

The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design



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1. Key findings

Total direct expenditure on supporting people with a mental illness in Australia far exceeds that previously estimated

- Australia spends at least \$28.6 billion per year, excluding capital expenditure, supporting people with mental illness.
- Direct health expenditure is at least \$13.8 billion.
- Direct non-health expenditure is at least \$14.8 billion
- The total expenditure of \$28.6 billion is equivalent to 2.2% of Australia's Gross Domestic Product. This excludes indirect costs, such as lost productivity.

Governments have given substantially more policy attention and funding to mental health since the early 1990s

- Australian governments have made significant policy and funding commitments to improve mental health.
- The majority of expenditure on mental health is funded by governments, with the balance funded by insurers, consumers, employers, non-government organisations and other private payers.
- There has been a range of reforms in mental health. The system is also affected by broader health reforms.

The critical issue in mental health is system design

- The nature of mental illness increases the likelihood that consumers will interact frequently with multiple parts of the healthcare and broader social services (including employment services) and support payments systems. Yet the mental health, social services and support payments systems are characterised by fragmentation and insufficient coordination.
- Mental health services, and broader non-health services and supports, are comprised of a complex network of care settings and service providers, with mixed and overlapping responsibility for service delivery, funding and expenditure.
- Poor system design compounds Australia's mental health challenges:
 - new initiatives can add complexity to an already fragmented system and fail to address the critical issue of system design
 - it is impossible to tell if Australia is spending the right amount of money to support people with mental illness and if money is being spent in the right areas (especially the appropriate mix of health and non-health support)
 - mental health outcomes are likely to be sub-optimal, leading to additional health and non-health costs, especially as mental health is the fastest growing cause of disability in Australia

Mental health outcomes in Australia are sub-optimal

- Despite the significant expenditure and focus:
 - the prevalence of mental illness is both high and stable.
 - significant numbers of mentally ill people do not seek or receive appropriate treatment.
 - for those that do seek and receive treatment their needs are not consistently met and they are less satisfied with mental health services than are consumers of other health services.

Selected reform models in Australia and internationally suggest key elements of a successful overall service system

- Successful whole-of-system reform is rare. Whole-of-system approaches require key enablers including integrated funding, IT and care pathways. Some of the changes are achievable in Australia; others may not be.
- For people with severe and very severe mental illness, there is evidence to support comprehensive service coordination.
- Evidence from the United States, applicable to Australia, indicates people with moderate mental illness can be successfully treated in primary care settings.
- There are promising models to improve treatment and treatment rates of people with mild mental illness, with applicability for Australia.

Australia has an unprecedented opportunity to lead the world in end-to-end mental health system redesign to deliver better outcomes at the same or lower cost

- Major system-level changes are needed, to improve outcomes covering detection to diagnosis to treatment to ongoing recovery. The system needs to integrate health and non-health support and funding.
- With mental health service provision a continuing challenge, there is an opportunity for Australia to lead the world.
- Subsequent work will focus on identifying and testing system-wide to improve outcomes and value for money.

2. Overview of report

Mental illness is a significant and growing challenge for Australia.

Research consistently confirms the high prevalence of mental illness in our community and its impact on the lives of people with mental illness, their families and carers.

Since the early 1990s, governments have recognised the issue and devoted increasingly focused policy efforts to address it. Major funding injections have accompanied this policy attention, to the point where it is generally recognised that governments and other funders are spending significant sums on supporting mental health in Australia, through both health and non-health expenditure.

However, until now there has been no comprehensive picture of just how much is really being spent.

This report develops that comprehensive picture. It calculates total direct expenditure, both health and non-health, on supporting people with mental illness in Australia and examines the limited available knowledge of system-wide outcomes that this funding supports. It notes that, despite the significant policy attention and substantial additional

funding to mental health over the past two decades, the mental health and social services systems remain fragmented.

Funding, spending and service delivery comprise a complex network with overlapping responsibilities. Recent initiatives, which are not designed from whole-of-system perspective and often lack substantive evidence, can add greater complexity. The report then investigates reform models, both in Australia and internationally, which may help address those systemic issues and therefore achieve better outcomes for those with mental illness, their families and carers, for the same or lower expenditure. It identifies key elements of a reformed mental health service system.

The data analysis in this report was finalised on May 2012.

2.1 Governments have given substantially more policy attention and funding to mental health since the early 1990s

Australia spends at least \$28.6 billion per year supporting people with mental illness. The majority of expenditure is funded by governments, with the balance funded by insurers, consumers, employers, non-government organisations and other private payers. The key components of this expenditure are detailed below.

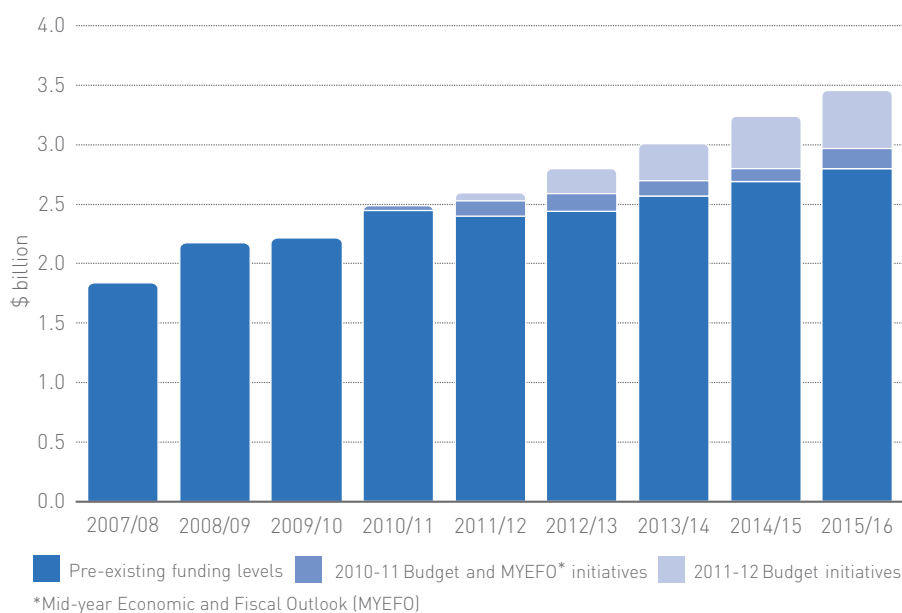
Since the early 1990s, governments have committed to a range of progressively wider mental health policy and planning initiatives, including:

- National Mental Health Strategy (1992), including the first five year National Mental Health Plan (and three further Plans in 1997, 2003 and 2009)
- Council of Australian Governments (COAG) National Action Plan (2006)
- National Partnership Agreement (2012)

- Development of COAG's 10 year Roadmap for National Mental Health Reform (2012)
- Establishment of the National Mental Health Commission (2012) and a number of state-level commissions.

The major policy and planning announcements have in many cases been accompanied by significant increases to mental health expenditure. Figure 1 indicates the increase in Australian Government expenditure over the period from 2007/08 to 2011/12. It includes \$2.2 billion in funding for mental health for the five years from 2011-12 that is additional to the funding committed under the National Partnership Agreement.

Figure 1: Federal funding has increased significantly in recent years



Source: Commonwealth Government Budget 2011-12. Available at http://www.budget.gov.au/2011-12/content/glossy/health/html/health_overview_04.htm

A range of reforms have occurred in mental health, but the system is also affected by broader health reforms

Over the two decades that mental health has been the subject of national approaches described above, a number of reforms have been undertaken. These include the following changes:¹

- Significant growth has occurred in the number of mental health professionals working directly with consumers.
- Given the limitations on psychiatric beds in the hospital system, care is now delivered primarily in community settings.
- Access to mental health care in primary care settings has been substantially increased, following changes to the Medicare Benefits Schedule in 2006.
- Community mental health literacy has improved.
- Integrated approaches and stronger partnerships have begun to emerge.

These themes are likely to continue to underpin future reforms.

A number of non-government organisations also play a key role in mental health reforms

In recent years a number of mental health-specific organisations have been established at both the national and local level across Australia. These include government, academic and community organisations. Some of the key organisations are *beyondblue*, the Mental Health Council of Australia, Black Dog Institute and other University Centres.

1. Department of Health and Ageing (2009), Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014, Commonwealth of Australia, Canberra.

2.2 The critical issue in mental health is system design

Mental health services encompass a complex network of care settings and service providers

Australia's mental health system lacks a clear end-to-end system design. The nature of mental illness increases the likelihood that consumers will interact frequently with multiple parts of the healthcare system. Yet the system is characterised by fragmentation and insufficient coordination. This is compounded by similar problems with social services (including employment services) and the support payment system.

The number of service providers illustrates the complexity of the system. In 2008-09, there were 156 public hospitals providing mental health care, 150 residential facilities, 990 community services, and 50 private psychiatric hospitals.² There are hundreds of mental health NGOs (with estimates ranging from 400 (in 2008)³ to 798 (in 2011)⁴) and there are currently 36 private health insurers. This is in addition to the numerous other service providers who deliver mental health services.

There are mixed and overlapping responsibilities for mental health funding and expenditure

A number of bodies – the Australian Government, state/territory governments, private health insurers, the corporate sector and consumers – are responsible for both health expenditure (i.e. spending the money) and health funding (i.e. providing the funds that are used to pay for health expenditure).⁵ NGOs, funded by governments, donations and other sources, also contribute to health expenditure.⁶

Of the \$28.6 billion in total direct expenditure in 2010-11, the funding sources for \$22.6 billion are able to be determined: approximately 90% is funded by government with the balance funded by insurers, consumers (out-of-pocket), employers, NGOs and other private payers. The funding split is unable to be determined for the remaining \$6 billion which comprises drug and alcohol services, and health and non-health payments by insurers – both government and private sector.

Fragmentation of funders and services is exacerbated by the lack of coordination within the healthcare system and between the healthcare and social services systems

The fragmentation that arises from diverse funding and expenditure arrangements is exacerbated by the lack of coordination within the healthcare system. Individuals with more severe mental illness face a further level of fragmentation. In addition to healthcare services, they may also receive a range of government transfer payments and services, as well as insurance and income protection payments.

2. AIHW (2011), *Mental health services – in brief 2011*, AIHW Cat. No. HSE 113, Canberra, p. 25.

3. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 5.

4. National Health Workforce Planning and Research Collaboration (2011), *Mental Health Non-Government Organisation Workforce Project: final report*. Available at: <http://www.ahwo.gov.au/documents/Publications/2011/Mental%20Health%20NGO%20Workforce%20Project%20Final%20Report.pdf>.

5. These definitions follow AIHW (2011), *Health expenditure Australia 2009-10*, AIHW Cat. No. HWE 55, Canberra, Box 1.1, p. 1.

6. NGO services that are funded by government are a component of the estimates of government expenditure in this report.

The absence of coordinated, collaborative and consistently reliable recovery-based services for people with a mental illness has meant that the mental health system has become heavily reliant on the goodwill and ongoing care provided by carers to fund and resource recovery-based care. This was highlighted in a 2010 survey of mental health carers conducted by the Mental Health Council of Australia (MHCA) which found that the majority of mental health carers are responsible for organising the bulk of care for the person they care for. Medical workers, social workers or case managers organised approximately 10% of care, with community workers arranging a slightly higher amount.⁷

Fragmentation of the mental health service system also leads to frustration, confusion and distress for service users – people with mental illness and also family and carers. As the 2011 Australian Government Budget Paper on national mental health reform stated, people with severe mental illness have to “deal with fragmented and uncoordinated systems”.⁸ It continued: “despite previous attempts at reform and investment by governments, too many people with severe and debilitating mental illness are still not getting the support they need, don’t know where to find it, and are falling through the cracks in the system. The families and people who care for them struggle with a system which often causes them frustration and even despair”.⁹

Poor system design compounds Australia’s mental health challenges

There is a strong case that the poor mental health system design exacerbates Australia’s mental health challenges. Three key challenges are:

- 1. New initiatives can add complexity to an already fragmented system and fail to address the critical issue of system design** – As noted above, the Australian and state/territory governments have introduced a number of initiatives in recent years to improve health and non-health services for people with mental illness. Yet, in a fragmented service system, without clear pathways for people with mental illness, new initiatives can add greater complexity. The introduction of new initiatives also diverts attention from what remains the key challenge – designing a mental health service system that improves the health of people with a mental illness in a cost-effective way.
- 2. It is impossible to tell if Australia is spending the right amount of money to support people with mental illness and if money is being spent in the right areas** – Expenditure to support people with mental illness is substantial, and far exceeds the amounts previously estimated (see Section 2.3 below). Without a clear system design, it is not possible to assess if total expenditure is appropriate to meet Australia’s

mental health challenges. It is also not possible to assess if:

- Health expenditure is appropriately focussed across different degrees of severity of mental illness and between prevention, early intervention, management and treatment
- Non-health expenditure is appropriately balanced between income and other supports and social services (such as housing or employment)
- The balance is appropriate between health expenditure and non-health expenditure.

- 3. Mental health outcomes are likely to be sub-optimal, leading to additional health and non-health costs** – Fragmentation and insufficient coordination contribute to Australia’s sub-optimal mental health outcomes (see Section 2.4 below). With mental health the fastest growing cause of disability in Australia, it is evident that poor outcomes, in turn, lead to additional health expenditure and also non-health expenditure, such as income support and other non-health services.

7. Mental Health Council of Australia (2010), *Mental Health Carers Report*, p. 20.

8. Australian Government (2011), *Budget: National mental health reform*, Canberra, p. 5.

9. Australian Government (2011), *Budget: National mental health reform*, Canberra, p. 12.

2.3 Total direct expenditure on supporting people with a mental illness in Australia far exceeds that previously estimated

In 2010-11, Australia's total direct expenditure to support people with mental illness was at least \$28.6 billion, equivalent to 2.2% of Australia's GDP. Total expenditure includes direct health expenditure of at least \$13.8 billion and direct non-health expenditure of at least \$14.8 billion (see Section 4 for more detail). Of the \$28.6 billion, the funding sources for around 80% are able to be determined while the remainder cannot be determined.

The cost of supporting people with mental illness can be divided into direct and indirect costs; this report deals with direct costs only. **Direct cost is defined as the expenditure incurred to provide health and non-health support to people with mental illness, and expenditure on the promotion of, and research into, mental health,** (This report excludes capital expenditure.) Indirect cost is defined as the broader individual, social and economic costs of mental illness. These costs include indirect and non-financial costs such as lost productivity and the debilitating impact on the lives of those with a mental illness, their families and carers.

It is difficult to estimate the true cost of mental illness

Although the significance of mental illness is now increasingly understood, it is extremely difficult to develop a comprehensive and accurate picture of the costs involved. No comprehensive estimate presently exists, though a number of partial estimates have been developed. The range of costs to be considered is diverse, and the fragmentation of the mental health system (in funding, expenditure and service delivery) makes data gathering problematic. In addition, there are a number of specific challenges affecting estimates of costs:

- **Direct health expenditure:** data is often unavailable; available data is not fully disaggregated; and Medicare only partially maps services to mental illness.
- **Direct non-health expenditure:** for many government transfer payments and social services, mental illness is one reason, typically of many, why people may receive assistance. Available data is not typically disaggregated to show expenditure attributable to various 'reasons' for the person needing the support, such as mental illness.

This report provides a more comprehensive estimate of expenditure than previous studies yet the true expenditure to support people with mental illness is much greater than the \$28.6 billion estimate provided here. The conservative approach used to estimate expenditure means a number of figures are likely to underestimate true expenditure. (An asterisk is used in such instances.) While there are also a few instances of possible double counting due to non-availability of disaggregated data, the amounts are relatively small. All such instances are noted in the report. The approach used is explained in more detail in Section 6.1 and in the *Detailed expenditure calculations* companion document.

The available data often does not easily enable a breakdown of where money is being spent. So, despite total expenditure of at least \$28.6 billion it is difficult to assess if the current approach to mental health service provision is best directed to achieving better health outcomes for people with a mental illness.

Direct health expenditure is at least \$13.8 billion per annum

Total direct health expenditure on mental health services was at least \$13.8 billion in 2010-11. This includes expenditure by the Australian Government, state/territory governments, NGOs, private health insurers, consumers and the broader corporate sector.

Key insights on direct health expenditure are:

- Total estimated direct expenditure in 2010-11 was \$13.8 billion. This compares to \$130.3 billion of total health care expenditure in Australia in 2010-11¹⁰
- Expenditure on drug and alcohol services was the largest element of the known expenditure on mental health services (\$4,628 million, and the true figure is probably larger).
- There was substantial expenditure on health care services for treating chronic physical conditions where the patient had a comorbid mental illness (\$1,964 million, and the true figure is probably larger).
- Expenditure on specialised public hospital mental health services was over four times larger than expenditure on mental health inpatient services covered by private health insurers (\$1,778 million compared to \$402 million).
- Available expenditure data indicates spending on psychology services was the largest share of expenditure on 'other mental health services provided by health professionals' (\$336 million). Expenditure on mental health services provided by GPs was likely to be significantly larger, but robust data is not available.

- Of the mental health funding provided by the Australian and state/territory governments and private health insurers, 36.0% was from the Australian Government, 60.5% was from state/territory governments and 3.5% was from the private health insurers.^{11,12} Of the Australian Government funding, 4.2% is provided as grants to the states and territories.¹³

A detailed breakdown of direct health expenditure is provided in Section 6.3, and summarised in Table 1.

The estimate of \$13.8 billion is likely to significantly underestimate true expenditure. For a number of services, expenditure is only available by some groups (for example, governments) and not available for other groups (such as consumers). For other areas of health services (such as out-of-pocket expenditure on private psychiatry services and private psychology services), no estimate of expenditure is possible as data is not available. (This report does not consider expenditure across specific population groups in any detail, though a brief discussion about expenditure on mental health services for Indigenous and non-Indigenous Australians is presented within Section 6.3 of this report.)

Table 1: Summary of direct health expenditure to support people with mental illness

Direct health expenditure	Estimated expenditure (\$m)
Public mental health services	\$3,580
Private mental health services*	\$402
Other mental health services provided by health professionals*	\$924
Medication*	\$1,235
Drug and alcohol services*	\$4,628
Comorbid physical conditions*	\$1,964
Other mental health services*	\$293
Australian Government expenditure on selected national programs and initiatives	\$570
Mental health-related payments by injury compensation insurers*	\$106
Corporate expenditure on mental health services*	\$120
Mental health services in the criminal system*	\$7
Total	\$13,829

* An asterisk indicates the expenditure estimate provided is an underestimate of the true value.

10. AIHW (2011) *Health expenditure Australia 2010-11*, Health and welfare expenditure series No. 47., Cat. No. HWE 56. Canberra.

11. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Canberra.

12. Funding by consumers, NGOs and the broader corporate sector is not considered here.

13. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Canberra.

Direct non-health expenditure is at least \$14.8 billion per annum

Total direct non-health expenditure to support people with mental illness was \$14,757 million in 2010-11. This includes expenditure by the Australian, state/territory governments and private insurers. Non-health expenditure can be broken down into:

- Support payments: income support payments; insurance payments; non-income support; carers payments
- Services provided to people suffering from mental illness: aged care; services for people with a disability; housing and homelessness; employment services; education and training; justice.

Key insights on direct non-health expenditure include:

- Total non-health expenditure was estimated to be \$14.8 billion. This compares to:
 - total Australian Government social security and welfare spend of \$116.9 billion in 2010-11
 - total state/territory government expenditure on social security and welfare of \$14.4 billion in 2010-11.
- Expenditure was split fairly evenly between support payments (\$7,236 million) and service provision (\$7,521 million).
- Two specific payments – Disability Support Pension (\$3,913 million) and insurance payments for total and permanent disability and income protection (\$1,045 million) – accounted for over two-thirds of total support payments.
- Expenditure on justice services – police, courts, specialised mental health courts/tribunals, prisons and community corrections, and juvenile justice – accounted for almost 40% of expenditure on service provision (\$2,918 million).
- The largest element of expenditure on service provision was expenditure on social housing (\$1,506 million).

A detailed breakdown of direct non-health expenditure is provided in Section 6.4, and summarised in Table 2.

Table 2: Summary of direct non-health expenditure to support people with mental illness

Direct health expenditure	Estimated expenditure (\$m)
Support payments*	
Income support*	\$4,661
Insurance payments	\$1,293
Non-income support	\$591
Carers*	\$691
Total support payments*	\$7,236
Services provided*	
Housing and homelessness	\$1,650
Aged care*	\$390
Education and training	\$720
Services for those with a disability	\$1,843
Justice*	\$2,918
Total services provided*	\$7,521
Total	\$14,757

* An asterisk indicates the expenditure estimate provided is an underestimate of the true value.

2.4 Mental health outcomes in Australia are sub-optimal

Mental illness is highly prevalent

The Department of Health and Ageing (DoHA), based on results from the 2007 National Survey of Mental Health and Wellbeing (NSMH&W), has estimated that every year one in five Australians experience a mental illness and almost half the Australian population will experience a mental illness at some point in their lifetime.¹⁴ According to these figures, the prevalence of mental illness is slightly less than obesity (experienced by one in four adults), but significantly exceeds diabetes (4% of adults) and cancer (2.5% of adults).

The true rate of mental illness in Australia will be higher than these estimates because dementia and less common mental disorders (e.g. schizophrenia and other psychotic disorders) are excluded from the NSMH&W survey. For example, dementia affected 1.1% (or 245,400) Australians in 2009.

Of all Australians aged 16-85 years, 11.9% utilised health services for mental health problems in the preceding 12 months.¹⁵

Overall prevalence levels remain static but the types of disorders are changing

The proportion of Australians experiencing high or very high-levels of mental distress has remained relatively stable over the past three National Health Surveys, at around 9%.

Data from the 1997 and 2007 National Survey of Mental Health and Wellbeing surveys indicates that, while the overall prevalence of mental illness has remained relatively stable, the prevalence of particular categories of disorders has changed. Anxiety disorders have increased in prevalence, while substance use disorders have decreased.

Long-term data related to Disability Support Pension (DSP) recipients suggests that the proportion of people with more debilitating mental illness may have increased.

The focus of mental health services is changing

The proportions of people with mental health issues who are accessing different mental health services have stayed relatively static according to a high-level comparison between the results of the 1997 and 2007 National Surveys of Mental Health and Wellbeing. The key exception is the proportion of people who used a psychologist, which has almost doubled. A similar increase is reported in the Productivity Commission's National Agreement

Performance Report covering the three years from 2007-08.¹⁶

Longitudinal data from the People Living with Psychotic Illness 1997-98 and 2010 surveys paint a different and more nuanced picture of how service demand is changing for a particular sub-population living with more severe mental health issues.^{17,18} The results show that:

- **General practitioners remain key providers** of health care to people with psychotic illness
- **Hospital admissions for mental health reasons decreased markedly** with a 35.9% decrease in admissions
- **Community services increased markedly** with 92.8% of people in 2010 having contact with an outpatient or community clinic (against 75.3% reported in 1997-98) and 36.8% undertaking community rehabilitation or day programs (60.7% higher than the 22.9% in 1997-98).
- **NGO provided services increased** with one quarter of the sample (26.5%) receiving mental health services through non-government organisations compared with 18.9% in 1997-98.

14. Slade T, et al. (2009), *The Mental Health of Australians 2, Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra, p. xii.

15. Slade T, et al. (2009), *The Mental Health of Australians 2, Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra, p. xii.

16. Productivity Commission (2008-2011), *National Agreement Performance Reporting-National Healthcare Agreement*, Indicator 21.

17. Australian Government (1999), *People living with psychotic illness: an Australian study 1997-98*, Canberra.

18. Australian Government (2011), *People living with psychotic illness 2010: Report on the second Australian national survey*, Canberra.

Treatment rates for mental illness are low

People with a mental illness often have low rates of service use. This can be due to them choosing not to access services, unavailability of appropriate services, lack of awareness that services are available or negative experiences associated with the previous use of services.

The 2007 NSMH&W revealed that most people with mental illness do not receive any treatment for their condition. According to the survey, 65.1% of people who experienced mental disorders in the previous 12 months received no treatment at all. Mental health service use was more common among people with more severe disorders.

Even when people do access mental health services, their needs are often not being met

The 2007 NSMH&W found that, of the people who had both symptoms of a mental disorder and a need for the service, the need was fully met by mental health services in only: 31% of cases for social intervention; 44% for skills training; and 57% for information. Counselling met the needs of 68% of respondents and medication 87%.¹⁹

Satisfaction levels with mental health services are low relative to other health services. In the 2012 Menzies-Nous Australian Health Survey, only 58% of those receiving health care services from a mental health provider were happy with the treatment.²⁰ This is significantly lower than for specialist doctors, general practitioners nurses and community care.

Evidence to support improved mental health outcomes is limited

Relative to other health outcomes, there is limited longitudinal data related to mental health outcomes that can be aggregated at a national level.

Longitudinal outcomes data for Australians with a psychotic illness show positive changes over the past 15 years. However, mental health outcomes overall remain mixed. Longitudinal data from the most consistently applied mental health outcomes measurement tool in Australia – the Health of the Nation Outcome Scales (HoNOS)²¹ – does not indicate any notable trends in outcomes.

Key insights gleaned from the available data, noted in the National Mental Health Report 2010, paint a mixed picture for mental health outcomes in Australia – these can be found in Box 13 in Section 5.3.3.

19. ABS (2007), National Survey of Mental Health and Wellbeing: Summary of results, October 2008, Cat No. 4326.0, Canberra.

20. Menzies Centre for Health Policy and Nous Group (2012), *The Menzies-Nous Australian Health Survey 2012*, Sydney.

21. HoNOS is a clinician completed measure which assesses a client's health status and the severity of their mental disorder over the previous two weeks. It is used as a standard outcome measure for specialist mental health services across Australia, as well as internationally.

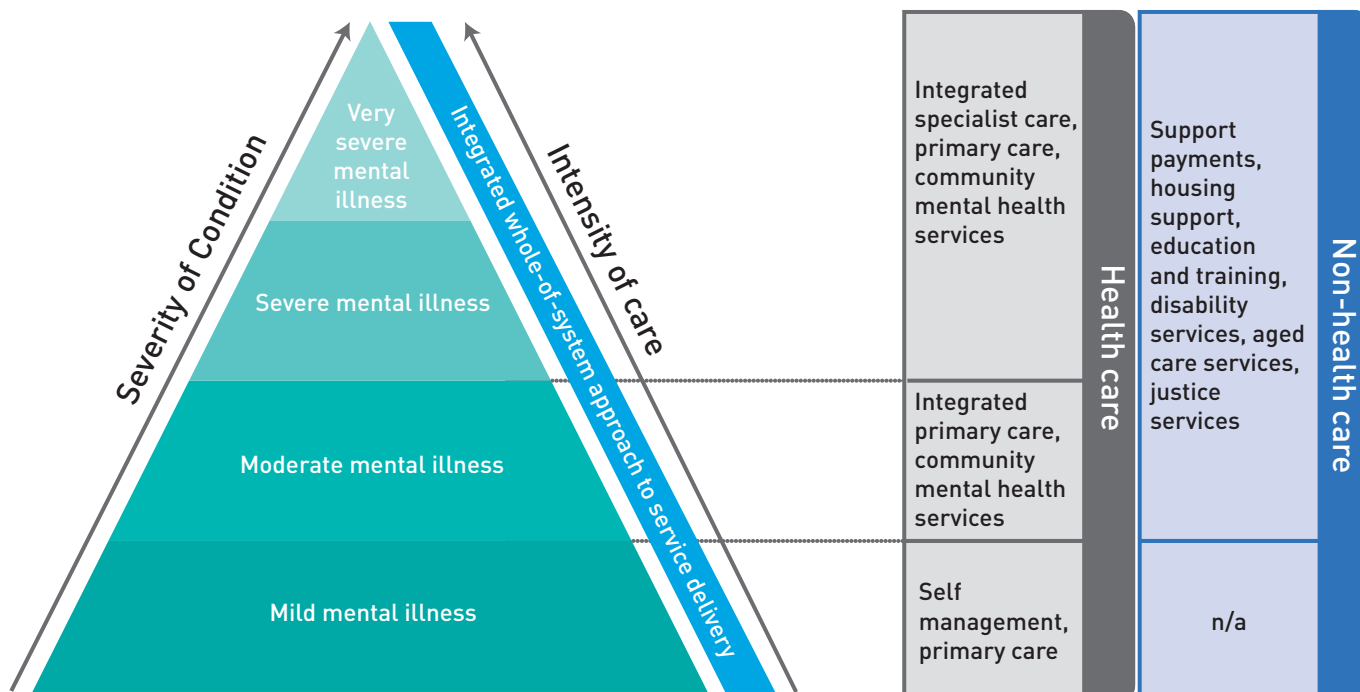
2.5 Selected reform models in Australia and internationally suggest key elements of a successful overall service system

Mental health problems and mental illness, as well as the mental health system, are complex. They include a very diverse set of conditions, each with its own prevalence rate, approach to management and level of impact on individuals, their families and carers. In this report, mental illnesses are categorised by severity into those that are very severe, severe, moderate and mild.

The intensity of health care services required to manage mental illness varies in accordance with the level of severity of the illness. Non-health care services are typically received by people who experience moderate, severe or very severe mental illness. These relationships are illustrated in Figure 2. This model has been developed specifically for use within this report.

Reform approaches in this report are broken down between whole-of-system reforms, and those targeted at specific levels of severity of illness.

Figure 2: Conceptual model to differentiate systemic approaches to supporting those with mental illness



Successful whole-of-system reform is rare internationally, with mixed relevance to Australian circumstances

The fragmentation of Australia's mental health system is replicated globally; there are few international examples of whole-of-system reform. In those instances where major reform has occurred, there have been varying degrees of success. The prime examples are:

- The US Veterans Health Administration Mental Health Program which is trying to provide uniform, evidence-based services to its geographically dispersed population, with greater transparency over what services are being provided (or not) across its network.
- Trieste in Italy, which provides evidence that deinstitutionalisation of mental health services can be achieved, provided the gap is filled by strong community mental health organisations.

The experiences of these two reforms reveal **some key enablers for system-level reform**:

- Stratification of populations according to risk, with an evidence-based approach to each population sub-group that applies funding and service commensurate with need.
- A single funding/payment model.
- Sophisticated and integrated information technology systems (e.g. electronic health records and provider payment systems) to underpin the coordination of services.
- Integrated care pathways within the health care system.
- Integration between the health care and broader social services system,

including employment services.

- Clear clinical guidelines and benchmarks.

Self-contained care systems, with a single stream of funding, mean that the jurisdictions are in a unique position to improve quality and efficiency in mental health care. To apply this kind of whole-of-system reform in Australia would require payment and structural reform beyond that outlined in any previous mental health plans or the Roadmap for Mental Health Reform. Other aspects of the reforms, while still requiring significant change, would require less transformation to the existing mental health service system. For example, the development of a national framework to ensure consistency and access to mental health services, as seen in the US Veterans example, is not beyond the realm of the existing Australian system. The use of community-based Mental Health Centres operating around the clock, which were fundamental to the success in Trieste, would require some transformation of existing community-based mental health services in Australia.

There is some evidence for very intensive person-centred case management of comprehensive community-based services to support people with very severe mental illness

Patients with very severe mental illness are a key challenge for most mental health systems, as they account for a disproportionately large share of service utilisation and cost. Such patients spend a significant amount of time moving in and out of the hospital system.

There are a range of initiatives that use a very intensive, person-centred, coordinated case management approach to effectively assist people with very severe mental illness with comprehensive ongoing support in all key aspects of their lives including health, housing, social connection and safety. Intensive Case Management (ICM) models such as Assertive Community Treatment can decrease rates and length of hospital stays and produce cost savings.

People with severe mental illness require similar services to those with very severe mental illness but with less intensive case coordination

People with severe mental illness less frequently require inpatient care than those with very severe mental illness. However, the literature supports the widely held view that gaps in care result in a high-level of hospitalisations and readmissions for people with severe mental illness.

There is evidence that effective support requires the clear integration of a comprehensive range of hospital-based care, community clinical treatments, primary care and non-health services such as housing and employment programs. At the core of most successful models, and supported by a growing evidence base, is a somewhat intensive case management / care coordination function that helps patients to navigate their way through clinical and community services, thereby avoiding hospitalisation. In that context, a number of models have shown promise (see Section 8.3).

Evidence from the United States, applicable to Australia, indicates people with moderate mental illness can be successfully treated in primary care settings

A number of US initiatives provide evidence that people with moderate mental illness can be successfully treated in primary care settings. The improvements built on systematic changes in the delivery of care and show that General Practice is able to implement and sustain improvements when offered a standardised care management program and adequate support. There is also evidence that other chronic conditions (comorbid or not) that would benefit from such programmes include chronic heart failure (CHF), diabetes, and asthma.

The successful models incorporate three key features:

- Standardised programs, but implementation is customised to each setting (to accommodate large or small health care organisations).
- A care manager (a centralised resource not necessarily located in the primary care practice) to manage patients in collaboration with the clinician, who retains overall responsibility for patient care.
- Psychiatrist supervision of the care manager, providing guidance to the clinician through the care manager, and advising the clinician directly as needed.

These initiatives could be translated to the Australian context.

There are promising models to improve treatment and treatment rates of people with mild mental illness, with applicability for Australia

According to *beyondblue*, only 35-40% of Australians with high prevalence and mild severity mental illness adequately access appropriate services. This low treatment rate is reflected internationally. A number of cost-effective, evidence-based models to reach these patients are being explored.

In the UK, increasing access to “talking therapies” using a stepped care approach, as with the Improving Access to Psychological Therapies program, is showing promise. In Australia, evidence is emerging that online Cognitive Behavioural Therapy (CBT) models increase the rate of treatment and quality of life. Another approach has been to explore primary care based models that integrate/co-locate mental health services. The Hamilton Family Health Team in Ontario, Canada, has shown that this model can increase the rate of treatment of mental illness, and can be a crucial part of providing prevention and detection in early stages. Intermountain Health in the US has made mental health screening as routine as screening for physical conditions.

Stepped type services such as Improving Access to Psychological Therapies could be easily adapted in the Australian environment. Experience delivering evidence-based online psychological therapies (such as CBT), and existing primary care mental health initiatives, suggest that only limited system or payment changes would be necessary.

In 2009, *beyondblue* commissioned a feasibility study to investigate whether a similar model would work in Australia and presented a business case to the Australian government. In October 2012, the Australian Government announced Access Macquarie, developed by Macquarie University, would provide confidential mental health assistance, available to all Australians, via the internet, phone or email.

Mental health and wellbeing have been integrated into primary care (through the Access to Allied Psychological Services (ATAPs) program and the Better Access Initiative). International initiatives suggest some key lessons. Services need to be seen as a partnership between mental health and primary care, rather than a traditional referral process, and embedded in the primary care system with each contributing to the program design.

Key elements can be identified for a reformed mental health service system

The review of successful reforms in Australia and internationally does suggest some key elements of a reformed mental health system. At a system-wide level, international experience suggests a number of key enablers of reform, noted above. Some of these enablers, such as a single funding/payment model, would require substantial change to the existing mental health service system; other elements, such as the development of clear clinical guidelines and benchmarks, would require less transformation in the current Australian context.

For mental illness at different levels of severity, the review suggests a tailored service approach with services commensurate with the severity of the condition:

- **Very severe and severe mental illness** – successful treatment requires a very intensive, person-centred, coordinated case management approach, with clear integration of a comprehensive range of hospital-based care, community clinical treatments, primary care and non-health services such as housing and employment programs
- **Moderate mental illness** – successful treatment is possible in primary care settings, with the right balance between a standardised care management program and a collaborative, interdisciplinary approach between the clinician, care manager and psychiatrist
- **Mild mental illness** – a variety of approaches offer promise such as “talking therapies”, online CBT models and primary care based models that integrate/co-locate mental health services. Further analysis is needed to assess which approach, or combination of approaches, is most appropriate for Australian circumstances.

2.6 Australia has an unprecedented opportunity to lead the world in end-to-end mental health system redesign to deliver better outcomes at the same or lower cost

As identified in the report, at least \$28.6 billion is spent annually supporting people with mental illness, an amount likely to grow with the increased policy focus on mental health. Despite this, overall levels of mental illness are static, many of those with mental illness do not access services and, when they do, their needs are often not met.

The current system is extremely fragmented — both in terms of supply of services and funding. Health services are supplied in and out of hospitals (public and private), by psychiatrists and general practitioners and other doctors, psychologists, counsellors and other allied health professionals. Non-health support is provided by governments (at the Australian and state/territory level), not-for-profit organisations and others. Funding, across health and non-health services, comes from the Australian and state/territory governments, insurers and non-insurance businesses and not-for-profits (and donors). Individuals with mental illness and their families also shoulder much of the burden.

Major system-level changes are required. There is a need for an end-to-end redesigned system, covering detection to diagnosis to treatment to ongoing recovery. The system needs to integrate health and non-health support and funding. This includes better integration across government departments (at the federal and state/territories levels) of the assistance they provide and/or fund. The review of reforms in Australia and internationally suggests some elements to inform an improved mental health service system. There is an opportunity for Australia to lead the world in designing and implementing a whole-of-system approach to support those with mental illness.

Pursuant to this paper, Medibank Health Solutions will be working with other key stakeholders to detail options for systemic reform of mental health – to ensure the needs of people with mental illness are better met, and to deliver better outcomes and greater efficiency.

3. Purpose and scope of this report

This report is designed to contribute to a better understanding of Australia's current mental health system and opportunities for system-level improvement. It provides the most comprehensive estimate to date of expenditure to support people with a mental illness in Australia. It also examines a number of Australian and international mental health system-level initiatives and draws out the elements of those initiatives relevant to Australia.

The level and scope of discussion about mental health has increased substantially in Australia and internationally in recent years. Mental health is an Australian national health priority. The current system's failure to adequately meet the needs of people with mental illness is the subject of widespread agreement – among policymakers, health care professionals, service providers, advocacy groups, researchers, and people with a mental illness, their families and carers. While some real improvements have been made to the Australian mental health system over the past two decades, "there is still much to be done".²²

Widely accepted definitions of 'mental health problem' and 'mental illness' are used in this report

Mental health problems and mental illnesses include a diverse set of medical conditions. Box 1 describes the definitions used in this report and companion documents.

Box 1: Definitions of mental health problem and mental illness used in this report and companion documents

Mental health problems and mental illnesses include a diverse set of medical conditions. They affect people at all ages. For children and adolescents, relevant conditions include autism and attention deficit hyperactivity disorder (ADHD); for new mothers, post-natal depression; and for the elderly, dementia and Alzheimer's disease. Across all age groups relevant conditions include affective disorders, anxiety disorders, psychotic disorders and substance use disorders.

Common medical investigations (such as biopsies and blood tests) are typically not available to define a mental health problem or mental illness (used interchangeably with mental disorder). Diagnoses are usually based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic categories. This report follows the classifications from the Productivity Commission and World Health Organisation (ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines, WHO, Geneva, 1992).

- Mental health problem: problems involving "diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness".
- Mental illness: "the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions".

These definitions includes dementia, disorders of psychological development and psychoactive substance use (including alcohol, illicit drugs and tobacco). The definitions exclude mental retardation and intellectual disability.

22. DoHA (2009), *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*, Commonwealth of Australia, Canberra, p. 21.

This report's analysis of expenditure focuses on costs

This report is focused entirely on direct costs to support people with mental illness, excluding capital expenditure. It explicitly excludes any analysis of indirect and non-financial costs such as lost productivity or the debilitating impact on the lives of those with a mental illness, their families and carers.

The discussion of reforms focuses on system-level changes

This report analyses successful mental health system reforms in Australia and internationally that have contributed to better outcomes for people with mental illness and/or a lower cost of providing services. The report does not address improvements at the level of clinical management.

Over 45 reforms have been reviewed as part of the research for this report. They are drawn from Australia, New Zealand, Europe (in particular, the UK), USA and Canada. Of these reforms, 23 are examined in this report. They were selected by Medibank Health Solutions and Nous Group following discussions with several of Australia's leading mental health researchers, advocacy groups and policymakers.

The reforms detailed in this report encompass adult, adolescent and child mental health services. They exclude dementia programs and services specifically designed to treat alcohol and substance abuse.

The report is designed to contribute to public discussion

The report is designed to contribute to the considerable public discussion of Australia's mental health challenge. It is appreciated that policymakers, advocacy groups, researchers and others may have:

- suggestions to improve the accuracy of the expenditure estimates presented
- further evidence on the mental health system initiatives analysed
- suggestions for reforms that may be implemented to improve Australia's mental health system.

Such contributions are welcome.

Structure of the report

The main part of this report is structured as follows:

- Section 4 provides an overview of Australian governments' substantial increase in policy attention and funding to mental health since the early 1990s
- Section 5 notes the critical issues in mental health – poor system design, and describes the fragmentation and lack of coordination in funding, expenditure and service delivery and how these challenges compound Australia's mental health challenges
- Section 6 discusses direct expenditure to support people with a mental illness including the difficulty of estimating this expenditure, the components of direct health expenditure and direct non-health expenditure
- Section 7 analyses data that indicate a stable prevalence of mental illness in Australia, low treatment and satisfaction rates and sub-optimal mental health outcomes

- Section 8 outlines the conceptual model used in this report to differentiate systemic approaches to support those with mental illness and explores key mental health system reforms undertaken in Australia and internationally.
- Section 9 sets out the challenge: to design and implement an integrated end-to-end model to support those with mental illness and achieve better outcomes more efficiently.

There are four appendices:

- Appendix A – explains the common acronyms and terminology with specific meanings used in this report
- Appendix B – describes the approach undertaken to evaluate the system-level reforms discussed in Section 8
- Appendix C – lists all mental health system improvements considered in the research for Section 8

- Appendix D – lists all materials referenced in this report, with those included in the discussion of expenditure (in Section 6) and those relating to the system-level reforms (Section 8) documented separately.

A detailed expenditure calculations document, which fully describes the estimation techniques used to calculate health and non-health expenditure, is available upon request.

4. Governments have given substantially more policy attention and funding to mental health since the early 1990s

As mental health has occupied increasing public and media attention, so too governments have devoted more policy resources and funding to it. Although there is still uncertainty over the most effective future reform path (see Section 8 of this report), governments are certainly focused on addressing the challenges. In 2010-11, of the \$28.6 billion in expenditure to support people with mental illness (detailed in Section 6), the majority of expenditure was funded by governments, with the balance funded by insurers, consumers, employers, non-government organisations and other private payers.

the sequence of significant mental health policy and planning initiatives that governments have adopted in recent years. Table 3 below provides a summary of key government initiatives. Each of these initiatives is discussed in more detail in Section 4.1 below.

This section of the report outlines

Table 3: Key national mental health initiatives since 1992

Initiative	Year	Key features	Associated funding
National Mental Health Strategy	1992	<ul style="list-style-type: none"> First five-year National Mental Health Plan (three further National Mental Health Plans followed in 1997, 2003 and 2009) 	-
COAG National Action Plan	2006	<ul style="list-style-type: none"> Shift from health centred to whole-of-system Significant commitments by both national and state governments 	\$4.1 billion over 5 years from 2006-2011 ²³
National Partnership Agreement	2012	<ul style="list-style-type: none"> Focus on the provision of secure housing arrangements and decreasing movement through health institutions 	Commonwealth provision of up to \$200 million over 4 years from 2011-12 to 2015-16 ²⁴
COAG's 10 year Roadmap for National Mental Health Reform	2012 and ongoing	<ul style="list-style-type: none"> Setting of the long-term vision for mental health in Australia 	-
Creation of the National Mental Health Commission (NMHC)	2012	<ul style="list-style-type: none"> Creation of a central point for long-term mental health reform 	\$32 million over five years from 2011-12 to support the establishment and operation of the Commission ²⁵

23. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Canberra, p. 15.

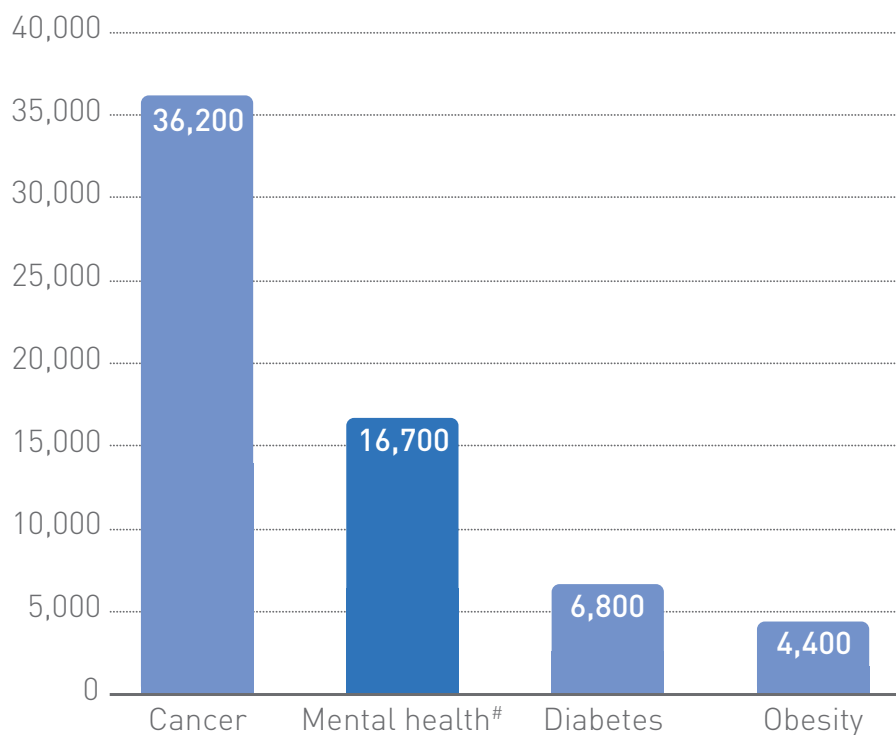
24. COAG Standing Council on Federal Financial Relations (2012), *National Partnership Agreement Supporting National Mental Health Reform*, Canberra, p. 3.

25. National Mental Health Commission (2012), National Mental Health Commission website at <http://www.mentalhealthcommission.gov.au/about-us/faq.aspx>.

The number of major policy and planning initiatives shown in Table 3 has been accompanied by significant increase in mental health expenditure. The \$2.2 billion increase announced in the 2011 Budget, as part of the National Mental Health Reform package, is additional funding to that outlined above.²⁶

The significant policy attention and substantial additional funding have occurred alongside increased public and media attention on mental health. One indicator of the level of attention is the number of media references to mental health. In 2010-11, the Australian media contained 16,700 articles referring to mental health (and related terms mental illness, mental problem and mental disorder).²⁷ As a point of comparison, this is significantly more references than obesity (4,400) and diabetes (6,800), though less than half the number of references to cancer (36,200) – see Figure 3. (As noted, the prevalence of mental illness far exceeds cancer.) The number of media references to mental health has increased significantly in recent years, with annual growth of greater than 10% from 2005-06 to 2010-11.

Figure 3: Australian media references to health issues 2010-11



[#] Includes related terms mental illness, mental problem and mental disorder.

Source: Factiva archive of Australian media sources.

26. Department of Health and Ageing (2011), *Health Budget 2011-12: Delivering mental health reform*, available at <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2011-hmedia02.htm>.

27. Statistics are drawn from a search of the Factiva archive of all available Australian media sources. Factiva is a newswire and information aggregation and research tool.

4.1 The Australian Government has made significant policy and funding commitments

The National Mental Health Strategy of 1992 heralded Australia's stronger focus on mental health

The current enhanced focus on mental health can be traced back to 1992, with the development of the initial National Mental Health Strategy. This Strategy has since guided mental health reform in Australia. In that year Australian health ministers also agreed to the original National Mental Health Policy (which was revised in 2008) and the first five-year National Mental Health Plan. Three further National Mental Health Plans followed in 1997, 2003 and 2009.

COAG's National Action Plan in 2006 emphasised the need for reform to shift from health centred to a whole-of-system approach

Mental health in Australia has traditionally been seen through a very 'health-centric' lens. Many of the reforms have provided more money to health programs.

With the advent of a stronger role for the Council of Australian Governments (COAG), mental health became a COAG priority from 2006, when the National Action Plan on Mental Health 2006–2011 was created. The National Action Plan outlined a range of measures for all states/territories targeting COAG's priority outcomes – reducing the prevalence and causes of mental health, increasing the accessibility of appropriate health care for those with a mental illness and enhancing the ability for those with a mental illness to participate in the community.

The National Action Plan committed the Australian and state/territory governments to a significant increase in mental health expenditure. This included greater investment by state and territory governments in community-based

mental health services and increased investment in services delivered outside the health sector, including employment, education and community services. The funding allocated under the COAG Plan totalled approximately \$4.1 billion over the five years and all governments committed to continued investment beyond this amount after the period ended. In addition to the National Action Plan, the Australian Government allocated \$2.2 billion in funding for mental health for five years from 2011-12 and the states have also made significant investments. Alongside these national activities, states and territories have developed their own specific mental health plans or strategies and have made significant investments as well.²⁸

28. COAG Communique of 19 August 2011.

The National Partnership Agreement of 2012 focuses on the provision of secure housing arrangements and decreasing movement through health institutions

In April 2012, COAG announced further measures to improve mental health in the *National Partnership Agreement Supporting Mental Health Reform*. The National Partnership Agreement outlines a range of measures in each state designed to target the priority outcomes of stable housing and reduced cycling through health institutions for people with severe and persistent mental illness. The Australian Government funding allocated to these measures totals approximately \$200 million.²⁹

COAG's Ten Year Roadmap will describe the long-term direction for Australia's mental health system

In further recognition of the importance of mental health to the Australian community, COAG has commenced work on its *Ten Year Roadmap for National Mental Health Reform*. The Roadmap will set out the long-term vision for mental health in Australia, COAG priorities and the main steps to take to achieve this vision in coming years.³⁰

The National Mental Health Commission has been created to provide a central point for long-term reform

The creation of the National Mental Health Commission (NMHC) in January 2012 signalled an intention from the Australian Government to focus on long-term reform of the mental health system. The Commission has been allocated \$32 million over the five years from 2011-12 (included in the *Delivering National Mental Health Reform* package) to support its establishment and operation as an Executive Agency within the Prime Minister's Portfolio.

The Commission is charged with more effective planning for the future mental health needs of the community, creating greater accountability and transparency in the mental health system and ensuring national prominence for mental health. Its Chair Professor Allan Fels summarises its purpose as: "to observe, listen and then report and advise on what needs to happen".³¹ Fels notes the Commission is the first organisation of its kind to have a national whole-of-government scope, and also a whole-of-life view – from health to employment to housing to stigma and discrimination.

The Commission believes there is a need to ask more of non-health sectors and at the same time better integrate service and support systems. Fels again: "For recovery to occur, you need somewhere decent, stable and safe to live, you need education and rehabilitation, you need physical health and ideally you also need a job".³²

Separate state-level mental health commissions have also been established in NSW, Queensland and Western Australia.

29. COAG Communique of 13 April 2012.

30. Further detail is in the COAG Communique's of 14 July 2006, 19 August 2011 and 13 April 2012.

31. Professor Allan Fels AO (2011) "How do you Measure a Contributing Life? Australia's First National Report Card on Mental Health and Suicide Prevention", *Speech to the National Press Club*, Canberra, 1 August, p. 14.

32. Professor Allan Fels AO (2011) "How do you Measure a Contributing Life? Australia's First National Report Card on Mental Health and Suicide Prevention", *Speech to the National Press Club*, Canberra, 1 August, p. 4.

4.2 A range of reforms have occurred in mental health. The system is also affected by broader health reforms

Several system-level reforms have occurred during the time of the National Mental Health Strategy and National Action Plan

Over the two decades that mental health has been the subject of the national approaches described in above, a number of reforms have been undertaken. These include the following changes:³³

- Significant growth has occurred in the number of mental health professionals working directly with consumers.
- Care is now delivered primarily in community settings rather than previous heavy reliance on inpatient services.
- Access to mental health care in primary care settings has been substantially increased, following changes to the Medicare Benefits Schedule in 2006.
- Community mental health literacy has improved.
- Integrated approaches and stronger partnerships have begun to emerge.

These themes are likely to continue to underpin future reforms.

Broader national health reforms may impact the mental health system

The particular initiatives in mental health at the national level do not sit in isolation from other national health reforms. There are concerns that system-level reforms under COAG that will fund hospitals based on a price per activity (an activity-based funding approach set by the Independent Hospital Pricing Authority) could have negative impacts on the mental health system. Professor Allan Fels expressed NHMC's concern that unless carefully designed, these reforms "could drive investment and activity back into hospitals – going against the trend of the last decades – and seriously undermine effective and efficient care".³⁴

33. Department of Health and Ageing (2009), *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*, Commonwealth of Australia, Canberra.

34. Professor Allan Fels AO (2011) "How do you Measure a Contributing Life? Australia's First National Report Card on Mental Health and Suicide Prevention", *Speech to the National Press Club*, Canberra, 1 August, p. 19.

4.3 The Australian Government and state governments have introduced a number of mental health reforms

In conjunction with the greater national focus on mental health, a number of reforms have been introduced in recent years. Some of the reforms, briefly described below, and considered further in the discussion of useful reform models in Australia and internationally in Section 8, are:

- **Multiple and Complex Needs Initiative (MACNI)** – Introduced in 2003, the initiative provides specialist intervention for those, aged 16 years and older, with the most complex mental health needs who pose a risk to themselves and/or to the community.
- **Housing and Accommodation Support Initiative** – Introduced in 2002, the NSW government initiative supports eligible adults with mental illness with packages of mental health, housing and accommodation support, under a collaboration between NSW Health, Housing NSW and NGOs.
- **Prevention and Recovery Care** – Introduced in 2003, the Victorian government initiative provides people with severe mental illness with clinical intervention, treatment and recovery support in a safe and supported residential setting. The initiative is a partnership between Area Mental Health clinical services and NGO recovery services.
- **Consultant Liaison in Primary Care Psychiatry (CLIPP)** – Developed in the late 1990s in Victoria, the model introduced three key components to facilitate effective collaboration between the private (GPs) and public sectors (Community Mental Health Services): Consultation Liaison psychiatrist attachments provided to General Practices from Public Sector Mental Health Services; a CLIPP liaison clinician (usually a psychiatric nurse) identifies suitable individuals in community mental health services into collaborative care with their GP for clinical management; and a system for case registration and tracking of patients to ensure high-levels of retention and effective follow-up.
- **THIS WAY UP (formerly Clinical Research Unit for Anxiety and Depression Clinic)** – Introduced in 2006, the program offers five courses which use a self-guided cognitive behavioural treatment approach to treat common mental health conditions. The program is a joint facility of the University of New South Wales and St Vincent's Hospital.
- **Partners in Recovery** – Set to commence in early 2013, the initiative will establish non-government "Partners in Recovery" organisations to employ support facilitators who will use flexible funding to coordinate multiple services to provide individually tailored support to people with severe and persistent mental illness with complex support needs.

Other reforms of note are:

- **Early Psychosis Prevention and Intervention Centre (EPPIC)** – Introduced in 1992, EPPIC, based in the western and north-western regions of Melbourne, is an integrated and comprehensive mental health service aimed at addressing the needs of people aged 15-24 with a first episode of psychosis. The initiative is a specialist clinical program of Orygen Youth Health (OYH) which is a component service of NorthWestern Mental Health and Melbourne Health.
- **Better Access Initiative** – Introduced in 2006, the initiative expanded the Medicare Benefits Schedule to improve access to mental health care delivered by psychologists and other allied health professions, general practitioners and psychiatrists.
- **Headspace**, the National Youth Mental Health Foundation – Established in 2006, Headspace provides support for people aged 12-25 across mental health and counselling, general health, education services, employment services, and alcohol and drug services. Services can be accessed in-person, at one of the current 40 Headspace Centres, electronically (through the eheadspace portal) or by telephone.
- **Personal Helpers and Mentors (PHaMs)** – Introduced in 2007, the program assists people aged 16 years and over whose ability to manage their daily activities and to live independently in the community is impacted because of a severe mental illness. The Pham's service is provided by NGOs.

Australian researchers have pioneered online mental health services and Australia is now seen as a world leader in the area. Three prominent examples of e-mental health services include:

- *beyondblue* and Inspire Foundation's web site www.reachoutcentral.com.au website
- Lifeline's online Crisis Support Chat
- Online CBT through THIS WAY UP Clinic (noted above).

A number of benefits are cited for e-mental health, and especially online, services:

- people can work at their own pace – with professional support – to learn how to deal with their difficulties
- the online delivery mechanism helps to overcome the fear of potential stigma from walking into a mental health service
- addresses the challenges faced by people (especially in rural and remote areas) who do not have ready access to services
- immediate and flexible access (from almost any location and at any time of any day) to services
- continuity of care, follow-up and pathways to face-to-face care
- greater opportunities for promotion and prevention
- potential to deliver services in a cost-effective manner (for governments, providers and consumers)
- potential to decrease demands on the mental health workforce.

4.4 A number of non-government organisations also play a key role in mental health reform

In recent years, a number of mental health-specific organisations have been established at both the national and local level across Australia. These include government, academic and community organisations. Their increasing profile reflects the growing policy importance of mental health. Some key organisations are briefly described below.

Mental Health Council of Australia

Established in 1997, the MHCA is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector. Its members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state / territory community mental health peak bodies.

Beyondblue

Beyondblue: the national depression initiative advocates and provides services for people with depression and anxiety. The independent national organisation, established in 2000, is designed to raise awareness, build networks and motivate action in the area of depression prevention. Its mission encompasses building a “society that understands and responds to the personal and social impact of depression, works actively to prevent it, and improves the quality of life for everyone affected”. The organisation is funded by the federal and state governments, and other financial grants.

Black Dog Institute

The Black Dog Institute was established in 2002 with the goal of advancing the understanding, diagnosis and management of mood disorders by continuously raising clinical, research, education and training standards. It focuses on diagnosis, treatment and prevention of mood disorders such as depression and bipolar disorder. Attached to the Prince of Wales Hospital, and affiliated with the University of New South Wales, it is an educational, research, clinical and community-oriented facility.

Other University Centres

Research into mental health systems is undertaken across a number of Australian universities. The University of Queensland Centre of Research Excellence, in particular, leads a strong program of research into the design of a better mental health system for Australia.

5. The critical issue in mental health is system design

Mental health services encompass a complex network of care settings and service providers

Australia's mental health system lacks a clear end-to-end system design. The nature of mental illness increases the likelihood that consumers will interact frequently with multiple parts of the healthcare and broader social services system (including employment services). Yet the system is characterised by fragmentation and insufficient coordination. This is compounded by similar problems with social services and the support payment system.

The number of service providers illustrates the complexity of the system. In 2008-09, there were 156 public hospitals providing mental health care, 150 residential facilities, 990 community services, and 50 private psychiatric hospitals.³⁵ There are hundreds of mental health NGOs (with estimates ranging from 400 (in 2008)³⁶ to 798 (in 2011)³⁷) and there are currently 36 private health insurers. This is in addition to the numerous other service providers who deliver mental health services.

There are mixed and overlapping responsibilities for mental health funding and expenditure

A number of bodies – the Australian Government, state/territory governments, private health insurers, the corporate sector and consumers – are responsible for both health expenditure (i.e. spending the money) and health funding (i.e. providing the funds that are used to pay for health expenditure).³⁸ NGOs, funded by governments, donations and other sources, also contribute to health expenditure.³⁹ The structure and flow of money through the Australian mental health care system is illustrated in Figure 4 on page 31.

Of the \$28.6 billion in total direct expenditure in 2010-11, the funding sources for \$22.6 billion are able to be determined: approximately 90% is funded by government with the balance funded by insurers, consumers (out-of-pocket), employers, NGOs and other private payers. The funding split is unable to be determined for the remaining \$6 billion which comprises drug and alcohol services, and health and non-health payments by insurers – both government and private sector.

Fragmentation of funders and services is exacerbated by the lack of coordination within the healthcare system and between the healthcare and social services systems

The fragmentation that arises from diverse funding and expenditure arrangements is exacerbated by the lack of coordination within the healthcare system. Individuals with more severe mental illness face a further level of fragmentation. In addition to healthcare services, they may also receive a range of government transfer payments and services, as well as insurance and income protection payments.

The absence of coordinated, collaborative and consistently reliable recovery-based services for people with a mental illness has meant that the mental health system has become heavily reliant on the goodwill and ongoing care provided by carers to fund and resource recovery-based care. This was highlighted in a 2010 survey of mental health carers conducted by the Mental Health Council of Australia (MHCA) which found that the majority of mental health carers are responsible for organising the bulk of care for the person they care for. Medical workers, social workers or case managers organised approximately 10% of care, with community workers arranging a slightly higher amount.⁴⁰

35. AIHW (2011), *Mental health services – in brief 2011*, AIHW Cat. No. HSE 113, Canberra, p. 25.

36. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 5.

37. National Health Workforce Planning and Research Collaboration (2011), *Mental Health Non-Government Organisation Workforce Project: final report*. Available at: <http://www.ahwo.gov.au/documents/Publications/2011/Mental%20Health%20NGO%20Workforce%20Project%20Final%20Report.pdf>.

38. These definitions follow AIHW (2011), *Health expenditure Australia 2009-10*, AIHW Cat. No. HWE 55, Canberra, Box 1.1, p. 1.

39. NGO services that are funded by government are a component of the estimates of government expenditure in this report.

40. Mental Health Council of Australia (2010), *Mental Health Carers Report*, p. 20.

Fragmentation of the mental health service system also leads to frustration, confusion and distress for service users – people suffering mental illness and also family and carers. As the 2011 Australian Government Budget Paper on national mental health reform stated, people with severe mental illness have to “deal with fragmented and uncoordinated systems”.⁴¹ It continued: “despite previous attempts at reform and investment by governments, too many people with severe and debilitating mental illness are still not getting the support they need, don’t know where to find it, and are falling through the cracks in the system. The families and people who care for them struggle with a system which often causes them frustration and even despair”.⁴²

Poor system design compounds Australia’s mental health challenges

There is a strong case that the poor mental health system design exacerbates Australia’s mental health challenges. Three key challenges are:

1. New initiatives can add complexity to an already fragmented system and fail to address the critical issue of system design

– As noted above, the Australian and state/territory governments have introduced a number of initiatives in recent years to improve health and non-health services for people with mental illness. Yet, in a fragmented service system, without clear pathways for people with mental illness, new initiatives can add greater complexity. The introduction of new initiatives also diverts attention from what remains the key challenge – designing a mental health service system that improves the health of people with a mental illness in a cost-effective way.

2. It is impossible to tell if Australia is spending the right amount of money to support people with mental illness and if money is being spent in the right areas

– Expenditure to support people with mental illness is substantial, and far exceeds that previously estimated (see Section 6 below). Without a clear system design, it is not possible to assess if total expenditure is appropriate

to meet Australia’s mental health challenges. It is also not possible to assess if:

- health expenditure is appropriately focussed across different degrees of severity of mental illness and between prevention, early intervention, management and treatment
- non-health expenditure is appropriately balanced between income and other supports and social services (such as housing or employment)
- the balance is appropriate between health expenditure and non-health expenditure.

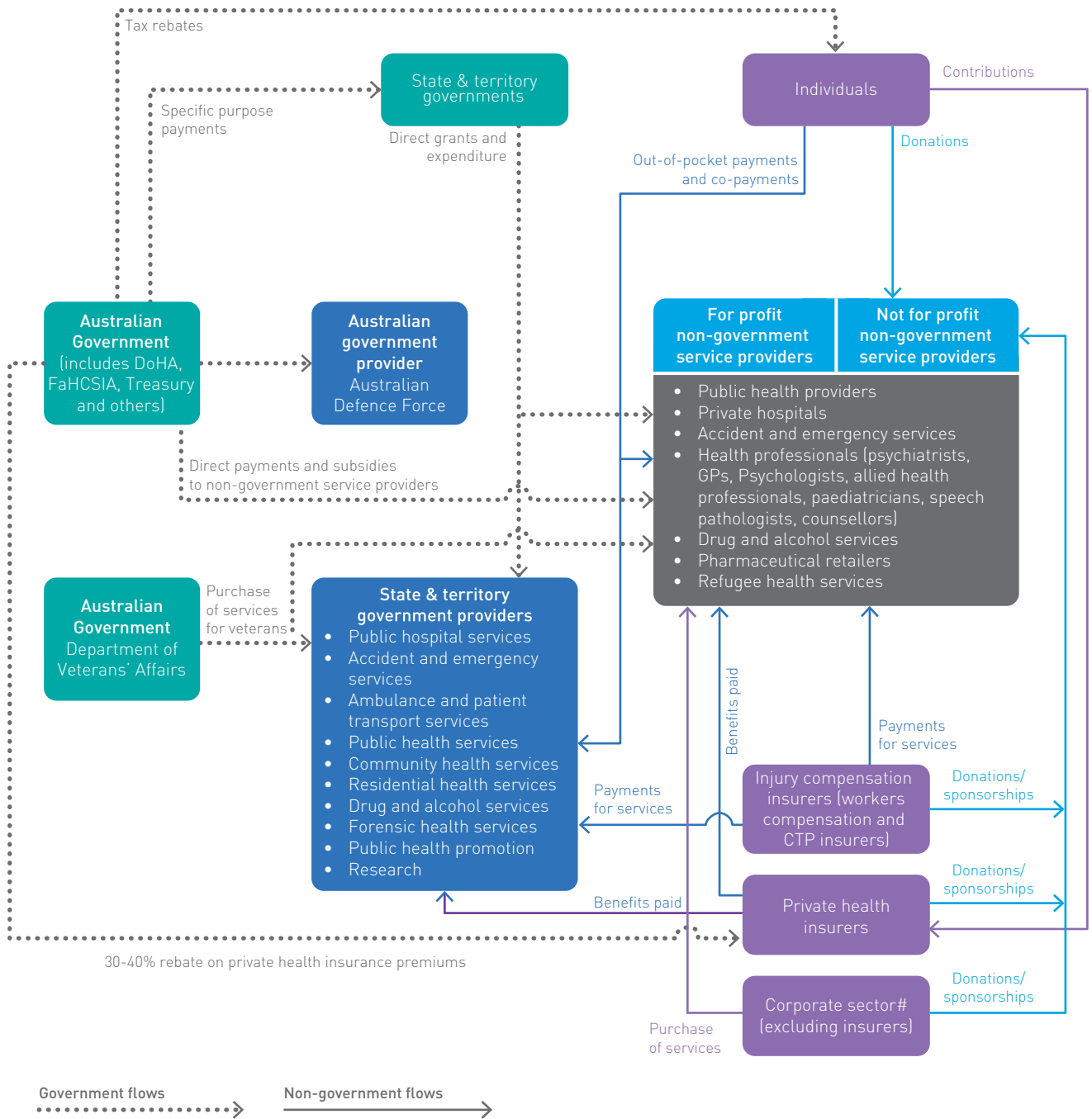
3. Mental health outcomes are likely to be sub-optimal, leading to additional health and non-health costs

– It is reasonable to conclude that fragmentation and insufficient coordination contribute to Australia’s sub-optimal mental health outcomes (see Section 7 below). With mental health the fastest-growing cause of disability in Australia, it is evident that poor outcomes, in turn, lead to additional health expenditure and also non-health expenditure, such as income support and other non-health services.

41. Australian Government (2011), *Budget: National mental health reform*, Canberra, p. 5.

42. Australian Government (2011), *Budget: National mental health reform*, Canberra, p. 12.

Figure 4: The structure and flow of money through the Australian mental health care system



The corporate sector purchase services from a sub-set of non-government service providers. These include providers of Employee Assistance programs and other corporate health and wellness programs.

Source: Based on Figure 1.1 'The structure of the Australian health care system and its flow of funds', p. 5, of AIHW [2011] Health expenditure Australia 2009-10, AIHW Cat. No. HWE 55, Canberra.

6. Total direct expenditure on supporting people with a mental illness in Australia far exceeds that previously estimated

Total direct expenditure to support people with mental illness is substantial, at least \$28.6 billion in 2010-11

This report concentrates on direct expenditure to support people with mental illness. Total direct expenditure was at least \$28.6 billion in 2010-11. This is equivalent to 2.2% of Australia's GDP. Total expenditure includes direct health expenditure of at least \$13.8 billion and direct non-health expenditure of at least \$14.8 billion [see Sections 6.2 to 6.4 for more detail]. Of the \$28.6 billion, the funding sources for around 80% of expenditure can be determined.

This report provides a more comprehensive estimate of expenditure than previous studies yet the true cost of mental illness is greater than the \$28.6 billion estimate provided here. Reasons for this are discussed in detail in Section 6.1 and include:

- Conservative assumptions have been used where data availability and granularity are lacking. On the health side, this may be due to a range of reasons including the fragmentation of the mental health system, absence of data capture, confidentiality of data, insufficient data disaggregation or the incomplete mapping of Medicare data to services related to mental illness. On the non-health side, disaggregation of data to link it with mental illness occurs to a very limited extent.
- There are a number of categories of expenditure and of smaller programs, services and pilots that have not been captured in this report.
- The analysis in this report is limited to direct expenditure. It does not include the broader economic and social costs of mental illness, such as lost productivity and consequential costs for families and carers.

Higher quality and more granular data is required in order to determine if money is well-spent

The available data often does not easily enable a breakdown of where money is being spent. So despite total expenditure of at least \$28.6 billion, the following key questions to determine whether the money is well-spent cannot be answered:

- How much is spent on specific mental health services? For example, what is the expenditure on child and adolescent mental health services relative to adult mental health services?
- How much is spent on specific mental health conditions? For example, what is the expenditure on depression or bipolar disorder?
- How is expenditure allocated, for each condition and overall, by severity (as per the levels of Figure 18 on p. 79)? For example, expenditure on mild depression relative to severe depression?
- What proportion of expenditure relates to prevention, early intervention, management and treatment?

In the absence of data to adequately answer such questions, it is difficult to assess if the response to Australia's mental health challenge (and associated expenditure) is best directed to achieving better health outcomes for people with a mental illness. Higher quality data will be required to analyse whether resources are being allocated to the highest priority cohorts and conditions.

6.1 It is difficult to estimate the cost of mental illness

Mental illness imposes significant and diverse costs

There are a wide range of costs in relation to mental illness. This report makes two key distinctions in cost types: (1) whether the cost is direct or indirect; and (2) who is responsible for health expenditure (i.e. who spends the money).

1. **Direct costs** are defined as the expenditure incurred to provide health and non-health support to people with mental illness, and expenditure on the promotion of, and research into, mental health. **Indirect costs** are defined as broader individual, social and economic costs of mental illness.
2. A number of groups spend money to support people with mental illness, including:
 - people directly affected by mental illness
 - families and carers of those with mental illness
 - insurance companies
 - corporate sector (excluding insurance companies)
 - governments
 - NGOs.

This report focuses solely on the direct costs of supporting people with mental illness. For each element of expenditure, this report includes the best available data at the time the report was compiled for expenditure by:

- Health expenditure – governments (Australian and state/territory), private health insurance companies and consumers
- Non-health expenditure – Australian Government and state/territory governments. Comprehensive data on private non-health expenditure to support people with mental illness is not available.

Total NGO expenditure on all health and non-health services (not only those related to mental illness) is available, but is not sufficiently disaggregated for inclusion in this report.⁴³

Table 4 lists all major costs (direct and indirect) of supporting people with mental illness, as well as the group who spends the money in each cost category. The cost components covered in this report are italicised.

43. The most comprehensive examination of NGO expenditure is a 2009 ABS publication *Australian National Accounts: Non-Profit Institutions Satellite Account, 2006-07*. The publication provides statistics across a number of broad industry areas. Four areas are relevant to this project – education and research, health excluding hospitals, hospitals, and social services. These areas are not disaggregated further. This means it is not possible to make reliable estimates of expenditure to support people with mental illness. A number of expenditure components in this report include funding for NGOs to provide services.

Table 4: Summary of direct health expenditure to support people with mental illness

Group who spends the money	Area of costs	
	Major direct costs	Major indirect costs
People with mental illness	<ul style="list-style-type: none"> Medical expenditure, including out-of-pocket spending on:⁴⁴ <ul style="list-style-type: none"> mental health services provided by health professionals outside the public system (e.g. general practitioners, psychiatrists, psychologists) private mental health services, including drug and alcohol services medications ambulance and patient transport services private accident and emergency services counselling services Expenditure on paid carers 	<ul style="list-style-type: none"> Suffering, pain, disability and distress Negative impact on personal relations and connection to and participation in the community Lower educational attainment Forgone earnings
Carers and families	<ul style="list-style-type: none"> May also incur some of the costs attributed to the person with the mental illness (as set out above) 	<ul style="list-style-type: none"> Strain on relationships, emotional suffering, etc. Foregone earnings Mortality costs of family members

Group who spends the money	Area of costs	
	Major direct costs	Major indirect costs
Insurance companies	<ul style="list-style-type: none"> Private health insurance expenditure on:⁴⁵ <ul style="list-style-type: none"> Private mental health services, including drug and alcohol services Ambulance and patient transport services Private hospital inpatient services (e.g. psychiatrists) Medications Comorbid physical conditions Employee Assistance Programs for own staff Other mental health services for employees General and other insurer expenditure on: <ul style="list-style-type: none"> Workers' compensation payments Compulsory Third Party payments Total and Permanent Disability payments Income protection payments Life insurance premiums and payouts 	<ul style="list-style-type: none"> n/a
Corporate sector (ex. insurance companies)	<ul style="list-style-type: none"> Employee Assistance Programs Other health and wellbeing programs Expenditure by companies who self-insure for workers' compensation 	<ul style="list-style-type: none"> Lower profitability due to: <ul style="list-style-type: none"> staff not working at their full capacity due to mental illness staff absence from work caused by mental illness

44. Insurance premiums (including private health, workers' compensation and CTP insurance) are not incorporated in the expenditure estimates. It is assumed the cost of these is a component of the price of the final output.

Group who spends the money	Area of costs	
	Major direct costs	Major indirect costs
Governments	<ul style="list-style-type: none"> • Recurrent expenditure in health including: <ul style="list-style-type: none"> • <i>Pharmaceutical Benefits Schedule-subsidised medications</i> • <i>Medicare Benefit Schedule subsidised services</i> • <i>Public mental health services</i> • <i>Care for comorbid physical conditions</i> • <i>Public health promotion</i> • <i>Services to special populations (e.g. forensic, Australian Defence Force, refugee)</i> • <i>National programs and initiatives managed by DVA, DoHA and FaHCSIA and the National Suicide Prevention Program</i> • <i>Injury compensation insurance (Work Cover Australia)</i> • <i>Research</i> • Recurrent expenditure in non-health including: <ul style="list-style-type: none"> • <i>Income support, such as Disability Support Pension, Youth allowance, etc.</i> • <i>Support for carers</i> • <i>Non-income support including rent and transport assistance</i> • <i>Provision of various services such as housing, disability and justice services</i> • Capital expenditure in health (such as building new hospitals and facilities) • Capital in non-health (such as building new community care facilities) 	<ul style="list-style-type: none"> • Health costs treating the victims of crime where mental illness is a principal factor • Recurrent expenditure in non-health including: <ul style="list-style-type: none"> • <i>Services provided to care for children, dependents and families of people who suffer from mental illness</i> • <i>Justice costs for victims (such as of domestic violence) where mental illness is a principal factor</i>
NGOs (funded by a mix of governments, donations and service charges)	<ul style="list-style-type: none"> • NGOs provide a number of health services also provided by government including hospital services, psychological services and outreach services. • NGOs provide a number of non-health services also provided by government including disability services and housing support 	<ul style="list-style-type: none"> • n/a

This report is the first comprehensive estimate of health and non-health expenditure to support people with mental illness

Despite the significance of Australia's mental health challenge, and the greater attention that mental illness has received in recent years, comprehensive estimates of the costs of supporting people with mental illness are limited.

Previously, some components of costs have been examined in detail:

- The Australian Institute of Health and Welfare's (AIHW) *Mental health services in Australia* online resource⁴⁵ and annual publication *Mental Health Services – In Brief 2011*⁴⁶ provide comprehensive health expenditure data by the Australian and state / territory governments, with limited data on expenditure by private health funds. It reports expenditure of at least \$5.8 billion on mental health-related services in 2008-09. This figure includes only certain components of Australian Government, state / territory government and private health insurer expenditure.
- The Productivity Commission's annual *Report on Government Services*⁴⁷ chapter on mental health, and the Department of Health and Ageing's *National Mental Health Report*,⁴⁸ include expenditure on mental health services by the Australian and state / territory governments. The Productivity Commission considers mental health services expenditure by the Australian and state/territory governments only. It reported expenditure of \$6.1 billion in 2009-10.

- The costs of some mental health conditions have been considered in reports on specific mental illnesses.⁴⁹
- An estimate of the Australian government's 2001-02 health and non-health expenditure on mental illness was included in the Australian Government's submission to the 2005 Senate Enquiry into the Provision of Mental Health Services in Australia.⁵⁰
 - The estimate of health expenditure was \$3.09 billion. This comprised expenditure by the Australian Government (\$1,146m), private health insurers (PHI) (\$145m) and states/territories (\$1,798m)
 - The estimate of total non-health (referred to as "indirect") Australian Government expenditure on mental health was \$3.7 billion. This is comprised of income support payments (\$2b), aged care programs (\$1.3b), veteran's disability compensation (\$180m), housing (\$109m), employment (\$71m), disability services (\$43m) and home and community care programs (\$10m). The submission notes this figure is drawn from data provided by Australian Government departments. No further detail, or the methodology used to calculate expenditure, is provided.

This report builds on these studies. It provides an estimate of **direct health and non-health expenditure** for supporting people with mental illness. Relative to the Productivity Commission report, it includes a range of additional mental health expenditures (e.g. the impact of mental illness on the cost of treating comorbid physical conditions) and higher estimates for some services (e.g. drug and alcohol services).

45. AIHW (2010), *Mental Health Services in Australia*, HSE 88, Canberra. Available at: <http://mhsa.aihw.gov.au/home/>.

46. AIHW (2011), *Mental Health Services – in Brief 2011*, HSE 113, Canberra.

47. Productivity Commission (2012), *Report on Government Services 2012*, Canberra, p. 12-70.

48. Department of Health and Ageing (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra.

49. For example, the cost of autism spectrum disorder has been examined by Synergies Economic Consulting (2011), of schizophrenia and bipolar disorder by Access Economics (2002 and 2003 respectively) and psychosis by Barry Frost et al on behalf of the Low Prevalence Disorders Study Group (2002).

50. Australian Government (2005), *The Contribution of the Australian Government to Mental Health in Australia*, Submission 476 to the Senate Inquiry into the Provision of Mental Health Services in Australia.

Significant challenges exist to accurately estimate expenditure

It is difficult to estimate expenditure to support people with mental illness. A major reason for this difficulty is the fragmentation of Australia's mental health system (discussed in detail in Section 5). There is also fragmentation of social services and support payments.

Challenges related to each type of expenditure are described below.

Key challenges to estimate health expenditure

The fragmentation in health service delivery creates three broad challenges to estimate expenditure on mental health services: 1. data is often unavailable; 2. available data is not fully disaggregated; and 3. Medicare only partially maps services to mental illness. These points are discussed in turn.

1. Data is often unavailable

- In numerous cases, expenditure data on mental health services is not available. Reasons for this include: (i) data is not captured or (ii) data is deemed confidential and not publicly released. In addition, some data exists but is held within organisations and could not be accessed within the timeline of this project.
- Considerable information exists for government expenditure. Relatively little information is available for non-government expenditure, including for NGOs, private health insurers (PHI) and consumers. This means only a partial estimate is available for expenditure on many mental health services.

2. Available data is not fully disaggregated

- Overall *health* expenditure is available for many of the components examined in this report. Data is often unavailable for the proportion of that expenditure that is related to *mental illness*. This is the case for ambulance and patient transport, refugee health care, Australian Defence Force (ADF) health care, public health promotion and compulsory third party insurance payments. In these instances, we assume mental health expenditure is 7.0% of national (government and other) total expenditure on health services and 7.5% of government health spending (following estimates provided in the Department of Health and Ageing's National Mental Health Report).⁵¹
- The available mental health expenditure data is often only partially disaggregated (e.g. by service type or by disorder) or not disaggregated at all. For example, estimates exist for the overall health expenditure by PHIs. Limited information is available on PHI expenditure for key mental health services. The lack of disaggregation results in unavoidable double counting for some expenditure components as sub-components cannot be separately identified. This occurs in only a few instances, relates to a relatively small amount of expenditure and is noted in the appropriate places throughout this report.

51. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 24.

3. Medicare only partially maps services to mental illness

- Many Medicare item numbers are based on general parameters (such as duration of consultation, or 'initial' or 'follow-up' consultation) that do not specify the underlying condition. This means the true quantity of mental health-related services, and expenditure by the Australian Government and consumers on Medicare Benefits Schedule (MBS) subsidised mental health services, cannot be accurately determined. Three areas of expenditure in this report are affected – general practitioners (GPs), paediatricians and speech pathologists.
- Mental health-specific Medicare items are available for GPs. However, these do not apply to all GP consultations for mental health problems/mental illness. There is also evidence that a significant number of consultations are allocated to a general Medicare item number rather than a more appropriate mental health-specific Medicare item number. The Bettering the Evaluation and Care of Health (BEACH) data (based on a survey of GPs about the symptoms and disorders they manage) indicates GPs engage in a much greater number of mental health-related episodes of care than is suggested by the Medicare data.⁵²

These challenges mean estimates of expenditure for different mental health services are not directly comparable. Estimates for some services are based on more complete data than other services.

Key challenges to estimate non-health expenditure

The Australian and state / territory governments provide a range of transfer payments and social services to assist people. The impact of mental illness is one reason, typically of many, why people may receive assistance.

Available data is not typically disaggregated to show expenditure attributable to various 'reasons', such as mental illness, for the person needing the support. To estimate expenditure, this report uses the proportion of recipients of payments or services whose principal reason for assistance is mental illness.⁵³ This proportion is clear for some payments and services (see the list to the right). In others, determining this proportion is difficult. Two examples illustrate the challenge:

- A significant proportion of people who receive homelessness services suffer from mental illness and / or have a high-level of psychological distress.⁵⁴ Mental illness or psychological distress may be a major *cause* of a person's homelessness; yet it can also be a *consequence* of being homeless. It then becomes difficult to estimate expenditure on homelessness (and housing services) that flows directly from people suffering mental illness.
- A significant proportion of people in detention or correctional facilities suffer from mental illness and / or have a high-level of psychological distress.⁵⁵ Mental illness may be a *contributing factor* behind the crime that led to incarceration, though it could also be unrelated. Mental illness and psychological distress may also flow from incarceration. As with

homelessness services, it is difficult to estimate expenditure on detention/correctional services that results directly from people suffering mental illness.

In a number of non-health payments and services where data is available, the proportion of expenditure directly related to mental illness is around 30%. Some examples are:

- Disability Support Payments (DSPs) – The proportion of total DSP recipients whose primary medical condition is classified as 'Psychological / Psychiatric' is 29%.⁵⁶
- Disability services – The proportion of users of National Disability Agreement services whose primary disability is mental illness is 30.1%.⁵⁷
- Employment services – The proportion of job seekers assisted by Commonwealth Rehabilitation Services Australia who had a mental health condition as the primary barrier to entering the workforce is 31.7%.⁵⁸

These examples cover both transfer payments and the delivery of government services, all with separate eligibility criteria. This suggests that where a more exact proportion is not available, a figure of 30% is a reasonable assumption to make for the proportion of expenditure due to mental illness. This proportion is used to estimate elements of expenditure in: income support; non-income support; services for those with disability; housing and homelessness; and education. The robustness of this approach was confirmed by discussions with a number of government policy experts.

52. AIHW (2010), *Mental Health Services in Australia*, HSE 88, Canberra. Available at: <http://mhsa.aihw.gov.au/home/>. The Bettering the Evaluation and Care of Health (BEACH) survey is an annual survey of GP activity conducted by the Family Medicine Research Centre, University of Sydney, in collaboration with AIHW. The survey uses a random sample of 1,000 GPs who each report details of 100 consecutive GP encounters. These details include information about the patient (including demographics, risk factors and health status), consultation, problems managed, management of each problem, and the GP.

53. This report does not consider whether the value of transfer payments received, or the costs of services provided, varies according to the circumstances of the individual who receives assistance.

54. For example, a study by Mission Australia (2012) noted that 46.2% of Sydney men assisted in a homeless program suffered from high or very high psychological distress and 50% suffered from a substance-use disorder (Mission Australia (2012), *The Michael Project, 2007-2010: New perspectives and possibilities for homeless men*, Sydney, p. 28).

55. For example, a 2009 NSW survey reported that 86.7% of juveniles in custody suffered from any psychological disorder and 72.7% suffered from two or more disorders (Indig, D. et al (2012) *2009 NSW Young People in Custody Health Survey: Full Report*, Sydney: Justice Health and Juvenile Justice, p. 145). The identified disorders and proportion of those affected were: any attention and/or behaviour disorder (69.6%); any alcohol and/or substance disorder (63.5%); any anxiety disorder (31.7%); any mood disorder (23.5%); and any schizophrenic and/or other psychotic disorder (5.5%).

56. FaHCSIA (2011), *Characteristics of Disability Support Payments Recipients*, p. 21.

57. Productivity Commission (2012), *Report on Government Services 2012*, Attachment Tables, Table 14A.14. Mental illness is defined as the following conditions – development delay, specific learning autism and psychiatric. The value is calculated as a proportion of those conditions reported.

58. Department of Human Services (2011), *Annual Report 2010-11*, p. 77.

This report uses a conservative approach to estimate expenditure

The estimation technique for each component of health expenditure and non-health expenditure is detailed in a separate *Detailed expenditure calculations* companion document (available upon request).

This report takes a conservative approach to estimate expenditure. This means a number of the figures presented are likely to underestimate true expenditure. These figures are highlighted in Sections 6.2 to 6.4 with an asterisk (*). In a small number of instances, the absence of suitably disaggregated data has resulted in the possibility of a double count occurring. These double counts are typically of relatively small value and are noted in this report when they may occur.

All expenditure and related data presented in this report are for 2010-11, unless noted otherwise. In some instances, the latest available data is for earlier years. Such data has been adjusted using the relevant inflation rate (to account for price changes) and population growth rates (to account for volume changes). In other instances, where national data or complete state and territory data are not available, extrapolations are made on the basis of state and territory population.

Note that some totals in this report may not sum due to rounding.

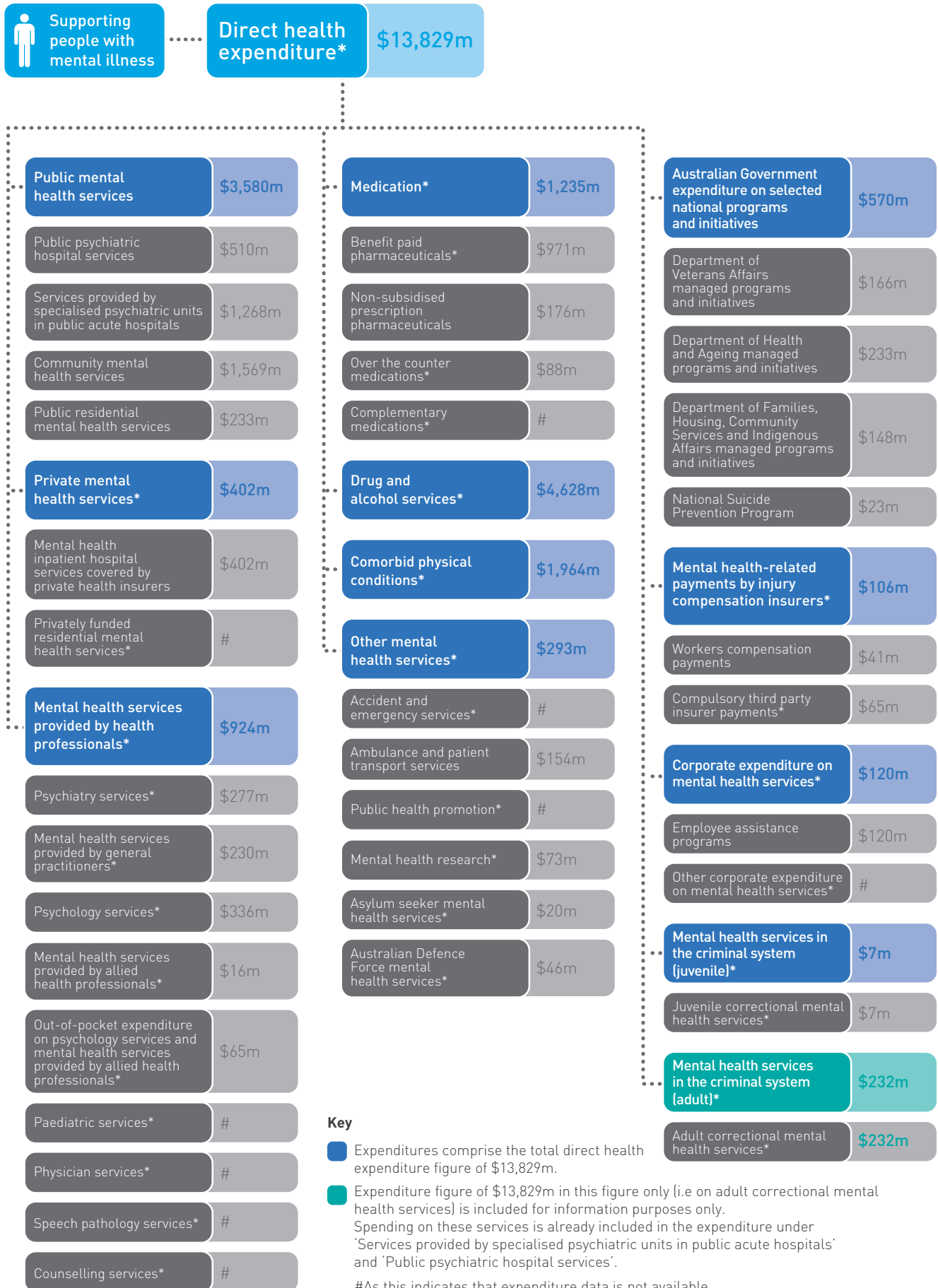
6.2 There are many components of direct health and non-health expenditure

The \$28.6 billion estimation of total expenditure was determined by adding together direct health and direct non-health expenditure to support people with mental illness. The components of each are summarised in Figure 5 and Figure 6 on the following two pages and discussed in detail in Sections 6.3 and 6.4 respectively.

It is worth noting that direct expenditure on non-health services for the mentally ill exceeds direct health care spending. Some components of non-health expenditure are substantial and growing rapidly. For example, the DSP provides income support to people with a physical, intellectual or psychiatric impairment that prevents them from

working for more than 15 hours per week. The number of DSP recipients whose primary medical condition is psychological / psychiatric has increased more than three times faster than all other DSP recipients. DSP expenditure related to mental illness was \$3.9 billion in 2010-11.

Figure 5: Components of health expenditure to support people with mental illness



Key

- Expenditures comprise the total direct health expenditure figure of \$13,829m.
- Expenditure figure of \$13,829m in this figure only (i.e. on adult correctional mental health services) is included for information purposes only. Spending on these services is already included in the expenditure under 'Services provided by specialised psychiatric units in public acute hospitals' and 'Public psychiatric hospital services'.

#As this indicates that expenditure data is not available

*An asterisk indicates the expenditure estimate provided is an underestimate of the true value.

Note that certain totals may not sum due to rounding.

Figure 6: Components of non-health expenditure to support people with mental illness



Key

- Expenditure related to support payments
- Expenditure related to services provided.

*An asterisk indicates the expenditure estimate provided is an underestimate of the true value.

Note that certain totals may not sum due to rounding.

6.3 Direct health expenditure is at least \$13.8 billion per annum

Total direct health expenditure on mental health services was at least \$13.8 billion in 2010-11. This includes expenditure by the Australian Government, state / territory governments, NGOs, private health insurers, consumers and the broader corporate sector. Some key insights on health expenditure are in Box 2.

Box 2: Key insights on health expenditure

- Total estimated direct expenditure on mental health care is \$13.8 billion. This compares to:
 - total Australian Government expenditure on health and pharmaceuticals of \$56 billion in 2010-11⁵⁹
 - total state/territory government expenditure on health of \$51.7 billion in 2010-11.⁶⁰
- Expenditure on drug and alcohol services is the largest element of the known expenditure on mental health care services (\$4,628 million, and the true figure is probably larger).
- Increased expenditure on health care services for treating chronic physical conditions where the patient had a comorbid mental illness is substantial (\$1,964 million, and the true figure is probably larger).
- Expenditure on specialised public hospital mental health services is over four times larger than expenditure on mental health inpatient services covered by private health insurers (\$1,778 million compared to \$402 million).
- Available expenditure data indicates spending on psychology services is the largest share of expenditure on other mental health services provided by health professionals (\$336 million). Expenditure on mental health services provided by GPs is likely to be significantly larger, but robust data is not available.
- Of the mental health funding provided by the Australian and state/territory governments and private health insurers, 36.0% is from the Australian Government, 60.5% is from state/territory governments and 3.5% is from the private health insurers.^{61,62} Of the Australian Government funding, 4.2% is provided as grants to the states and territories.⁶³

The estimate of \$13.8 billion is likely to significantly underestimate true expenditure. For a number of services, expenditure is only available for some groups (for example, governments) and not available for other groups (such as consumers). For other health expenditure, no estimate is possible as data is not available.

The main categories of services and their associated expenditures are illustrated in Figure 7. The light blue columns (i.e. public mental health services and Australian Government expenditure on national programs and initiatives) reflect service areas where a complete estimate of expenditure is available. The dark blue columns indicate service areas where only a partial estimate exists.

59. ABS (2011), *Government Finance Statistics, Australia, 2010-11*, Canberra, Table 130.4 – Commonwealth General Government Expenses by Purpose.

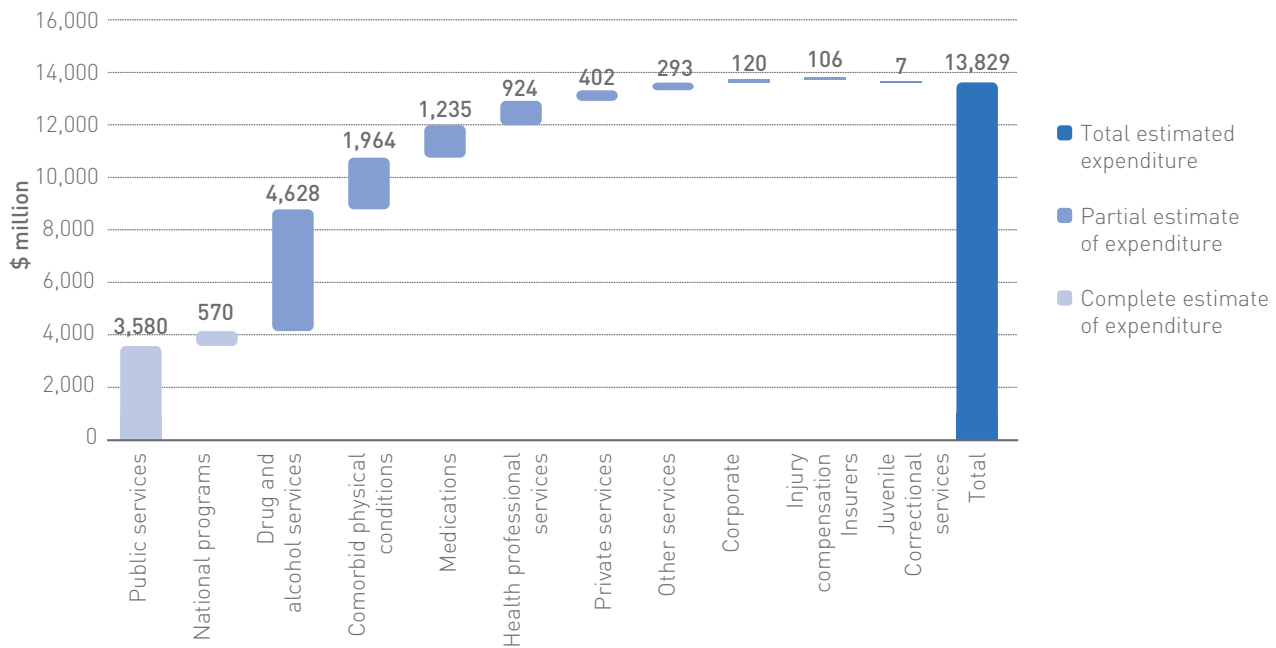
60. ABS (2011), *Government Finance Statistics, Australia, 2010-11*, Canberra, Table 239.4 – Total State General Government Expenses by Purpose.

61. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Canberra.

62. Funding by consumers, NGOs and the broader corporate sector is not considered here.

63. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Canberra.

Figure 7: Estimated direct health expenditure on mental health services in 2010-11 (\$m)



Box 3: Differences in per capita spend on mental health services for Indigenous compared to non-Indigenous Australians

Per capita expenditure on mental health services varies across population groups. The most striking example is the difference between the amount spent on Indigenous Australians and non-Indigenous Australians. Expenditure by the Australian and state / territory governments on two public mental health services in 2008-09 illustrates this difference:

- Expenditure on hospital-based mental health institutions was \$98 per capita for Indigenous Australians compared to \$31 for non-Indigenous people.
- Expenditure on community mental health services was \$163 per capita for Indigenous Australians compared to \$83 for non-Indigenous people.

Reasons for this discrepancy include: the considerable disadvantage of Indigenous Australians relative to non-Indigenous Australians; the higher cost of service provision in remote areas; and greater intensity of service use.⁶⁴ (Indigenous Australians use both Indigenous-specific and mainstream services.)

This report does not consider expenditure across specific population groups in any detail. A brief discussion about expenditure on mental health services for Indigenous compared to non-Indigenous Australians is presented in Box 3. Expenditure on mental health-related programs and initiatives targeted to assist particular at-risk populations (for example Indigenous Australians) may not be explicitly identified but is included in the expenditure estimates provided in this report.

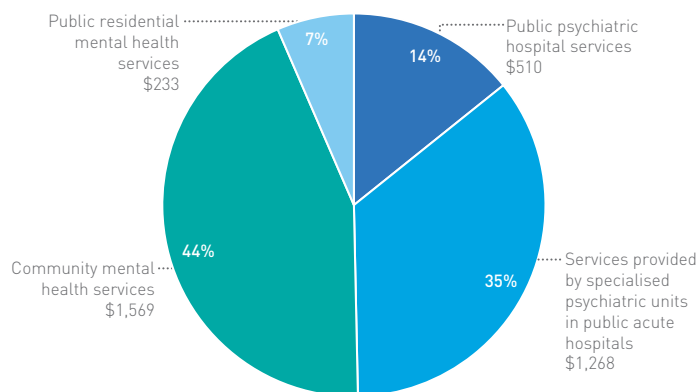
The remainder of this section describes each component of health expenditure in turn. The specific estimation method used for each component is described in detail in the *Detailed expenditure calculations* companion document (available upon request).

64. Statistics are from IERSC, *Indigenous Expenditure Report Steering Committee* (2010), Canberra, Table F.2 Hospitals 2008-09, p. 286 and Table F.3, p. 290, discussion, p. xix.

Public mental health services (\$3,580 million)

Public specialised mental health services are provided through public psychiatric hospitals, specialised psychiatric units or wards in public hospitals, community mental health facilities and residential mental health facilities. The expenditure on these facilities is illustrated in Figure 8 and described in greater detail in Table 5. All figures are derived from AIHW's Mental health services in Australia, 2008-09 and, like the majority of other expenditure figures, are presented in 2010-11 details.⁶⁵ Some key statistics on service delivery are provided in Table 6.

Figure 8: Expenditure on public specialised mental health services (\$m), 2010-11



Source: Based on Australian Institute of Health and Welfare (2010), *Mental health services in Australia, 2008-09: 14 Expenditure on mental health services (version 1.1) data tables*. Available at: <http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=8589934607&libID=8589934607>, Table 14.1.

Table 5: Expenditure on public mental health services

Expenditure component	Description	Amount (\$m)
Public psychiatric hospital services	Expenditure by state / territory governments on mental health services for admitted patients which occur partly or completely in a public psychiatric hospital (e.g. The ParkCentre for Mental Health in QLD). A component of expenditure on adult correctional mental health services is included here. Specialist public drug and alcohol services are excluded as they are incorporated in the 'Drug and alcohol services' section.	\$510
Services provided by specialised psychiatric units in public acute hospitals	Expenditure by state / territory governments on mental health services for admitted patients that occur partly or completely in a specialised psychiatric unit of a public acute hospital (e.g. The Kilo Centre at The Prince of Wales Hospital, Sydney). A component of expenditure on adult correctional mental health services is included in this total. Specialist public drug and alcohol services are excluded as they are incorporated in the 'Drug and alcohol services' section.	\$1,268
Community mental health services	Expenditure by state / territory governments on services provided in public hospital outpatient departments and public non-hospital community mental health care services (including crisis / mobile assessment and treatment services, day programs, outreach services and consultation / liaison services). This excludes public specialist drug and alcohol services as they are incorporated in the 'Drug and alcohol services' section.	\$1,569
Public residential mental health services	Expenditure on residential mental health services that are partially or entirely government-funded and non-government operated. This excludes public specialist drug and alcohol services as they are incorporated in the 'Drug and alcohol services' section.	\$233
Total		\$3,580

65. AIHW (2010), *Mental health services in Australia, 2008-09, Expenditure on mental health services (version 1.1) data tables*, Table 14.1. Available at: <http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=8589934607&libID=8589934607>.

Table 6: Usage of mental health services in 2008-09⁶⁶

Mental health service	Number of people who accessed the service	Number of separations / episodes of care	Age group with highest usage rate	Most common principal diagnoses
Inpatient hospital services in both public and private hospitals	Not available	215,000 (2.6% of all hospital separations)	Separations with specialised psychiatric care: 35-44 years Separations with non-specialised psychiatric care: 65 years and above	Separations with specialised psychiatric care: Depressive episode and recurrent depressive disorders (greater than 25% of separations) Separations with non-specialised psychiatric care: mental and behavioural disorders due to use of alcohol followed by depressive episode
Public community mental health services	336,000	Over 6 million	Not available	Schizophrenia (nearly one-third of contacts) Depressive episode (11.9%) Bipolar affective disorder (6.4%)
Public residential mental health services	2,400	3,500	25-34 years	Schizophrenia, followed by schizoaffective disorder and depressive episode

Private mental health services (\$402 million*)

The major component of private mental health service expenditure is inpatient hospital services (in both private and public hospitals) that are covered by private health insurers. In 2008-09, these services were provided through 50 private psychiatric hospitals and 156 public hospitals which deliver

specialised psychiatric services.⁶⁷ Total expenditure on inpatient services is estimated using Medibank data.

The remainder of private mental health services is delivered through privately funded residential mental health facilities. An estimate of this expenditure is not available, however, it is likely to be small.

Expenditure on private mental health services is detailed in Table 7.

Table 7: Expenditure on private mental health services

Expenditure component	Description	Amount (\$m)
Mental health inpatient hospital services covered by private health insurers	Expenditure by PHIs and consumers on inpatient mental health services for privately insured patients in private and public hospitals. This includes medical, hospital and inpatient pharmaceutical costs borne by the PHI and consumer (as out-of-pocket expenditure). It excludes inpatient hospital services related to drug and alcohol Diagnostic Related Groups (DRGs) as these are incorporated in the 'Drug and alcohol services' section.	\$402
Privately funded residential mental health services	Expenditure by PHIs and consumers on residential mental health services that do not receive any government funding. Discussions with industry experts indicate there are likely to be few, if any, of this type of residential mental health service.	Not available
Total		\$402*

66. AIHW (2011), *Mental health services – in brief 2011*, AIHW Cat. No. HSE 113, Canberra, p. 6-7, 12-13, 15-17.

67. AIHW (2011), *Mental health services – in brief 2011*, AIHW Cat. No. HSE 113, Canberra, p. 25.

Other mental health services provided by health professionals (\$924 million*)

Mental health services are provided by a range of health professionals including psychiatrists, paediatricians, physicians, GPs, psychologists, allied health professionals, speech pathologists and counsellors. These services are paid for by the Australian Government (as Medicare benefits), private health insurers (as benefits) and / or consumers (as out-of-pocket expenditure). Estimates based on AIHW data suggest total consumer out-of-pocket expenditure on mental health care services was \$1,086 million in 2010-11 and total out-of-pocket expenditure for psychiatrists, paediatricians and physicians was \$173 million.⁶⁸ The expenditure estimates in this section exclude out-of-pocket expenditure as this latter figure cannot be disaggregated.

There is also evidence that expenditure on GP mental health services is significantly underestimated. This is discussed in Box 4.

Data on GP management of mental health issues is presented in Box 5.

Box 4: Available data likely underestimates expenditure on mental health-related GP encounters

Medicare is the principal source of data for expenditure on GP visits. Total Australian Government expenditure (paid as Medicare benefits) and consumer out-of-pocket expenditure on mental health-related GP visits was \$230 million in 2010-11. This is likely to significantly underestimate true expenditure.

There is evidence of substantial under-reporting of mental health-related consultation. Medicare reports 1.8 million mental health-specific MBS-subsidised GP items in 2009-10. The BEACH survey reports 13.3 million encounters during which a mental health problem was managed and a further 2.7 million encounters during which psychologically related management was commenced (but a specific mental health problem was not identified).

The Medicare data is preferred as the BEACH survey uses a broader definition of mental illness than this report, with the inclusion of mental retardation (among other areas). The BEACH data does allow an estimate of mental health expenditure consistent with the definition used in this report (through the Family Medicine Research Centre at The University of Sydney), but such as estimation was not feasible for this report.

Box 5: GP management of mental health issues

The most common form of GP management for mental health in 2009-10, according to the BEACH data, was to prescribe, provide or suggest a medication to manage a mental health-related issue. This was followed by the provision of advice, counselling or other treatment. The mental health-related problems most commonly managed by GPs were depression, followed by anxiety and sleep disturbance. The relative expenditures on the 10 most commonly managed mental health-related problems by GPs are outlined in the following table.

Mental health-related problems managed	Proportion of total mental health-related problems managed	Approximate expenditure on GP services (\$m)
Depression	35.2%	\$81.0
Anxiety	14.7%	\$33.8
Sleep disturbance	12.0%	\$27.6
Tobacco abuse	6.3%	\$14.5
Acute stress reaction	4.9%	\$11.3
Dementia	3.9%	\$9.0
Schizophrenia	3.5%	\$8.1
Alcohol abuse	3.2%	\$7.4
Drug abuse	3.0%	\$6.9
Affective psychosis	2.2%	\$5.1

Source: Based on AIHW (2010), *Mental health services in Australia*, Table 2.3 'The 10 most frequent mental health-related problems managed, BEACH, 2009-10', Available at: <http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=25769803851&libID=25769803851>

68. AIHW (2011), *Health expenditure Australia 2009-10*, Cat no. HWE 55, Canberra, Table 3.7, p. 31 and Table 3.9, p. 34.

The Better Access initiative, introduced in November 2006, has led to a significant increase in the number of MBS-subsidised specialised mental health services⁶⁹ and Australian Government expenditure on Medicare benefits for these services. Services provided by psychologists account for the majority of this increase (and to a lesser extent services from GPs and allied health professionals, i.e. social workers and occupational therapists). The Better Access scheme is discussed further in Section 8.

Expenditure amounts on other mental health services provided by health professionals are detailed in Table 8. Estimates for mental health services provided by psychiatrists, GPs, psychologists and allied health professionals are based on Medicare expenditure in the AIHW *Mental health services in Australia, 2008-09* Section 14 data tables.⁷⁰

Additional expenditure is included for the following services:

- GP services – consumer out-of-pocket spend from additional Medicare data^{71,72}
- allied health services – data from an evaluation of the Better Access scheme⁷³
- psychology services – extrapolation based on Medibank data.

Table 8: Expenditure on mental health services provided by health professionals

Expenditure component	Description	Amount (\$m)
Psychiatry services	Expenditure on psychiatry services through a combination of Australian Government Medicare benefits, consumers' out-of-pocket expenses and / or PHI benefits. This figure only includes Australian Government expenditure, as out-of-pocket and PHI expenditures (for inpatient hospital services) are not available. (Total expenditure on inpatient medical services related to mental health can be estimated using Medibank data, but it is not possible to determine the proportion attributable to psychiatry services.) A component of this expenditure may be double-counted in the 'Drug and alcohol services' section.	\$277*
Mental health services provided by GPs	Expenditure on GP services through Australian Government Medicare benefits and consumer out-of-pocket expenditure. This value, derived from Medicare data, is a conservative estimate of total expenditure on mental health services provided by GPs based on a comparison with data from the BEACH survey. ⁷⁴	\$230*
Psychology services	Expenditure on psychology services by the Australian Government (through Medicare benefits) and PHIs. The remaining expenditure, out-of-pocket expenditure on private psychology services where the entire cost is borne by the consumer, is likely to be significant but is not available. (Out-of-pocket expenditure related to services provided through the Better Access scheme is included in the section 'Out-of-pocket expenditure on psychology services and mental health services provided by allied health professionals'.)	\$336*

69. AIHW (2011), *Mental health services – in brief 2011*, AIHW Cat. No. HSE 113, Canberra, p. 3-4.

70. AIHW (2010), *Mental health services in Australia, 2008-09*, Expenditure on mental health services (version 1.1) data tables, Table 14.11. Available at: <http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=8589934607&libID=8589934607>.

71. DoHA (2011), *Medicare Statistics – December Quarter 2011*, Table B2A. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/BF0C7BDDBB0840FBCA2579AD007E3F59/\\$File/tableb2a.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/BF0C7BDDBB0840FBCA2579AD007E3F59/$File/tableb2a.pdf).

72. DoHA (2011), *Medicare Statistics – December Quarter 2011*, Table B4A. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/BF0C7BDDBB0840FBCA2579AD007E3F59/\\$File/tableb4a.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/BF0C7BDDBB0840FBCA2579AD007E3F59/$File/tableb4a.pdf).

73. Ftanou, M. et al (2011), *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, Centre for Health Policy, Programs and Economics (The University of Melbourne), February 2011, Table 5, p. 24.

74. AIHW (2010), *Mental Health Services in Australia*, HSE 88, Canberra. Available at: <http://mhsa.aihw.gov.au/home/>.

Expenditure component	Description	Amount (\$m)
Mental health services provided by allied health professionals	Expenditure on services by the Australian Government (through Medicare benefits). The remaining expenditure, out-of-pocket expenditure on private allied health services where the entire cost is borne by the consumer, is likely to be small and is not available. (Out-of-pocket expenditure related to services provided through the Better Access scheme is included in the section 'Out-of-pocket expenditure on psychology services and mental health services provided by allied health professionals'.)	\$16*
Out-of-pocket expenditure on psychology services and mental health services provided by allied health professionals	This element comprises a portion of the out-of-pocket expenditure related to the previous two rows. It is expenditure by consumers on services provided through the Better Access scheme by clinical psychologists, psychologists, social workers and occupational therapists.	\$65*
Paediatric services	An estimate of expenditure on paediatric services related to mental illness is not available. Expenditure on paediatric services provided through specialised public mental health units is captured in the 'Public mental health services' section. Services provided to privately insured inpatients are included in the 'Mental health inpatient hospital services covered by private health insurers' section. Expenditure in the form of Medicare benefits and consumer out-of-pocket spending cannot be determined.	Not available
Physician services	An estimate of expenditure on physician services related to mental illness is not available. The majority of these services relate to the management of substance use disorders. Therefore, much of this expenditure will already be captured in the 'Drug and alcohol services' section. Services provided to privately insured inpatients are included in the 'Mental health inpatient hospital services covered by private health insurers' section. Expenditure in the form of Medicare benefits and consumer out-of-pocket spending cannot be determined.	Not available
Speech pathology services	A separate estimate of expenditure on speech pathology services related to mental illness is not available. Expenditure on speech pathology services provided through specialised public mental health units is captured in the 'Public mental health services' section. Medicare benefits, consumer out-of-pocket and PHI expenditure cannot be determined.	Not available
Counselling services	Expenditure on counselling services is not available. Counselling is an unregulated industry. Counsellors are not required to be registered with a single industry body and there are a number of different industry bodies. The costs of counselling services are overwhelmingly borne by the consumer as an out-of-pocket expense. According to industry experts, there is only one legacy extras private health insurance package that pays benefits for counselling services.	Not available
Total		\$924*

Medications (\$1,235 million*)

Medications used to manage mental disorders can be classified in four broad categories. A description of these categories, the estimation approach used and estimated expenditure are detailed in Table 9.

In 2009-10, approximately 22 million benefit-paid prescriptions and seven million non-subsidised prescriptions for mental health-related medications were dispensed.⁸⁰ Of the benefit-paid prescriptions, 58.9% were for

antidepressants, 14.2% for anxiolytics, 12.1% for antipsychotics, 11.1% for hypnotics and sedatives, 2.3% on psychostimulants and nootropics, and 1.3% on other mental health-related medication.⁸¹

Table 9: Expenditure on mental health-related medications

Expenditure component	Description	Estimation approach	Amount (\$m)
Benefit paid pharmaceuticals	Expenditure by the Australian Government on Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) mental health-related medications (other than those only used in the management of alcohol, tobacco and illicit drug attributable conditions. A partial estimate of expenditure on these medications is included under drug and alcohol services. It excludes Australian Government expenditure on relevant medications in the NT that are provided through special provisions under Section 100 of the National Health Act 1953 for Indigenous Australians in remote areas (less than \$26 million) due to a lack of available information.	Sum of expenditure on: <ul style="list-style-type: none"> PBS and RPBS mental health-related medications presented in the AIHW Mental health services in Australia, 2008-09 Section 14 data tables⁷⁵ an estimate of out-of-pocket expenditure derived from a DoHA data table.⁷⁶ 	\$971*
Non-subsidised prescription pharmaceuticals	Expenditure by consumers on private prescriptions for medications not listed on the PBS and under co-payment prescriptions (i.e. PBS-listed pharmaceuticals with a total cost under the co-payment level such that the consumer covers the entire cost). This cost is entirely borne by the consumer.	An estimate of total expenditure on all non-subsidised prescriptions ⁷⁷ is multiplied by the estimated proportion of all non-subsidised prescriptions that relate to mental health ^{78,79}	\$176
Over the counter medications	Expenditure by consumers on items related to smoking cessation. Estimates of expenditure on all other relevant over the counter medications are not available.	Estimated by applying the proportion of over the counter sales of medications associated with smoking cessation to the total pharmacy over the counter sales.	\$88*
Complementary medications	Expenditure on mental health-related complementary medications is not available.	Not available	Not available
Total			\$1,235*

75. AIHW (2010), *Mental health services in Australia, 2008-09*, Expenditure on mental health services (version 1.1) data tables, Table 14.11. Available at: <http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=8589934607&libID=8589934607>.

76. DoHA (2011), *Table 7(a): Significant drug groups (incl. Drs bag) by highest Government cost, year-end: Jun 2010 to year end: Jun 2011 – Section 85 Only*. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/99A860532C73A1EFCA257947008239E8/\\$File/J%20Table%207a.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/99A860532C73A1EFCA257947008239E8/$File/J%20Table%207a.pdf).

77. AIHW (2011), *Health expenditure Australia 2009-10*, Cat no. HWE 55, Canberra, Table 4.15, p. 70.

78. AIHW (2011), *Mental Health Services- in Brief 2011*, HSE 113, Canberra, p. 21.

79. DoHA (2011), *Australian Statistics on Medicines 2009*, Canberra, Table C (iii), p. 26.

80. AIHW (2011), *Mental health services – in brief 2011*, AIHW Cat. No. HSE 113, Canberra, p. 21.

81. AIHW (2010), *Mental health services in Australia*, Table 11.2 'Mental health-related subsidised prescriptions, by type of medication prescribed(a) and prescribing medical practitioner, 2009-10', Available at: <http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=2147484128&libID=2147484125>.

Drug and alcohol services (\$4,628 million*)

Drug and alcohol services comprise the largest component of known expenditure on health care services in this report. The estimated expenditure includes drug and alcohol medical and hospital services, and select pharmaceuticals. It excludes other aspects of drug and alcohol services, such as drug education. True expenditure is thus likely to be much greater than \$4,628 million. Further detail is provided in Table 10.

Comorbid physical conditions (\$1,964 million*)

Expenditure on health care services for chronic physical conditions linked to poor mental health is considerable. The estimate is calculated using the technique presented by Naylor et al (2012)⁸³ for the UK and is based on

AIHW data. It is likely to underestimate true expenditure on comorbid physical conditions as the data only includes: (1) people aged 16-85 years; and (2) the top 12 chronic physical illnesses. Table 11 provides further explanation.

Table 10: Expenditure on drug and alcohol services

Expenditure component	Description	Estimation approach	Amount (\$m)
Drug and alcohol services	Expenditure on medical and hospital services and prescription pharmaceuticals utilised for alcohol- or tobacco-attributable conditions that appear in the one hundred highest cost medications covered by the PBS. It excludes drug-related education, research and drug programs as robust estimates of these costs are unavailable.	Calculated as the sum of: <ul style="list-style-type: none"> • drug and alcohol pharmaceutical expenditure • drug and alcohol medical and hospital service expenditure.⁸² 	\$4,628*
Total			\$4,628*

Table 11: Expenditure on comorbid physical conditions

Expenditure component	Description	Estimation approach	Amount (\$m)
Comorbid physical conditions	Expenditure by the Australian, state / territory governments, PHIs, individuals, NGOs and other sources on healthcare services for chronic physical conditions that is linked to poor mental health. This figure is an underestimation of the true cost because: it does not consider people with comorbid physical conditions who are aged less than 16 years or over 85 years; and it only considers 12 key chronic illnesses. Additionally, this estimate is based on data from 2000-01 and patterns of comorbidity may have changed since then.	The estimation follows the technique used for the UK by Naylor et al (2012), ⁸⁴ drawing on relevant Australian data. It is calculated using the proportion of total health spending that constitutes the extra spend on chronic physical conditions due to a mental health comorbidity. This proportion, in turn, draws on the: <ul style="list-style-type: none"> • average increase in cost of treating chronic physical conditions for those with mental health comorbidity • proportion of people with a physical condition and a mental health comorbidity • total health expenditure • recurrent expenditure on 12 major diseases. 	\$1,964*
Total			\$1,964*

82. Collins, D. and Lapsley, H. (2008), The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004-05, National Drug Strategy Monograph Series, No. 64, Table 18, p. 51.

83. Naylor, C. et al (2012), *Long-term conditions and mental health: the cost of co-morbidities*, The King's Fund and Centre for Mental Health, UK.

84. Naylor, C. et al (2012), *Long-term conditions and mental health: the cost of co-morbidities*, The King's Fund and Centre for Mental Health, UK.

Other mental health services (\$293 million*)

The category of other mental health services is broad, comprising a range of disparate services which include: accident and emergency services; ambulance and patient transport services; public health promotion;

research; mental health services provided for asylum seekers; and mental health services provided by the Australian Defence Force.

Data deficiencies mean expenditure for a number of services are underestimated.

For some elements estimates are not available, such as expenditure on accident and emergency department services (see Box 6). A description of the various services and estimated expenditure are in Table 12.

Box 6: Mental health-related emergency department usage

Mental health-related visits to emergency departments increased at an average annual rate of 5.5% from 2004-05 to 2008-09,⁸⁵ somewhat higher than all emergency department visits [4.6%.⁸⁶ In 2008-09, there were 172,000 mental health-related visits to public hospital emergency departments, of which 65% were for people aged 15-44.⁸⁷ Just over a third of visits resulted in a hospital admission.

In 2008-09, the most common principal diagnoses for mental health-related episodes of care in public hospital emergency departments in descending order were: neurotic, stress-related and somatoform disorders (27.9%); mental and behavioural disorders due to psychoactive substance use (25.1%); mood disorders (16.7%); and schizophrenia spectrum disorders (13.6%).⁸⁸

85. AIHW (2011), *Mental health services – in brief 2011*, AIHW Cat. No. HSE 113, Canberra, p. 8.

86. AIHW (2010), *Australian hospital statistics 2008-09*, AIHW Cat. No. HSE 84, Canberra, p. viii.

87. AIHW (2010), *Mental health-related emergency department occasions of service [a] in public hospitals, by patient demographic characteristics, 2008-09*, Mental health services in Australia, Canberra, Table 3.3, available online at: <http://mhsa.aihw.gov.au/home/>.

88. AIHW (2010), *Mental health services in Australia*, Canberra, Table 3.4: 'Mental health-related emergency department occasions of service [a] in public hospitals, by principal diagnosis, states and territories, 2008-09'. Available online: <http://mhsa.aihw.gov.au/home/>.

Table 12: Expenditure on other mental health services

Expenditure component	Description	Estimation approach	Amount (\$m)
Accident and emergency services	<p>An estimate of the cost of mental health-related accident and emergency services is not available. Public and private expenditure is treated as follows:</p> <ul style="list-style-type: none"> Public – Expenditure on public accident and emergency services is captured in ‘Public mental health services’ expenditure (Section 6.3.1). It is included in the elements ‘Public psychiatric hospital services’ and ‘Services provided by specialised psychiatric units in public acute hospitals’ but cannot be broken out as a separate estimate. Private – An estimate of expenditure on private accident and emergency services is not available. Industry experts consulted indicate this amount is likely to be minimal. 	Not available	Not available
Ambulance and patient transport services	<p>Expenditure by state / territory governments on ambulance and non-emergency patient transport services, and by the Royal Flying Doctor Service (NGO) on transport services. Expenditure on services provided by the RFDS in Western Australia is double-counted. The value of this amount is small (less than \$5 million).</p>	<p>Total expenditure is based on:</p> <ul style="list-style-type: none"> total state / territory government expenditure on ambulance and patient transport services total Royal Flying Doctor Service expenditure.⁸⁹ <p>The relevant proportion of expenditure is assumed to follow the proportion of mental health services expenditure in government health spending and national total gross recurrent expenditure respectively.⁹⁰</p>	\$154
Public health promotion	<p>A separate estimate of expenditure on public health promotion is not available. Expenditure by the Australian and state / territory governments is included in multiple other sections of this report. Expenditure by not-for-profit and for-profit organisations is not available.</p>	Not available	Not available

89. Royal Flying Doctor Service (2011), *Royal Flying Doctor Service Australian Council: Annual Report 10/11*. Available at: <http://www.flyingdoctor.org.au/ignitionSuite/uploads/docs/Annual%20Report%202010-2011.pdf>. p.32 .

90. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia’s mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 24.

Expenditure component	Description	Estimation approach	Amount (\$m)
Mental health research	Expenditure by the Australian Government on mental health research. Mental health research is also funded by a range of other sources including individuals and NGOs. Estimates of expenditure / funding associated with these other sources are not available. (Expenditure by for-profit drug, medical device and related companies is excluded because such expenditure is a component of the price of the final output.)	Australian Government expenditure on mental health research, taken directly from the Productivity Commission's Report on Government Services 2012. ⁹¹	\$73*
Asylum seeker mental health services	Expenditure by the Australian Government on asylum seeker mental health services through International Health and Medical Services Pty Ltd (the company contracted to deliver public health services to people in immigration detention) and the Program of Assistance for Survivors of Torture and Trauma (PASTT). Estimates of expenditure on other asylum seeker mental health services, including health interpreters, are not available.	Calculated as the sum of: <ul style="list-style-type: none"> • estimated expenditure on health services for people in immigration detention, drawn from the value of contracts with International Health and Medical Services⁹², multiplied by the proportion of government health spending on mental health services.⁹³ • expenditure on services provided under the Program of Assistance for Survivors of Torture and Trauma, drawn from DoHA's Health Budget 2007-08.⁹⁴ 	\$20*
Australian Defence Force mental health services	Expenditure by the Australian Government.	Estimated by applying the proportion of government health spending on mental health services ⁹⁵ to total expenditure on Garrison Health Services, obtained from an Australian National Audit Office report (2010). ⁹⁶	\$46*
Total			\$293*

91. Productivity Commission [2012], *Report on Government Services 2012*, Canberra, Attachment Tables, Table 12A.1.

92. Department of Immigration and Citizenship [2012], *Murray Motion Report 22 – Department of Immigration and Citizenship*, Attachment A, p. 40-41. Available at: http://www.immi.gov.au/about/contracts-tenders-submissions/murray-motion/_pdf/murray22.pdf.

93. DoHA [2010], *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 24.

94. DoHA [2007], *Health Budget 2007-2008*. Available at <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2007-hfact09.htm>.

95. DoHA [2010], *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 24.

96. Australian National Audit Office [2010], *Defence's Management of Health Services to Australian Defence Force Personnel in Australia*, Audit Report No.49 2009-10, Performance Audit, The Auditor-General, p. 32-33.

Australian Government expenditure on selected national programs and initiatives (\$570 million)

This component includes a range of Australian Government programs and initiatives and the National Suicide Prevention Program. Expenditure on these programs is taken directly from the Productivity Commission's

Report on Government Services 2012.⁹⁷ A description of the programs and initiatives and the expenditure on these services is detailed in Table 13.

Table 13: Australian Government expenditure on selected national programs and initiatives

Expenditure component	Description	Amount (\$m)
DVA managed programs and initiatives	Expenditure by the Australian Government on DVA managed programs and initiatives includes the provision of services to eligible veterans, serving and former defence force members, their war widows and widowers and dependants through: private hospitals; public hospitals; consultant psychiatrists; Vietnam Veteran's Counselling Service; private psychologists and allied health; general practitioners; mental health promotion; the Australian Centre for Posttraumatic Mental Health; and the Military Rehabilitation and Compensation Scheme. The Veterans' Disability Pension and other income support and compensation are included in non-health expenditure.	\$166
DoHA managed programs and initiatives	Expenditure by the Australian Government on DoHA managed national programs and initiatives includes: certain initiatives funded under special appropriations linked to the Australian Health Care Agreements; DoHA-administered programs funded by the Australian Government under the COAG Action Plan on Mental Health 2006 (excluding MBS expenditure through the Better Access to Psychiatrists, Psychologists and General Practitioners initiative and the National Suicide Prevention Program); National Mental Health Program; National Depression Initiative; Better Outcomes in Mental Health Care program (including ATAPs); Youth Mental Health Initiative; and the Office for Aboriginal and Torres Strait Islander Health's Emotional and Social Wellbeing Action Plan.	\$233
FaHCSIA managed programs and initiatives	Expenditure by the Australian Government on FaHCSIA managed national programs and initiatives includes three initiatives funded under the COAG Action Plan on Mental Health: Personal Helpers and Mentors; Respite Care places to help families and carers; and Community-Based Program to help families coping with mental illness.	\$148
National Suicide Prevention Program	Expenditure by the Australian Government on the National Suicide Prevention Program.	\$23
Total		\$570

97. Productivity Commission (2012), *Report on Government Services 2012*, Canberra, Attachment Tables, Table 12A.1.

Mental health services in the criminal justice system (\$239 million*)

State / territory governments are responsible for correctional mental health services for juveniles (< 18 years old) and adults (18 years and above). These comprise prison and community-based health care services for people with mental illness. A description of these services and an estimate of expenditure are in Table 14.

Expenditure on adult correctional mental health services is taken from AIHW's *Mental health services in Australia, 2008-09*.⁹⁸ The estimate for juvenile correctional mental health services is derived from an extrapolation of confidential state data.

Table 14: Expenditure on mental health services in the criminal justice system

Expenditure component	Description	Amount (\$m)
Adult correctional mental health services	This figure is included for information purposes only and does not feature in the calculations to determine the total expenditure to support people with a mental illness. Spending on adult correctional mental health services is already included in the sections 'Services provided by specialised psychiatric units in public acute hospitals' and 'Public psychiatric hospital services'. It comprises expenditure by state / territory governments on mental health services provided to the inpatient forensic population aged 18 to 64 years. It excludes services for those aged 65 years and above, and those that are not receiving the service in hospital ('inpatients'), and is therefore an underestimate of the total expenditure.	\$232*
Juvenile correctional mental health services	Expenditure by state / territory governments on juvenile correctional mental health services provided to young offenders in custody and in the community. The services include non-psychiatric (i.e. psychology and counselling), psychiatric and other services. This figure only includes non-psychiatric services as estimates for the other components are not available.	\$7*
Total		\$239*

98. AIHW (2010), *Mental health services in Australia, 2008-09*, Expenditure on mental health services (version 1.1) data tables, Tables 14.5 and 14.7. Available at: <http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=8589934607&libID=8589934607>.

Payments for mental health goods and services by injury compensation insurers (\$106 million*)

Injury compensation insurance includes workers' compensation and compulsory third party insurance. Of relevance to this report are payments made due to mental illness that results from injuries sustained at work; workplace related stress; and injuries / stress caused by motor vehicle accidents. Payments may include the purchase of mental health-related goods and services, compensation and other costs.

The expenditure estimates in Table 15 only include the purchase of mental health-related goods and services. Data for the other elements of health expenditure are not available.

The expenditure figure for workers' compensation payments was provided by Safe Work Australia, an Australian Government statutory agency that collects data on workers' compensation claims and payments. Expenditure on

compulsory third party (CTP) insurer payments is derived by multiplying total expenditure by CTP insurers on all health goods and services⁹⁹ by the proportion of national total gross recurrent expenditure on health services that relates to mental health (7%, as the best estimate of the likely relevant proportion of expenditure).¹⁰⁰

Table 15: Expenditure on payments by injury compensation insurers

Expenditure component	Description	Amount (\$m)
Workers' Compensation payments	Expenditure by workers' compensation insurers on mental health-related health goods and services. Payments for compensation and to cover common law, legal and funeral costs are included in the non-health costs.	\$41
Compulsory Third Party insurer payments	Expenditure by CTP insurers on mental health-related health goods and services. This figure is likely to be an underestimate based on confidential discussions with CTP insurers. Other mental health-related payments by CTP insurers are included in the non-health costs.	\$65*
Total		\$106*

99. AIHW (2011), *Health expenditure Australia 2009-10*, Health and welfare expenditure series no 46. AIHW, Cat No. HWE55, Canberra, p. 41-42.

100. DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 24.

Corporate expenditure on mental health services (\$120 million*)

The corporate sector purchases a range of health goods and services to improve the health and wellbeing of their employees. Mental health-related expenditure is outlined in Table 16.

Expenditure on Employee Assistance Programs is based on Medibank data.

Table 16: Corporate expenditure on mental health services

Expenditure component	Description	Amount (\$m)
Employee Assistance Programs	Expenditure by organisations on work-based intervention programs designed to improve the wellbeing of employees and members of their immediate families.	\$120
Other corporate expenditure on mental health services	Expenditure by the corporate sector on mental health services other than Employee Assistance Programs, such as other corporate health and wellbeing programs. This expenditure is not available.	Not available
Total		\$120*

6.4 Direct non-health expenditure is at least \$14.8 billion per annum

Total direct non-health expenditure to support people with mental illness was \$14.8 billion in 2010-11. This includes expenditure by the Australian and state/territory governments and private insurers on support payments and service provision. Some key insights on non-health expenditure are in Box 7.

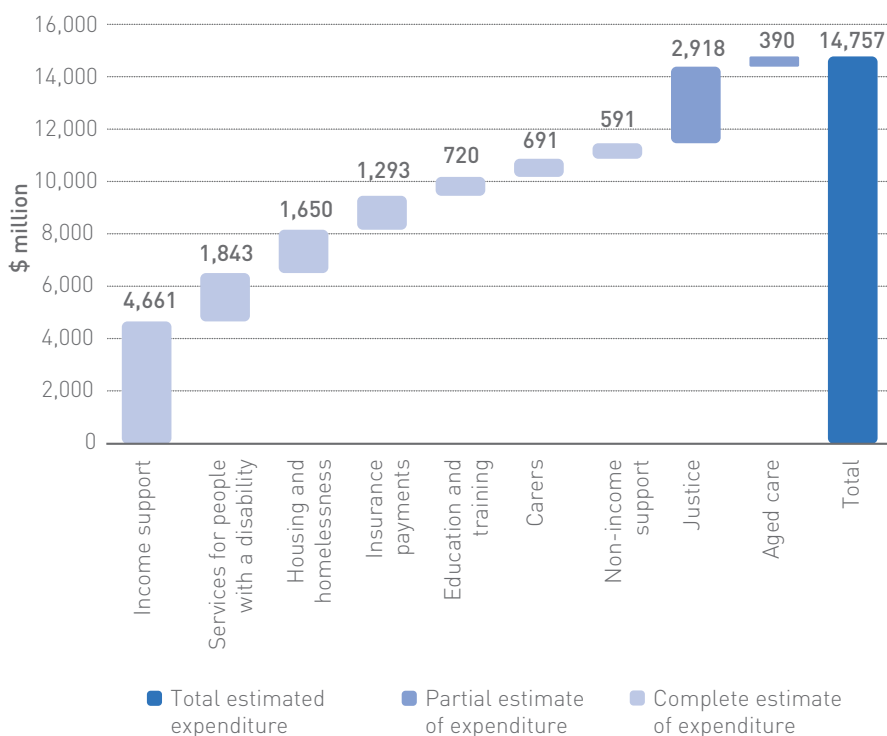
The main categories of services, and the associated expenditure, are illustrated in Figure 9. The light blue columns reflect expenditure amounts where a complete or reliable estimate is available. The dark blue columns indicate expenditure amounts that are likely underestimated.

The remainder of this section describes each component of non-health expenditure. The specific estimation method is described in detail in the *Detailed expenditure calculations* companion document (available upon request).

Box 7: Key insights on non-health expenditure

- Total non-health expenditure is estimated to be \$14.8 billion. This compares to:
 - total Australian Government social security and welfare spend of \$116.9 billion in 2010-11
 - total state / territory government expenditure on social security and welfare of \$14.4 billion in 2010-1.
- Expenditure is split fairly evenly between support payments (\$7,236 million) and service provision (\$7,521 million).
- Two specific payments – Disability Support Pension (\$3,913 million) and insurance payments for total and permanent disability and income protection (\$1,045 million) – account for over two-thirds of total support payments.
- Expenditure on justice services – police, courts, specialised mental health courts / tribunals, prisons and community corrections, and juvenile justice – accounts for almost 40% of expenditure on service provision (\$2,918 million).
- The largest element of expenditure on service provision is expenditure on social housing (\$1,506 million).

Figure 9: Estimated direct non-health expenditure to support people with mental illness in 2010-11 (\$m)



Support payments (\$7,236 million*)

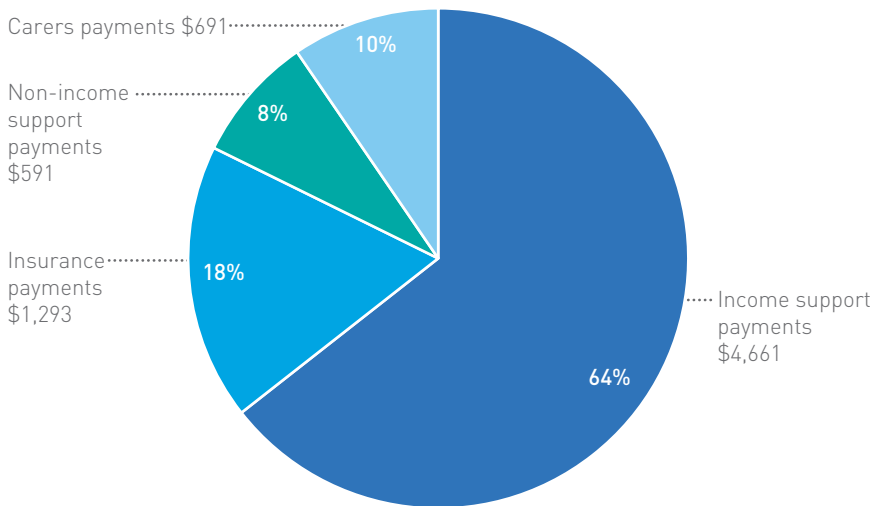
There are four main payments to support people with mental illness – income support provided by government, insurance payments, non-income support and carers support. Total expenditure for these payments is \$7,236 million: see Figure 10. Two specific elements – Disability Support Pension (DSP) (\$3,913 million) and Total and Permanent Disability (TPD) and Income Protection insurance payments (\$1,045 million) – account for 68.5% of total expenditure.

Income support payments (\$4,661 million)

The Australian Government provides a number of income support payments to assist people who (for reasons of disability or sickness) are unable to work, are looking for work or are in formal education and training.¹⁰¹ Expenditure on DSP represents the overwhelming majority of expenditure. Trends in DSP expenditure are discussed in Box 8.

Expenditure on income support was estimated by multiplying the total recurrent government expenditure on each income support component by the proportion of recipients whose primary medical condition was mental illness. The relevant proportion is available for the DSP, Newstart Allowance, Youth Allowance, Sickness Allowance, Veteran's Disability Pension and Veteran's income support and compensation. An assumption of 30% was used for the Pensioner Education Supplement. A description of these payments and an estimate of expenditure related to mental health are in Table 17.

Figure 10: Expenditure on support payments to people with mental illness (\$m)



101. People suffering from mental illness whose ability to work is restricted (either fully or partially or fully) may also be eligible for a range of other Australian Government income support payments, such as family tax benefits. Such items are not included in this report. To estimate expenditure on such payments related to mental illness would, firstly, require a comparison of the current income of people with mental illness with their estimated income absent mental illness. An assessment of eligibility for these payments would then be needed.

102. FaHCSIA (2011) *Characteristics of Disability Support Pension Recipients, June 2011*, Canberra p. 22.

103. FaHCSIA (2010), *Budget Statements 2009-10*, p.97.

Box 8: Trends in DSP recipients

Disability Support Pension (DSP) expenditure related to mental illness was \$3.9 billion in 2010-11. The number of people receiving a DSP whose primary medical condition is classified as “psychological / psychiatric” has been growing at a rate of 5.5%, more than three times the annual growth rate of all other DSP recipients (1.8%).¹⁰²

This evidence suggests the proportion of people with a more debilitating mental illness may have increased. As a proportion of all people with a mental disorder in the last 12 months, the number of DSP recipients with a primary medical condition of psychological / psychiatric increased from 5% to 7.3% (assuming overall prevalence of mental illness is unchanged, as the broader evidence suggests).

The possibility that the proportion of people with a more debilitating mental illness has increased warrants further consideration. Caution is necessary in drawing firm conclusions from DSP recipient data. The allocation of primary disability to psychological / psychiatric conditions may be influenced by the greater awareness of mental illness in recent years. A subtle change in diagnosis, assessment and statistical recording may have occurred. Yet the difference in relative growth rates appears significant.

Eligibility for DSP was tightened over the period. From 1 July 2006, people able to work more than 15 hours a week were no longer eligible for DSP. The previous work requirement was 30 hours. More recently, the Australian Government revised the impairment tables to more directly align DSP entitlements with how the person’s impairment affects their ability to work. The changes were effective from 1 January 2012. FaHCSIA estimates that around 1,600 previously ineligible people can now be granted DSP each year, whilst 6,500 new claimants would not be eligible for the DSP and may instead receive other income support payments such as Newstart Allowance.¹⁰³

Table 17: Expenditure on income support related to mental health

Expenditure component	Description	Amount (\$m)
Disability Support Pension	An income support payment to those with a physical, intellectual or psychiatric disability with significant impairment that prevents work or study.	\$3,913
Newstart Allowance	An income support payment for people aged over 21 who are unemployed or are temporarily unable to work due to illness, injury or disability.	\$492
Youth Allowance (other)	An income support payment – eligibility includes young people who are sick.	\$57
Sickness Allowance	An income support payment for people who are unable to work or study temporarily because of illness, injury or disability.	\$19
Pensioner Education Supplement	An income supplement for certain Australian Government income support recipients, including those with a disability, who are undertaking approved full-time or part-time study.	\$26
Veterans’ Disability Support Pension	An income support pension paid to compensate veterans for injuries or diseases caused or aggravated by war service or certain defence service rendered on behalf of Australia before 1 July 2004. ¹⁰⁴	\$141
Military Rehabilitation and Compensation payments	Programs to provide incapacity payments and lump sums for injuries resulting in permanent impairment and payments to dependants of deceased employees of the Australian Defence Force.	\$13
Total		\$4,661

104. Department of Veterans Affairs, Factsheet DP01, Overview of Disability Pensions and Allowances. Available at: <http://factsheets.dva.gov.au/factsheets/documents/DP01%20overview%20of%20Disability%20Pensions%20and%20Allowances.htm>, accessed 23 April 2012 ABS (2011), Australian Social Trends, September 2011 – Housing assistance for renters, Cat. No. 4102.0, Canberra, p. 3.

Insurance payments (\$1,293 million)

People may receive a payment from a range of insurance policies on account of mental illness. The relevant insurance policies are:

- Total and permanent disability (TPD) insurance – provides assistance to those who are unable to work due to serious injury. TPD policies offer a lump sum payment to the individual as a result of their disability.
- Income protection (IP) insurance payments – provides assistance to those who cannot work temporarily due to illness or temporary disablement.
- Workers' compensation insurance – compulsory insurance offered by employers and taken out by self-employed people that provides income support for those who are injured at work.
- Compulsory third party (CTP) insurance – compulsory insurance for all motor vehicle operators that provides compensation in the instance that the driver injures or kills a third party whilst on the road.

Expenditure for each of these components is detailed in Table 18. Most expenditure is for TPD and IP insurance payments. The process for estimating these payments is described in Box 9. Expenditure on workers' compensation payments was provided by Safe Work Australia. Expenditure on CTP payments was estimated using Australian Prudential Regulatory Authority (APRA) data¹⁰⁵ and an assumption of the proportion of expenditure attributable to mental illness (assumed to be half of the proportion used to calculate health-related CTP expenditure, or 3.5%). The data presented here exclude injury compensation payments for mental health-related goods and services, included in health costs in Section 6.3.10.

Box 9: Estimating expenditure on TPD and IP related to mental health

Data capture by insurers on the cause of injury claims is limited for TPD and IP insurance payments. A significant portion of claims are recorded for "unknown" or "other" causes.

The estimate of expenditure on TPD and IP is based on claims for which the cause is known and mental illness is cited as the primary cause.[#] Payments made for death and suicide claims are excluded (as the focus of this report is expenditure to directly support people suffering from mental illness, not their dependents).

Expenditure on claims related to mental illness is extrapolated from analysis of 2008 data by a major superannuation fund. The fund paid approximately \$270 million in TPD and IP claims during the year, of which 9.15% related to mental illness. This figure is extrapolated across the group risk market (insurance provided through employers and superannuation funds) using the fund's estimated market share.

Total TPD and IP expenditure for the group risk market is estimated to be \$291 million based on the fund's payment and market share. This figure is adjusted to account for the significantly larger retail risk market; retail and group risk are estimated to hold 66% and 34% of the total risk market respectively.

Estimated total expenditure in 2008 is then adjusted for inflation and population growth. This leaves an estimate of \$1,052 million for total expenditure on TPD and IP attributable to mental illness in 2010-11.

[#] Industry experts suggest that mental illness can be a secondary cause for many disability claims. Data on secondary causes was unavailable from insurers, APRA or the Insurance Council of Australia.

Table 18: Expenditure on insurance payments related to mental health

Expenditure component	Description	Amount (\$m)
Total and permanent disability and income protection payments	A personal insurance scheme that provides compensation and income support for those with a disability who are temporarily or permanently unable to resume work.	\$1,045
Workers' compensation insurance payments	A mandatory state / territory based insurance scheme that provides compensation and income support to people who are injured at work.	\$196
Compulsory Third Party insurance payments	A mandatory motor vehicle state / territory based insurance scheme that provides compensation to people (and / or their families) who suffer injury or death caused by motor vehicles driven by others.	\$52
Total		\$1,293

105. APRA Statistics, General Insurance Supplementary Statistical Tables, June 2011, Table 2, p. 7.

Non-income support (\$591 million)

In addition to direct income support, the Australian Government and state / territory governments provide a number of non-income supports to assist people – rent assistance, taxi subsidies, community transport, the Financial Management Program and mobility allowance. A description of these supports and an estimate of expenditure related to mental illness are in Table 19. Almost three-quarters of non-income support is rent assistance.

Expenditure data was drawn from Department of Education, Employment and Workplace Relations (DEEWR), Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and a range of state / territory publications. The proportion of expenditure or recipients due to mental illness is not available for most components. An estimate of 30% was used. (The only available data is for rent assistance where 44% of households that

receive assistance have a disability.¹⁰⁶ The report assumes 30% of those on disability-related rent assistance have a mental illness.)

Table 19: Expenditure on non-income support related to mental health

Expenditure component	Description	Amount (\$m)
Rent Assistance	An Australian Government income supplement payment added to the pension, allowance or benefit of eligible income support customers who rent in the private rental market.	\$431
Taxi subsidy schemes	Expenditure by state / territory governments to provide subsidised taxi transport to people with a disability who are unable to use public or private transport.	\$36
Community transport schemes	Expenditure by state / territory and local governments to provide community transport to assist people who are otherwise unable to travel using a private vehicle or public transport.	\$48
Financial Management Program	An Australian Government program designed to improve the financial knowledge, skills, capabilities and resilience of vulnerable people and families to address the impact of financial stress. A component of the program is to also coordinate a national approach to reduce problem gambling.	\$37
Mobility Allowance	An Australian Government income supplement to assist people with a disability who are undertaking approved activities (such as work or study) and are unable to use public transport without substantial assistance.	\$39
Total		\$591

106. ABS (2011), Australian Social Trends, September 2011 – Housing assistance for renters, Cat. No. 4102.0, Canberra, p. 3.

Carers (\$691 million*)

People who suffer debilitating symptoms due to mental illness may require intensive assistance with daily activities. Some people will receive full-time care in a facility; others will receive care in a private residence, often from a family member or close friend.

The Australian Government provides two income support payments to assist such carers: a carer's payment and a carer's allowance. A description of these support payments and an estimate of expenditure related to mental health are in Table 20. The expenditure on carers

support was calculated as the proportion of total expenditure¹⁰⁷ where recipients of care have a primary disability type related to mental illness (17% and 15% respectively¹⁰⁸).

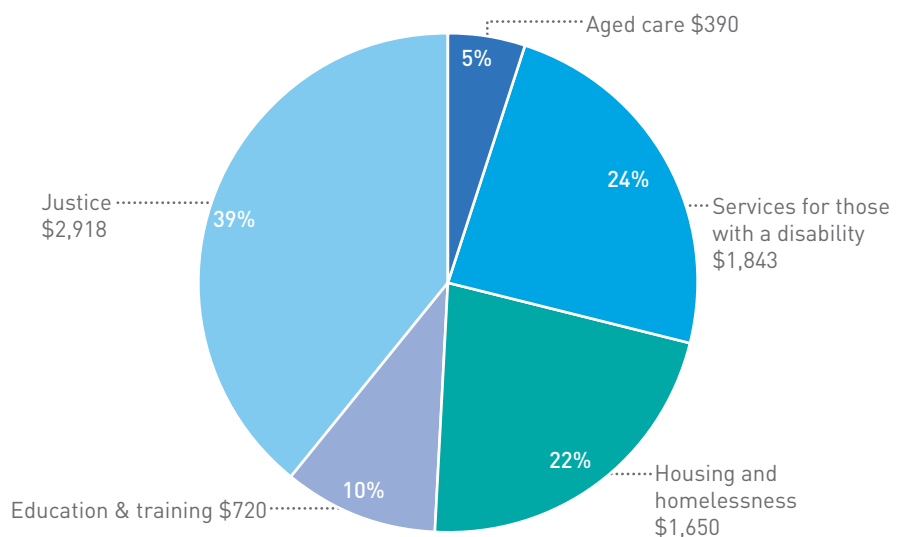
Table 20: Expenditure on carers related to mental health

Expenditure component	Description	Amount (\$m)
Carers Payment	An income support payment to carers who are unable to support themselves through substantial paid employment because they are caring for someone aged 16 years or over on a daily basis who has a severe disability, medical condition or who is frail aged.	\$457*
Carers Allowance	An income supplement to carers who provide daily care and attention for a person aged 16 years or over with a disability, medical condition or who is frail or aged with the care provided in the recipient or provider of care's home.	\$235*
Total		\$691*

Services provided to people suffering from mental illness (\$7,521 million*)

The Australian Government and state / territory governments provide a range of services to assist people. Five broad services are relevant to mental illness: aged care; services for those with a disability; housing and homelessness; education and training; and justice. Total expenditure on these services to support people with mental illness is \$7,521 million. Justice is the largest component: see Figure 11.

Figure 11: Expenditure on services provided that relate to mental illness (\$m)



107. FaHCSIA (2011) *Facts and Figures*, p. 10.

108. ABS (2009) *Caring in the community, Australia, 2009*, Cat No. 4436.0, Table 20.

Aged care (\$390 million*)

Aged care services are provided in residential and community settings. The estimate of residential care expenditure is based on specific mental illness payments made under the Australian Government's Aged Care Funding Instrument (ACFI). It is limited to expenditure on aged care residents with the highest level of the Behaviour Supplement. This requires one of the following diagnoses: dementia; provisional dementia; psychiatric diagnosis; or other diagnosed behavioural problem. Expenditure on the ACFI subsidy was then calculated using the proportion of all subsidies relating to behavioural high care (19%). This will underestimate true expenditure as the proportion of residents in behavioural high care is much larger (48%).¹⁰⁹ It would be inappropriate to use the higher figure as some of these residents also receive supplements unrelated to mental illness. It is not possible to calculate the true figure, which would be somewhere between 19% and 48%. The estimate will also exclude residents with an undiagnosed mental illness.

Expenditure on community care services is calculated as the Australian Government expenditure on the Extended Aged Care at Home – Dementia (EACH-D) package (from the Productivity Report 2012 *Report on Government Services*). The expenditure on dementia education and support is sourced from the same report.

Expenditure estimates for both residential care and community care exclude the base level of funding for people who receive care. It is possible that some people may not require residential or community care if they did not suffer from mental illness. Yet it is likely that the overwhelming majority of people would still require a base level of care, due to more general frailty. Data to clarify this point is not available. Base funding is therefore excluded. (For the same reason, this report also does not include Veterans' aged care and support).

An estimate of aged care expenditure related to mental health is in Table 21.

Services for people with a disability (\$1,843 million)

The Australian Government and state / territory governments provide a range of services for people with a disability. Total expenditure data is provided by the PC *Report on government services 2012*. Data on the proportion of service users whose primary disability is mental health-related is available from the PC and AIHW (the latter for employment services). Of the seven services, 45% of expenditure is for accommodation support. A description of each service and an estimate of expenditure related to mental health are in Table 22.¹¹⁰ It is assumed that 30% of total expenditure is related to mental health for all components, besides employment services (where the AIHW publishes statistics on the primary disability of people who receive assistance – 46.9% for open services and 16.3% for supported services).¹¹¹

Table 21: Expenditure on aged care related to mental health

Expenditure component	Description	Amount (\$m)
Residential care services	Expenditure by the Australian and state / territory governments to provide accommodation and care to the elderly in residential aged care facilities and nursing homes. Funded primarily through ACFI based on the dependency and complexity of care required for each resident.	\$270*
Community care services	Expenditure by the Australian and state / territory governments to provide accommodation and care to the elderly in non-residential settings (such as nursing care in private homes, meals and domestic assistance).	\$118*
Dementia education and support	Expenditure by the Australian Government on services and support to carers and families of those suffering from dementia (such as information, service and support referral).	\$2*
Total		\$390*

109. DoHA (2011), *Aged Care Funding Instrument Reports*, Quarterly Report 30 June 2011, Table 1.

110. This data does not include expenditure on psychiatric disability services. This is because the funding source for such services differs across jurisdictions. In Victoria and Queensland specialist psychiatric disability services are provided under the NDA. In other jurisdictions, such services are funded and provided under health, rather than disability, portfolios. See: AIHW (2011) *Disability support services 2009-10*, Report on services provided under the National Disability Agreement.

111. AIHW (2011), *Disability support services 2009-10: report on services provided under the National Disability Agreement*. Disability series, Cat. no. DIS 59. Canberra, Table 3.8, p. 22.

Table 22: Expenditure on services for those with a disability related to mental health¹¹²

Expenditure component	Description	Amount (\$m)
Accommodation support	Expenditure by state / territory governments to provide support to people with a disability in out-of-home accommodation settings (such as hostels, institutions and group homes), and in home (including attendant / personal care, in home support and alternative family placements). (Note – this category is separate to overall housing services, discussed in Section 6.4.2.3.).	\$837
Community support	Expenditure by the Australian and state / territory governments on programs that provide support for a person with a disability to live in a non-institutional setting — including therapy support, counselling and early childhood intervention.	\$290
Community access	Expenditure by the Australian and state / territory governments on programs that provide opportunities for people with a disability to gain and use their abilities to enjoy their full potential for social independence— including learning and life skills development and recreation / holiday programs.	\$199
Respite care services	Expenditure by the Australian and state / territory governments on programs that provide a short-term and time-limited break for families and other voluntary caregivers of people with a disability, to assist in supporting and maintaining the primary care-giving relationship, while providing a positive experience for the person with disability.	\$112
Employment services	Expenditure by the Australian Government on two programs: <ul style="list-style-type: none"> • open employment services — assistance in obtaining and / or retaining paid employment in the open labour market • supported employment services — support and employment in Australian Disability Enterprises outlets. 	\$333
Advocacy, information and print disability services	Expenditure by the Australian and state / territory governments in the following areas: <ul style="list-style-type: none"> • advocacy services to enable people with a disability to increase control over their lives by representing their interests and views in the community • information services to provide accessible information to people with a disability, their carers, families and related professionals about disabilities, and specific and mainstream services and equipment; and promote the development of community awareness • community awareness – alternative forms of communication for people who are, by reason of their disability, unable to access information provided in a print medium. 	\$17
Other support services	Expenditure by the Australian and state / territory governments in areas that include research and evaluation, and training and development projects.	\$55
Total		\$1,843

112. Descriptions are drawn from Productivity Commission [2012], *Report on Government Services 2012*.

Housing and homelessness (\$1,650 million)

State / territory governments provide social housing to assist people who would otherwise be unable to rent privately. State / territory governments also provide a range of homeless outreach programs and shelters and temporary accommodation to assist people who are, or at risk of becoming, homeless.

A description of these expenditure components and an estimate of the expenditure related to mental health are in Table 23. (Housing and homelessness prevention is separate to the accommodation support services provided to those with a disability in Section 6.4.2.2)

Expenditure on social housing is calculated as the proportion of total government expenditure on social housing for socially housed residents who require housing as a result of mental illness. Expenditure on accommodation and non-accommodation services is calculated by multiplying total recurrent government expenditure on homelessness services by the proportion of agencies delivering each respective service.¹¹³ Of this, the proportion attributable to mental illness is assumed to be 30%.

These estimates only include recurrent expenditure incurred by state / territory governments. Time-limited programs (such as the Social Housing Initiative administered by FaHCSIA¹¹⁴) are not considered in the estimated expenditure figures.

Table 23: Expenditure on housing and homelessness related to mental health¹¹⁵

Expenditure component	Description	Amount (\$m)
Social housing	Expenditure by state / territory governments on rental housing provided by non-government or government organisations to assist people who are unable to access suitable accommodation in the private rental market.	\$1,506
Shelters / temporary accommodation	Expenditure by state / territory governments on homeless shelters and temporary accommodation.	\$102
Homeless programs and services (non-accommodation)	Expenditure by state and territory governments on homeless programs and services (non-accommodation) that include counselling, advocacy, links to housing, health, education and employment services, outreach support, brokerage and meals services, and financial and employment assistance.	\$43
Total		\$1,650

113. Productivity Commission [2012], *Report on Government Services 2012*, Attachment Tables, Table 17A.3.

114. FaHCSIA (2011), *Annual Report 2010-11*, p. 52-57.

115. Descriptions are drawn from Productivity Commission [2012], *Report on Government Services 2012*, p. 16.2 and 17.3.

Education and training (\$720 million)

State / territory governments provide a range of special school and additional support classes to assist young people who, for a range of reasons, are unable to participate in regular schooling. At the tertiary education level, the Australian Government provides additional support to universities to assist with the education of students with a disability.

Expenditure on special schools and support classes is calculated by multiplying the national average

targeted funding per student with a disability by the total number of funded students with a disability in Australia. The proportion of this total disability expenditure attributable to mental illness is calculated using NSW Department of Education and Communities data on the average proportion of disability school services targeting students with a mental illness. (NSW is used as a proxy for all states and territories.)

Expenditure on higher education disability support is sourced from DEEWR. It is assumed 30% of expenditure relates to mental illness.

A description of the expenditure components and an estimate of expenditure related to mental health are in Table 24.

Table 24: Expenditure on education and training related to mental health

Expenditure component	Description	Amount (\$m)
Special schools and support classes	Expenditure by state / territory governments on special schools and support classes in regular schools.	\$718
Higher Education Disability Support Program	Expenditure by the Australian Government for universities to meet the educational support and equipment costs associated with supporting students with a disability. ¹¹⁶	\$2
Total		\$720

Justice (\$2,918 million*)

Justice – comprising police, courts, specialised mental health courts / tribunals, prisons and community corrections, and juvenile justice – is the largest component of government services expenditure to support people with mental illness. It is also the most challenging component to estimate. This reflects the need to determine causality between mental illness and the incident that led to an individual's involvement in the justice system, initially with the police. Estimates here are limited.

The research for this report found no evidence on the proportion of court appearances or prison sentences that can be attributed to mental illness.

The estimation approach for justice expenditure and the prevalence of mental illness in the justice system more broadly are discussed further in Box 10. Expenditure on specialised mental health courts / tribunals was obtained from respective state / territory justice departments' annual reports

or extrapolated based on other state / territory data if expenditure estimates were not available. A description of the expenditure components and an estimate of the expenditure related to mental health are in Table 25.

116. DEEWR (2011), *Annual Report 2010-11*, p. 59.

Box 10: The justice system and mental health

There is limited data on the amount of justice expenditure, or the proportion of criminal incidents, that can be directly attributed to mental illness. In this report, the proportion of justice expenditure attributable to mental illness is calculated as 15% of the total recurrent government expenditure of each component of justice (the latter data is sourced from the PC's *Report on Government Services 2012*). This figure is drawn from unpublished UK research which found that 15% of incidents responded to by the London Metropolitan Police were mental health-related.¹¹⁷ (The only Australian evidence, based on an early 2000s survey of 131 Sydney police officers, reported that 10% of police time is spent dealing with people with mental health problems.¹¹⁸) The relevant proportion of criminal court expenditure, criminal system (prisons and correctional facilities) and juvenile justice expenditure related to mental illness may be higher, though the research for this report did not uncover any estimates.

Some research has been conducted by the AIHW and others on the general prevalence of mental illness amongst the adult prison population. A 2010 AIHW study noted that 31% of surveyed prison entrants self-reported that they had ever been told that they had a mental illness. This proportion varied significantly between state and territories; it was lowest in the Northern Territory (19%) and highest in the ACT (67%). The number of prison entrants who reported psychological stress related to their current incarceration after four weeks imprisonment was 40%. The trend and variation in this figure between states and territories was largely consistent with the prisoners' previous reports of mental illness; again lowest in the Northern Territory (26%) and highest in the ACT (75%).¹¹⁹ Some of the variation may reflect different definitions used for mental illness. (NSW and Victoria did not participate in the AIHW survey. A 2009 NSW study indicated that 49% of inmates self-reported ever having been told they had a mental illness.¹²⁰ No comparable data is available for Victoria.)

There is evidence to suggest the prevalence of mental illness is more pronounced amongst the juvenile inmate population. A 2009 NSW study found that the overwhelming majority of people in juvenile detention (87%) reported having a psychological disorder, with 73% reporting two or more disorders.¹²¹ Behavioural disorders and alcohol and / or substance abuse were the most prevalent conditions reported. The majority of information in the survey relates to current diagnosis; data on past disorders and stress related to detention is not available.

Table 25: Expenditure on justice related to mental health

Expenditure component	Description	Amount (\$m)
Police	Expenditure by state / territory governments on police services.	\$1,330
Courts	Expenditure by state / territory governments on Magistrates, Children's, District and Supreme Courts.	\$1,072*
Specialised mental health courts/tribunals	Expenditure by state / territory governments on independent statutory courts / tribunals to assess treatment and care for people treated as involuntary patients.	\$9
Prisons and community corrections	Expenditure by state / territory governments on prisons and community corrections.	\$436*
Juvenile justice	Expenditure by state / territory governments on community-based services and custodial facilities for attending to young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile.	\$70*
Total		\$2,918*

117. Sainsbury Centre for Mental Health (2008), Briefing 36, The police and mental health.

118. Fry, A.J. et al (2002) "Social control agents or front-line carers for people with mental health problems: police and mental health services in Sydney, Australia", *Health and Social Care in the Community*, 10(4), 277–286, p. 280.

119. AIHW (2011), *The health of Australia's prisoners 2010*, Cat. No. PHE 149. Canberra, Table 3.1, p. 28.

120. Indig, D. et al. (2010), *2009 NSW Inmate Health Survey: Key Findings Report*, Justice Health. Sydney, Table/Figure 6.1.1, p. 135.

121. Indig, D. et al. (2011), *2009 NSW Young People in Custody Health Survey: Full Report*, NSW Justice Health and Juvenile Justice NSW, Sydney, p. 144–161.

7. Mental health outcomes in Australia are sub-optimal

7.1 Mental illness is very prevalent. The types of disorders and services are changing

The prevalence of mental illness is high

Australia's mental health challenge is stark. DoHA has estimated that every year one in five Australians experience a mental illness and almost half the Australian population will experience a mental illness at some point in their lifetime.¹²² Given Australia's population at June 2011, this represents 4.5 million and 10.3 million people respectively. According to these figures, the prevalence of mental illness is slightly less than obesity (experienced by one in four adults), but significantly exceeds diabetes (4% of adults) and cancer (2.5% of adults).

The true rate of mental illness in Australia will be higher than these estimates because dementia and less common mental disorders (e.g. schizophrenia and other psychotic disorders) are excluded from the 2007 National Survey of Mental Health and Wellbeing (NSMH&W) from which the DoHA figures are drawn. For example, dementia affected 1.1% (or 245,400) Australians in 2009.

The profile of mental illness in Australia is summarised in Box 11, which contains some key findings from DoHA's study.

Using the lifetime prevalence figures (which exclude dementia), affective disorders are experienced by 15% of the population, anxiety disorders 26.3% and substance use disorders 24.7%.¹²⁴

Box 11: The Mental Health of Australians – some key findings

- Females were more likely than males to have experienced mental disorders in the 12 months prior to the survey (22.3% compared to 17.6%).
- Females were more likely than males to have experienced anxiety disorders (17.9% compared with 10.8%) and affective disorders (7.1% compared with 5.3%).
- Males were more than twice as likely as females to have experienced substance use disorders (7.0% compared with 3.3%).
- A number of other social factors were strongly associated with having mental disorders in the previous 12 months, including not being married or in a de facto relationship, level of education and not being in the labour force.
- Of all Australians aged 16-85 years¹²³, 11.9% utilised health services for mental health problems in the preceding 12 months.

Source: Slade T, et al. (2009), *The Mental Health of Australians 2, Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra, p. xii-xiii.

122. Slade T., et al. (2009), *The Mental Health of Australians 2, Report on the 2007 National Survey of Mental, Health and Wellbeing*, Department of Health and Ageing, Canberra, p. xii.

123. The 2007 National Survey of Mental Health and Wellbeing is a general household survey of people aged 16-85 years that was undertaken by the Australian Bureau of Statistics during the latter half of 2007.

124. The terms affective disorders, anxiety disorders and substance use disorders are classes of mental illness. They are described by the Department of Health and Ageing (DoHA) as follows:

- Affective disorders include episodes of depression (mild, moderate and severe), dysthymia and bipolar affective.
- Anxiety disorders involve the experience of intense and debilitating anxiety. The survey included panic disorder, social phobia, agoraphobia, generalized anxiety disorder (GAD), posttraumatic stress disorder (PTSD) and obsessive compulsive disorder (OCD).
- Substance use disorders relate to problems arising from the use of alcohol and drugs [p. 55-59].

Overall prevalence levels remain stable but the types of disorders are changing

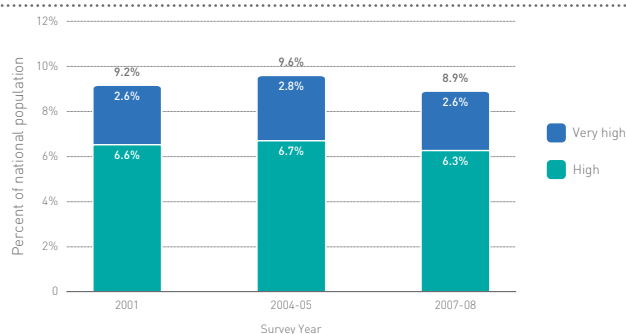
The long-term overall prevalence of mental illness in Australia has remained relatively static. However, the prevalence of particular categories of mental disorders is changing, with some data sources indicating an increase in the more debilitating forms of mental illness.

At an overall level, longitudinal data from the past three National Health Surveys shows the proportion of Australians experiencing high or very high-levels of mental distress has remained relatively stable at around 9%, as shown in Figure 12.

Data from the 1997 and 2007 NSMH&W surveys indicates that while the overall prevalence of mental illness has remained relatively stable, the prevalence of particular categories of disorders has changed. Table 26 illustrates that anxiety disorders have increased in prevalence, while substance use disorders have decreased.

Comparisons between the responses to the 1997-98 and 2010 People Living with Psychotic Illness surveys shed more light on how the prevalence levels of affective disorders have changed. Table 27 illustrates that around two thirds of each survey sample were diagnosed with schizophrenia or schizoaffective disorders. The prevalence of less common psychotic disorders differed notably over the 13 year period though. In particular, the proportion of people diagnosed with 'delusional and other non-organic psychoses' was considerably less in 2010 (4.5% compared with 13.2% in 1997-98).

Figure 12: Percentage of Australian population with high or very high-levels of mental distress[#]



[#] Based on Kessler 10 Psychological Distress Scale (K10). Score for High is (22–29) and Very high is (30–50).

Sources: ABS (2002), National Health Survey: Summary of results, 2001, Cat No. 4364.0, Canberra; ABS (2006), National Health Survey: Summary of results, 2004-05, Cat No. 4364.0, Canberra; ABS (2009), National Health Survey: Summary of results, 2007-08 (reissue), Cat No. 4364.0, Canberra; ABS (2009), Australian Historical Population Statistics, 2008, Cat No. 3105.0.65.001, Canberra.

Table 26: Prevalence of 12-month mental disorders

	1997 (%)	2007 (%)
Anxiety disorders		
Panic disorder	1.3	2.6
Agoraphobia	1.1	2.8
Social phobia	2.7	4.7
Generalized anxiety disorder	3.1	2.7
Posttraumatic stress disorder	3.3	6.4
Obsessive-compulsive disorder	0.4	1.9
Affective disorders		
Depression	5.1	
Depressive episode		4.1
Bipolar affective disorder		1.8
Dysthymia	1.1	1.3
Substance use disorders		
Alcohol harmful use	3.0	2.9
Alcohol dependence	3.5	1.4
Drug use disorders	2.2	1.5

Source: Slade T, et al. (2009), The Mental Health of Australians 2, Report on the 2007 National Survey of Mental, Health and Wellbeing, Department of Health and Ageing, Canberra; ABS (1998), Mental Health and Wellbeing: Profile of Adults, Australia, Cat No. 4326.0, Canberra.

Long-term data related to Disability Support Pension (DSP) recipients suggests the proportion of people with more debilitating mental illness *may have increased*. The DSP provides income support to people with a physical, intellectual or psychiatric impairment that prevents work of more than 15 hours per week.

The number of recipients whose primary medical condition is classified as psychological / psychiatric has increased substantially – from 140,965 in June 2001 to 241,335 in June 2011. The average annual increase in recipients (5.5%) is more than three times all other DSP recipients (1.8%).¹²⁵ Eligibility for the DSP was tightened over this period.

The focus of mental health services is changing

A high-level comparison between the results of the 1997 and 2007 NSMH&W surveys indicates the proportions of people with mental health issues accessing different mental health services have stayed relatively static. The key exception is the proportion of people who used a psychologist, which increased from 6.8% to 13.2%, (see Figure 13).

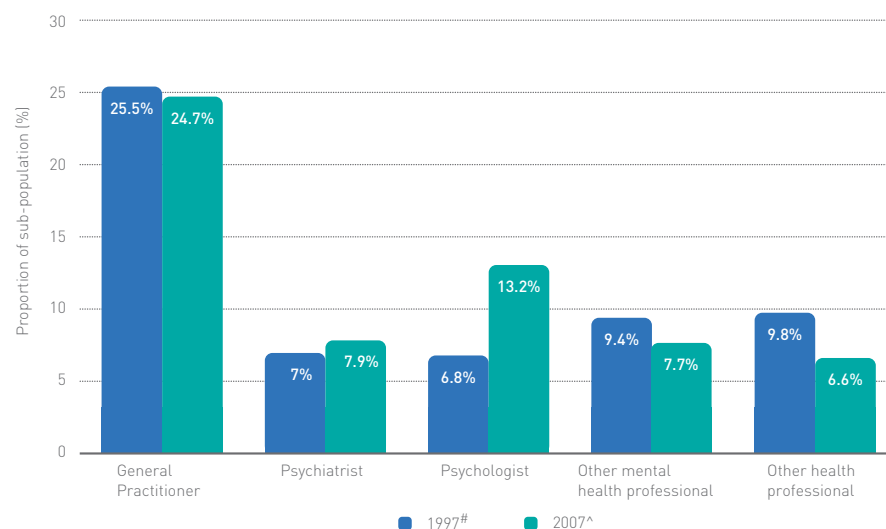
Recent data from the Productivity Commission related to the proportion of people accessing Medicare-funded clinical mental health services, shown in Figure 14, also illustrates the increase in the proportion of Australians receiving services provided by psychologists. Additionally, the Productivity Commission data shows the proportion of people accessing GPs for clinical mental health services is increasing.

Table 27: ICD-10 lifetime diagnosis, by proportion of survey respondents

Diagnosis	1997-98 (%)	2010 (%)
Schizophrenia	53.4	50.8
Schizoaffective disorder	11.5	16.4
Bipolar, mania	12.4	17.1
Depressive psychosis	6.0	3.7
Delusional and other non organic psychoses	13.2	4.5
Severe depression without psychosis	0.7	7.0
Other	2.8	0.5

Source: Australian Government (2011), *People living with psychotic illness 2010: Report on the second Australian national survey*, Canberra, p. 92.

Figure 13: Proportion of people with mental disorders using mental health services



#1997 proportions calculated using total number of people with 'mental disorders only'.

^2007 proportions calculated using total number of people with 'Lifetime mental disorder with symptoms in 12-month period prior to interview.'

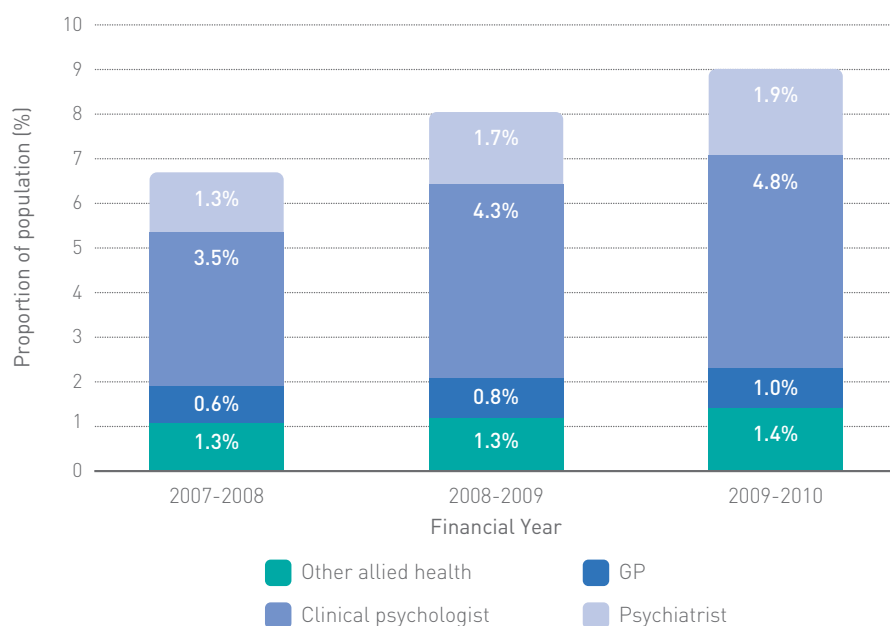
Source: ABS (2007), *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. No. 4326.0, Canberra, p. 44; ABS (2007), *Mental Health and Wellbeing: Profile of Adults, Australia, 1997*, Cat. No. 4326.0, Canberra, p. 35.

125. FaHCSIA (2011), *Characteristics of Disability Support Pension Recipients*, Canberra, Table 13, p. 21.

Longitudinal data from the People Living with Psychotic Illness surveys paint a different and more nuanced picture of how service demand is changing for a particular sub-population living with more severe mental health issues. A comparison of the results from the 1997-98 and 2010 surveys in Table 28 shows that:

- *General practitioners remain key providers* of health care to people with psychotic illness
- *Hospital admissions for mental health reasons decreased markedly* with a 35.9% decrease in admissions
- *Community services increased markedly* with 92.8% of people in 2010 having contact with an outpatient or community clinic (some 23.2% higher than the 75.3% reported in 1997-98) and 36.8% undertaking community rehabilitation or day programs (60.7% higher than the 22.9% in 1997-98).
- *NGO-provided services increased* with one quarter of the sample (26.5%) receiving mental health services through non-government organisations compared with 18.9%, an increase of 40.2% from 1997-98.

Figure 14: Proportion of Australians receiving Medicare-funded clinical mental health services



Note: Persons seen by more than one provider type are counted only once in the total.

Source: Productivity Commission (2008-2011), National Agreement Performance Reporting-National Healthcare Agreement, Indicator 21.

Table 28: Proportion of people using health services in past year

	1997-98 (%)	2010 (%)
Inpatient – Any admission	62.9	45.6
Inpatient – Mental health	58.7	37.6
Inpatient – Physical health	7.9	12.6
Involuntary admission	31.4	22.7
Emergency department attendance	47.6	43.0
Outpatient/community clinic contact	75.3	92.8
Community rehabilitation/day program	22.9	36.8
Case manager	71.9	78.1
Non-government organisation for mental health	18.9	26.5
General practitioner visits	76.7	87.8

Source: Australian Government (2011), People living with psychotic illness 2010: Report on the second Australian national survey, Canberra, p. 93.

7.2 There is a low rate of mental health treatment, with limited effectiveness and satisfaction

There is a low treatment rate for mental illness

The 2007 NSMH&W revealed most people with mental illness do not receive any treatment for their condition. According to the survey, 65.1% of people with mental illness received no treatment at all, with mental health services use more common among people with more severe disorders.

A comparison with the data from the 1997 NSMH&W shows the proportion of people who did not use services increased very slightly over the ten year period from 64.6% to 65.1%, as shown in Figure 15.

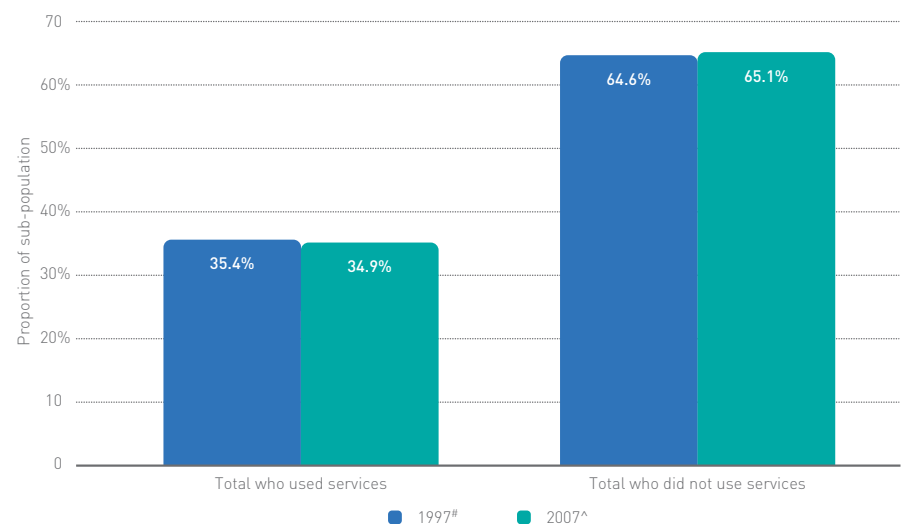
People with a mental illness often have low rates of service usage. This can be for a range of reasons including:

- choosing not to access services
- unavailability of appropriate services
- lack of awareness that services are available
- negative experiences associated with the previous use of services.¹²⁶

Even when services are accessed, people's needs are not being adequately met

Even when people do access mental health services, their needs are often not being met. The 2007 NSMH&W found that, of the people who had both symptoms of a mental disorder and a need for the service, the need was fully met by mental health services in only 31% of cases for social intervention, 44% for skills training and 57% for information (see Figure 16). Counselling met the needs of 68% of respondents and medication 87%.¹²⁷

Figure 15: Proportion of people with mental disorders using mental health services

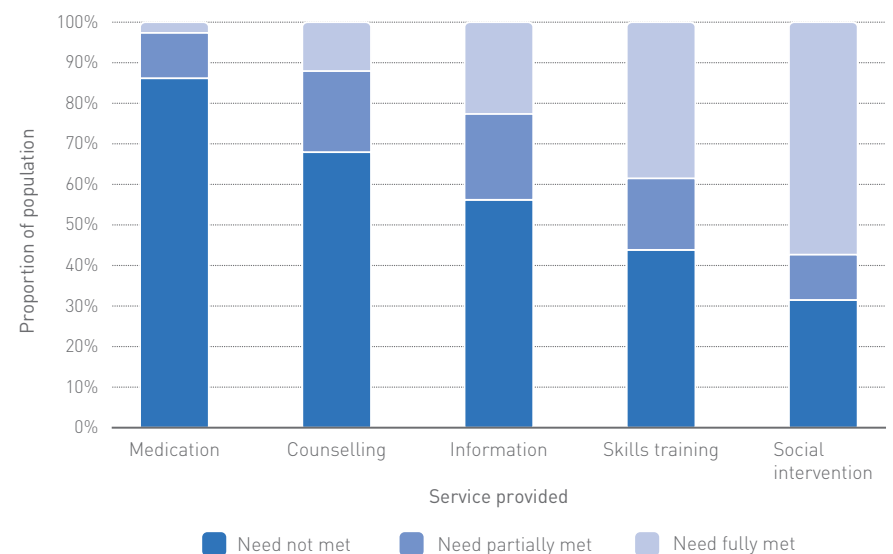


[#]1997 proportions calculated using total number of people with 'mental disorders only'.

[^]2007 proportions calculated using total number of people with 'Lifetime mental disorder with symptoms in 12-month period prior to interview'.

Source: ABS (2007), *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. No. 4326.0, Canberra, p. 44; ABS (2007), *Mental Health and Wellbeing: Profile of Adults, Australia, 1997*, Cat. No. 4326.0, Canberra, p. 35.

Figure 16: Perceived need for help by persons who used services for mental health with any 12 month disorder



Source: ABS (2007), *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. No. 4326.0, Canberra, p. 48.

126. Productivity Commission (2012), *Report on Government Services 2012*, Canberra.

127. ABS (2007), *National Survey of Mental Health and Wellbeing: Summary of results, October 2008*, Cat No. 4326.0, Canberra.

Satisfaction with mental health services lags behind other health services

Satisfaction levels with mental health services are low relative to other health services. Data from the 2012 Menzies – Nous Australian Health Survey found that only 58% of Australians receiving health care services from a mental health provider were happy with the treatment. This is significantly lower than for specialist doctors, general practitioners, nurses and community care, as shown in Table 29.

Table 29: Percentage of people satisfied with their most recent service contact

Type of visit	% satisfied
Visit to a pharmacy	89
Visit to nurse in general practice	85
Visit to private hospital	85
Visit to other allied health provider (e.g., physiotherapist or dietician)	82
Visit to a specialist doctor	79
Visit to GP	78
Visit to a dentist	78
Experience with a community care service delivered at home	72
Visit to public hospital	59
Visit to a mental health provider	58
Experience with a residential aged care facility or nursing home	54

Note: This question was only answered by those who used or experienced the service in the last 12 months.

Source: Menzies Centre for Health Policy and Nous Group (2012), *The Menzies-Nous Australian Health Survey 2012*, Sydney.

7.3 There is limited evidence to support improved mental health outcomes

There is limited longitudinal mental health outcomes data

Relative to other health outcomes, there is limited longitudinal data related to mental health outcomes that can be aggregated at a national level. This is largely due to the changing levels of attention that mental health has received as a health priority in Australia, differences in reporting requirements across states, and the limited number of consistently applied outcomes measurement tools that capture a broad set of health, social and economic indicators. Longitudinal mental health outcomes data is also often limited to small samples that have been used in evaluations for individual projects or programs.

The issue of inadequate outcomes data was highlighted by the Senate Select Committee on Mental Health in their 2006 report: “The dearth of outcome reports in the mental health sector also means there is little ongoing, systematic assessment of the actual health outcomes provided by mental health services. There is generally no data to contradict many of the systemic issues illustrated by personal anecdotes to this committee”.¹²⁸

Table 30: Course of psychotic disorder

Course of psychotic disorder	1997-98 (n=1,087) (%)	2010 (n=738) (%)
Single episode	8.0	7.6
Multiple episodes – good recovery in between	21.3	29.3
Multiple episodes – partial recovery in between	29.5	30.1
Continuous chronic illness	17.6	21.7
Continuous chronic illness with deterioration	23.6	11.3

Source: Australian Government (2011), *People living with psychotic illness 2010: Report on the second Australian national survey*, Canberra, p. 93.

Outcomes for people with a psychotic illness show some positive changes

Longitudinal outcomes data for people with a psychotic illness demonstrates significant and positive changes over the past 15 years in Australia.

Results from the 1997-1998 and 2010 People Living with Psychotic Illness surveys show marked and positive changes in the course of illness for people.

Table 30 shows around half the total survey respondents experienced multiple episodes of psychotic illness, but more experienced periods of good recovery in between these in 2010 than in 1997-98 (29.3% compared with 21.3%). Around 10% of respondents in 2010 experienced continuous chronic psychotic illness with deterioration, half that found in 1997-98.

The People Living with Psychotic Illness surveys also collected data for a suite of demographic, housing and social indicators. These indicators are shown in Table 31 with key changes for 2010 relative to 1997-98 summarised to the right.

Income, education and employment – small positive changes

- Consistent proportion of people on some form of government income support and those that have completed Year 12
- Small increase in people enrolled in formal studies and in paid employment

Housing status – marked positive changes

- Significant increase in people in a rented home or unit
- Double the proportion of people in supported accommodation
- Marked decrease in people experiencing homelessness

Smoking, drug and alcohol abuse/dependent – marked negative changes

- Virtually no change in the proportion of smokers
- Significant increase in the proportion of people with lifetime alcohol and drug abuse/dependence

Social and family relationships – minor negative changes

- Increase in proportion of people who have never had a confiding relationship
- Decrease in people with daily or almost daily face-to-face contact with family.

128. Commonwealth of Australia (2006), *The Senate Select Committee on Mental Health: A national approach to mental health – from crisis to community: First report*, Canberra, p. 208.

Outcomes overall remain mixed

In a discussion of the historical limitations of mental health outcomes data, the National Mental Health Report 2010 acknowledges that existing data is 'both complex and difficult to distil to a single message'. The report's analysis of existing data suggests the clinical outcomes of consumers of state and territory mental health care 'cannot be described by a simple average statistic'.¹²⁹

Longitudinal data from the most consistently applied mental health outcomes measurement tool in Australia — the Health of the Nation Outcome Scales (HoNOS)¹³⁰ — does not indicate any notable trends in outcomes.

Key insights noted in the National Mental Health Report 2010, based on available outcomes data, are shown in Figure 17 and Box 12.

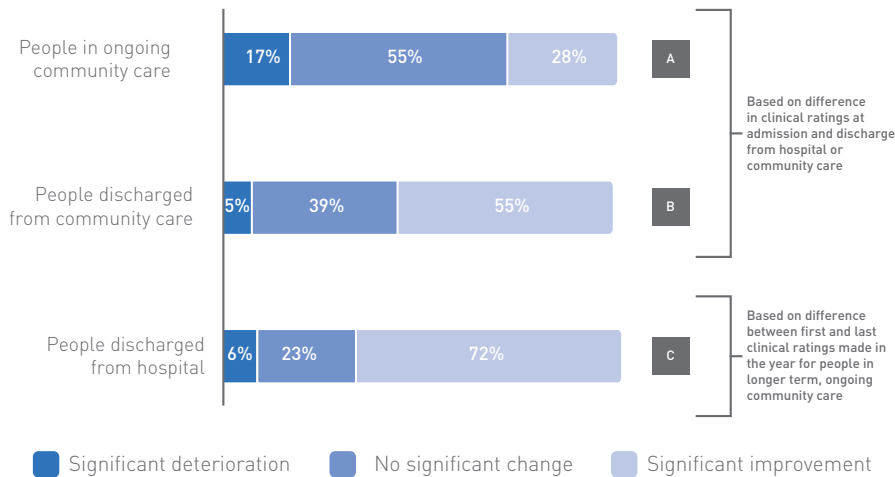
Table 31: Other key health and social outcomes (% of survey respondents)

Key outcomes	1997-98 (%)	2010 (%)
Income, education and employment		
Private health insurance	10.6	14.3
Main source of income: government payment	86.9	87.4
Completed Year 12 education	33.9	31.2
Enrolled in formal studies (past year)	15.3	19.0
In paid employment (past year)	24.3	30.5
In paid employment (past 7 days)	14.8	19.2
Housing status		
Rented home or unit	34.2	49.2
Own home	14.8	12.3
Family home	16.3	19.2
Supported housing	5.2	10.9
Homeless – primary, secondary or tertiary	13.0	5.0
Smoking, drug and alcohol abuse/dependence		
Current smoker	68.9	67.2
Lifetime alcohol abuse/dependence	29.0	50.5
Lifetime drug abuse/dependence	30.4	56.4
Social and family relationships		
No friends	13.2	13.3
Has never had a confiding relationship	9.6	15.7
Daily or almost daily face-to-face contact with family	67.1	55.2
Victim of violence (actual not threatened)	17.0	15.3

129. DoHA [2010], *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 59.

130. HoNOS is a clinician completed measure which assesses a client's health status and the severity of their mental disorder over the previous two weeks. It is used as a standard outcome measure for specialist mental health services across Australia, as well as internationally.

Figure 17: Clinical outcomes of people receiving various types of mental health care, 2006-07



Note: Indicators for all groups based on changes in ratings on the Health of the Nation Outcome Scale 'family' of measures (HoNOS and HoNOSCA), completed by clinicians at various points over the course of a consumer's treatment and care.

Source: Drawn from DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 58.

Box 12: Key outcomes findings, as stated in the National mental health report 2010

- For people admitted to state- and territory-managed psychiatric inpatient units (Group A in Figure 17), approximately three quarters (72%) have a significant reduction in the symptoms that precipitated their hospitalisation. Notwithstanding the changes in symptoms for this group, most remain symptomatic at discharge, pointing to the need for continuing care in the community. For a small percentage (6%), their clinical condition is worse at discharge than at admission. About one in five (23%) is discharged with no significant change in their clinical condition.
- The picture for people treated in the community by state and territory mental health services is more complex because it covers a wide range of people with varying conditions. Some people receive relatively short-term care in the community, entering and exiting care within the year (Group B in Figure 17). For this group, approximately half (55%) experience significant clinical improvement, 5% deteriorate and close to 40% (39%) experience no significant clinical change.
- A second group of consumers of state and territory community care is in longer term ongoing care (Group C in Figure 17). This group, representing a significant proportion of people treated by state and territory community mental health services, is affected by illnesses that are persistent or episodic in nature. More than half of this group (55%) experience no significant change in their clinical condition, compared with around one quarter (28%) who improve and 17% who undergo clinical deterioration. An important caveat to understand for this group is that, for many, 'no clinical change' can be a good result because it indicates that the person has maintained their current level and not undergone a worsening of symptoms.

Source: DoHA (2010), *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993-2008*, Commonwealth of Australia, Canberra, p. 59

8. Selected reform models in Australia and internationally suggest key elements of a successful overall service system

Mental health problems and mental illness, as well as the mental health system, are complex. They include a very diverse set of conditions, each with its own prevalence rate, approach to management and level of impact on individuals, their families and carers. A conceptual model provides categories to help us understand mental illness and the associated service system.

In this report, mental illnesses are categorised by the following degrees of severity – mild, moderate, severe and very severe. The intensity of health care services required to manage mental illness varies in parallel with the level of severity of the illness:

- a relatively low intensity of health care is required for those with mild mental illness
- medium intensity is required for those with moderate mental illness
- high intensity is required for those with severe and very severe mental illness.

Non-health care services are typically received by people who experience moderate, severe or very severe mental illness. These relationships are illustrated in Figure 18.

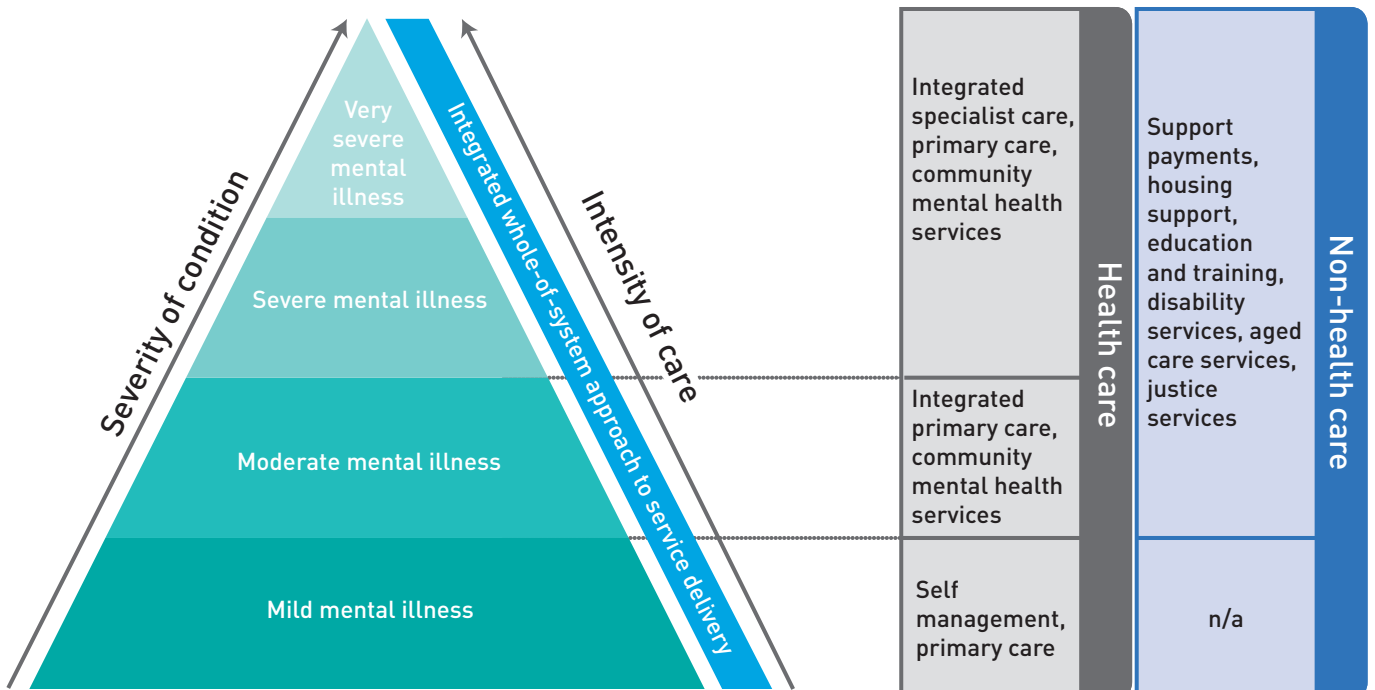
This model has been developed specifically for use within this report.

This section of the report explores Australian and international system-level reforms related to:

- all severities of mental illness (i.e. whole-of-system reforms)
- very severe mental illness
- severe mental illness
- moderate mental illness
- mild mental illness.

In each sub-section, a summary is followed by more detail of particular models. Some overall key elements are presented at the end of this section. Please note that references for this section are listed in Appendix D.

Figure 18: Conceptual model to differentiate systemic approaches to supporting those with mental illness



8.1 Successful whole-of-system reforms are rare internationally, with mixed relevance to Australian circumstances

There are few examples of successful whole-of-system reforms

The complexity of mental health systems means there are few international examples of wholesale reform. In those instances where major reform has occurred, there have been varying degrees of success. The prime examples are:

- The US Veterans Health Administration (VHA) Mental Health Program which is trying to provide uniform, evidence-based services to its geographically dispersed population, with greater transparency over what services are being provided (or not) across its network.
- Trieste in Italy, which provides evidence that deinstitutionalisation of mental health services can be achieved, provided the gap is filled by strong community mental health organisations.

The key enablers of reform would require varied degrees of transformation to Australia's current mental health service system

The experience of these two reforms reveal some key enablers for system-level reform:

- a defined population, either geographically or by need
- a single funding/payment model
- a sophisticated and integrated information technology system (e.g. electronic health record and provider payment systems)
- integrated care pathways between community and tertiary services
- clear clinical guidelines and benchmarks.

Self-contained care systems, with a single stream of funding, meant that the jurisdictions were in a unique position to improve quality in mental health care. To apply this kind of whole-of-system reform in Australia would require payment and organisational reform beyond that outlined in any previous mental health plans or the draft Roadmap for Mental Health Reform. Other aspects of the reforms, while still requiring significant change, would require less transformation to the existing mental health service system. For example, the development of a national framework to ensure consistency and access to mental health services, as seen in the US Veterans example, is not beyond the realm of the existing Australian system. The use of community-based Mental Health Centres operating around the clock, which were fundamental to the success in Trieste, would require some transformation of existing community-based mental health services in Australia.

US Veterans Health Administration Mental Health Program

The VHA introduced a whole-of-system strategy to facilitate the delivery of evidence-based mental health services

The VHA is the largest integrated health-care system in the United States, with more than 150 medical centres, 780 community-based outpatient clinics, 230 Vet Centres, 130 nursing homes and 200,000 full-time-equivalent employees. In the 2009 financial year, the VHA had an annual health budget of US\$44.5 billion, with more than eight million enrollees and treated over 5.7 million patients. The VHA offers a full array of mental health services at its medical centres, including 145 post-traumatic stress disorder (PTSD) specialty clinics. Many of the community-based outpatient clinics offer basic mental health services.

In 2004, VHA introduced a new approach to mental health. A five year strategic plan included more than 200 initiatives to transform the service to focus on recovery, rather than pathology, and integrate mental health care into overall health care for veteran patients.

In 2008, in recognition that the size and organisation of mental health services within different regions vary, the VHA released *The Uniform Mental Health Services in VA Medical Centers and Clinics Handbook*. The handbook set clear standards for the availability of services at Veteran Affairs Medical Centres and Community-Based Outpatient Clinics, to ensure veterans receive the same levels of care, regardless of geographic location.

Location	United States
Size of treated population	5.7 million (over one year) received some form of health care
Type of intervention	Mental health system
Strength of evidence	Fair
Time commenced	2004
Status	Ongoing
Evaluation technique	External evaluation
Applicability to Australia	Low

A substantive external evaluation found increases in capacity, though continued service gaps

In 2009, the VHA commissioned the Altarum Institute and the RAND Corporation to conduct a four-year evaluation of changes to mental health services provided for veterans with schizophrenia, bipolar disorder, PTSD, major depression, and substance use disorders. The evaluation study, known as the 'Capstone Report', is widely seen as the largest and most comprehensive systematic assessment of a mental health system.

The evaluation found that although capacity for treating seriously mentally ill veterans increased since the implementation of the strategic plan, important gaps remained. There was variability in the availability of both basic and specialised mental health services, as well as in the provision of evidence-based practices, suggesting that, for some veterans, access remained a problem. In most instances, VHA care performance was as good as or better than that reported by other organisations or shown by direct comparisons with other systems of care.

Trieste Mental Health Department

Community-based services are at the heart of the Trieste mental health system

The Mental Health Department (MHD) of Trieste is a single organisation that provides a range of mental health services to the region (approximately 250,000 people). It is a psychiatrist-driven model that has a commitment to de-institutionalisation and community-based services. The MHD is made up of four key bodies:

1. **Mental Health Centres (MHC)** are responsible for providing psychiatric assistance for a specific catchment area. The MHC's operate 24 hours a day, seven days a week and are staffed by nurses, social workers, psychologists and psychiatrists. Services include out-patient visits, individual, group and family therapy, social network capacity building, and provision of meals, either in the centre or in people's homes. There are eight beds in each centre for day and overnight "hospitality" that offer an alternative to hospitalisation, and help avoid recourse to the Psychiatric Diagnostic and Treatment Station (PDTS) within the General Hospital.
2. **Psychiatric Diagnostic and Treatment Station (PDTS)** is an emergency psychiatric service located within the region's General Hospital. It has eight beds and provides psychiatric primary care and counselling services for the other hospital wards. It also provides mental health triage services to the General Hospital Emergency Room, and makes referrals to the community mental health services (where necessary). MHC's control and manage the PDTS' activities and are responsible for developing community treatment for patients.

Location	Italy
Population base	250,000
Type of intervention	Mental health system
Strength of evidence	Self reported
Time commenced	2004
Status	Ongoing
Evaluation technique	Internal evaluation
Applicability to Australia	Medium

4. **Day Centres** provided psycho-social services, such as accommodation, rehabilitation, education, training and social-welfare interventions (directly or indirectly through the activation of other agencies). People from the greater community without mental illness are encouraged to use these centres to promote integration.
 5. **Specialised work co-operatives** provide employment for worker-members and training for young people with mental illness. The co-operatives include cooking, cleaning, hotel, book-bindery and construction.
- **Lower rates of involuntary treatment** – only seven Trieste residents per 100,000 residents are subject to involuntary treatment, compared with 30 per 100,000 for Italy overall
 - **No homelessness and little incarceration** – no one with mental illness is homeless in the region and only one mentally ill person is in a forensic hospital
 - **Employment opportunities** – 400 people with mental illness are employed on award wages in social co-operatives and a further 200 people are employed in private firms.

Trieste is internationally recognised as achieving successful de-institutionalisation of mental health services

The Trieste mental health system is lauded internationally. In 2010, it was designated as a World Health Organisation (WHO) Collaborating Centre for Research and Training in Mental Health. Evidence of its achievements, as reported by the Trieste Mental Health Department and repeated by Senator Lynn Alison, Chair Senate Select Committee on Mental Health in 2006, include:

- **Substantial population coverage** – 70% of the Trieste population now have access to a local, 24 hour, 7 day a week mental health service
- **Decreased suicide** – suicide rates have been reduced by 30%

There is no available independent evaluation of this model.

8.2 There is some evidence for very intensive person-centred case management of comprehensive community-based services to support people with very severe mental illness

The characteristics of people with very severe mental illness and the key services and challenges associated with supporting these people are outlined in Table 32.

Table 32: Overview of services and challenges for people with a very severe mental illness

Description of illnesses	Complex needs associated with the presence of multiple, often severe, mental illnesses
Key clinical services	Crisis planning, mobile emergency treatment, intensive case management, psychopharmacologic treatment, acute and sub-acute clinical care, alcohol and substance abuse treatment
Key social services	Secure housing (staffed and non-staffed residential care), intensive psychosocial rehabilitation services (employment, education, day programs), welfare and carer support payments, legal support, justice services, social connectedness, family and network support
Major challenges to support those with very severe mental illness	<ul style="list-style-type: none"> • High and very complex needs • High rates of intensive treatment • Maintenance of continuity of care – a lack of continuity results in regular relapses of the mental illness • Breakdown of relationships with family and friends leading to social isolation and a lack of informal supports • High-levels of carer stress from mental, emotional, physical, financial and social perspectives • High rate of unemployment • High rate of comorbid substance use • Very poor physical health • High rate of homelessness • High rates of incarceration in the justice system • Case coordinators/case managers experience high workloads

Effective service provision for people with very severe mental illness is a worldwide challenge

The delivery and cost of providing services to patients with very severe mental illness are key challenges faced by mental health systems worldwide. In most jurisdictions, such patients account for a disproportionately large proportion of utilization and costs. People with very severe mental illness often spend a lot of time in and out of hospitals.

There is evidence to support a coordinated approach to treating people with very severe mental illness

There are a range of initiatives that use a very intensive, person-centred, coordinated case management approach to effectively assist people with very severe mental illness with comprehensive ongoing support in all key aspects of their lives including health, housing, social connection and safety. Most effective models include both health and non health services; different programs place a different emphasis on each.

There is evidence that effective management of these patients in community settings, with Intensive Case Management (ICM) models such as Assertive Community Treatment, can decrease rates and length of hospital stays and produce cost savings. Since the early 1990s, the Assertive Community Treatment model has been adopted in some Australian states. It is part of Victoria's general framework for adult mental health services in the form of Mobile Support and Treatment Teams (MSTTs).

Small scale initiatives such as the Multiple and Complex Needs Initiative (MACNI) in Victoria have also trialled a co-ordinated approach to assist people with very severe mental illness.

There is robust data to support the use of evidence-based ICM programs such as Assertive Community Treatment in frameworks for the delivery of services to people with very severe mental illness.

Multiple and Complex Needs Initiative

A multifaceted approach was introduced to coordinate the care of complex clients in Victoria

The Multiple and Complex Needs Initiative was developed by the Victorian Department of Human Services in 2003.¹³¹ It provides specialist intervention for those aged 16 years and older with the most complex mental health needs. This includes people with multiple mental illnesses, substance abuse issues, intellectual impairment, acquired brain injury, frequent contact with forensic services, and who posed a risk to themselves and/or to the community.

The initiative was designed to achieve a more effective and coordinated approach to provide the target population with stable health, housing, social connection and safety, and comprehensive ongoing support. To support the initiative, new legislative and service frameworks were developed. *The Human Services (Complex Needs) Act 2003* established a new statutory panel to ensure appropriate service delivery for the target population.

The initiative involved three key components:

- A **Multiple and Complex Needs (MACN) Panel** determined eligibility from referrals made by MACNI Regional Coordinators, oversaw the development and execution of care plans for individuals, and allocated brokerage funds where appropriate.

Location	Victoria
Size of population	<100
Type of intervention	Case management
Strength of evidence	Weak
Time commenced	2003
Status	Ongoing
Evaluation technique	External evaluation
Applicability to Australia	High

- A **Multidisciplinary Assessment and Care Planning Service** with NGOs funded to conduct comprehensive assessments and care planning with the individual and relevant services. A care plan coordinator then works in partnership with the individual and the services identified in the care plan to achieve the aims documented in the plan.
- An **Intensive Case Management Service** provided by a care plan coordinator if no care services are available.

There is some evidence for small improvements, though at significant cost

An external evaluation of the initiative was completed in 2007. It found that of the 56 consumers with a MACNI care plan, around half demonstrated behavioural improvements and a quarter demonstrated greater engagement with care managers and other community supports. Overall functional improvements were not seen across the population and for almost one quarter there had been a deterioration in behaviour. Improved outcomes for many consumers was dependent on lower substance abuse. The evaluation also noted limited cost-effectiveness, reflecting the significant set-up costs and relatively small trial population. It was suggested that, over time, cost-effectiveness should increase.

MACNI services continue to be available in Victoria, drawing on the networks and infrastructure developed for the initial trial. Ongoing evaluation of the initiative will be needed to establish a firmer evidence base.

131. The initiative was jointly funded by the Department of Human Services and the Department of Justice.

Assertive Community Treatment

The Assertive Community Treatment approach involves multidisciplinary inpatient type services provided in the community

Assertive Community Treatment is an intensive and highly integrated approach for community mental health service delivery. Assertive Community Treatment has been widely implemented in Australia, Canada and England. The Department of Veterans Affairs has also implemented Assertive Community Treatment across the United States.

The program is delivered by a team of professionals, with backgrounds and training in social work, rehabilitation, counselling, nursing and psychiatry. Unlike other community-based programs, Assertive Community Treatment provides highly individualised services directly to consumers. Recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit but within their own home and community.

Assertive Community Treatment involves comprehensive treatment, rehabilitation and support services. Across these areas, the key services include:

- **Treatment:** psychopharmacologic treatment, individual supportive therapy, mobile crisis intervention, hospitalisation and substance abuse treatment
- **Rehabilitation:** behaviour therapy and skill teaching, supported employment (paid and volunteer work) and support for resuming education
- **Support services:** support and collaboration with family members, assistance obtaining legal and advocacy services, financial support, supported housing, money-management services and transportation.

Location	Numerous countries
Size of population	n/a
Type of intervention	Intensive case management
Strength of evidence	Good
Time commenced	1970s
Status	Ongoing
Evaluation technique	Randomised controlled trials (RCTs) and Cochrane review
Applicability to Australia	High

Assertive Community Treatment is a proven approach for patients with a history of multiple hospitalisations

There is fairly robust evidence that Assertive Community Treatment, as a form of ICM, is effective. This claim has been supported by experimental research replicated in numerous studies. A 2010 Cochrane Review of ICM for severe mental illness found that, compared to treatment as usual or standard care, ICM models like Assertive Community Treatment reduced hospitalisation and increased retention in care. The authors found ICM models that adhere most closely to the Assertive Community Treatment approach are more effective in decreasing time in hospital. The review by Mueser et al (1998) of RCTs, found that, compared with “usual mental health care”,

Assertive Community Treatment teams:

- increased and maintained contact with care
- decreased use of hospital-based mental health care
- improved consumer outcomes (including quality of life)
- reduced symptoms experienced
- increased housing stability.

Most economic analyses have found Assertive Community Treatment reduces treatment costs compared with standard case management approaches. This reduction has been largely attributed to reduced hospital bed days. The treatment is therefore most cost-effective for individuals with a history of multiple hospitalisations.

8.3 People with severe mental illness require similar services to those with very severe mental illness but with less intensive case coordination

The characteristics of people with severe mental illness and the key services and challenges associated with supporting these people are outlined in Table 33.

Table 33: Overview of services and challenges for people with a severe mental illness

Description of illnesses	Bipolar disorder, schizophrenia, schizoaffective disorders, severe depression, severe anxiety, acute psychotic disorders, severe personality disorders, severe substance use disorders
Key clinical services	Case management, acute and sub-acute clinical care, psychopharmacologic treatment, crisis planning, mobile emergency treatment, alcohol and substance abuse treatment
Key social services	Intensive psychosocial rehabilitation services (employment, education, day programs), housing services (to coordinate access to stable housing and provide partially staffed residential care), welfare and carer support payments, social connectedness, family and network support, legal support, justice services
Major challenges to support those with severe mental illness	<ul style="list-style-type: none"> • Maintenance of continuity of care – a lack results in regular relapses of the mental illness • Breakdown of relationships with family and friends leading to social isolation and a lack of informal supports • High-levels of carer stress from mental, emotional, physical, financial and social perspectives • High rate of unemployment • High rate of comorbid substance use • Poor physical health • High rate of homelessness • High rate of contact with the criminal justice system • Case coordinators/case managers experience high workloads

Severe mental illness requires case management approaches integrating health and non health services

People with severe mental illness less frequently require inpatient care than those with very severe mental illness. However, the literature supports the widely held view that gaps in service provision result in a high-level of hospitalisations and readmissions for people with severe mental illness.

There is evidence that effective support requires the clear integration of a comprehensive range of hospital-based care, community clinical treatments, primary care and non-health services such as housing and employment programs.

Some case management and care coordination approaches show promise

At the core of most successful models is a case management / care coordination function helping patients to navigate their way through clinical and community services and avoid hospitalisation. In that context, a number of models have shown promise:

- “Step up, step down” services like Prevention and Recovery Care have had some success in reducing hospitalisations
- Intensive psychosocial rehabilitation programs, such as community Clubhouses and Wraparound services, have aided people’s recovery
- An example of how severe mental illness can be treated in a primary care setting, with collaboration between specialist level care and primary care, is provided by the Consultant Liaison in Primary Care Psychiatry model
- There is emerging evidence that integrated care models such as HealthChoicesHealthConnections are effective ways to manage comorbid patients.

Further development and a better evidence base is needed to understand the applicability for Australia

Community-based recovery programs are provided in Australia, though there is no evidence to support the efficacy of many programs. The evidence-based practice incorporated in the Clubhouse model is currently being used at nine sites in NSW, Queensland, South Australia and Tasmania. The services are a part of the psychosocial support provided by NGOs, but the degree of integration in Australia does not match Finland. The model does warrant further consideration, as strengthening existing partnerships with clinical mental health services is possible.

The use of “navigators”, as in the HealthChoices initiative, to provide the “glue” between clients and a range of services (both clinical and psychosocial) is being explored in Australia with the Partners in Recovery Program. The program (still in development) will use Support Facilitators to navigate the complex health and social services system on behalf of the client. The program is being developed by Medicare Locals in partnership with NGOs to respond to local needs. It remains to be seen if these organisations will have the capacity to deliver the services effectively.

Prevention and Recovery Care (PARC)

PARC services provide a short-term residential clinical treatment and social rehabilitation program

Adult prevention and recovery care (PARC) services are a partnership between Area Mental Health clinical services and NGO recovery services. They enable people with severe mental illness to receive clinical intervention and treatment with active support for their recovery in a safe and supportive setting. The services are short-term and provided in a residential setting with a focus on daily living and practical assistance.

“Step up, step down” PARC services provide early intervention for people who are either becoming unwell or are in the early stages of recovery from an acute psychiatric episode. A person can enter a PARC service from their place of residence (step up) or from an inpatient unit (step down). Admission to a PARC service is voluntary.

PARC services include clinical community intervention and treatment (crisis support planning, symptom control and relapse prevention). This involves individually-tailored recovery care planning and implementation in addition to different types and levels of psychosocial and other support to encourage functionality and engagement with the community (including family, study or work).

Location	Victoria, Australia
Size of population	800 (as at 2008)
Type of intervention	Residential rehabilitation
Strength of evidence	Emerging
Time commenced	2003
Status	Ongoing
Evaluation technique	External evaluation
Applicability to Australia	High

The PARC model shows promise and is highly regarded by clients and health professionals

The initial PARC pilots were independently evaluated in 2008. A consistent finding was that PARC services had a positive effect on people’s well-being and were also well regarded by carers and users of services. Clinical professionals believed continuity of care improved under the PARC model. The combination of clinical and psychosocial care was regarded as one of the PARC model’s main strengths. Although readmission rates were no lower in the pilot, there was evidence that PARC services improved clients’ abilities to access community-based services. PARC services were found to be less expensive than inpatient care, although the low occupancy rates meant they were more expensive than alternative community-based services. Like Assertive Community Treatment, treatment is most

cost-effective for individuals with a history of multiple hospitalisations.

It should be noted that although PARC services show promise, further evaluations are needed to assess their impact on client outcomes. The conclusions in the 2008 evaluation were based on qualitative data gathered from interviews with professional staff associated with delivering or managing PARC services. The 2008 evaluation did not include any analysis of client outcomes data or qualitative data collected directly from current or former PARC clients.¹³²

132. Forwood A, Reed C, Reed M, Roose D, Ryan S (2008), *Final Report for Evaluation of the Prevention and Recovery Care (PARC) Services Project*, Dench McClean Carlson, p. v.

Clubhouse model

The Clubhouse model involves local community centres providing psychosocial rehabilitation

Clubhouses offer a psychosocial rehabilitation programs that operate out of community centres in numerous countries. They are a place where people with serious mental illness – known as “members” – participate in their own recovery process by working and socialising together in a “clubhouse”. It is a community-based approach that complements available psychiatric treatment. The key components of successful Clubhouses are:

- A **work-ordered day** that parallels the typical business hours of the working community where the Clubhouse is located. Members and staff work side by side as colleagues to perform work that is important to their community.
- **Community support** for members in acquiring and maintaining affordable housing, psychiatric and general medical services, government disability benefits and other services.
- **Employment programs** that provide members with opportunities to return to paid employment in integrated work settings through both transitional employment and independent employment programs.
- **Evening, weekend and holiday social and recreational activities** organised by members and staff that provide social and recreational programming.
- A **'reach-out' service** when a member does not attend the Clubhouse or is in hospital, provided through a telephone call or visit. This process not only encourages members to participate, but it is also an early warning system for members who are experiencing difficulties and may need extra help.

Location	Numerous countries
Size of population	300 Clubhouses around the world
Type of intervention	Residential rehabilitation
Strength of evidence	Fair
Time commenced	1948
Status	Ongoing
Evaluation technique	RCT, Cohort trials
Applicability to Australia	High

- **Educational opportunities** for members to complete or start certificate and degree programs.

There is evidence to support a positive effect on employment

The Clubhouse model has been rigorously evaluated, unlike a number of other mental health initiatives. In 2010, the US National Registry of Evidence-based Programs and Practices conducted a meta review of research on the Clubhouse model. The review found strong evidence that the model contributed to better employment outcomes for members, though weaker evidence for improved quality of life and recovery.

Finland has incorporated Clubhouses as a part of an integrated mental health system

The Clubhouse model is used in Finland as a central part of their “Integrated Pathway from Dependency to Independent Living” for those living with mental illness. The first Finnish Clubhouse was opened in 1995 and 22 Clubhouses existed in 2010. The model is accepted as an evidence-based psychosocial rehabilitation model in the new Finnish national development program for mental health services.¹³³ The network of Clubhouses is planned to expand to all of the nation’s health Regions and Service Districts by 2015.

133. Ministry of Social Affairs and Health (2010), *Plan for mental health and substance abuse work: Proposals of the Mieli 2009 working group to develop mental health and substance abuse work until 2015*. Available at http://info.stakes.fi/NR/rdonlyres/F0094BDE-EEBE-4635-93B5-BE77571B4FE0/0/Mieli_Plan_1607.pdf.

The Wraparound model

The Wraparound model provides a holistic individualised care planning and management process

The Wraparound model is an intensive, holistic method of engaging with individuals with complex needs (typically children, youth, and their families) to help them live in their homes and communities. The term “wraparound” has been defined in different ways since it was first coined in the 1980s. It has been described as a philosophy, an approach and a service. In recent years, “wraparound” has been most commonly conceived of as an intensive, individualized care planning and management process.

Wraparound plans are more holistic than traditional care plans and are designed to meet the needs of clients and their families in a range of life areas. A team of people relevant to the client (such as family members, members of the family’s social support network and service providers) work with a care coordinator to collaboratively develop the plan of care, implement the plan, monitor the efficacy of the plan and work towards success over time. This team-based planning and implementation process aims to develop the problem-solving skills, coping skills, and self-efficacy of individuals and their families. There is also an emphasis on integrating the individual into the community and building the family’s social support network.

Location	Numerous countries
Size of population	89,000
Type of intervention	Care planning
Strength of evidence	Emerging
Time commenced	1980s
Status	Ongoing
Evaluation technique	Controlled trials
Applicability to Australia	High

There is mixed evidence on the effectiveness of the Wraparound model relative to alternative approaches

Proponents of the Wraparound model believe there is growing evidence that implementation of High Fidelity versions of the model (models that strictly follow the framework developed by the National Wraparound Initiative) for youth with multiple and complex needs and their families are an improvement over more traditional service delivery methods. The widespread adoption of the model in the US and elsewhere reflects the model’s:

- documented success in promoting shifts from residential treatment and inpatient options to community-based care (and associated cost savings)
- alignment with the value base for systems of care (services that are community-based, child centred, family focused and culturally competent)
- resonance with families and family advocates.

A number of controlled studies have indicated modest improvements in living situation, behavioural, functional and community outcomes for Wraparound clients when compared to “services as usual”. However “real world” implementations have not been as positive. A 2011 study that compared the Wraparound model with a more traditional ICM program found the controlled outcomes were not replicated.¹³⁴ The study concluded that ICM provided by an individual who also provided clinical services was more effective.

134. Eric Bruns, Michael Pullmann, April Sather Ramona Denby-Brinson & Michelle Ramey, *Implementation and outcomes of wraparound in a “real world” system: Results of a randomized study* Presentation at the Seattle Implementation Research Conference October 14, 2011, available on at: <http://www.nwi.pdx.edu/index.shtml>.

Consultant Liaison in Primary Care Psychiatry (CLIPP)

CLIPP is a collaborative primary care model for patients with severe mental illness

The CLIPP model was developed in the late 1990s by Professor Graham Meadows from Monash University. It is used in many health districts in Australia.

The model has three key components that enable effective collaboration between the private (GPs) and public sectors (Community Mental Health Services):

- Consultation Liaison which involves psychiatrist attachments provided to general practices from public sector mental health services to **conduct assessment of patients** referred by GPs. This helps to facilitate early intervention and provides advice and support for GPs caring for transferred patients.
- A CLIPP liaison clinician (usually a psychiatric nurse) who **identifies suitable individuals in community mental health services** to enter into collaborative care with their GP for clinical management. The liaison clinician engages with case managers and psychiatrists, and the transfer of care is supported by a detailed management plan. The liaison clinician also offers direct support and practical assistance to the individual, their carer and their GP, and the support of crisis services after hours (if necessary).
- A system for **case registration and tracking of patients** to ensure high-levels of retention and effective follow-up. A software program provides regular clinician reminders and recall systems that can be tailored to particular patients. Attendance is typically monitored every three months and psychiatrist reviews are prompted every six to 12 months.

Location	Australia
Size of population	Unknown
Type of intervention	Collaborative care
Strength of evidence	Emerging
Time commenced	1990s
Status	Ongoing
Evaluation technique	Observational studies
Applicability to Australia	High

There is emerging evidence to support collaboration between public sector mental health services and GPs

The CLIPP program has not been evaluated extensively. Observational findings, yet to be confirmed by more robust research, suggest that, under CLIPP processes, there is not a substantial or continuing clinical or functional deterioration in patients after transfer from specialist management to collaborative care managed by GPs. The model has also been praised internationally as an example of how severe mental illness can be managed in a primary care setting.

The CLIPP approach, in various guises, is used across Australia. Central to the success of the program, according to its supporters, is the development of a sound and informed professional working relationship between GPs and mental health service staff, and acknowledgment of the roles and capacities of both parties in the provision of mental health care services to people with severe mental illness.

HealthChoicesHealth Connections

The navigator model is designed to coordinate an individual's package of care and services in the community

HealthChoicesHealthConnections is a collaborative demonstration project in south-eastern Pennsylvania.¹³⁵ It aims to integrate primary and behavioural care services for Medicaid beneficiaries with serious mental illness through the use of a navigator model or "Wellness Recovery Team" (WRT).

The WRT, consisting of a Clinical Navigator (either a registered nurse or a Masters level counsellor/psychologist) and an Administrative Navigator, are based in the community. The team performs a number of roles, including:

- triage and planning
- informing primary carers and behavioural (mental health) carers of any hospitalisations
- conducting discharge planning and coordination
- providing links to community support and referrals (where necessary)
- retaining an ongoing relationship with the primary care professionals and psychiatrists
- consulting and collaborating with pharmacists
- undertaking preventative care and education.

To facilitate the provision of integrated services, a member's comprehensive health profile – including treatment plans, medications and provider contacts – is provided to all involved physicians, therapists and treatment teams. This helps to ensure maximum coordination of the individual's care.

Location	United States
Size of population	4,788
Type of intervention	Care coordination
Strength of evidence	Emerging
Time commenced	2008
Status	Demonstration project
Evaluation technique	External evaluation
Applicability to Australia	High

An initial evaluation provided evidence of reduced admissions and increases in patient functionality

As a US government funded demonstration project, HealthChoicesHealthConnections is the subject of ongoing evaluation by the Independent Pharmaceutical Research Organization (IPRO) and Mathematica Policy Research. An initial cost impact study conducted by Magellan Behavioral Health of Pennsylvania (the administrator of the project) in 2011 examined 137 participants in the WRT model. It considered their health care utilisation patterns in the six months prior to and subsequent to joining the program. The study found:

- admissions to emergency rooms decreased by 11%
- admissions to medical facilities decreased by 56%
- admissions to psychiatric hospitals decreased by 43%
- the need for an assisted residential environment decreased by 14%.

A self assessment monitoring status and quality of services also revealed that program participants, compared to non-participants, experienced greater improvement in behavioural symptoms, strength, work/school participation and improvements in both emotional and physical health.

135. The initiative was sponsored by the Pennsylvania Department of Public Welfare and the Center for Health Care Strategies. Program partners were Keystone Mercy Health Plan, the Behavioral Health leadership of Bucks, Delaware, and Montgomery counties and Magellan Behavioral Health of Pennsylvania (the administrative partner of the counties).

Housing and Accommodation Support Initiative (HASI)

HASI links mental health services, housing and social support

HASI supports eligible adults with mental illness with packages of mental health, housing and accommodation support. The support is designed to achieve improvements in mental health, housing stability and quality of life, and increase community participation.

Under HASI, NSW Health, Housing NSW and NGOs collaborate to provide:

- accommodation support and rehabilitation associated with disability (delivered by NGOs and funded by NSW Health)
- clinical care and rehabilitation (delivered by specialist mental health services)
- long-term, secure and affordable housing and property, and tenancy management services (delivered by social housing providers).

Since the implementation of HASI Stage One, which funded high-level support services (up to five hours of support per day, seven days per week) in 2002, HASI has expanded to provide low (up to five hours of support per week) to very high (up to eight hours of support per day, seven days per week) levels of support to people with mental illness across NSW.

Location	NSW, Australia
Size of population	> 1000
Type of intervention	Supported housing program
Strength of evidence	Good
Time commenced	2002
Status	Ongoing
Evaluation technique	External evaluation
Applicability to Australia	High

An independent evaluation found significant improvements in a number of areas

HASI has been independently evaluated by the Social Policy Research Centre (SPRC) at the University of NSW. The SPRC's longitudinal evaluation of HASI found:

- almost 85% of clients successfully maintained their tenancy
- hospitalisation rates were reduced by 34%
- the average number of days people spent in hospital per year decreased by 60%
- the average number of days hospitalised per mental health admission decreased by 68%

- frequency and quality of contact with family improved
- at least 60% of clients were reported to be independent or supported less than half the time in all areas of daily living including personal care, cooking, taking medication and transport, cleaning and exercise.
- a statistically significant decrease in behavioural issues.

An economic analysis of HASI revealed the recurrent annual program costs were significant at \$57,530 per person. This needs to be considered against the significant cost savings through reduced need for emergency department and psychiatric hospitalisation, and improved quality of life.

8.4 Successful primary care initiatives to treat clients with moderate mental illness are applicable to Australia

The characteristics of people with moderate mental illness and the key services and challenges associated with supporting these people are outlined in Table 34.

Table 34: Overview of services and challenges for people with a moderate mental illness

Description of illnesses	Major depression, moderately severe anxiety disorders, moderately severe personality disorders, moderately severe eating disorders, moderately severe dementia, moderately severe substance use disorders
Key clinical services	Integrated primary care, community mental health care, case management, psychiatrist supervision, psychopharmacological treatment
Key social services	Welfare payments, social connectedness, family and network support
Major challenges to support those with moderate mental illness	<ul style="list-style-type: none"> • Provision of adequate support through primary and community care settings to prevent the need for hospitalisation • Sufficient coordination of care • Breakdown of relationships with family and friends leading to social isolation and a lack of informal supports • Moderate levels of carer stress from mental, emotional, physical, financial and social perspectives • Moderate rate of comorbid substance use • Poor physical health

A number of US initiatives provide evidence that clients with moderate mental illness can be successfully treated in primary care settings. The improvements built on systematic changes in the delivery of care and show that general practices are able to implement and sustain improvements when offered a standardised care management program and adequate support. There is also evidence that other chronic conditions (comorbid or not) including chronic heart failure, diabetes and asthma would benefit from such programs.

The successful models incorporated three key features:

- standardised programs with implementation customised to each setting (to accommodate large or small health care organisations)
- a care manager who is a centralised resource not necessarily located in the primary care practice who managed patients in collaboration with the clinician and retained overall responsibility for patient care
- a psychiatrist who supervised the care manager, provided guidance to the clinician through the care manager, and advised the clinician directly as needed.

These initiatives could be translated to the Australian context.

Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)

IMPACT is a collaborative depression care model based in primary care

IMPACT is a model of collaborative care for depression, developed by Jurgen Unutzer at the University of Washington. It is a stepped care program that utilises a depression care manager along with the patient, primary care physician (PCP) and a consultant psychiatrist. The model has been piloted (and subsequently used) in a number of states in the US.

The patient's PCP works with a care manager to develop and implement a treatment plan (including medications and/or brief, evidence-based psychotherapy). The depression care manager (nurse, social worker or psychologist) provides: education regarding depression, medication effects and side effects; brief courses of counselling; and monitoring of the patient using the PH-Q9 (a self reported, nine question Patient Health Questionnaire) with adjustments to treatment plans as needed. A designated psychiatrist consults the care manager and PCP on the care of patients who do not respond to treatments as expected.

Treatment is adjusted based on clinical outcomes and according to an evidence-based algorithm. The initial aim is for a 50% reduction in symptoms within 10-12 weeks. If the patient has not significantly improved by this time, the treatment is "stepped up".

Location	US
Size of population	1801 (initial study population)
Type of intervention	Collaborative care
Strength of evidence	Fair
Time commenced	1998
Status	Ongoing
Evaluation technique	Controlled trials
Applicability to Australia	High

There is evidence IMPACT substantially improves the effectiveness of depression treatment and reduces total care costs

The efficacy of IMPACT has been subject to a substantial treatment trial. In one of the largest treatment trials for depression to date, 1,801 depressed, older adults from 18 diverse primary care clinics across the US were followed for two years. The results showed that participation in the IMPACT model more than doubled the effectiveness of depression treatment for older adults in primary care settings and led to improved physical functioning for patients. The benefits of the IMPACT intervention (both mental and physical) also persisted after one year.

IMPACT has also proved to be a cost-effective way of reducing total health care costs. When healthcare costs were examined over a four year period, IMPACT patients had lower average costs for all their medical care than patients receiving usual care (by approximately US\$3 300) even when the cost of implementing the program was included.

These findings are consistent with a substantial body of evidence for collaborative care for depression that has emerged over the past 10 years.

Depression Improvement Across Minnesota— Offering a New Direction (DIAMOND)

The DIAMOND program introduced a primary care program for treating people with depression

DIAMOND is a primary care program that aims to improve health care for people with depression. It was launched in March 2008 by The Institute for Clinical Systems Improvement (ICSI), a non-profit quality improvement organisation. The program is available through 74 primary care clinics in Minnesota. The model is based on the collaborative care model IMPACT.

The DIAMOND program's six key components are:

1. Use of a validated screening tool, the PHQ-9 (Patient Health Questionnaire), for diagnosis and ongoing management of depression.
2. Systematic patient follow-up, tracking and monitoring with PHQ-9 measurements and use of a patient registry to track changing PHQ-9 scores over time.
3. Use of evidence-based guidelines and a stepped-care approach for treatment modification.
4. Relapse prevention planning for patients.
5. A care manager who educates, coordinates care and troubleshoots services for patients.
6. Psychiatric consultation and caseload review.

Location	Minnesota, United States
Size of population	8,000
Type of intervention	Collaborative care
Strength of evidence	Emerging
Time commenced	2008
Status	Ongoing
Evaluation technique	Internal evaluation
Applicability to Australia	High

There is evidence the DIAMOND program leads to a substantial reduction in remission

An internal research study was conducted by the ICSI four years into the program after more than 8,000 patients were assisted.

Participating DIAMOND clinics collectively reported that after six months:

- 30% of their patients with depression achieved remission (PHQ-9 score of 9 or lower)
- 40% achieved a response (a drop of at least 50% in the initial PHQ-9 score).

These results improved after 12 months:

- 53% of patients achieved remission
- 70% achieved a response.

The ICSI concluded that these results indicate the program's effectiveness over time and the success of its relapse prevention component.

The Three Component Model (3CM)

The 3CM is a primary care based collaborative care model for depression management

The 3CM is a specific clinical model for depression management. It was developed by the Macarthur Initiative on Depression in Primary Care and is widely used across the US by major health care providers such as Magellan, Beacon Health, Blue Cross Blue Shield of Georgia, Aetna, the US Military, and the New York City Department of Health and Mental Hygiene.

The three components of the model are: (1) a physician; (2) a care manager (usually a medical assistant or practice staff); and (3) a mental health specialist. These individuals work collaboratively with the patient and each other to provide care. The key features of the model are:

- responsibilities and routines are clearly defined for all parties
- education to prepare the practice staff and the physician to deliver the program (including assessment tools and patient education materials)
- patients receive scheduled calls from care managers to assist them to overcome adherence barriers and to support them in self-management activities
- the care manager provides feedback about the patient's response to treatment to the mental health specialist and physician
- a close relationship between the physician and mental health specialist
- the mental health specialist, typically a psychiatrist, provides guidance to care managers and physicians (including changes in management) through weekly telephone calls.

Location	US
Size of population	8,000
Type of intervention	Collaborative care
Strength of evidence	Fair
Time commenced	2008
Status	Ongoing
Evaluation technique	Controlled trials
Applicability to Australia	High

3CM has led to increased treatment responses and patient satisfaction

A clinical trial of 3CM, known as the RESPECT-Depression Initiative, was conducted on over 400 participants from five health care organisations across the US in 2002. The results indicated that, over a six-month period, patients in the program achieved better outcomes than patients in usual care with a greater:

- response rate for program patients (60%) than patients in usual care (47%)
- remission rate for program patients (37%) than patients in usual care (27%)
- proportion of program patients rating their depression care as either good or excellent (90%) compared with patients in usual care (75%).

A number of organisations involved in the pilot have continued the model with minimal modification, despite there being no further examination since the initial research in the early 2000s. The model has also been adopted more broadly, including by the US military. In spite of initial research into the military version of the program showing an increase in utilisation and costs, the US Army Medical Command in 2011 directed the program be implemented in military medical facilities.

TEAMCare model

TEAMCare is a collaborative care model for depression and comorbid physical conditions

The TEAMCare model was developed by the University of Washington and the Group Health Research Institute. The model integrates a chronic care model with collaborative depression care (IMPACT, 3CM) principles and approaches to systematically provide comprehensive care for patients with diabetes, coronary heart disease and depression simultaneously.

The program is delivered in the patient's primary care clinic and by telephone. It relies on collaboration between the patient, the TEAMCare nurse care manager, the patient's primary care physician, a supervising specialist (i.e. psychiatrist or psychologist) and consultants as needed (such as a diabetologist or cardiologist).

The core elements of the team care intervention are:

- evidence-based treatment guidelines for each chronic condition – diabetes, hypertension, depression and coronary heart disease
- continuity of care with the primary care physician and nurse care manager to enhance accountability for better outcomes
- a clinical information system
- weekly case review and supervision by physicians
- specialty consultations as needed.

Location	US
Size of population	8000
Type of intervention	Collaborative care
Strength of evidence	Fair
Time commenced	2008
Status	Ongoing
Evaluation technique	Controlled trials
Applicability to Australia	High

There is some evidence for improvements in disease and depression control

The efficacy of the TEAMCare model has been considered through experimental research. The findings showed the intervention significantly improved control of medical diseases and depression relative to usual care. These improvements came at a neutral or reduced cost (not found to be significant). The model is currently being used in other sites across the US and Canada.

8.5 There are promising models to treat people with mild mental illness, with applicability for Australia

The characteristics of people with mild mental illness and the key services and challenges associated with supporting these people are outlined in Table 35.

Table 35: Overview of services and challenges for people with a mild mental illness

Description of illnesses	Mild depression, mild anxiety, mild eating disorders, mild substance use disorders
Key clinical services	Psychological therapies, pharmacotherapy, primary care and community mental health services, online services
Key social services	Nil
Major challenges to support those with mild mental illness	<ul style="list-style-type: none"> • Identification of people with mild mental illness – many do not recognise they have a mental illness and/or do not seek help, and the relatively low severity of the illnesses often make this population difficult to recognise • Stigma – people with mild mental illness can be reluctant to identify themselves as such • The mental health system is seen as separate to, rather than part of, the primary care system • Out-of-pocket costs associated with accessing private psychological care and waiting lists to access public psychological care • GPs' lack of time, confidence and/or experience in managing mental illness • Sufficient coordination of care

Different approaches have shown promise to treat people with mild mental illness

According to *beyondblue*, only 35-40% of Australians with high prevalence and mild severity mental illness, like mild depression and anxiety, adequately access appropriate services. This low treatment rate is reflected internationally. A number of cost-effective, evidence-based models to reach these patients are being explored.

In the UK, increasing access to 'talking therapies' using a stepped care approach, such as the Improving Access to Psychological Therapies (IAPT) program, is showing promise. In Australia, strong evidence is emerging that online Cognitive Behavioural Therapy (CBT) models increase the rate of treatment and quality

of life. Another approach has been to explore primary care based models that integrate/co-locate mental health services. The Hamilton Family Health Team in Ontario, Canada, has shown this model can increase the rate of treatment of mental illness and can be a crucial part of providing prevention and detection in early stages. Intermountain Health in the US has made mental health screening as routine as screening for physical conditions.

International successes provide some key lessons for Australia

Stepped IAPT type services could be easily adapted to the Australian environment. Experience delivering evidence-based online psychological therapies (such as CBT) and existing primary care mental health initiatives suggest that only limited system or payment changes would be necessary. In 2009, *beyondblue* commissioned a feasibility study to investigate whether a similar model would work in Australia and presented their case to the Australian Government.

The introduction of mental health and wellbeing into primary care is underway (through ATAPs and the Better Access Initiative). International initiatives suggest some key lessons. Services need to be seen as a partnership between mental health and primary care, rather than a traditional referral process, and embedded in the primary care system with each contributing to the program design.

Improving Access to Psychological Therapies (IAPT)

The IAPT program is designed to increase access to psychotherapies

The IAPT program delivers evidence-based psychological therapy for people with depression and anxiety disorders. CBT is the cornerstone of the program (as per the National Institute for Health and Clinical Excellence [NICE] guidelines).

The IAPT program uses a “stepped care” model of service delivery. If suitable, patients are started on low-intensity treatment involving guided self-help or computerised CBT sessions, and if necessary, interventions with a non specialist practitioner (largely by telephone). Escalation up the stepped grades of treatment occurs if the patient has not improved. More involved treatment can include high-intensity interventions such as evidence-based psychological therapy delivered by a specialist psychological therapist.

Services are delivered primarily within GP surgeries to help improve access. Referrals for specialist mental care (e.g. community mental health services) are available where necessary. IAPT also aims to integrate with psychosocial services, such as employment, financial and NGO services.

The program has since been widely rolled out across the UK National Health Service Primary Care Trusts.

Location	UK
Size of population	40,000
Type of intervention	Evidence-based CBT
Strength of evidence	Fair
Time commenced	2006
Status	Initially a demonstration project – now rolled out across the UK
Evaluation technique	External evaluation
Applicability to Australia	High

The program had psychological and employment benefits but variable conformity to guidelines

An evaluation of two demonstration sites was conducted in 2008, two years after the sites were established. The initial results were promising, however neither service met the aim of the program – to deliver comprehensive services that implemented the NICE guidelines for the psychological treatment of depression and all anxiety disorders. The key benefits were:

- increased access – nearly 5,500 people were referred to the services
- psychological – both sites achieved good recovery rates (52%) for people who had depression and/or anxiety disorder for more than six months. A follow-up study indicated these gains were largely maintained 4-12 months later

- employment – at the end of the treatment (six months) an average of 5% (a range 4-10%) more of the treated population was in employment (a statistically significant result). This includes reductions in those receiving sick pay and on social welfare.

The cost for the first year was £2.6m (including system costs and set-up), which equates to £743 (\$1,100) per patient who completed the program. The evaluation concluded that the initial cost was moderate to high, but noted the program should become more efficient with greater scale.

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THIS WAY UP Clinic (formerly Clinical Research Unit for Anxiety and Depression Clinic)

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The THIS WAY UP Clinic offers self-directed online CBT designed to help people help themselves

The THIS WAY UP Clinic is a joint facility of the University of New South Wales and St Vincent's Hospital in Sydney. The Clinic offers five courses which use a CBT approach to treat common mental health conditions, such as depression, generalised anxiety disorder, social phobia, panic, and mixed anxiety and depression.

Patients need a referral from a clinician (GP, psychologist, medical specialist, mental health nurse) to access the online clinic. The clinician can refer patients directly, retain clinician responsibility and prescribe the program, or they can refer patients to the Clinic at St Vincent's Hospital Sydney to take clinical oversight. Each course costs patients \$44 for 90 days access (a course contains 5-6 lessons). Courses for patients of rural practitioners are free.

The courses are designed to be self-guided. Patients, once referred by their doctor or clinician, can therefore progress at their own pace to gain insight and knowledge into their condition.

Location	Australia
Size of population	1,600
Type of intervention	Online CBT
Strength of evidence	Fair
Time commenced	2006
Status	Ongoing
Evaluation technique	Clinical trials
Applicability to Australia	High

Each course contains an illustrated story of a fictional character that experiences symptoms of anxiety and/or depression. In following the character's story through the course, a patient learns about their symptoms and the steps required to help them recover. Every lesson includes written information and activities the patient completes between lessons. Each lesson takes about 20 minutes to read and patients generally need 3-4 hours to complete the suggested homework activities.

There is evidence for high retention rates, symptom control and patient satisfaction

Over 22 clinical trials, with more than 1,600 participants, have been conducted by the Clinical Research Unit for Anxiety and Depression team to build and evaluate the programs to treat depression, generalised anxiety disorder, social phobia, panic, PTSD, and obsessive-compulsive disorder. The results have shown promise, with:

- completion rates of about 90% for those who start a program
- three out of four people reporting good progress at managing symptoms by the end of a program
- results sustained at three month follow-up
- nearly all participants (95%) agreeing they would recommend the program to a friend with the same symptoms
- nearly all participants (98%) agreeing that it was worth their time joining the program.

Intermountain Health Care Mental Health Integration (MHI)

The MHI program embedded mental health into primary care

Intermountain Health Care is a Utah-based non-profit integrated health care organisation. The MHI program was developed in response to reports that primary care physicians faced considerable challenges assisting patients and families with mental health concerns. Insufficient time, training and use of evidence-based treatments, along with financial constraints, meant that many mental health conditions were routinely untreated.

The MHI program aimed to make mental health care a key component of all primary health care, including prevention and wellness. The program is designed to:

- promote changes in primary care practice
- improve the detection and management of depression and other mental health conditions
- reinforce relationships with patients to promote adherence and self-management
- provide and adjust treatment if there is evidence of increasing complexity and inadequate response.

The MHI program uses a team based approach for caring for patients. The team may include the primary care physician and their staff, mental health professionals, care management community resources, and the patient and their family.

Location	US
Size of population	1,600
Type of intervention	Mental health integration into primary care
Strength of evidence	Emerging
Time commenced	2006
Status	Being rolled out across the US
Evaluation technique	Quasi experimental
Applicability to Australia	High

The primary care physician uses a purpose-built tool to screen, establish diagnoses, and communicate treatment options to the patient and family. Patients and families are then matched to an appropriate level of treatment and team resource for their needs. The care manager is responsible for education, follow-up and communicating with the MHI team.

Psychiatrists and other mental health specialists, such as psychologists, social workers, and nurses, provide consultation and are available either by telephone or on-site. They also provide ongoing training to other team members, on-site, brief, CBT and offer support for follow-up care when needed.

Community groups, such as the National Alliance for the Mentally Ill, are engaged as a consumer advocacy community resource in order to enhance the education and peer mentoring support needed by the families at each clinic site.

The program delivered improved patient functionality and physician confidence, at neutral cost

Evidence from preliminary evaluations and a quasi experimental study of over 700 patients reviewed as part of routine primary care services showed a collaborative primary and mental health care approach leads to improved functional status in patients, and improved satisfaction and confidence among physicians in managing mental health problems this was at neutral cost.

These findings were consistent with the intended impact of the MHI intervention, that timely diagnosis and collaborative primary care require less intensive, higher-order treatment (such as inpatient admission and use of the Emergency Department).

Since the project was evaluated, it has been rolled out to around 70 clinics (primary care medical group practices) in the 130-clinic system. It is also being replicated in non-Intermountain Health settings in several states, and also local Utah state health agencies.

Hamilton Family Health Team

Mental health professionals are integrated in Family Health Teams in a network of primary care practices

The Hamilton Family Health Team is the largest Family Health Team (FHT) in Ontario, Canada.¹³⁶ Since 1994, it has successfully integrated mental health personnel into the offices of family physicians. It has 81 locations throughout the city of Hamilton which support 150 family physicians serving approximately 280,000 patients.

The physician, nurse, and administrative staff core team of each FHT is supplemented by a mental health team. Using a “stepped” approach, the family physician or nurse attempts to address mental health and addiction issues before involving members of the mental health team. People with severe mental illness may be referred directly to secondary and tertiary services in Hamilton’s mental health and addictions network.

The roles of the mental health team are as follows:

- Physicians retain ultimate responsibility for the care of patients, continue to see patients during the course of specialised care and follow-up with patients once specialist care is no longer required.
- Onsite counsellors are available to assist any patient in the practice. They conduct triage, refer patients when necessary, and provide education, care coordination and short-term group and individual counselling.

	Ontario, Canada
Size of population	280,000
Type of intervention	Mental health integration into primary care
Strength of evidence	Emerging
Time commenced	1994
Status	Ongoing
Evaluation technique	Quasi experimental
Applicability to Australia	Strong

- A psychiatrist visits each practice for around half a day per month, working as a consultant to the physicians, practice nurses and mental health counsellors. Psychiatrists may take responsibility for ongoing treatment of a patient, though they will more often provide indirect care via case discussions and patient reviews.
- Pharmacists assist with patient medication management and provide advice to physicians on up-to-date evidence-based literature about drugs and drug interaction.
- Dieticians are available to screen for depression, identify mental health problems in obese children and adults, and assist patients with eating disorders.

The program is coordinated by a small management team (including a part-time medical director) who have responsibility to set program standards, manage resources and funding, and respond to problems in liaising with the funding body. The management team’s presence is seen as crucial in sustaining the program’s success.

There is emerging evidence for improved access to mental health services and better care coordination

The program has been discussed in numerous peer-reviewed papers, though consideration has focussed on program methodology and process evaluation, with limited quantitative results published. Since its inception, the program claims to have increased patient referrals by family physicians for mental health assessments 11-fold over the 15 year period. Improved access is reported for patients that may traditionally underutilise mental health services (such as Indigenous people, seniors and children).

There has been a reduction in waiting times for an initial assessment and the program has assisted in earlier detection and treatment of mental or addiction problems. Improved care coordination has resulted from the integration of physical and emotional care and the ability to treat patients in primary care settings.

Efficiencies have been achieved through the continuum of care from primary to secondary to tertiary services, with triage of patients in primary care before referral. Since inception of the program, patient visits to outpatient mental health services decreased by 66% and inpatient services by 10%.

136. Canada has over 200 Family Health Teams. They comprise a family doctor working with other health care professionals such as nurse practitioners, nurses, mental health counsellors, dieticians and pharmacists.

8.6 Key elements can be identified for a reformed mental health service system

The review of successful reforms in Australia and internationally suggests some key elements of a reformed mental health service system. At a system-wide level, international experience suggests a number of key enablers of reform, noted previously. Some of these enablers, such as a single funding/payment model, would require substantial change to the existing Australian mental health service system; other elements, such as the development of clear clinical guidelines and benchmarks, would require less transformation in the current Australian context.

In terms of degree of severity of mental illness, the review suggests a more prescriptive approach to system design for very severe, severe mental illness and moderate mental illness, and a variety of system approaches for mild mental illness:

- **Very severe and severe mental illness** – successful treatment requires a very intensive, person-centred, coordinated case management approach with clear integration of a comprehensive range of hospital-based care, community clinical treatments, primary care and non-health services such as housing and employment programs
- **Moderate mental illness** – successful treatment is possible in primary care settings with the right balance between a standardised care management program and a collaborative, interdisciplinary approach between the clinician, care manager and psychiatrist
- **Mild mental illness** – a variety of approaches offer promise such as “talking therapies”, online CBT models and primary case-based models that integrate/co-locate mental health services. Further analysis is needed to assess which approach, or combination of approaches, is most appropriate for Australian circumstances.

9. Australia has an unprecedented opportunity to lead the world in end-to-end mental health system redesign to deliver better outcomes at the same or lower cost

As identified in this paper, at least \$28.6 billion is spent annually to support people with mental illness and this spending will be enhanced with significantly increased policy focus on mental health. Despite this, overall levels of mental illness are static, many of those with mental illness do not access services and, when they do, their needs are often not met.

The current system is extremely fragmented – across the supply of services, expenditure and funding. Health services are supplied in and out of hospitals (public and private), by psychiatrists and general practitioners and other doctors, psychologists, counsellors and other allied health professionals. Non health support is provided by governments (at the Australian and state/territory level), not-for-profit organisations and others. Funding, across health and non-health services, comes from the Australian and state/territory governments, insurers, non-insurance businesses and not for profits (and donors). Individuals with mental illness and their families also shoulder much of the burden.

Major system level changes are required. There is a need for an end-to-end redesigned system, covering detection to diagnosis to treatment to ongoing recovery. The system needs to integrate health and non-health support and funding. This includes better integration across government departments (at the federal and state/territories levels) of the assistance they provide and/or fund. The review of reforms in Australia and internationally suggests some elements to inform an improved mental health service system. There is an opportunity for Australia to lead the world in designing and implementing a whole of system approach to support those with mental illness.

Pursuant to this paper, Medibank Health Solutions will be working with other key stakeholders to detail options for systemic reform of mental health to ensure their needs are better met, with better outcomes and greater efficiency.

Appendix A

Glossary and acronyms

Acronym/Term	Meaning
ABS	Australian Bureau of Statistics
ACOSS	Australian Council of Social Services
ACFI	Aged Care Funding Instrument
ADF	Australian Defence Force
ADHD	Attention Deficit Hyperactivity Disorder
AIHW	Australian Institute of Health and Welfare
APRA	Australian Prudential Regulatory Authority
ATAPS	Access to Allied Psychological Services
BEACH	Bettering the Evaluation and Care of Health
CBT	Cognitive Behavioural Therapy
CHF	Chronic Heart Failure
CLIPP	Consultant Liaison in Primary Care Psychiatry
COAG	Council of Australian Governments
CPI	Consumer Price Index
CRUFAD	Clinical Research Unit for Anxiety and Depression
CTP	Compulsory Third Party
DEEWR	Department of Education, Employment and Workplace Relations
DIAMOND	Depression Improvement Across Minnesota – Offering a New Direction
DoHA	Department of Health and Ageing
DRG	Diagnosis Related Group
DSP	Disability Support Pension
DVA	Department of Veterans' Affairs
EACH-D	Extended Aged Care at Home – Dementia
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FHT	Family Health Team (in Canada)
Forensic population	As per the AIHW definition: "Services [that] principally target people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component".
GDP	Gross Domestic Product
GP	General Practitioner
HASI	Housing and Accommodation Support Initiative
Health expenditure	Who spends the money, rather than who ultimately provides the money for any particular expenditure
Health funding	Who provides the funds that are used to pay for health expenditure (eg. government provides funds to an NGO which actually spends the money to deliver housing support)
HoNOS	Health of the Nation Outcome Scales
IAPT	Improving Access to Psychological Therapies
ICD-10	International Classification of Diseases – version 10
ICM	Intensive Case Management
ICSI	Institute for Clinical Systems Improvement

Acronym/Term	Meaning
IMPACT	Improving Mood-Promoting Access to Collaborative Treatment
IP	Income Protection
IPRO	Independent Pharmaceutical Research Organization
MACN	Multiple and Complex Needs
MACNI	Multiple and Complex Needs Initiative
MBS	Medicare Benefits Schedule
MHCA	Mental Health Council of Australia
MHC	Mental Health Centres (in Trieste)
MHD	Mental Health Department (of Trieste)
MHI	Mental Health Integration program (in the US)
MSTT	Mobile Support and Treatment Team
N/A	Not applicable
NDA	National Disability Agreement
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
NHS	National Health Service (in the UK)
NMHC	National Mental Health Council
NICE	National Institute for Health and Clinical Excellence
NSMH&W	National Survey of Mental Health and Wellbeing
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PARC	Prevention and Recovery Care
PASTT	Program of Assistance for Survivors of Torture and Trauma
PBS	Pharmaceutical Benefits Schedule
PC	Productivity Commission
PCP	Primary Care Physician
PDTS	Psychiatric Diagnostic and Treatment Station
PHI	Private Health Insurer
PHIAC	Private Health Insurance Administration Council
PH-Q9	A 9 question Patient Health Questionnaire
PTSD	Post Traumatic Stress Disorder
RCT	Randomised Controlled Trial
RFDS	Royal Flying Doctor Service
RPBS	Repatriation Pharmaceutical Benefits Scheme
SPRC	Social Policy Research Centre (University of NSW)
TPD	Total and Permanent Disability
VHA	Veterans Health Administration (in the United States)
VRGP	Vocationally Registered General Practitioner
WRT	Wellness Recovery Team
WHO	World Health Organisation
3CM	Three Component Model

Appendix B

Approach for evaluating system initiatives

Framework

- The project involved scanning Australian and international research to highlight successful system-level reforms that have contributed to better outcomes for people with mental illness or a lower cost of providing services, and preferably both.
- The aim of the scan was to find evidence of successful whole-of-system-level reform. It became apparent from initial scans that these were few and far between. Further research revealed reforms and initiatives that were occurring in just one part or between two parts of the mental health system that deserved attention. Therefore a conceptual model was developed to differentiate these different systemic approaches to supporting those with mental illness.

Criteria for defining “success”

When evaluating initiatives / reforms research that addressed the following criteria were examined:

1. clinical outcomes (hospitalisations, medication management, relapse)
2. quality of life (employment, satisfaction etc)
3. cost outcomes
4. social outcomes (poverty, homelessness etc).

Programs/ Approaches did not have to meet all criteria.

Rating success

When evaluating a program, a rating was assigned to it.

The rating of evidence was loosely based on the NHMRC grades of recommendations and the U.S. Preventive Services Task Force (USPSTF) grades (<http://www.uspreventiveservicestaskforce.org/3rduspstf/ratings.htm>).

Rating	Source of indicator
Good	At least one properly conducted RCT
Fair	Well-designed cohort, case-controlled, randomisation controlled or time series trials without randomization
Emerging	Opinions of respected authorities based on clinical experience, observational and descriptive studies, and case reports or external reviews/ reports of expert committees
Weak	Unpublished or published internal review by the organisation

Appendix C

Mental health system improvements considered

C.1 Australian initiatives

Rating	Location	Who	Date	Type of program
Australian Integrated Mental Health Initiative (AIMHI NT)	Northern Territory	Top end division of General Practice and Menzies School of Health Research	2003-2009	Research
Community Forensic Mental Health Service	Townsville/ Cairns	Northern Area District Mental Health Service	Ongoing	Forensic mental health
Consultant Liaison in Primary Care Psychiatry	Melbourne	Monash University	1990's	Collaborative primary care
THIS WAY UP Clinic (formerly Clinical Research Unit for Anxiety and Depression Clinic)	Sydney	Joint facility of University of NSW & St Vincent's Hospital, Sydney	2007-current	Internet based CBT
Early psychosis prevention and intervention Centre	Melbourne	Orygen Youth Health	1992	Early psychosis prevention and intervention
Headspace	Australia-wide	National Youth Mental Health Foundation, NGO's and local service providers	2006	Community-based mental health service
Illawarra Mental Health Integration Project (MHIP)	Illawarra (NSW)	Illawarra Area Health Service, Department of Health and Ageing	2001-2003	Mental health integration initiative
Integrated Homeless Mental Health Initiative	Melbourne	The Alfred Homeless Outreach Psychiatry Service, Sacred Heart Mission, Hanover Welfare Services in Inner Melbourne	2005	Integrated mental health and homelessness services
Integrated Rehabilitation and Recovery Care Program (IRRCP)	Metropolitan Melbourne	Consortiums consisting of Area Mental Health Services and local community mental health organisations (NGO's)	2007	Care-coordination/case management
Mental Health Nurse Incentive Program	Australia-wide	Department of Health and Aging	2007	Primary care coordination
Multiple and Complex Needs Initiative (MACNI)	Victoria	Department of Human Services / Department of Justice	2003	Intensive case management
Housing and Accommodation Support Initiative (HASI)	NSW	NSW Health, NSW Department of Housing, non-government organisations	2002-current	Supported housing program
Adult Prevention and Recovery Care (PARC)	Victoria	Victorian Area Mental Health Services (AMHS) and NGO psychiatric disability rehabilitation and support service (PDRSS)	2003-current	Step up step down residential services
Personal Helpers and Mentors (PHaMs)	Australia-wide	Delivered by NGO's for the Australian Government Department of Families, and Housing, Community Services and Indigenous Affairs (FaHCSIA)	2007	Service coordination and planning

C.2 International initiatives

Rating	Location	Who	Date	Type of program
Canadian Collaborative Mental Health Initiative	Canada	Canadian Psychiatric Association (CPA), College of Family Physicians of Canada (CFPC)	2007-current	Collaborative care initiatives
Greater Vancouver Mental Health Services	British Columbia, Canada	Greater Vancouver Mental Health Service Society	1970's-current	Community-based non-institutional mental health service
Hamilton Family Health Team Mental Health Program (FHT-MHP)	Ontario, Canada	Hamilton Family Health Team	1994-current	Primary care mental health
Trieste Mental Health Services	Italy	Trieste Mental Health Department	1980-current	Mental health system
Primary Mental Health Initiatives (PMHI)	New Zealand	42 PHOs distributed around 26 Primary Mental Health Initiatives	2011-current	Primary care mental health
Care Program Approach (CPA)	UK	English Department of Health	1991-current	Mental health care coordination
Choice and Partnership Approach (CAPA)	UK	National Health Service	2003	Child and adolescent mental health services
Improving Access to Psychological Therapies (IAPT)	UK	National Health Service Primary Care Trusts	2005	Primary care mental health
Individual Budget Program	UK	Department of Health	2005	Payment system
Lambeth Living Well Collaborative	UK	National Health Service	2008	Primary care/self-management
Assertive Community Treatment	US / International	Various	1970's-current	Intensive case management
Cherokee Health System	East Tennessee, US	Cherokee Health System	1960-current	Integrated primary health care model
Clubhouse Model	International	ICC	1948-current	Rehabilitation services
Depression Improvement Across Minnesota—Offering a New Direction (DIAMOND)	Minnesota, US	The Institute for Clinical Systems Improvement (ICSI)	2008	Collaborative primary care
Harris County Community Behavioral Health Program	Texas, US	The Harris County Hospital District	2004-2010	Primary Care / Case Management
HealthChoicesHealth Connections	Pennsylvania, US	Pennsylvania Department of Public Welfare (DPW), Keystone Mercy Health Plan (KMHP), the County Behavioral Health services, Magellan Behavioral Health	2008-current	Care coordination

Rating	Location	Who	Date	Type of program
Integrated Collaborative Accessible, Respectful, and Evidence-based (ICARE) demonstration	North Carolina, US	North Carolina Foundation for Advanced Health Programs	2006 – 2009	Care coordination
Improving Mood- Promoting Access to Collaborative Treatment (IMPACT)	US	University of Washington	1998	Collaborative care
Mental Health Integration program	Utah, US	Intermountain Health Care	1998	Primary care integration
Magellan Behavioural Health	Arizona, Pennsylvania and other states of the US	Magellan Behavioural Health	2007	Public sector behavioural health management organisation
Massachusetts Behavioral Health Partnership	Massachusetts, US	ValueOptions	1996	Public sector mental health system
The New Mexico Behavioral Health Collaborative	New Mexico, US	15 state agencies managed by Optum Health	2004	Public sector mental health system
Recovery Innovation, Arizona	Maricopa County, Arizona, US	Recovery Innovation	1990	Care management
TEAMcare Model	US	Group Health Research Institute	2008	Collaborative care
Three Component Model	US	The MacArthur Foundation	2008 – current	Collaborative care
Washington Medicaid Integration Partnership (WMIP)	Washington State, US	Washington Medicaid Integration Partnership (WMIP)	2005	Integrated mental and physical health services
Wraparound Model	US / Worldwide	National Wraparound Initiative	1980s	Care planning
US Veterans Health Administration Mental Health Program	US	Veterans Health	2005	Mental health system

Appendix D

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