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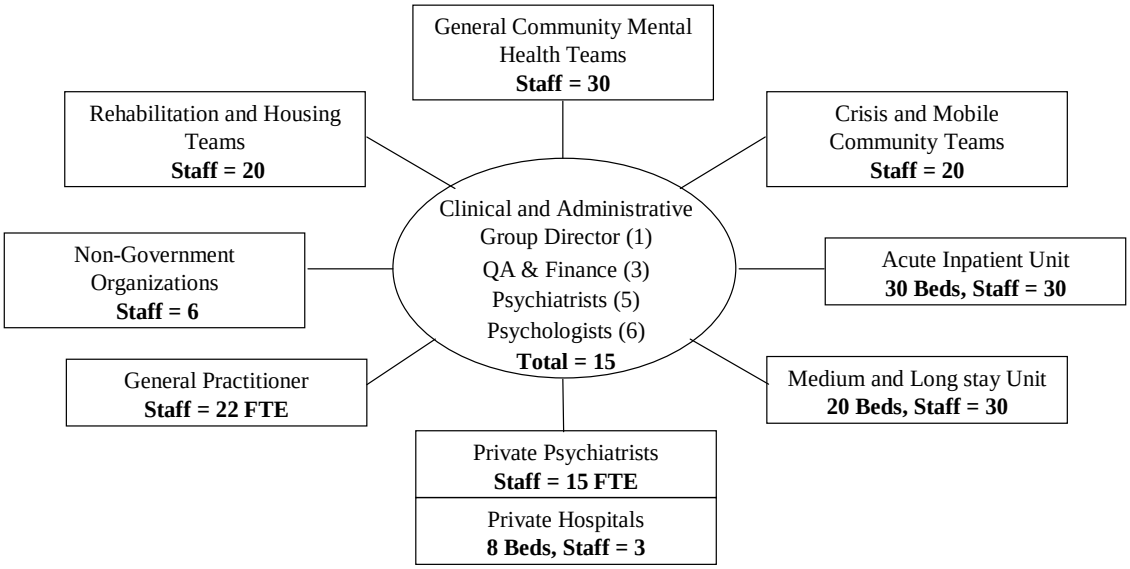
Thank you for inviting a submission. My name is Gavin Andrews and I qualified in psychiatry in Melbourne in 1962. Since then I have worked in academic psychiatry and have researched how services for people with mental disorders could be improved. At various times I have directed inpatient units and community clinics, and presently direct the Clinical Research Unit for Anxiety and Depression at St Vincent's Hospital. I am also the director of a World Health Organization Collaborating Centre in mental health that was primarily concerned with evidence for mental health policy but is now central to the revision of the mental health chapter of the International Classification of Diseases [ICD-10].

Having a mental disorder means having symptoms and signs that match one of the mental disorders listed in ICD-10. It is difficult to think about 'mental illnesses' as a homogeneous group and any discussion of a generic mental disorder is obscuring important information, just as discussion of a generic physical disorder would do. ICD-10 lists ten blocks of disorders but four blocks account for the majority of patients, the burden and the cost. Mental disorders affect people in very different ways. The four blocks are 'F10 substance misuse disorders' in which young people abuse and become dependent upon drugs and alcohol; 'F20 psychotic disorders' particularly schizophrenia, a disorder of brain development that becomes obvious in young adults who have difficulty thinking rationally; 'F30 mood disorders' which again begin in young adults who show distress and difficulty regulating mood, and 'F40 anxiety disorders', disorders of fear and distress that first show in teenage or earlier. Few people over the age of 40 become ill with one of these disorders for the first time.

I have been involved in five initiatives that are germane to the present submission.

1. Tolkien Report: In 1991 we were asked by NSW to develop a model for a mental health service for a standard catchment area of 200,000 people. We could redeploy existing staff and facilities but no extra money was to be spent. We thought the existing workforce was sufficient and that such a service would need 30 acute beds, 20 longer stay step down rehabilitation beds and 100 accommodation places in the community, all of which existed at that time, it was the proposed organization that was new. Integration with private psychiatry and with general practice was anticipated. Details are in the diagram below. The 'Tolkien Report' [after all it was a theoretical model] became seminal to the thinking of many. The staffing arrangements and the facilities, if available today, might go someway to resolve the present crisis that comes from an inadequate supply of step down beds and the alienation of staff, patients and the community.

ORGANIZATION OF MENTAL HEALTH SERVICES FOR 200,000 PEOPLE



2. RAPS report 1994: The US National Alliance for the Mentally Ill had produced an annual score card rating public sector psychiatric services in the US. We repeated that exercise in Australia in 1993. The results were exciting. Some services in NSW – North Sydney, North Ryde, Darlinghurst – were excellent in all respects, certainly exceeding all international benchmarks. Other services, particularly those in Queensland, were less good, but overall there was a sense that optimal patient care was within our reach and the mental Health Services Conferences of the time echoed this optimism. Dr Teesson and I noted the decline in funding in NSW and published a piece saying that some states were getting more than they paid for and reasoned that the excellence in NSW would be hard to maintain. This has proved to be true.

3. National Survey: In 1994 Henderson, Hall and myself approached the federal Government to do national mental health surveys to determine how many people had which disorder(s), how disabled they were by their disorders and what services did they use and want. There were three surveys, adult, low prevalence and young people, and the survey of adults is the largest national survey in the world, interviewing 10,641 adults, randomly identified from households. About one in five reported symptoms in the previous twelve months that matched criteria for an ICD-10 mental disorder, rates that

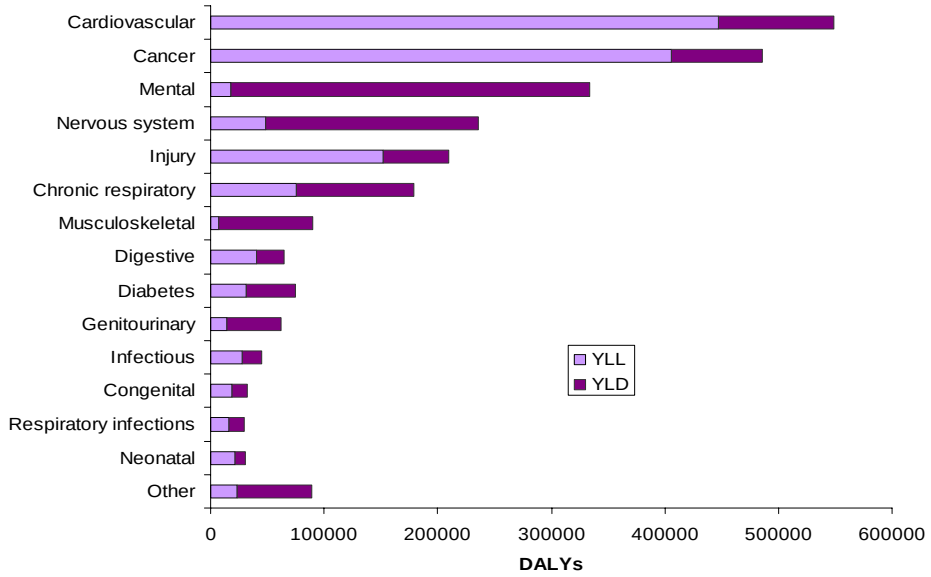
are less than those in the US, comparable with rates in Canada and probably higher than rates in Europe or Asia. The raw rates for disorders are in the table below..

ICD-10 twelve month Mental Disorders: Adult Survey	%(s.e)
Affective disorders	
Major depression	6.7 (0.4)
Dysthymia	1.3 (0.2)
Bipolar Disorder	******
Any affective disorders	7.2 (0.4)
Anxiety disorders	
Panic disorder with/without agoraphobia	1.1 (0.2)
Agoraphobia without panic disorder	1.1 (0.2)
Social phobia	2.7 (0.3)
Generalized anxiety disorder	3.0 (0.2)
Obsessive-compulsive disorder	0.3 (0.1)
Post-traumatic stress disorder	3.3 (0.2)
Any anxiety disorder	9.5 (0.4)
Substance use disorders	
Alcohol harmful use/abuse	3.0 (0.3)
Alcohol dependence	3.5 (0.5)
Drug harmful use/abuse	0.2 (0.1)
Drug dependence	2.0 (0.2)
Any substance use disorder	7.7 (0.5)
Any CIDI-defined ICD-10 disorder	18.6 (0.5)
Other disorders (defined by screening questionnaire only)	
Neurasthenia	1.5 (0.2)
Any personality disorder	6.5 (0.3)
Cognitive impairment	1.3 (0.1)
Psychosis	0.4 (0.1)
Any disorder	22.7 (0.6)

4. Burden of Disease and the Cost Effectiveness of Treatment: We had designed the National survey to inform two additional purposes, a burden of disease calculation and a bottom up, i.e. using the services that people said they had received, calculation of the cost effectiveness or efficiency of current treatment. The burden of a disease is the sum of years of life lost to an illness [YLL] and the years lived with disability (weighted according to the impact of the disease) due to that illness [YLD]. It is measured in Disability Adjusted Life Years lost (DALYs). Mental disorders rank third after heart disease and cancer as the largest causes of burden in Australia but are the largest single cause of disability, as they are elsewhere in the world. [See chart below] The mood and anxiety disorders are common and account for two thirds of this total disability, with schizophrenia at 6%, a relatively minor contributor because of the relative rarity of this very disabling condition.

How disabled are they?

Mental disorders are the largest single cause of disability



Using the survey data we looked at the cost effectiveness of current treatment and we calculated that some 13% of the burden of mental disorders was being averted, in part because only 4 in 10 people with a disorder were seeking treatment (called coverage), in part because half who did consult were not getting a treatment known to be effective and in part because of the intrinsic weakness of many treatments. The efficiency, measured in $/DALY averaged $30,000/ Disability Adjusted Life Years averted which means that, overall, psychiatric treatment was affordable. Treatment for alcohol use disorders and for schizophrenia was less efficient and the cost effectiveness of treatment for schizophrenia, at $196,000/DALY averted, appears to be the least efficient treatment known for any medical disorder. We argued that societal concerns made the treatment of people with schizophrenia imperative and that no money should be withdrawn from their treatment. The cost of treatment for these four groups of disorders was some $1800 million, about 80% of recurrent expenditure in 1997. All costs are in 1997 dollars.

Cost Effectiveness of Current Treatment

	Coverage %	% burden averted	Efficiency $/DALY
Depressive disorders	60	15	20,000
Anxiety Disorder	35	13	15,000
Substance use disorders	11	2	98,000
Schizophrenia	~100	13	196,000
All disorders	40	13	30,000

5. Tolkien II: Beginning in 2003 we developed a method whereby we could use the information from the Surveys, the Burden and Cost Effectiveness studies together with the information from the Clinical Practice Guidelines prepared by the College to define optimal care. We have completed the process for 8 of the 14 disorders which account for 95% of all psychiatry: depression, the five anxiety disorders, schizophrenia and borderline personality disorder. The remaining six will be completed within the next six months. The aim is to define as clinical flow charts, the various professional elements of care involved in the treatment of these disorders, then calculate the total inputs and costs required. For example, while social phobia and schizophrenia generate a similar burden, the staff and cost differences are very different. They illustrate the process.

Tolkien II: Method

- Prepare a structured summary of 14 disorders
- Expert group defines what is expected of each service provider for each disorder by level of severity.
- Calculate the total number to be treated, and the number and cost of the required GP, psychiatrist, clinical psychologist, and mental health team visits,
- Calculate the number and cost of inpatient, rehabilitation and hostel bed days and the number and cost of medications required.
- Get verification from experts, consumers & carers
- Reconcile for all 14 disorders to identify the budget, facility and workforce needs.

Social Phobia

N = 43,000
GP visits = 228,000
Psychiatrist visits = 10,000
Clinical Psychologist visits = 231,000
Mental Health Service visits = 0
Inpatient days = 0
Drug days = 4,720,000
Cost = $35,000,000

Schizophrenia in Australia

N = 41,000
GP visits = 278,000
Psychiatrist visits = 8,000
Clinical Psychologist visits = 20,000
Mental Health Team visits = 1,084,000
Inpatient & rehab days = 537,000
Long term accommodation days = 3,207,000
Drug days = 14,282,000
Cost = $ 633,000,000

Social phobia was seen to be the province of the general practitioner aided by cognitive behaviour therapy from psychologists whereas schizophrenia was deemed to always require medication and specialist intervention. Schizophrenia is a disorder of brain

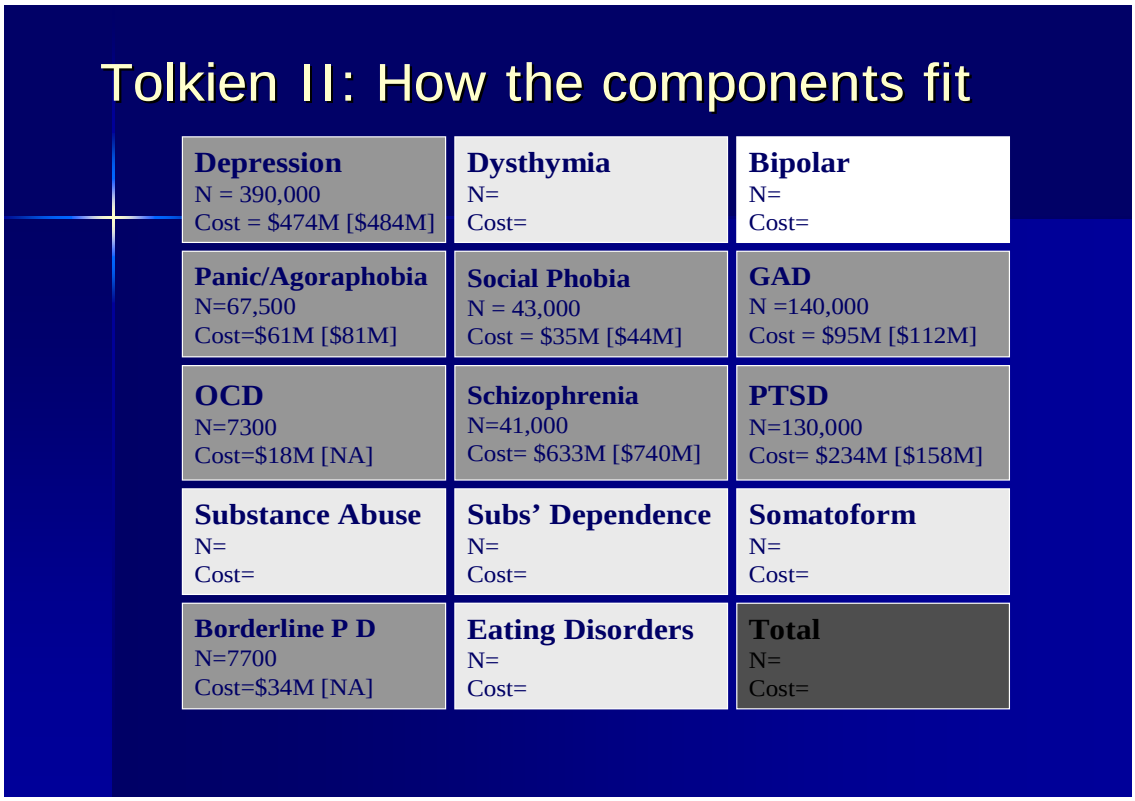
development that impairs a person's ability to think and work. In the first year of schizophrenia the experts requested that the community mental health teams see patients an average of twice each week to educate about the disorder, manage medication, educate and support the family and maintain the possibility of vocational and social engagement. For patients who remained continuously symptomatic in following years the experts thought that weekly community mental health visits would be required and that up to 70% of these patients would require step down accommodation in either rehabilitation units, or in community accommodation under the supervision of the mental health staff. If schizophrenia is a developmental disorder of brain organization then the more severely afflicted patients were unlikely to be able to live alone for some time. The accommodation requirements for schizophrenia were considerable, not so much for acute unit beds but for 14 rehabilitation and 100 community accommodation beds per 200,000, figures that are quite consistent with the estimates in the original Tolkien report. These resources were available in 1991, they are not available in any state today. The surprise is that the total costs for ideal treatment for both social phobia and for schizophrenia are, if anything, less that what we currently spend. Money is not the issue. The issue is informed management.

Just for the record, the locus of treatment for social phobia is general practice, the disorder costs $800 to treat a case ideally for a year and the efficiency is $8,500 per DALY gained. In contrast the locus of treatment for schizophrenia is the community mental health centre and sheltered accommodation, the disorder costs $15,500 to treat a case ideally for a year and the efficiency is $107,500 per DALY gained, 13-20 times more than social phobia. All mental disorders are not treated in the same locus, the overall cost is different and the cost effectiveness can be very different. Any discussion of a generic 'mental disorder' is obscuring important information.

Units that can't discharge can't admit. Australia presently has sufficient acute short stay beds if the beds were occupied only by acute care patients. However it has only a quarter of the rehabilitation beds requires and perhaps only 40% of the community beds required. It is no wonder that the present crisis is in the acute units.

The crisis is also in staff retention. Doctors and nurses are ceasing to work in public sector in-patient and community mental health services, instead choosing alternatives like the more lucrative and more congenial private sector. In the absence of step down beds, public sector staff are being asked to maintain patients in the community who are too sick to live in the community and who should be in stable supervised accommodation.

The issue of harm to self or others is real, and in the absence of alternatives, inappropriate management decisions are made on a crisis basis. It is surprising that tragedies involving patients and staff are not more common. In the US and in Denmark the association between violent crime and schizophrenia is well established. In France, a number of tragedies in a short space of time brought the matter to public attention. A careful compilation of state statistics might well show that a comparable situation exists in Australia.



In the diagram above it is clear that we have completed the model for eight of the fourteen disorders and that so far ideal treatment on average is no more expensive than our estimates for current treatment, the costs of which are displayed in square brackets. Whether we have the correct skill balance remains to be determined.

Addressing the terms of reference:

1. **The extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;**

Comment: The Strategy has been excellent and the Branch should be proud. The National Mental Health Report is an invaluable source document. But coordination of all participants is hard to achieve. Collaboration does result in improved efficiency, has been trialled in Australia and has been effective.

2. **The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;**

Comment: the proportion of people with a mental disorder who access care is half that of comparable physical disorders and it is not clear why people with mental disorders should be deprived. Almost all with schizophrenia are in care but only 60% of people

with depression, 35% of people with anxiety disorders and 11% of people with substance use disorders consult for their disorder. Why is this so? In part the low rate of consulting may be because of stigma, in part because of poor experiences of prior attempts to get effective treatment, and in part because people are too proud and prefer to 'manage themselves'.

Of great concern is that those who did consult only about half did not get a treatment proven to be of benefit. These levels of effective coverage have to be improved and may well be beginning to change given the Better Outcomes in Mental Health Initiative to facilitate GP care of people with common mental disorders. Therefore the issues are of access to care and access to effective care.

There are clear deficits in prevention, early intervention, acute care, community care, after hours crisis services and respite care but they pale into insignificance given the overall poor level of coverage suffered by people with mental disorders.

3. **Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;**

Comment: Coordinated care will have to wait until we have a coordinated system, not the six independent systems we have at the moment. The six are the private sector GPs, psychiatrists, hospitals and psychologists who receive varying levels of tax payer support from an Australian Government that pays but does not manage, the State funded public sector services and the non-government organizations. Only the state funded services staff can be directed as to what they should do, the remaining providers have to be cajoled with money, a strategy that distorts the cost of health care.

The mental health integrated care trials in Australia were evaluated as a success. Both the NHS in the UK and the Kaiser Permanente in California are good examples of successful mental health systems in which good integration has been successfully achieved.

4. **The appropriate role of the private and non-government sectors;**

Comment: As neither have a job description this question is hard to answer. Traditionally, private psychiatrists do what interests them among the patients presenting for treatment. Private hospitals have welcomed people with health insurance and have run programs that are profitable, treating people who are less severe than in the public sector and keeping them in hospital longer. Ideally, private GPs, psychologists and psychiatrists should contribute their skills where they are needed. The system at present creates artificial silos of skills that are not always used to the benefit of people with mental disorders.

5. **The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;**

Comment: The need for supported accommodation is most relevant to schizophrenia. As argued in Tolkien II above it would be cheaper and better to provide more accommodation rather than depend on inappropriate acute hospital admissions. Vocational rehabilitation has fallen into disfavour despite good models being available. Family support is an intrinsic part of good treatment. Interagency cooperation is poor. See Andrews and Henderson, Unmet Need in Psychiatry, Cambridge University Press. 2000.

6. The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and comorbid conditions and drug and alcohol dependence;

Comment: There is a document outlining a cost effective strategy to improve services for children and adolescents prepared by an expert group before the recent election and this can be supplied on request. Similar documents are almost certainly available for the aged, indigenous Australians, the socially and geographically isolated and for people with complex and comorbid conditions and drug and alcohol dependence**.**

7. The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

Comment: That carers feel the need for training and support is an indictment of the inadequacy of current services. Again we are mostly talking about schizophrenia and again adequate family intervention programs will result in access to all the support and training required by carers. Tolkien II envisaged an average of weekly visits to all people with schizophrenia living at home that would continue throughout the course of their illness, very different to what is presently happening. [see also 10 below].

8. The role of primary health care in promotion, prevention, early detection and chronic care management;

Comment: The Tolkien II flow charts make it clear that role of the GP in most disorders apart from schizophrenia is central. The Better Outcomes in Mental Health Care initiative is enabling GPs to cope with people with the common mental disorders. There is a limit on how poly-competent one can expect GPs to become. Patient education systems like CLIMATE can help with prevention and promotion (see Q:16 below). Early detection is a matter for professional education. Chronic care management is what GPs can do well, but find it difficult to do in a system in which patients disabled by illness incur a fee for consulting. Perhaps we can train the practice nurses in proactive care for people with chronic depression and anxiety, recruiting the doctor's help when necessary. Many GPs maintain people with chronic psychosis and with severe personality disorders. When Tolkien II is finished we may need some structural adjustment in the workforce mix.

9. **Opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;**

Comment: Iatrogenesis is a separate issue and will not be discussed. That consumers feel they could do better is important and is another indictment of service failure. There is no consumer group wanting to do appendectomies, and for that matter, as this potentially fatal disease is well managed, there is no interested consumer group at all. During the sixties we had consumer groups taking responsibility for the treatment of people with early psychosis. This experiment failed – people with psychosis did need medication. There is professional knowledge, and for all disorders evidenced-based care is better than compassionate care. The age of moral treatment of the insane as the only therapy is past. Treatment should be expert and moral. But why people with mental disorders have to be treated by bare foot doctors when people with physical disorders are entitled to treatment by trained doctors is a key issue for the Committee.

Given that the average level of accessing professional help in people with mental disorders is 40%, there is room for consumer driven organizations to provide care. They already do. There are support groups for the anxiety and affective disorders, family support groups for schizophrenia and of course alcoholics anonymous for substance dependence. All should be encouraged.

Nobody suggests that we restrict funding for osteoarthritis so we only treat half the sufferers and require community groups to provide exercise and weight loss programs to the remainder. Nor do people suggest we restrict the supply of statins to reduce cholesterol levels to half the people with high cholesterol and require community groups to encourage lifestyle modifications for the remainder of people at risk of cardiovascular disease. Why do we accept low coverage levels and inadequate treatment for people with mental disorders? It is one of the enduring puzzles that is not unique to Australia.

We do not need additional funds to provide care to the 40% of people currently consulting, we just need good management to ensure that the appropriate care is supplied in the least restrictive environment We will need to double the funds if we are to double the proportion of people in need who are seeking care, to the levels of people with physical disorders who seek care. I cannot think of any justification for the under-treatment of people with mental disorders.

10. **The overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;**

Comment: The prevalence of mental disorders in inmates is four times the prevalence in an age, sex and education matched sample. Some of the disorders – antisocial personality disorder, drug dependence – do lead to crime and treatment in jail may be the safest option for society. Psychosis is associated with violence and treatment in a secure facility

for some is essential, whether we call this a hospital or a jail is irrelevant as long as treatment is delivered. Anxiety and depression are three times more common among inmates than in the matched general population. They are seldom the reason the crime was committed and may be an indication of the person's background or current predicament, again treatment should be offered. Once we get 80% of people with mental disorders getting treatment [the level of treatment in most physical disorders] we could look at diversion programs for those in the criminal justice system. Until then let us be proactive in arranging good treatment in jail

11. The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

Comment: Mental health Acts throughout the world concur that people with mental disorders who are a risk to themselves or others should be detained and treated, that is forcibly deprived of their liberty. It is the risk and not the mental disorder that is the key. Thirteen percent of people in Australia have a mental disorder today, in most the risk issue will never arise.

Among those in whom it does arise, the need for detention and seclusion is less if well trained staff are available. The use of police to convey mentally ill people to hospital, which is common in Australia, is a confrontational model that ensures that cooperation will be minimal and violence maximized. Some countries use health services to convey such people to hospital. Violence is minimized and the need for detention is then lessened. Adequate compassionate staff reduces the need for, but does not eliminate the need for detention and seclusion.

12. The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

Comment: Consumer groups complain about stigma. The literature does not suggest that greater community understanding of mental illness reduces stigma. We used to believe it would and in 1959 I carried a 16mm movie projector to Victorian country towns to show films about mental illness in the hope of reducing stigma. Knowledge has little effect. Being able to cure mental disorders would reduce stigma, which is why the stigma attached to the curable anxiety disorders is so much less. And why there is no stigma attached to appendicitis.

13. The proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

Comment: Not even medicine deals appropriately with people with mental disorders, it is rather far fetched to ask that other agencies do better.

14. The current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

Comment: Mental health research in Australia is excellent, given that we publish more than would be expected from our population size or GDP. Funding is currently appropriate to the magnitude of the problem. However, new technologies are appearing and the imaging and genomic strategies seem likely to generate profound advances in our understanding of mental disorders. This research is expensive and greater funds will be required.

15. The adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

Comment: We now collect outcome data from private and public hospitals. It is not used to improve patient care or to identify good or poor facilities. We should use it for both purposes. We do not collect routine outcome data from ambulatory care that is used either to guide clinical practice or to evaluate the services. We should. New York City primary care services use routine measurement of depression levels in all patients to ensure that depression is properly treated, just as they use routine blood pressure measurement to ensure that hypertension is well treated. This is a management issue but as the system is presently organized the relation between private practitioners and the government precludes such a mandate.

16. The potential for new modes of delivery of mental health care, including e-technology.

Comment: We have some experience of the new modes of delivery. We publish the most widely distributed book on the 'Management of Mental Disorders' in Australia's history, (There are also editions in New Zealand, Canada, United Kingdom, Italy, China and soon in Russia). We publish a book on "Acute Psychiatric Inpatient Care", the most widely distributed book on running an inpatient unit. We have CLIMATE, an internet based, physician prescribed, patient education system that provides eight modules for the treatment of people with anxiety and depressive disorders. We have modules in development for the prevention of alcoholism and for the reduction of stress. Likewise we have modules in development for use in the Health and Personal Development part of the high school curriculum that are being field tested. Certainly new technologies will be helpful. Our successful websites www.crufad.org and www.climate.tv get more than 250,000 hits per month. We are abreast the new modes of delivery of beneficial information.

CODA:

Responding to the terms of reference means responding to what others think is important. But how does one **prioritize** the responses. My top five responses, in no particular order, were:

- Need for **increased funding** to provide coverage that is consistent with the coverage provided to people with comparable physical disorders (Expansion needs to be carefully managed; funding that increases at more than 5% per annum is bad policy, it runs the risk of having to employ poorly trained people with a consequent reduction in quality of service);
- Need for **integration**, for a system to allow all elements of the system to work together to reduce the burden of mental disorders (our current system of eight state and territory governments, the private hospitals, private psychiatrists, GPs, psychologists, and the NGOs cannot be governed),
- Need for more **step down accommodation** to reduce the present crisis (this is important but is largely in the hands of the States and Territories),
- Need for routine **outcome monitoring** of patient care and routine outcome monitoring of practice/facility performance. This would improve patient care (doctors are good at responding to numbers (Your blood pressure is over 150, we'll have to do something about that, your depression score is above 6, we'll have to do something about that).
- Need for **free self help** management provided by book or by internet for the common mental disorders. This would be considerably more cost effective than just seeing the doctor. Evidence shows that it should be combined with seeing the GP, when it would be cost effectiveness.

But the question remains, what are the most important priorities:

- Most reduction in the burden of mental disorders **- increase funding to improve coverage of care.**
- Most easily achievable (and most cost effective) change – **free self help materials supervised by GPs.**
- Most urgent change – **increase the step down accommodation for people with schizophrenia.**

Thank you for the invitation to respond.

Gavin Andrews