Australian mental health reform: time for real outcomes

Ian B Hickie, Grace L Groom, Patrick D McGorry, Tracey A Davenport and Georgina M Luscombe

ABSTRACT

- After 12 years of national mental health reform, major service gaps and poor experiences of care are common.
- The mental health community reports little progress in implementing its key priorities, such as expanded early-intervention programs, comanagement of people with mental health problems and related alcohol or substance misuse, and widening of the spectrum of acute care settings.
- We propose new national targets for reducing the social and economic costs of poor mental health; these include increased access to effective care, reduced suicide rates and improved rates of return to full social and economic participation.
- We detail specific service reforms designed to maximise the chance of achieving these targets, and prioritise youth health and integrated primary care programs.
- New independent and national reporting systems on the progress of mental health reform are urgently required.

MJA 2005; 182: 401–406

> His suicide was tragic, made all the more so because it was preventable, we believe, but for the inadequacy of the public mental health system. [Our son] died just two weeks after his first suicide attempt, eight days after his discharge from the psychiatric unit, two days after being refused admission following a second suicide attempt, and within hours of contact with the mental health crisis team. On the day of his death, [our son] had contact with the mental health system no less than three times. (Parents, Public Consultations of the Mental Health Council of Australia, the Brain & Mind Research Institute and the Human Rights & Equal Opportunity Commission, 2004; submission #288[1])

A 2002 survey of Australia's leading mental health organisations, conducted by the Mental Health Council of Australia (MHCA), asked respondents to nominate their priorities for national mental health reform.[2] The top 10 priorities are shown in Box 1, and include national implementation of early-intervention strategies, development of innovative services for comorbid alcohol and other substance misuse problems, provision of a wider spectrum of acute and community-based care settings and enhanced services in rural and regional areas. While the most recent National Mental Health Report 2004 suggests reasonable progress,[4] a complementary survey in 2003–04 by the MHCA of 723 mental health organisations, health professionals, consumers and carers indicated that there was very little evidence that these community-derived priorities were actually being achieved (Box 1). This community view is consistent with other recent reports that suggest that we still struggle to provide the most basic spectrum of acute and ongoing care.[1,2,5-7]

> Recently when I phoned the triage service for help, I was told that I had been categorised by the Mental Health Team as 'Not for Service'. (Consumer; forum #17[1])

The problems

Despite having developed world-leading innovations in population-based mental health policy, having recognised the legitimate roles of consumers and carers, having developed novel early-intervention programs for young people with psychosis, and having promoted primary care psychiatry, we have not achieved widespread implementation of these advances.[4] In 2003, people aged between 25 and 49 years accounted for 56% of all suicides in Australia, and rates were highest in men aged 25 to 29 years (31.1 per 100 000[8]). Sixty per cent of all health-related disability costs in 15–34-year-olds are attributable to mental health problems, and 27% of all years lived with disability in Australia are attributable to mental disorders.[9] Less than 40% of people with mental disorders receive any mental health care in a 12-month period compared with almost 80% for other common physical health problems.[10] Currently, 75% of that mental health care is provided in the primary care sector,[11] with limited access to specialist support.[11,12] Additionally, almost 50% of people with mental disorders are not recognised by their general practitioner as having a psychological problem.[13]

> Three months later he succeeded in killing himself. I was so angry at having been so consistently "fobbed off" that I went to the mental health unit . . . and complained and the lady I spoke to said "These things happen" as if it simply wasn't important. (Wife; submission #96[1])

Although most common mental disorders commence before 18 years of age,[14] people aged 25–44 years and 45–64 years are more than twice as likely as those aged under 25 years to receive an active treatment when seen in general practice.[12] This pattern of poor population coverage — particularly among young people — and delayed delivery of effective care means that less than 10% of the health burden due to depression is currently averted.[15] Similarly, most psychotic disorders commence before age 25, and there is commonly a delay of 2–8 years before first presentation for treatment.[16,17] It has been estimated that up to 60% of cases of alcohol or other substance misuse could be prevented by earlier treatment of common mental health problems.[18]

FOR EDITORIAL COMMENT, SEE PAGE 372; SEE ALSO PAGE 396

Brain & Mind Research Institute, University of Sydney, Camperdown, NSW.
Ian B Hickie, MD, FRANZCP, Executive Director, Professor of Psychiatry, University of Sydney; and Clinical Advisor, *beyondblue: the national depression initiative*; Tracey A Davenport, BA(Hons), GCM, Research Director; Georgina M Luscombe, BSc(Hons), Research Officer.
Mental Health Council of Australia, Deakin West, ACT.
Grace L Groom, DHSc, Chief Executive Officer.
ORYGEN Research Centre, ORYGEN Youth Health, Parkville, VIC.
Patrick D McGorry, FRANZCP, Director; and Professor of Psychiatry, University of Melbourne.
Reprints will not be available from the authors. Correspondence: Professor Ian B Hickie, Brain & Mind Research Institute, University of Sydney, PO Box M160, Camperdown, NSW 2050.
ianh@med.usyd.edu.au

1 Community evaluation of implementation of priorities for national mental health reform

Priorities outlined	% In favour*	Implemented locally†
1. Implementation of early-intervention strategies nationally	56%	17%
2. Innovative services for people with mental health and alcohol or other substance misuse disorders	54%	11%
3. Develop wider spectrum of acute and community-based care settings	52%	12%
4. Support for service development in rural and regional areas	49%	7%
5. Implementation of national standards for mental health services	45%	16%
6. Support for service development in poorly resourced areas	44%	2%
7. Support for programs that promote attitudinal change among mental health workers	44%	10%
8. Increased support for stigma reduction campaigns	43%	11%
9. Development of specific inter-governmental service agreements (eg, between health, education, housing, employment and social security)	42%	15%
10. More genuine consumer participation at regional and local service levels	42%	17%

*Data from a survey of 270 mental health organisations and key individuals.[2] † Data from a survey of 723 mental health organisations, providers, consumers and carers.[3]

> Our core business is education — we identify children with intellectual disability but not psychiatric disability. I have staff using the expulsion/suspension guidelines to exclude these kids... Because of a lack of services there's nothing left but to exclude these kids. Actually they really need care. (Teacher; forum #17[1])

The rate of workforce participation in Australia among people with mental illness is low (29%) compared with people with physical disability (49%[19]). Indeed, the relative employment rate of people with any disability (not just mental health) compared with those with no disability in Australia (0.55) is among the lowest for Organisation for Economic Co-operation and Development (OECD) countries (OECD average, 0.62; Canada, France and Norway, each, 0.72; Switzerland, 0.79[20]). Furthermore, on average, only one in nine disability-benefit recipients in Australia are employed, compared with the OECD average of one in three.[20]

Australia's national health spending continues to grow, reaching $72.2 billion or 9.5% of gross domestic product (GDP) in 2002–03.[21] As a proportion of this expenditure, and despite a decade of active mental health care reform being supported by all Australian governments, total recurrent mental health spending has consistently remained below 7%.[4] The medical and allied health workforce required to deliver improved mental health care is in short supply.[22] Medicare-reimbursed services provided by psychiatrists have declined by 6.5% since 1995–96, while total out-of-pocket expenses per attendance have increased by 48.6% (calculated from tables in National Mental Health Report 2004[4]). An increase in services will require not only a swift and effective increase in the resource-base but also major enhancements in workforce recruitment and support.

> Government cannot continue to blame lack of staff for our current mental health care problems... Any money thrown at the current system without a fundamental change... will not work. (General practitioner; submission #326[1])

In the recent federal election, the coalition government committed to increase funding for mental health care by $110 million over 4 years, with an emphasis on youth health, enhanced primary care and increased community awareness of mental disorders.[23] The large deficits in specialist care, particularly within the public sector, however, have been left to the state and territory governments. Between 1992–93 and 2001–02, the federal government proportion of national mental health expenditure increased from 27% to 37%.[4] About two-thirds of this increase was accounted for by an almost sixfold increase in the costs of medications reimbursed through the Pharmaceutical Benefits Scheme.[4] With nine governments and the private heath sector (which contributes 4.7% of total spending) variously responsible for different aspects of health care in Australia, the opportunity to avoid direct responsibility for mental health service gaps, or shift costs, remains large.

> Perhaps the greatest disconnection has occurred between the consumers, the providers and the decision makers. Consumers are no longer being consulted about their needs here. It was 12 months ago that we clinicians wrote to the District Director... Nothing was done!... The clinicians don't want to work like this but we are forced to work in crisis-mode. (Psychiatrist; forum #15[1])

While any new funding for mental health care is welcome, we have estimated that $110 million over four years represents only 10% of the federal government investment that is needed.[3] The state governments are not immune. A similar increase in their spending is also needed. Over the past decade, under two 5-year plans,[24,25] all Australian governments promoted a broad and gradual approach to reform, with the most recent third national plan (2003–08) failing to define specific targets for increased investment or enhanced care.[26] Instead, it states blandly that "the next five years provide an important opportunity to build upon the policy platform that has been put in place so firmly over the past decade. A whole-of-government, cross-sectoral approach will put the policies into practice, improving the mental health of the Australian community, and improving the care of people with mental illness across the lifespan".[26]

> If consumers need acute care (in a country centre) they have to be taken to a GP and then tranquilised and strapped to a stretcher to be transported to Perth. I was told, when I was suicidal, to drive myself to the city. (Consumer; forum #45)

New challenges

Community demand for appropriate and accessible mental health services will continue to escalate.[1,2,6,7] Grass-roots pressures reflect an increasing incidence of mental disorders in young people,[27]

increased numbers of presentations for care[28,29] and more disturbed behaviour,[29,30] often in association with alcohol or other substance misuse problems. Most likely, the incidence of illness will continue to increase, particularly among younger people, partly because of the adverse effects of current social and environmental factors. These include increased family breakdown, decreasing participation in other community-based structures such as churches, sporting and recreational associations and social clubs, and increased exposure to substances such as cannabis and illicit stimulants.[31-35] The prevalence of mental disorders among older people will also continue to rise as the ageing of Australians is accompanied by an increased incidence of vascular, degenerative and other brain disorders.[36]

New national targets

We propose that it is time to set new and specific 10-year national targets for mental health (Box 2). These targets are distilled from the key priorities proposed by leading mental health organisations,[2] the adverse economic and social impacts of current gaps in services,[3,37-39] and the opportunities for improved outcomes, such as reduced suicide rates,[40] that are supported by both population health approaches[32] and enhanced delivery of treatments.[41,42] Other specific measures of quality and safety (eg, number of people who die within 1, 3 and 12 months of contact with specialist mental health services) need to be agreed on and reported annually. Once we know these figures, we can set targets for appropriate reductions.

Our targets can be contrasted in their specificity with the 34 general or process outcomes detailed under the 2003–08 National Mental Health Plan.[26] For example, the first two recommended outcomes of the new plan are an "Increase in the extent to which mental health promotion is incorporated into policy and planning, at Commonwealth, State/Territory and local levels" and an "Increase in the extent to which mental health and social well-being is promoted within communities".

Their implementation

We need a 10-year implementation plan designed to build a cohesive spectrum of community-based and hospital-based care that can deliver these targets. The current preoccupation with enhancing only the most resource-intense and specialised domains of emergency and acute care[30] may further delay development of cost-effective community-based and early-intervention models.[43,44]

Within early-intervention frameworks, we need to develop and evaluate new, youth-friendly, models[45,46] to complement more traditional forms of primary care. While young people often prefer general practice to other existing care pathways,[47] actual use of general practitioners' services for mental health problems remains low, and GP responses to young people underestimate their need for psychological assessment and intervention.[13]

> After his discharge from hospital [X] had a couple of appointments with the psychiatrist . . . then was discharged from there and told to go to his GP for his medication. So far [X] has gone twice to be issued with six month repeat prescriptions. There has been no other contact — not even a phone call to ask how he is doing. (Mother; submission #99[1]).

We need to allocate financial and human resources across the whole spectrum of care. In our view, only 25% of new funds should be devoted to expanding acute hospital-based services and forensic or other restrictive-care environments. We argue that most new spending needs to track innovative models of youth and primary care (20% of funding), stepped care (20%),[42,48-52] as well as specialised recovery programs (20%). While some of these models are under development in Australia,[41,42,48,49] others have been trialled in other health care and social contexts.[50-54] Additionally, sustained investments are still required in broad population measures (10% of funding), and research and innovation (5% of funding).

We now propose seven specific steps that link these service development elements with our 10-year targets for mental health.

2 Proposed 10-year national targets for mental health outcomes

- That 60% of those with mental disorders be provided with care in any 12-month period (currently, this figure is 38%).
- That national disability costs attributable to mental disorders be reduced from 27% to 20%.
- That national disability costs among 15–34-year-olds attributable to mental disorders be reduced from 60% to 40%.
- That participation in work among those on disability support pensions for psychological reasons be increased from 29% to 60%.
- That national suicide rates be reduced from 11.8 to 8 per 100 000.

1. Sustained implementation of broad population measures

Unfortunately, general mental health promotion, specific illness awareness and prevention, and broader destigmatisation programs remain in their infancy. To develop a robust base, we need to sustain initiatives that have delivered early results (eg, MindMatters,[55] *beyondblue: the national depression initiative*,[32,56,57] and VicHealth's Mental Health Promotion Plan 1999–2002[58]).

2. Rapid expansion of youth-health and primary care services

A "sea change" is now under way in Australian primary care. The population-based benefit of the rapid expansion in depression treatments that occurred in the 1990s was reflected in reductions in suicides among those who reached medical care.[40] GPs are increasing their skills, providing new evidence-based medication and psychological treatments, and beginning to emphasise long-term functional outcomes rather than short-term relief of symptoms.[41] Early-intervention paradigms depend on earlier presentation for treatment.[42] Future progress now depends on development of an effective and accessible youth-health and related primary care network.

> I have been advocating for improved psychiatric services in this region for eight years now. Over one-third of our GPs have undertaken additional training. But there are no psychiatrists east of Dandenong! As GPs we have little to no support from the specialist sector. (GP; forum #8[1])

3. Development of "stepped-care" programs, particularly for young people with first episode psychosis and severe mood disorders

Commonly, more complex mental health problems respond best to the interventions provided by a multidisciplinary team. "Stepped

care" is a term used to describe service systems in which the primary care team is central, but where other levels of professional service are then added proportionately to the severity and complexity of the clinical scenario. Thus, effective primary medical care is linked with the appropriate and timely use of specialist resources. Internationally, such models have proved to be cost-effective.[50-52] Such systems do not operate in Australia because of the dislocation of specialist practice from community need.[59] In particular, young people with psychotic or severe mood disorders typically need specialised interventions as well as continuing medical and psychological care to achieve the best education, training and social outcomes.[42,48,49] Given Australia's place in the development of such ground-breaking early-intervention[42,48,49] and primary care systems,[41] we should lead the world in these developments. A strong case can be made for developing and evaluating a new nationally-funded youth network focusing on this priority area.

4. A new spectrum of acute care programs

> Recently a friend of mine went to hospital willingly and was turned away. So out of sheer frustration . . . she picked up an ashtray and threw it at the window and smashed it. They called the police. They took her to the police station and called the Crisis Assessment Team (CAT) who then admitted her! It's a joke that someone has to do something like that to get care. (Consumer advocate; forum #5[1])

The current crisis in acute mental health care usually evokes a "build more beds" response. After 3 decades of moving acute mental health care from stand-alone centres to general emergency and general hospital psychiatry units, there is an increasing realisation that we have not delivered an effective or safe acute care system.[1,2,6,7,29,30]

> When I turn up there and [my child] is in crisis, I call the Crisis Assessment Team and they tell me to call the police! I want to know why I'm left standing there alone and nobody is coming to help me. (Mother; forum #1[1])

In some states, there appears to be an increasing trend towards a "law and order" rather than a clinical-care approach. Accounts from consumers and carers emphasise increased use of physical security measures, forced detention, increased use of sedation, protection of staff rather than patients, and rebuilding of new separate secure areas.[1] By contrast, some states (notably Victoria) are increasing their commitment to a range of graded levels of acute care facilities that are more likely to result in better movement through various hospital and non-hospital settings.

5. Specialised recovery and workforce participation programs

> . . . in some countries such programs (ie, special employment programs for people with disabilities) . . . seem to make an important contribution to the employment of severely disabled people and of people with certain types of disabilities, such as intellectual and mental health disabilities. (Organisation for Economic Co-operation and Development[20])

The potential for return to education, training and full employment by young people with first onset major psychiatric disorders is not often realised in the Australian system. Our systems just do not deliver the workforce participation rates achieved in other OECD countries.[20] Specialised recovery and work participation programs are not only of great benefit to young people with first episodes of illness,[42] but also deliver benefits for those with more chronic forms of illness.[42,54]

6. National standards of care for people held in custodial settings

> The psychiatric consultant who examined [my son] phoned me and told me he was going to be discharged as he was only homesick. I pleaded with him not to discharge him as he was really sick and needed help . . . I begged him to keep my son in hospital . . . [my son] was discharged the next morning and on the drive on the way home he killed his friend because he was still sick and hallucinating. He was sent to jail and had his glasses and hearing aid removed. He was sent to a jail which does not have a psychiatric ward . . . That is where he stayed for two months. We spent two months trying to get him his glasses and hearing aid. He didn't phone on father's day and none of us knew where he was or what was happening . . . I informed and pleaded with the authorities to make them aware he was sick and suicidal. They informed me he would be put in a cell with another inmate who could watch him but in fact he was placed in a single cell . . . [He] hung himself on the Friday night. (Mother; forum #1[1])

Australia has a poor record in providing appropriate services for those who have committed crimes while mentally ill. The inadequacy of forensic systems and the increasing demand for psychiatric services within the prison system continue to be reported.[1,2] Only Victoria has supported the development of a high-quality system through investment and clinical and academic leadership.[60] New South Wales has recently articulated a similar vision. However, national standards for such services must be developed, agreed on and implemented in all States within the next 5 years.

> It is becoming obvious, that people who previously were treated within the mental health system are increasingly being shunted into the criminal justice system. People with mental illness must not be criminalized as a result of inadequate funding for the mental health system. (Police Association of New South Wales, submission #59[1])

7. Investment in medical research and innovation

Australia's total public expenditure in health-related research and development is 0.1% of GDP, and compares unfavourably with Switzerland (0.29%) and the United States (0.23%).[61] Research investment in mental health (both public and private expenditure) is low by comparison with other major health areas (2.8% of total expenditure or $48 million, compared with cancer at 9.4% or $160 million, and pharmaceutical treatments at 8.3% or $141 million).[61] However, there is a new national willingness to develop a serious research and innovation agenda.[62]

Making governments accountable

> It is essential that, to qualify as best practices, the activities in question be evaluated in terms of the criteria of innovation, success and sustainability by both experts and the people concerned. (United Nations Educational, Scientific and Cultural Organization, best practice[63])

For serious progress to occur, there is a need for genuine leadership. Without a clear commitment by a range of political leaders, we are unlikely to see the necessary financial investments.

A range of new accountability measures have been proposed including reporting to the national parliament, reporting to the Prime Minister, oversight by the Australian Human Rights and Equal Opportunity Commission, establishment of a new national commission modelled on United States or New Zealand examples, or expansion of the reporting powers of the MHCA.[2,64] While we may have led the world in mental health policy, we have not yet come close to achieving the "best practice" that may be of real benefit. Continuing to monitor systematically and then report annually the experiences of those receiving care should be a fundamental aspect of all government-funded mental health systems.

Competing interests

None identified.

References

1 Mental Health Council of Australia. "Not for service": experiences of injustice and despair in mental health care in Australia. A report of consultations by the Mental Health Council of Australia, the Brain & Mind Research Institute, University of Sydney, in association with the Human Rights & Equal Opportunity Commission. Canberra: Mental Health Council of Australia, 2005.

2 Groom G, Hickie I, Davenport T. Out of hospital, out of mind! A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008. Canberra: Mental Health Council of Australia, 2003. Available at: http://www.mhca.com.au/Public/PoliciesDocumentation/OutHospitalOutofMind_FinalReport.pdf (accessed Mar 2005).

3 Hickie I, Groom G, Davenport T. Investing in Australia's future: the personal, social and economic benefits of good mental health. Canberra: Mental Health Council of Australia, 2004.

4 National mental health report 2004. Eighth report — summary of changes in Australia's mental health services under the National Mental Health Strategy 1993–2002. Canberra: Australian Government Department of Health and Ageing, 2003.

5 Steering Committee for the Evaluation of the Second National Mental Health Plan, 1998-2003. Evaluation of the Second National Mental Health Plan. Canberra: Commonwealth of Australia, 2003. Available at: http://www.mentalhealth.gov.au/mhinfo/nmhs/pdf/eval.pdf (accessed Mar 2005).

6 Parliament of New South Wales. Legislative Council committee report. Select Committee on Mental Health (Chair: Brian Pezzutti). Inquiry into mental health services in New South Wales, final report. Sydney: NSW Government, 2002. Available at: http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/f742b6b2e561abdeca256c73002b7f87?OpenDocument (accessed Mar 2005).

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

8 Australian Bureau of Statistics. Suicides: recent trends, Australia. Canberra: ABS, 2003. (ABS Catalogue No. 3309.0.55.001.) Available at: http:/www.abs.gov.au/Ausstats/abs@.nsf/0/a61b65ae88ebf976ca256def00724cde?OpenDocument (accessed Mar 2005).

9 Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia. Canberra: Australian Institute of Health and Welfare, 1999. (AIHW Catalogue No. PHE 17.) Available at: http://www.aihw.gov.au/publications/health/bdia/bdia.pdf (accessed Mar 2005).

10 Andrews G, Henderson S, Hall W. Prevalence, comorbidity, disability and service utilisation. Overview of the Australian National Mental Health Survey. *Br J Psychiatry* 2001; 178: 145-153.

11 Andrews G, Carter GL. What people say about their general practitioners' treatment of anxiety and depression. *Med J Aust* 2001; 175 (2 Suppl): S48-S51.

12 Hickie IB, Davenport TA, Naismith SL, et al. Treatment of common mental disorders in Australian general practice. *Med J Aust* 2001; 175 (2 Suppl): S25-S30.

13 Hickie IB, Davenport TA, Scott EM, et al. Unmet need for recognition of common mental disorders in Australian general practice. *Med J Aust* 2001; 175 (2 Suppl): S18-S24.

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

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

16 Hafner H. Onset and early course as determinants of the further course of schizophrenia [The psychosocial basis of schizophrenia]. *Acta Psychiatr Scand* 2000; 102 Suppl 407: 44-48.

17 Hafner M, Maurer K, Loffler W, et al. Onset and early course of schizophrenia. In: Hafner H, Gattaz WF, editors. Search for the causes of schizophrenia III. Berlin: Spriner Verlag, 1995: 43-66.

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

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

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

21 Australian Institute of Health and Welfare. Health expenditure Australia 2002–03. Canberra: AIHW, 2004. (AIHW Catalogue No. HWE 27.) Available at: http://www.aihw.gov.au/publications/hwe/hea02-03/hea02-03.pdf (accessed Mar 2005).

22 Australian Medical Workforce Advisory Committee. The specialist psychiatry workforce in Australia, AMWAC report 1999.7. NSW: AMWAC, 1999. Available at: http://amwac.health.nsw.gov.au/amwac/amwac/pdf/psychiatrya 201999.7.pdf (accessed Mar 2005).

23 Liberal Party of Australia. Mental health: executive summary (29 September 2004). Available at: http://www.liberal.org.au/default.cfm?action=plaintext&id=430 (accessed Mar 2005).

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

25 Australian Health Ministers. Second national mental health plan: 1998–2003. Canberra: Australian Government Publishing Service, 1998.

26 Australian Health Ministers. National mental health plan 2003–2008. Canberra: Australian Government, 2003. Available at: http://www7.health.gov.au/hsdd/mentalhe/resources/pdf/mhplan.pdf (accessed Mar 2005).

27 Murphy JM, Laird NM, Monson RR, et al. A 40-year perspective on the prevalence of depression: the Stirling County Study. *Arch Gen Psychiatry* 2000; 57: 209-215.

28 Britt HC, Miller GC. The BEACH study of general practice. *Med J Aust* 2000; 173: 63-64.

29 Kalucy R, Thomas L, King D. Changing demand for mental health services in the emergency department of a public hospital. *Aust N Z J Psychiatry* 2005; 39: 74-80.

30 NSW Mental Health Sentinel Events Review Committee. Tracking tragedy: first report of the committee, 2003. Available at: http://pandora.nla.gov.au/pan/40156/20040203/www.ppc.health.nsw.gov.au/pubs/n/serc_contents.html (accessed Mar 2005).

31 Sanders MR. Parenting interventions and the prevention of serious mental health problems in children. *Med J Aust* 2002; 177 (7 Suppl): S87-S92.

32 Hickie IB. Preventing depression: a challenge for the Australian community. *Med J Aust* 2002; 177 (7 Suppl): S85-S86.

33 Patton GC, Coffey C, Carlin JB, et al. Cannabis use and mental health in young people: cohort study. *BMJ* 2002; 325: 1195-1198.

34 Arseneault L, Cannon M, Poulton R, et al. Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study. *BMJ* 2002; 325: 1212-1213.

35 Zammit S, Allebeck P, Andreasson S, et al. Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study. *BMJ* 2002; 325: 1199-1201.

36 Bird MJ, Parslow RA. Potential for community programs to prevent depression in older people. *Med J Aust* 2002; 177 (7 Suppl): S107-S110.

37 Carr V, Neil A, Halpin S, Holmes S, on behalf of the Low Prevalence Disorders Study Group. Costs of psychosis in urban Australia. Canberra: Australian Government Department of Health and Ageing, 2002. Avail-

able at: http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mentalhealth-resources-reports-costs.htm (accessed Mar 2005).
38 Andrews G, Issakidis C, Sanderson K, et al. Utilising survey data to inform public policy: a comparison of the cost-effectiveness of treatment of ten mental disorders. *Br J Psychiatry* 2004; 184: 526-533.
39 Sanderson K, Andrews G, Corry J, Lapsley H. Reducing the burden of affective disorders: is evidence-based health care affordable? *J Affect Disord* 2003; 77: 109-125.
40 Hall WD, Mant A, Mitchell PB, et al. Association between antidepressant prescribing and suicide in Australia, 1991–2000: trend analysis. *BMJ* 2003; 326: 1008-1012.
41 Hickie IB, Pirkis JE, Blashki GA, et al. General practitioners' response to depression and anxiety in the Australian community: a preliminary analysis. *Med J Aust* 2004; 181 (7 Suppl): S15-S20.
42 McGorry PD, Edwards J, Mihalopoulos C, et al. EPPIC: an evolving system of early detection and optimal management. *Schizophr Bull* 1996; 22: 305-326.
43 Mihalopoulos C, McGorry PD, Carter RC. Is phase-specific, community-oriented treatment of early psychosis an economically viable method of improving outcome? *Acta Psychiatr Scand* 1999; 100: 47-55.
44 Von Korff M, Katon W, Bush T, et al. Treatment costs, cost offset, and cost-effectiveness of collaborative management of depression. *Psychosom Med* 1998; 60: 143-149.
45 ORYGEN Youth Health. Available at: http://www.orygen.org/index.html (accessed Mar 2005).
46 Clockwork: young people's health service (Geelong, Victoria). Available at: http://www.clockhealth.com.au (accessed Mar 2005).
47 Highet NJ, Hickie IB, Davenport TA. Monitoring awareness of and attitudes to depression in Australia. *Med J Aust* 2002; 176 (10 Suppl): S63-S68.
48 McGorry PD, Yung AR, Phillips LJ. The "close-in" or ultra high-risk model: a safe and effective strategy for research and clinical intervention in prepsychotic mental disorder. *Schizophr Bull* 2003; 29: 771-790.
49 McGorry PD, Yung AR, Phillips LJ et al. Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. *Arch Gen Psychiatry* 2002; 59: 921-928.
50 Katon W, Von Korff M, Lin E, Simon G. Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse. *Gen Hosp Psychiatry* 2001; 23: 138-144.
51 Von Korff M, Katon W, Unutzer J, et al. Improving depression care: barriers, solutions, and research needs. *J Fam Pract* 2001; 50: E1.
52 Lin EH, VonKorff M, Russo J, et al. Can depression treatment in primary care reduce disability? A stepped care approach. *Arch Fam Med* 2000; 9: 1052-1058.
53 Leucht S, Barnes TR, Kissling W. et al. Relapse prevention in schizophrenia with new-generation antipsychotics: a systematic review and exploratory meta-analysis of randomized, controlled trials. *Am J Psychiatry* 2003; 160: 1209-1222.
54 Marshall M, Crowther R, Almaraz-Serrano A, et al. Systematic reviews of the effectiveness of day care for people with severe mental disorders: (1) acute day hospital versus admission; (2) vocational rehabilitation; (3) day hospital versus outpatient care. *Health Technol Assess* 2001; 5: 1-75.
55 mindmatters: a mental health promotion resource for secondary schools. Available at: http://cms.curriculum.edu.au/mindmatters (accessed Mar 2005).
56 beyondblue: the national depression initiative. Available at: http://www.beyondblue.org.au (accessed Mar 2005).
57 Hickie IB. Reducing the burden of depression: are we making progress in Australia? *Med J Aust* 2004; 181 (7 Suppl): S4-S5. http://www.mja.com.au/public/issues/181_07_041004/hic10389_fm.html
58 VicHealth. Mental health promotion plan 1999–2002. Melbourne: Victorian Health Promotion Foundation, 1999. Available at: http://www.togetherwedobetter.vic.gov.au/resources/pdf/Funded_Projects_1999-2000.pdf (accessed Mar 2005).
59 Burgess P, Pirkis J, Buckingham B, et al. Mental health needs and expenditure in Australia, 2002. Canberra: Mental Health and Special Programs Branch, Australian Government Department of Health and Ageing, 2002. Available at: http://www.health.gov.au/hsdd/mentalhe/resources/reports/pdf/needsexp.pdf (accessed Mar 2005).
60 Forensicare. How we deliver clinical services. Available at: http://www.forensicare.vic.gov.au/website.nsf/web/clinicalservices.html (accessed Mar 2005).
61 Access Economics for the Australian Society for Medical Research. Exceptional returns: the value of investing in health R&D in Australia. September 2003. Available at: http://www.asmr.org.au/general/Except.pdf (accessed Mar 2005).
62 National Neuroscience Consultative Taskforce. Available at: http://www.health.gov.au/nnct/index.htm (accessed Mar 2005).
63 United Nations Educational, Scientific and Cultural Organization. Most Clearing House: best practices. Available at: http://www.unesco.org/most/bphome.htm (accessed Mar 2005).
64 Rosen A, McGorry P, Groom G, et al. Australia needs a mental health commission. *Australas Psychiatry* 2004; 12: 213-219.

(Received 11 Nov 2004, accepted 14 Mar 2005) ❑

People with mental illness experience discrimination within society, and even within the health care system; mental illness can cause significant social disadvantage that under-resourced services may fail to adequately address; during episodes of acute illness, a person with mental illness may be unable to assert their rights at the very time when those rights may be most vulnerable to being breached; people. experiencing acute mental illness may be treated against their will, or confined against their will, which can be a serious threat to their rights. 3.2 Human rights have been central to d These reform efforts, while significant, are in our opinion insufficient to ensure the future sustainability of Australiaâ€™s health system with Australia in transition. As noted in the 2015 Intergenerational Report, Australiaâ€™s growing population is living longer. The cost of health services is also rising at twice the rate of GDP.Â It is clear that tinkering around the edges will not deliver serious, effective and sustained health reform. By contrast, an approach that considers the system as a whole is most likely to optimise its effectiveness and efficiency and actually improve Australiansâ€™ health. Such an approach would seek to understand and enhance both the way that every element of the health system works â€“ on the supply and demand sides â€“ and how these elements interact. The last decade and a half of mental health system reform under the National Mental Health Strategy has led to significant change. Public sector specialist mental health services are now staffed by a significantly larger mental health workforce.Â clinician rated and consumer rated outcomes in all services. Access to mental health care in primary care settings has been substantially increased as a result of changes to the Medicare Benefits Schedule at the end of 2006, with more than 1.3 million mental health treatment plans developed by general practitioners, and 4.95 million services provided by psychologists and other allied health professionals through Medicare subsidised services.