Australian Government
National Mental Health Commission

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Unless otherwise stated, all Australian statistics cited in
NMHC Report of the National Review of Mental Health Programmes and Services

CHECK AGAINST DELIVERY

INTRODUCTION

I would like to acknowledge the Ngunnawal people who are the traditional custodians of this land on which we are meeting and pay my respect to the Elders of the Ngunnawal Nation both past and present. I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

I also would like to pay my respects to people with lived experience of mental health issues, their families and other supporters. My topic today is: Time to aim higher and why mental health must be part of Australia's economic and social reform agenda.

The Commission completed a national review of mental health programmes and services last December.

The vision for our review is highlighted in the title – Contributing Lives, Thriving Communities. Our review is based on the Contributing Life Framework – a whole-of-person, whole-of-life approach to mental health and wellbeing. It recognises that if we enable people to live contributing lives – to have relationships, stable housing, and to maximise participation in education, employment and the community more broadly – we will help build economically

and socially thriving communities, and a more productive Australia.

Sadly, a contributing life can seem unattainable for people living with mental illness. The review found that Australia's mental health programmes and services are not maximising the best outcomes from either a social or economic perspective.

As an economist, I want to emphasise that mental health is a significant problem for our economy – as significant as, often more significant than, tax or microeconomic reform. Many people do not get the support they need, and governments get poor returns on substantial investment. The economic or GDP gains from better mental health would dwarf most of the gains – often modest ones – being talked about in current economic reform debates.

This is starting to be recognised internationally.

The world's leading economic commentator, the *Financial Times*' Martin Wolf, has concluded mental ill health is the developed world's most pressing health problem. He said:

> "Given the economic costs to society, including those caused by unemployment, disability, poor performance at work and imprisonment, the costs of treatment would pay for themselves."

Recognition comes also from *The Economist* magazine which has just published a special report on the growing incidence and costs of mental illness and the Economist Intelligence Unit has done the same.

From Davos, the World Economic Forum has warned finance ministers and economic advisers that they need to react to the 'formidable economic threat' posed by non-communicable diseases, including mental health disorders.[1]

The OECD estimates the average overall cost of mental health to developed countries is about four per cent of GDP. In Australia, this would equate to more than $60 billion or about $4,000 a year for each person who lodges a tax return or over $10,000 per family. The costs include the direct costs of treatment; the indirect costs e.g. disability support pensions, imprisonment, accommodation and so on; the costs of lost output and income and finally costs to carers and families, not to mention that their workforce participation is held back by caring demands.

Reducing this cost – even by a fraction – would generate sizeable gains. I'll come back to this.

Treasury looks at economic growth through the three Ps: population, participation and productivity. I will address each in turn.

POPULATION

The population affected is huge, with as many as 20 per cent of the adult population affected by mental ill-health in any given year. In fact, one in two Australian adults will experience mental ill-health at some point – this is 7.3 million Australians (aged 16-85). And the issue is greatest for our young Australians, those who should be participating in the education system and

[1] Bloom, D.E., Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Feigl, A.B., Gaziano, T., Mowafi, M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A.Z., & Weinstein, C. (2011).
The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum

embarking on their working lives. One in four 18-24 year olds experience a mental ill-health problem every year.

To reinforce the point about the size of the problem, I note that mental illnesses are the leading causes of the non-fatal disease burden in Australia – they account for about a quarter of the total burden. Mental illness also accounts for about 13 per cent of our total burden of disease (including deaths).

Unlike other diseases, a major impact of mental illness on our economy is due to lost income from unemployment and expenses to support an illness that begins when we're young and lasts many years – this is what makes this economic burden so great.

PARTICIPATION

Labour force participation is the second major variable in economic growth. The higher the number of people working, the higher the rate of economic growth. Mental illness is responsible for a very significant loss of potential labour supply and output.

Today 37.5 per cent of people affected by mental ill-health are either unemployed or not in the labour force. This compares to 22.3 per cent of people without mental health conditions. And our performance is low by the standards of the leading OECD countries.

The World Economic Forum estimates the cost of lost output and income as being about 1.75 per cent of GDP.

This is not good enough and there is a clear productivity cost. Many people with mental illness want to work but find it difficult to find a job, also impacting on families, carers and other support people. We need to provide better support for people living with mental illness to get into the workforce and stay in it, not only for the benefit of individuals, their families and support people but also for the benefit of the whole population.

There are many very specific measures that can be taken that would have a substantial economic impact. For example, specific measures to get young people from school to post-school education and employment; greater individual support for those in trouble; and other market mechanisms to encourage sustained employment and skill development during this period.

PRODUCTIVITY

The third variable is productivity. Mental ill-health generates considerable absenteeism and presenteeism (on the job productivity loss). Those with mental health difficulties are both more likely to take time off from work and to accomplish less than they would like to when they are on the job.

Mental health conditions result in around 12 million days of reduced productivity for Australian businesses each year.[2] And given one in six people in employment experience a mental health issue each year, even small businesses are likely to employ people with a mental illness, which requires proper support.

[2] PwC PricewaterhouseCoopers Australia, Creating a mentally healthy workplace: Return on investment analysis, 2014. Available from www.headsup.org.au

Mental health and wellbeing is recognised as a serious workplace matter. That's why at the Commission we have formed a collaboration with a very interested business sector, the mental health sector and government through the Mentally Healthy Workplace Alliance.

The Alliance is made up of important entities including the Business Council of Australia, the Australian Chamber of Commerce and Industry, COSBOA, Australian Industry Group, Comcare, Australian Psychological Society, Safe Work Australia, SuperFriend, the Black Dog Institute, beyondblue, Mental Health Australia, SANE, and The University of New South Wales.

To quote Jennifer Westacott, who chairs Mental Health Australia and is CEO of the Business Council of Australia, the business case for change in mental health is "not only morally and socially compelling, it is economically fundamental".

THE COSTS

Our Review identified that the direct costs of Commonwealth expenditure alone on mental health and suicide prevention programmes are about $10 billion a year (2012-13).

This gives rise to another set of important economic questions: the allocation of spending – is that expenditure effective and efficient?

- Are scarce resources being used cost-effectively to achieve identified objectives?
- Are decisions on what programmes and services the Commonwealth invests in resulting in maximising net benefits to the community?

From the limited evidence available, the Commission's view is that much of the funding from the Commonwealth is neither effective nor efficient.

An indicator of this is that a very large amount of spending occurs in downstream programmes engaged in income support and crisis responses, as well as in other benefits and activity-related payments – $8.4 billion or 87.5 per cent of Commonwealth funds is spent in five major programmes:

- Disability Support Pension
- Carers Payments
- Payments to the States and Territories for hospitals
- Mental health related Medicare Benefits Schedule payments (including Better Access)
- Pharmaceutical Benefits Scheme payments

Much of this is payment for failure, payment for failure to treat the problems early and cost effectively.

I believe this heavy expenditure could be reduced with a greater emphasis and investment in prevention, early detection, a focus on recovery from mental ill-health and the prevention of suicide.

THE REVIEW

Our Review – Contributing Lives, Thriving Communities – highlighted that mental health is not just an issue for governments. It touches every industry, every workplace, the vast majority of families and is everyone's responsibility.

We heard from many people with lived experience, their families and supporters, and people who work in the sector.

We found many examples of wonderful innovation and that effective strategies do exist for keeping people and families on track to participate and contribute to the social and economic life of the community.

Fundamentally, the approach we recommend calls for the system to be realigned from a focus on service providers, to a focus on people, where those with lived experience, their families and support people are engaged and involved at all levels —"nothing about us without us".

Central to this are person-centred design principles, where through an integrated stepped care model, services are designed, funded and delivered to match the needs of individuals and particular population groups. This involves a participative and inclusive approach, focused on achieving better outcomes for individuals, their families and communities – not on the role of providers and what activity they produce, though they are indispensable and valuable players.

Importantly, the right approach requires a holistic focus on people, taking into account all of their needs – their mental health and fitness, social and emotional wellbeing, physical health, and other determinants such as culture and a sense of belonging.

We need to shift the focus from downstream to upstream services – from income support and crisis responses, to early intervention, prevention and support for recovery-based community services, stable housing and participation in employment, education and training.

We have to catch people before they fall.

Our Review shows that we have a once-in-a-generation opportunity to create a system that will support the mental health and wellbeing of millions of individuals to enable them to live contributing lives and participate in thriving communities. What's more, the Review shows this is achievable and sets out a blueprint on how we can get there.

We have identified measures that will enable the Commonwealth to maximise value for taxpayers by using its resources as incentives to leverage desirable – and measurable – results.

We need to start that change now.

STEPPED CARE FRAMEWOK

Key to this is a stepped care framework as outlined in the Review.

This means that there is a range of options that vary in intensity according to an individual's level of need or functional impairment.

People's needs vary dramatically across the spectrum of mental illness. Of the 3.7 million estimated to have mental ill-health problems in any given year, the majority, or 3 million, have a mild to moderate condition, such as anxiety or depression.

Another 625,000 have a persistent complex and chronic illness such as schizophrenia or severe depression. And 65,000 people have severe illness and suffer from a psychosocial disability.

Stepped care services would range from no-cost and low-cost options for people with the most common mental health issues, through to support and wrap-around services for people with severe and persistent mental illness. It includes a greater range of services being available according to need and functional impairment – for example:

- a graduated range of services from self-help and prevention
- a strengthened primary health care approach
- non-clinical psychosocial support within the community, and
- a variety of options between specialised community mental health services and acute hospitalisation – for example, step-up/step-down services where, for example, people can leave costly hospitals and go to less restrictive accommodation with adequate levels of care
- more generally, we need to build community capacity and rely less on new hospital beds – in both the public and private sector.

The overarching aim is to enable all to participate as much as possible within their families and communities, and to lead contributing lives.

Easy to access service delivery models such as e-mental health have an important role to play in assisting people and those who care for them. This would in turn enable more cost effective use of the time and skills of clinical and other professionals.

A fundamental element of a stepped care approach is prioritising the delivery of care through general practice and the primary health sector.

International experience shows countries that have strong primary health care infrastructure have healthier populations and lower overall costs for health care than countries that focus more on specialist and acute care.

NEW SYSTEM ARCHITECTURE

Our report recommends new system architecture, with a focus on the needs of particular population groups.

In particular, it recommends a stronger focus on the early years and a healthy start to life, to build resilience in children and families, reduce childhood trauma which can have an intergenerational impact, and protect those who are vulnerable.

The most important years in a child's development are those that occur by the age of three.

We also recommend that agreement be reached on the respective roles of the Commonwealth on the one hand, and the States and Territories on the other. Our view is that the Commonwealth should focus on national leadership and programmes, and that their other key role should be in enabling a much better coordinated, joined up system at a regional and local level.

The current system is too fragmented and with too many siloed services, meaning that the more functionally impaired you are the harder it becomes to navigate the system.

PRIMARY AND MENTAL HEALTH NETWORKS

Right now, organisations are rolling out across the country that could spearhead this change to a more regional, localised approach.

For example, July 1 saw the formation of 31 Primary Health Networks covering the entire country. These provide the ideal architecture to better target mental health resources to meet population needs on a region by region basis.

We propose renaming these as Primary and Mental Health Networks and providing them with bundled funding for planning and purchasing mental health programmes, services and integrated care pathways for mental health that are tailored to individual needs and different communities.

We envisage these Primary and Mental Health Networks will engage with local services, with people with lived experience and with their families and support people to identify local priorities and local responses.

We see it as vital that mental health and wellbeing is identified as intrinsic to primary health care – Australia cannot take a person centred, holistic approach to better outcomes for individuals and communities unless we deal with both the physical and mental health of populations and people's overall wellbeing.

Some of the most disturbing findings of our review related to the physical health of people with a mental illness and in particular the failure of the system to recognise the physical clinical deterioration of people with a mental illness. Few people probably realise that people with psychosis die on average earlier than the general population with the causes being the side-effects of antipsychotic

medications, high, increasing rates of smoking and the fact that many people with a mental illness do not get good treatment of their physical illness.

SUICIDE

A good example of what we mean in relation to a regional or local approach is in the area of prevention of suicides and suicide attempts.

In our country seven people die every day from suicide, approximately double the road toll. But while the number of deaths on our roads has diminished substantially, there has been no major reduction in the suicide rate over the past decade.

In particular, death from suicide among Aboriginal and Torres Strait Islander peoples is twice that of non-Indigenous Australians.

There are excellent examples of suicide prevention, treatment, follow-up and postvention in Australia.

However too often services are not joined up, too fragmented, lack sufficient focus and operate from too small a resource base to achieve a meaningful impact.

A new approach is needed and there is some evidence about a range of strategies that work.

Suicide is not just about mental health and nor is it about any one sector. What we need are locally organised and properly coordinated or joined up responses to this major problem.

So we have proposed that the Commonwealth use its resources as incentives to drive the development of community partnerships which co-create solutions at a local level for suicide prevention. These partnerships should encourage buy-in (including financial or in-kind contributions) from local communities, including health services, schools, NGOs, businesses, local government, media, community organisations and clubs, and in particular from families and communities, to all play a part in developing local solutions which provide comprehensive strategies based on local knowledge.

And we want to commence this approach with 12 regions as the first wave of nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

REGIONAL CHANGES

We need to acknowledge diverse regions have different needs and to plan appropriately, and that there is significant regional variation in need, and in access to services and regional equity. A one-size-fits-all approach cannot be applied across metropolitan, regional, rural and remote Australia.

We need to think about the local health landscape and consider the prevalence of mental health concerns as well as demographic, environmental, socioeconomic, cultural and other factors.

A regional approach provides the opportunity to improve service equity for rural and remote communities through place-based models of care.

We know that the further away you get from major cities the harder it is to access mental health specific services.

Our view is that changing this will require national leadership combined with local responses.

On a per capita measure, for example, when compared to remote or very remote areas, major cities have almost four times as many psychiatrists, three times as many registered psychologists and twice as many mental health nurses.

Because access to Better Access services funded under Medicare is dependent on the availability of providers rather than demand for the service, people in rural and remote communities are less able to use services under this programme.

Although Mental Health Services in Rural and Remote Areas (MHSRRA) has helped improve the workforce situation, the service deficit in rural and remote locations remains significant and the lack of psychiatrists and psychologists is particularly acute.

The lack of rural incentives under Better Access appears to be an anomaly when compared with other programmes where there is a rural loading—for example, for GPs, practice nurses and mental health nurses**.**

We therefore have made recommendations for the Commonwealth to consider changes to the Better Access program that would encourage a more equitable geographical distribution of psychological services.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Finally, in recent weeks, we have seen news coverage that has further amplified areas of crisis in indigenous mental health, social and emotional wellbeing and suicide. In 2011–12, 30 per cent of Aboriginal and Torres Strait Islander adults had high or very high levels of psychological distress. That's almost three times the rate for other Australians.

In 2012–13, the annual suicide rate for Australians generally was 10.3 deaths for every 100,000 population – for Aboriginal and Torres Strait Islander peoples it was 21.4 deaths per 100,000.

The system as it stands is tragically ill-equipped to help.

This must change. Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing must become a national priority.

There is a strong Aboriginal and Torres Strait Islander presence which flows throughout our review recommendations, with many of the system changes we recommend expected to have a positive impact on Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing. However, there are two specific recommendations which I want to draw to your attention:

Recommendation 5: Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional CoAG Closing the Gap target for mental health:

- Establish a new and dedicated National Aboriginal and Torres Strait Islander mental health plan

- Implement the National Strategic Framework for ATSI Peoples' Mental Health and Social and Emotional Wellbeing 2014–2019, the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, National ATSI Suicide Prevention Strategy 2013 and National ATSI Peoples' Drug Strategy

What that Closing the Gap target should be needs to be worked out with the Indigenous community – it may be there need to be two, one on social and emotional wellbeing and the other on suicide prevention.

Recommendation 18: Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations, linked to Aboriginal and Torres Strait Islander specialist mental health services.

- Ensure through contractual performance requirements that general population mental health services are accountable for better Aboriginal and Torres Strait Islander mental health outcomes.

- Train and employ the Aboriginal and Torres Strait Islander workforce needed to close the mental health gap.

CALL TO ACTION

The Commission would like to thank the many in the mental health sector who have supported our reform plan, some of whom are in the audience today. We know we are a dedicated sector that wants to work collectively to make change happen.

Together, we are determined not to let this opportunity for change pass us by.

In this context, I want to quote from the response of the Mental Illness Fellowship of Australia to the Review report:

> "It's not perfect. We could argue with some of the detail. But our own experiences with mental illness and the mental health services tell us that it seems to be about right on all the big issues. Most importantly, it gives us all a framework that we can get started on as the first part of a ten year plan. Let's argue the detail **after** we get started on implementation."

Whether we measure the cost of mental illness in terms of individual misery or the burden it places across society, it is clear we are currently paying too high a price for a system in urgent need of reform.

We have had successful reform programs in the past. The National Competition Reforms that kicked off in the mid-1990s and took ten years are credited with a two per cent improvement in GDP.

If we can improve the mental health system by 25 per cent, we can deliver a 1 per cent improvement in GDP. That would be a huge contribution. To put it another way for every 10 per cent gain in mental health, GDP would rise by 0.4 per cent.

There is much scope for addressing the three Ps of economic growth – reducing the impact of mental illness on a large population; improving participation; and improving productivity at work.

In fact, as I hope this address and our report makes clear, there is immense scope for significantly reducing the high costs of mental illness and improving

the outcomes for individuals whose quality of life can be so damaged by mental illness. In short, the costs of mental health to the economy are high. They can be greatly reduced.

I get some comfort from the fact that, at last month's leaders' retreat, the Prime Minister and the State and Territory leaders agreed to focus reform on health, education, infrastructure and housing.

When it comes to chronic care, they recognised that mental health requires particular attention and included a new focus on primary care and keeping people out of hospital.

We welcome this recognition and urge our political leaders to continue to look beyond health costs to the full burden of mental illness in our society and to give mental health the priority it needs.

So let's set in place a world-leading mental health system while we have that appetite for change. It will pay dividends for decades and generations to come.

It will not only improve the lives of many individuals and families. It will make us a more productive society, reduce the numbers of those in need of support, increase the numbers of those who are contributing and help secure future economic growth.

The Commission delivered on time last December a major report with major reform proposals based on the fullest consultation.

Government – and that includes State Governments – needs to act on it as soon as possible to demonstrate commitment to the millions of people in the mental health sector.