to those patients with melancholic rather than non-melancholic major depression. However, the factors accounting for this impaired immunity are unclear.

Hickie IB, Pirkis JE, Blashki GA, et al. General practitioners' response to depression and anxiety in the Australian community: a preliminary analysis. *Medical Journal of Australia* 2004; 181 Suppl Oct 4: S15-S20. Available at: [http://www.mja.com.au/public/issues/181\\_07\\_041004/hic10846\\_fm.pdf](http://www.mja.com.au/public/issues/181_07_041004/hic10846_fm.pdf) (Accessed January 2005).

This paper presents the results of a study on the rate of uptake by general practitioners (GPs) of the *Better Outcomes in Mental Health Care* (BOiMHC) initiative during the first 15 months of the scheme. The BOiMHC initiative is a federally funded four-year program designed to improve mental healthcare provision within general practice via education, partnership development and financial compensation. Over the first 15 months of the scheme, approximately 15% of GPs across Australia (3,046) had completed educational programs on the recognition and management of mental health problems. Of these GPs, 387 had also completed training on focused psychological strategies, and 6,472 sessions of psychological intervention had been provided to patients. A similar number of GPs (346) had referred 1,910 patients with mental health problems to an allied health professional. These results were considered to be evidence of expansion of the ability of Australian primary care to respond to the unmet need of patients with common mental disorders.

Higley NJ, Hickie IB, Davenport TA. Monitoring awareness of and attitudes to depression in Australia. *Medical Journal of Australia* 2002; 176 Suppl May 20: S63-S68. Available at: [http://www.mja.com.au/public/issues/176\\_10\\_200502/hig10079\\_fm.pdf](http://www.mja.com.au/public/issues/176_10_200502/hig10079_fm.pdf) (Accessed January 2005).

In 2001, *beyondblue* conducted a telephone survey of 900 persons from New South Wales, Victoria, Queensland and South Australia to assess depression literacy in the community. More specifically the survey questioned respondents regarding awareness of depression, knowledge regarding symptoms and treatment, attitudes towards people with depression and treatment seeking behaviours. People from the Australian community generally did not perceive depression as a major general health issue despite 58% claiming a personal or family experience of depression. Depression was identified as the most common mental health problem by 39% of the sample, but only half the respondents could distinguish depression from normal sadness. Just under half the sample (45%) said they would first turn to a family member, and 28% a general practitioner if they thought they might be experiencing depression. Approximately a quarter of respondents selected non-pharmacological therapies as a first line of treatment, compared with 11% choosing a pharmacological therapy.

Hoult J, Reynolds I, Charbonneau-Powis M, et al. Psychiatric hospital versus community treatment: the results of a randomised trial. *Australian New Zealand Journal of Psychiatry* 1983; 17: 160-167.

This manuscript presents the results from a randomised trial of patients presenting for psychiatric hospital admission. Patients randomised to the control group were provided standard hospital care, whereas those in the intervention group were not admitted if possible, instead receiving comprehensive treatment in the community, in combination with a 24-hour crisis service. The study demonstrated that community treatment dramatically reduced hospital admissions (96% controls versus 40% of community treatment group) and days spent in psychiatric hospital (controls: 54 days; community treatment: eight days), was more cost effective and achieved better clinical outcomes. Subjectively, community treatment was considered to be more helpful and acceptable to patients and their carers/ families.

Human Rights and Equal Opportunity Commission. Human rights and mental illness. Report of the National Inquiry into the human rights of people with mental illness: Burdekin Report. Canberra: Australian Government Publishing Service, 1993.

This report outlines how people with mental illness experience widespread discrimination and are constantly denied their entitled rights and services. It also found that deinstitutionalisation had a positive effect via reduction in stigma as psychiatric services became more mainstream. However, economic savings resulting from deinstitutionalisation have not been put back into the community services, and these services are vital to enable people with mental illness to live in the community. Finally, not all areas of Australia have access to community psychiatric services, and where services are available, they are under-funded.

Issakidis C, Sanderson K, Corry J, et al. Modelling the population cost-effectiveness of current and evidence-based optimal treatment for anxiety disorders. *Psychological Medicine* 2004; 34: 19-35.

This study used data from the Australian National Survey of Mental Health and Wellbeing and known treatment costs to estimate costs relative to a population-based summary measure of disability burden: the years lived with disability. The current cost of care for anxiety disorders in Australia totalled \$400 million.

With a hypothetical optimal care package of evidence-based treatments, the authors estimated that costs would be similar, but the health gains would result in an overall reduction in cost per years lived with disability.

Jablensky A, McGrath J, Herrman H, et al. National Survey of Mental Health and Wellbeing. Report 4. People living with psychotic illness: an Australian study 1997-98. Canberra: Commonwealth of Australia, 1999.

The report presents findings gathered through a census of 3,800 Australians with psychotic disorders who attended mental health services in Canberra, Queensland, Victoria and Western Australia. The study recognises that psychotic disorders (60% of which are schizophrenia and schizoaffective disorder) represent major public health challenges for Australia. The level of burden of ill-health, disability and stigma experienced in this population is high, with the majority having a poor quality of life. In any given month between four and seven people per 1,000 adults with psychotic disorders in urban areas are in contact with mental health services. The report concluded that there is a need to support this disadvantaged group by forming better partnerships across all service providers – not only pertaining to health, but accommodation, employment and training, legal aid and rehabilitation services.

Jorm A, Griffiths K, Christensen H, Medway J. *Research priorities in mental health*. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing, 2002. Available at: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-resources-reports-rpimh.htm> (Accessed January 2005).

Jorm and colleagues present a report compiled by the Centre for Mental Health Research (The Australian National University) for the Mental Health and Special Programs Branch of the Commonwealth Department of Health and Aged Care on the state of Australian mental health research in 2001. The aim of the report was to strengthen Australian research by reviewing funding received and publications emanating from mental health research, and contrast the work produced against various standards with a view to highlighting areas of research that have been relatively neglected. The main conclusion of the report was a need for a more strategic approach to research with greater attention paid to depression, suicide, prevention and promotion, non-pharmacological treatments, service evaluation, community and primary care-based samples, and samples focussing on Aboriginal and Torres Strait Islander peoples, children and adolescents, and people with social and economic disadvantage.

Jorm AF, Korten AE, Jacomb PA, et al. Attitudes towards people with a mental disorder: a survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry* 1999; 33: 77-83.

This study surveyed members of the Australian public, as well as GPs, psychiatrists and clinical psychologists regarding the long-term treatment outcome and likelihood of discrimination toward two hypothetical people with mental illness – one with schizophrenia and one with depression. Whilst all people surveyed believed the treatment outcome would be poorer for the person with schizophrenia, health professionals had more negative attitudes, suggesting also that discrimination was more likely. Possible reasons for this finding are health professionals have more realistic attitudes, or are biased by exposure to more severe or chronic disorders.

Kaszubska G. Patients suffer as mental health plans fail [A special report]. *The Australian*. Friday 20 February 2004; 1 (4).

This newspaper article discusses recent findings by the Mental Health Council of Australia (see Groom *et al.* 2003) that Australian governments are currently falling well short of nationally agreed targets for improving mental health services.

Kendall PC, Kessler RC. The impact of childhood psychopathology interventions on subsequent substance abuse: policy implications, comments, and recommendations. *Journal of Consulting and Clinical Psychology* 2002; 70: 1303-1306.

In this article the authors outline the evidence for the effects of preventing or treating child psychopathology on the prevention of secondary substance use disorders. They suggest: the mandate for early interventions should be expanded to appeal to a broader range of policy makers, such as those in education and criminal justice systems; that randomised clinical trials be expanded to include measurement of indirect effects of treatment of child psychopathology; and that further emphasis be placed on evidence-based treatment, with a view to presenting models of cost effective strategies/ early interventions to policy makers.

Kim-Cohen J, Caspi A, Moffitt TE, et al. Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry* 2003; 60: 709-717.

The authors demonstrated, through a longitudinal study following over 1,000 children from age 11 through to 26 years, that most adults with psychiatric diagnoses also met criteria for a psychiatric diagnosis as a child. They argue that prevention strategies should focus on children, especially those with juvenile conduct disorder.

Lamb HR. Is it time for a moratorium on deinstitutionalization? *Hospital and Community Psychiatry* 1992; 43: 669.

Professor Lamb describes the continuing decrease in numbers of state hospital beds for mentally-ill people living within the ever increasing United States population (1955: 559,000 beds for 165 million population; 1992: 103,000 beds for 248 million population). He subsequently recommends a moratorium on any further reductions in hospital beds until: 1) the problem of a severe shortage of essential community resources is solved; and, 2) there are more accurate assessments of the numbers of chronically and severely mentally-ill people requiring immediate or long-term care.

Lawrence D, Holman CDJ, Jablensky AV. *Duty to care: preventable physical illness in people with mental illness*. Perth: The University of Western Australia, 2001. Available at:

[http://www.populationhealth.uwa.edu.au/welcome/research/chsr/chsr/consumer\\_info/duty\\_to\\_care](http://www.populationhealth.uwa.edu.au/welcome/research/chsr/chsr/consumer_info/duty_to_care)

(Accessed January 2005).

The report documents the results of a study into the physical health of people with mental illness. Whilst the social and economic burdens experienced by people with mental illness are gaining greater recognition, physical health is often neglected. The project examined the physical health of 240,000 persons using mental health services in Western Australia between 1980 and 1998, using data on rates of hospital

admissions, the incidence of cancer and the rate of death. The aim of the project was to identify areas of physical health that could be targeted in public health campaigns for persons with mental illness as well as more general improvements to the healthcare system as it relates to people with mental illness.

Lehman AF, Goldberg R, Dixon LB, et al. Improving employment outcomes for persons with severe mental illnesses. *Archives of General Psychiatry* 2002; 59: 165-172.

This study evaluates the 'Individual Placement and Support' model of supportive employment as well as usual psychosocial rehabilitation services for improving employment among patients with severe mental illnesses. It found the 'Individual Placement and Support' model was most effective in helping patients achieve employment goals, but that achieving job retention was a challenge of both.

Leong K. Rozelle Hospital (1819-1984): its origins and development: the amalgamation of Callan Park Mental Hospital and Broughton Hall Psychiatric Clinic [Dissertation]. Thesis submitted for the Degree of Bachelor of Architecture, University of New South Wales, 1984.

Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia. Canberra: Australian Institute of Health and Welfare, 1999. (AIHW Catalogue No. PHE-17). Available at:

<http://www.aihw.gov.au/publications/health/bdia/bdia.pdf> (Accessed January 2005).

This study is the first comprehensive assessment of the health status and burden of disease within the Australian population. All aspects of disease burden (mortality, disability, impairment, illness and injury) were calculated and used to produce figures on disability adjusted life years or DALYs (one DALY = one lost year of 'healthy' life). The report found that in 1996, mental disorders were the leading cause of years of life lost due to disability (YLD), and comprised nearly 30% of the total non-fatal burden. When considering specific conditions, depression was the leading cause of YLD, comprising 8% of the total burden. Disability burden for substance misuse, affective and anxiety disorders and borderline personality disorder was dependent on socioeconomic position – the most disadvantaged quintile losing approximately 43% more years of healthy life than the least disadvantaged quintile. Mental disorders were considered the third leading cause of burden (based on DALYs) after cardiovascular disease and cancers. For specific disorders, depression is the fourth leading cause of disease burden, except when cardiovascular disease due to diabetes is grouped under diabetes, in which case depression and diabetes share equal third place as leading causes of disease burden, following ischaemic heart disease and stroke.

McGorry PD, Chanen A, McCarthy E, et al. Posttraumatic stress disorder following recent-onset psychosis: an unrecognised postpsychotic syndrome. *Journal of Nervous and Mental Disease* 1991; 179: 253-258.

This paper presents the results on a follow-up study of 36 patients hospitalised for acute psychotic episode. All patients had recent-onset psychosis, experiencing their first episode within three years prior to the study. The authors assessed patients for posttraumatic stress disorder (PTSD), and found approximately half the sample (46%) met DSM-III criteria for PTSD at four months, and approximately one-third (35%) at 11 months. The symptoms were related to depressive rather than negative symptomatology.

McGorry PD, Jackson HJ, eds. Recognition and management of early psychosis: a preventive approach. New York: Cambridge University Press, 1999.



The main thesis of this monograph is that early identification of psychosis is possible and that obtaining treatment in a timely fashion is pivotal in order to arrest the course of the illness. The authors suggest that psychosis has generally been conceptualised as a chronic and deteriorating condition, and this has probably hindered investigation into prevention and early treatment. They review the evidence for treatments, as well as providing practical models for intervention.

McLennan W. Mental health and wellbeing: profile of adults, Australia 1997. Canberra: Australian Bureau of Statistics, 1998. (ABS Catalogue No. 4326.0).

This publication presents selected results from the National Survey of Mental Health and Wellbeing of Adults, conducted from May to August 1997. The survey was designed to ascertain the prevalence of several major mental disorders (anxiety, affective and substance use disorders, ICD-10 classifications) in Australian adults. Other information collected in the survey includes physical conditions, disability associated with mental illness, health service utilisation and perceived need for health services for mental health problems. Results of the survey are presented in this publication.

McNair BG, Highet NJ, Hickie IB, Davenport TA. Exploring the perspectives of people whose lives have been affected by depression. *Medical Journal of Australia* 2002; 176 Suppl May 20: S69-S76. Available at: [http://www.mja.com.au/public/issues/176\\_10\\_200502/mcn10080\\_fm.pdf](http://www.mja.com.au/public/issues/176_10_200502/mcn10080_fm.pdf) (Accessed January 2005).

This report summarises the key themes emerging from public meetings, focus groups and *beyondblue* website-based discussions with people with depression or anxiety and their families and carers. These discussions were conducted nationally, with the intention of providing a forum to discuss issues relating to the experience of depression. A commonly expressed theme was stigma experienced as a consequence of mental illness, and lack of understanding of depression as an illness. Other concerns related to unmet needs in healthcare settings and barriers to social participation (eg. workplace discrimination).

Meadows G, Burgess P, Bobevski I, et al. Perceived need for mental health care: influences of diagnosis, demography and disability. *Psychological Medicine* 2002; 32: 299-309.

This report discusses findings from the Australian National Survey of Mental Health and Wellbeing of 1997 where 10,641 people were interviewed. The Composite International Diagnostic Interview was administered to diagnose mental disorder. The survey assessed perceived need for mental healthcare, which was associated with being female, middle-aged, having a mood or a comorbid disorder and experiencing greater disability.

Menadue J. Healthcare reform: possible ways forward. *Medical Journal of Australia* 2003; 179: 367-369. Available at: [http://www.mja.com.au/public/issues/179\\_07\\_061003/men10561\\_fm.pdf](http://www.mja.com.au/public/issues/179_07_061003/men10561_fm.pdf) (Accessed January 2005).

This is the transcript of a keynote address presented at the Australian Health Care Summit in 2003, when John Menadue discussed possible ways forward for healthcare reform in Australia. Menadue argues that whilst there is consensus about the issues that need to be addressed in healthcare reform (eg. prevention, primary care, duplication of service provision), serious consideration still needs to be given to how persons in positions of power in the health system (whether they be political, clinical or managerial) guide the implementation of these changes.



Mental Health Consumer Outcomes Task Force. Mental health: statement of rights and responsibilities. Canberra: Australian Government Publishing Service, 1991. [Reprinted 1992, 1995, 1999, 2000]. Available at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-standards-nsrr.htm/\\$FILE/nsrr1.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-standards-nsrr.htm/$FILE/nsrr1.pdf) (Accessed January 2005).

Whilst limited progress has been achieved in Australia in terms of the destigmatisation of mental illness and countering discrimination, many consumers and carers have not been provided equity, access and social justice. In response to this situation, consumer, professional and government groups concerned with mental health collaborated to produce this statement of rights and responsibilities for persons affected by mental health problems. The aim of this document is to ensure that all members of society have access to reliable information on mental health rights and responsibilities.

*mindmatters*: A Mental Health Promotion Resource for Secondary Schools [homepage on the Internet]. Available at: <http://cms.curriculum.edu.au/mindmatters> (Accessed January 2005).

*mindmatters* is a resource and professional development program to support Australian secondary schools in promoting and protecting the social and emotional wellbeing of members of school communities.

Moynihan R. Too much medicine: the business of health and its risks for you. Sydney: ABC Books for the Australian Broadcasting Commission, 1998.

Ray Moynihan is an investigative journalist who explored the issue of evidence-based treatment in medicine. An evidence-based treatment is one with efficacy proven through rigorous, independent scientific study. The book explores the influences on doctors' treatment decisions: from training at medical school, personal experiences, colleagues' experiences and drug company information.

Mueser KT, Clark RE, Haines M, et al. The Hartford study of supported employment for persons with severe mental illness. *Journal of Consulting and Clinical Psychology* 2004; 72: 479-490.

This study compares three approaches to vocational rehabilitation for severe mental illness. It found that patients participating in the 'Individual Placement and Support' program had better employment outcomes than those participating in psychosocial rehabilitation or standard brokered vocational services.

Murray CJL, Lopez AD, editors. The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, MA: Harvard University Press, 1996.

The Global Burden of Disease is a document in which concepts in health economics are explored and data on patterns of mortality and disability across the world are presented. The authors describe a measure they developed, the disability-adjusted life-year (DALY). The main findings of relevance for mental health planning, research and education are that in 1990 depression was the fourth contributor, in terms of specific diseases, to burden, and is projected to be the primary cause of disease burden in 2020.

National Breast Cancer Centre and National Cancer Control Initiative. Clinical practice guidelines for the psychosocial care of adults with cancer. Camperdown, NSW: National Breast Cancer Centre, 2003. Available at: <http://www.nhmrc.gov.au/publications/pdf/cp90.pdf> (Accessed January 2005).

The aims of these clinical practice guidelines are to promote wellbeing and to lessen the emotional distress experienced by people with cancer and their families by addressing psychological as well as physical needs. These strategies are based on previously developed guidelines for the support and counselling of women with breast cancer, but have been broadened to include psychological themes applicable for all adults with cancer. The document has a multidisciplinary focus, and is designed for application in diverse treatment settings.

National Health Priority Action Council, Advisory Group on Mental Health. *Body and mind: a summary paper*. Canberra: National Health Priority Action Council, 2003.

This summary report brings together literature on the relationships between mental health problems (such as depression, anxiety and related disorders) and physical illnesses deemed to be national health priority areas (eg. asthma, cancer, cardiovascular disease). The complexity of the relationships between physical and mental health problems (such as interdependence and multiplicity of factors) is explored, as is the impact of coexisting conditions on treatment and outcome.

National Neuroscience Facility [homepage on the Internet]. Available at: <http://www.nnf.com.au> (Accessed January 2005).

The website for the National Neuroscience Facility (NNF) describes the establishment of this new Australian organisation as well as its current business and research operations.

New South Wales. Royal Commission on Callan Park Mental Hospital. Report of the Honourable Mr Justice McClemens, Royal Commissioner appointed to inquire into certain matters affecting Callan Park Mental Hospital, 1961. Sydney: Government Printer, 1961.

Following articles published in The Sydney Morning Herald about overcrowding, cruelty and neglect at Callan Park, a Royal Commission was called into the conditions at the hospital. Justice McClemens' commission supported these allegations: "*Callan Park is too big, too overcrowded, its standards of accommodation low, its emphasis mainly custodial; owing to lack of staff and amenities there is little active treatment or rehabilitation*". Recommendations from the commission pertained to patients' rights, which he concluded could not be upheld without reform to funding, service provision, government and community support. The other outcome of the commission was an emphasis on de-institutionalisation, resulting in the high stone walls and fences around Callan Park being removed.

New South Wales Health. The Australian health care agreement, 1998-2003. Available at: <http://www.health.nsw.gov.au/fcsd/rmc/cib/information-bulletins/1998/ib98-32.htm> (Accessed January 2005).

The Australian Health Care Agreement (1998-2003) replaces the Medicare Agreement which expired on 30 June 1998. The Agreement commenced on 1 July 1998 and remained in force until 30 June 2003. This information bulletin details the key components of the agreement.

Organisation for Economic Co-operation and Development. *Transforming disability into ability: policies to promote work and income security for disabled people*. France: OECD Publications, 2003.

This report has been written to assist member countries in reviewing or implementing policies to ensure people with disabilities are not excluded from gainful participation in the workforce, and that they can secure a decent income.

Pan American Health Organization (PAHO). Declaration of Caracas, 1990. *International Digest of Health Legislation* 1991; 42: 336-338.

In 1990, the Caracas Conference was convened in an attempt to review mental health policy and psychiatric services in Latin America. Principles formulated by the World Health Organization were employed as a basis for reform. The conference concluded that revisions to legislation as well as enhanced community involvement were required to promote the human and civil rights of persons with mental illness.

Patton GC, Coffey C, Carlin JB, et al. Cannabis use and mental health in young people: cohort study. *BMJ* 2002; 325: 1195-1198. Available at: <http://bmj.bmjournals.com/cgi/reprint/325/7374/1195> (Accessed January 2005).

The authors present the results from a six-year longitudinal study of cannabis use in 1,601 Victorian students aged 14 to 15 years. They found 60% of the sample had used cannabis by the time they were 20, with 7% being daily users. In young women, daily use was associated with 5.6 times the risk of experiencing depression and anxiety, confirming a link between cannabis use and mental health. However, depression and anxiety did not predict subsequent weekly or daily cannabis use.

Paykel ES, Tylee A, Wright A, et al. The Defeat Depression Campaign: psychiatry in the public arena. *American Journal of Psychiatry* 1997; 154 Suppl: 59-66.

This paper describes the Defeat Depression Campaign, a five-year project conducted in the United Kingdom. A media campaign was designed to counter negative public attitudes towards depression and its treatment. Conferences were held to improve general practitioner knowledge about depression and its treatment, and consensus meetings convened to discuss depression recognition and management guidelines.

Picker Institute Europe [homepage on the Internet]. Oxford, United Kingdom: Picker Institute Europe. Available at: <http://www.pickereurope.org/> (Accessed January 2005).

The Picker Institute is a European charity that conducts research and provides educational activities on quality improvement in healthcare, with a view to improving care and promoting patient focus. The feedback provided to healthcare providers comes from patient surveys.

Public Health Division. The health of the people of New South Wales – Report of the Chief Health Officer. North Sydney: NSW Health Department, 1996.

The Chief Health Officer's report provides a detailed description of the health status of the New South Wales population, highlighting issues facing priority population groups. Data in the report are based on epidemiological surveys, routinely collected administrative details as well as specifically implemented research studies. The report also focuses on key health issues in the New South Wales community such as cardiovascular disease, cancer, mental health, injury, diabetes and asthma.

Read L, Mendelsohn F, Bennett M, et al. Brain and mind disorders: impact of the neurosciences. Report presented to the Prime Minister's Science, Engineering and Innovation Council 10th Meeting, 27 June 2003. Available at: <http://www.detya.gov.au/science/pmseic/documents/Neuroscience%20report.pdf> (Accessed January 2005).

This report highlights the high social and economic burdens associated with brain and mind disorders (from psychiatric illness to neurodegenerative disorders such as dementia or stroke) and projects a 'blowout' in the Australian health and welfare budgets if campaigns are not employed to help curb these burdens. In the report, the advantages of research into prevention and treatment are advanced and arguments are outlined that Australian research into the neurosciences is under-funded. A call for support for multidisciplinary research that incorporates the perspectives of both 'nature' (eg. genetics) and 'nurture' (eg. environment) is also made. The authors propose a Brain and Mind Research Alliance to bring together researchers in basic neuroscience and behavioural disciplines.

Regier DA, Hirschfeld RM, Goodwin FK, et al. The NIMH Depression Awareness, Recognition, and Treatment Program: structure, aims and scientific basis. *American Journal of Psychiatry* 1988; 145: 1351-1357.

Regier and colleagues describe the process of developing and implementing a program to educate both health professionals and the community about the prevalence, potential impact and available treatments for depression, with a view to improving mental healthcare.

Review of mental health services in Australia 2003-2008. Part II: consumer and carer direct experiences of care. Available at: [http://www.mhca.com.au/ConsumerCarerSurvey\\_000.html](http://www.mhca.com.au/ConsumerCarerSurvey_000.html) (Accessed January 2005). Under the auspices of the Mental Health Council of Australia, this survey asks consumers, carers and family members about their experiences with mental health services. The survey assesses direct experiences of care against internationally developed benchmarks for quality healthcare.

Rey JM, Tennant CC. Cannabis and mental health: more evidence establishes clear link between use of cannabis and psychiatric illness. *BMJ* 2002; 325: 1183-1184. Available at: <http://bmj.bmjournals.com/cgi/reprint/325/7374/1183> (Accessed January 2005).

In this paper, the authors review evidence of the link between use of cannabis and psychiatric illness and the direction of causality, i.e. does cannabis cause psychological distress, or do people with psychological distress use cannabis to help lessen the distress?

Rey JM, Walter G, Giuffrida M. Australian psychiatrists today: proud of their profession but stressed and apprehensive about the future. *Australian and New Zealand Journal of Psychiatry* 2004; 38: 105-110. The results of a survey of Australian psychiatrists in 2002 indicated that the majority of psychiatrists were satisfied with their work as a healthcare professional, but two thirds found their job had been stressful in the previous year. Public psychiatrists expressed dissatisfaction with lack of beds, and private psychiatrists with litigation and indemnity issues.

SANE Australia. SANE Mental Health Report 2002-2003. Melbourne: SANE Australia. Available at: <http://www.sane.org/images/assets/PDFs/sanehealthreport.pdf> (Accessed January 2005).

This is a report compiled by SANE Australia, a national charity supporting education and research into mental illness and providing advocacy for people affected by mental illness. SANE Australia sought the opinion of consumers, carers and mental health workers about mental health services and the impact of the 1992 National Mental Health Strategy on provision of these services. The report concluded that mental health services were in crisis and that the Second National Mental Health Plan was not achieving the goals outlined in the National Mental Health Strategy.

Sartorius N. Fighting schizophrenia and its stigma: a new World Psychiatric Association educational programme. *British Journal of Psychiatry* 1997; 170: 297.

This article outlines the details of an educational program on schizophrenia developed by the World Psychiatric Association. The objectives of the program are to increase community awareness about schizophrenia in an attempt to decrease discrimination and stigma, and to enhance management. The program is targeted at the community, consumers and their families, providers of mental health services, community leaders and general practitioners.

Sartorius N. The economic and social burden of depression. *Journal of Clinical Psychiatry* 2001; 62 Suppl 15: 8-11.

In this article, depression is presented as a major public health problem. The disability, comorbidity and mortality associated with depression are outlined, as is the expected increase in prevalence. Acknowledging the burden of depression and the urgent need to manage the disorder, new treatments that do not require specialised mental health providers are also reviewed.

Sawyer MG, Arney FM, Baghurst PA, et al. Mental health of young people in Australia. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000. Available at: [http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mentalhealth-resources-young-index.htm/\\$FILE/young.pdf](http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mentalhealth-resources-young-index.htm/$FILE/young.pdf) (Accessed January 2005).

This publication presents the results of the child and adolescent component of the National Survey of Mental Health and Wellbeing. The prevalence of mental health problems, the impact of problems on quality of life, and access to appropriate services were assessed based on interviews with 4,500 children and adolescents aged between four and 17 years. The prevalence of mental health problems in Australian children and adolescents was 14%, but only a quarter of these received professional help.

Sawyer MG, Arney FM, Baghurst PA, et al. The mental health of young people in Australia: key findings from the child and adolescent component of the National Survey of Mental Health and Well-being. *Australian and New Zealand Journal of Psychiatry* 2001; 35: 806-814.

The main findings of the child and adolescent component of the National Survey of Mental Health and Wellbeing are also presented in this publication. The issues of balancing needs of individuals against population-based interventions, in the context of limited funding, are discussed, as is the need to consider comorbid problems in children with mental illness.

Schizophrenia: costs. An analysis of the burden of schizophrenia and related suicide in Australia. An Access Economics Report for SANE Australia 2002. Melbourne: SANE Australia, 2002. Available at: <http://www.sane.org/images/assets/Factsheets-PDF/szcosts.pdf> (Accessed January 2005).

Access Economics compiled this report, which calculated the direct costs (doctors, hospitals, pharmaceuticals) and indirect costs (lost earnings, premature death, carer costs) of schizophrenia in 2001 as approximately \$1.85 billion. The main conclusion from the report is that unless the issue of service provision for people with schizophrenia is addressed, direct costs will almost double in the next decade, and stigma and marginalisation will continue.

Select Committee on Mental Health. Mental health services in New South Wales: final report, December 2002. NSW: Legislative Council, 2002. Available at:

[http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/f742b6b2e561abdeca256c73002b7f87/\\$FILE/fullreport.pdf](http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/f742b6b2e561abdeca256c73002b7f87/$FILE/fullreport.pdf) (Accessed January 2005).

The report details the findings of an inquiry conducted by the New South Wales Legislative Council Select Committee on Mental Health. Over 300 submissions were made to the Inquiry and the report makes 120 recommendations covering organisation and policy, service provision, treatment and care, funding, privacy information, housing and homelessness, multicultural and Indigenous issues, dual diagnosis, older and younger people and forensic issues.

Steering Committee for the Evaluation of the Second National Mental Health Plan, 1998-2003. Evaluation of the Second National Mental Health Plan. Canberra: Commonwealth of Australia, 2002. Available at:

<http://www.mentalhealth.gov.au/mhinfo/nmhs/pdf/eval.pdf> (Accessed January 2005).

This Evaluation report acknowledges that whilst much has been achieved in the 10 years since the National Mental Health Strategy objectives were first introduced and in the five years of the Second National Mental Health Plan, many of the benefits expected for consumers, carers and the general community have not been realised. The Committee recognised that whilst progress has been made, the constraints of the mental health budget had slowed implementation of the Plan. More specifically, the mental health agenda has been broadened and some progress has been made in improving consumer rights and carer participation. There have also been structural reforms and the strengthening of community treatment and support services, however more work in this area is needed. The Evaluation report points to areas where greater focus needs to be applied.

Szasz TS. The myth of mental illness: foundations of a theory of personal conduct. New York: Hoeber-Harper, 1961.

This is a controversial and provocative book written by the psychiatrist, Dr Szasz. His main argument is based on the philosophical works of John Stuart Mill who outlined theses on the logic of proof and causation and used these to provide a framework for the application of scientific methodology to social as well as the more traditionally studied natural phenomena. Dr Szasz claims that if, under the empirical system, medical illnesses are defined as demonstrable biological conditions, diagnosable only by objective observations of pathology, the concept of mental illness cannot make sense since there is no observable pathology and no way to objectively measure behaviours, thoughts or feelings. He suggests that mental illness is a construct resulting from a medicalisation of certain behaviours, and this has been used to control 'undesirable' persons

and disapproved behaviours. Using psychiatry as a tool to control behaviours can ultimately result in involuntary detention and medication, both of which he sees as violating a person's right to self-ownership of body and mind. As a consequence he argues that psychiatry should only be practiced on a contractual basis between consenting adults.

Tansella M, Thornicroft G. A conceptual framework for mental health services: the matrix model. *Psychological Medicine* 1998; 28: 503-508.

These authors propose a conceptual framework, 'the matrix model', to clarify issues relating to the reform of mental health services. Rather than simply using a model of healthcare based on one service and applying this to large-scale service reform, they suggest that geographic and temporal needs must be considered. More specifically, reform must consider the complexities of need based on 'geographical' levels (country, local and patient) and temporal phases (input, process and outcome). The 'matrix' is comprised of nine cells from these two dimensions.

Thompson KN, McGorry PD, Harrigan SM. Recovery style and outcome in first-episode psychosis. *Schizophrenia Research* 2003; 62: 31-36.

The authors present results of a study on the association between 12-month clinical outcome for first-episode psychosis and recovery styles (integrative versus sealing over). Based on a sample of 196 patients from the Early Psychosis Intervention Centre, outcome and function one-year later was superior for patients with an integrative recovery style. However, recovery styles changed over time, suggesting that the conceptualisation of recovery style as a stable personality trait needs to be questioned. The authors conclude that psychological treatments and psychoeducation require further research.

Treat mental illness with more sensitivity [Editorial]. *The Australian*, Friday 04 October 2002, p.10.

This newspaper article argues that we (community, health professionals, politicians etc) need to become more sympathetic to those with mental illness.

Trewin D. Year book Australia: 2003. Canberra: Australian Bureau of Statistics, 2003. (ABS Catalogue No. 1301.0).

Each year the Australian Bureau of Statistics publishes a general reference book containing basic statistics on the economic and social conditions in Australia, as well as articles on a major theme, which differs from year to year.

Twenge JM. The age of anxiety? Birth cohort change in anxiety and neuroticism, 1952-1993. *Journal of Personality and Social Psychology* 2000; 79: 1007-1021. Available at: <http://www.apa.org/journals/psp/psp7961007.html> (Accessed January 2005).

In this article the author presents the results of two meta-analyses, one in an adult and one in a child sample, examining changes in levels of anxiety over time. Studies included in the meta-analyses spanned the 1950s to the 1990s. Levels of anxiety in both samples increased by approximately one standard deviation over time, and this rise in anxiety was correlated with measures of social connectedness and environmental dangers, but not economic factors.



United Nations. Principles for the protection of people with mental illness and for the improvement of mental healthcare. UN General Assembly Resolution A/RES/46.119. United Nations, 1991. Available at: <http://www.un.org/documents/ga/res/46/a46r119.htm> (Accessed January 2005).

Principles adopted by the United Nations. These principles cover: fundamental freedoms and basic rights; protection of minors; life in the community; determination of mental illness; medical examination; confidentiality; role of community and culture; standards of care; treatment; medication; consent to treatment; notice of rights; rights and conditions in mental health facilities; resources for mental health facilities; admission principles; involuntary admission; review body; procedural safeguards; access to information; criminal offenders; complaints; monitoring and remedies; implementation; scope of principles relating to mental health facilities; and saving of existing rights.

Vos T, Haby MM, Barendregt JJ, et al. The burden of major depression avoidable by longer-term treatment strategies. *Archives of General Psychiatry* 2004; 61: 1097-1103.

This article describes a study which aims to quantify the burden of disease currently averted in people seeking care for major depression. Data included secondary analysis of the (Australian) National Mental Health Survey, studies of the natural history of major depression and meta-analyses of effectiveness studies. The authors conclude that longer-term drug and psychological treatment strategies are needed to impact the large disease burden associated with major depression in the Australian population.

Walker V. Community care fails mentally ill: abandoned to the streets [A special report]. *The Australian*. Monday 29 April 2002a: 1.

This newspaper article argues that 10 years after the Burdekin Inquiry and after two National Mental Health Plans, with a 30% increase in funding through the 1990s, we have still made very little real progress in mental healthcare reform.

Walker V. The forgotten ones: abandoned to the streets [A special report]. *The Australian*. Monday 29 April 2002b: 9.

This newspaper article outlines the problems of community care and makes the powerful comment that "*Mental health is in crisis and sending the sick on to the streets.*"

Whiteford HA, Behan S, Leitch E, et al. Help where help is needed: continuity of care for people with chronic mental illness. *Issues Paper (National Health Strategy [Australia]); no. 5*. Melbourne: National Health Strategy, 1993. Available at: [http://www7.health.gov.au/pubs/nhs/help\\_is/help\\_int.htm](http://www7.health.gov.au/pubs/nhs/help_is/help_int.htm) (Accessed January 2005).

This paper explores issues concerning persons with chronic mental illness and considers the effect of the shift towards community care and away from institutionalisation. As part of the deliberation on the lack of continuity of care, the fragmentation of provision of services by health and welfare or disability services is addressed. Within the issues paper, strategies for reform are discussed in the context of government, private and non-government organisations providing community care.

Whiteford H, Thompson I, Casey D. The Australian mental health system. *International Journal of Law and Psychiatry* 2000; 23: 403-417.



In this article Whiteford and colleagues provide an overview of the Australian mental health system, including current government provisions (eg. medical benefits), and the range of mental health services available (from government funded health and welfare programs, to public and private services). This document also includes a review of the National Mental Health Strategy, consumer and carer participation and mental health legislation.

World Health Organization. The World Health Report, 2001. Mental health: new understanding, new hope. Geneva: World Health Organization, 2001. Available at: [http://www.who.int/whr/2001/en/whr01\\_en.pdf](http://www.who.int/whr/2001/en/whr01_en.pdf) (Accessed January 2005).

The World Health Report 2001 provides a review of the burden, both current and future, resultant from mental disorders across the world. The costs of this burden are presented in both economic and social terms, with a view to counter stigma and discrimination. The report also considers service provision and treatments, and provides recommendations for care.

World Health Organization. The World Health Report, 2002. Reducing risks, promoting healthy life. Geneva: World Health Organization, 2002. Available at: [http://www.who.int/whr/2002/en/whr02\\_en.pdf](http://www.who.int/whr/2002/en/whr02_en.pdf) (Accessed January 2005).

This report describes the amount of disease, disability and death in the World today that can be attributed to a selected number of the most important risks to human health. It also shows how much this burden could be lowered in the next 20 years if the same risk factors were reduced.

World Health Organization. Neuroscience of psychoactive substance use and dependence. Geneva: World Health Organization, 2004. Available at: [http://www.who.int/substance\\_abuse/publications/en/Neuroscience.pdf](http://www.who.int/substance_abuse/publications/en/Neuroscience.pdf) (Accessed January 2005).

This is a report produced by the World Health Organization (WHO) within the framework of the WHO Mental Health Global Action Programme. The WHO felt it was timely to review current knowledge of substance use and dependence given 8.9% of the total burden of disease in 2002 was attributable to the use of psychoactive substances. This publication describes the neuroscience of substance use, an area that has undergone dramatic developments due to increased understanding of the biochemical actions of substances. Reasons behind psychoactive substance use, despite serious health consequences, as well as the progress from use to dependence, are also explored.

Zammit S, Allebeck P, Andreasson S, et al. Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study. *BMJ* 2002; 325: 1199-1203. Available at: <http://bmi.bmjournals.com/cgi/reprint/325/7374/1199> (Accessed January 2005).

Using self-report data on cannabis and other substance use in a sample of over 50,000 Swedish conscripts (aged 18 to 20), the authors examined whether previously reported associations between adolescent use of cannabis and risk of schizophrenia were confounded by use of other substances or personality traits. Diagnoses of schizophrenia and other psychoses were determined by hospital admissions. The link between cannabis use and risk of developing schizophrenia remained even when the results were adjusted for other substance use and personality traits.

**APPENDIX 1**

REVIEW OF MENTAL HEALTH SERVICES IN AUSTRALIA FOR 2003-2008

**APPENDIX 2**

REVIEW OF MENTAL HEALTH SERVICES IN AUSTRALIA FOR 2003-2008

PART II: CONSUMERS & CARERS DIRECT EXPERIENCES OF CARE



## REVIEW OF MENTAL HEALTH SERVICES IN AUSTRALIA FOR 2003-2008.



### Introduction: Community review of services

In April 2003, the Mental Health Council of Australia launched its national review of mental health services in Australia: "Out of Hospital, Out of Mind!". The report highlighted the obvious deficiencies in care but also presented community priorities for further action. A key proposal was increased accountability. To date, we have insufficient data from government agencies about what really happens in mental health at local, regional and state/ territory levels. Consequently, the Mental Health Council of Australia, with academic support from the Brain & Mind Research Institute, is undertaking a state-by-state review of services in 2003. Our goal is to produce a report in each state/ territory to underpin urgent reform in your local area.

The study is being conducted by Professor Ian Hickie, Professor of Psychiatry and Executive Director, Brain & Mind Research Institute, The University of Sydney; and, Dr Grace Groom, Chief Executive Officer, Mental Health Council of Australia.

If you agree to participate in this study, you will be asked to complete the following questionnaire. It is not expected that you will experience any discomfort from this process. It should take you no more than 15-20 minutes to complete.

All aspects of the study, including results, will be strictly confidential and only the investigators named above and research staff will have access to information on participants except as required by law. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Participation in this study is entirely voluntary: you are not obliged to participate and - if you do participate - you can withdraw at any time. Whatever your decision, it will not affect your relationship with the investigators, The University of Sydney, or the Mental Health Council of Australia.

If you would like to know more at any stage, please feel free to contact Professor Ian Hickie on 02 9556 9418. This information sheet is for you to keep.

**Any person with concerns or complaints about the conduct of a research study can contact the Manager for Ethics Administration, The University of Sydney on 02 9351 4811 or at [gbriody@mail.usyd.edu.au](mailto:gbriody@mail.usyd.edu.au).**

### Instructions for completing the survey

Our intention is to evaluate the extent to which national and community priorities have been supported and are being implemented at both the local and state level. We believe that this is a unique opportunity for genuine and broad mental health sector input to priorities for the next five years.

This survey is divided into three sections:

- The first asks some demographic information about you or your service.
- The second asks you to rate how the priorities have been supported or implemented within your **LOCAL** area.
- The third asks you to rate how the priorities have been supported or implemented at the **STATE** level.

Please return the completed survey in the **reply paid** envelope enclosed or **fax to 02 9556 9171**. For any further queries, our contact details are:

Brain & Mind Research Institute  
Top Floor, Broughton Hall  
PO Box 1  
ROZELLE NSW 2039  
PH: (02) 9556 9113  
Fax: (02) 9556 9171

**SECTION ONE: Your details.**

As part of the survey, we would like to ask you some details about yourself and the area of the mental health sector you represent.

Your name (or organisation) will not be reported in connection with your responses to the remainder of the survey, so your opinions and comments remain confidential.

**Are you completing this survey as an individual or on behalf of an organisation?**

Individual

Organisation

**Name of organisation (optional):** \_\_\_\_\_

Please tick ONE of the following descriptions which BEST describes your position or role in the mental health sector, or the position or role of your organisation:

- |   |  |
|---|--|
| <input type="checkbox"/> Consumer of mental health services       | <input type="checkbox"/> Non-government community service provider |
| <input type="checkbox"/> Carer of a person with a mental illness  | <input type="checkbox"/> Mental health promotion or education      |
| <input type="checkbox"/> Consumer or carer advocacy group         | <input type="checkbox"/> Mental health research or evaluation      |
| <input type="checkbox"/> Public provider of specialist treatment  | <input type="checkbox"/> Health policy maker or advisor            |
| <input type="checkbox"/> Private provider of specialist treatment | <input type="checkbox"/> Human services agency other than health   |
| <input type="checkbox"/> Provider of early intervention services  | <input type="checkbox"/> Other (please specify): _____             |
| <input type="checkbox"/> General practitioner                     | _____  |
| <input type="checkbox"/> Divisions of General Practice            | _____  |

What is your postcode/ the postcode of your organisation:

--	--	--	--

Today's date:

day		month		year					

**SECTION TWO: Local area.**

This section asks you to rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA. Please mark the appropriate box with a cross.

	No action taken OR no support	Discussion and planning OR low level support	Implementation begun OR moderate support	Nearly complete OR high level support	Fully implemented OR full support
1. Implementation of early intervention services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Development of innovative services for people with mental health and alcohol or substance abuse disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Development of a wider spectrum of acute and community-based care settings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Implementation of the national standards for mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Programs that promote attitudinal change among mental health workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(
6. Increased support for stigma reduction campaigns	(	(	(	(	(
7. Development of specific inter-governmental service agreements (eg. between health, education, housing, employment, and social security)	(	(	(	(	(

8.	More genuine consumer participation	(	(	(	(	(
9.	Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health	(	(	(	(	(
	Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA.	No action taken OR no support	Discussion and planning OR low level support	Implementation begun OR moderate support	Nearly complete OR high level support	Fully implemented OR full support
10.	Introduction of specific schemes to enhance access to mental health specialists	(	(	(	(	(
11.	More genuine carer participation	(	(	(	(	(
12.	Support for enhanced role of non-government organisations in all aspects of care	(	(	(	(	(
13.	Clear accountability for expenditure of mental health strategy funds	(	(	(	(	(
14.	Specification of clear primary care and specialist workforce roles	(	(	(	(	(

SECTION THREE: State level.

*This section asks you to rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE. Please mark the appropriate box with a cross:*

		No action taken OR no support	Discussion and planning OR low level support	Implementation begun OR moderate support	Nearly complete OR high level support	Fully implemented OR full support
1.	Development of specific inter-governmental service agreements (eg. between health, education, housing, employment, and social security)	(	(	(	(	(
2.	Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health	(	(	(	(	(
3.	Introduction of specific schemes to enhance access to mental health specialists	(	(	(	(	(
4.	Support for specific disease prevention initiatives (eg. in anxiety, depression, alcohol or substance abuse)	(	(	(	(	(
5.	Support for general mental health promotion	(	(	(	(	(

6.	Support for enhanced role of non-government organisations in all aspects of care	(	(	(	(	(
7.	Clear accountability for expenditure of mental health strategy funds	(	(	(	(	(
8.	Ongoing support for suicide prevention campaigns	(	(	(	(	(
9.	Development of datasets for monitoring the quality of local services	(	(	(	(	(
	Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.	No action taken OR no support	Discussion and planning OR low level support	Implementation begun OR moderate support	Nearly complete OR high level support	Fully implemented OR full support
10.	Service development for those in forensic (i.e. prison-based) services	(	(	(	(	(
11.	Specification of clear primary care and specialist workforces	(	(	(	(	(
12.	Service enhancement for persons from culturally- and linguistically-diverse backgrounds	(	(	(	(	(
13.	Support for community leadership in mental health	(	(	(	(	(
14.	Support for professional leadership in mental health	(	(	(	(	(
15.	Development of specific procedures for reporting Human Rights abuses or neglect	(	(	(	(	(
16.	Increased support for stigma reduction campaigns	(	(	(	(	(
	If you are in a regional or rural area of Australia, please answer the following question.					
17.	IN YOUR STATE, what is the level of support for service development in rural and regional areas?	(	(	(	(	(
	If you are in a poorly resourced area of Australia, please answer the following question.					
18.	IN YOUR STATE, what is the level of support for service development in poorly resourced areas?	(	(	(	(	(

**Other comments:**

Thank you for completing this survey.  
Please return it in the reply paid envelope.



## ▣ REVIEW OF MENTAL HEALTH SERVICES IN AUSTRALIA FOR 2003-2008: PART II: CONSUMERS & CARERS DIRECT EXPERIENCES OF CARE



### **Introduction: community review of services**

In April 2003, the Mental Health Council of Australia launched its national review of mental health services in Australia: "Out of Hospital, Out of Mind!". We continue to have insufficient data about what really happens in our mental health services. Consequently, the Mental Health Council of Australia, with academic support from the Brain & Mind Research Institute, is committed to ongoing review of these services. The study is being conducted by Professor Ian Hickie, Executive Director, Brain & Mind Research Institute, The University of Sydney; and, Dr Grace Groom, Chief Executive Officer, Mental Health Council of Australia.

If you agree to participate in this study, you will be asked to complete the following questionnaire. It is not expected that you will experience any discomfort from this process. It should take you no more than 15-20 minutes to complete.

All aspects of the study, including results, will be strictly confidential and only the investigators named above and research staff will have access to information on participants except as required by law. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Participation in this study is entirely voluntary: you are not obliged to participate and - if you do participate - you can withdraw at any time. Whatever your decision, it will not affect your relationship with the investigators, The University of Sydney, or the Mental Health Council of Australia.

If you would like to know more at any stage, please feel free to contact Professor Ian Hickie on 02 9556 9418. This information sheet is for you to keep. If you wish to add any details of your ongoing care, or any other detailed comments, please forward them directly to Professor Ian Hickie at: [ianh@med.usyd.edu.au](mailto:ianh@med.usyd.edu.au)

**Any person with concerns or complaints about the conduct of a research study can contact the Manager for Ethics Administration, The University of Sydney on 02 9351 4811 or at [gbriody@mail.usyd.edu.au](mailto:gbriody@mail.usyd.edu.au).**

### **Instructions for completing the survey**

Our intention in this second survey is to evaluate the direct experience of mental health care by consumers, carers and family members. This is the second survey. The first survey, which you can also complete (<http://www.mhca.com.au/Survey/default.html>), asks about your knowledge of service developments at your local and state level. These surveys provide a unique opportunity for genuine and broad community input to priorities for the next five years.

This survey is divided into two sections:

- The first asks consumers, carers and family members about their experiences with mental health services as well as some demographic information. It basic domains are drawn from those identified by the Picker Institute Europe as critical elements of quality health care.
- The second asks consumers only more specific questions about their experiences with mental health services. It is based on a current survey being undertaken also in the United Kingdom to evaluate consumer's direct experiences of care.

**Please return the completed survey in the reply paid envelope enclosed or fax to 02 9556 9171. For any further queries, our contact details are:**

Brain & Mind Research Institute  
Top Floor, Broughton Hall  
PO Box 1  
ROZELLE NSW 2039

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## SECTION 1: TO BE COMPLETED BY CONSUMERS, CARERS OR FAMILY MEMBERS

### BACKGROUND INFORMATION:

i. Have you, or someone else very close to you, received treatment for a mental health problem in the last 12 months?

- Yes
- No [STOP HERE]

ii. Who provided this treatment?

- Public health services (eg. emergency department, public hospital, community health centre)
- Private health services (eg. general practitioner, private psychiatrist, private hospital)
- Public and private health services

iii. Was the main provider a...

- A general practitioner
- A clinical psychologist/ counsellor**
- A specialist psychiatrist
- Hospital/ emergency service
- Community mental health service
- Other non-government organisation

iv. Have you, or someone else very close to you, been admitted to a hospital as a mental health inpatient in the last 12 months?

- No
- Yes, once**
- Yes, two or three times
- Yes, more than three times

A. IF YOU, OR SOMEONE ELSE VERY CLOSE TO YOU, DID RECEIVE TREATMENT FOR A MENTAL HEALTH PROBLEM IN THE LAST 12 MONTHS:

1. To what extent were you/ they treated with respect and dignity by health professionals?

- Always**
- Nearly always

- Sometimes
- Not often
- Never

2. How much information about your/ their condition or treatment was given to you?

- Too much
- Right amount
- Some
- Not enough
- None

3. To what extent were you able to access adequate services for your/ their mental health problems?

- Always**
- Nearly always
- Sometimes
- Not often
- Never

4. Did you find a health professional to talk to about your concerns?

- Yes, definitely
- Yes, to some extent
- Yes, a little
- No
- I had no concerns

5. If your family or someone else close to you wanted to talk to a health professional, did they have enough opportunity to do so?

- Yes, definitely
- Yes, to some extent
- No
- No family or friends were involved
- My family didn't want or need information
- I didn't want my family or friends to talk to a health professional

6. How much information about your condition or treatment was given to your family or someone else close to you?

- Not enough
- Right amount
- Too much
- No family or friends were involved
- My family didn't want or need information
- I didn't want my family or friends to have any information

7. If you/ they were prescribed any medication for a mental health problem, was its purpose, benefits and/or side-effects fully explained?

- Yes, definitely
- Yes, to some extent
- Yes, a little
- No
- I was not prescribed any medications

8. If you/ they were admitted as a hospital inpatient for treatment of a mental health problem, did staff attend to your/ their physical health needs (eg. assistance eating, or getting to a bathroom) in a timely manner?

- Yes, definitely
- Yes, to some extent
- Yes, a little
- No
- I did not require assistance with any physical health needs

**9. Sometimes, one health professional will say one thing and another health professional will say something quite different. Did this happen to you?**

- Always**
- Nearly always
- Sometimes
- Not often
- Never

## B. OVERALL

1. Did you have enough say in decisions about your/ their care and treatment?

- Yes, definitely
- Yes, to some extent
- No

2. Has your/ their diagnosis been discussed with you?

- Yes, definitely
- Yes, to some extent
- No

## C. ABOUT YOU

1. Gender?

- Male
- Female

2. Age?

3. Postcode?

4. What is the geographical nature of the area you live in?

- Rural/ district (less than 10,000 people)
- Regional centre (greater than 10,000 people)
- Major urban area (greater than 100,000 people)

5. In which country were you born?

- Australia
- Overseas (please specify) \_\_\_\_\_

6. Are you an Aboriginal or Torres Strait Islander?

- Yes**
- No

7. What language do you most commonly speak?

- English**
- Other (please specify)\_\_\_\_\_

**8. What language do you most commonly speak at home?**

- English**
- Other (please specify)\_\_\_\_\_

<http://www.nhssurveys.org>

**9. Who else, if anybody, do you live with?**

- No-one, I live alone**
- Partner
- Child/ children under 18
- Child/ children over 18
- A parent or guardian
- With other family members
- With people other than family members

**10. Are you a:**

- Consumer (i.e. receive care yourself)
- Carer
- Family member or close friend

**11. During the past four weeks how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable?)**

- Not at all
- Slightly
- Moderately
- Quite a lot
- Extremely

**12. In general, how is your mental health right now?**

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

**SECTION 2: TO BE COMPLETED BY CONSUMERS ONLY**

## D. YOUR CARE AND TREATMENT

1. How long have you been in contact with mental health services?

- One year or less
- One to five years
- More than five years
- Don't know/ Can't remember
- I have never been in contact with mental health services [STOP HERE]

**2. Overall, how would you rate the health care you have received for your mental health problem in the last 12 months?**

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

## E. HEALTH PROFESSIONALS

### Psychiatrists

1. Have you seen a psychiatrist in the last 12 months?

- Yes
- No GO TO Q7, SECTION E

### The LAST time you saw a psychiatrist...

2. Did the psychiatrist listen carefully to you?

- Yes, definitely
- Yes, to some extent
- No

3. Did you have trust and confidence in the psychiatrist you saw?

- Yes, definitely
- Yes, to some extent
- No

4. Did the psychiatrist treat you with respect and dignity?

- Yes, definitely
- Yes, to some extent
- No

**Still thinking about the LAST time you saw a psychiatrist...**

5. Were you given enough time to discuss your condition and treatment?

- Yes, definitely
- Yes, to some extent
- No

6. The last two times you had an appointment with a psychiatrist, was it...?

- With the **same** psychiatrist both times
- With two **different** psychiatrists

**Community psychiatric nurse (CPN)**

7. Have you seen a CPN in the last 12 months?

- Yes
- No            GO TO Q11, SECTION E

**The LAST time you saw a CPN...**

8. Did the CPN listen carefully to you?

- Yes, definitely
- Yes, to some extent
- No

9. Did you have trust and confidence in the CPN?

- Yes, definitely
- Yes, to some extent
- No

10. Did the CPN treat you with respect and dignity?

- Yes, definitely
- Yes, to some extent
- No

**Other health professionals**

11. Have you seen anyone else in mental health services in the last 12 months?

- Yes
- No            GO TO Q1, SECTION F

12. *The last time you saw someone, other than a psychiatrist or CPN, who did you see?*

- A social worker**
- An occupational therapist
- A psychologist
- Someone else

The LAST time you saw this person...

13. Did they listen carefully to you?

- Yes, definitely
- Yes, to some extent
- No

14. Did you have trust and confidence in the person that you saw?

- Yes, definitely
- Yes, to some extent
- No

15. Did the person treat you with respect and dignity?

- Yes, definitely
- Yes, to some extent
- No

## F. MEDICATIONS

1. In the last 12 months have you taken any medications for your mental health problems?

- Yes
- No            GO TO Q1, SECTION G

2. Do you have a say in decisions about the medication you take?

- Yes, definitely
- Yes, to some extent
- No

3. In the last 12 months, have any **new** medications (eg. tablets, injections, liquid medicines) been prescribed for you by a psychiatrist?

- Yes
- No
- Can't remember



**The LAST time you had a new medication prescribed for you...**

- 4. Were the purposes of the medications explained to you?
  - Yes, definitely**
  - Yes, to some extent
  - No
  
- 5. Were you told about possible side-effects of the medications?
  - Yes, definitely
  - Yes, to some extent**
  - No

**G. TALKING THERAPIES**

- 1. In the last 12 months have you had any talking therapy (eg. counselling) from mental health services?
  - Yes
  - No
  
- 2. In the last 12 months, did you want talking therapy?
  - Yes**
  - No**

**H. YOUR CARE PLAN (CPA)**

*A care plan shows your mental health needs and who will provide services to you. It might be a document given to you by one of the mental health team, or it might be a letter, explaining how your care has been planned.*

- 1. Have you been given (or offered) a written or printed copy of your care plan?*

  - Yes
  - No            GO TO Q4, SECTION H
  - Don't know/ Not sure

- 2. Do you understand what is in your care plan?*

  - Yes, definitely
  - Yes, to some extent
  - No
  - Don't know
  - I do not have a care plan

- 3. Do you agree with what is in your care plan?*

  - Yes, definitely
  - Yes, to some extent

- No
- Don't know

### **Your care review**

A care review is a meeting with you and the people involved in your care in which you discuss how your care plan is working.

4. In the last 12 months have you had a care review?

- Yes, I have had more than one**
- Yes, I have had one
- No, I have not had a care review in the last 12 months                      GO TO Q8, SECTION H

5. Were you told that you could bring a friend or relative to your care review meetings?

- Yes
- No
- Don't know/ Can't remember

### **The LAST time you had a care review meeting...**

6. Were you given a chance to express your views at the meeting?

- Yes, definitely
- Yes, to some extent
- No**

7. Did you find the care review helpful?

- Yes, definitely
- Yes, to some extent
- No**

### **Your care co-ordinator**

A care co-ordinator (or keyworker) is someone from mental health services who keeps in regular contact with you. For example, this person could be a community psychiatric nurse (CPN) or a social worker.

8. Have you been told who your care co-ordinator is?

- Yes
- No                      GO TO Q1, SECTION I
- Not sure/ Don't know

9. How long is it since you last saw your care co-ordinator?

- **Less than one month**
- One to three months
- Three to six months
- More than six months

10. Can you contact your care co-ordinator if you have a problem?

- Yes, always
- Yes, sometimes
- No

## I. SUPPORT IN THE COMMUNITY

### Day centres or day hospitals

*Some mental health service users go to a day centre where staff are available to help with problems, and activities are arranged.*

1. In the last two months, how often have you visited a day centre?

- Most days
- Once or twice a week
- Once or twice a month
- I have not visited a day centre in the last two months      GO TO Q3, SECTION I

2. Were the activities provided by the centre helpful?

- Yes, definitely
- Yes, to some extent
- No

### Where you live

3. In the last 12 months, have you received any help with accommodation?

- Yes
- No, but I would have liked help
- I did not need any help

### Other support in the community

*4. In the last 12 months have you received help with finding work?*

- Yes
- No, but I would have liked help
- I did not need any help
- I am unable to work because of my mental health problems

**5. Are you currently in paid work?**

- Yes
- No
- No, but I work on a casual or voluntary basis
- No, but I am a full-time student

**6. In the last 12 months have you received help with getting benefits?**

- Yes
- No, but I would have liked help
- I did not need any help

7. In the last 12 months have you received any information about local support groups for mental health service users?

- Yes**
- No, but I would have liked information
- I did not need any information

8. When was the last time you saw someone about your mental health problem?

- Less than one month ago**
- One to three months ago**
- Three to six months ago
- More than six months ago

**9. In the last 12 months, have any appointments been cancelled or changed by mental health services?**

- No
- Yes, one appointment was cancelled or changed
- Yes, two or three appointments have been cancelled or changed
- Yes, four or more appointments have been cancelled or changed

**J. CRISIS CARE**

1. Do you have the number of someone in mental health services that you can call out of office hours?

- Yes
- No           GO TO Q1, SECTION K
- Not sure/ Don't know

**2. In the last 12 months, have you called this number?**

- Yes
- No

3. The last time you called the number, how long did it take you to get through to someone?

- I got through immediately
- I got through in one hour or less
- A few hours
- A day or more
- A could not get through to anyone

**K. STANDARDS**

**Mental Health Act**

**1. In the last 12 months, have you been detained (sectioned or scheduled) under the Mental Health Act?**

- Yes
- No           GO TO SECTION L

2. When you were detained, were your rights explained to you?

- Yes
- No

**L. OTHER COMMENTS**

If there is anything else you would like to tell us about your experiences of mental health care in the last 12 months, please do so here.

*Is there anything particularly good about your care?*

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*Is there anything that could be improved?*

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