Submission to the Productivity Commission Enquiry into Mental Health

Anthony Jorm, Emeritus Professor, University of Melbourne

Summary

- Australia has tried to improve population mental health by getting more people into treatment (reducing the 'treatment gap'). However, despite large increases in provision of treatment in Australia, the mental health of the population has not improved. To improve population mental health, we may need to pay more attention to the quality of treatment (the 'quality gap') and to give greater resources to prevention (the 'prevention gap').
- Reducing the quality gap requires action at two levels: (1) Greater public education of consumers so that they know the level and quality of treatment they need to be receiving, and (2) Constraints on Australia's largely fee-for-service private practice system which currently gives a lot of autonomy to practitioners about what they do, where they practice and what groups they target in their work. Funding needs to be targeted to ensure quality of services and dissemination to people in greatest need.
- The prevalence of mental disorders is unlikely to reduce without greater attention to prevention, particularly interventions to reduce the major risk factors. To achieve this Australia needs to develop a National Strategy for the Prevention of Mental Disorders.
- Australia has often rolled out reforms nationally in advance of proper evaluation. Once the evaluation data are collected retrospectively, the reforms may be found not to work as well as anticipated. Australia needs to adopt a more cautious approach, with reforms rigorously evaluated experimentally on a local scale before national dissemination.

Reducing the Treatment Gap Has Not Improved Australia's Mental Health

Australia has had two National Surveys of Mental Health and Wellbeing (in 1997 and 2007), which showed that mental disorders are common and that many people affected do not get treatment. This 'treatment gap' has been found to occur in many countries, leading the World Health Organization in 2002 to call for global action on reducing the gap (Kohn et al., 2004). Modelling of the expected benefits from reducing the treatment gap indicated that it should reduce the national burden of mental disorders (Andrews et al., 2004). However, in practice, increasing the provision of treatment has not had the expected benefits. Analyses of data from a number of high-income countries, including Australia, has shown that the prevalence of mental disorders and mental health problems has not reduced despite

substantial increases in the provision of pharmacological and psychological treatments (Bastiampillai et al., 2019; Jorm et al., 2017; Mulder et al., 2017).

Figure 1 below shows Australian data on prevalence of psychological distress found in National Health Surveys between 2001 and 2017-18. It is clear that psychological distress has not reduced over this period, despite increasing use of antidepressants and large increases in Medicare services for mental disorders (Jorm, 2018, 2019). We obviously need a different approach to improving population mental health.

I have previously proposed that if we are to reduce the prevalence of mental disorders in the population, we need to pay more attention to two other gaps, which I have called the 'quality gap' and the 'prevention gap' (Jorm et al., 2017).

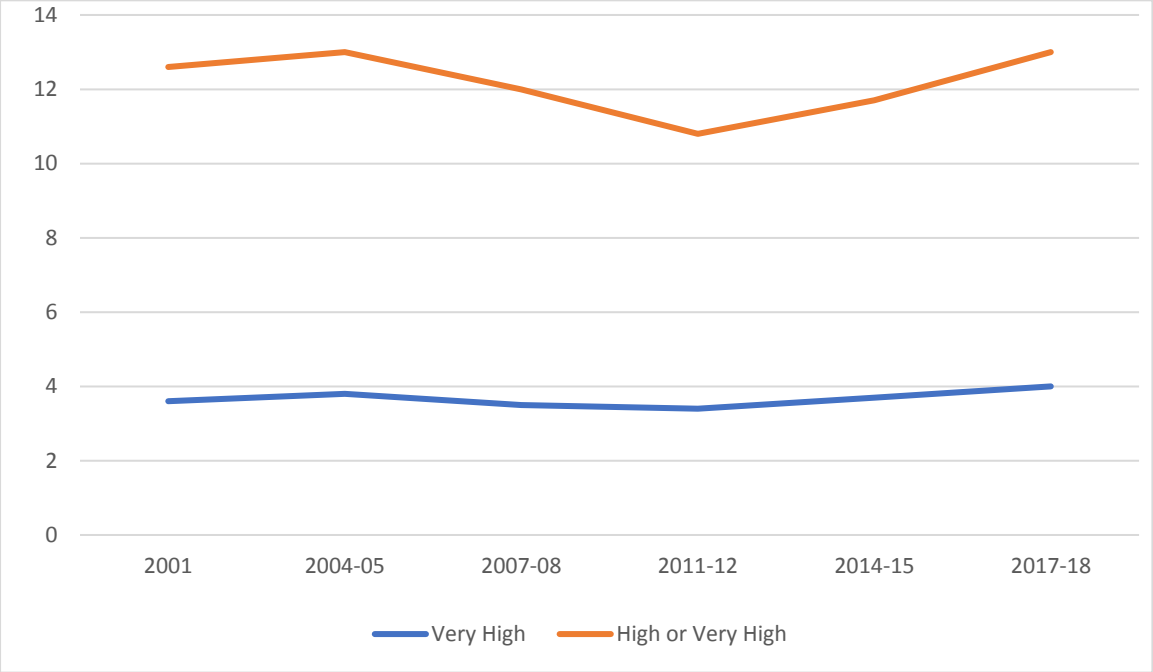

Figure 1. Prevalence (%) of psychological distress measured by the K10 questionnaire in National Health Surveys

We Need to Reduce the Quality Gap

The quality gap refers to the situation where much of the treatment that is received is not of adequate quality (Jorm, 2015). Treatments for mental disorders clearly have a net beneficial effect when evaluated under research conditions in randomized controlled trials. The modelling that was done showing the potential benefits of reducing the treatment gap assumed that similar benefits would be seen in everyday practice. However, what people with mental disorders receive in practice may fall far short of the ideal. Harris et al. (2015) have defined 'minimally adequate treatment' as involving a sufficient number of treatment

consultations and receiving evidence-based pharmacological or psychological treatment. Using their definition, Harris et al. estimated that less than half the Australian adults who are treated for mood or anxiety disorders receive minimally adequate treatment (with the others receiving even less than this minimal standard). It should be noted that this is 'minimally adequate treatment', not treatment of the quality recommended in clinical practice guidelines.

A similar situation is seen with children and adolescents. Using Australian national survey data linked to Medicare and Pharmaceutical Benefits Scheme records, Sawyer et al. (2019) found that only 11.6% of children with mental disorders had sufficient contact with professionals to meet the criteria for minimally adequate treatment, with the rest either untreated or getting less than the minimal standard.

Another aspect of the quality gap is that treatments may not be optimally targeted. For example, antidepressant medications are often used by people with milder depression, whereas clinical practice guidelines recommend psychological therapy as the first line of treatment. Furthermore, the age distribution of antidepressant use does not match the prevalence of mental disorders, with older people having the highest medication use but a comparatively low prevalence of depression (Jorm, 2015). There are also socio-economic mismatches, with socially disadvantaged areas having a higher prevalence of psychological distress but lower receipt of treatment (Meadows et al., 2015).

Recommendation

Reducing the quality gap requires action at two levels:

1. **Greater public education of consumers so that they know the level and quality of treatment they need to be receiving.**
2. **Constraints on Australia's largely fee-for-service private practice system which currently gives a lot of autonomy to practitioners about what they do, where they practice and what groups they target in their work. Funding needs to be targeted to ensure at least minimal quality of services and dissemination to groups in greatest need.**

We Need to Reduce the Prevention Gap

There are two ways to reduce the prevalence of mental disorders. One is to reduce the incidence of disorders through prevention and the other is to reduce the duration of disorders through treatment. The 'prevention gap' refers to the fact that high-income countries such as Australia have focused largely on reducing duration of mental disorders through treatment and have put relatively few resources into prevention. This is in stark contrast to the situation with chronic physical diseases, like cancer, cardiovascular disease and diabetes, where we have a better balance between treatment and prevention.

There are now a number of systematic reviews showing that prevention of mental disorders is possible and that there is an economic case for prevention (Jorm, 2014). However, much of the research on prevention is with psychosocial interventions that are amenable to randomized controlled trials. This represents only a limited set of possibilities for

prevention. What we particularly lack is research on how to reduce the big risk factors for mental disorders, which are adverse childhood experiences (Jorm & Mulder, 2018). These include physical, sexual and emotional abuse, neglect, poverty, serious physical illness, and exposure to parental mental illness, substance misuse and criminal behaviour. Such experiences are common in the population, tend to cluster in families, are risk factors across a wide range of mental disorders and their effects persist across the lifespan. Fortunately, there is some evidence for interventions that can reduce adverse childhood experiences, although many of these are outside the domain of the mental health care system. These interventions include (Jorm & Mulder, 2018):

- Strengthen economic supports to families.
- Change social norms to support parents and positive parenting.
- Provide quality care and education early in life.
- Enhance parenting skills to promote healthy child development.
- Intervene to lessen harms and prevent future risk.
- Broaden public and professional understanding of the links between adverse childhood experiences and mental disorders.
- Train clinicians to routinely enquire about childhood experiences to inform treatment and avoid re-traumatization.

For these interventions to have the desired effect, it will be necessary for them to be structurally embedded at multiple levels in society. It has been proposed that there are two forms of embedding (Ormel et al., 2019): "First, the 'socio-political form', in which local administrations and national governments embed prevention (programs/activities) in existing institutions in the domains of education, pregnancy and child care, health and social work. Second, the 'social-psychological form', in which mental health values and behaviors develop into widely accepted social norms (as is happening with smoking)." Thus, prevention of mental disorders requires action across a wide spectrum of government activity and is not confined only to the health sector.

Prevention of mental disorders does not seem to be high on government agendas. It is notable that Australia's Fifth National Mental Health and Suicide Prevention Plan has suicide prevention as a priority area, but completely neglects prevention of mental disorders. It is also notable that some years ago the Australian Government, working in collaboration with some of the states, produced a National Mental Health Service Planning Framework, in which some work was done towards the inclusion of prevention interventions, but this was never taken forward into practice (Jorm, 2014). I have argued previously that Australia needs a separate National Strategy for the Prevention of Mental Disorders (Jorm, 2014). This is needed because prevention does not get enough attention when it has to compete with more immediate clinical service needs in policy documents.

Recommendation

Australia needs to develop a National Strategy for the Prevention of Mental Disorders.

We Need Better Evaluation of Reforms Before National Rollout

Another factor in the lack of progress in reducing prevalence is that mental health reforms are often rolled out nationally in advance of a full evaluation. Proposed reforms may have a sound rationale, but this does not mean that they work in practice. When an evaluation is carried out retrospectively, the reform may be found not to have the expected benefits, but by then it is very difficult to backtrack and explore other alternatives. Two examples of this in Australia are the Medicare Better Access scheme and headspace youth mental health services.

The Better Access scheme was devised to provide greater access to GP and psychological services for people with mental disorders. The scheme has proved to be very popular with the Australian public and has cost much more than anticipated. The Australian Government commissioned an independent evaluation which found a number of benefits, but the evaluators were hampered by the inability to get a controlled comparison in a scheme that had been rolled out nationally. When population data on the prevalence of psychological distress were examined many years later, there was no detectable reduction in prevalence despite a massive increase in the use of Better Access services (Jorm, 2018, 2019). Given that the scheme is well established and very popular, it would be very difficult to redirect the resources in alternative ways that might produce greater benefit.

Headspace provides early intervention services for youth and has a sound rationale: mental disorders often have first onset during youth, they can have an adverse effect on key developmental outcomes and many young people do not get treatment. Early intervention services would seem to be a good way to reduce the potential lifelong impact of mental disorders. However, when evaluation data became available, the benefits of headspace were found to be modest. A study carried out by headspace staff found that only 36% of headspace clients had significant improvement on symptoms and 37% had significant improvement on functioning, as against 13% and 20% respectively who showed significant deterioration in these areas (Rickwood et al., 2015). It was not clear whether these effects were any more than would occur with spontaneous remission. Subsequently, an independent evaluation commissioned by the Australian Government found that compared to a matched control group receiving no treatment, the effects of headspace were "relatively weak" (Hifferty et al., 2015). One of the reasons for these weak effects may be that few headspace clients are engaged in treatment beyond the short term, with 45% receiving only 1-2 sessions, which is far below the recommendations of clinical practice guidelines for psychological therapies (Jorm, 2016). Furthermore, headspace services have not fulfilled the aim of early intervention, with services typically received many years after the onset of a mental disorder (Jorm, 2018). Despite these concerning findings, the Australian Government continues to expand headspace services, at the expense of the opportunity to explore alternative approaches to improving youth mental health.

What these examples illustrate is the need for a more cautious rollout of proposed reforms. It would have been preferable for Better Access and headspace to be trialed on a smaller regional scale with comparisons made with control regions, before a decision was made on national rollout. What we need is a more experimental approach to social and health policy.

This sort of approach has been adopted in Finland where, according to Kangas et al. (2019): "The Government also strives to promote a culture of experimentation as a part of representative democracy. The idea is that by trying out different new models for delivering social benefits and services on a small scale it is possible to obtain useful information about the way in which these new models can be implemented nationwide." An excellent example of this is the Finnish basic income experiment in which a sample of citizens who were unemployed were randomly assigned to receive either a basic income or the current unemployment benefits. While the primary purpose of this experiment was to investigate the effects on employment and income, it is also notable that several indicators of mental health and well-being were also included as secondary outcomes. The experiment has not been completed, but the preliminary results show that the basic income group had higher scores on a number of the mental health and well-being indicators (Kangas et al., 2019). This is the type of experimental approach that Australia needs to adopt if it is to get effective social and health policy.

A notable exception to the 'roll it out first, evaluate later' approach are the regional trials currently underway on suicide prevention, including the National Suicide Prevention Trial, the LifeSpan study by the Black Dog Institute and the Victorian Government place-based trials. This sort of experimental approach in a number of small localities with appropriate controls needs to be the standard for the future.

Recommendation

Australia needs to adopt a more cautious experimental approach to mental health reform, with controlled trials in local areas carried out before any national rollout.

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