John has a mental health problem and has lost his job.

His illness costs Australia $46,180 a year in treatments and lost earnings.*

Investing in Australia's future:

the personal, social and economic benefits of good mental health

SUMMARY

December 2004

Professor Ian Hickie, Brain & Mind Research Institute, University of Sydney, NSW

Dr Grace Groom, Mental Health Council of Australia, ACT

Ms Tracey Davenport, Brain & Mind Research Institute, University of Sydney, NSW

From cover: *Carr *et al*. 2002

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SUMMARY

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FOREWORD

The Mental Health Council of Australia (MHCA) has placed increasing emphasis on developing a solid base of medical, social and economic research to underpin its advocacy role. Currently, we are presented with daily stories of basic service failure and a wider lack of community support for ongoing reform. Governments of all persuasions have not backed the rhetoric of national mental health reform with real investment, real leadership or real accountability. The spectre of re-institutionalisation has now been raised as the media and State Governments pursue a 'law and order' rather than clinical care agenda. These undesirable outcomes reflect, in part, our collective failure to present a coherent strategy for increased national investment in mental health.

For too long we have accepted the argument that existing health funds will need to be redistributed to back new service or research developments. Additionally, we have relied heavily on personal, social or conventional medical advocacy. There is now a strong need to balance these approaches with sound economic arguments. Today, mental health more actively embraces the fields of health economics and health services research. We must emphasise the benefits that Australia would derive from moving to a cost-effective spectrum of mental health care and welfare reform. In this report, our goal is to provide key community and political leaders with the sound economic arguments that could underpin such reforms.

The community remains ill-informed about the successes that can be achieved in our field and that such advances can be delivered within a cost-effective system of care. While a small number of people do become actively involved in mental health advocacy (usually after a close relative or friend experiences the deficits in our system), the majority still believe that poor mental health only happens to others. As mental disorders affect more and more young people, and related alcohol and illicit substance misuse rises, demand for mental health services will continue to grow rapidly. Currently, every Australian family expects to use the medical care system for their physical health problems. In time, every Australian family will also need to access mental health care. Hopefully, we can now move rapidly to create a system where families do receive the effective mental health care they need and, consequently, our nation reaps the wider social and *<u>financial</u>* benefits.

Professor Ian Hickie
Professor of Psychiatry and Executive Director
Brain & Mind Research Institute
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December 2004

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EXECUTIVE SUMMARY

> *"I have seen numerous surveys of community priorities in health. They all tell very largely the same story. Whilst the community appreciates the important role of hospitals, they see mental health as today's top priority, followed by the health of children (particularly children subject to violence), and Aboriginal heath. The community speaks very clearly and consistently on these issues, but they do not shape the priorities in spending. Insiders make the decisions."* John Menadue AO, 2003, p.368

Government leaders, health ministers and other politicians all have the potential to leave their mark on the national stage by delivering genuine health improvements. In Australia, there have been recent and notable achievements. These include restoration of child immunisation, reduction in adult smoking rates, declining deaths due to cardiovascular diseases and confinement of the spread of HIV infection. In mental health, there has been a 10.6% reduction in the national suicide rate since 1992. That success is likely to be due to a range of health and social factors but appears, at least in part, to be a consequence of rapidly expanding access to effective medical and psychological treatments for depression (Hall *et al*. 2003).

Government leaders, health ministers and other politicians all have the potential to leave their mark on the national stage by delivering genuine health improvements.

It is now time we set genuine national targets for mental health and placed a particular emphasis on the possible economic returns that could result from new investments. Independent analyses suggest that by Organisation for Economic Co-operation and Development (OECD) standards, Australia under invests in promoting good mental health or providing mental health services (Schizophrenia: costs, 2002). Australian health authorities dispute this claim arguing that such international comparisons are methodologically difficult and that Australia's overall level of expenditure on mental disorders (6.2%, excluding dementia or substance misuse) is comparable to the Netherlands (6.6%) and the United States (7.3%) (Australian Institute of Health and Welfare, 2003a). Importantly, frequently repeated claims that Australia spends 9.6% of health spending on mental health are not credible as they include the costs associated with treating persons with dementias including Alzheimer's disease, substance misuse disorders and intellectual disability (Table 1) (Australian Institute of Health and Welfare, 2003a).

Table 1: Health expenditure in Australia, 1992-2003.

	1992-93[a]	2001-02[b]	2002-03[b]
Total health expenditure	$35.1 billion	$66.6 billion	$72.2 billion
Total health expenditure as percentage of GDP[c]	8.2%	9.3%	9.5%
Total recurrent mental health expenditures (excluding dementias, substance misuse disorders and intellectual disability)	6.2%	6.4%	Not yet available

[a]1992-93 figures (Australian Institute of Health and Welfare, 2003b); [b]2001-02 figures and 2002-03 figures (Australian Institute of Health and Welfare, 2003a); [c]GDP is gross domestic product.

It is now time we set genuine national targets for mental health and placed a particular emphasis on the possible economic returns that could result from new investments.

The patterns of health expenditure for each major health area (2000-01), and changes in those patterns over recent years, indicate that mental health does very poorly given its impact on overall health burden (Table 2). Although mental health is the third largest contributor to total health burden (13.2%) and the largest overall cause of disability (27.0%), it is only the seventh ranked disease area by expenditure (6.0%) (Australian Institute of Health and Welfare, 2004b). These figures for health burden do not include the additional contributions of suicide or self-inflicted injury (which are listed under the alternative illness category of 'injuries'). However, if these premature deaths and self-inflicted injuries are added, they result in a 2.3% increase bringing mental health to 15.5% of the total health burden. As the monies spent on suicide or self-inflicted injury are trivial (0.2%), the gap between expenditure and relative health burden is even more stark.

Table 2: Key relative health expenditure and health burden statistics by illness category in Australia, 2000-01.

DISEASE: Ranked by health expenditure	Total health system costs 2000-01[a]	Total health burden[b]	Ratio of health expenditure to health burden	Ratio of YLL to YLD[c]	Total % of YLL (deaths)	Total % of YLD (disability)
1. Cardiovascular	11.2%	21.9%	0.51	4.39	32.9%	8.8%
2. Nervous system (including dementia care)	9.9%	9.4%	1.05	0.28	3.6%	16.1%
3. Musculoskeletal	9.5%	3.6%	2.64	0.11	0.7%	7.1%
4a. Injuries	8.2%	8.4%	0.98	2.78	11.3%	5.0%
4b. Injuries (excluding suicide)	8.0%	6.1%	1.31	2.08	8.4%	4.95%
5. Respiratory	7.4%	8.3%	0.89	0.79	6.8%	10.1%
6. Oral health	6.9%	1.0%	6.90	-	-	2.1%
7a. Mental disorders	6.0%	13.2%	0.45	0.06	1.4%	27.0%
7b. Mental disorders (including suicide)	8.0%	15.5%	0.52	0.18	4.3%	27.05%
8. Digestive system	5.7%	2.6%	2.19	1.17	3.2%	2.1%
9. Neoplasms	5.5%	19.4%	0.28	5.20	29.5%	7.0%
10. Genitourinary	4.2%	2.5%	1.68	0.36	1.1%	4.1%

[a]Proportion of total allocated health expenditure (Australian Institute of Health and Welfare, 2004a); [b]Total health burden based on disability-adjusted life years (Mathers *et al*. 1999); [c]YLL is years of life lost due to premature mortality, YLD is 'healthy' years of life lost due to disability (Mathers *et al*. 1999).

The formal comparison with other relevant areas of health expenditure, such as nervous system diseases (9.4% health burden, 9.9% health expenditures) and musculoskeletal disorders (3.6% health burden, 9.5% health expenditures) is intriguing. The ratio of health expenditure to health burden generally increases for those disorders that result in disability rather than death. Hence, musculoskeletal disorders have the highest

ratio at 2.64 while cancers (0.28) and cardiovascular diseases (0.51) are relatively low. There is a significant inverse and almost linear relationship across the major health areas in Australia (Figure 1). The major exception is mental health where the actual ratio is 0.45! (Table 2). That is, people with mental disorders are treated as if they had an acute or life-threatening disorder, or that they die shortly after onset of illness. In reality, they may require years or decades of episodic or ongoing medical care. Put another way, unlike persons with other well-recognised forms of chronic disability, they are denied access to appropriate and ongoing medical care.

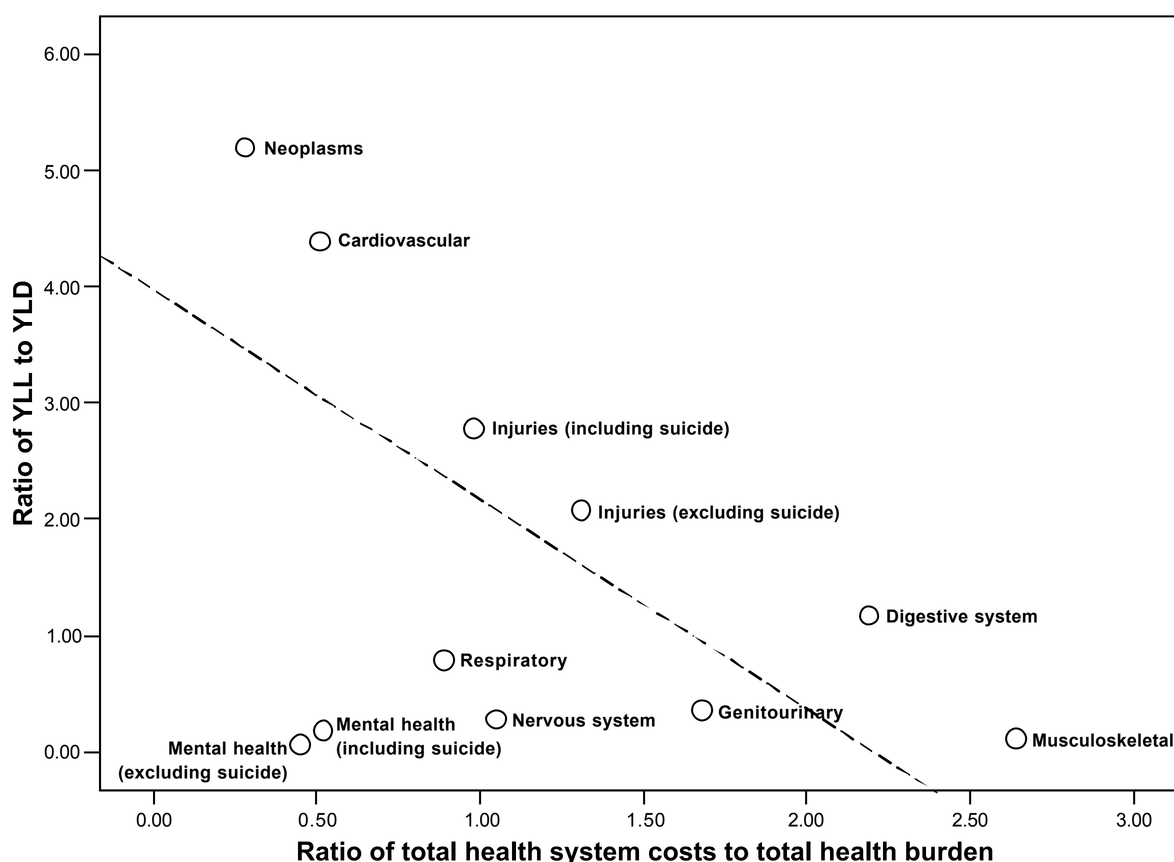


Figure 1: The inverse relationship between premature death and health expenditure in Australia. The correlation between two key health ratios is depicted, namely the ratio of health expenditure to health burden (disability adjusted life years) and the ratio of years of life lost (YLL) to years lived with disability (YLD) (Australian Institute of Health and Welfare, 2004a; Mathers *et al*. 1999). The line represents the correlation between the two ratios when mental health is excluded (r=-0.72).

By the end of 2002, national recurrent mental health spending was $3.088 billion annually, up from $1.908 billion in 1992-93, and reflecting 6.4% of total national *recurrent* health expenditure (Department of Health and Ageing, 2003). By contrast with other expenditure figures produced by the Australian Institute of Health and Welfare (AIHW; variously reported as 6.1% to 7.9% and either including or excluding community-base elements of care), the 2004 National Mental Health Report (Department of Health and Ageing, 2003) figures have been consistently tracked over a decade and include community aspects of health care (eg. preferential move away from hospital-based modes of care in mental health). Despite having had a National Mental Health Strategy in place for over a decade, the often-reported increase in expenditure in mental health (65%) was just ahead of the general rate of rise in total government recurrent expenditures on health

(61%) (Figure 2; Department of Health and Ageing, 2003). The 2004 National Mental Health Report figures can also be used to generate a national per capita expenditure rate (for 2002 AUS$158.00; Department of Health and Ageing, 2003) which could then be used for more meaningful international comparisons.

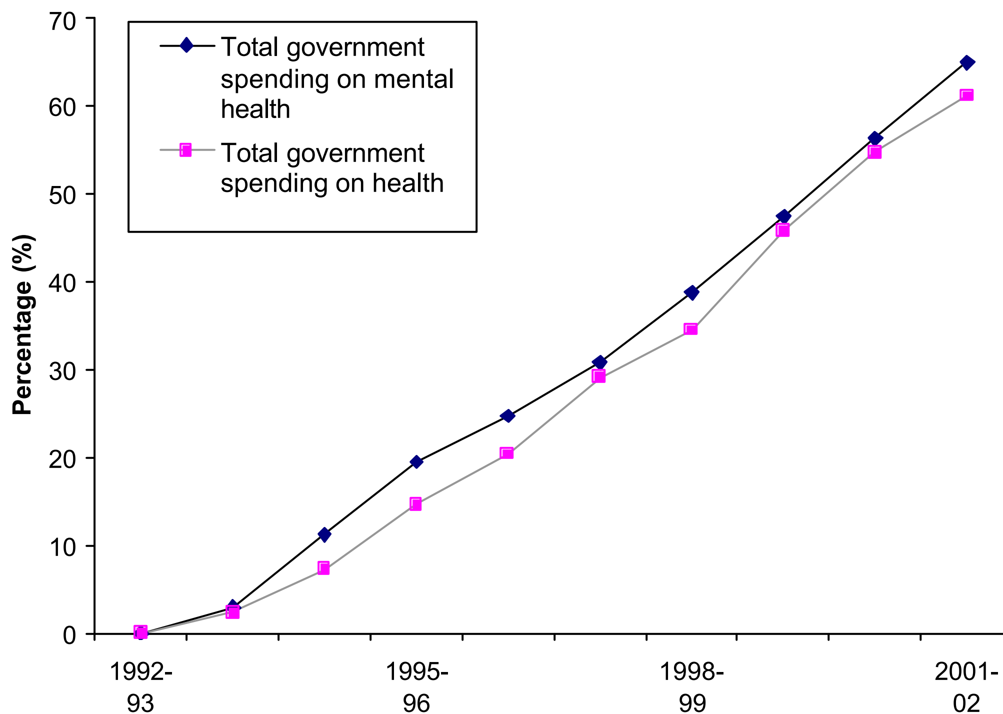


Figure 2: No real growth in government recurrent mental health expenditure as compared with general health expenditure since 1992-93 (Department of Health and Ageing, 2003).

Further scrutiny of national recurrent expenditures highlight the poor performance of the states who reported only a 40% (or 26% per capita) increase in spending over a nine-year period of the National Mental Health Strategy. By contrast, the Australian Government's contribution increased 127%, though 66% of this increase was accounted for simply by the increase in expenditure on medications through the Pharmaceutical Benefits Scheme. While new medications play an important role in improving mental health outcomes, to achieve value for money they need to be backed by complementary psychological, social, informational and self-management strategies. To date, significant developments in these other areas have been promising but limited in scope or reach (Hickie *et al*. 2004) and now require more overt long-term support by the Australian Government. By 2002, the Australian Government accounted for 37% of total mental health spending compared with 27% in 1993 (Department of Health and Ageing, 2003).

It is important to note that national *health* spending continues to rise rapidly. By 2003, it had reached $72.2 billion annually or 9.5% of gross domestic product (GDP; up from 8.4% in 1995-96) (Table 1; Australian Government Department of Health and Ageing, 2004). However, a significant proportion of that increased spending has supported provision of elective medical, dental and surgical services (underpinned by the private health insurance rebate) and ongoing support of the acute care and hospital sectors. Consequently, it is likely that overall mental health spending as a proportion of national health spending is now actually declining.

Despite a decade of policy initiatives, there is still no estimate available as to whether services provided to persons with mental disorders have actually increased in number or improved in quality. While there has been a very large increase in the number of persons employed in ambulatory care settings (109% greater than pre-1993), the 2004 National Mental Health Report notes that these figures *"…do not tell us…levels required to meet priority community needs nor the amount of care actually provided"* (Department of Health and Ageing, 2003, p.21). After a decade, our National Mental Health Strategy has still not even implemented the first round of key performance indicators for services or other proposed key quality or safety measures (eg. deaths of persons within three months, or 12 months, of presenting for mental health care). The 2004 National Mental Health Report notes that less than 50% of public mental health services have completed their review under the National Standards for Mental Health Services, even though this specific item was required under the 1998-2003 Australian Health Care Agreements (Department of Health and Ageing, 2003; New South Wales Health). With regard to actual systematic review of experiences of care, the only significant progress has been driven by the mental health advocacy sector (eg. www.mhca.com.au/ConsumerCarerSurvey_000.html).

In this report, we present surveys of those who use care. The results highlight fundamental problems with our service systems. The majority of respondents (70%) did not have adequate access to services, with 19% being unable to find a health professional to talk to about their concerns. Forty-two percent of respondents said they were always or nearly always not treated with respect and dignity. Forty percent of participants felt they were given insufficient or no information about the condition or treatment. Of those who wanted information given to family and friends, 59% felt that not enough information was given. In situations where medication was prescribed, only 23% responded that the purpose, benefits and side-effects were fully explained. Over one-third (38%) did not feel they had enough say in decisions about care and treatment and 19% had not had the diagnosis discussed with them. Less than 10% had received a care plan, which is a document that outlines mental health needs and who will provide services. About one-third (34%) rated the health care received in the last 12 months as poor to very poor, 29% as fair to good, and 37% as very good to excellent.

While poor mental health costs the economy directly through medical and social welfare costs, for each dollar spent directly on services, four more dollars are lost indirectly through poor education and training achievement, reduced workplace productivity, lost tax earnings and reduced participation by carers in the wider economy. Seventy-four per cent of major mental illnesses commence before 18 years of age (Tables 3 and 4; Kim-Cohen *et al*. 2003). Sixty percent of disability costs in 15 to 34 year olds are due to mental disorder (Figure 3; Mathers *et al*. 1999). Up to 60% of cases of alcohol or other substance misuse could be prevented by earlier treatment of common mental health problems (Kendall & Kessler, 2002). Less than 30% of people with psychological reasons for receiving the Disability Support Pension in Australia participate in the workforce (Table 5; Trewin, 2003). This contrasts with up to 60% in other comparable countries. Suicide rates are now highest among 25 to 44 year olds reflecting largely our previous neglect of the mental health problems that emerged rapidly in the teenagers of the 1980s and 1990s (Figures 4 and 5; Australian Bureau of Statistics, 2003a,b).

Table 3: One-year prevalence of mental disorders in Australian children and adolescents aged six to 17 years (Sawyer *et al*. 2001).

	PERCENTAGE (POPULATION ESTIMATE)			
	Males		Females	
Any depressive disorder	3.2%	(52,000)	2.8%	(43,000)
Any conduct disorder	4.4%	(71,000)	1.6%	(24,000)
Attention deficit hyperactivity disorder	15.4%	(250,000)	6.8%	(105,000)

Table 4: One-year prevalence of mental disorders in Australian adults (Andrews *et al*. 1999).

	PERCENTAGE (POPULATION ESTIMATE)			
	Males		Females	
Any depressive disorder	4.2%	(275,300)	7.4%	(503,300)
Any anxiety disorder	7.1%	(470,400)	12.0%	(829,600)
Any substance use disorder	11.1%	(734,300)	4.5%	(307,500)
Any mental disorder	17.4%	(1,151,600)	18.0%	(1,231,500)

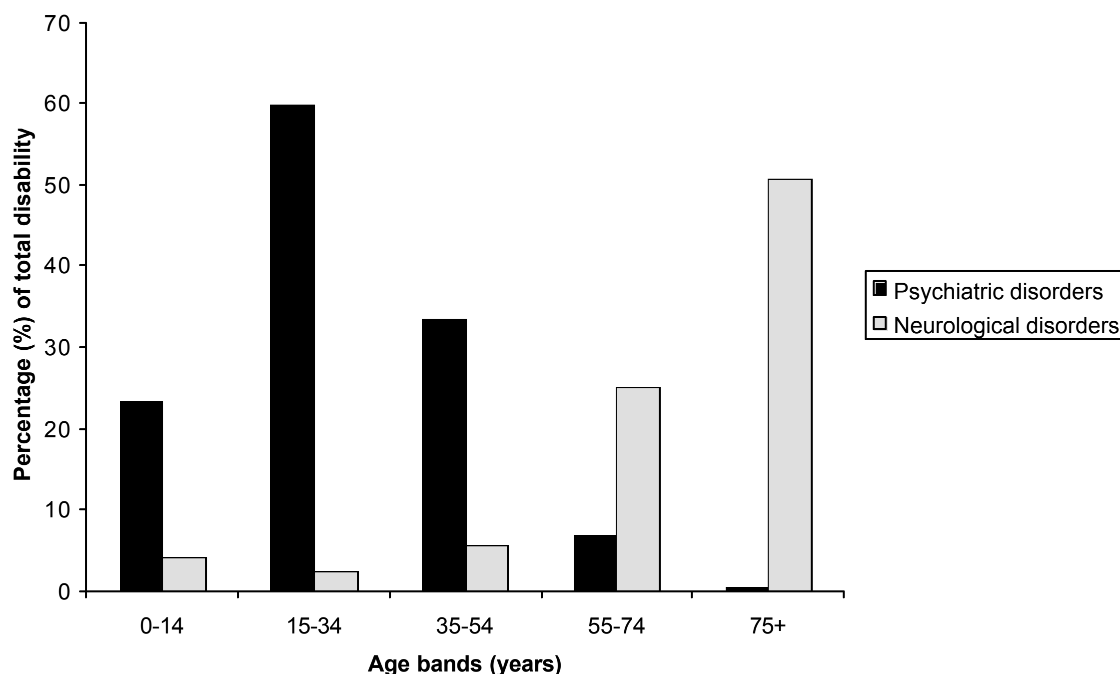


Figure 3: Common mental disorders and substance misuse rob the young of productive lives and cost our community through ongoing disability and income support (Mathers *et al*. 1999, p.53).

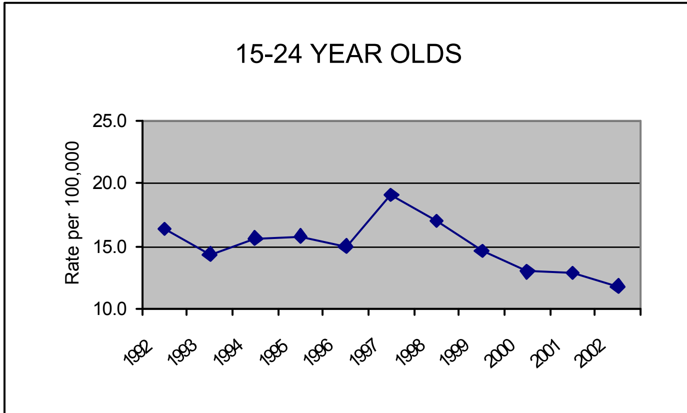
Less than 30% of people with psychological reasons for receiving the Disability Support Pension in Australia participate in the workforce. This contrasts with up to 60% in other comparable countries.

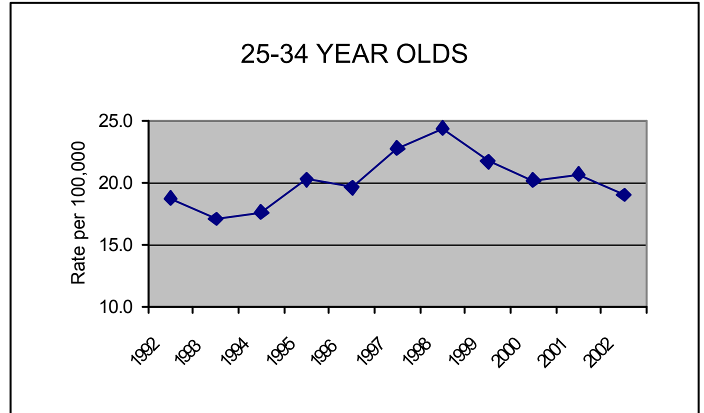
Table 5: Less than 30% of people with disability[a] due to mental illness participate in the workforce (Trewin, 2003, p.260).

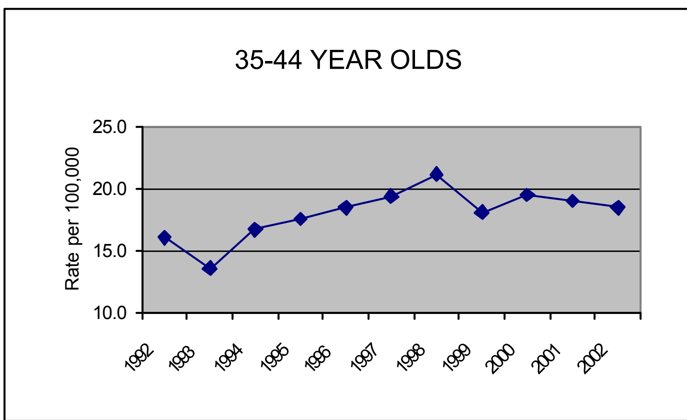
	PERCENTAGE (%)						
	Psychol -ogical	**Intellect -ual**	**Head injury, stroke or brain damage**	**Sensory or speech**	**Physical**	**All with a disability[b]**	**All persons[b]**
Employed full-time	11.3%	17.1%	17.3%	37.2%	27.6%	31.0%	49.1%
Employed part-time	10.2%	12.8%	12.6%	13.9%	15.5%	16.1%	20.3%
Unemployed	7.2%	8.3%	6.6%	4.7%	6.0%	6.1%	6.3%
Participation rate	*28.7%*	*38.2%*	*36.5%*	*55.8%*	*49.1%*	*53.2%*	*75.7%*
Not in labour force	**71.3%**	61.8%	63.5%	44.2%	50.9%	46.8%	24.3%
Total[c]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

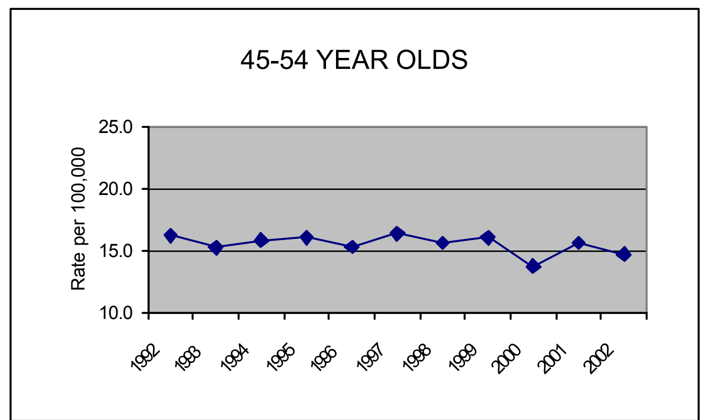
[a]People aged 15 to 64 years and living in the community; [b]The sum of the components exceeds the total because a person can report more than one impairment; [c]Includes those for which the type(s) could not be determined.

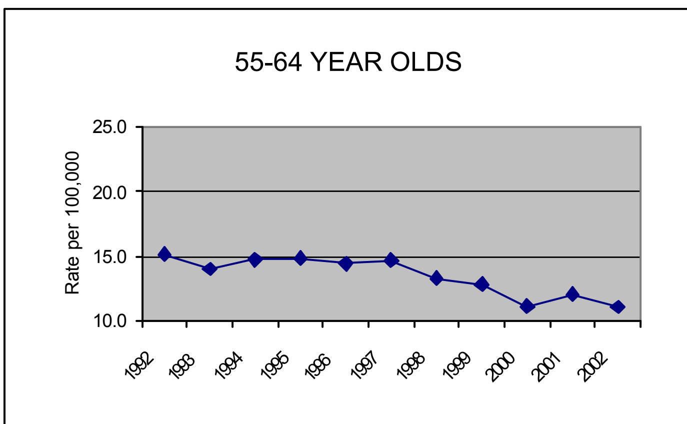
Figure 4: Suicide death rates in Australia have decreased for older people but increased for younger age groups (Australian Bureau of Statistics, 2003a,b).

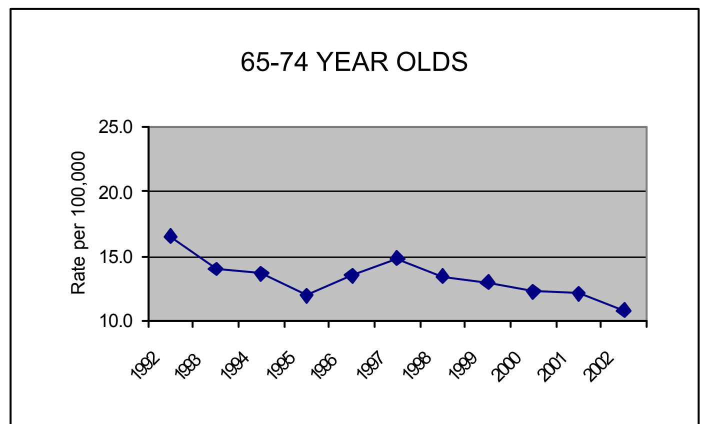


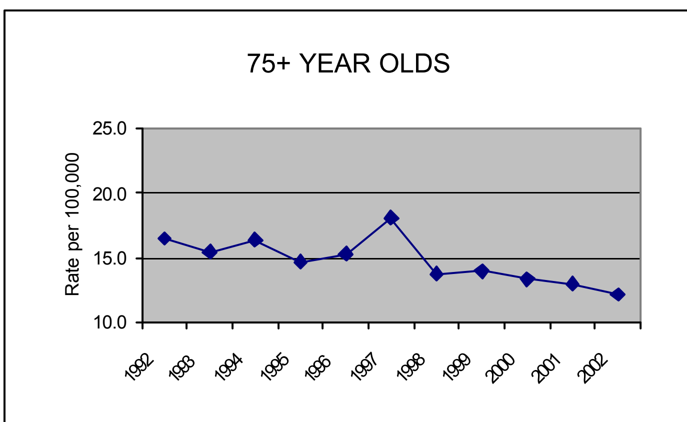


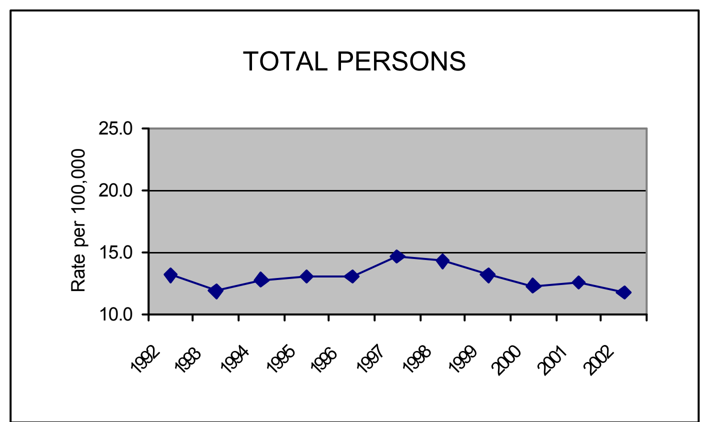












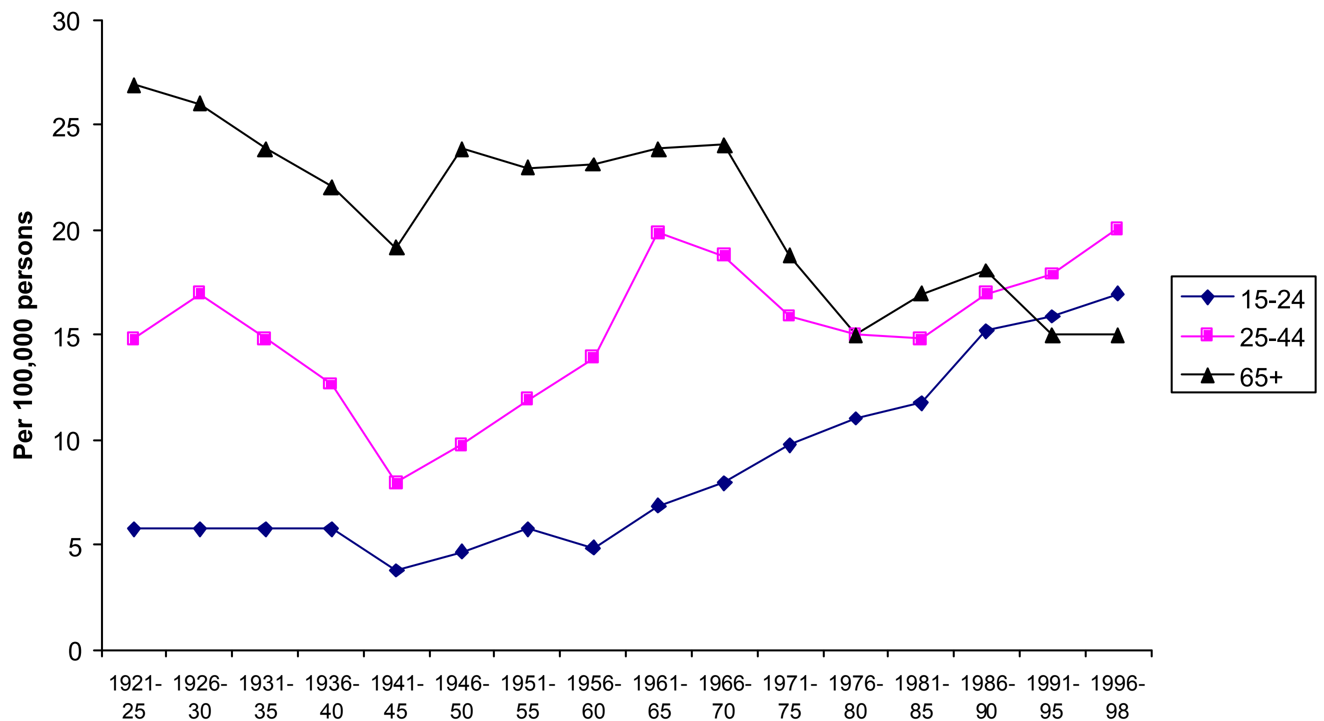


Figure 5: Suicide death rates by age, 1921-98 (Australian Bureau of Statistics, 2003a,b).

In reality, health expenditures are not equitable. They track those who use the traditional health system, and particularly the acute care or surgical aspects of the hospital system. Health system costs are strongly linked to older age (Figure 6). As mental disorders commence mainly in younger age groups, are not treated extensively in the hospital sector and are more closely linked to ongoing welfare and income support, they contribute greatly to health burden rather than health expenditures. For the years 1999-2000 (Commonwealth Department of Health and Ageing, 2002), poor mental health (eg. for schizophrenia and bipolar disorder see Table 6) cost Australia at least $13 billion annually ($2.6 billion directly and $10.4 billion indirectly). The efficient delivery of early intervention, effective treatment and positive return to work programs we estimate could have reduced this cost to $9 billion annually ($3 billion directly and $6 billion indirectly).

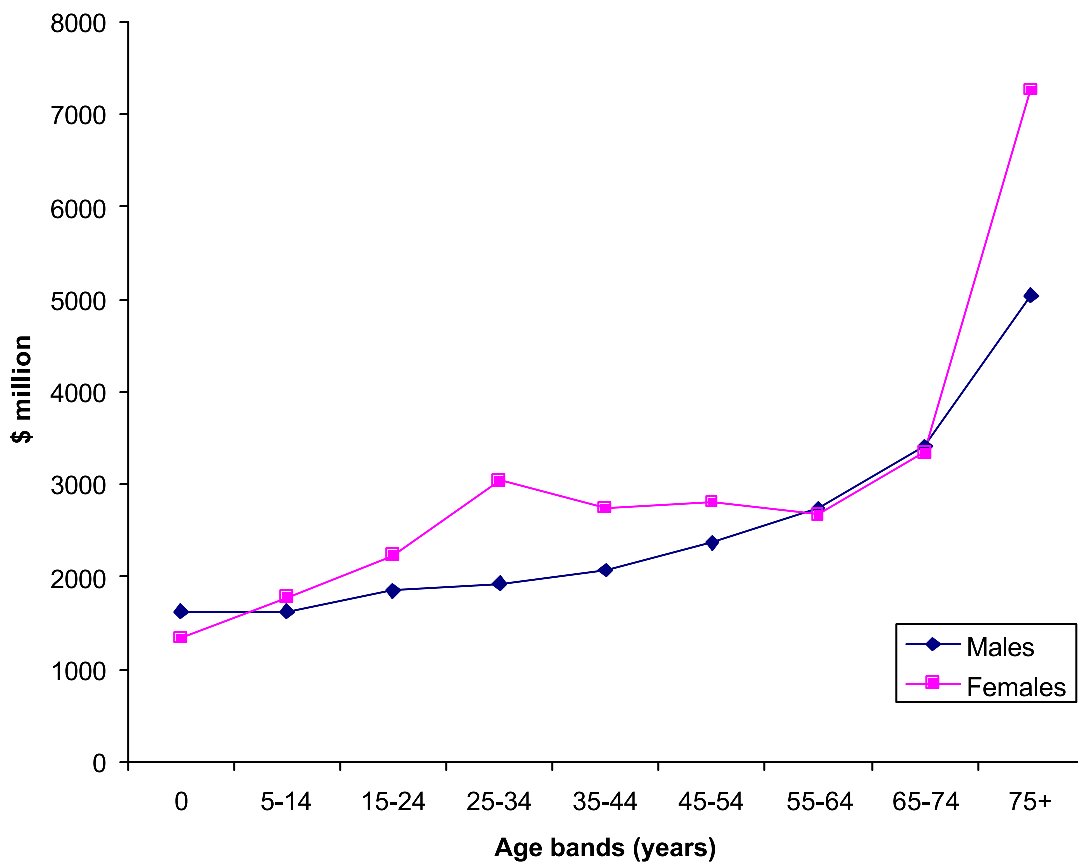


Figure 6: Total allocated health expenditure by age and sex, Australia 2000-01 (Australia Institute of Health and Welfare, 2004b, p.22).

Table 6: Access Economics reports show real, direct and indirect costs for schizophrenia and bipolar disorder exceed $3.5 billion dollars annually.

	Schizophrenia (2001)[a]	Bipolar disorder (2003)[b]
Real financial costs	$1.85 billion	$1.59 billion
Direct health system costs	$661 million	$298 million
Real indirect costs	$722 million	$833 million

[a]Schizophrenia figures (Schizophrenia: costs, 2002); [b]Bipolar disorder figures (Bipolar disorder: costs, 2003).

In response to these issues, we propose four key themes: promoting early intervention for all severe disorders among young people; providing effective pharmacological and psychological treatments in primary care; maximising returns to full social and economic participation; and investing in innovation, research and sustainability. To operationalise these themes we need to build a logical spectrum of community and hospital-based care.

Our explicit goals are to increase the workplace participation rate for those receiving disability support (due to psychological disorders) from 29% to 60% and reduce the suicide rate among 25 to 34 and 35 to 44 year olds from 19.0 and 18.5 respectively to 15 per 100,000 for each of these key age bands (Table 7). To achieve these goals, we will need to engage in both community-based initiatives and significant health

service reform (Figure 7). We will need to: reduce the duration of untreated illness among young people from five to 15 years to two to five years; reduce the rate of people untreated in primary care from 50% to 25%; and increase the provision of specific psychological treatments in primary care from 17% to 50%. For those with psychotic or more chronic mental disorders, and those more dependent on specialist services, we will need to increase access to specialist assessments, access to acute and emergency services and participation in targeted education and workplace-based rehabilitation and recovery services.

Table 7: Comparison of 1992 and 2002 suicide rates in the Australian population (Australian Bureau of Statistics, 2003a,b).

Age bands	1992 suicide rate[a]	2002 suicide rate[b]	Percentage change
15-24 years	16.4	11.8	- 28.0%
25-34 years	18.8	19.0	+ 1.1%
35-44 years	16.1	18.5	+ 13.0%
45-54 years	16.3	14.8	- 9.2%
55-64 years	15.2	11.1	- 27.0%
65-74 years	16.6	10.9	- 34.3%
75+ years	16.5	12.2	- 26.1%
All ages	13.2	11.8	- 10.6%

[a]Total rate per 100,000 is the standardised death rate per 100,000 of the mid-year 1991 total Australian population; [b]Total rate per 100,000 is the standardised death rate per 100,000 of the mid-year 2001 total Australian population.

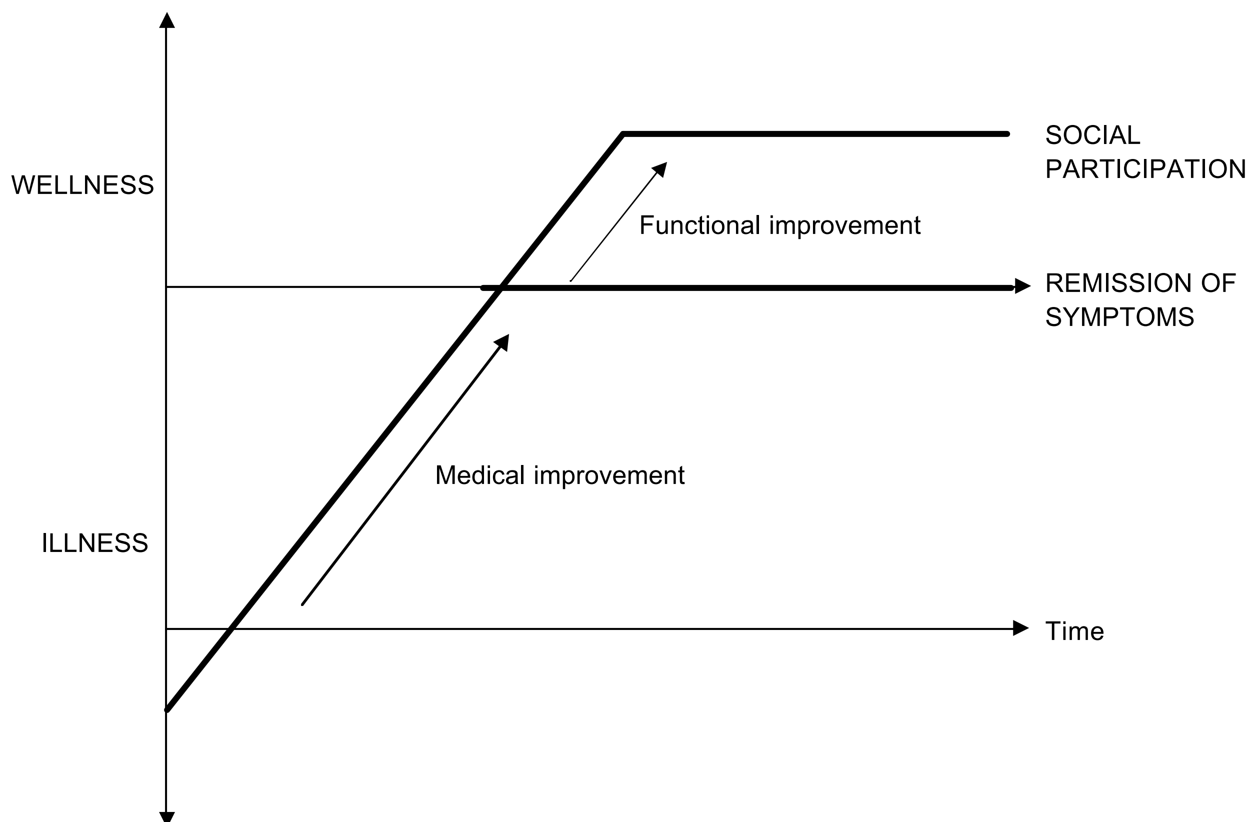


Figure 7: The goal of good mental health is social and workforce participation. Traditional high cost medical investments only return persons with mental illness to low levels of social participation. Investment in additional lower cost rehabilitation and workplace strategies is required to achieve social and workforce participation.

Our explicit goals are to increase the workplace participation rate for those receiving disability support (due to psychological disorders) from 29% to 60%.

This report focuses on the need to shift thinking, recognise new challenges and implement new ways forward. New thinking is increasingly backed by community support and emerging scientific evidence. We must be willing to move beyond broad statements of principle (see our National Mental Health Strategy of 1993 and National Mental Health Plan 2003-2008) to real programs of implementation. Leadership, investment, innovation and accountability lie at the heart of our concerns.

New thinking is increasingly backed by community support and emerging scientific evidence. We must be willing to move beyond broad statements of principle to real programs of implementation.

FOUR KEY THEMES

> *"While the aims of the Second (National Mental Health) Plan have been an appropriate guide to change, what has been lacking is effective implementation. The failures have not been due to lack of clear and appropriate directions, but rather to failures in investment and commitment."* Steering Committee for the Evaluation of the Second National Mental Health Plan (1998-2003), 2002, p.3.

Mental illnesses are increasingly recognised as a major health challenge in both developing and developed countries. As disorders such as depression, anxiety, alcohol or other substance misuse, schizophrenia and manic-depressive illness (bipolar disorder) are extremely common they now pose a significant threat to both social and economic development. In the next 20 years, the incidence of all these disorders is expected to rise as will the complication rates in terms of physical health problems, premature death and lifelong disability. The size and coherence of each nation's response will vary not only as a result of current economic and health status but also according to social attitudes and perceived opportunities for strategic investment. Good mental health is a key determinant of education and training achievement, workforce participation and family and social cohesion.

This report highlights four key themes for a new style of reform. These are: promoting early intervention for all severe disorders among young people; providing effective pharmacological and psychological treatments in primary care; maximising returns to full social and economic participation; and investing in innovation, research and sustainability. To operationalise these themes, we need to build a logical spectrum of community and hospital-based care. Here, we propose those changes of existing systems or major extensions of innovative programs that demand immediate attention.

THEME 1: Promoting early intervention for all severe disorders among young people

a. Adopting early intervention models for psychosis nationally;
b. Emphasising early intervention for mood, anxiety and alcohol or other substance misuse disorders;
c. Basing early intervention on new youth health networks and increased primary care detection, with interventions co-ordinated through the specialist service sector;
d. Emphasing social recovery and completion of education and training rather than just workplace participation; and
e. Establishing a national network of early intervention centres that share common clinical, research, education and family support structures.

THEME 2: Providing effective pharmacological and psychological treatments in primary care

a. Expansion of general practitioner-based and allied health services (notably psychological treatments) under the *Better Outcomes in Mental Health Care* and related Australian Government initiatives;
b. Introduction of quality use of medicines initiatives designed to maximise effective use of affordable pharmaceuticals, including linking prescribing rights to increased education, training and practice-organisation systems; and
c. Maximising links between the general practice, specialist psychiatry and allied health sectors to ensure timely delivery of specialised assessments and interventions.

THEME 3: Maximising returns to full social and economic participation

A. *Maintaining employment* through:
   a. Workplace awareness programs;
   b. Workplace screening and intervention programs;
   c. Workplace treatment services; and
   d. Expansion of general practitioner-based and allied health services (notably psychological) under the *Better Outcomes in Mental Health Care* initiative.

B. *Promoting treatment services and related income support* through:
   a. Expanding current goals of treatment to include 'return to work' programs and not just a reduction of symptoms;
   b. Ensuring treatment goals include attention to the need for provision of access to stable and appropriately individualised, supported accommodation (not a return to institutionalised boarding homes); and
   c. Support through Job Network programs for those with chronic disability.

THEME 4: Investing in innovation, research and sustainability

a. Researching predictors of transition to psychosis or other chronic and disabling mental disorders during the teenage years;
b. Studying the effects of medical, social and psychological intervention strategies during the early stages of illness;
c. Evaluating the benefits and costs associated with assertive completion of education and return to work programs for those with severe mental disorders;
d. Researching the short and longer-term effects of alcohol or other substance misuse on our youth's cognitive and emotional functioning; and
e. Establishing a national network of brain and mind research centres with a strong emphasis not only on the identification of the interplay of basic biomedical and social causative factors, but also on the support of families and communities at risk.

KEY RECOMMENDATIONS AND URGENT RESPONSES

The MHCA and a wider coalition of health, community and social welfare groups, propose the following immediate actions. These actions are outlined below, with background arguments for each developed throughout the text. The immediate implementation of these actions by the Australian Government would send a clear signal to the community of an intention to restore confidence in our mental health service system and maximise the national benefits of increased investments in good mental health.

1. Implementation of an *annual and independent* reporting system
    a. This is most easily achieved through direct contractual arrangements with the MHCA. The estimated cost of this process is **$300,000** per year and should be mandated for an initial five-year period. The MHCA should report to the Minister for Health on progress in national mental health reform and a formal report should be presented to the National Parliament annually.
    b. The governments of Australia should be required to continue their own yearly reporting of expenditures in mental health (which is surprisingly not included in the most recent National Mental Health Plan; Australian Health Ministers, 2003).
    c. Consideration should be given to increasing the powers of the Australian Human Rights and Equal Opportunity Commission to monitor human rights abuses and incidents of discrimination in employment, education or other Federal agencies related to people with mental disability. The Commissioner should also be further empowered to proactively liaise and work with appropriate state-based agencies and commissioners whose work may overlap.

2. Continuation of the *Better Outcomes in Mental Health Care* initiative beyond 2005
    a. This landmark program in integrated mental health services is considered to be a lapsing program of the Australian Government.
    b. The component of it devoted to allied health services (such as clinical psychology) should be immediately expanded (currently $10-12 million in 2004) to provide reasonable access to non-pharmacological treatment services.
    c. A range of recently developed allied health service models is feasible, and they should reasonably be expected to attract **$50 million per annum by 2008**.
    d. Urgent consideration should be given to reform of the Medicare Benefits Schedule rebate for psychiatrists to encourage better delivery of consultancy services. Current modelling suggests this could be achieved at low cost initially and could be cost neutral in the longer-term.

3. Direct support for novel workplace employment schemes
    a. Immediate implementation of specialised schemes for people on a Disability Support Pension to resume some work. Such schemes must include attention to the provision of stable, appropriately individualised supported accommodation (not a return to institutionalised boarding homes). An initial investment of **$49 million annually** is required to produce a cost-neutral result.
    b. Support for trials of workplace mental health awareness, screening and implementation programs. This could be achieved through currently supported initiatives such as *beyondblue: the national*

depression initiative or contractors such as the MHCA, SANE Australia or the Centre for Mental Health Research (The Australian National University).

4. Backing of innovation, research and sustainability
   a. National implementation of early intervention programs for psychosis. This should occur through direct funding models and not through state transfer models. A national network of early intervention centres should be established. The range of models available vary, but **$30 million annually** is required to develop a sustainable system.
   b. Support research into early intervention models for youth-onset mood and alcohol or other substance misuse disorders.
   c. Support research for early intervention into later-life depressive and brain degenerative disorders.
   d. Immediate support for *Brain & Mind Australia* to evaluate the consequences of the Prime Minister's Science, Engineering and Innovation Council (PMSEIC) 'Neurosciences' development. The estimated cost of this is **$250,000 for one year**.

Full copies 'Investing in Australia's Future' can be obtained from the mental Health Council of Australia.

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Also see: www.mhca.org.au