

10. Supporting people living with mental illness

Key messages
<ul style="list-style-type: none"> • The scale of mental illness in our community is larger than we may think and mostly emerges in adolescence or youth.
<ul style="list-style-type: none"> • In 2003, mental disorders were the third largest contributors to the total burden of disease and injury in Australia, accounting for over 40 per cent of disability and costing our economy about \$20 billion each year.
<ul style="list-style-type: none"> • There is a wide range of mental disorders that will adversely affect up to half the population during their lifetime.
<ul style="list-style-type: none"> • It is estimated that 65 per cent of people who need mental health care go untreated. Adolescents and young adults are particularly reluctant to seek treatment or assistance for mental disorders.
<ul style="list-style-type: none"> • With appropriate diagnosis, treatment and support, most can recover and function normally.
<ul style="list-style-type: none"> • By systematically applying the current and evolving knowledge and evidence about what works, we can further significantly reduce the health, social and economic burden of mental illness.
<ul style="list-style-type: none"> • We need to shift mental health spending towards prevention and the treatment and supports required for those most vulnerable. This is imperative since a significant proportion of those suffering from mental illness still receive no treatment.
<ul style="list-style-type: none"> • Those most vulnerable are young people, as the burden of mental illness is greatest in early adulthood, and for those with a diagnosed psychotic disorder, such as schizophrenia.
<ul style="list-style-type: none"> • A range of social support services beyond clinical care is needed to help those suffering from mental illness – including employment support and assisted housing.
<ul style="list-style-type: none"> • A high proportion of those who suffer from severe forms of mental illness have a co-morbid alcohol and drug dependency, often further compounded by other chronic illnesses.
<ul style="list-style-type: none"> • Social exclusion is a significant contributing factor to, and often a consequence of, mental illness

Our reform directions

10.1 We propose that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service.

10.2 We propose that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.

10.3 We believe that every acute mental health service should have a rapid-response outreach team for those individuals experiencing psychosis.

10.4 We propose that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care.

10.5 We strongly support greater investment in mental health competency training for the primary health care workforce, both undergraduate and postgraduate, and that this training be formally included as part of accreditation processes.

10.6 We propose that each state and territory government provide those suffering from severe mental illness with stable housing that is linked to support services.

10.7 We want governments to increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

10.8 As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services.

10.9 We propose that state and territory governments recognise the compulsory treatment orders of other Australian jurisdictions.

10.10 We propose that health professionals should take all reasonable steps in the interests of patient recovery and public safety to ensure that when a person is discharged from a mental health service that:

- there is clarity as to where the person will reside; and
- someone appropriate at that location is informed.

10.11 We propose a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness.

10.12 We propose there must be more effective mechanisms for consumer and carer participation and feedback to shape programs and service delivery.

We have a vision for mental health. In keeping with our principles to invest in prevention, recognise the health needs of the whole person, improve access to services, and for access to relate to need as opposed to ability to pay, we want to better support people with mental illness. To do this, the health system needs to make much better use of the knowledge and evidence that indicates that mental health expenditures need to be reoriented around mental health need and have a greater focus on prevention.¹ Experts believe that a modest increase (30 per cent) in expenditures could treat many more (60 per cent) people and produce a very significant (90 per cent) health gain.²

More than any other clinical conditions, mental health disorders require a unique approach to care provision. Currently, there is a myriad of service providers from all sectors who provide services across the age and care location continuum. Mental health services therefore require a particular focus on integration and partnership, both for the individual and the health service team. Care also needs to be provided across a continuum, allowing the consumer to enter and exit the system easily. To achieve this, additional investment and a fundamental shift in the centre of gravity of services is required – a movement to community-based and hospital in-reach.³

10.1 Defining and scoping mental health care

Mental health is important. It enables us to fulfil our capabilities, cope with the normal stresses of life, work effectively, and participate in our communities. Mental health problems are common. Nearly half of all adult Australians will experience a mental disorder at some point in their life.⁴

Mental health problems – such as feeling down or being tense and angry – can be normal reactions to personal and social circumstances and tend not to be long lasting. However, if these problems are long lasting and/or severely affect a person's life, this might point to a mental illness, which includes a range of conditions that affect a person's thoughts, feelings, actions and mental functioning.⁵ Mental illnesses may:

- be one-off problems;
- happen on a recurring basis; or
- lead to continuing symptoms.

Mental health is a major issue. The best available data indicate that, in 2003, mental disorders (problems and illnesses) represented 13.3 per cent of the total burden of disease and injury in Australia, which was the third largest group after cancers and cardiovascular disease.⁶ Anxiety and depression, alcohol abuse, and personality disorders accounted for almost three-quarters of that burden. Dementia (3.6 per cent), suicide (1.8 per cent) and intellectual handicap, if included, would have taken the total to 20 per cent.

■ Mental health problems are common. Nearly half of all adult Australians will experience a mental disorder at some point in their life

1 Participant (25 August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

2 G Andrews and the Tolkien II Team (2007), Tolkien II: A needs-based, costed, stepped-care model for Mental Health Services, Final Report (World Health Organization, Collaborating Centre for Classification in Mental Health: Sydney).

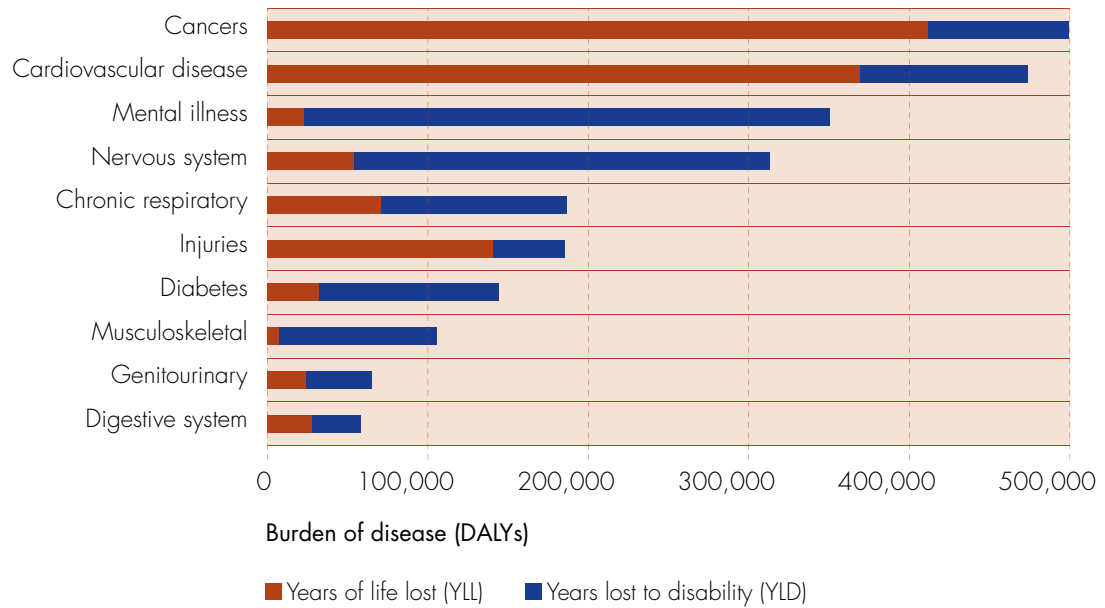
3 Price Waterhouse Coopers (2008), Mental health funding methodologies, Roundtable Discussion paper for Australian Healthcare and Hospitals Association.

4 Australian Bureau of Statistics (2008), National survey of mental health and wellbeing: summary of results (Australian Bureau of Statistics: Canberra).

5 Orygen Youth Health, 'Mental health and mental illness', Factsheet, at: <http://youth.wyndham.vic.gov.au/home>

6 S Begg, T Vos, B Barker and colleagues (2007), The burden of disease and injury in Australia 2003 (Australian Institute of Health and Welfare: Canberra).

Figure 10.1 Mental illness is one of the major contributors to burden of disease



1. Includes malignant and other neoplasms
2. Includes intentional and unintentional injuries
3. Disease Adjusted Life Years (years lost through death by disease, and years lost to disability by disease)
4. Mental health data is complex. Increased self-reporting rates may be due to greater willingness to report, rather than increased prevalence

Source: S Begg, T Vos, B Barker and colleagues (2007), *The burden of disease and injury in Australia 2003* (Australian Institute of Health and Welfare: Canberra).

Of note, mental health does not make up 13 per cent of health expenditure. Presently, it accounts for approximately seven per cent of total health expenditure (\$3.9 billion in 2005).⁷ Further, it is estimated that only about 12 per cent of this funding is allocated to supporting people with mental illness who are living in the community.⁸

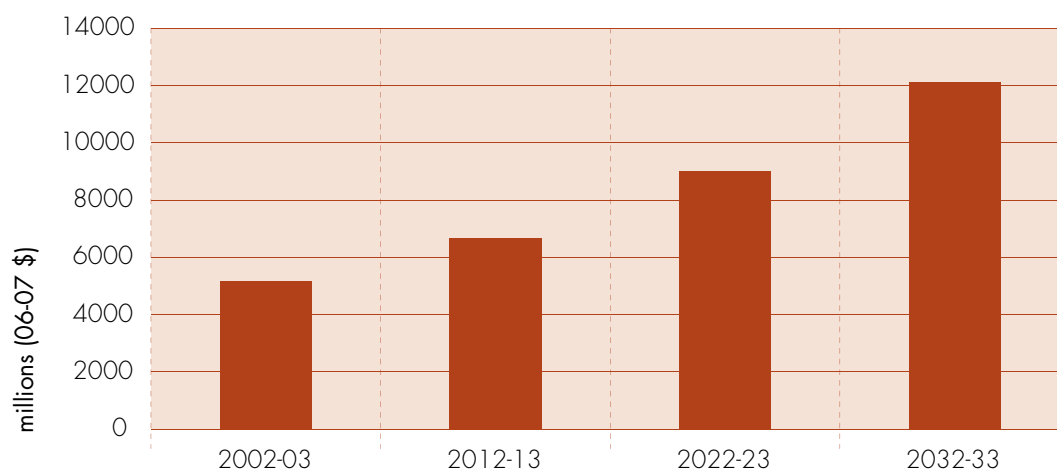
It is estimated that a majority, perhaps over two-thirds, of people with a mental disorder do not receive any treatment in any twelve month period

In 2004–05, 11 per cent of the population self-reported a current long-term mental or behavioural problem. This is a reported increase from 5.9 per cent in 1995 and 9.6 per cent in 2001.⁹ Of those people with a mental-health related disability, 45 per cent report severe core-activity limitations, 29 per cent moderate limitations, and 59 per cent work or schooling restrictions. Concerningly, it is estimated that a majority, perhaps over two-thirds, of people with a mental disorder do not receive any treatment in any twelve month period.

As Australia’s population ages over coming decades, the burden of, and expenditure on, mental health is set to increase significantly. Figure 10.2 illustrates how expenditure is projected to rise.

7 National Mental Health Report (2007) (Commonwealth of Australia).
 8 Mental Illness Fellowship of Australia (2008), Submission 317 to the National Health and Hospitals Reform Commission.
 9 Australian Institute of Health and Welfare (2007), *Mental health services in Australia 2004–05* (Australian Institute of Health and Welfare: Canberra).

Figure 10.2: Projected mental health expenditure



Source: J Goss (2008), *Projection of Australian health care expenditure by disease, 2003 to 2033*, Discussion paper commissioned by National Health and Hospitals Reform Commission.

The Australian Institute of Health and Welfare's most recent modelling indicates that, assuming current health trends and policy settings, expenditure on mental disorders alone is likely to rise by 135 per cent between 2003 and 2033. General population growth and an expected increase in the volume of services per case are the main drivers of this increase combined with a small increase in incidence and price inflation.

If the projected increase in health and residential aged care expenditure for people with dementia of 364 per cent is added into the mix, the picture looks even gloomier. Although age-standardised prevalence rates of dementia are not expected to rise, over half of the expected increase in expenditure is due to a 200 per cent increase in absolute numbers due to population growth and the ageing of the population.¹⁰ In addition, experts are concerned about the long-term mental health implications, and broader social and economic consequences, of binge drinking and the use of illicit substances by growing numbers of Australia's young people.¹¹

A variety of illnesses make up the total mental illness burden. Anxiety, depression and alcohol dependence are the most common forms of mental illness – about 18 per cent of the adult population (or 2.4 million people) experience symptoms within a 12 month period. Figure 10.3 shows the different degrees of mental illness and how it can affect people's lives.

10 J Goss (2008), *Projection of Australian health care expenditure by disease, 2003 to 2033*, Discussion paper commissioned by National Health and Hospitals Reform Commission.

11 Participants (25 August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

Figure 10.3: Mental illness affects different people in different ways

Prevalence	Key disorders	Typical example
Severe disability – approximately 3 per cent of the population	<ul style="list-style-type: none"> • psychotic disorder • bipolar disorder • severe depression • severe anxiety • severe eating disorder 	37 year old male who episodically hears voices. He also has severe depression and attempted suicide several times. He is unemployed, lives in public housing and is alienated from family and friends.
Moderate disability – approximately 4 per cent	<ul style="list-style-type: none"> • moderate depression • moderate anxiety disorder • personality disorder • substance-related disorder • eating disorder • adjustment disorder 	21 year old male with chaotic behaviour and complex problems. He is suicidal, uses drugs heavily and experiences panic attacks. Gets into fights and was arrested for assault 4 weeks ago. He can not hold onto a job and is currently unemployed.
Mild disability – approximately 12 per cent	<ul style="list-style-type: none"> • mild depressive disorder • mild anxiety disorder 	42 year old female who feels down, tearful, irritable and has withdrawn from friends over the past 4–6 months. She takes many sick days because she feels down.

Source: The Boston Consulting Group (2006), *Improving mental health outcomes in Victoria: the next wave of reform*.

A much smaller proportion of the population (0.4–0.7 per cent at any given time) is affected by severe mental illness – or psychotic disorders (see Figure 10.4). However, the numbers of people affected are still significant. Each month about 58,000 adults contact mental health services because of psychosis.¹² Other research suggests that there could be up to 200,000 Australians with psychotic illnesses using hospital-based inpatient or outpatient mental health services on a recurring basis.¹³

12 National Mental Health Report (2007) (Commonwealth of Australia).

13 I Hickie (2008), *A new model for delivering selected mental health services in Australia*, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Figure 10.4: Understanding psychosis

The word psychosis is used to describe conditions that affect the mind where there has been some loss of contact with reality. When someone becomes ill in this way it is called a psychotic episode. Psychosis is most likely to occur in young adults and is quite common. Around 3 out of every 100 young people will experience a psychotic episode – making psychosis more common than diabetes in young people. Most make a full recovery from the experience.

Psychosis can lead to changes in mood and thinking and to abnormal ideas, making it hard to understand how the person feels. Some of the more characteristic symptoms include: confused thinking; false beliefs; hallucinations; changed feelings; and changed behaviour. There is some indication that psychosis is caused by a poorly understood combination of biological factors that create vulnerability to experiencing psychotic symptoms during adolescence or early adult life. These symptoms often emerge in response to stress, drug abuse or social changes in such vulnerable individuals.

Everyone's experience of psychosis is different and attaching a specific name or label to the psychotic illness is not always useful in the early stages. Young people experiencing a psychotic episode are not always able to understand, or willing to explain, what is happening to them. Most fear they will be labelled as 'mad'.

With appropriate treatment the majority of young people who experience a psychotic illness will recover. The earlier treatment is started, the quicker and better the recovery.

Source: Orygen Youth Health, Psychosis and young people, extracts from Factsheet: Psychosis and Young People, at: http://www.orygen.org.au/docs/INFO/fact_psychosis.pdf

Finally, it is important to note that it is common for those suffering from mental illness to have more than one pressing health problem. Dual diagnosis relates to individuals who have co-occurring mental and substance use disorders where alcohol and/or illicit drugs help bring on or exacerbate mental health problems. Dual diagnosis is a growing problem amongst Australia's youth and those affected have complex needs.¹⁴ For example, the 2007 ABS Survey reports that one in three young people aged 16–24 years will also have a substance abuse issue, almost twice as likely as among the general population. Further, people with a mental illness are four times more likely to have another health problem such as cardiovascular disease, cancer or arthritis.

■ It is common for those suffering from mental illness to have more than one pressing health problem

The mental disorder burden is not evenly spread across the population. In any 12 month period, one in five Australians between the ages of 16 and 85 years experiences some form of mental illness.¹⁵ However, the burden of mental illness is greatest in late adolescence and early adulthood, which is when most new cases of chronic mental illnesses, such as psychotic disorders like schizophrenia, tend to emerge and have maximum impact.¹⁶ Just over one in four (26 per cent) young people aged 16–26 years have a mental disorder, compared to six per cent of people aged 75–85.¹⁷ It is of concern that almost 15 per cent of the younger age group (12–17 years) also experience a mental health problem in any given year.

A wide range of services beyond health services – such as social (including income) support, assisted housing and education and training services – is needed to help those suffering from severe mental disorders. These services are necessary because mental illness can be very debilitating and have profound social and economic effects beyond the pain and suffering it inflicts on individuals. Families and friends are significantly affected and are not always able to cope, and mental illness lessens an individual's likelihood of productively participating in the workforce.

14 Senate Select Committee on Mental Health (2006), A national approach to mental health – from crisis to community, first report.

15 Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics: Canberra).

16 S Begg, T Vos, B Barker and colleagues (2007), The burden of disease and injury in Australia 2003 (Australian Institute of Health and Welfare: Canberra); and P McGorry, E Killackey and A Yung (2008), 'Early intervention in psychosis: concepts, evidence and future directions', *World Psychiatry* 7 (3), 1.

17 Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics: Canberra).

For example, recent studies have shown that less than 30 per cent of Australians with a disability due to mental illness participate in the workforce. This is less than half the rate of comparable OECD countries.¹⁸

Together, these broader factors can create a vicious cycle – with mental illness leading to isolation and reduced participation in society, which, in turn, can make mental illness worse. Consistent with this cycle, mental illnesses are more common among the unemployed and in people who have been imprisoned. In addition, many mentally ill people may end up homeless.¹⁹

Fortunately, public awareness and understanding of mental health has improved a little over recent years – and increasing numbers of Australians are seeking help when they need it. Yet, as we heard as part of our consultation and submission processes, there is still substantial room for improvement:

Mental health is chronically under-funded and resources allocated to assist people to live in the community are critically low ... There is now evidence that shows [that] with best practice service models we can significantly reduce mental illnesses from becoming chronic, disabling conditions. There needs to be a paradigm shift in thinking from the focus on the biological-medical treatment to a response to needs. A change from the illness to the person.²⁰

The numbers of people with mental illness who are homeless, in prisons, living in poverty and unable to get treatment until the most acute stages of illness are testimony to the long under-resourcing of community-based mental health care and support.²¹

10.2 Building on our strengths

The promised rhetoric of new community-based services was not, and still has not, been effectively achieved

■ Much has been done in recent years to reform Australia's mental health services, which, like those in other developed countries, were historically regarded as inadequate, inappropriate or simply not available.²² Many people with mental illness were 'kept' in separate psychiatric hospitals until the 1980s when these hospitals were closed in favour of community-based alternatives. This change was widely accepted as more humane and progressive, although the promised rhetoric of new community-based services was not, and still has not, been effectively achieved. However, mental health services remained controversial and, by the early 1990s, governments felt compelled to act.

In April 1992, the Commonwealth and state and territory governments adopted the first National Mental Health Strategy, which committed governments to a five-year reform process aimed at improving the quality and range of mental health services available to the community. The strategy's aims were to:

- promote the mental health of the Australian community and, where possible, prevent the development of mental health problems;
- reduce the impact of mental health problems on individuals, families and the community; and
- assure the rights of people with mental illness.²³

The strategy was significant in that it marked the first attempt to coordinate the development of public mental health services. Two other five-year plans followed. The plans led to positive changes

18 D Trewin (2004), Year Book Australia 2003 (Australian Bureau of Statistics: Canberra).

19 Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics: Canberra).

20 Mental Illness Fellowship of Australia (2008), Submission 317 to the National Health and Hospitals Reform Commission.

21 Senate Standing Committee on Community Affairs (2008), Towards recovery: mental health services in Australia (Commonwealth of Australia).

22 Hon Nicola Roxon MP, Minister for Health and Ageing, Grace Groom Memorial Lecture, National Press Club, Canberra, 12 June 2008.

23 National Mental Health Report 2007 (Commonwealth of Australia).

in the structure and mix of mental health services. However, governments, the mental health sector, and the public remained frustrated at the limited extent and slow pace of change.²⁴

This situation led the Council of Australian Governments (COAG) to endorse a National Action Plan on Mental Health (2006–2011) in July 2006. The plan gives impetus to further mental health reform and focuses on areas that had not progressed sufficiently under the National Mental Health Strategy.²⁵ The plan includes initiatives over five years to improve services for people with mental illness and their families and carers. The initiatives are designed to:

- increase clinical and health services available in the community and establish a new team approach for psychiatrists, general practitioners, psychologists and mental health nurses;
- provide new non-clinical and respite services for people with mental illness and their families and carers;
- increase the mental health workforce; and
- provide new programs for community awareness of mental health.²⁶

The most well-known of the initiatives has been the Better Access Program initiative, which provides new Medicare rebates to improve access to clinical care within the community. This program, first introduced in 2006 and worth \$753.8 million over five years, enables improved access to mental health care provided by general practitioners, psychiatrists, clinical psychologists, psychologists and other trained social workers and occupational therapists.²⁷ It aims to improve early detection, treatment and management of low and high prevalence disorders in the community and encourage health professionals to work together.

Demand for community-based mental health services through Medicare has been very strong, with expenditure running at more than three times that which was originally expected (see Figure 10.5).²⁸ Spending on the four major Medicare Better Access items, which together make up 87 per cent of the expenditure, had already reached \$440 million over the first 20 months of the new program.

■ Demand for community-based mental health services through Medicare has been very strong

24 National Mental Health Report 2007 (Commonwealth of Australia).

25 National Mental Health Report 2007 (Commonwealth of Australia).

26 Australian Government Department of Health and Ageing, Mental Health, Council of Australian Governments National Action Plan on Mental Health (2006–2011), at: <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-coag>

27 Australian Government Department of Health and Ageing (2008), Commonwealth's component of the Council of Australian Governments National Action Plan on Mental Health (2006–2011), Progress Report.

28 Mental Health Council of Australia (2008), Council of Australian Governments Mental Health Reform – Mental Health and the new Medicare Services – 2nd Report November 2006 – August 2008 (Commonwealth of Australia).

Figure 10.5: There has been strong uptake of new mental health items under Medicare by both general practitioners and psychologists

Service	Number provided	MBS benefits paid \$m
<i>Preparation of a Mental Health Care Plan by a GP</i>	895,544	135.7
<i>GP Mental Health consultation (20 minutes +)</i>	841,094	56.3
<i>Psychological assessment and therapy for a mental disorder by a clinical psychologist lasting at least 50 minutes (up to 12 planned sessions a year)</i>	946,224	108.0
<i>Focused psychological strategies for an assessed mental disorder by a registered psychologist lasting at least 50 minutes (up to 12 planned sessions a year)</i>	1,781,859	140.5
	4,464,721	440.6

Source: Mental Health Council of Australia (2008), Council of Australian Governments Mental Health Reform – Mental Health and the new Medicare Services – 2nd Report November 2006–August 2008 (Commonwealth of Australia).

Consistent with the strong demand for the new services, the program has been described as ‘the most important and practical reform in Australian mental health care in the past 15 years’.²⁹ Researchers have also noted that the new items will help to more than double the mental health workforce.³⁰ Early evaluation suggests that good results are being achieved, particularly for women with high prevalence disorders and people on low income who have had difficulty accessing mental health care in the past. We also heard during our consultations that some believe it has failed to deliver truly multidisciplinary team care because of its narrow fee-for-service funding approach. Others felt that the maximum twelve sessions were insufficient to manage many mental disorders which require often lengthy and sustained treatment and support.

Another significant mental health initiative over recent years has been the national depression initiative – better known as beyondblue (see Figure 10.6).

29 I Hickie and P McGorry (2007), ‘Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?’, *Medical Journal of Australia* 187 (2), 101.

30 G Andrews and the Tolkien II Team (2007), *Tolkien II: A needs-based, costed, stepped-care model for Mental Health Services*, Final Report (World Health Organization, Collaborating Centre for Classification in Mental Health: Sydney).

Figure 10.6: Understanding beyondblue

beyondblue, the national depression initiative, is working successfully to raise community awareness and reduce stigma and discrimination associated with depression and related disorders in Australia. Established in 2000 by the Australian and Victorian governments, beyondblue works with all governments, professional groups, research agencies, the public and private sectors, the community and individuals to address depressive illnesses.

beyondblue's national leadership role in raising awareness of depression has contributed significantly to reducing stigma and improving recognition that the illness is a serious health problem in Australia. As noted by the Hon. Jeff Kennett, the Chair:

In 2000, when beyondblue started out, few people were willing to speak in public about depression and their experiences, media coverage was often negative, barriers in insurance and employment were considerable and there was no national voice or advocacy service for those whose lives were affected. Australian general practitioners were not rewarded directly for providing better services and no systems for improving access to non-drug treatments were available. While we still have many challenges in front of us ... we can report that major advances in all these areas have now been achieved.

Sources: beyondblue, Annual Report 2002–2003, and beyondblue, Strategic Framework for Action 2005–2010: Opening our eyes to depression across Australia.

Many of the states and territories have also implemented a range of innovative models that have improved mental health outcomes. Some of these are discussed in the following section in the context of future reform directions.

10.3 Identifying the case for change

Our submissions and national consultation processes highlighted a number of areas where the need for reform is still significant. Such insights and ideas for reform were complemented by a number of timely official reports, including:

- the National Survey of Mental Health and Wellbeing 2007 by the Australian Bureau of Statistics (released in October 2008) – this is the first such survey in ten years; and
- Towards recovery: mental health services in Australia, by the Senate Standing Committee on Community Affairs (released in September 2008).

We believe that Australia's mental health services as currently configured are inadequate and incapable of meeting present, let alone future, needs. Indeed, in the eyes of many, the mental health system is in an ongoing state of crisis. If we want this situation to change, we need to act, and act decisively. The following discussion highlights the key challenges and the approaches that have been shown to be both effective and cost-effective.

Reforming Australia's mental health services will require some additional investment. However, this is not the most significant change that is required. The most important reform needed is to reorient mental health expenditures towards prevention and the treatment and supports required for those most vulnerable. Making this happen relies on two main things:

- Targeting resources and efforts. For example, as highlighted earlier, anxiety, depression and substance-use disorders, such as alcohol dependence, are the most common mental health problems. Together, they account for three-quarters of the mental health burden and existing services avert only a small proportion of the burden – for example, 15 per cent for mood disorders, 13 per cent for anxiety disorders and two per cent for alcohol disorders. Prevention is vital as researchers estimate that half of the burden of these three

■ The most important reform needed is to reorient mental health expenditures towards prevention and the treatment and supports required for those most vulnerable

mental disorders cannot be averted by maximising the number of people being treated effectively by health professionals.³¹

- Reorganising health care services so that they represent 'stepped-care'. This is about investing initially in the least intensive and least expensive treatment in place of a more expensive but equally effective treatment that might become necessary if the first one fails.³² In practical terms, this approach is about investing more in mental health services in both primary health care and sub-acute settings, instead of relying unduly on acute or hospital care.

If we shift mental health spending so that the health system can deliver better treatment to those in need, we can significantly reduce the burden of mental illness by 2020. This would bring broader social and economic benefits too, with increased workforce participation and reduced reliance on social security. If we let this opportunity pass and continue the existing pattern of mental health investment, we will continue to not intervene sufficiently early. This will mean the optimal level of treatment and support will not be provided when and where it is needed. By 2020, therefore, the situation is likely to be worse for people who are mentally ill and their families – and our society will be poorer for it.

10.4 Creating a better future

During our consultations we heard that improved access to primary and community health care and stronger interagency links are reform priorities for better supporting people with mental health problems. The conceptual model and framework that needs to be developed for mental health care in the future should comprise:

- community- and primary health care-based service development to promote integration of mental health care;
- recovery and rehabilitation services to reduce disability;
- better engagement with carers and consumers in planning and evaluation; and have an
- early intervention and prevention focus to mitigate illness progression.³³

10.4.1 Improving access to mental health services

The extent of unmet need for mental health services is cause for serious reflection

■ Access considerations are always front and centre in health care. However, the extent of unmet need for mental health services is cause for serious reflection. All state governments have made significant increases in funding to acute or hospital-based mental health services. However, the Australian Bureau of Statistics' recent survey indicates that 2.1 million Australians with a mental health disorder over the past 12 months did not access mental health services even though they perceived they had an unmet need.³⁴ People with mental health problems also have a premature mortality rate 2.5 times that of the general population. This reflects poor access or usage of primary health care for physical health problems and increased lifestyle-related risk factors such as smoking, poor diet and substance use.³⁵

31 G Andrews and the Tolkien II Team (2007), Tolkien II: A needs-based, costed, stepped-care model for Mental Health Services, Final Report (World Health Organization, Collaborating Centre for Classification in Mental Health: Sydney).

32 G Andrews and the Tolkien II Team (2007), Tolkien II: A needs-based, costed, stepped-care model for Mental Health Services, Final Report (World Health Organization, Collaborating Centre for Classification in Mental Health: Sydney).

33 Participant (5 June 2008), National Health and Hospitals Reform Commission special interest forum on chronic and complex needs in Sydney.

34 Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results (Australian Bureau of Statistics: Canberra).

35 Participant (5 June 2008), National Health and Hospitals Reform Commission special interest forum on chronic and complex needs in Sydney.

It is not clear from the Australian Bureau of Statistics survey itself why these people did not access mental health services. However, such access issues exist for well-known reasons. First, the availability of mental health services differs significantly within states, regions and cities. For example, the availability of private psychiatrists in the inner suburbs of Melbourne is approximately ten times greater than in outer suburbs and rural areas.³⁶ The situation in Sydney is similar. A submission to the Commission pointed out that, 'Blacktown has almost 300,000 people, not far from the demographic centre of Sydney, but has only one private psychiatrist doing 3 hours per month.'³⁷ And, of course, access to a skilled mental health workforce lessens outside major cities.

Access problems can also exist because some individuals 'fall between the cracks' of the Commonwealth Government and state government mental health programs. For example, it is possible to have a mental illness of mild to moderate severity and complex needs and yet not meet the criteria to receive support from the state mental health system. Similarly, it is very difficult for homeless people with mental illness to access private mental health services. In addition, some people with a mental illness may be unwilling to seek help. For example, they may be concerned about the stigma of mental illness or unaware of the services available.³⁸

Mental health experts have long been aware that many Australians with mental health needs are not accessing mental health services when they need them. The situation is especially serious when we consider those who are susceptible to psychosis and those who have a diagnosed psychotic disorder. The submissions made to us, and the feedback from the mental health sector, point to the pressing need for more to be done to improve access to appropriate mental health services for these especially vulnerable groups. The issues related to each group are considered in turn.

Research suggests that presently only one in four young people with a mental health problem receives professional help.³⁹ Strategies must be put in place to provide more integrated, community-based mental health services for children and young people which recognise their particular needs and preferences and which better engage and support families. Support for families where a parent has a mental health problem or a drug and alcohol problem also requires strengthening.

■ Presently only one in four young people with a mental health problem receives professional help

Embedding care of people with mental health problems into the integrated primary health care system would increase access to general medical care and early intervention services and improve overall health outcomes for people with mental illness.⁴⁰

The Commonwealth Government has already invested around \$50 million to establish the National Youth Mental Health Foundation – not to provide services, but to establish links between service organisations. It aims to deliver improvements in the mental health, social wellbeing and economic participation of young Australians aged 12–25. *headspace* is an integrated service network that focuses on early identification and treatment for young people. The benefits from this approach are profound:

The greatest outcome from intervening early is the reduction in the number of young people and families that experience the deepest sense of despair and enormous disruption to their lives when a young person's mental health has deteriorated to the point where they require hospitalisation.⁴¹

36 The Boston Consulting Group (2006), Improving mental health outcomes in Victoria: the next wave of reform.

37 R Gurr (2008), Submission 223 to the National Health and Hospitals Reform Commission.

38 The Boston Consulting Group (2006), Improving mental health outcomes in Victoria: the next wave of reform.

39 G Andrews, S Henderson and W Hall (2001), 'Prevalence, comorbidity, disability and service utilisation: overview of the Australian national mental health survey', *British Journal of Psychiatry* (178): 145–153.

40 Participant (5 June 2008), National Health and Hospitals Reform Commission special interest forum on chronic and complex needs in Sydney.

41 *headspace* – the National Youth Mental Health Foundation (2008), Submission 88 to the National Health and Hospitals Reform Commission.

headspace involves private medical, psychological and psychiatric practitioners sitting alongside mental health and drug and alcohol workers and vocational assistance providers in one central location.⁴² Funding of \$35.6 million has been announced to fund *headspace*, the National Youth Mental Health Foundation, to continue its vital work on youth mental health. This will support young people across a range of areas including general and mental health, education, employment opportunities, and drug and alcohol rehabilitation.⁴³

Mental health practitioners and experts support this type of model as it is youth-friendly, easily accessed and focuses on identification and appropriate early intervention for the range of mental health problems affecting young people. They would like to see enough centres established so that all young Australians can access them.⁴⁴ We support this sentiment and consider that this type of model should also incorporate sexual health services as there is growing evidence that young people do not make sufficient use of conventional sexual health services.⁴⁵

Evaluation of *headspace* and other models which encourage engagement from children and young people at risk should be conducted to ascertain the best national approach to service delivery. Thought should be given to a model which incorporates a comprehensive, family oriented and developmental approach to service delivery. The current trend of establishing separate youth services – which split the mental health care of children and adolescents – needs to be carefully considered given the high degree of continuity of psychopathology from childhood to early adulthood. Recent studies have also suggested that web-based therapy and telephonic support with clinician supervision and interaction can be extremely cost effective and less confronting methods of treating social phobias, panic and depression.⁴⁶

The above model provides a platform for referral to appropriate specialist services for particular disorders – for example, personality disorders, eating disorders, addictive disorders, and early psychosis, where evidence shows early diagnosis and treatment improves outcomes.

Reform direction 10.1

We propose that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service- and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service.

Mental health practitioners and experts also support the Early Psychosis Prevention and Intervention Centre (EPPIC) model, which is a specialist clinical service located in metropolitan Melbourne. EPPIC involves case managers and clinical experts working closely with a young person and their family to facilitate early treatment and understanding of psychosis, and to reduce disruption to the young person. Often a young person can be successfully treated while they continue to live at home. Research has shown that this early intervention model delivers better health and social outcomes for those affected and savings to the health system.⁴⁷ The greatest savings are initially from reduced hospitalisations. We support the concept of the EPPIC model of care and consider that it should be implemented Australia-wide.

42 *headspace* – the National Youth Mental Health Foundation (2008), Submission 88 to the National Health and Hospitals Reform Commission.

43 Media release, 12 December 2008, Minister for Health and Ageing, 'Supporting youth mental health: new funding and new chair for *headspace*'.

44 Participant (25 August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

45 S Skinner and M Hickey (2003), 'Current priorities for adolescent sexual and reproductive health in Australia', *Medical Journal of Australia* 179 (3): 158–161.

46 G Andrews (22 July 2008), Distance treatment of the girl next door. Are our therapy models flawed? Personal communication.

47 P McGorry, E Killackey and A Yung, 'Early intervention in psychotic disorders: detection and treatment of the first episode and the critical early stages', *Medical Journal of Australia* 187 (7): S8.

Reform direction 10.2

We propose that the Early Psychosis Prevention and Intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.

Beyond early intervention, mental health practitioners, carers and consumer groups all expressed significant concern to us about the social supports and organisation and culture of many hospital-based mental health services that cater to those Australians suffering from serious mental illness. These services, which are meant to work together to sustain and where necessary improve mental health, are regarded as inadequate. This situation does not meet the needs of the severely mentally ill or their families and carers – and, over time, it has worsened the mental health of many of these vulnerable people.

There are other effects too. One of the most telling has been increasing pressure on the nation's public hospitals, whether or not they have specialist mental health services, as people in crisis have nowhere else to go.

Hospitals are bedevilled by a number of well-known problems. For the severely mentally ill, emergency departments are a particular case in point. People experiencing a psychotic episode frequently turn up or are brought to public hospital emergency departments, often by the police. While these people are entitled to present to an emergency department, the care that they can receive there is not appropriate to their needs. Tellingly, experts indicate that an emergency department is one of the worst places to be for someone experiencing psychosis.⁴⁸

■ An emergency department is one of the worst places to be for someone experiencing psychosis

The situation with dedicated hospital-based mental health services is not necessarily much better. Sadly, while health professionals are very dedicated and do their utmost to assist and improve the lives of the mentally ill, it was put to us that:

... the culture of clinical services in hospital mental health inpatient settings is often appalling and supports a system that is about incarceration rather than therapy or recovery.⁴⁹

The mental health sector is committed to improving standards of clinical care for those people experiencing psychosis and agrees that conventional models of care and funding are failing badly.⁵⁰ All too often, the police are the first line of response to someone experiencing psychosis. Like other elements of health care, mental health services vary across the country as states and territories organise and implement services independent of each other. However, over time, states and territories have experimented with different models that are improving care and leading to better health outcomes. We consider that there are two models in particular related to the care of severely mentally ill people that warrant attention.

The first model involves a rapid-response outreach team that is part of hospital-based mental health services in some jurisdictions. Known as Crisis Assessment and Treatment teams, this service configuration enables those experiencing psychosis to be treated effectively away from an emergency department environment. We believe that this model should be adopted more broadly as an important first step in improving care for this patient group and alleviating some of the pressure on emergency departments. Attention will need to be given to ensuring that the safety of team members is protected by working collaboratively with law enforcement agencies. Nonetheless, the vast number of people living with a mental illness are more likely to harm themselves than others.

48 Participants (August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

49 National Mental Health Consumers and Carers Forum (2008), Submission 126 to the National Health and Hospitals Reform Commission.

50 Participants (August 2008), National Health and Hospitals Reform Commission special interest forum on mental health in Sydney.

Reform direction 10.3

We believe that every acute mental health service should have a rapid-response outreach team for those individuals experiencing psychosis.

The second model involves prevention and recovery care, or 'stepped' care, along the lines of those provided in Victoria that are linked to hospital-based mental health services (see Figure 10.7). This model functions as a two-way bridge between primary health care services and hospital services for adults with severe mental illnesses. Additionally, this type of care can be linked to specialist and community services, including those related to drugs and alcohol, eating disorders and supported accommodation.

Figure 10.7: Making a difference to people's lives – Victoria's Prevention and Recovery Care (PARC) Model

Victoria has provided funding for PARC services over recent years and this sector is the most developed in Australia. A number of PARC facilities exist both in metropolitan Melbourne and in regional Victoria.

The Specialist Residential Rehabilitation Program in Shepparton is a partnership between the Goulburn Valley Area Health Service, which provides treatment and clinical rehabilitation services, and the Mental Illness Fellowship, which provides residential and rehabilitation support. The program, which has operated in Shepparton since 2001, enables people with a mental illness to learn and where necessary relearn living skills in a safe and supportive live-in environment.

Source: I Hickie (2008), A new model for delivering selected mental health services in Australia, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Early intervention and community-based 'stepped' services are a major gap in our mental health system. This gap has forced many of those with mental disorders to rely on hospital-based mental health services as the first, and indeed only, option for getting help. A recent survey of mental health inpatients confirms this situation – some 43 per cent (or 1333 patients) could have been discharged if appropriate alternative services were available.⁵¹ For those that are admitted and discharged from a hospital, there is concern that they are left largely unsupported and at risk of relapsing. If going home isn't possible straight away, the system should offer the same suite of clinical and non-clinical services as well as access to short- to medium-term accommodation options (step-down care). The same suite of community-based services should be available to manage the care of people before they become acutely unwell and require hospitalisation (step-up care).⁵²

We believe that the prevention and recovery care model should also be adopted more broadly to improve health outcomes for this vulnerable group and ensure that people receive the right care in the right setting. This reform direction is consistent with our vision for enhanced sub-acute services as outlined in Chapter 5.

Reform direction 10.4

We propose that every hospital-based mental health service should be linked with a multi-disciplinary community-based sub-acute service that supports 'stepped' prevention and recovery care.

51 Australian Mental Health Inpatient Snapshot Survey 2006, Draft Report.

52 Mental Health Council of Australia (2006), Time for Service. Solving Australia's mental health crisis, at: <http://www.mhca.org.au/>

Finally, another way to improve access to appropriate mental health care is to provide better mental health training to those in the primary health workforce, particularly those practicing in rural areas (see Chapter 3). This is vitally important since the majority of mental health services, which overwhelmingly relate to the treatment of anxiety and depression, are best delivered through primary health care. The Commission's Mental Health Special Interest Forum noted the pressing need to build workforce capacity by providing training (undergraduate and 'in-service') and support to a wider range of professionals who come into contact with people with mental illness.

Research suggests that a significant health burden associated with anxiety and depressive disorders remains untreated although both can be treated cost-effectively.⁵³ The economic impact of depression, in terms of foregone productivity, is estimated at over \$3 billion per year.⁵⁴ To reduce this burden, researchers recommend that health care providers be encouraged to practise evidence-based medicine, even if the budgetary and organisational requirements of implementation are considerable.⁵⁵ Better education and training will provide a platform for the practice of more evidence-based mental health care.

Reform direction 10.5

We strongly support greater investment in mental health competency training for the primary health care workforce, both undergraduate and postgraduate, and that this training be formally included as part of accreditation processes.

10.4.2 Improving access to stable housing and other community support services

As indicated earlier, social supports such as income support, assisted housing and education and training, are essential to adequately providing for the needs of those suffering from severe mental illness. Social supports help prevent episodes of mental illness and help people recover from such episodes. Improving health outcomes for those with mental disorders requires more than better access to quality health care. It requires seriously coming to grips with and providing for the multitude of needs that this group has. We heard through our submission process:

Those of us working in the area of mental illness know all too well that issues such as housing, employment, carer education and social security often fall 'off the radar' when it comes to health policy. With the notable and very welcome exception of the Council of Australian Government-driven funding from 2006, most funding decisions end up focussed mainly on clinical services.⁵⁶

We are supportive of the Council of Australian Government's work to increase investment in social support services. While our terms of reference do not extend beyond the borders of the health system, we would like to encourage all state and territory governments to provide people suffering from severe mental illnesses with stable supported accommodation linked to specialist support services along the lines of the model pioneered in New South Wales (see Figure 10.8).

■ Social supports help prevent episodes of mental illness and help people recover from such episodes

53 G Andrews, C Issakidis, K Sanderson and colleagues (2004), 'Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders', *British Journal of Psychiatry* (184): 532.

54 beyondblue (2005), Submission to the Senate Select Committee on Mental Health.

55 G Andrews, C Issakidis, K Sanderson and colleagues (2004), 'Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders', *British Journal of Psychiatry* (184): 532.

56 Mental Illness Fellowship of Australia (2008), Submission 317 to the National Health and Hospitals Reform Commission.

Figure 10.8: Making a difference to people's lives – News South Wales's Housing and Supported Accommodation Initiative (HASI)

HASI was established in 2002–03 as a joint initiative between NSW Health, NSW Housing and non-government organisations. It assists people with mental illness that need accommodation support to participate in the community, maintain tenancies and recover from their illness.

By 2007 the program was providing stable housing and accommodation support to over 1000 people with mental illness. However, the program's benefits extend far beyond housing. Significantly, evaluations have determined that the vast majority of participants required fewer visits and shorter stays in hospital due to their mental illness and nearly all had established friendships and were able to participate in social and community activities.

HASI makes a tremendous difference to people's lives. As noted by a HASI client:

My life would be a terrible misery without HASI. With the medication and support, I'm on top of the problems and I can enjoy life. For many, many dark years I was very suicidal all the time because I just did not enjoy being alive. I was in so much emotional and mental pain and being psychotic and too scared and taking drugs to numb it all out; something had to give. ... It took ten years to get that support. I was in and out of hospital like a revolving door. Now I've got the support I need, plus the very effective medication ... and now I'm quite well.

Source: Social Policy Research Centre (2006), *Housing and Accommodation Support Initiative: Evaluation, Report II*

It was also suggested to us that the traditional hospital-based accommodation could be redesigned to include a set of units similar to retirement villages which:

... provide a peaceful environment ... and where privacy would be maintained to help with recovery from acute episodes of illness. They should be located close to shops, public transport and other services like libraries and educational facilities.⁵⁷

Reform direction 10.6

We propose that each state and territory government provide those suffering from severe mental illness with stable housing that is linked to support services.

Employment is critical to good mental health

■ In addition, we heard that employment support for people with mental illness is managed poorly. Employment is critical to good mental health. Australia's rate of employment support for the 70 per cent of people living with a mental disorder who wish to work is very low. In comparison to other OECD countries, who manage to support 60 per cent of work participation for those with a mental disorder, Australia's rate is a low 29 per cent. Research suggests that efforts would be best placed by increasing the level of post-placement vocational support in order to help someone keep their job and advance their career.

Reform direction 10.7

We believe that governments must increase investment in social support services for people with chronic mental illness, particularly vocational rehabilitation and post-placement employment support.

⁵⁷ K Mostafanejad (2008), Submission 498 to the National Health and Hospitals Reform Commission.

10.4.3 Reducing inconsistencies and inequities that affect mental health outcomes

There are a number of other areas where change is necessary to reduce inconsistencies and inequities that affect outcomes for people with a mental health condition. Three sets of circumstances stand out.

First, the mental health needs of many older people are not well served under the current arrangements. The intersection between aged care and mental illness is a key factor. Some nursing homes do not accommodate people with a mental illness, which causes some people to have to rely on hospital care because of a lack of alternatives.⁵⁸ This situation is unfair for the individuals concerned, who are invariably denied the aged care services they may need. This situation is also an issue for hospitals, which generally cannot care for such patients on a cost-effective basis.

■ The mental health needs of many older people are not well served

As Australia's population ages, there will be a rapidly increasing need for psychogeriatric residential care services across all jurisdictions. We believe that concrete steps need to be taken to reduce this service gap and effectively meet the needs of this vulnerable group. Responsibility for taking action requires government collaboration in the short term due to the existing division in accountabilities and funding.

Reform direction 10.8

As a matter of some urgency, governments must collaboratively develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to specialty mental health and dementia care services.

Second, not all Australians with mental health problems require medication. However, some who do are subject to court orders that require them to comply with treatment. Compulsory treatment orders, which are an incursion on an individual's civil liberties, are used for a wide range of reasons. However, the most common reason is to stop the recurring self-harm and chaos associated with unmedicated severe mental illness:

It is one of the failures of contemporary psychiatry that many patients who respond well to medication given to them when they are inpatients relapse after discharge due to not taking any further medication. Those working closely with the acute psychiatric patient in the community are often forced to stand by powerlessly as the patient deteriorates, causing damage to himself and his social milieu until such a point is reached when he is again ill enough to warrant compulsory admission and treatment.⁵⁹

As part of our formal consultations, we heard that Australia's states and territories do not formally recognise other jurisdictions' compulsory treatment orders. This means that those affected individuals can relatively easily get around treatment orders, which is of great concern to their families and health care providers. We believe it is time for this legal glitch to be fixed.

Reform direction 10.9

We propose that state and territory governments recognise the compulsory treatment orders of other Australian jurisdictions.

58 Senate Standing Committee on Community Affairs (2008), *Towards recovery: mental health services in Australia* (Commonwealth of Australia).

59 P Dedman (1990), 'Community treatment orders in Victoria, Australia', *Psychiatric Bulletin* (14): 462.

Third, while it is important to recognise that mental health patients are entitled to privacy, we were made aware during the consultations of various sets of circumstances where this right contravened public safety, and sometimes with utterly tragic consequences. We believe that, in the interests of patient recovery and public safety, health professionals should take reasonable steps to establish where a person being discharged from a mental health facility is going and to let someone appropriate at the location know. The need for community-based, post-discharge support has already been highlighted in Reform direction 10.4.

Reform direction 10.10

We believe that health professionals should take all reasonable steps in the interests of patient recovery and public safety to ensure that when a person is discharged from a mental health service that:

- there is clarity as to where the person is going; and
- someone appropriate at that location is informed.

10.4.4 Raising community awareness and consumer involvement

Research conducted in three Australian states points to relatively low levels of mental health literacy among the population

Research conducted in three Australian states points to relatively low levels of mental health literacy among the population. This lack of understanding as individuals and as communities can lead us to unnecessarily discriminate against those who are struggling with a mental health problem. For someone experiencing a mental health illness, the last thing that they need is for others to question their integrity or their value to society. This lack of community understanding also leaves those that experience mental illness isolated and fearful.

Mental disorders are hard illnesses to deal with but the plight of consumers is made infinitely worse by the demeaning and dehumanising attitude of the public and the ensuing condemnation and even blame.⁶⁰

It is perhaps not surprising then, that so many people struggling with mental health problems do not seek help to diagnose and manage their illness. We, as a community, need to change this. We need a cultural shift in our understanding and attitudes about what we can do to promote good mental health and what we can do to better help support those who may be suffering from a mental health problem.

A national comprehensive community awareness campaign combined with education for consumers, carers and health care professionals will go some way to shifting unhelpful attitudes. This requires strong leadership, greater involvement of consumers and carers in deciding what works and what does not, and more information so that we can measure how well the system is performing.⁶¹ One suggestion made to the Commission was that a national awareness campaign could:

... concentrate on portraying people with a mental disorder in a positive light by using prominent society figures who also have a mental disorder as examples ... to illustrate that living with a mental illness is not the end of the world but can be overcome, especially with the support of society.⁶²

60 K Mostafanejad (2008). Submission 498 to the National Health and Hospitals Reform Commission.

61 National Mental Health Consumer and Carer Forum (2008) Submission 126 to the National health and Hospitals Reform Commission.

62 K Mostafanejad (2008). Submission 498 to the National Health and Hospitals Reform Commission.

Reform direction 10.11

We propose a sustained national community awareness campaign to increase mental health literacy and reduce the stigma attached to mental illness.

Involvement by consumers is sometimes perceived as tokenistic; real engagement requires a participation framework and a genuine effort to capture and measure consumer feedback. For example, Orygen Youth Health is a strong advocate for a 'participation' approach to improving mental health care. Their programs specifically harness the input of young people and work on the basis that those who have experienced the mental health system have a stronger passion for improvement and change.⁶³ We advocate an approach to mental health service planning and delivery which engages consumers and carers as active participants in the process.

Reform direction 10.12

We propose there must be more effective mechanisms for consumer and carer participation and feedback to shape programs and service delivery.

63 ORYGEN Youth Health Submission (2008), Submission 141 to the National health and Hospitals Reform Commission.