RESEARCH REPORT NO. 39

A GROUND-BREAKING REPORT ON MENTAL HEALTH IN AUSTRALIA: A GRIM PAST AND A WAY AHEAD

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INTRODUCTION

Hugh Childers has an Economics Honours degree and a Masters degree in Public Administration from The University of Queensland. He was a winner of the University's Postgraduate Public Administration Prize in 1994. He had a career of over 30 years in College and University administration and worked for almost 10 years in the 1980s-1990s in Queensland postgraduate medical education.

While he has no medical or health science qualifications, his views on mental health are shaped by his experience of coping for 25 years with the acute bi-polar disorder condition of his son Paul, who committed suicide in 2012.

In this article Hugh Childers gives a personal response to the National Mental Health Commission report *Contributing Lives, Thriving Communities - Review of Mental Health Programs and Services*, presented to the Commonwealth Government in December 2014:

> The ultimate goal of this Review was to make a set of recommendations for Government to consider, that will create a system to support the mental health and wellbeing of individuals, families and communities in ways that enables people to live contributing lives and participate as fully as possible as members of thriving communities.

This included programmes and services which have as a main objective:

> The prevention, early detection and treatment of mental illness;
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> The prevention of suicide;
> Mental health research, workforce development and training; and/or
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> The reduction of the burden of disease caused by mental illness.

The Review provides 25 recommendations across nine strategic directions which guide a detailed implementation framework of activity over the next decade. Taken together, they form a strong, achievable and practical plan to reform Australia's mental health system.[1]

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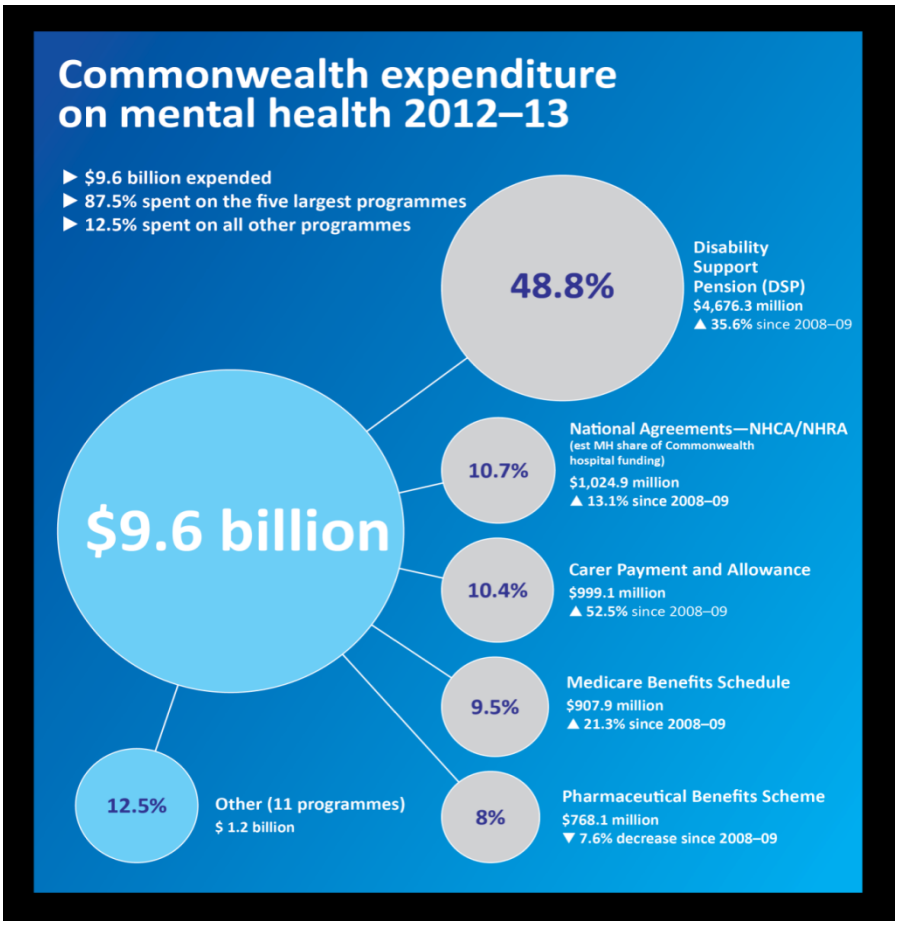
[1] Australian Government National Mental Health Commission, *Contributing Lives, Thriving Communities - Review of Mental Health Programs and Services*, 1 December 2014. The various volumes of the report, and other related links (including Fact Sheets) can be found at: http://www.mentalhealthcommission.gov.au

1. '*Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services*'

Contributing Lives, Thriving Communities is probably the most systematic and far-reaching report on mental health funding, issues and outlook ever undertaken in Australia. It is of crucial importance but its solutions are contested and its scope is likely to be limited by certain 'stakeholders' and State Health department interests.

Cost efficiency of current programs

The first major finding questions the efficiency and effectiveness of all Commonwealth programs on mental health as well as overall spending patterns relating to the 3.6 million Australians who need mental health support annually. The cost is staggering. In 2012-2013, it amounted to almost $10 billion annually. The real issue in Australia is that we have 3.6 million people who experience mental health problems, who generate 15% of all health costs but mental health is allocated only 5% of the health budget overall.



The relationship between personal circumstances and mental health

The second set of data (after costs) relate to the interaction between mental health and personal characteristics ie. genetic predispositon, age, culture and family environment, sexual orientation and gender. These influences include life circumstances such as employment, housing, health and chronic physical illness, substance abuse, and instances of trauma and abuse. The report addresses the overall environment which is shaped by mental health and its impact on personal and life circumstances. The interaction of these factors determines the way mental illnesses progress.

Stark and challenging statistics

The report contains some extremely stark and challenging statistics:

- nearly half the adult population will experience mental illness at some point in their lives;

- 7.2 million adults between the ages of 16 and 85 will be affected, but fewer than half will access treatment;

- 600,000 children have a mental health issue of some sort each year.

The recommendations are complex but describe a system in crisis. The review found that the patchwork of services, programs and systems supporting mental health are not maximising health outcomes for individuals from either a social or economic perspective.[2] Overall the system is inefficient and not cost effective. There is duplication of some services, significant gaps in others for at-risk populations, and inconsistent levels of support.

This was especially the case for indigenous communities. Indigenous people have significantly higher rates of mental distress, trauma, suicide and intentional self-harm, as well as higher exposure to mental health risks such as stressful life events, family breakdown, discrimination, imprisonment, crime victimisation and alcohol and substance misuse;

Individuals are treated in isolation through poorly designed and mismanaged programs that are overwhelmed by red tape.

The Report concludes that there is a clear case for structural and policy reform and a person-centred approach to redesign and redirect and re-balance the whole system of mental health delivery. Funding could be better spent on early intervention, supporting community mental heath rather than on acute care hospital funding.

[2] There was limited information which would allow a review of such services and programs but the Commission did not recommend defunding any of them.

2. The evolution of public mental health services over 150 years

Mental health 'care' evolved from religious foundations or asylums like the Bethlem Royal Hospital in London (Bedlam, a place of hellish noise, chaos and confusion). This 'Bedlam' phase lasted from the 1600s to around 1900.[3]

In the Victorian era, large hospitals/prisons were established in which mental health patients were incarcerated following the passage of the Lunacy Act of 1845. This form of institutionalised care lasted right through to the 1970s in Australia. Patients were sometimes confined for decades, mistreated, wrongly diagnosed, and held against their will with their cases often not being adequately reviewed. Typical of such places was Goodna at Wolston Park where many abuses occurred and were never reported; all this was justified as 'reasonable force used to protect the patient'.

Appalling abuses were commonplace including treatments such as the frontal lobe lobotomy operation[4] and Electric Shock Therapy (ECT). The patient's consent was not required. Lobotomies continued from the mid-1930s into the 1960s and were then finally abandoned when new strong mind-altering drugs were developed and came into use from the mid-60s. The last lobotomy was performed in the USA in the late 1970s.

By the end of the 1960s, the move to de-institutionalise mental health gathered strength in Britain, the United States and Australia. De-institutionalisation introduced new problems, such as significant increases in the number of homeless people who were ill-equipped to look after themselves and become engaged in everyday life, or manage the medication that could help them, medication that was becoming available through pharmaceutical advances.

3. Massive increase in the use of pharmaceutical mental health treatments - the role of 'Big Pharma'

While institutional care declined, pharmaceutical remedies increased. Community care languished and follow-up was minimal. This is essentially the situation today. Community care is insufficient and delivered in a mish-mash of poorly co-ordinated ways, as the Mental Health Report clearly shows. We have a more humane system, but one which has major systemic flaws which allow many vulnerable people to fall through the cracks.

'Big Pharma', is a collective term that has been used to describe the world's biggest pharmaceutical companies. The large pharmaceutical companies obviously have to make profits, and these profits are generated by providing pharmaceutical remedies covering the

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[3] Read J. In *Models of Madness* 2nd ed. Routledge 2013.pp.9-19

[4] A lobotomy involved cutting or scraping away most of the connections to and from the prefrontal cortex of the brain. The procedure, controversial from its inception, was a mainstream procedure in some Western countries for more than two decades (prescribed for psychiatric and occasionally other conditions) despite general recognition of frequent and serious side effects.

whole spectrum of human illnesses.[5] Leaving aside conspiracy theories [6], what is the role of these large pharmaceutical companies in providing medications for psychiatric use?

First and foremost, anti-psychotic and mood stabilising drugs have brought about a far greater level of humane and effective care for mental health patients, ending the dreadful straight-jacket or fire hose treatments of the past.

However, there is concern that testing regimes are becoming compromised in the rush to get products onto the market. The Reagan administration de-funded virtually all US government-run testing laboratories in the 1980s and made the US Food and Drug Administration adopt a 'user pays' approach to drug development. So medical teams are, in effect, paid by their 'employer' to get results. This compromises what should be an 'arms-length' process.

Some people have suggested that this involves 'borderline' corrupt practices and poor outcomes in the development of dangerous and powerful mind-altering drugs. US specialist Peter Breggin has highlighted some of these on his website, and they include an adverse finding on how the industry deals with dangerous side effects. Or as Billy Connolly put it, a short time ago, ' the side effects are the effects'.[7]

It is illegal in Australia to market pharmaceutical drugs directly. Yet the influence of Big Pharma grows significantly through three marketing techniques to distort the mental health agenda. Mosher Gordon and Beder, looking mainly at the US institutional settings, identify these as:

1. Co-ordinated campaigns to fund consumer advocate groups pushing the agenda for particular drugs;
2. Media campaigns and planted stories to gain public acceptance of their value; and
3. Insider access to government through industry lobbying and strategic direct donations to political parties and individuals who can advance their cause.[8]

They conclude that the power of Big Pharma can only be curbed by assertive governmental regulatory intervention and by legal action against the industry where failure to disclose adverse drug effects and overuse/misuse leads to real harm.[9]

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[5] These profits have been estimated at well over $100 billion annually worldwide. Total sales of pharmaceuticals are likely to hit $1 trillion by 2020.

[6] For an article explaining 'Big Pharma' see: http://www.nybooks.com/articles/archives/2004/jul/15/the-truth-about-the-drug-companies/. See also Goldacre B, *Bad Pharma*, Fourth Estate, 2012.

[7] See, for example, Bergen P, *Medication Madness*, *The Role of Psychiatric Drugs in Cases of Violence, Suicide and Murder*, St. Martin's Press 2008, http://www.breggin.com/index.php?option=com_content&task=view&id=5. See also comedian Billy Connolly's rationale for ceasing medication for his Parkinson's Disease, http://www.dailymail.co.uk/news/article-2576338/Billy-Connolly-stops-taking-Parkinsons-drugs-doctors-warn-damaging-effects-medication.htm

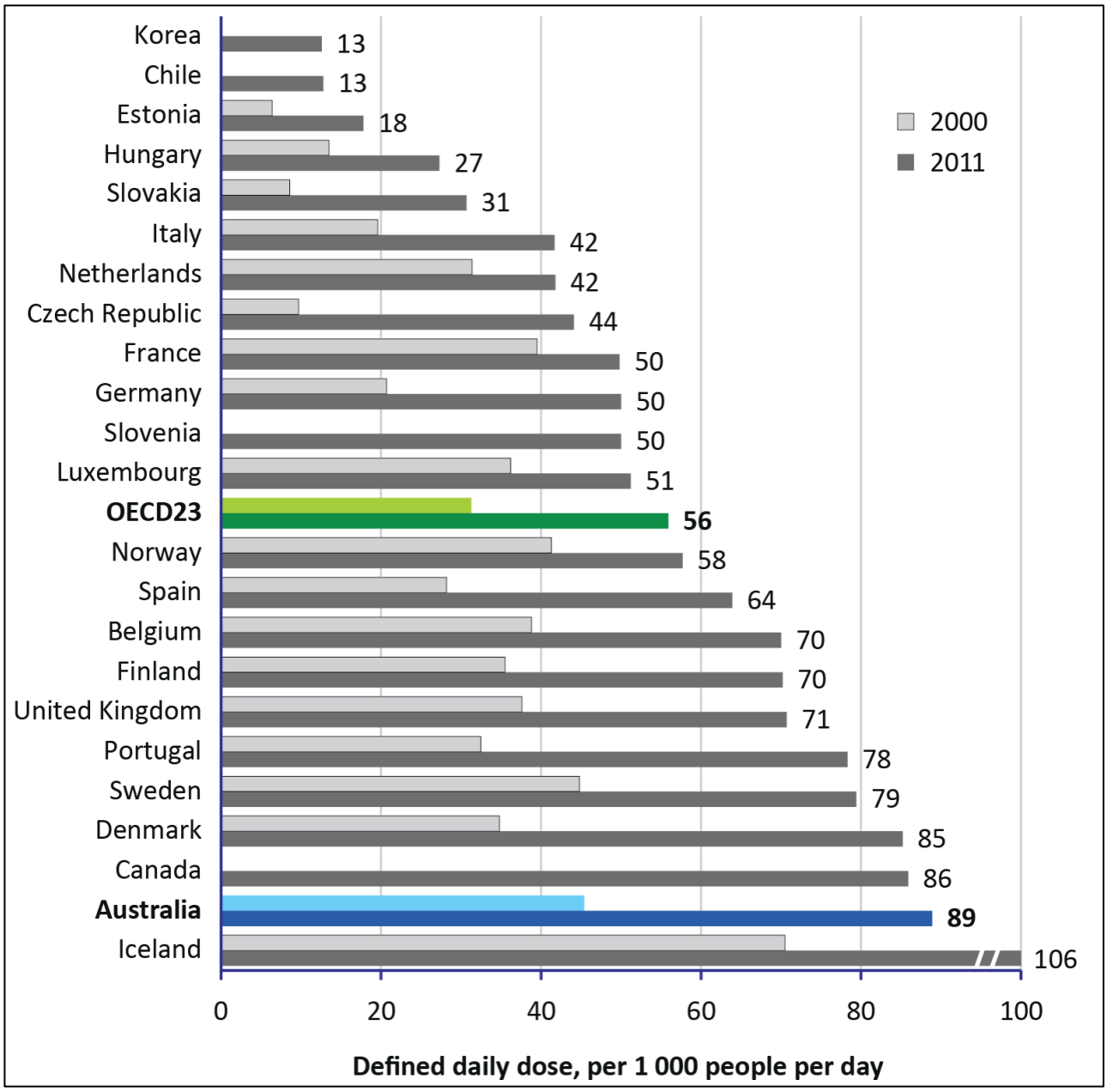
[8] *Models of Madness*. p.133

[9] Mosher Gordon and Beder. P134.

Lack of funding for Australian drugs testing

The Australian Therapeutic Goods Administration has no budget to do such research and has to rely on overseas mainly US testing.

The use of anti-depressants by Australians is staggering as shown by the chart which shows our annual consumption is higher than any other nation except Iceland.[10]



Do these medications do more harm than good?

To what extent is the problem being worsened? How can the pharmaceutical companies demonstrate that they takes individual differences into account when there is no coherent theory of brain biochemistry in existence?

[10] There is no comparable US data in this chart but other studies suggest a 400% increase in anti-depressant prescribing in the 5 years until 2008.

Pharmaceuticals are just tinkering around the edges. Without stronger evidence, how do we know that they are actually doing good? The 'positive' effects on, say, hallucinations and delusional behaviour could just be that the brain is even more confused by the medication and these other effects are no longer so prevalent?

The 'real life' conditions of testing regimes are widely questioned by a number of commentators. [11] However there is also evidence to contradict that position, in that many patients do benefit from drug treatments unavailable as recently as 10-20 years ago.

[11] Kirsch R. *The Emperor's New Drugs*. Basic Books 2010; Breggin. PR. T*alking Back to Ritalin,* Da Capo Press 2001..

4. The training of psychiatrists in Australia

The various Mental Health Acts in the past and the new Draft Mental Health Bill of 2015 do not attempt to define a mental illness. That is the responsibility of properly trained and registered psychiatrists, specialists who must have completed, or are completing, the examinations for membership of the Royal Australian and New Zealand College of Psychiatry (RANZGP) which has more than 5,000 members. Outside observers have expressed concerns about the extent of the College's control.

The role of the Royal College of Psychiatry

Psychiatrists are now accredited by the Royal College of Psychiatry. The College appears to view medication is the key to everything and to place lesser importance on other treatments. It has played down the importance of taking a detailed patient history and even the need to connect with patients by getting to know them as individuals.

The College dominates all levels of postgraduate training. Universities have dropped all their accredited psychiatry programs, leaving the College to run its own. There have been criticisms of the College's approach. In particular, the use of the Gold Standard schema for diagnosing patients, the *Diagnostic and Statistical Manual* (DSM), which is prepared and updated at intervals by the American Psychiatric Association.

The DSM is fully supported by the College. It sets down what it claims to be a detailed list of every mental health condition ever encountered, its symptoms, its short and long term effects, and a 'tick box' list which assists doctors to identify the condition. There is no agreed scientific foundation. Joseph describes psychiatry's uncritical acceptance of unscientific conclusions particularly relating to evidence of genetic influences on mental illness. [12] Further he identifies the process as being one which relates much more to psychiatry's interest in maintaining itself as a viable profession.

Diagnostic and Statistical Manual - a blunt tool

Since its introduction in 1952, the DSM has become a bible for Medicare, Centrelink, private health insurers, the courts and governments since it was introduced. Like all bibles, it has a mix of fact, conjecture, folk lore, prejudice and actual misinformation which must be accepted because there is no proven science behind the DSM process. Many psychiatrists across the world have vigorously attacked the DSM but we have great need for certainty as a species and so the DSM lives on. It has now reached its fifth iteration.

The College cannot compel every psychiatrist to stay as a member. A number have resigned in protest. My particular concern is with the lack of transparency of the College and their conduct as a powerful professional organization. It would be all too easy to become too close to the large pharmaceutical companies with their vested interest in pharmaceutical remedies. All the Royal Colleges in the medical profession have significant market power which is effectively beyond the political process.

Psychiatrists can be seen as a group just tinkering around the edges in the absence of any coherent theory of the biochemistry of the human brain. The DSM helps to foster a lazy and unreflective outlook where labels can be applied, and then pharmaceuticals

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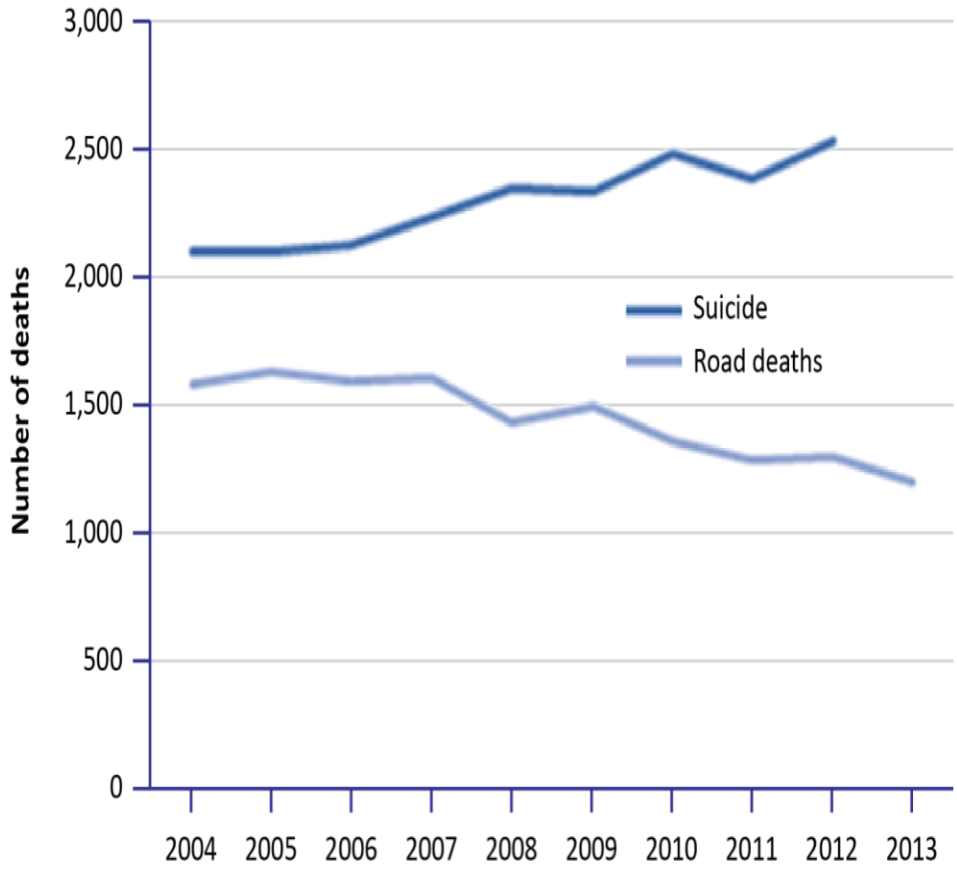
[12] Joseph J. In *Models of Madness*. P.85.

prescribed, rather than examining the case history of each individual patient in any degree of detail.

5. The unique human tragedy of suicide



A COMPARISON OF SUICIDE AND ROAD DEATH DATA IN AUSTRALIA

2004-2013

The facts are stark

Each year an estimated 65 000 Australians attempt to take their own life. We know that suicide attempts are a large cause of health-related disability as well as being one of the main predictors of subsequent attempts and of later suicide deaths.

Suicide rates are increasing, men more than women, and young people particularly noticeably. Around seven people a day kill themselves (2,535 in Australia, 400 in Queensland, 155 in Brisbane based on 2014 figures). This is an annual rate higher in total than the road toll, higher than forms of skin cancer.

Suicide rates in Indigenous communities

Suicide is reckoned to be almost at an all-time high in this country. Youth suicide is particularly worrying and in Indigenous communities it is catastrophic. On the basis of Australian Bureau of Statistics figures, Indigenous children accounted for half the suicides of all children between 10 and 17 in Queensland up until 2012. Across Australia, young Indigenous men and women up to 24 years old are 5.2 times more likely to die by self harm than other young people in the same range.[13] Suicide rates are particularly high among Aboriginal and Torres Strait Islander people generally. Nationally there were 21.4

[13] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3303.0main+features100052013.

suicides per 100 000 Aboriginal and Torres Strait Islander people, more than double the rate of 10.3 for other Australians. Aboriginal and Torres Strait Islander people report stressful events at 1.4 times the rate of non-Indigenous people.[14]

Need for secure environments

Despite widespread community concern, the causes of suicide cannot simply be 'cured' by a doctor's care or the right medication. Hospitals may not be the best place for highly suicidal people but the dilemma is, until patients are stabilised, that they must be kept in a secure environment and prevented from absconding. But many psychiatric patients are not acutely ill. They have a very complex, enduring disability and a combination of problems. They may possibly become suicidal but this is extremely difficult to predict.

Need for follow-up and support at times of high risk

People who attempt suicide are not receiving sufficient support and follow-up to help prevent further attempts. This is a missed opportunity to reduce suicide rates. The risk is particularly high in the period following discharge from hospital or an emergency department after a suicide attempt. Hospital follow-up has been found to be very poor indeed. People are still being turned away or discharged into situations in which they receive no support, even though they have an expressed a known suicidal intent and are at the highest level of risk. There is no consistent and agreed data collection mechanism for suicide attempts and very little direct support received prior to, or following a suicide attempt.[15]

Overseas models of suicide prevention which rely on a multi-component, whole-of community approach have been shown to produce real reductions in suicidal thinking, attempts and deaths. The current Australian system is failing suicidal patients as the report shows. The system is not working: not enough people; not enough caseworkers' not enough psychiatrists and psychologists; not enough co-ordination among agencies and community organisations.

The key thing to recognise is that no single approach will work. Many suicides are people who have had no contact with the health system for their condition and are not on strong medication.

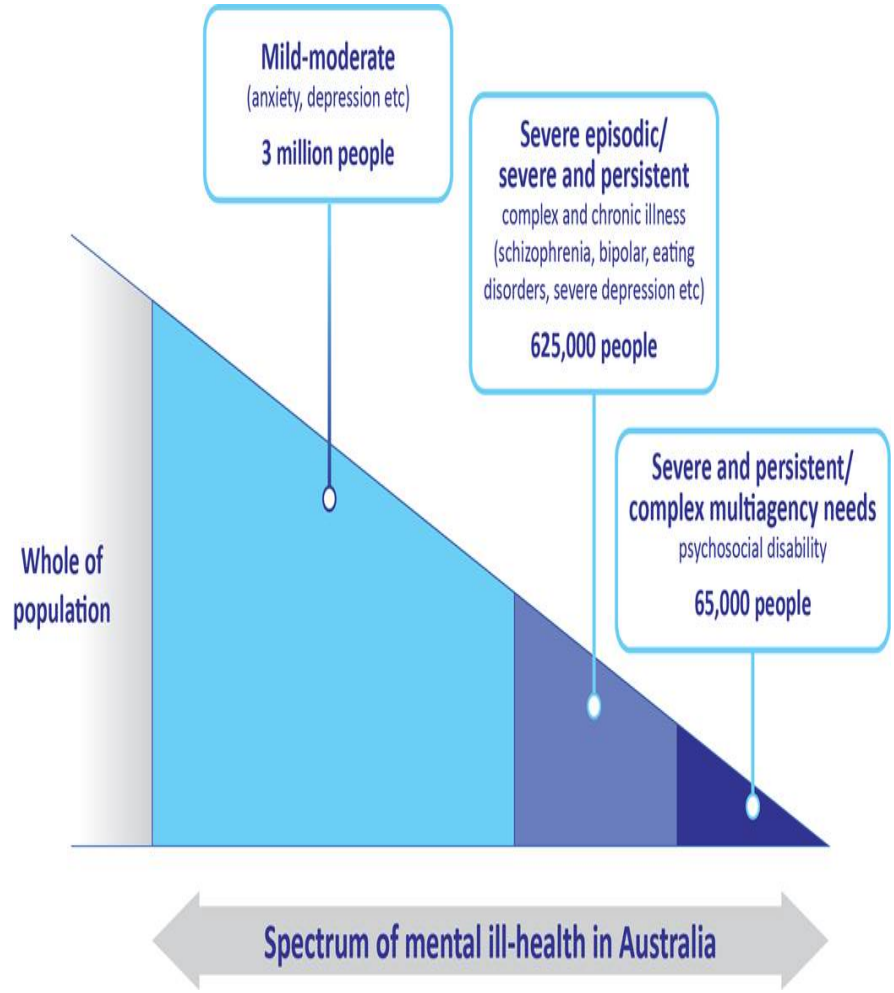
[14] Matt Wordsworth in an ABC News report Youth Suicide at crisis levels in Indigenous Population ABC News Website 14 June 2015

[15] Sophie Scott, *ABC News,* 'Nearly half of all patients receive no follow-up mental health treatment. ABC News website 9 August 2015.

Health Commission recommendation for national framework

The Mental Health Commission proposes the urgent development of a national framework to connect what works, to build momentum, encourage creativity, and collectively guide investment in activities to make the greatest possible impact on suicide in Australia.

The aim of the new Mental Health Commission report is to reduce suicide by 50% over the next decade.



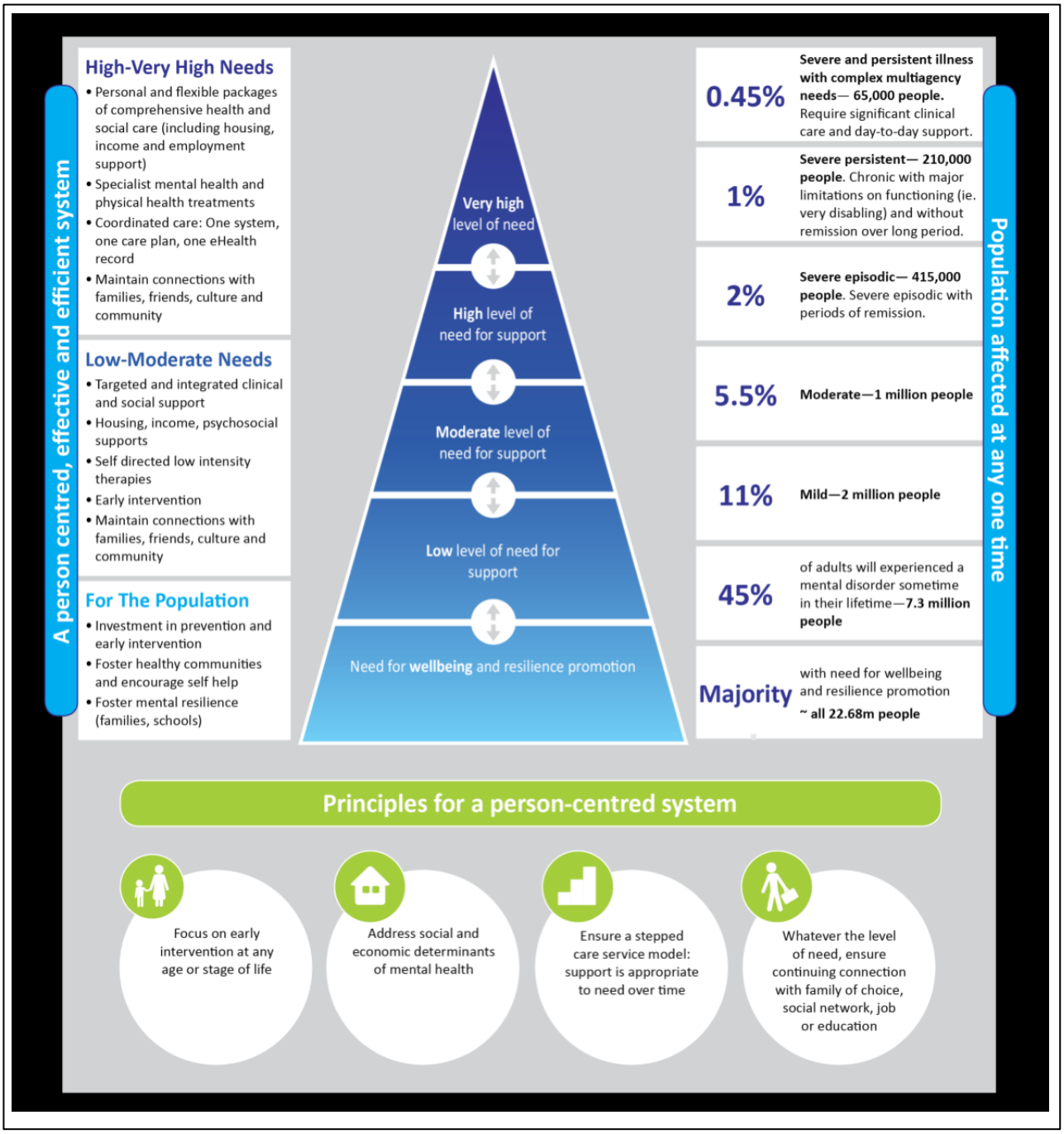
6. Are things getting worse in mental health?

We have an entirely 'crisis-driven' mental health system that cannot cope with a range of social ills which just about sum up our modern way of life. So 'yes' I believe things are getting worse. The cost to the economy itself is enormous, calculated by economist Nicholas Gruen at a staggering $190 billion or around 12% of GDP. The NMHC figure is less $28.6 billion but this doesn't rely on an estimation of lost productivity.[16]

Dangerous substance abuse is increasing: in alcohol abuse - a known depressant; in stronger marihuana - (hydroponic cannabis is 10 times stronger than the older kind (increased risk of schizophrenia); in amphetamine-based drugs - like Ice.

The chart below, from the Mental Health Commission's report, demonstrates the extent of the problem as it is at present.

[16] Gruen's work is cited by Mendoza J. Mental Illness Hurts Our Economy.The Conversation 10 October 2014


A person centred, effective and efficient system
High-Very High Needs
• Personal and flexible packages of comprehensive health and social care (including housing, income and employment support)
• Specialist mental health and physical health treatments
• Coordinated care: One system, one care plan, one eHealth record
• Maintain connections with families, friends, culture and community
Low-Moderate Needs
• Targeted and integrated clinical and social support
• Housing, income, psychosocial supports
• Self directed low intensity therapies
• Early intervention
• Maintain connections with families, friends, culture and community
For The Population
• Investment in prevention and early intervention
• Foster healthy communities and encourage self help
• Foster mental resilience (families, schools)
Very high level of need
High level of need for support
Moderate level of need for support
Low level of need for support
Need for wellbeing and resilience promotion
0.45%
Severe and persistent illness with complex multiagency needs— 65,000 people. Require significant clinical care and day-to-day support.
1%
Severe persistent— 210,000 people. Chronic with major limitations on functioning (ie. very disabling) and without remission over long period.
2%
Severe episodic— 415,000 people. Severe episodic with periods of remission.
5.5%
Moderate—1 million people
11%
Mild—2 million people
45%
of adults will experienced a mental disorder sometime in their lifetime—7.3 million people
Majority
with need for wellbeing and resilience promotion
~ all 22.68m people
Population affected at any one time
Principles for a person-centred system
Focus on early intervention at any age or stage of life
Address social and economic determinants of mental health
Ensure a stepped care service model: support is appropriate to need over time
Whatever the level of need, ensure continuing connection with family of choice, social network, job or education

A recent study by Princeton University health economists cited by Paul Krugman[17], appears to show an alarming trend of increasing suicides and drug and alcohol related deaths among lower income less educated 45-54 year old Americans. This rend has been compared in profile to the spike in AIDS-related mortality from the 1980s . Krugman speculates it might be causally linked to the transformation of the US economy which has led to rapid structural change impacting employment opportunities for low skilled workers.

Even more significantly, the data currently seems to be unique to the USA compared with OECD countries identified by the Princeton researchers and cited by Krugman in his commentary. We might well ask whether these effects will manifest themselves in Australia.

[17] Paul Krugman. Heartland of Darkness blog in the *New York Times,* 4 November 2015. http://krugman.blogs.nytimes.com/2015/11/04/heartland-of-darkness/