



Setting the context

The magnitude of the problem

Mental illness is widespread in Australia, as it is in other developed countries, and has substantial impact at the personal, social and economic levels. Results from the *2007 National Survey of Mental Health and Wellbeing*, conducted by the Australian Bureau of Statistics (ABS), indicate that one in five people aged 16 to 85 years experience one of the common forms of mental illness (anxiety, affective or mood disorders, and substance use disorders) in any one year. Prevalence rates vary across the lifespan and are highest in the early adult years, the period during which people are usually establishing families and independent working lives (Figure 2). Earlier surveys of children and adolescents aged 4–17, conducted in 1998, found 14% to have a mental illness.

Anxiety related and affective disorders are the most common, affecting approximately 14% and 6%, respectively, of adults each year, with about a quarter having more than one disorder. Collectively referred to as 'high prevalence' illnesses, these disorders include diverse conditions (e.g. post traumatic stress disorder, obsessive compulsive disorder, depression, bipolar disorder) that have different treatment requirements and outcomes.

Mental illness includes 'low prevalence' conditions such as schizophrenia and other psychoses that affect another 1 to 2% of the adult population that were not included in the ABS 2007 survey of adults. Although relatively uncommon, people affected by these illnesses often need many services, over a long period, and account for about 80% of Australia's spending on mental health care.

Mental illness impacts on people's lives at different levels of severity. Depending on definitions, an estimated 3% of Australian adults have severe disorders, judged according to the type of illness (diagnosis), intensity of symptoms, duration of illness (chronicity),

Figure 2: Prevalence of selected mental illnesses by age group

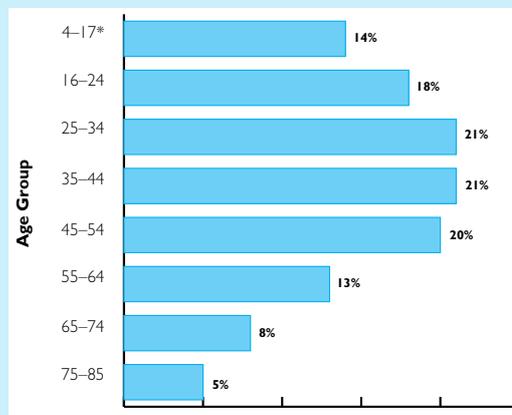
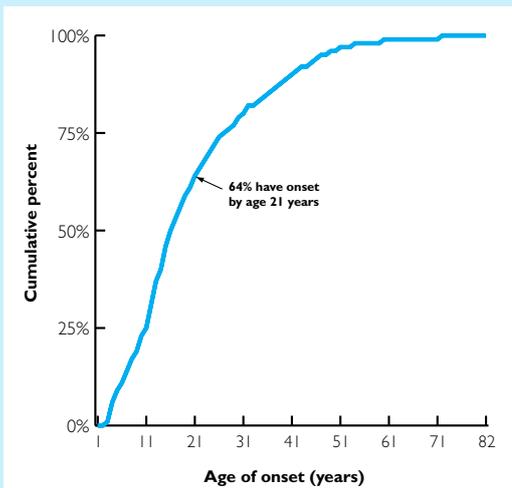


Figure 3: Age of onset for the most common mental illnesses (anxiety and affective disorders)



Notes:

Figure 2: Ages 16–85 based on supplementary analysis of data collected in the Australian Bureau of Statistics (ABS) *2007 National Survey of Mental Health and Wellbeing*. Prevalence estimates exclude counts of persons with drug and alcohol disorders for whom there is no other co-existing mental illness (3% of adults). Prevalence data for ages 4–17 are based on the 1998 child & adolescent component of the first National Survey of Mental Health and Wellbeing.

Figure 3: Based on supplementary analysis of data collected in the ABS *2007 National Survey of Mental Health and Wellbeing*.

Sources:

Australian Bureau of Statistics (2008). *National Survey of Mental Health and Wellbeing 2007: Summary of results*. ABS Cat. No 4326.0. Australian Bureau of Statistics: Canberra.

*Sawyer, MB et al. (2000). *The mental health of young people in Australia*. Commonwealth Department of Health and Aged Care: Canberra.

and the degree of disability caused. This group represents approximately half a million Australians. About 50% have a psychotic illness, primarily schizophrenia or bipolar affective disorder. The remainder mainly comprise individuals with severe depression or severe anxiety disorders.

For most people, the mental illness they experience in adult life has its onset in childhood or adolescence. For example, of those who will experience an anxiety or affective disorder, two thirds will have had their first episode by the time they are 21 years of age (Figure 3).

Because many illnesses affect the individual's functioning in social, family, educational and vocational roles, the early age of onset can have long term implications. Mental illnesses are the largest single cause of disability in Australia, accounting for 24% of the burden of non-fatal disease (measured by total years of life lived with disability, Figure 4). This has a major impact on youth and people in their prime adult working years.

People who live with a mental illness are also more at risk of experiencing a range of adverse social, economic and health outcomes. Analysis by the Productivity Commission found that of six major health conditions (cancer, cardiovascular, major injury, mental illness, diabetes, arthritis), mental illness is associated with the lowest likelihood of being in the labour force. For those affected by severe illnesses, particularly those with psychotic disorders, average life expectancy is shorter and is second only to Indigenous Australians, due mainly to high levels of untreated comorbid physical illness.

People with mental illness are also over represented in the homeless and prison populations. Australian data suggests that up to

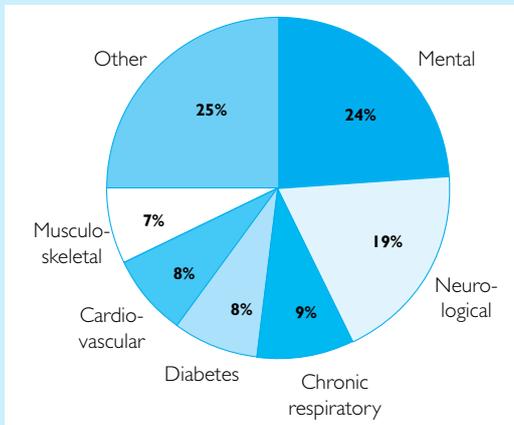
75% of homeless adults have a mental illness and, of these, about a third (approximately 29,000 people) are affected by severe disorders. Additionally, Australian studies have found that around 40% of prisoners have a mental illness and that 10–20% are affected by severe disorders.

The economic costs of mental illness in the community are high. Outlays by governments and health insurers to provide mental health services in 2006–07 totalled \$4.7 billion, representing 7.3% of all government health spending. Mental health as a share of overall government spending on health has remained stable over the 15 year course of the *National Mental Health Strategy*.

These figures reflect only the cost of operating the specialist mental health service system and do not indicate the full economic burden of mental illness and costs to government. Because of the disability often associated with mental illness, many people depend on governments for assistance that extends beyond specialist mental health treatment. They require an array of community services including housing, community and domiciliary care, income support, and employment and training opportunities. The *National Mental Health Report 2007* most recently analysed these costs and estimated that outlays by government on mainstream support for people with mental illness substantially exceed the costs of specialist mental health care (Figure 5).

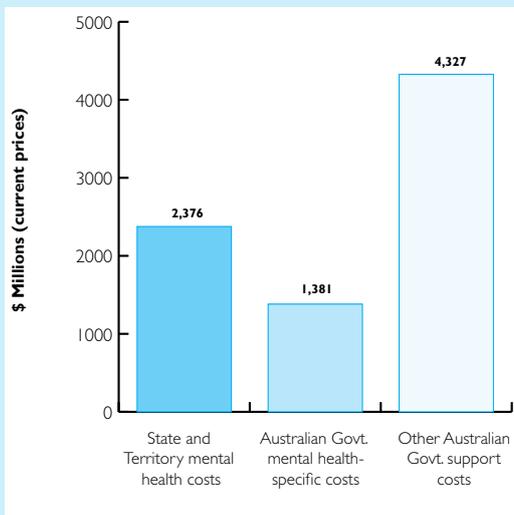
In addition to outlays by government, mental illness impacts on the broader economy by reducing workforce participation and impairing the productivity of those who are in employment. Estimates of the annual costs of the productivity losses attributable to mental illness range from \$10 to \$15 billion.

Figure 4: Burden of mental illnesses relative to other disorders, in terms of years lost as a result of disability



Source: Begg S et al. (2007). The burden of disease and injury in Australia 2003. PHE 82. Australian Institute of Health and Welfare: Canberra.

Figure 5: Comparing the direct and 'indirect' cost to governments of mental illness, 2004–05



Source: Department of Health and Ageing (2007). *National Mental Health Report 2007*. Commonwealth of Australia: Canberra.

The National Mental Health Strategy

The *National Mental Health Strategy* has guided mental health reform in Australia since 1992, the year in which Australian health ministers agreed to the original National Mental Health Policy and the first five-year National Mental Health Plan. Two further National Mental Health Plans followed in 1997 and 2003, and complementary action was guided by the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011. The original National Mental Health Policy was recently revised (see below for more detail). The Fourth Plan is set in the context of the updated Policy, and builds on the work of previous plans. Like its predecessors, it is underpinned by the *Mental Health Statement of Rights and Responsibilities*.

The *National Mental Health Strategy* has steered a changing reform agenda over time, and understanding this agenda helps to set the context for the Fourth Plan. The *First National Mental Health Plan* (1993–98) represented the first attempt to coordinate mental health care reform in Australia, through national activities. It focused on state/territory based, public sector, specialist clinical mental health services and advocated for major structural reform, with particular emphasis on the growth of community based services, decreased reliance on stand alone psychiatric hospitals, and 'mainstreaming' of acute beds into general hospitals.

The *Second National Mental Health Plan* (1998–2003) consolidated ongoing reform activities and expanded into additional areas of focus. It built on the First Plan by adding a focus on the promotion of mental health and the destigmatisation of mental illness, with the Commonwealth Government and selected state and territory governments providing funding for major initiatives like *beyondblue*. It attended to the question of how

the public mental health sector could best dovetail with other government and non-government areas (e.g., private psychiatrists, general practitioners, general health services, and community support services) to maximise treatment outcomes and opportunities for recovery. Whereas the First Plan focused largely on severe and disabling low prevalence illnesses that are principally the responsibility of the states and territories, the Second Plan expanded the emphasis to include the more common illnesses such as depression and anxiety disorders that are treated in primary health care settings.

The *Third National Mental Health Plan 2003–2008* set out to consolidate the achievements of the First and Second Plans, by taking an explicit population health approach and reaffirming an emphasis on the full spectrum of services that are required to assure the mental health of Australians. It focused on mental health promotion and mental illness prevention, improving service responsiveness, strengthening service quality, and fostering innovation.

Both the Second and Third Plans recognised the importance of cross sectoral partnerships in supporting mental health and wellbeing, and in responding to mental illness through an integrated and inclusive service system. The *COAG National Action Plan on Mental Health 2006–2011* was developed between governments to provide further impetus to mental health reform and sharpen the focus on areas that were perceived by stakeholders to have not progressed sufficiently under the various National Mental Health Plans. The *COAG National Action Plan* emphasised the importance of governments working together, and the need for more integrated and coordinated care. It also committed governments to a significant injection of new funds into mental health, including the expansion of the Medicare Benefits Schedule to improve access to mental health care delivered by psychologists and other allied

health professionals, general practitioners and psychiatrists. The *COAG National Action Plan* led to increased investment by states and territories in community based mental health services, enabling them to better respond to consumers with severe and persistent mental illnesses, and their carers and families. It also increased investment in services delivered outside the health sector that are needed by people who live with mental illness, including employment, education and community services.

Alongside these national activities, states and territories have developed their own specific mental health plans or strategies which help set the context for the Fourth Plan. Consistent with the *COAG National Action Plan*, state and territory plans and strategies have reflected the shift towards a whole of government, cross sectoral approach to mental health. At a state/territory level, stronger partnerships have been forged between mental health and other areas within health such as emergency departments, and with programs operating outside the health system, such as community services and correctional services. Models of accommodation and support have been developed in each jurisdiction, as have specific mental health social and emotional wellbeing frameworks to work with people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander communities.

Progress of mental health system reform in Australia

The last decade and a half of mental health system reform under the *National Mental Health Strategy* has led to significant change. Public sector specialist mental health services are now staffed by a significantly larger mental health workforce. Nationally, the number of state and territory employed professionals who work directly with consumers in specialist

Figure 6: Growth in the state and territory clinical workforce 1993 to 2007

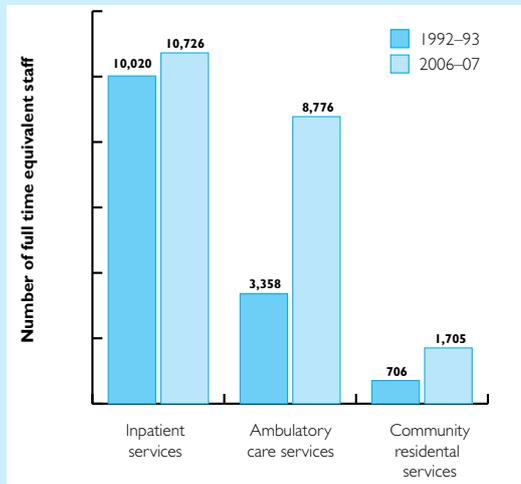
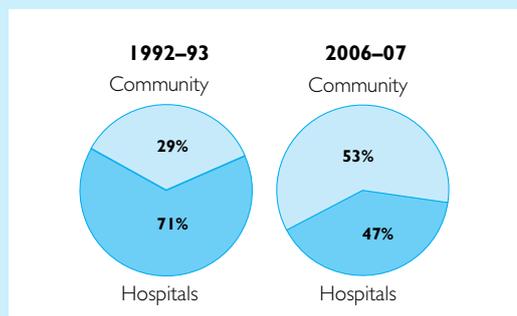


Figure 7: Community based services as percentage of total state and territory spending on mental health services, 1992-93 and 2006-07



Sources:
Figure 6 and Figure 7: Australian Government Department of Health and Ageing.

mental health settings grew by 51% between 1993 and 2007 (Figure 6). This workforce is complemented by employed consumer consultants and peer workers who did not previously exist as a professional group but are now growing in number.

Care is now delivered primarily in community settings, compared with the previous heavy reliance on inpatient services that characterised Australia’s mental health system. At the commencement of the Strategy, 29% of state and territory mental health spending was dedicated to caring for people in the community; by 2007, the community share of total mental health expenditure had increased to 53% (Figure 7). There has also been an increased emphasis on the safety, quality and outcomes of care, as evidenced by activities like the routine measurement of clinician rated and consumer rated outcomes in all services.

Access to mental health care in primary care settings has been substantially increased as a result of changes to the Medicare Benefits Schedule at the end of 2006, with more than 1.3 million mental health treatment plans developed by general practitioners, and 4.95 million services provided by psychologists and other allied health professionals through Medicare subsidised services.

The *2007 National Survey of Mental Health and Wellbeing* provided evidence of the impact of these changes, with the finding that the percentage of those with a mental illness who saw a mental health professional in 2007 was almost double those who did so in 1997 (Figure 8).

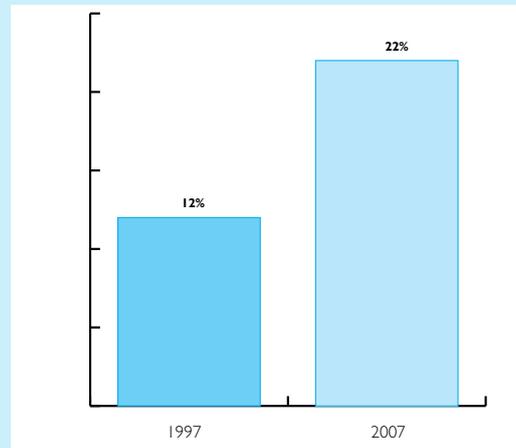
Community mental health literacy has also improved during the life of the *National Mental Health Strategy*, indicating that the substantial investment in mental health promotion initiatives—particularly those driven by *beyondblue*—are bearing fruit. Research undertaken by the University of Melbourne has demonstrated an increase in awareness of depression and the issues associated with

it (e.g. discrimination) between 1995 and 2004, which was most pronounced in states and territories that contributed funding to *beyondblue*.

The broader, cross sectoral activities are gaining traction too. Across most states and territories, work in the housing sector has begun to recognise the needs of those with mental illness when planning social housing initiatives. Similarly, developments in the justice sector have seen diversionary programs developed for people with mental illness or substance dependency. In other areas, state and territory cross portfolio COAG Mental Health Groups are beginning to take forward whole of government initiatives and foster stronger partnerships.

These achievements have led to Australia being regarded as a world leader in mental health system reform, but the Fourth Plan acknowledges that there is still much to be done. While the directions of each of the previous plans have been broadly supported, the pace of reform has varied, often considerably, across jurisdictions. The prevalence and impact of mental health problems remain significant issues, and, according to the *2007 National Survey of Mental Health and Wellbeing*, only one-third of those with a mental illness receive mental health services each year. Major disparities continue between different states and territories in the mix and level of services. Demand for mental health care—particularly for acute and emergency care—continues to outstrip supply. Challenges in recruiting, retaining and supporting a workforce with appropriate competencies also continue to compromise the quantity and quality of care available. Consumers and carers still report that they experience difficulties in accessing the right care at the right time, and that they experience discrimination from within the mental health system, from other sectors with which they come into regular contact, and from the general community.

Figure 8: Percentage of people with a current mental illness who consulted a mental health professional, 1997 and 2007



Sources:

Figure 8: Based on supplementary analysis of data collected in the Australian Bureau of Statistics 1997 and 2007 National Surveys of Mental Health and Wellbeing.

The Fourth Plan extends the reform efforts of the *National Mental Health Strategy* to improve the mental health of all Australians. Its whole of government emphasis distinguishes it from the three previous National Mental Health Plans, and it gives particular consideration to a collaborative approach that will foster complementary programs that deliver responsive services.

The new National Mental Health Policy

As noted, the original National Mental Health Policy marked the beginning of the *National Mental Health Strategy* in 1992. A revised *National Mental Health Policy 2008* was endorsed by the Australian Health Ministers' Conference (AHMC) in December 2008 and released in March 2009. The Policy was updated to align with the whole of government approach articulated within the *COAG National Action Plan* and with developing policy and practice in other areas.

The Policy provides an overarching vision for a mental health system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community. This vision should be seen in the context of the social inclusion agenda which focuses on engagement of the whole community, especially in areas of social and economic disadvantage. The Policy does not set out to provide explicit guidance for service delivery, nor does it set funding expectations, targets or deliverables.

The aims of the *National Mental Health Policy 2008* are to:

- promote the mental health and wellbeing of the Australian community and, where possible, prevent the development of mental health problems and mental illness;
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community;
- promote recovery from mental health problems and mental illness; and
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The Fourth Plan furthers the aims of the Policy through actions which will:

- maintain and build on existing effort;
- integrate recovery approaches within the mental health sector;
- address service system weaknesses and gaps identified through consultation processes; and
- better measure how we do this and the outcomes achieved.

Consistent with the *National Mental Health Policy 2008*, the Fourth Plan acknowledges our indigenous heritage and the unique contribution of Indigenous people's culture and heritage to our society.

Furthermore, it recognises Indigenous people's distinctive rights to status and culture, self determination and the land. It acknowledges that this recognition and identity is fundamental to the wellbeing of Indigenous Australians. It recognises that mutual respect and responsibility are required to close the gap on indigenous disadvantage and to improve mental health and wellbeing.