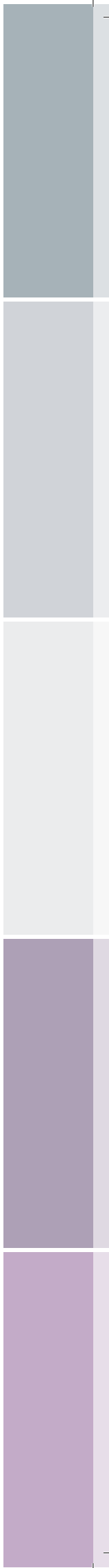




Part 1: Introduction and background



1.1 Purpose of the report

At the time of releasing this report, Australia is at the beginning of a third decade of targeted reform of mental health services that is referred to as the National Mental Health Strategy. Commencing in April 1992 with the endorsement by Health Ministers of a *National Mental Health Policy*,² the National Mental Health Strategy committed governments to undertake action within their respective jurisdictions, as well as to collaborate on policy and service development issues requiring a national focus. This was the first attempt in Australia to set a common course of action by governments in the development of public mental health services which had been the exclusive responsibility of the eight state and territory governments since Federation.

Much has changed since the original agreement of 1992, with the Strategy progressing through a series of five year national mental health plans, and more recently, a number of whole-of-government national plans and initiatives endorsed through Australia's peak intergovernmental coordinating body, the Council of Australian Governments (COAG). The national policy environment for mental health reform in Australia is now far more complex than was the case when the original agreement to a *National Mental Health Policy* was signed in 1992.

The *National Mental Health Report* has been a constant throughout this process. In agreeing to the National Mental Health Strategy, Health Ministers recognised that an important aspect of the reform process was to ensure that progress is monitored and publicly reported. The *National Mental Health Report* was prescribed as the main vehicle for this to be achieved.

Its original stated purpose was to:

- present relevant information about the resources that underpin mental health service delivery (human and financial), their funding sources and how those resources are being applied to achieve the national reform aspirations;
- monitor changes that have taken place in the provision of mental health care;
- act as an information resource on the state of mental health services in Australia, for use by a range of interested parties; and
- improve community understanding of the reform of Australia's mental health services.

The *Fourth National Mental Health Plan*,³ covering the current period to 2014, placed greater emphasis on monitoring of outcomes than its predecessors and committed to a restructured *National Mental Health Report*. The current report is consistent with this new focus. It includes the most current information on a series of indicators associated with particular outcomes, and reports on the progress of the actions committed to by governments in each of the five priority areas outlined in the *Fourth Plan*. At the same time, it continues to provide an analysis of the key measures that were central to all previous *National Mental Health Reports* (for example, per capita expenditure, workforce levels, hospital/community mix).

This redesigned *National Mental Health Report*, the twelfth in the series, draws on a range of sources to present an analysis of reform trends, and has the imprimatur of Health Ministers who have bound their respective administrations to collecting and reporting on relevant data in a timely fashion. The reference year for the majority of the data presented in the report is 2010-11.

1.2 The magnitude of the problem: Indicators of mental illness in Australia

In order to examine the achievements of the National Mental Health Strategy, it is necessary to gauge the number of people affected by mental illness in the Australian population, and to understand how mental illness affects their lives.

When the National Mental Health Strategy began, no information was available about the extent and impact of mental illness in Australia, so, in the late 1990s, a program of population surveying was commenced. Known collectively as the National Survey of Mental Health and Wellbeing, it comprised three cross-sectional surveys. The first took place in 1997 and investigated the prevalence and impact of common mental disorders (depression, anxiety and substance use disorders) in adults.⁴ The second survey, also conducted

in 1997 and targeted at adults, focused on the less common mental illnesses (in particular, psychotic disorders).⁵ Because neither of the first two surveys could shed light on young people's mental health, the third study was commissioned in 1998 to capture information about the mental health of children and adolescents.⁶ The two surveys of adults were repeated in 2007 and 2010, respectively.^{7,9} A new survey of children and adolescents has been commissioned and will be conducted in 2013. More detail about the scope of these studies is provided in Table 1

National Survey of Mental Health and Wellbeing: Epidemiological studies commissioned to measure the extent and impact of mental illness in Australia. The text below the table draws on data from the most recent surveys only.

Table 1
National Survey of Mental Health and Wellbeing Epidemiological studies commissioned to measure the extent and impact of mental illness in Australia

Survey	Year	Target group and focus	Sample size	Recruitment method	Data collection method	Prevalence estimates
Survey of adult population	1997	Adults (aged 18+), common mental disorders (depression, anxiety and substance use)	10,641	Recruited through households	Structured diagnostic interviews	One year prevalence (community): 17.7%
	2007	Adults (aged 16-85), common mental disorders (particularly depression, anxiety and substance use disorders)	8,841	Recruited through households	Structured diagnostic interviews	One year prevalence (community): 20.0% Lifetime prevalence (community): 45.0%
Survey of people living with psychotic illness	1997	Adults (aged 18-64), psychotic disorders	980	Recruited through specialist mental health services, GPs and private psychiatrists	Census, interviews, information from service providers	One month prevalence (treated): 0.4-0.7%
	2010	Adults (aged 18-64), psychotic disorders	1,825	Recruited through specialist mental health services and non-government organisations	Census, interviews, information from GPs and other service providers	One month prevalence (treated): 0.3%; One year prevalence (treated): 0.5%
Survey of children and adolescents	1998	Children and adolescents (aged 4-17), common mental disorders	4,509	Recruited through households	Interviews	Point prevalence (community): 14.1%
	Survey in the field May to December 2013	Children and adolescents (aged 4-17), common mental disorders	6,300	Recruited through households	Structured diagnostic interviews	Results due for publication late 2014

The 2007 survey of the adult population found that one in five (20%) – 3.2 million individuals – experienced one of the common mental disorders in the preceding year. Fourteen per cent experienced anxiety disorders, 6% mood disorders, and 5% substance use disorders. One quarter experienced two or more of these conditions in the year of interest. Prevalence was highest among those aged 16-24 (26%) and declined with age, and two thirds of those with depression and/or anxiety disorders had experienced their first episode before the age of 21. This highlights the need for an emphasis on early intervention services that target younger people.

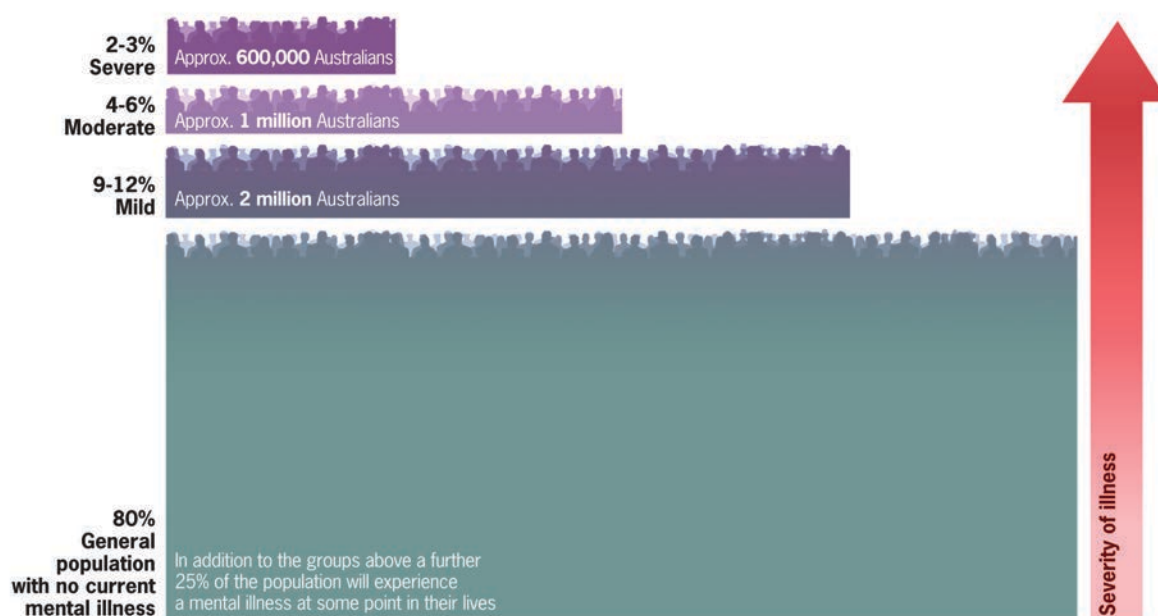
Turning to lower prevalence disorders, the 2010 Survey of People Living with Psychotic Illness found that 0.5% of the adult population had been treated for a psychotic disorder in the previous year. This equates to 64,000 people, almost half of whom had schizophrenia. Two thirds of these people experienced their initial episode before they turned 25, and many of them had experienced disabling, unremitting symptoms since the onset of their illness.⁷ Psychotic illnesses are the focus of many state and territory mental health services and account for the majority of resources devoted to specialist mental health care in Australia.

The above adult surveys showed that many people with mental illness experience symptoms quite early in their lives. The 1998 child and adolescent survey further emphasised the importance of the early years, showing that 14% of those aged 4-17 were affected by a clinically significant mental health problem. This amounted to about 500,000 individuals, including 93,000 with anxiety or depression, 200,000 with aggressive behaviours, and 93,000 with attention deficit disorders. As noted above, these figures will be updated by the 2013 survey data.

Prevalence estimates only provide part of the picture and need to be complemented by an understanding of the extent to which mental illness contributes to overall ill health. Figures from the 2003 World Health Organization's Global Burden of Disease (GBD) study provide some insights here. The GBD study measured the burden of all diseases using a common metric that is based on years of life lost due to premature mortality and years of life lived in less than full health (morbidity). Most of the burden of mental disorders is associated with morbidity, not mortality. Mental disorders accounted for 24% of the total burden of non-fatal disease and injury in Australia in 2003.¹⁰ The recently released figures from the 2010 GBD study present a similar picture.¹¹

Mental illness impacts on people's lives at different levels of severity. Various modelling exercises have been conducted that combine data from the Australian prevalence studies with data from other sources, including the GBD study, in order to inform service system planning (see Figure 1).¹² These analyses suggest that an estimated 2-3% of Australians – around 600,000 people – have severe disorders, as judged by diagnosis, intensity and duration of symptoms, and degree of disability. This group is not confined to those with psychotic disorders who in fact represent only about one third of those with severe mental illness; it also includes people with severe and disabling forms of depression and anxiety. Another 4-6% of the population (approximately 1 million people) have moderate disorders, and a further 9-12% (approximately 2 million people) have mild disorders.

Figure 1
12 month prevalence estimates of mental illness in the population by severity level, based on diagnosis, disability and chronicity



Taken together, the combined estimates of prevalence, disability and severity provide guidance for planning services, allocating resources and evaluating the overall effectiveness of the National Mental Health Strategy. They show that mental illness is a common problem in the Australian community. They also suggest, however, that individuals experience mental illness in different ways. Some people have severe and debilitating disorders, whereas others have mild or moderate conditions.

The corollary of this is that there is not a one size fits all solution to mental health care. Some people have extensive and ongoing needs for services whereas others may only need care occasionally or for a brief period, or may not need care at all. The 2007 National Survey of Mental Health and Wellbeing of adults showed that only 35% of those who met criteria for a mental disorder made use of services for mental health problems, but that this varied by level of severity (64% of those with severe disorders received services, 39% of those with moderate disorders did so, and 17% of those with mild disorders did so).^{8,13} However, 86% of those who did not receive mental health care indicated that they had no need for any of the kinds of services that are typically offered (for example, information, medication, talking therapy, social intervention and skills training).¹⁴ Ensuring

that appropriate, high quality services are available to those who need them, when they need them, has been a consistent goal of the National Mental Health Strategy since its inception.

The National Mental Health Strategy aims to reduce both the prevalence and severity of mental illness. This is embodied in the Strategy's population health approach, which recognises that the determinants of mental health status comprise a range of psychosocial and environmental factors (including, for example, income, employment, education and access to community resources), and encompasses the entire spectrum of interventions from mental health promotion and mental illness prevention through to recovery. A reduction in the prevalence of mental illness may be brought about by preventive efforts to stop an illness occurring in the first place, or by increasing access to effective treatments to reduce the duration of illness for those who already have symptoms. Reducing the severity of mental illness requires a range of services designed to alleviate the disablement that may be associated with a person's social, personal and vocational functioning.

1.3 Setting the scene: The national mental health reform context

Overview of the National Mental Health Strategy

The National Mental Health Strategy has provided the overarching policy framework that has guided an extensive process of mental health reform in Australia for the last 20 years. Commencing with the endorsement of the *National Mental Health Policy* in 1992, the concept of the National Mental Health Strategy has grown to encompass the range of national policy and planning documents relating to mental health reform that have been agreed by all governments, either through their respective Health Ministers, or at the level of First Ministers through the Council of Australian Governments (COAG). These include four five year *National Mental Health Plans* covering the period 1993 to 2014, a revised *National Mental Health Policy* released in 2008,¹⁵ the COAG *National Action Plan on Mental Health* endorsed in 2006¹⁶ and, more recently, an agreement by COAG in December 2012 to the *Roadmap for National Mental Health Reform 2012-2022*.¹ As a national agreement endorsed by all heads of governments, the *Roadmap* represents the most current statement of intergovernmental commitment to mental health reform as an ongoing national priority, and outlines the directions that reform will take over the next 10 years.

The direction of reform has changed considerably over the 20 years that the National Mental Health Strategy has been in place, reflecting both the achievement of previous objectives and the incorporation of new priorities, driven by emerging knowledge and changing community expectations. A brief, chronological history of the policy directions of the Strategy is provided below.

The *First National Mental Health Plan* (1993-1998) represented the first attempt to coordinate mental health care reform in Australia. It focused primarily on state and territory mental health services and advocated for major structural reform, with a particular emphasis on decreasing the reliance on stand-alone psychiatric hospitals, expanding community based care alternatives, and ‘mainstreaming’ the delivery of acute inpatient care into general hospitals.

An evaluation of the *First National Mental Health Plan* was conducted in 1997.¹⁷ This was generally positive, but observed that there were some areas that could be strengthened. As a result, when the *Second National Mental Health Plan* (1998-2003)¹⁸ was released in 1998 it continued the work of the *First Plan* towards structural reform, but expanded into additional areas such as mental health promotion, mental illness prevention and destigmatisation. In terms of mental illnesses, the remit of the *Second Plan* was broader than that of the *First Plan*; it moved beyond the severe and disabling disorders that are typically treated in state and territory-funded services, and also considered more prevalent conditions like depression and anxiety. It also fostered important partnerships – between the public and private sectors, between specialist services and primary care providers, and, more broadly, between the health sector and sectors outside health that have an influence on people’s lives.

The *Second National Mental Health Plan* underwent a mid-term review in 2001.¹⁹ It was evaluated more formally in 2003,²⁰ and the *Third National Mental Health Plan* (2003-2008)²¹ was released later that year. Again, the findings of the review and evaluation of the *Second Plan* helped to shape the directions of the *Third Plan*. The *Third Plan* set out to consolidate the achievements of the previous two plans by taking an explicit population health approach and reaffirming an emphasis on the full spectrum of services that are required to assure the mental health of Australians. It focused on mental health promotion and mental illness prevention, improving service responsiveness, strengthening service quality, and fostering innovation.

Both the *Second* and *Third Plans* emphasised the importance of cross-sectoral partnerships in supporting mental health and wellbeing, and the need to respond to mental illness through a whole-of-government approach. These themes were elevated as priorities in 2006 when COAG

agreed to the *National Action Plan on Mental Health*. The *National Action Plan* was developed by governments to give further impetus to mental health reform and sharpen the focus on areas that were perceived by stakeholders to have not progressed sufficiently under the first three *National Mental Health Plans*. It represented the first time that heads of governments had focused on the issue of mental health and agreed to a national plan of action to reform mental health services. It took the delivery of services for people with mental illness into areas beyond the boundaries of traditional health care. Key human service programs operating outside the health system with major responsibilities under the COAG *National Action Plan* include housing, employment, education and correctional services. The *National Action Plan* also emphasised the role of the non-government sector in the delivery of a wide range of community support services.

In 2008, the National Mental Health Strategy was extended through a new *National Mental Health Policy*, endorsed by Health Ministers. The new *Policy* carried forward the central tenets of the previous *Policy*, but updated various elements of it to bring it into closer alignment with the whole-of-government approach articulated in the COAG *National Action Plan*. The new *Policy* provided an overarching vision for a mental health system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

2008 also saw a summative evaluation of the *Third National Mental Health Plan*,²² the findings from which influenced the *Fourth National Mental Health Plan* which was released in the following year. The *Fourth Plan* specified priorities for collaborative government action, identifying 34 reform actions to be undertaken across five priority areas, namely:

- social inclusion and recovery;
- prevention and early intervention;
- service access, coordination and continuity of care;
- quality improvement and innovation; and
- accountability.

In 2010, Health Ministers endorsed the Implementation Strategy for the *Fourth National Mental Health Plan* that detailed specific implementation strategies against each of the 34 actions in the *Fourth Plan*, and the first report on implementation progress was released in 2011. More recently, the Australian Health Ministers' Advisory Council endorsed a more focused approach to implementation, with a view to integrating mental health reform efforts outlined in the 2011-12 Federal Budget and broader reforms that are being progressed through the COAG *National Action Plan*. The result of this decision was that the approach to implementation of the *Fourth Plan* became more streamlined and strategic in focus. Emphasis was given to 22 of the actions that were identified as capable of being progressed independently of the wider national reforms, and this was later increased to 23.

In January 2012, the Federal Government established a new agency – the National Mental Health Commission – to provide a new approach to guiding and monitoring mental health reform in Australia. The Commission's core function is to monitor and evaluate the mental health system as a whole, and do this by working closely with consumers, carers, stakeholders and all jurisdictions. The Commission is located in the Prime Minister's portfolio, recognising the importance to mental health reform of cross sectoral, whole-of-government leadership. Similar state-level Commissions have also been established by New South Wales and Queensland. The Western Australian Mental Health Commission, the first in Australia, was established with a broader range of functions including the responsibility for public investment in mental health.

Most recently, in December 2012, COAG agreed to the *Roadmap for National Mental Health Reform* that outlines the directions that will be taken by governments over the next 10 years. The *Roadmap* set out new governance and accountability arrangements designed to directly engage stakeholders and ensure that governments are held to account. These new arrangements include the establishment of a COAG Working Group on Mental Health Reform that is required to develop, for COAG's consideration by mid-2014, a successor to the

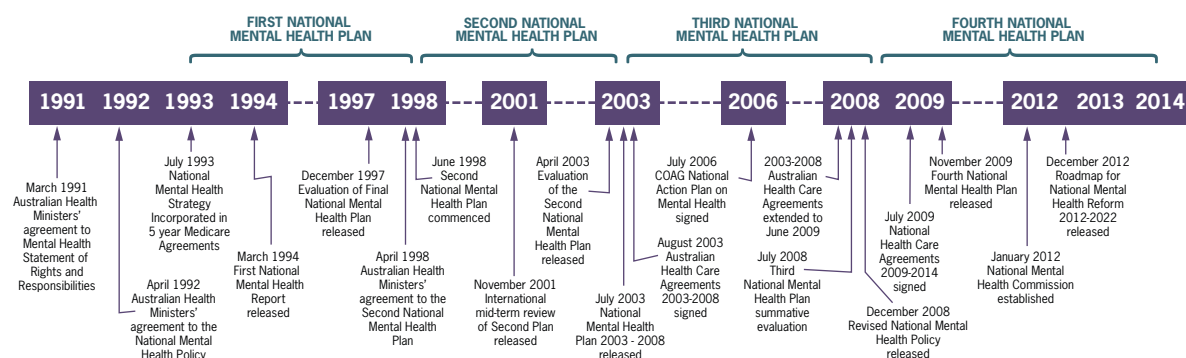
Fourth National Mental Health Plan that will set out how the Roadmap will be implemented.

Alongside the above national activities, states and territories have developed their own mental health plans that have reflected the goals and principles of the national approach, but have been tailored to meet local requirements. Jurisdictions' own

plans remain the key documents for setting out the specific details of how they will work towards achieving the objectives agreed under the National Mental Health Strategy.

A summary of key milestones in the life of the National Mental Health Strategy is provided in Figure 2.

Figure 2
Milestones in the life of the National Mental Health Strategy



Framework for national action

From its inception, the National Mental Health Strategy has been premised on an understanding of the complementary roles of the Australian Government and state and territory governments.

The states and territories have traditionally been responsible for the funding and provision of the public sector mental health services that provide specialist care for people with severe mental illness. These include services delivered in inpatient settings and services delivered by community-based teams. As the main source of both funding for specialised mental health services, the states/territories have occupied a central position in Australia's mental health system.

For its part, the Australian Government is responsible for providing leadership to guide national action, and monitoring the reform process. It also funds a range of services for people with mental illness via the Medicare Benefits Schedule, the Pharmaceutical Benefits

Schedule and programs administered by the Department of Health and Ageing (DoHA), the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the Department of Veterans' Affairs (DVA). Its role expanded substantially as a result of the COAG *National Action Plan on Mental Health* in 2006, and more recently through a broad range of new and expanded programs announced in the 2011 Federal Budget. These included the expansion of mental health services subsidised by Medicare, and a range of mental health specific community support programs managed through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). The Australian Government also funds a range of mainstream programs and services which provide essential support for people with mental illness. These include income support, social and community support, disability services, workforce participation programs, and housing assistance.

1.4 Reporting on mental health services in Australia

Few national policy areas in Australia are subject to an equivalent level of reporting and accountability as required under the National Mental Health Strategy. The *National Mental Health Report* is complemented by four other major reports on mental health services and mental health reform, described below:

- *Mental Health Services in Australia* is published by the Australian Institute of Health and Welfare and presents detailed information on the activity and resourcing of mental health services, primarily drawing on the National Minimum Data Sets for Mental Health.²³
- Annual *Progress Reports on the COAG National Action Plan on Mental Health* are prepared under the auspices of the Australian Health Ministers Standing Council on Health (SCoH) and focus on the agreed actions and indicators in the COAG *National Action Plan*. The final report on the *National Action Plan* is due for release in 2013.²⁴⁻²⁷
- The mental health chapter of the *Report on Government Services (RoGS)* is published by the Productivity Commission on behalf of the COAG Steering Committee on Government Service Provision.²⁸ It provides summary information on resourcing and delivery of mental health services, drawing on data presented in *Mental Health Services in Australia* and the *National Mental Health Report*, and data provided by the Australian Bureau of Statistics.
- The annual *National Report Card on Mental Health and Suicide Prevention* is prepared by the National Mental Health Commission.²⁹ This new report aims to give a whole-of-government view of mental health reform in Australia, giving greater transparency to the performance of the systems that support people with a lived experience of mental health issues, their families, carers and other support people. The Commission released its first *Report Card* in November 2012.

All of these publications are published annually or biennially, and, with the exception of the COAG *National Action Plan on Mental Health Annual Progress Reports*, all are expected to continue into the foreseeable future.

Most recently, an additional report on mental health reform has been endorsed by COAG as a component of its *Roadmap for National Mental Health Reform 2012-2022*. The National Mental Health Commission will prepare three yearly reports to COAG to document progress towards achieving the *Roadmap* vision, with monitoring of progress focused on long term change at the national level, reflecting the ten year span of the *Roadmap*.

1.5 Structure of the current report

This report is presented in four parts, followed by a set of appendices:

- Part 1 outlines the purpose of the report and sets the scene by providing an overview of the National Mental Health Strategy.
- Part 2 presents system-level indicators of mental health resourcing and service delivery in Australia. It is organised around five groups of indicators (national spending on mental health, national workforce trends, trends in state and territory mental health services, trends in private sector mental health services, and consumer and carer participation in mental health care).
- Part 3 is dedicated to monitoring the actions of the *Fourth National Mental Health Plan*. It is organised around the *Plan*'s five priority areas, and describes progress in implementation of key action areas and presents data for relevant indicators.
- Part 4 presents jurisdiction-level indicators, and includes resourcing indicators on the provision of mental health services and selected indicators reported at a national level in Part 2.
- The appendices identify the sources of data used in the report and provide explanatory notes on selected indicators.

1.6 Conventions used in the current report

Several conventions are used to improve the readability of this report.

- Financial years are generally presented in a standard format (for example, 2010-11 refers to the year from 1 July 2010 to 30 June 2011). Occasionally, financial years are abbreviated by referring to the last calendar year of the pair (for example, 2010-11 is abbreviated to 2011 and the period 1992-93 to 2010-11 is abbreviated to 1993-2011).
- Unless otherwise stated, all expenditure and revenue are expressed in 2010-11 constant prices.
- Unless otherwise stated, all population data are expressed as crude (non-age standardised) rates.
- In general, figures are rounded to whole numbers and decimal points are only used in the text, figures and tables when an individual number in the series is less than 10. The effect of this rounding is that totals do not always equal 100%.
- Government bodies, initiatives and reports are referred to by their full name the first time they are mentioned in a given section but are often abbreviated on subsequent mentions (for example, the Council of Australian Governments is sometimes referred to as 'COAG', the 'National Mental Health Strategy' is sometimes referred to as 'the Strategy' and the *Fourth National Mental Health Plan* is sometimes referred to as the *Fourth Plan*).

