# Submission to Senate Select Committee on Mental Health: Improving and Disseminating Mental Health Research

## Person Making Submission

Professor Anthony Jorm
ORYGEN Research Centre, University of Melbourne, Locked Bag 10, Parkville, Victoria 3052, Phone 0401449672.

## Summary of Main Points

- Research on mental disorders receives much less allocation of National Health and Medical Research Council (NHMRC) funding (8.9%) than should be the case given their contribution to national burden of disease (19.1%). Mental health research clearly requires additional funding.
- There is too little consumer input into setting research priorities and in the conduct of research.
- An effective way to increase research, while ensuring it is practical and consumer-relevant, would be to channel any additional public funding through the Australian Rotary Health Research Fund on a dollar-for-dollar matching basis.
- Dissemination of research knowledge needs to be directly to the public as well to health professionals. The gap in evidence-based practice in Australia is not simply due to clinicians not adopting best practice, but also to a lack of public knowledge about mental health. This lack of knowledge has adverse effects on help-seeking and adherence to evidence-based treatments.
- We know very little about whether mental health in the Australian population is improving or worsening. The only regularly collected indicator of population mental health we currently have is the suicide rate. The Australian Bureau of Statistics needs to collect regular data in a consistent manner on various aspects of mental health. This would allow evaluation of current efforts to improve population mental health and the targeting of resources to help sub-groups that are doing poorly.

## Relevance of the Submission to the Committee's Terms of Reference

This submission is relevant to the following terms of reference:
n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated.
o. 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.

## Current State of Mental Health Research and Adequacy of Funding

I was part of a research team that was commissioned by the Australian Department of Health and Ageing to examine research priorities in mental health for Australia (Griffiths et al., 2002; Jorm et al., 2002a, 2002b). We compared the current distribution of research activities (measured by funding allocated and publications produced) against various standards for what should be done. The standards we used were: disease burden (measured by "disability-adjusted life years"), disease costs, and the priority ratings of various stakeholders (researchers, clinicians, policy makers, consumers and carers). Copies of reports on this work are attached. Some of the findings of relevance to the Committee are:

- Mental disorders in Australia contribute 19.1% of disease burden and 9.8% of health system costs, but receive only 8.9% of National Health and Medical Research Council (NHMRC) funding.[1] NHMRC was by far the biggest funder of mental health research (75.2%), followed by the Australian Research Council (11.9%). All other sources put together made up only 12.9%. It thus appears that the allocation of resources to mental health research is consistent with the allocation of health expenditure (which many would argue is poor), but very low compared to the burden of disease. This low allocation is largely driven by NHMRC funding, since this is the dominant funding agency.
- A striking finding was that the stakeholder groups which have the most influence in determining what sort of research gets funded (viz. members of research funding committees) sometimes have different views about priorities from the groups that are supposed to ultimately benefit from the research (viz. consumers and carers). While all stakeholder groups agree that we should fund research that has “the potential for research to make a difference to people’s lives”, the research funding committee members placed more emphasis on “the potential for research to advance scientific knowledge”, while the consumer and carer advocates placed more emphasis on “the involvement of mental health consumers in planning the research”. This finding indicates that there is room for greater engagement of consumers in the research process.

The question is then, what is the best way to increase the research funding to mental health and to better meet the priorities of all stakeholders? Having served on many NHMRC committees and panels, I do not believe that NHMRC is the best organization to work through to achieve these goals. It is a large and complex organization which works under many constraints. Change in its operations is not simple to achieve and the needs of specific areas of research are easily swamped. I have also served as a member of the scientific committee of the Australian Rotary Health Research Fund (ARHRF). This is a small organization disbursing philanthropic funds which is flexible in its operations. The sort of research it funds tends to be on community-based interventions to improve mental health and gives shorter-term benefits to the community. The ARHRF has also been very responsive to accommodating the perspectives of consumers in its evaluation of grants. Currently, the ARHRF gives most of its money to mental health research. If there was any increase in government funding available for mental health research, I believe this would achieve more if channeled through the ARHRF on a dollar-for-dollar matching basis. The advantages are that it would lever more philanthropic money into research, it would ensure the research has a practical focus, it would allow greater consumer input into the grant evaluation process, and the administrative overheads would be low.

## The Need for Public Dissemination of Research Knowledge

It is known that many Australians with mental disorders either receive no treatment or delay getting treatment until the disorder is severe. Of those who do receive treatment, this is often not the sort of treatment supported by the scientific evidence as most appropriate. There are many factors contributing to this situation, but one of them is lack of public knowledge about mental disorders and their treatments. It is recognized that clinicians need to be informed about evidence-based treatments, but this approach is not sufficient in itself. We have data from national surveys of the Australian public, and parallel surveys of mental health clinicians, showing that there is often a big gap between what the public believe and what experts believe (Jorm et al., 1997). This gap in belief about treatments is a major barrier to more appropriate help-seeking and to the adoption of evidence-based treatments. For this reason, dissemination of some key aspects of best practice needs to directed at the whole community. Examples would be the availability of evidence-based self-help methods, such as books or web-sites based on cognitive-behaviour therapy, the value of physical exercise for depression and anxiety, as well as which types of professional treatment are most likely to be helpful.

Fortunately, public knowledge about mental disorders ("mental health literacy") can be improved. We have evidence of some major positive changes in Australia in recent years (Jorm et al., in press), to which "beyondblue" has been one contributing influence (Jorm et al., 2005). The improvements have been strongest for depression, where public education efforts have been concentrated.

This approach now needs to be extended to improve the public's knowledge of other mental disorders, in particular about evidence-based treatments. An example of this sort of work is the TIPS program in Norway which showed that increased knowledge of mental disorders in the population could reduce delays in getting professional help by young people who are developing severe mental disorders. This program has been replicated in Melbourne and Geelong (under the label "The Compass Strategy") and deserves a wider dissemination throughout Australia.

## The Need for Population Monitoring of Mental Health

It is amazing that we know so little about whether mental health in Australia is improving, worsening or stable. The only routinely collected indicator of population mental health is the suicide rate. While this is a valuable indicator that has served to focus attention on some major problems, such as the loss of life in young men, it is imperfect. Suicide reflects several factors besides mental health. For example, men are more likely to suicide than women, but women are more likely to suffer from depression. We need to have other population indicators which will monitor how we are doing as a nation and allow resources to be focussed on sub-groups that are not doing well. I recently reported the first ever national data on changes mental health in Australia, using a measure of anxiety and depression symptoms given in 1995 and in 2003-04 (Jorm & Butterworth, in press). This measure was stable in all age and gender groups except for young men aged 20-29 years, who showed significant worsening. This finding illustrates that there could be changes occurring in certain sub-groups which require action.

Why doesn't Australia already have population monitoring? The Australian Bureau of Statistics has been collecting national data on mental health since the 1980s. However, they have changed the measure they have used several times, making comparison over time impossible. Even when a consistent measure has been used, other aspects of the methodology have been changed. There is a need for consistent measures collected at regular intervals using the same methodology.

There is value in population monitoring not only for policy makers, but also to inform the public and to bring attention to mental health as a national issue. In other areas of health, routine statistics have performed an important function in this regard, e.g. the road toll, heroin deaths. Some colleagues and I have proposed a National Depression Index which can be calculated from a simple questionnaire and which is easily understood by the public (Mackinnon et al., 2004). This index has a base rate of 100, with 110 meaning a 10% increase in the prevalence of depression over the base year and 90 meaning a 10% decrease. This is the first proposal in any country for such an index. It would be relatively cheap for the Australian Bureau of Statistics to routinely collect data to allow the calculation of this index and would place Australia in the forefront of the world in population monitoring of mental health.

### Recommendations to the Committee

1. The Australian Government should provide a boost to mental health research. A cost-effective way of achieving this would be by providing dollar-for-dollar matching funds to the Australian Rotary Health Research Fund.
2. The greater use of evidence-based treatments for mental disorders requires that research knowledge be disseminated to the public, as well as to clinicians. “beyondblue” has contributed to this dissemination for depression, but this approach needs to be extended to other mental disorders. One worthwhile model is the Compass Strategy which was aimed to decrease delays in seeking treatment by young people developing severe mental disorders.
3. The Australian Bureau of Statistics should routinely collect data on aspects of population mental health. This should be reported in ways that are easily understood by both the public and policy makers, such as the use of a National Depression Index.

**Footnotes**

1. NHMRC often quotes a higher figure. However, this is inflated by having neurosciences combined with mental health. Most of the neurosciences research included is not on mental health. We only counted research that dealt with mental or behavioural disorders as designated by the International Classification of Diseases.

### References

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