**Ideas and Society Program**

**Mental Health in Australia**

**Thursday 5 April 2012**

**John Dewar**

Welcome everyone. I’d like to begin by acknowledging the Wurundjeri people as the traditional owners of the land on which this Melbourne campus of La Trobe University is located and to pay my respects to elders past and present. Apologies for the slight delay. We wanted to make sure that the webcast was working properly so that colleagues from our other campuses were able to join in today’s event. So welcome to those of you who are here, welcome to those who are watching over the web and welcome in advance to those of you who will be watching this in iTunes U on the Ideas and Society Program page of the La Trobe website or on Slow TV.

It’s a real pleasure to welcome you here to the latest in La Trobe University’s Ideas and Society Program and on everyone’s behalf I’d just like to thank Professor Robert Manne for bringing such an illustrious and highly qualified panel together today. Robert can’t be with us. He’s recovering from an operation but I know he’ll be delighted, not just that we’ve been able to attract such a high quality panel but that we’ve got such a good audience to hear them speak.

Universities have a really important role to play in public debate. Many public intellectuals find their home in universities and I’m delighted that this is a role that La Trobe has taken very seriously over the years and to which we continue to attach enormous importance. This Ideas and Society Program is a really good example of that. It’s also important that we engage with topics of pressing national interest and public concern and today’s topic on mental health is undoubtedly one of those. I’d just like to quote briefly from the introduction to a document which I gather is still in draft. It’s called the *Ten Year Roadmap for Mental Health Reform* but the opening paragraphs say this. “Mental health is fundamental to a person’s ability to lead a fulfilling and rewarding life. We know that in any year, one in five Australians will suffer from a mental illness. We also know that mental illness disproportionately affects those who are socially and economically disadvantaged, while also contributing to their social and economic circumstances.” And this is a comment of particular interest to universities of course. The impact of poor mental health is particularly significant among young people. So this is undoubtedly a really important topic and an entirely appropriate one for the university through its Ideas and Society Program to engage with.

It’s fortunate therefore that we have such extraordinary champions and advocates for mental health as our speakers today. Before I introduce them though I’d just like to introduce our chair for today, Professor Simon Crowe. Many of you will know Simon. He’s a familiar figure around campus. He’s recently taken over as Chair of our Academic Board and therefore is very practised at keeping speakers in order. But more relevantly, he’s Professor of Neuroscience and Clinical Neuropsychology here at La Trobe and is President of the Australian Psychological Society. So Simon, thank you for taking on this task. But it’s my great pleasure to welcome our three distinguished speakers and to introduce them to you briefly. Next to Simon, we have Professor Allan Fels AO. Allan I’m sure will be a familiar face, at least to many of you who will remember him from his days as Chair of the ACCC and a regular commentator on the latest perfidious doings of business in the Australian community, a figure who inspired I think great trust as a regulator, now Dean of the Australian and New Zealand School of Government and also relevantly for these purposes, head of the National Mental Health Commission. Next to me is Professor Patrick McGorry, also AO, who is head of Orygen Youth Health and a former Australian of the Year. And in the middle is Barbara Hocking AM, who’s Executive Director of SANE Australia. Between the three of them, I don’t think you could possibly hope for a better qualified panel, or indeed three more passionate advocates for the subjects we’ll be considering today.

So with that introduction Simon, I now hand over to you. Thank you.

**Simon Crowe**

Thank you Vice Chancellor. Robert has done me a great favour by having his operation, so it’s a great pleasure to be able to step into his shoes. I’m going to begin with just an outline of the nature of the problem that we face and certainly mental health has been a hidden issue, it is an issue that is often dropped from government agendas, it is an issue that governments sometimes think that it has dealt with and moves on to other things, and creates a very disconcerting and patchy approach to the whole issue. And hopefully, with the advent of the report card, with the roadmap, we will move to a much more balanced, managed and concerted and maintained program of delivery in this area.

A couple of facts: two thirds of those who suffer with mental illness will have experienced their first symptom by the age of 21 and without support, some will experience lifelong disadvantage. 25% of people with depression and anxiety disorders experience their onset before age 12, 64% by age 21, and suicide remains a leading cause of death amongst these young Australians, second only to motor vehicle accident. Women experience mental illness at higher rates than do men, and the higher diagnosis of high incidence disorders in women, anxiety disorders and effective disorders, is disproportionate with men experiencing higher rates of substance use and are a greater risk for suicide, particularly if they are rural and remotely focussed. Men suicide at higher rates than do women, and while the male suicide rate has declined gradually over the last decade, it still is sixteen deaths per hundred thousand males in 2008. The female rate has remained at around 5 deaths per hundred thousand since the late 90s, declining gradually from 6 in 1997. Young men suicide at higher rates than young women, and men aged 20 to 24 are particularly vulnerable to suicide, with a rate of about 19 suicides per hundred thousand in 2008, a higher rate than for young men aged 15 to 19 at 9 per hundred thousand, or for young women at 3 per hundred thousand in 15 to 19s, and 5 per hundred thousand in 20 to 24s. Of all people, middle aged men and older men suicide at the highest rate. In 2008 men aged 40 to 44 had the highest suicide rate at over 26 deaths per hundred thousand, only mirrored by individuals, men in the age group of 85+ with a similar number. Aboriginal and Torres Strait Islander people experience the higher rates of mental health problems as compared with other Australians and this is reflected in high rates of self harm, suicide, substance use disorders and family violence. The prevalence of mental illness is approximately two and a half times greater among people who have experienced homelessness and other vulnerable population groups include refugees, other humanitarian entrants, people with chronic diseases, gay, lesbian and bi-sexual as well as trans-gender groups. Mental health problems and mental illness account for 50% of the burden of disease for people aged 16 to 24 and only around 28% of people with mental or behavioural disorders complete Year 12 compared with 54% of people who do not have it. People with mental illness have lower rates of post-compulsory education, with 8% of people with mental or behavioural disorders completing university degrees, and 22% of the wider community. 25% of mental health problems in adults are potentially preventable, through treatment and optimising protective factors during childhood and early adolescence. Less than half of Australians who experience mental illness in the last year consulted mental health practitioners. 10 to 15% of older people experience depression, and approximately 10% experience anxiety. Rates of depression among people living in residential aged care facilities ranges between 34 and 45%. Based on recent estimates in terms of the econometric costs associated with mental illness, productivity losses associated with mental illness amount to 5.9 billion dollars to the Australian economy annually. Labour force participation rates for people with mental illness and behavioural disorders is only 42% compared to 80% of the uninjured, unimpaired population, and the World Health Organisation has recognised that governments across the globe have tended to focus investment and energy on acute services and support whereas far more benefit to consumers, carers and their families, can be achieved through greater reliance on self-care and primary care for less complex issues.

We need a system that can provide *all* the levels of care people experiencing a mental illness need, available in the right place, at the right time, and organised to facilitate services for accessing via need. Put simply, mental health is everyone’s business and we all need to know that we are spending every tax dollar on the most effective programs and initiatives to ensure that we provide the most effective attack on this devastating social problem.

And so the point of today is to actually start to maintain our rage with regard to doing something about this issue and I certainly welcome the roadmap, I certainly welcome Allan’s initiative in terms of the report card, and I feel sure that our speakers today are really going to enthuse you about the fact that this, the outcomes that I have already outlined, can be different. It’s my great pleasure to introduce Professor Patrick McGorry, who will join us, and since John has already introduced you, I think we probably won’t need to go further. So, Patrick.

**Patrick McGorry**

Well, hello everyone and I’d like to thank Robert Manne also and La Trobe for inviting me to be part of this great discussion today. I think Simon has given you enough facts and figures but I liked his last comment about maintaining the rage, but he also, if you recall what Gough Whitlam actually said, it was – maintain your rage and maintain your enthusiasm. And I think in Australia we’ve got to actually be positive and optimistic and enthusiastic to solve this problem. The figures that Simon quoted … they’re quite stark. And I’ll just add a couple of others. They do make you frustrated and angry when you see the level of neglect that’s actually going on across the life span, but I think Australia is extremely well placed as a country to actually show the rest of the world how we can actually address these problems in a much more effective way. So, I’m pretty positive and optimistic about the future.

If you try to visualise what Simon was saying. 4 million Australians a year are affected at least by mental ill health, that’s directly affected. If you add their families and their friends it’s almost everybody. But 4 million Australians, that’s 40 MCGs full of people. And the shocking side of that statistic is that only about a third, a bit more than a third, only 40% at the most of those people will be getting any kind of mental health care. And that’s just access. The quality of that care is another story, which I’ll come to in a minute. And if that was happening in cancer or a heart disease or any other area of health care, that would be a national scandal. And it probably is, actually. But we are addressing it, I think.

One million of those people are young people and you know, all the statistics about suicide and all the rest of it that Simon quoted are absolutely, you know, key here, but I think another statistic is that 75% of onsets of disorder, I think you said that, didn’t you, are before 25. And that leads … I’ll come back to that in a minute, because I want to go now into what’s actually been happening in the last … really in my professional lifetime in mental health care. I often joke that I started training in the 19th century, and people believe it these days, which is a bit of a problem, but actually what I mean is, the thinking and the settings that I trained in as a young doctor, were 19th century settings. They were the old asylums. Simon was saying this university was surrounded by those asylums until probably until about fifteen years ago and so when we trained, the whole ambience, even though it was well-intentioned, was of a 19th century attitude to mental illness, you know, full of stigma, pessimism, if you had actually had a diagnosis of schizophrenia and you got better, well, they changed the diagnosis. So there was so much pessimism and stigma you could feel it. And the thinking was 19th century as well – very deterministic, very – I don’t know – there was no sense of a personal story, there was no sense of the possibility of a recovery for people. So we had to sweep that away, and that has been steadily swept away over the last few years, the last ten or twenty years, but sadly, we haven’t replaced it with a 21st century model of care. We made a very half-baked effort at it about ten or fifteen years ago under the rubric of what was called mainstreaming of mental health care into the general health system and people thought this was going to be the magic wand that would just wipe away stigma by making mental health just the same as any other health problem. But what happened was there a disinvestment if anything, and certainly no relative improvement in a share of the health dollar. Simon’s given you the burden of disease figures. We’re currently spending about 7% of the health budget on mental health care. It’s at least 13% of the burden of disease across the lifespan and in the younger age groups, it’s a much, much bigger figure. So there’s a huge differential in terms of access and quality to care as a result.

Now, the other thing that wasn’t even considered at the time and it’s only just become clearer in the last five years or so, is that the architecture of illness and disease in mental health is the mirror image of physical illness. So that in physical illness we have children’s hospitals which looks after all those younger children that have got serious medical illnesses. And we’ve got other hospitals and general practice and the whole range of health services that look after people over 50 with physical illnesses. And in between from puberty through to about at least middle age, but certainly until the mid 20s, people are very physically healthy. If you go into a doctor’s surgery, you see little kids and you see older people. You see very few people in that age range. And yet the design of our mainstream health system was carried out without any regard to the age of onset or the pattern of illness across the lifespan. So we have a huge missing hole in our mental health care system for adolescents and young adults and even people up into higher middle age which has not been funded – it hasn’t been designed right, it’s not culturally right, its access and portals are really hopeless. And so the people who need the help the most have got the worst access to care. And if they do happen to get access, I saw a cartoon this morning which was showing a huge wall with people trying to scramble over one way and other people trying to scramble over the wall going the other direction. But this was basically the barrier into mental health services. People desperately trying to get in, and as soon as they get in, they’re desperate to get out again. So in other words, access is poor, and if you do get in, the culture of care isn’t right for you, particularly if you are in certain age groups. I think to some extent that applies across the lifespan too, so I’ll come back to that.

So we’ve had a crude attempt to reform the system, going from the 19th century to the 20th century. We need another serious wave of root and branch reform. What we’ve also seen since the mainstream occurred is that because it’s been handed over to state governments, the public mental health system, or it remained with state governments, and the old system was a hospital-based system, the state governments were able to create initially a sort of a basic base camp of community mental health care. And what’s happened to that base camp around Australia, since that was done, it’s just withered basically. The state governments see the world through hospitals in terms of health care. They’re able to look after beds, and think that way – emergency departments and beds, but when it comes to community services, they’ve really neglected them, they’ve failed to grow them and invest in them and evolve them in terms of the needs of the community. So they’re not built to scale. State governments have got no capacity to grow them, financially, and they can’t integrate them properly with primary care, which is where the rest of the community actually live.

So that’s I suppose the bad news, and leads to experience of care which I’m sure Barbara and Allan could talk about and I can too. I saw a young woman up in Coffs Harbour on Monday at the headspace there. She was fresh out of the emergency department and was sent across to the headspace. I saw her with her mother. She had been wandering in the traffic on the Pacific Highway, very suicidal, at about 2 am, this is a young woman with depression, borderline personality, and a number of other problems, and they were very … this is a very standard presentation in Headspace land and actually in Orygen, in our service as well. So she was basically kept in the emergency department for about five or six hours, surrounded by about four security guards, no nurses to be seen, you know, when I trained in psychiatry, nurses used to do the caring-type job and keep people safe. Nowadays it’s a bunch of, you know, seven foot tall security guards, a completely traumatising and horrifying experience for this young woman. And then a junior hospital doctor turned up at 9 am and kicked her out, and sent her down to the headspace. And this is the type of thing that is happening every day of the week in the Australian public hospital system. The emergency department model, a mainstream model, is you know, really the wrong model for what we are trying to do. The in-patient unit – Vaughan Carr in New South Wales, Professor of Psychiatry, describes them as menageries. They are not therapeutic environments and this is a serious issue. The one thing the state governments are clearly responsible for, and are committed to, it’s a very poor experience for most people. Now I’m not blaming the staff. The staff and clinicians are trying to do their best in a beleaguered micro-managed, under-funded system, all around Australia. The morale is poor because of the way our hospitals have actually evolved in this direction. So, a serious, serious problem. Needs root and branch reform. Everyone I think in mental health care in Australia would support that sort of serious review of mainstreaming and the whole system. It’s not that we’re advocating any return to 19th century models, but we’ve got to move forward into the 21st century.

OK. So, trying to get back onto a more positive note. What we are doing, and we spoke about this at the Senate enquiry into mental health last year – we’re building a mental health system. It’s a bit like the Sydney Harbour Bridge in 1928. You remember that fantastic picture with one arch of the bridge being built and it’s about a third of the way across, and then the other arch from the North Shore is being built and you’re wondering – is it going to meet in the middle? You know, are they going to run out of steel? What’s going to happen? Well, that’s our mental health system. The state governments have built one end of the arch, and actually they’ve dismantled bits of it as well, and pulled it back. And the Federal government is building. Now, is it building in the right direction? You know, I’m sure Allan’s going to be talking about that. Have we got enough steel? We probably, last year we probably bought a year’s supply of steel, you know. What’s going to happen this budget? What’s going to happen next budget? Is the building just going to grind to a halt? In the budget last year they dismantled a bit of the arch. They stopped better access, and then they brought it back again, and that was a really unhelpful decision. And they did build some new things. They added another sixty headspaces, or another fifty headspaces, which was a fantastic decision. And they added another 571 million dollars for severe enduring mental illness, even though they didn’t know which direction they were going to build that bit in. So, this is the way it’s going. And there’s a whole lot of people caught in the middle of that bridge at the moment, who need care. You know, some of them have got severe mental illness, some of them have got moderate levels of mental illness and they don’t fit into the better access model that well, they don’t fit into the public mental health system model, but they need a multi-disciplinary sort of consistent response for a fairly long period of time but they’re not covered by either arch of the bridge at the moment. So, we’ve got a major building project.

What are the encouraging signs of the reform? Well, I think over the last ten or fifteen years, finally in mental health care we’ve embraced the idea that cancer or heart disease – any other area of health care would say that we’ve got to look after people across all stages of illness. In mental health care, until recently, we said, the only people we’re going to look after are people with severe and enduring and disabled forms of mental illness. Everybody else has just got to take their chances, and come back when they’re more severe. Then, better access was funded, back about a decade ago, and that started to pick up the mild to moderate end of the spectrum, but nevertheless, there was still no concept – this is about ideas and society – well, early intervention, early diagnosis was a missing idea in mental health care until the last ten or fifteen years. Now it’s got a place, and it’s linked with the youth mental health reform, because as you can see, most of the early stages of illness are actually in young people, not all, about 25% are not. But the early intervention idea has come of age and I think it’s unstoppable now. And we’re seeing that in Australia. It’s very hard to argue against it. Some of our colleagues are still arguing against it. That happened in other countries, but actually it’s a difficult argument to sustain. And the point is, you wouldn’t hear cancer specialists saying we’ve got to get palliative care right and it’s got to be perfect before we start to do early diagnosis for breast cancer. They’d be laughed out of court. We’ve got to do all of these things. We’ve got to make sure every stage of illness is properly supported and funded and hopefully by doing that, we will shrink the number of people that will actually end up needing more intensive or long term care. And we’ve got encouraging evidence suggesting that’s the case. So, it’s not an either-or, zero-sum game. And especially when there’s new money on the table. You might have a point if you were shifting money and taking money away from one group and giving it to another. That would be a recipe for disaster. But we’ve got to invest new money where it’s going to do most good. And there are many areas to do that. So we just look at the lifespan. Children, obviously a key emphasis on prevention and mental health promotion of those sort of activities in younger children. A lot of the people we see in headspace have had massive attachment disturbances, you know, statutory care, blended family, lots of disruption in their lives – they come in when they’re 13 or 14, they’re very angry but they’ve had mental health problems in earlier childhood. So preventive work at that stage would be critical. Strong services across the adolescent, emerging adult divide, 12 to 25, as headspace is doing. And then later in life, or with later onsets, people with more established or severe mental illness, the one thing that became really clear to me in 2010, was that housing was the number one issue for those people, a decent place to live. It’s the hierarchy of needs, housing, enough to eat, a meaningful purpose in life – all of these things, whether it’s work or education or whatever it is, these are what people really feel they need and what they do need. And they’re not freely available but they are beginning to be addressed.

We also need expert care. If you go into a cancer hospital in Australia, the cancer service, you’re going to get the best care in the Western world, you know, real experts in every aspect of these illnesses. And in Australia, that does exist, but it’s patchy in mental health. You know, there’s not respect for that. There’s not the same sort of respect for developing the specialist skills in psychology and psychiatry – there’s a dumbing down, generic – all you’ve got to do is have this generic, one size fits all sort of approach. We’ve got to move beyond that.

And I think finally, we’ve got to modernise other aspects of mental health care system. I’ve given the public sector a bit of a bashing today. I’ve worked in the public sector for thirty years, but the private mental health sector really needs to take a good hard look at itself as well. It’s very uni-dimensional. It’s not multi-disciplinary in the same way. It can be now, with these federal streams of funding now. It could be a lot more integrated and effective and the NGO sector as well. That is now governments channelling lots of money into the NGO sector and trying to cover these more human and more holistic aspects of care that are missing, but if that’s done in a fragmentary way like it currently is being done, and not integrated with the clinical care, that’s also not going to serve people well. So, all the sectors need to have a really good think.

Now, how are we going to maintain – this is the last thing I’m going to say – how are we going to maintain this momentum that I think Simon was referring to. We were discussing this beforehand. How is this not going to be just a one-shot deal for 2011 and we’ll be back here in 2016, saying, you know, nothing’s happened in the last five years. The only way that is going to occur and maybe Allan’s Commission can play a role here, but I think the only way this is going to occur is if the public in large numbers, get behind this and stick with it. Because that’s what got that investment last year in the budget, because both sides of politics knew at that time, and hopefully they still know, the public are going to be on their case on this issue. Because it affects every single Australian, one way or another. And our job as a sort of a group, I think, of people who are interested in reform, is to kind of harness and maintain that public … that mass movement sort of element that we can mobilise. And so everyone listening to this today, in the audience or through the media, just think about that, because that’s the one thing that you can do to help us keep this issue on the agenda. Make it a voting issue. Make it a political issue. And that will help everyone effective on mental health in Australia. Thanks.

**Simon Crowe**

We’re going to have each of our speakers speak in turn and then we’re going to move on to questions as we move towards … at the end of each of our speakers. Barbara.

**Barbara Hocking**

Well, good afternoon everyone. Thank you. Pat has really set the scene beautifully in terms of the system and how it’s been working or not working. We got all the stats from Simon earlier about the extent of the problem. I think it’s very significant that this is the first time this group has actually tackled the issue of mental health, and I think that that is a real indication that it is an issue whose time has come and not before time.

Getting back to the Commission though, I want to say that the establishment of the Commission is one of the most exciting things I think that has happened, in recent years. We’ve had a lot of rhetoric. The rhetoric is starting to turn into a little bit of reality of some funding coming through, and I think then having the Commission established is really going to give us some sense of holding people accountable. So we’re actually having someone who’s monitoring what’s happening, and trying to make sure that that is actually going to be paying dividends for the people who are living with mental illness.

Apart from its establishment, the other really key thing is that the Commission will report to the Prime Minister, and this means that it’s not kept within the health dimension, and Allan, you’ll probably talk much more about this later, but I think because of what I want to focus on, it’s very significant. It is a cross-government issue, so all the things that impact on someone’s life will in fact be in the remit of the Commission, and that is very important when we’re talking about people who are living longer term with mental illness, it is something that impacts on every aspect of their lives. And as an organisation, SANE Australia works for a better life for people affected by mental illness, so we’re looking not only at clinical care, but we’re also looking to make sure that people have the ongoing services and supports and opportunities that will enable them to have a good life.

When we – we have a very busy help line a national free call help line, and when we are talking with people through our help line, the sorts of issues that they raise with us, yes, people are interested in signs and symptoms of illness and how to get treatment, but more often than that, they are asking us about the other things that impact on their lives, that is, where they can find somewhere to live. If it’s a family member calling, they’re often asking about where can my relative find somewhere to live where they’re going to get the support that they need? Or they may ask, how can I get a job? The thing I want more than anything else is to have a job. Where can I have education so I can learn the skills for the job? Where can my family get some support for ourselves? We’re managing and supporting a person we care about, but we’re not being given any help. Where can I get help managing my money? If you’re living on a pension you don’t have a lot of money, and people need budgeting skills. Or where can I get some legal advice? All the sorts of issues that each and every one of us will need at some stage in our lives. So we say that people with a mental illness are wanting the same things that each and every one of us wants, and that’s a home, a job and people to share our lives with. And I bet if I was to ask each and every one of you, you would come back with the same sorts of things. And yet we know that these are the things that very many people with mental illness miss out on. And I’m focussing here a little bit more on people who’ve got a longer term disabling form of illness. Pat has stressed very, very effectively how important it is to get in early. I totally agree with that. The earlier we get in, the more effective the treatment people get, for as long as is needed, then the better the chances are that they’re not going to have a disability.

But the reality is that for many people, their illness is a disabling one and so they do have to have these ongoing supports available to them, as and when they need them. It may not be every day – we are talking about episodic illnesses, so people may have years in between having an episode, whether it’s depression they’re experiencing, or a psychotic illness or an anxiety disorder of any sort.

I’m going to put my glasses on now because I’ve got a few figures that I want to report on. If we look at housing, which I think as Pat said is the major number one thing, and it’s really good that the Commission will be looking at these things. And in fact, before I came out here this morning, I did have a meeting with two of the consultants who are looking at forming the report card, so it was very good and very reassuring for me to learn that the Commission is mindful of all these other aspects of people’s lives and is going to be looking at it. We do have data already. It’s maybe not the Cochrane-standard data, but we do have data from many community surveys and things about what the situation is at the moment. SANE Australia ourselves, we do do some applied research and for example, when we looked at housing issues a couple of years ago, we found that 47% of respondents were in unsatisfactory accommodation. They were looking for somewhere else to live. So however it was they perceived it being unsatisfactory, that’s how they thought it was.

ACOSS, it’s worth also looking at ACOSS data because they know that, in a survey they did in ’09-’10, that in any given day, 135 people are away from homelessness and housing services. Now that’s across the board, but the unmet need was greatest in the mental health area. So that gives us some indication of the extent of it.

Now we are getting new, more programs but not nearly enough. Not nearly enough to meet with the need, but it is encouraging that there are some more.

Also we know that in trying to get into work, education that provides you with the skills for work, that’s often disrupted by mental illness. So we must make sure that the treatment programs for people incorporate that sort of skills building and education to help people continue. If someone becomes unwell at 16, the chances are they’re not going to finish Year 12, and we got stats on that earlier. We want to provide many more opportunities for people to be able to complete their education, certainly as far as they’re optimally able to. Work we did last year when we were looking at the employment sector we find that most people who responded to the survey, and it was over 500 people so it was quite a good sample – they felt that they were getting no understanding from their employer and that many were unable to keep their job because there wasn’t much flexibility available. So we’ve got a major education role to do in the employment, the education sectors, to ensure that they’re much more mindful and understanding and aware to the benefits to them of providing that flexibility.

Probably though I think the most powerful and poignant of the things is the actual loneliness and isolation that people are experiencing. Other research that we’ve done found that 49%, that’s close to half, people were not in a relationship, so as they determined it, and almost as many, 43%, said they didn’t have a close friend. Now this research was done across the board, so the largest number of people responding were people who were experiencing anxiety and depression, so not just talking about people with what many people would think of as the more severe end of the spectrum.

Mental illness does impact on every area of someone’s life. So we really want to make sure the report card can tap into this sort of thing. We also know that the suicide rates are appalling. The very recent *People Living with Psychotic Illness* survey found 49.5% of people living with a psychotic illness have made a suicide attempt. High, high risk. Yet we know that when someone with a mental illness has made a suicide attempt, we’ve been told that they’re not given a crisis plan, when they are in contact with professionals. So we’ve got people at high risk because they’ve got a mental illness. We’ve got people at high risk because they’ve made a suicide attempt, so they’re doubly at risk, and even that group is not being provided with a basic crisis plan which would help someone be better prepared if they experienced the same situation that had precipitated it previously. And that may be just something as simple as knowing … who can I call? What did I do previously when I felt very hopeless and helpless that helped me? Where can I go? It’s very, very simple things. It doesn’t have to be rocket science at all.

Now, we have in the reform package, there have been very good encouraging things implemented, well, they haven’t been implemented – that’s part of the problem. With the rhetoric we’ve had some of the funding and I know Pat, you have commented on that recently as it’s very slow to get the implementation. And partly that is the federal/state stuff, and that problem is much, much too big for my brain. But people have to somehow confront that. We’ve got personal helpers as mentors, a scheme that’s been introduced to provide that day to day support for people, and certainly the colloquial reports, informal reports I’m getting, are very, very positive for that. There are partners in recovery schemes that are being established. Again, these are all to try and help fit with the improvement of life overall.

However, I think that we’re all going to be wasting an awful lot of time and effort and a lot of the initiatives will be only half successful if we don’t get to grips with the fact that we’re going to need a national, well-resourced, well-coordinated, campaign that’s got community activities as well as mass media activities, that is improving community awareness and understanding about mental illness and its early signs, its symptoms, the importance of getting treatment, where you can get treatment, but also most critically of all, that is going to improve attitudes and improve social inclusion, so that people are going to be better understood and accepted, even when they are different. Especially when they are different. Because we’re not saying that everyone’s mental illness is exactly the same as everyone else’s. No two people in this room are exactly the same as everyone else. We want to make sure that the Australian community is more welcoming of people if they’re in education, when they’re in employment, when they’re in their local sporting clubs, so that people are going to feel welcome and supported, and I guarantee you that that is going to improve their recovery, maybe not equally, but once they’ve had the basic clinical treatment, it’s certainly going to make an enormous difference to their lives. And that’s I think where your enthusiasm can be maintained. Pat wants everyone to keep that enthusiasm going. I think we’ve got to make sure that your interest in coming here today, your enthusiasm for the issue, is translated to everyone out there. Everyone who’s in the corner milk bar, on the trains, in the sporting arenas, at work, local neighbours – everyone has got a much better understanding so that we can really help people take the place that’s going to be best for them in the community. Thank you.

**Allan Fels**

Thank you very much for having me speak here and there have been two very excellent presentations. So I’m going to mainly say a few words about the National Mental Health Commission and what it’s going to do, and then, as we’ve already had excellent presentations, I only have a couple of comments to kind of build off a couple of things that they said before I turn to the Commission.

Both speakers, maybe particularly Pat, emphasised the somewhat hospital-centric approach to the treatment of mental health issues in our community, and I wanted to mention one current development of some concern in that regard, and that is arising out of the major, or claimed major reforms to our health system that are being agreed between the Commonwealth and the states and the territories under COAG processes. They’re said to be health reforms but they’re really about an aspect of health, namely hospitals, and one of the broad outcomes is that, over the next few years, the Commonwealth is going to move to a position where it covers half the costs that states incur in running hospitals. And, as a result of that, there’s going to be quite a strong incentive for the states and territories to have as much health treatment moved into hospitals as possible, because they get half the money back. Whereas, if they’re doing things outside the province of hospitals, then they pay the 100%. This is very important for mental health, because the whole aim of the mental health community, widely agreed, I would say there’s not quite a consensus, but just about everyone agrees that we need to do a lot more in the community. From the point of view of the person with mental illness, it’s actually best if they’re treated in the community, they’re not too far from their locality, from their family, and anyway, there are a whole lot of other advantages of community treatment. But the states pay nearly all of those costs, and the agreement between the Commonwealth and the states is setting up an incentive to get a lot of that treatment back into the hospitals, and I think that is quite undesirable. It has to a degree been recognised by the Commonwealth and the states in making their agreement that there could be a problem, but less signs that they’re actually going to do anything about it. That’s a pretty important current issue.

And since I’m on that topic, I’ll mention one other thing, and that is, as part of the reforms, the way in which money is allocated to hospitals is based on a so-called pricing model and the idea is that once money was allocated in slightly random fashion to different hospitals, without hardly any science to it, but now they’re bringing in a bit of science. And this story is actually … Victoria has been well ahead of the game on this, but talking nationally, other states have not had the pricing system, so they are being talked about at the moment. But the idea is that, to determine how much each hospital gets, you do an analysis of the different jobs they do. So for example, say they do hip replacements, they figure out how many are being done in each hospital and then they put a cost for the average cost, or the average price for those things, and then they allocate on that basis. And there is quite a lot to be said for that system. But in regard to its application to mental health, it is very problematic. It is fairly easy to cost a straightforward clinical activity like a hip replacement, get an average cost. And it’s true that one in every 50 people, there’s some complication and instead of spending you know, an average of four days or whatever in hospital, occasionally someone will spend fifty days. You can still build that in. With mental health treatment, it is different. There is no easy way at arriving at formulas, the approach to the treatment of each person is different. And so introducing a pricing system in this area presents immense challenges. I’m personally not at the point where I’d say we in the mental health sector walk away from the attempt to put prices into the system – I just say that it’s obviously a huge challenge and both of these challenges have some potential to undo quite a lot of the reforms that people have been pressing for in the last few years.

We’ve already mentioned it to the regulator dealing with this, who has a fairly good understanding of our concerns but keeps coming back to the point that they are there to deal with hospital issues and they may do some things at the margin to say that what we’d call a community activity can be regarded as a hospital activity. But in the end, it’s got to be part of hospitals for them to take an interest.

So that was one point I just wanted to kind of add to what’s gone before. And then one other point I wanted to touch on. That is that I am generally concerned about the context in which mental health policy and some of the things that go with it – such as, you’ve heard about housing today. The context therein – the fact is that we all know that both the Commonwealth and states are under really tight fiscal constraints. The Commonwealth is really starting to get pretty serious about cutting back spending and not spending anything new. And the situation for the states seems to me to be a good deal worse. It’s really tough on most states. There are one or two, maybe Western Australia, where they can still do some things. But the rest of the states are very, very squeezed and under great pressure.

Now on the other side, the demands on governments are pretty big. And you have a lot of talk for example, about having a national disability insurance scheme. I think that would probably be a pretty good thing. I was actually on the original working party that proposed that before it went to the Productivity Commission. There is a significant issue there about the role of mental health. Is the national disability insurance scheme about physical disability or does it include mental health? And there is a kind of ongoing debate about this issue. And I for one will be watching it very carefully as to how mental health is treated under a national disability insurance scheme. In any case, everyone is saying that that scheme is going to be pretty slow to actually take off, if it is indeed … it has been more or less supported in principle on both sides of politics, subject to budget constraints however.

Another potential important pressure on the Commonwealth budget is the Gonski Report on education. The Gonski Report seems to be quite a good piece of work on education, at least to my mind it is, but it does call for a very, very heavy increase in government spending on education to get it all sorted out. And we also have quite big demands on aged care. They’re getting more and more difficult. Generally, my own feeling always about aged care is that no government has been prepared to bite the bullet on the tough questions such as bonds and that kind of thing, and each year or two they patch up a very deficient system by spending a bit more of the current revenue on building some more accommodation for aged people. And that’s likely to continue.

So, the mental health needs are facing quite a lot of other competitors for government funding and that story is true, not only of mental health care, but also in the housing area. There was a period when the governments were spending quite a lot on housing and accommodation needs, but this has been heavily cut back and the prospect is rather gloomy there.

Now, having said those things, let me say a couple of things about the Commission and also what we were asked to talk about. I think we were asked, mental health in Australia, how is it rating? Now, I don’t really know terribly well about how we rate compared to other countries. There’s a bit of data but I don’t really want to comment on it. Rather, I’d want to say, if I were asked to comment about it in an international context, that mental health does badly everywhere in nearly every country, there’s not been a sufficient commitment and the story you heard from Pat, reinforced by Barbara, seems to be true of most countries around the world. And indeed, one of the few countries I’ve noticed, and I was there not so long ago – Norway, where they decided to spend a lot more money on mental health, it’s not that clear whether it’s come off that well, but it stands out as a country that at least has decided it needs to devote more resources to the problem.

The way I think of answering the question, how well do we rate, is more by saying I think our health system, broadly speaking, works fairly well. It’s not perfect. It has got some quite significant challenges lying ahead but on the whole it works relatively well but for two extremely sore points – mental health and indigenous health, and of indigenous health, mental health issues are a very important component of that problem. But mental health has always had a low priority both at national and at state level. It’s the sore thumb of the health system.

Now, what I wanted to talk about a little bit was the Commission because we have been set up with some great hopes, incidentally, and Barbara perhaps touched on that in the hopes for us. And I’m spending a little bit of my time saying what we expect to do as a new commission in the first year, just being set up with quite a modest budget, a fairly small number of staff, a pretty good commission – we have very good people on it. We, I have to kind of handle expectations about the Commission. The Commission is not going to be able to deliver miracles, and indeed, it’s been given a fairly narrow assignment but quite a difficult one to do in its early years, and that’s to do a report card. And I’m going to say a bit about the report card. That is the first big task of the Commission although we’ve already been diverted a bit about our concerns about the new pricing system that’s being talked about, so we’re spending a bit of time on that. And I can see other sorts of immediate important policy questions coming through where we may get drawn into expressing opinions and so on and so forth. But the general … as has been mentioned, the Commission is an independent one. It has been established in the Prime Minister’s portfolio, as has been mentioned, because that’s in recognition of the fact that mental health involves issues about not only clinical care, but community care, support and programs. Accommodation and housing is a really very important problem. What’s the good of someone being treated in community care if they sleep under a bridge at night? You don’t make much progress with people who feel very insecure about their accommodation or live in a sub-standard accommodation, or simply don’t have it, or regard prison as their least bad form of accommodation. And likewise there are severe significant issues about employment. The employment record of people with mental illness is not that great. The participation rates are low. I think it’s worth saying, as has already been mentioned actually today, that there is also an economic case for doing things that make it easier for people with some form of mental illness to work. We’ve been hearing for quite a few years that almost the most important driver of productivity in our economy is having high rates of workforce participation. And the biggest opportunities for that, almost, are in getting more people who have some form of mental illness into work. They do have real employment prospects – they can be productive. There are people who may have some intermittent episodes of mental illness who find it hard to get jobs and I think there is a whole important agenda there for governments and business and the mental health community to get together and try to do more about getting jobs for the mentally ill, to improve productivity and to improve their lives.

I’ve been struck in the Commonwealth, by how many parts of the Commonwealth alone have an interest in mental health. There’s immigration, there’s defence, there’s health and ageing, the list is very, very large. There’s employment and education and so on. So it is a good thing that we’re in the Prime Minister’s areas and that also means that we get the ear of the central agencies and the central ministers, which is very often important for getting support for reform.

We also like to have a whole of life approach, and again, we’ve had such excellent speakers, this idea has been mentioned, but I just want to say that it has been recognised that mental illness is an issue that arises in the whole of people’s lives, and also, there are some interesting questions about how much we should get into discussions about good mental health of ordinary citizens who are not actually suffering illness. There is an emerging, quite interesting, wellbeing agenda which I think it’s worth taking some interest in.

Now, the Commission is a relatively new organisation. An interesting feature of it is that there is significant representation on it of consumers and carers. There’s one consumer, there are two carers on the nine person Commission. That’s somewhat novel but it is intended that more weight should be given to their views and experiences. And the Commission’s first task is to do a report card on the state of mental health in Australia. We’ll do that later in the year. That is quite challenging. There is actually quite a lot of data around but it’s not very well organised and it’s largely input data about how much has been spent on treating mental illness, and not much data on outcomes, what’s actually happened. So we want to look much more on outcomes. The trouble is, there’s not much data around so we’re worried already that our first report won’t have that much data on it, but it is immensely important that we look at it.

We also want to supplement existing data by saying a lot more about the lived experience of mental illness, and we’re looking to consumers, carers, families and so on to tell us their stories and for us to be an outlet for them, because they bring to life the way in which the system works, and they also help in grasping the dimensions of the issue. They hear the story of a person’s life and where mental illness fits in, and its far-reaching effects on their life, their relationships, their jobs, their education and their economic plight and so on. So we feel that if we can tap into that source of information, we will be able to give the community a much more informed report about what is really going on in mental health.

Naturally we expect to find big gaps in the system. Pat mentioned a very large number of people with mental illness who receive no treatment. We also believe that the system operates in a pretty uncoordinated manner. So, at the opening of the Commission we invited a consumer and a carer to speak and one of them spoke about how he’d been in hospital, he’d been treated, and he came out and there was nothing after that and he went back to his apartment, had sat there in rather miserable condition, had a relapse, went back into hospital because there wasn’t a follow-through. And there are lots of other instances where there’s a lack of coordination and integration in the system. And we hope to focus on that. We are keeping some kind of eye on the roadmap, which is having a bit of a struggle at the moment.

So I think maybe I will leave it at that. Just to give you a rough idea of what we’re trying to do at the Commission. So thank you for listening to me thus far.

**Simon Crowe**

It’s been a wonderful feast of riches with regard to our topic and a great opportunity for us to open more widely for questioning, both from the audience both here and virtually. Perhaps if I kick off. It is clear that this budget is going to be a very stringent one and I would hate to see what progress we made be eroded in the context of fiscal restraint. Certainly as a psychologist and president of the society, I’m very mindful of the fact that there was changes to the Better Access program last year. We took our case, we fought against them, we tried to redress those, and they have been … their execution has been stayed only until November of this year. And so the issue is, how subject to the vagaries of the fiscal situation of the Treasury is this initiative going to be, and perhaps Allan if you’d like to go first and then maybe to the rest of the speakers.

**Allan Fels**

Well, I know nothing about the forthcoming budget, but I would be surprised if there are significant cutbacks in the most recent initiatives this time around. They’re too recent and it would be too credibility destroying for the government to cut back. That is my hope. However, the idea of new initiatives and further steps being taken I doubt that that’s even on the agenda. And that concerns me a lot because obviously the most recent package was just a start, and I can already see ministers being interested in other topics and moving on to other things and I fear we will be getting into one of these five-year cycles. At state level I am quite concerned about what is happening there, to a degree in mental health, and also in all those things like housing. I really think the state outlook is quite grim, everywhere, not just Victoria, all states are struggling.

**Barbara Hocking**

I can’t add too much more to what Allan has been saying, but certainly I think it’s even more evident for us all to maintain our rage and our enthusiasms, so speak with local MPs, tell personal stories, I think the story-driven idea is definitely the way to go. I know any time I’m talking with parliamentarians, it’s having someone with lived experience is the most powerful thing of all, because it’s harder then for them to ignore the issue when they know someone and the situation and the experiences they’ve been having.

**Patrick McGorry**

I can’t believe how the spirit of Gough Whitlam is so present in the room. But it’s good to hear. Just to echo what Allan said, just even going back one step, the money that was allocated last year – the 2.2 billion, you know, very little of that has been spent yet, you know, and so that’s the priority at the moment. It’s been slowed up by a whole series of bureaucrat and red tape things, and for example, the Epic Initiative, sixteen epics were planned. Unfortunately the government tried to force the state governments to co-invest, and Allan’s just alluded to the difficulties with that, and so they tried to do it on the cheap, the Epic Initiative actually, and at the same time they put 571 million dollars into the very worthy area of severe and enduring mental illness, but with no real plan. So there’s so much lack of logic in this area. None of that money’s been spent to my knowledge yet, either. And as Simon alluded to, at the same time they cut the Better Access scheme which caused a furore, you know, and actually undermined confidence in other aspects of the package. So unfortunately, and I think the government’s actually understood that and taken some steps to remedy that, but it took a fair bit of Senate enquiry effort to actually sort that out. I’m not being critical of Mark Butler here because I think he’s been a very good Minister for Mental Health but clearly governments make mistakes and they misread things and you know, we can help them with that.

So I think the priority is to unlock and get that money flowing and into things that are going to work. We’ve got to stop actually putting money into schemes which are drawn up on the back of an envelope the night before the budget. There’s been several examples of that in mental health and at the same time schemes that are tried and trusted and evidence-based – I’ll give another example – home-based treatment for acute mental health care. Assertive community health models, intensive case management – they’re really strongly evidence based and they’ve been dis-invested in around Australia. So this is the problem. There’s policy – not just policy weakness in some areas, but there’s also implementation failure and really, what’s the word? Perverse things happen. Like they start to disinvest in community services and then they invest in emergency department, mental health systems, like in New South Wales and Victoria, and these act like magnets, or honey pots. Patients are referred, CAT teams back off and everything ends up crashing into the emergency department. So very perverse things are happening in our system.

Coming back to the point of how to keep further investment growing, because if we’ve gonna get up to 13% of the health budget, every single year between now and 2020, we’ve got to see growth in investment. But how do we achieve that? I think the only way – the Commission can play a role as I said, but Allan’s already managing expectations, as he said. No one, none of us, the Commission, none of us advocates can do anything without mainstream and massive public support, and that’s what Barbara was alluding to. So every chance you get, talk to politicians, talk it up, try to get the stories out there. The facts are strong enough to sell the story anyway, but it’s the stories.

**Barbara Hocking**

And possibly it’s the way in which the report card is written will help keep it on the agenda in a fashion that will engage decision makers.

**Simon Crowe**

We’ve got the opportunity for you to have a say. You are … yes, would you like to step to the microphone?

**Question**

Thank you Simon and thank you to all the speakers today. I’m having to be careful to suppress my rage and not to get over excited here but I do actually have accountability for supporting students with mental health problems at the university and it is a major, major challenge for us. Allan, we have so many stories for you. If we can help in any way through passing on those stories about the lived experience of students at university who are managing mental health, major mental health problems, we’d be more than happy to give that to you. We’ve also had an inverse statistic now around the students who identify with a disability and our data is really poor, through the whole sector, about capturing students with mental health problems, because the only way you can do it now is by ticking a box on enrolment, saying whether or not you’ve got a disability. But even that statistic is completely turned around, that 80% of our students prior had a physical disability, now they’re ticking the box to say they have a mental health disability. So we’ve got some data that can inform your Commission as well and we’d be happy to provide you with, and I know that Pat presented the national summit on mental health for the sector last year as well and that was fantastic, so we’re all working together.

My comment and question to the panel is, how can we work cross-sector because one of the things that we’re experiencing is the lack of being able to refer students on to community resources. So we’re having to build and build and build our own resources to support students, and as you can imagine, universities are really challenged in this area of putting more resources into it. And sometimes people think, we’ll send a student to university because it’s a therapeutic community. Well, it’s not a therapeutic community – it supports students’ access and participation in education, but we’re not a therapeutic community, we’re a supportive community for students who have got mental health problems. But somehow we’ve got to work across the sector, rather than replicate, replicate, and not joining the dots in some ways, because now, it’s tough. It’s tough. And if any of the counsellors are here, I commend them to all of our students and they do a fabulous job but I know they’re groaning under the burden. Thank you.

**Patrick McGorry**

Thank you so much for bringing that up and I hope you don’t mind me jumping in. I’m very excited about this issue as well, because I think there’s a chance for major, major reform, led by universities on this issue. Nearly 40% of young Australians will be in some kind of tertiary course fairly soon. And we’ve never had great access to the emerging adult group. Obviously most adolescents are sort of captured in high school, so there’s some way of accessing them, but actually the main incidence of mental illness and mental ill health is during the 18 to 25 period, so if we can get access to 40% of young Australians … and they’re in big numbers here, like you said, you know. And mostly the resourcing and models for providing them with mental health care which is their main health issue within tertiary settings are sort of old fashioned models aren’t they? They haven’t been modernised really in a systemised way. So the business model, the cultural models, and Melbourne University and Sydney University have been seriously looking at this. Ian Marshman at Melbourne University has been taking the lead on this. He’s a director of headspace and we’ve been talking to other universities – we’ve had students on the councils and the senate of different universities bringing this issue up, so I think there’s a chance that universities at Australia level for this to become a major issue. Because, there’s a duty of care for the first thing for universities, which they’re definitely not meeting at the moment. Only a fraction of the students are getting access to mental health, often again, too late in the piece, as you pointed out. And so, I think there’s a huge opportunity there …

**Question**

I think you’re absolutely right Pat, and one of the things we struggle with enormously with is we’ve got students who are at high risk. We have to deal with their safety and their duty of care, which is taking an enormous amount of our effort and funds to do that. And we *have* to do that in the first instance but we know that early intervention is the key, but in order to keep all of those things going, I think we’ve got to have another vision. We have peer mentors that support students with mental health, who’ve had a mental health illness, so there’s some really innovating things going, so the sharing of that and elevating that in the sector is absolutely fundamental, but you know, that cross sectoral with headspace – I know headspace is in ACT on one of the campuses …

**Pat McGorry**

Well, Chris Tanti, the CEO of headspace was at a recent meeting around this at Melbourne Uni and it was a very productive … and the other point that you’ve made is the cross sectoral links, and the issue that faces headspace generally across Australia is it’s really a primary care, an enhanced primary care model, and it can deal with mild to moderate levels of complexity, but it needs a back-up system, so that just does not exist in the public sector, or the private sector for that matter, around this youth thing. And we’re building it slowly but the sort of things that you’re talking about need a specialised expert team at the next level up. That’s possible, but you know, it’s a reform thing. This is transformational reform, not just bandaid stuff, or going cap in hand to government every five years and saying, can you fix this with a rescue plan? Or you know, a roadmap. There’s so much trivialisation of this issue, it makes you very frustrated, but the opportunities are there but it has to come with this sort of, I suppose, really coordinated, strategic effort, so there’s no choice but to deal with it.

**Question**

Thank you. That was just such a stimulating …

**Simon Crowe**

Very mindful of the fact that we’ve got lots of students and our university runs from five to the hour, so it’s unfortunate it’s going to have to be the last question we can take.

**Question**

I’ll make this brief. I wanted to thank our speakers so very much. I particularly wanted to ask a question of Barbara, because she mentioned something that I think is really important, and that relates to the stigmatisation of people with mental illness. And I know we have had some success, particularly in dealing with the stigma around depression, but I was wondering if you would like to make any other comments, and probably the other speakers too about how we can address stigmatisation around mental illness, because not only is it affecting employment as you say, but it’s one of the major things that prevents people from seeking treatment.

**Barbara Hocking**

Well, certainly people will say that often the stigma associated with their illness is often worse than the symptoms of the illness itself, and then it does impact on how people view themselves, so they’ll self stigmatise. So it’s an enormous issue and it can be quite complex. I think we’ve made great inroads into raising awareness of depression, reducing the stigma, and Beyond Blue has done a lot of work on that. They’ve had generous funding to do that, so I mean, you don’t just throw money willy nilly, but certainly if you’ve got money it really does enable you to buy advertising space. I think one of the major … most effective ways in which we can reduce stigma and discrimination though, is to help people get to know and understand the stories of people who are living with the illness. We know that attitudes are most positive when somebody knows somebody living with the illness. So we’ve got to find whatever ways we can to introduce at a conscious level … every single one of us knows someone living with a mental illness, whether we are conscious of it or not, because it is so common. In some ways we were hearing, I think it was Kerry, talking about the large numbers of students who are identifying with problems. Probably ten years ago they didn’t feel comfortable talking about that, so that in a sense is an encouraging comment, while also helping us understand the enormity of the issue and the need to get really good supports and services in there early. So if everyone who is experiencing illness is prepared to, and feels comfortable talking about it, it suddenly, well not suddenly, gradually we will reach a stage where it’s accepted and it’s considered to be an OK thing to have a mental illness just as it would be to have asthma or diabetes. But it’s something you talk about and you know when you talk about it with your friends, you’re not going to be rejected. In fact, I’ve often said before, when I first started working in this area, over twenty years ago, if you said what work you were doing it would stop a conversation. These days, it starts the conversations. And I think that we’ve all got to keep starting those conversations to make it an acceptable illness to have and an unacceptable thing to not have the treatments and supports to help.

**Simon Crowe**

Thank you and please join me in thanking our …