SENATE SELECT COMMITTEE ON MENTAL HEALTH

SUBMISSION BY

THE MENTAL HEALTH RESEARCH INSTITUTE

APRIL 2005

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Part A - Summary

Mental Health service delivery has undergone substantial changes over the last decade and is now facing a series of new challenges requiring innovative answers. There is the need for a new stage of service reform to create, within a cohesive framework, a more versatile mental health service system that:

- tailors services to different levels and areas of need
- incorporates more effective triage and assessment
- establishes step-down services between acute and community care
- empowers consumers and carers with information and self-management tools
- builds a sophisticated evidence base to inform service models and interventions.

Research and evaluation needs to be recognised, and resourced, at the heart of these reforms. Research and evaluation contributes to the elimination of irrational and ineffective practices and sustains a knowledge-based framework for policy reform and dissemination of best practice.

The Mental Health Research Institute makes the following submissions to the Committee:

1. That future national policy give high priority to supporting research and evaluation as an integral component of mental health service reform.
2. That the research and evaluation agenda for the next stage of service reform encompass integrated fundamental, clinical, population and genetic/genomic and pharmacogenomic research.
3. That the National Mental Health Strategy set aside specific funds for the roll-out of service improvements and innovative intervention programs shown to be effective in research trials.

Part B - Context

The Senate Select Committee on Mental Health has been appointed at a crucial time for the provision of mental health services in Australia.

A decade ago the National Inquiry into the Human Rights with Mental Illness and the National Mental Health Strategy made the reform of mental health services a more prominent part of the national health agenda than ever before.

Since that time there have been substantial strides forward in increasing knowledge about mental illness in the community. National initiatives have been buttressed by the fact that groundbreaking epidemiological studies under the auspices of the World Bank and World Health Organisation have disclosed the true burden that mental illnesses impose on humanity. The *Global Burden of Disease* study has demonstrated that psychiatric illnesses represent five of the ten leading causes of disability worldwide, with their share of the global disease burden projected to grow even further in coming decades.[1]

The dollar value of this burden is being progressively revealed in Australia by economic analysis. For example:

- Schizophrenia and associated suicide - $1.85 billion p.a. in real financial costs.[2]
- Bipolar disorder and associated suicides - $1.59 billion p.a. in real financial costs.[3]
- Depression and mental disorders in the workplace – $3.3 billion p.a. in lost productivity plus compensation claims.[4]
- Dementia, of which Alzheimer's disease is the most common form, and other mental illnesses of ageing –currently $6.6 billion p.a. and projected to double over the next decade increasing in line with the ageing population.[5]

It is now clear that the move from institutional to community-based care (with in-patient units in general hospitals) that lies at the heart of the National Mental Health Strategy has given rise to a new series of challenges, many of which are reflected in the Committee's terms of reference:

- People with a mental illness are massively over-represented in the prison and the homeless populations
- There is an increased burden on families as primary carers in the community
- The demand for mental health services is increasing across the population, but the nature of the demand differs between age ranges, social groups and regions
- Gaps have opened up or been exacerbated between different services and service sectors under more decentralized service delivery, especially in regard to people with co-morbid mental illness and substance misuse conditions.

In this context the Mental Health Research Institute is pleased to have the opportunity to present the following series of submissions to the Senate Select Committee, with a view to informing the next stage of reform priorities.

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[1] Murray CJL and Lopez AD. *The Global Burden of Disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. (1996, Harvard University Press). Overview at The Global Burden of Disease website http://www.who.ch/mnh/mnh/ems/dalys/intro.htm#figure1

[2] Access Economics. 2002. *Schizophrenia: Costs – An Analysis of the Burden of Schizophrenia and Related Suicide in Australia*. An Access Economics Report for SANE Australia

[3] Access Economics. 2003. *Bipolar disorder: Costs – An Analysis of the Burden of Bipolar Disorder and Related Suicide in Australia*. Access Economics for SANE Australia,

[4] beyondblue: the National Depression Initiative. 11/11/2004. "beyondblue: Opening our Eyes to Depression in the Workplace". < http://www.beyondblue.org.au/index.aspx?link_id=9.234 Hatch, Brad. 4/11/2004. "Mental health at work emerges as an issue" *Australian Financial Review* 4/11/2004, p. 16. Cave, Michael. 23/10/2004. "Despair and the middle aged man" *Australian Financial Review* 23/10/2004, p.22>

[5] Access Economics. 2003. *The Dementia Epidemic: Economic Impact and Positive Solutions for Australia*. Prepared for Alzheimer's Australia by Access Economics. Australian Institute of Health and Welfare. 2004. *Australia's Health 2004*, Chapter 8 Health of older Australians 354-387

Part C – Submissions

1) Research and Service Reform – Terms of Reference (n) & (o)

The next stage of service reform needs to create, within a cohesive framework, a more versatile mental health service system that:

- tailors services to different levels and areas of need
- incorporates more effective triage and assessment
- establishes step-down services between acute and community care
- empowers consumers and carers with information and self-management tools
- builds a sophisticated evidence base to inform service models and interventions.

As 'New Directions for Victoria's Mental Health Services' (2002) states, research and evaluation will necessarily be at the heart of the next phase of mental health reform, "a new stage of service development [that] will be underpinned by evidence-based practice, informed by research and evaluation".[6]

All too often research and evaluation is at the tail end of policy-making on service reform. It should be at the very forefront. Research and evaluation contributes to the elimination of irrational and ineffective practices and sustains a knowledge-based framework for policy reform and dissemination of best practice. We need to evaluate current practice to ensure that we are delivering, and continue to deliver, best practice at clinical and rehabilitation and support levels.

SUBMISSION 1	- That future national policy give high priority to supporting research and evaluation as an integral component of service reform.

2) Adequacy of various modes of care for people with a mental illness, Comprehensiveness of care, Unmet need (b), (c), (e)

Most resources are put into acute treatment (crisis services and hospitals). There is no question that this is an extremely important area of care for people with a mental illness and it is understandable that it commands a lion's share of resources.

However, better and more cost-effective health outcomes can be achieved by preventing people ending up in crisis. More resources should be put into intervention (notably research into other methods of treatment and the existing practices of community rehabilitation and support) and prevention (such as suitable housing, personal security, social inclusion, infrastructures to support people living in poor socio-economic circumstances, preventing childhood abuse).

Four streams of work are essential here. In summary they are:

Fundamental biological research

This stream of research is often overlooked in policy making because it is prone to be seen as remote from service delivery. Such a view is counterproductive in its own terms. In fact, fundamental research has generated very substantial benefits for service delivery by producing new or improved interventions such as medications, and demonstrating that mental illnesses are

[6] Victoria. Department of Human Services. 2002. 'New Directions for Victoria's Mental Health Services: The Next Five Years', p.5

treatable conditions, not character flaws. Potentially the discovery of vulnerability genes through biological research will open the way to improved timing of interventions, attuned to points when those genes are active. It also opens the way for high-impact epidemiology that concentrates on precisely delineated risk factors.

Clinical research
Clinical research has also generated a substantial body of knowledge about the causes and courses of mental illnesses. Yet its potential remains largely untapped in terms of achieving system improvements. In fact there is a lack of specific funding opportunities to carry out this type of systems improvement research and later to roll it out.

For example, medication compliance is necessarily a focus in community care, but it is not routinely supported by validated psychosocial treatments that bolster coping skills and self-management of mental health. Case Study 1, Collaborative Therapy, outlines some research results and potential for further development.

Population measures
Research has played a crucial role in underpinning changes in the health behaviour of populations. There is significant potential for this to be further researched and developed in the mental health field. Early awareness of the symptoms of mental illnesses can prevent conditions exacerbating.

Psychogenetics/genomics and Pharmacogenetics/genomics and Proteomics
The elucidation of the human genetic code coupled with new molecular biological technology offers a hitherto unrivalled opportunity for elucidating genetic factors that (i) trigger psychiatric disorders, (ii) render individuals susceptible/vulnerable to stress-induced mental illness and (iii) determine patient responsiveness to different drug or other therapies. It is recognised that with relatively rare exceptions psychiatric disorders are likely to prove polygenic and that the pathogenic mutations may comprise clusters of polymorphisms including single nucleotide polymorphisms (SNPs). Pharmacogenetics/genomics may help to prevent adverse side effects and change the management and treatment of patients from the current empirical to a rational (cost-effective and efficient) mode. Exploitation of human genome information requires a multidisciplinary approach that integrates fundamental, clinical and population research.

SUBMISSION 2 - That the research and evaluation agenda for the next stage of service reform encompass integrated fundamental, clinical, population and genetic/genomic and pharmacogenomic research.

Case Study – Collaborative Therapy for Australian Mental Health Services

The Project - Collaborative Therapy brings together the various strands of the treatment that each patient undergoes into a unifying program that can underpin a patient's recovery and health maintenance. It enables all people involved in the patient's treatment, whether as professionals or carers, to work in parallel towards the patient's wellness goals and helps to ensure that:

- all components of the patient's treatment are integrated
- psychosocial support and medication work in concert with one another
- problems with medication-compliance and side-effects are identified early and are not repeated

- face-to-face consultation times are used productively because information on treatment is up-to-date and ready to hand; and
- medical management and monitoring are integrated.

MHRI's Collaborative Therapy Group has tailored packages for: bipolar disorder, schizophrenia, mental illness and substance abuse (dual diagnosis) and body dysmorphic disorder. Evaluations of the effectiveness of the interventions are being undertaken in regard to schizophrenia, bipolar disorder and dual diagnosis.

The Potential - Collaborative Therapy is being used by the Australian Capital Territory (A.C.T.), Adult Mental Health Service as a service delivery model and is also being piloted in individual services in South Australia and Victoria.

Granted adequate resources, there is the potential for Collaborative Therapy to be rolled out in other services and delivered on-line.

3) <u>Education, Peer support, Consumer empowerment and Special needs (l), (i), (f)</u>

Mental health policies around Australia agree on the importance of education, peer support, consumer empowerment and meeting special needs in improving service provision. However, there is less agreement about the best way of ensuring that these objectives are met. Fortunately, there are models available that have been validated in research.

One is the Depression Awareness Research Project (DARP), run by MHRI with funding from *beyondblue*, the National Depression Initiative. Rather than using mass advertising or a top-down information campaign, it trained volunteers ('community educators') to disseminate key messages about depression among people in their communities ('secondary contacts') – that depression is common, treatable, serious and an illness not a character flaw.

The effectiveness of the program was measured through:

- Quantitative assessment of knowledge in the target communities prior to commencement of project (by *beyondblue*), and of community educators (volunteers) and stakeholders using pre- and post-survey questions (by MHRI).
- Qualitative evaluation of training materials and communication strategies by community educators (by MHRI).

DARP released the following results in 2004:

- 25% increase in knowledge levels among people who attended a community presentation (2413 tested an average of 17 weeks after they had heard a presentation).
- 59% greater knowledge among this group than the general community in:
    - recognising depression
    - modifying risk factors
    - enhancing protective factors
    - taking early action to prevent deterioration of health.
- Over 200 volunteers trained to become educators about major depression.
- Over 7,500 people attended presentations by educators in the five regions of Victoria.
- 5,443 surveyed on depression awareness in communities before awareness raising presentations.

These outcomes stand out in the international literature as representing a singularly effective campaign to improve literacy about major depression.

Importantly, the DARP model is flexible and can be used in other mental health promotion campaigns, such as increasing literacy about schizophrenia and to reach other groups such as young people, Indigenous communities, and groups in rural and remote areas (there is a much higher suicide rate in young rural men than young urban men in Australia). Education in rural communities could help people to recognise their own and others' mental illnesses. In addition the model is well suited to delivery in the workplace or in the criminal justice system.

The model is also an effective one for reducing effects of iatrogenesis. There needs to be education of the general public alongside education of health workers. If people know what to look for when they seek medical help and can ask relevant questions about the treatment being offered, the risk of iatrogenic illness is lessened.

While effective models such as DARP, Collaborative Therapy and TORCH (see Case Study below) can be developed and validated, there is a dearth of funding opportunities to take them into widespread practice. The types of funding available to take drug or device discoveries from proof-of-concept to the marketplace do not exist for rolling out these innovative population and service improvement programs.

MHRI submits that there is a specific need for national policy to redress this gap in the interests of improved service provision.

SUBMISSION 3 - That the National Mental Health Strategy set aside specific funds for the roll-out of service improvement and innovative intervention programs shown to be effective in research trials.

Case Study - Coping Strategies for Auditory Hallucinations and Treatment Resistant Command Hallucinations

Auditory hallucinations typically experienced as hearing voices are a common and distressing symptom of schizophrenia and can cause considerable disability. Alongside investigating the neurobiological causes of this symptom, MHRI's Auditory Hallucinations Group has developed new psychological interventions to assist patients to cope with hallucinations. The Group has worked with SANE Australia on a multimedia CD "Voices" which features people describing their hallucinatory experiences and the range of treatment options available and which has been widely distributed to sufferers of hallucinations, their families and clinicians.

In 2002-03 the Group developed an innovative approach to dealing with an important subgroup of hallucinations, command hallucinations. The group has examined why it is that some individuals feel compelled to follow harmful instructions while others are more able to resist. Using the previously developed Mental Health Research Institute Unusual Perceptions Schedule (MUPS), the group found that patients who complied with their voices had fewer coping strategies and described their voices as more authoritative in tone, but less intrusive. Compliers also reported less frequent hallucinations and were more likely to be assessed as having delusions.

This work has led to the new psychological treatment named TORCH (Treatment of Resistant Command Hallucinations), which focuses on the personal management of symptoms, self-efficacy and individual empowerment.

The group has won competitive funding to trial TORCH in a wide range of mental health services. This evaluation is currently being undertaken and will include measurement of improved health outcomes and reduction in crisis-driven service usage.

Conclusion

To this point, the National Strategy has not given a high priority to integrated fundamental, clinical and population research. This needs to change to carry service reform forward.

There is a great deal of promising research in Australia and substantial potential to translate this into improved service delivery across the mental health system.

The Case Studies included in this submission demonstrate examples of this potential. The individual submissions, numbered 1-3, are directed to turning that promise into service improvement that is sustained, measurable and comprehensive.

Part D - About the Mental Health Research Institute (MHRI)

MHRI is the leading research organisation in Australia dedicated to research on mental illness with emphasis on the major functional psychoses and Alzheimer's disease. The Institute is unique in that it carries out multidisciplinary research that tightly integrates molecular/bench to bedside research. Poignant examples of this multidisciplinary-integrated approach are provided by MHRI's work on: (i) the psychogenetics/genomics and proteomics of schizophrenia and bipolar disorder; (ii) the pharmacogenomics of atypical antipsychotics; (iii) the investigation of delusions and cognitive deficits in functional psychoses by way of cognitive neuropsychology, neuroimaging and neurophysiology; and (iv) the investigation of the role of brain oxidative and metal biology in the causation of Alzheimer's disease. A company limited by guarantee, MHRI has a successful and productive track record of publication and commercialisation. The Institute is funded by competitive grants from national and international sources, philanthropy, commercial investment and operational support from the Mental Health Branch of the Victorian Department of Human Services and the Department of Innovation, Industry and Regional Development.

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