3.3 Priority area 2: Prevention and early intervention

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists eight actions that relate to prevention and early intervention. Progress has been made on five of these (see Appendix 3). A key example is the activity that has occurred in relation to Action Area 10, which involves expanding community based youth mental health services which are accessible and combine primary health care, mental health services and alcohol and other drug services. Funding was provided in the 2011-12 Federal Budget for 90 fully sustainable *headspace* sites across Australia by 2014-15. Seventy sites have been announced, and 40 are currently operational. When fully established, these sites will help up to 72,000 young people each year.

Indicator 6: Proportion of primary and secondary schools with mental health literacy component included in curriculum

KEY MESSAGES:

- Australia has invested significant resources in programs that promote mental health literacy in schools – notably MindMatters in secondary schools and Kidsmatter in primary schools.
- In 2011, 45% of schools had implemented a mental health framework, 60% were offering mental health programs, and 69% were providing mental health literacy resources.

There is a growing body of evidence that suggests that school-based mental health literacy programs can boost resilience in children and adolescents, assist school staff in identifying and intervening with students showing early signs of mental health problems, and encourage help seeking among students themselves.[47]

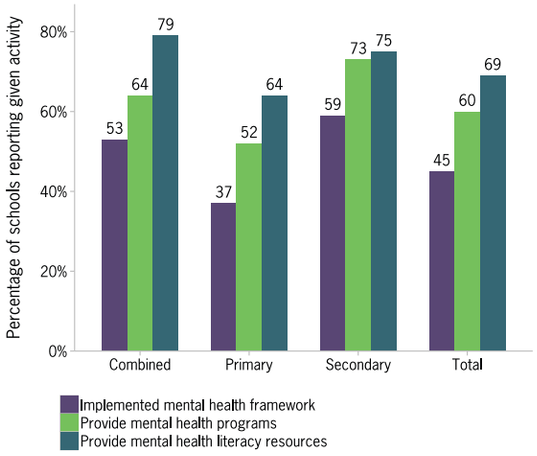
Commencing with the introduction of MindMatters in secondary schools in 1997-98, Australia has invested significant resources in organising frameworks that guide whole-of-school approaches to mental health issues. MindMatters provides a broad framework to assist secondary schools in promoting mental health and identifying and responding to mental health issues where they are present in the school community. Kidsmatter, which followed in 2006 and commenced with an initial pilot, provides a mental health and wellbeing framework specifically designed for primary schools and early childhood education and care services. Both support schools in promoting and protecting the mental health and social and emotional wellbeing of students and other members of the school community. Both have been evaluated positively by students and teachers.[48,49] In addition to MindMatters and Kidsmatter, a range of other mental health frameworks are in use by Australian primary and secondary schools.

Figure 51 shows the percentage of schools that include mental health literacy components in their curricula, using data from Principals Australia's National Market Research Survey which was conducted in 2011.[50] It shows that, in total, 45% of schools had implemented a mental health framework, 60% were offering mental health programs, and 69% were providing mental health literacy resources. 'Combined' schools (i.e., those which cater for both primary and secondary grade levels) generally fell somewhere in between primary and

secondary schools, except in the case of the provision of mental health literacy resources where their uptake rates were the highest.

The uptake of mental health literacy initiatives in schools is positive, but there is still scope for further expansion, particularly in primary schools. Schools appear to perform relatively well in terms of providing resources and offering relevant programs, but are perhaps less successful in embedding these activities within an overarching mental health framework. These activities are less likely to be effective if they are conducted in relative isolation, and should be integral to the school's ethos and environment and woven through its curriculum.[51]

Figure 51
Percentage of schools reporting implementation of mental health frameworks, programs and literacy resources, by school type



Indicator 7: Rates of contact with primary mental health care by children and young people

KEY MESSAGES:

- There was a three-fold increase in the number of children and young people receiving Medicare-funded primary mental health care services from 2006-07 (79,139) to 2011-12 (337,177). This represents an increase from 1.1% of children and young people receiving these services to 4.6% of children and young people doing so.
- The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%).
- This improvement is largely due to the introduction of the Better Access initiative in 2006.

Primary mental health care services have a central role to play in identifying and treating children and young people who are showing signs of mental illness. Childhood, adolescence and young adulthood are crucial developmental periods, and appropriate treatment at these life stages can not only have positive outcomes in the immediate term but can also help to avert or ameliorate problems in later life.

Medicare-funded mental health services provide the main vehicle for delivering mental health services in primary health care settings. Table 9 shows the number and percentage of children and young people making contact with Medicare-funded primary mental health care services from 2006-07 to 2011-12, broken down by age group. It shows that the absolute number of children and young people (aged 0-24) receiving these services has risen substantially over time, from a low of 79,139 in 2006-07 to a high of 337,177 in 2011-12. This represents an increase from 1.1% of children and young people receiving these services to 4.6% of children and young people doing so. The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%).

This improvement is largely due to the introduction of the Better Access initiative in 2006. Better Access introduced a suite of new Medicare-funded services (provided by eligible allied health professionals) and expanded the existing range of services provided by GPs and psychiatrists. Annually, children, adolescents and young adults account for slightly over 20% of all users of Better Access.[52]

Several other primary mental health care initiatives of relevance to this group have been implemented under the National Mental Health Strategy. The most notable of these is *headspace*, which was first funded in 2006 and provides youth-friendly access to 12-25 year olds who may be developing, or are already experiencing, mental and/or substance use disorders. *headspace* operates through integrated service hubs and networks. Another example is Access to Allied Psychological Services (ATAPS) which offers similar services to those provided by Better Access, but is funded by the Commonwealth through Medicare Locals rather than via the Medicare Benefits Schedule fee for service system. ATAPS has been running since 2002, and in 2010 an initiative was added which specifically targets children and their parents and offers interventions like family therapy, training in behaviour management, and play therapy.

A range of other providers (for example, community health centres, school counsellors and health nurses, and university and TAFE counselling services) also offer primary mental health care services for children and young people. In addition, child and adolescent specialist public mental health services deliver some primary mental health care services, for example, in their work in school settings.

Taking into account *headspace*, ATAPS and relevant services provided in educational, community health and specialist mental health settings would boost the figures in Table 9, but their specific contribution is unknown. It is likely that there is considerable overlap between those who receive Medicare-funded services and those who see providers in these other settings. For example, a significant proportion of *headspace* clients are referred on to GPs or allied health professionals providing care under Better Access. Similarly, individuals who see an allied health professional through ATAPS require a referral from a GP, and the GP would typically bill Medicare using a Better Access item number.

Without a system of identifying unique individuals accessing all primary mental health care across service streams, it is not possible to include the broader group of services in the counts shown in Table 9. These numbers should therefore be regarded as a conservative estimate, but one which probably does account for the majority of children and young people in contact with primary mental health care.

Table 9
Number and percentage of children and young people receiving relevant Medicare-funded mental health services, 2006-07 to 2011-12 , by age group

		0-4 (Preschool)	5-11 (Primary school)	12-17 (Secondary school)	18-24 (Youth/young adult)	All children and young people aged <25 years
2006-07	Number	1,479	12,298	18,941	46,421	79,139
	%	0.1%	0.7%	1.1%	2.2%	1.1%
2007-08	Number	2,791	28,238	38,984	89,011	159,024
	%	0.2%	1.5%	2.3%	4.2%	2.2%
2008-09	Number	3,931	40,126	55,246	114,458	213,761
	%	0.3%	2.1%	3.2%	5.2%	3.0%
2009-10	Number	4,643	50,434	70,850	130,896	256,823
	%	0.3%	2.7%	4.2%	5.9%	3.5%
2010-11	Number	5,320	60,852	83,671	153,412	303,255
	%	0.4%	3.2%	4.9%	7.0%	4.2%
2011-12	Number	5,862	70,156	94,032	167,127	337,177
	%	0.4%	3.6%	5.5%	7.5%	4.6%

Indicator 8: Rates of use of licit and illicit drugs that contribute to mental illness in young people

KEY MESSAGES:

- Data from the National Drug Strategy Household Survey show that use of both licit and illicit drugs has decreased over time.
- In 2001, 47% of 14-29 year olds engaged in risky drinking in the previous year. This had reduced to 42% by 2010, the lowest figure recorded to date.
- In 1998, 36% of 14-29 year olds used cannabis. By 2010, this figure had halved (19%), although the latter figure represented a rise from 2007.
- Ten per cent of 14-29 year olds used amphetamines in 1998 compared with 4% in 2010. As with alcohol, these are the lowest figures recorded to date.

Agreement to this indicator in the *Fourth National Mental Health Plan* reflected concern at the level of government and at the broader community level about substance abuse in young people and its perceived contribution to increased rates of mental illness and associated demand upon health services. While national programs have been initiated under the National Drug Strategy, further targeted efforts were acknowledged as necessary to reduce substance abuse, particularly the use of illicit drugs that may contribute to mental illness, and to deal with the challenge of providing services to people presenting with comorbid mental health and substance abuse problems.

Regular updates on the level of substance abuse in young people are provided through the National Drug Strategy Household Survey. This survey is conducted every three years by the Australian Institute of Health and Welfare, and provides insights into whether patterns of drug and alcohol misuse by young people have changed over time. Three substances of major priority are considered below, namely alcohol, cannabis and amphetamines. Usage rates for each of these drugs by younger people are of particular concern due to the mental health problems often associated with them. Data on alcohol consumption are available from the National Drug Strategy Household Survey from 2001 to 2010, and data on use of cannabis and amphetamines are available from 1998 to 2010.

Alcohol is the most commonly used and abused substance in the Australian community, and is a major cause of death, injury and illness. Figure 52 profiles 'risky drinking' of alcohol by young people. 'Risky drinking' is defined as drinking any amount on a daily basis over the course of the previous year, or drinking at risky levels (i.e., more than four standard drinks on one occasion) at least once per month during that year. The percentage of young people aged 14-29 engaging in risky drinking dropped from 47% in 2001 to 42% in 2010. In each year, the proportion of 'risky drinkers' was higher among 20-29 year olds than among 14-19 year olds.

Cannabis is the most commonly used illicit drug in the community, across all age groups. Research evidence is accumulating that cannabis use may precipitate psychotic symptoms or the onset of schizophrenia in people who have a family history or other vulnerability to psychosis. Cannabis use may also exacerbate the symptoms of schizophrenia, but it remains unclear whether or not cannabis causes additional cases of schizophrenia. Cannabis use also poses a moderate risk for later depression, with heavy cannabis use also possibly conferring a small additional risk for suicide.

Figure 53 shows the 12 month prevalence of cannabis use for young people. In 1998, 36% of 14-29 year olds indicated that they had used cannabis in the past 12 months; by 2010 this figure had halved (19%). The drop was greater for 14-19 year olds (35% in 1998 to 16% in 2010) than for 20-29 year olds (37% in 1998 to 21% in 2010). In each group, 2007 was the lowest prevalence year.

Growth in the use of methamphetamines in the 1990s has been associated with a range of mental health and related problems. Symptoms of psychosis are one of the particularly troubling consequences of methamphetamine use and dependent methamphetamine users also suffer from a range of comorbid mental health problems.

Figure 54 shows the use of amphetamines by young people. As with alcohol use and cannabis use, there is evidence of a downward trend in the use of this class of drugs. In 1998, 10% of 14-29 year olds reported using amphetamines, whereas in 2010 only 4% did so. Again, the relative decline in use was greater for 14-19 year olds (from 6% in 1998 to 2% in 2010) than for 20-29 year olds (from 12% in 1998 to 6% in 2010).

The three substances selected here represent a range of licit and illicit drugs that contribute to mental illness in young people. It is positive to note that the use of all three substances has shown an overall decline over time in young people, although it should be acknowledged that use of ecstasy, not reported here, has increased. Various national programs that have been initiated under the National Drug Strategy may have played a role in this decline. Further targeted efforts are required to ensure that the downward trajectory continues.

Figure 52
Percentage of 14-29 year olds engaging in 'risky drinking' in the past 12 months, 2001-10

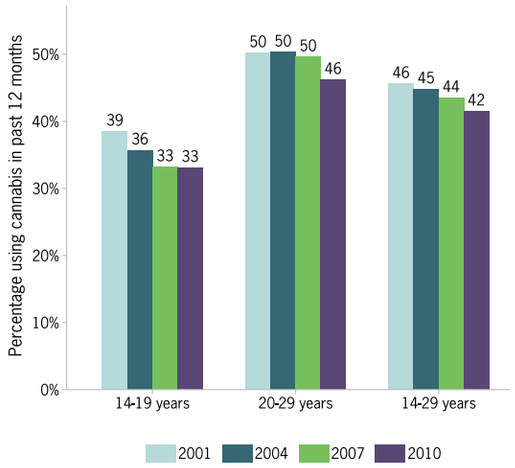


Figure 53
Percentage of 14-29 year olds using cannabis in the past 12 months, 1998-2010

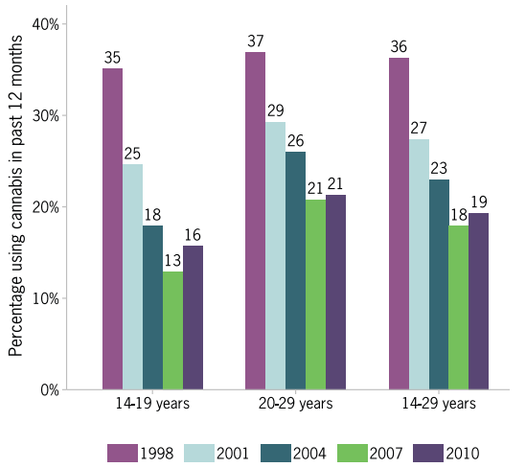


Figure 54
Percentage of 14-29 year olds using amphetamines in the past 12 months, 1998-2010

Indicator 9: Rates of suicide in the community

KEY MESSAGES:

- In 2011, there were 2,273 suicides in Australia, 76% of which were by males.
- Nationally, the average annual suicide rate for the period 2007-11 was 10.6 per 100,000 (16.3 per 100,000 for males; 4.9 per 100,000 for females). The Northern Territory stood out as having particularly high rates.
- The average suicide rate has remained stable since 2003-07. The rate is considerably lower than it was before Australia began its concerted efforts to address suicide through strategic national action.

Arguably, suicides are the starkest indicator of the mental health of the nation. In Australia, suicide ranks as the 15th leading cause of death overall, but it is the leading cause of death for younger people.[53] Suicide is a devastating event for the bereaved; it has been estimated that for every suicide at least six people suffer intense grief and between 80 and 100 more may be affected.[54]

In 2011, there were 2,273 suicides (see Table 10). Three quarters of these suicides (76%) were by males.[53]

Some caution should be exercised in interpreting suicide trends. The number of suicides can fluctuate considerably, and increases in a given year can be matched by commensurate decreases in the following year. These year-on-year changes can sometimes be misinterpreted as significant, when in fact the underlying trend may be relatively flat. This situation may be exacerbated in states and territories with relatively small numbers of suicides.
A common way of reducing the impact of temporal fluctuations in suicides is to convert them to age standardised rates and average them across several years. This allows for more meaningful interpretation of patterns across jurisdictions and over time.

Table 10
Number of suicides by state and territory, 2003-2011

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2003	640	540	466	227	193	69	35	44	2,214
2004	587	521	453	194	178	88	26	51	2,098
2005	549	506	459	203	231	74	35	45	2,102
2006	577	485	494	245	180	72	32	33	2,118
2007	611	474	520	266	205	66	32	55	2,229
2008	620	545	553	300	175	73	36	38	2,341
2009	623	576	525	279	185	79	32	37	2,337
2010	639	536	583	315	197	64	41	45	2,420
2011	566	483	559	306	209	73	34	43	2,273

Figure 55 compares the average annual age standardised suicide rates in states and territories for the period 2006-10, using five year averages. In all states and territories, the rate for males was over three times higher than that for females. The Northern Territory stands out as having the highest rate, almost double the national figure (19.3 per 100,000 compared with 10.6 per 100,000). Tasmania's rate (14.1 per 100,000) was 33% higher than the national average, Western Australia's (13.1 per 100,000) was 24% higher, Queensland's (12.4 per 100,000) was 17% higher, and South Australia's (12.0 per 100,000) was 13% higher. Lower than average suicide rates were recorded in New South Wales (8.6 per 100,000), Victoria (9.6 per 100,000) and the Australian Capital Territory (9.9 per 100,000).[53] Relative numbers of Indigenous people and people living in rural and remote areas may contribute to these jurisdictional differences.

Figure 55
Average annual age standardised suicide rates (per 100,000 population) by state and territory, 2007-11

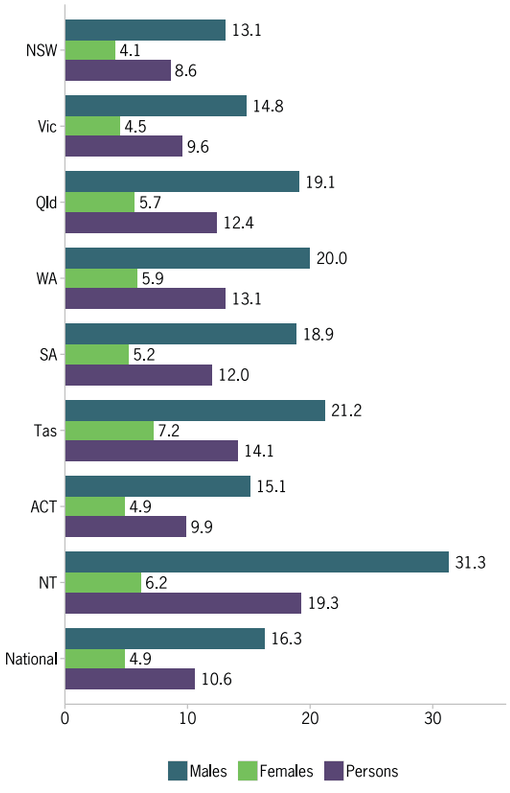
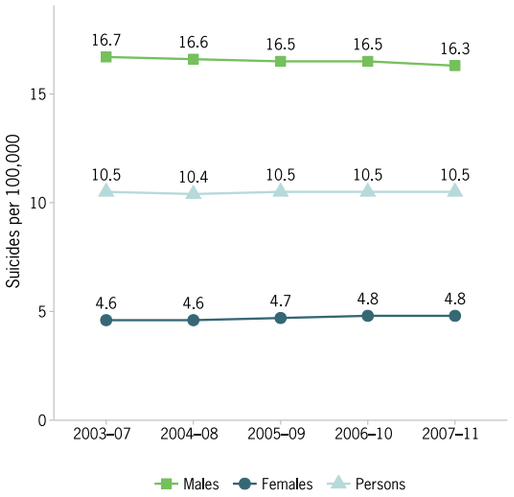


Figure 56 uses unpublished figures from the Australian Bureau of Statistics (ABS) and shows the national trend in suicide rates from 2003-07 to 2007-11, again using five year averages. The overall rate has been stable at 10.5 per 100,000, the male rate has declined slightly (from 16.7 to 16.3 per 100,000) and the female rate has increased slightly (from 4.6 to 4.8 per 100,000).

Figure 56
Average annual suicide rates (per 100,000 population) by five year period, 2003-07 to 2007-11[a]



(a) These figures are based on recent unpublished data provided by the Australian Bureau of Statistics. The 2007-11 figures vary slightly from those presented in Figure 55 due to a different upper age group being used in the calculation of each rate.

The ABS has drawn attention to significant data quality problems that impact on the apparent fluctuation in suicide rates, arising primarily from the increasing number of 'open cases' that are the subject of coronial inquiry. Commencing with its 2008 Causes of Death publication[55] (released in March 2010), the ABS introduced changes to its coding and reporting practices to reduce the impact of these problems and improve the accuracy of overall statistics on causes of death in Australia. These changes particularly affect suicide statistics. They include revisions to historical data back to 2007. The ABS has cautioned that, as a result of these changes, care should be taken when comparing recent data with earlier years.

Australia was one of the first countries to establish a national suicide prevention strategy, and the above suicide statistics should be considered in that context. In 1995, Australia

put in place the National Youth Suicide Prevention Strategy (Here for Life), which was broadened in 1999 with the introduction of the National Suicide Prevention Strategy to consider suicide and suicidal behaviours across the life span. The National Suicide Prevention Strategy has continued since that time, and it aims to: build individual resilience and capacity for self-help; improve community strength, resilience and capacity in suicide prevention; provide targeted suicide prevention activities; implement standards and quality in suicide prevention; take a coordinated approach to suicide prevention; and improve the evidence base and understanding of suicide prevention. The National Suicide Prevention Strategy comprises several components, most notably the Living Is For Everyone (LIFE) Framework which sets out an evidence-based strategic policy framework for suicide prevention that has been agreed to by the Australian Government and all states and territories. In 1998, the year before the National Suicide Prevention Strategy began, the age standardised suicide rate sat at 14.3 per 100,000.[56]

Australia's suicide prevention efforts are continuing. In late 2010, against the background of the National Suicide Prevention Strategy, the Australian Government invested an additional $274m over four years to reduce suicide via its *Taking Action to Tackle Suicide* package. The funding was directed at four key action areas, namely boosting frontline services to support those at risk, investing more in direct suicide prevention and crisis intervention, targeting men who are at heightened risk of suicide but unlikely to seek help, and promoting good mental health and resilience in young people.

Indicator 11: Rates of understanding of mental health problems and mental illness in the community

KEY MESSAGES:

- In 2011, nearly three quarters (74%) of Australian adults could recognise depression. This figure was even higher (86%) for depression accompanied by suicidal thoughts.
- Rates of recognition of early and chronic schizophrenia and post-traumatic stress disorder were lower, with only about one third of the population being able to recognise these disorders. Rates of recognition of social phobia were the worst at 9%.
- Rates of recognition of depression have improved since 1995, whereas rates of recognition of schizophrenia peaked in 2003-04 and have declined slightly since. Recognition of post-traumatic stress disorder and social phobia were only assessed in 2011, so no comparison data are available.

Mental health literacy can be thought of as the knowledge and beliefs about mental illnesses which aid their recognition, management and/or prevention. Accurately recognising the symptoms of a mental illness is a necessary first step in the process of seeking professional help, with failure to identify the problem leading to delays in treatment.[57] Research has demonstrated an association between extended duration of untreated mental illness and poorer outcomes in terms of response to treatment,[58 59] and suicidality.[60]

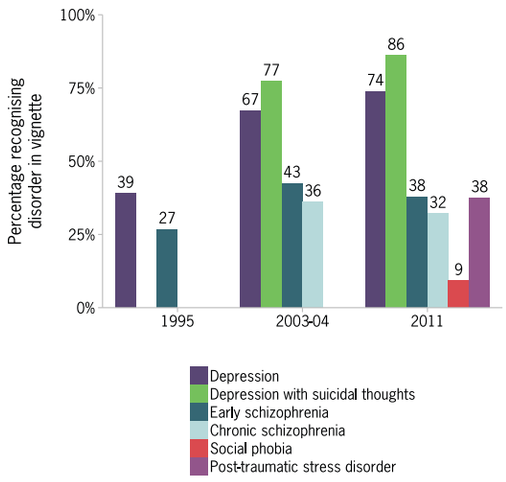
Data for this indicator come from the National Surveys of Mental Health Literacy and Stigma, conducted in 1995, 2003-04 and 2011, the same source as used for Indicator 3 (Rates of stigmatising attitudes within the community).

These surveys have used a vignette-based approach to investigate the ability of the Australian population to accurately identify a variety of mental disorders, namely depression and early schizophrenia (assessed in all years), depression with suicidal thoughts and chronic schizophrenia (assessed in 2003-04 and 2011), and social phobia and post-traumatic stress disorder (assessed in 2011).[46]

Figure 57 shows that in 2011, recognition rates for depression with and without suicidal thoughts were high (86% and 74%, respectively). Recognition rates for early schizophrenia and chronic schizophrenia were lower; 38% identified the former correctly, and 32% identified the latter. Recognition rates for post-traumatic stress disorder were similar to those for schizophrenia at 38%, and recognition rates for social phobia were the lowest at 9%.[46] Rates of recognition of depression have improved over time, whereas rates of recognition of schizophrenia peaked in 2003-04 and have declined slightly since.[46]

Australian initiatives such as *beyondblue*, MindMatters and Kidsmatter have focused considerable attention on improving the mental health literacy of the Australian population. Future efforts in this area might benefit from a focus on disorders other than depression. There is clearly still some way to go in terms of improving community understanding of schizophrenia, and other disorders – like anxiety disorders – might also be targeted. In addition, further monitoring is necessary to explore whether improvements in understanding of mental health problems translate into help seeking and, ultimately, whether they lead to gains in population mental health.

Figure 57
Recognition of the mental disorder experienced by the person described in the vignette, 1995, 2003-04 and 2011



Indicator 12: Prevalence of mental illness

KEY MESSAGES:

- In 1997, 18% of adults experienced a common mental illness (anxiety disorders, affective disorders and substance use disorders) in the past 12 months. In 2007, the figure was slightly higher at 20% but this may be explained by methodological differences in the way in which these prevalence figures were gathered.
- In both 1997 and 2007, young adults experienced higher rates of mental illness than older adults.
- In 1998, 14% of children and adolescents were affected by a clinically significant mental health problem. More current data will be collected in 2013.

Mental illness affects the lives of individuals, those close to them, and the wider community. The prevalence of mental illness provides a global indicator of the mental health of Australians.

As noted in Part 1, several major cross-sectional prevalence surveys have been conducted during the course of the National Mental Health Strategy. These include the National Surveys of Mental Health and Wellbeing (conducted in 1997 and 2007) which provide a picture of the prevalence of common mental disorders in adults,[4 8 9] and the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing (conducted in 1998) which profiles mental health problems among children and adolescents.[6]

Figure 58 summarises the findings from the National Surveys of Mental Health and Wellbeing at the two points in time. It shows that in 1997, 18% of adults experienced a common mental disorder (anxiety disorders, affective disorders and substance use disorders) in the 12 months prior to the survey. In 2007, this figure was slightly higher at 20%. Some caution should be exercised in comparing findings from the two surveys because they sampled from slightly different age ranges and used somewhat different approaches to gauge the presence of mental illness in the past 12 months. It may be the case that these methodological differences account for the small increase in overall prevalence over time.[9]

In both 1997 and 2007, rates of mental disorders diminished with age. Rates were highest in the early adult years, the period in which many people experience their first episode of mental illness. In 2007, the prevalence of mental disorders among 18-24 year olds (26%) was one third higher than the average for the total adult population. A similar pattern was evident from the 1997 figures.

Figure 58
Prevalence of common mental disorders in the Australian population, 1997/1998 and 2007

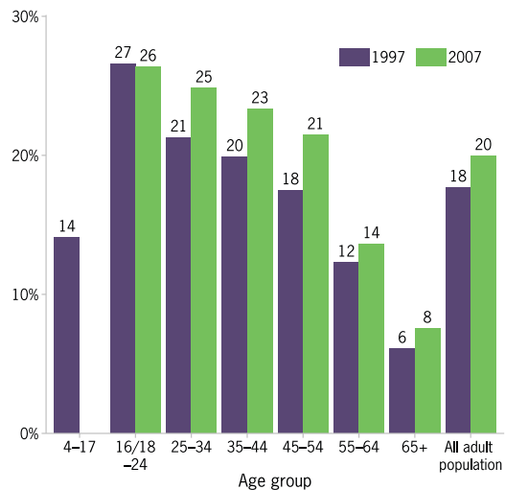


Figure 58 also provides a prevalence estimate from the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing. It shows that 14% of children and adolescents aged 4-17 years were affected by a clinically significant mental health problem. Updated figures are not yet available, but a new study of children and adolescents has been commissioned and will be conducted in 2013.

The available evidence indicates that we can protect individuals against mental illness by building resilience, particularly in young people. Steps can also be taken to minimise the impact of mental illness on the individual and his or her family and friends, by ensuring that high quality treatment and support is readily available. Evidence-based interventions are also available to minimise the likelihood of relapse following an initial episode by fostering coping strategies. Australian experiences also suggest that we can continue to work with the community to reduce the stigma surrounding mental illness, and put in place initiatives to promote social inclusion and recovery. The National Mental Health Strategy's population health approach encompasses all of these directions.