

CROSSROADS: ▶▶

RETHINKING THE
AUSTRALIAN MENTAL
HEALTH SYSTEM



by Inspire Foundation



Building a better
working world

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EXECUTIVE SUMMARY

One in two Australians will experience a mental health disorder during their lifetime. Less than half of those who do will receive appropriate support and treatment. Left untreated, mental health problems often get worse, affecting every aspect of a person's life and creating a significant economic burden on the Australian community.

For this reason the National Mental Health Commission has called for a doubling in the proportion of the Australian population who receive "timely and appropriate mental health services and support."

However, our projections show that if we continue with business as usual, the current mental health system will require at least 8,800 additional mental health professionals, at a cumulative cost of \$9 billion to Australia (in today's dollars) over the next fifteen years in order to be able to deliver on this objective. This presents a very significant cost-burden, which in the context of already fast-growing health costs is simply unsustainable.

It's clear therefore that Australia urgently needs a 21st century mental health care system to respond to the growing demand for, and rising costs of service delivery. An urgent effort to reconceptualise our mental health system is required, one that looks to better promote and integrate effective and scalable self-help and peer-support interventions, thus decreasing the burden on clinical services and professionals so that they are free to assist those in greatest need. Underpinning this we must prioritise, and fund, mental health promotion and prevention to keep people mentally healthy in the first place. Only then will we experience the health and economic benefits of a 21st century system of mental health care.



Existing systems will not meet the growing demand and cost

This report found that even a relatively modest increase in the proportion of people seeking help for mental health difficulties, combined with projected Australian population growth, would produce a cumulative increase in the use of mental health services ranging from 135% to 160% for select mental health professions, over 15 years. If services continue to be delivered unchanged, the increase in utilisation will drive demand for front line professions with an additional 4,500 general practitioners (GPs), 2,150 psychiatrists and 2,150 clinical psychologists projected as required. It is highly likely that existing services will not meet this demand.

Such growth would in turn cost the Australian taxpayer much more, with the bill for increased salaries alone rising to \$1.75 billion per year 2027, cumulatively adding \$9 billion (in today's dollars) to Australia's health spend over 15 years. This cost soars when you add on the costs of training and development, incentives, and the capital expenditure required to support 8,800 additional mental health professionals. Increased demand will also have an impact on other mental health professions such as nurses, allied health and support staff, with salary and other associated costs.

Meeting this increased demand would require a massive injection of financial resources imposing a very significant cost-burden, which is unsustainable in the context of Australia's fast-growing health costs. Even if additional money were available for this investment, significant steps would need to be taken today to begin expanding the mental health workforce to the required size. Given the well documented workforce shortages that already exist, especially in regional Australia, it is clear that recruiting enough suitably qualified personnel will be a considerable challenge for particular professions and in some regions impossible.

By 2027, the current system will require at least 8,800 additional mental health professionals at a cumulative cost of \$9 billion to Australia.

Investing in a sustainable system

With so few studies and so little evidence available on the effectiveness of our current mental health system, \$9 billion is a huge investment in expanding a system that still might not be able to get Australians with mental health issues the right help, at the right time.

Investing in mental health promotion and prevention helps to reduce demand for more resource intensive services, thus also reducing workforce pressure and overall health costs. In spite of this, and the endorsement by the Council of Australian Governments of the Roadmap for National Mental Health Reform 2012-22 that prioritised prevention and early intervention, the majority of State and Federal mental health spending continues to be disproportionately concentrated in downstream mental health interventions: in treating problems once they have become serious and complicated. This must change.

We must find a way to provide more Australians with the mental health support and treatment they need through services that are effective, cost-efficient and sustainable.

An expanded system may still leave one in three Australians with mental health problems without help or support.

Our call to action

Our mental health system can meet the challenges of growing need and expanded access if we rethink how mental health support and treatment is delivered, reconceptualising 'help' and evolving a new system of 'stepped' mental health care that offers a range of help options of varying intensity matched to people's level of need.

In fact, it is possible that such an approach presents the opportunity to deliver cost savings, predominantly by redirecting some people into self-help and peer-supported services and thus reducing the burden on clinical services and professionals so that they are free to assist those in greatest need. Indeed, if a stepped care, integrated service system reduced the annual increase in the number of services provided GPs, psychiatrist and clinical psychologists by only 1%, \$2.4 billion would be saved over 15 years. If that reduction was 4%, the savings would be \$7.2 billion and there would be no workforce shortfall for psychiatrists and clinical psychologists.

ACTION AREA 1 - A 21st century mental health care system

Australia's mental health service system should be reoriented around a stepped care framework that provides a range of help options of varying intensity matching people's level of need. In particular:

- a. Self-help and peer-based services, especially those delivered online, that are capable of providing help and support at massive scale should be prioritised by policy makers, funding bodies and researchers, with greater and more sustainable investment.
- b. Self-help, peer-based, and online services should be fully integrated with more 'traditional' existing services through clear treatment pathways, and a mental health workforce trained to optimise their access.
- c. Mental health workforce capacity should be maximised through greater utilisation of mental health peer workers where appropriate, freeing up clinicians to assist those in greatest need.

ACTION AREA 2 - Promotion, prevention and early intervention

Invest a greater proportion of overall mental health funding in promotion, prevention and early intervention.

- a. Prioritise initiatives that target vulnerable groups such as: young people; lesbian, gay, bisexual, transgender and intersex (LGBTI) people; young men; and Aboriginal and Torres Strait Islanders
- b. Maximise the reach of promotion and prevention efforts by delivering programs through a number of settings including peer-to-peer, online, and within schools.

INTRODUCTION & AIMS

Nearly half (45%) of all Australians will experience a mental health problem over the course of their lives, and one in five will do so in any given year.¹ Adolescence and young adulthood are an especially critical period, with 75% of mental health problems first appearing before the age of twenty-five.²

Timely and appropriate help-seeking, especially during adolescence, can reduce the long-term health, economic and social impact of many of these mental health problems³- however studies repeatedly show that more than 70% of young women and 80% of young men who need help and support don't get it⁴. Even among those who do receive care, many don't get the most suitable evidence-based treatments at the most opportune time⁵.

Left untreated, mental health problems can not only become more severe, but often lead to other difficulties including social withdrawal, the breakdown of family and personal relationships as well as poorer education⁶ and employment outcomes,⁷ and over-representation in the justice system.⁸ Untreated mental health problems are implicated in many cases of suicide, which tragically remains a leading cause of death amongst young people under the age of 30.⁹ Young men¹⁰, young people living in regional and remote areas¹¹, and LGBTI young people are especially at risk.¹²

Over the last fifteen years Australia has led the world in the development and implementation of a range of initiatives designed to get more help to more people. ReachOut.com, for example, which launched in 1998, and was the world's first online mental health service has greatly expanded the number of young people accessing appropriate and timely help by harnessing the power of technology to provide anonymous, 24/7 support. Similarly, public health organisations such as *beyondblue* and early intervention services such as *headspace* have also played a very significant role in combating stigma, encouraging help-seeking behaviour and delivering mental health services in a more welcoming and accessible manner. Whilst as a nation we can be rightly proud of these efforts, the fact still remains that the majority of people experiencing mental health difficulties are not accessing help.

This challenge is well recognised within the mental health sector and governments. In recent times, for example, the Fourth National Mental Health Plan, which received endorsement from all Australian governments in 2009, identified "service access, coordination and continuity of care" as one of five priority areas for government action on mental health, and nominated the "percentage of the population receiving mental health care" as a key indicator for progress in this area. This priority was then re-emphasised in the National Mental Health Commission's 2012 and 2013 Report Cards, which call for an increase in the delivery of "timely and appropriate mental health services and support from 6-8 per cent to 12 per cent of the Australian population."

Despite this considerable focus, relatively little work has been done exploring the potential impact on the mental health system when (or if) we are successful in increasing the number of people who seek help. There is not a clear picture of the impact that increased rates of help-seeking amongst the population will have on services, nor of the capacity of the mental health sector in either its current or projected future form to absorb increased demand.

This raises some particular alarm bells given the well-documented concerns that already exist regarding mental health workforce capacity constraints and waiting lists for services. Workforce shortages in areas such as psychiatry, nursing, psychology, and social work have already been identified¹³, and are particularly severe in rural and remote areas.¹⁴ Anecdotal, sometimes tragic accounts of long wait times and people 'falling through the cracks' are common.

Concerned about the capacity of both the youth and broader mental health sector to absorb the increased service use which would follow from greater numbers of people seeking help, ReachOut.com by Inspire Foundation collaborated with professional services firm EY to investigate the existing and projected capacity of the current mental health sector across key professions, and to explore options for ensuring that all Australians can get the help they need, when and how they want it.

"I think I had to wait two months or something for my first psychology - psychologist appointment and that's, I think that's a big issue because if you're going to see a psychologist you probably are in a bit of crisis and you can't wait two months to see someone" - young person



Approach

A range of existing studies, including those conducted by Australian Institute of Health and Welfare and the Health Workforce Australia, have examined the mental health workforce, identifying the types of professions, their numbers and their location. These provide valuable input into the current supply of mental health professionals but have not specifically addressed whether there will be a sufficient future workforce in the context of increased demand and use of mental health services.

Accordingly, EY undertook modeling regarding the potential impact of increased rates of help seeking, and the mental health system's capacity to respond. There were two key steps to the approach taken by EY:

1. A literature review and enquiries to identify the existing data relevant to mental health workforce, services, and utilisation, and thus to define the model scope through the development of assumptions.
2. Development of a workforce and service use model through an iterative process with input from a ReachOut.com by Inspire Foundation Advisory Committee.

Throughout, EY and ReachOut.com by Inspire Foundation were supported by an Advisory Committee that was made up of a range of mental health experts as listed in Appendix 1. The Committee drew on their own expertise and that of their professional networks, providing insight into the available data, the model designed through the process, the assumptions made, and the final model outcomes. This support was continuous, making development of the final model an iterative process.

Initially, a review of all the available data in Australia was conducted through a desktop review and input from the Committee. The most reliable sources and most appropriate data were used, discussing the gaps and limitations with the Committee throughout the process.

There was a long list of service types identified but the ones applied to the final model were those which best matched the scope of the project – specifically, the focus on non-admitted patient services such as General Practice, Medicare subsidised services and Community Care.

The model was designed to project three areas:

1. Population growth
2. Service utilisation
3. The mental health workforce capacity and cost

The population data was divided by state, area (metropolitan and non-metropolitan), age and gender, since different population groups may present different rates of demand for and use of mental health services in the future. In addition, the growth in population according to the Australian Bureau of Statistics (ABS) is expected to be higher in metropolitan areas than in non-metropolitan areas. The service use data applied to the final model was limited to publically available data.

One of the main assumptions made in developing the model is in regard to the future growth in mental health service demand and use. The projection model is very sensitive to this assumption as it has a direct impact on the estimated shortfall of health care professionals to provide the required mental health services and hence the associated costs resulting from this increased need.

As previously mentioned in the report, the National Mental Health Commission has placed a strong focus on getting more help to more people, specifically calling for effort that would *“increase timely and appropriate mental health services and support from 6-8 per cent to 12 per cent of the Australian population”*. Based on the above, we have determined that the ultimate increase should be 100% (from 6 to 12 per cent of the Australian population). Guided by the Advisory Committee, the ultimate increase of 100% was achieved by applying an annual increase of 6%. Based on this, we have applied an increase in use of mental health services of 6% per annum for 12 years, and then assumed the level of use would remain stable in future years. These assumptions are reasonable and in line with expected growth.

Using the population and service use projected over a 15-year period, we were then able to determine the impact that such an increase to the number of mental health related services would have on the workforce. The emphasis has been given to the following health care professionals:

- General practitioners
- Psychiatrists
- Clinical psychologists

Using publicly available data with respect to the projected workforce for these health care professionals as well as the average annual number of services performed by a professional (assuming a productivity gain of 1% per annum) we have determined the shortfall in the number of mental health services that the projected workforce would not be able to provide. We have then converted this shortfall in number of mental health services into a shortfall in health care professionals.

Finally, the cost associated with hiring sufficient health care professionals to meet the projected need has been determined using the average salary plus a loading of 25% of salary for all other benefits such as superannuation and worker's compensation. Current average salaries have been projected using an increase of 2.50% per annum and the total cost has been discounted back into the present value cost using a discount rate of 4.75%.

This is a simplified description of the model, for more details on the model components, please refer to Appendix 2, 3 and 4.

Assumptions and limitations

The model is not intended to be a comprehensive study of supply and use of mental health services and the related workforce and as a result there are a number of assumptions and limitations (including the availability and quality of data) to the model. Throughout, the authors sought to take a conservative approach to the model assumptions and to the outcomes.

The data selected for the final model, and the assumptions which were confirmed with the ReachOut.com by Inspire Foundation Advisory Committee, are presented in Appendix 3 and 4.

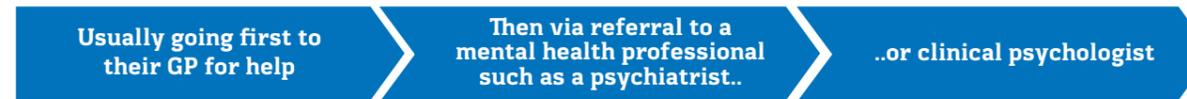
More water, same bucket: The impact of increased mental health service use on current service delivery models

Almost half (45%) of all Australian adults have experienced mental illness at some point in their lives, and one in five – 3.2 million – in any given year. The most common are anxiety disorders, affecting 14.4% (2.3 million) Australians, followed by substance abuse (5.1%), and depression (4.1%). But only 35% of those 3.2 million people get access to mental health services. For young Australians, more than 70% of young women and 80% of young men who require help and support do not get it, and at least one third of young people have had an episode of mental illness by the time they are 25 years old. 2.1 million Australians – 13% of all adults in any given year – are struggling with mental health issues and want help, but can't get it, while more than a quarter of those who did access services felt their needs weren't met.¹⁵

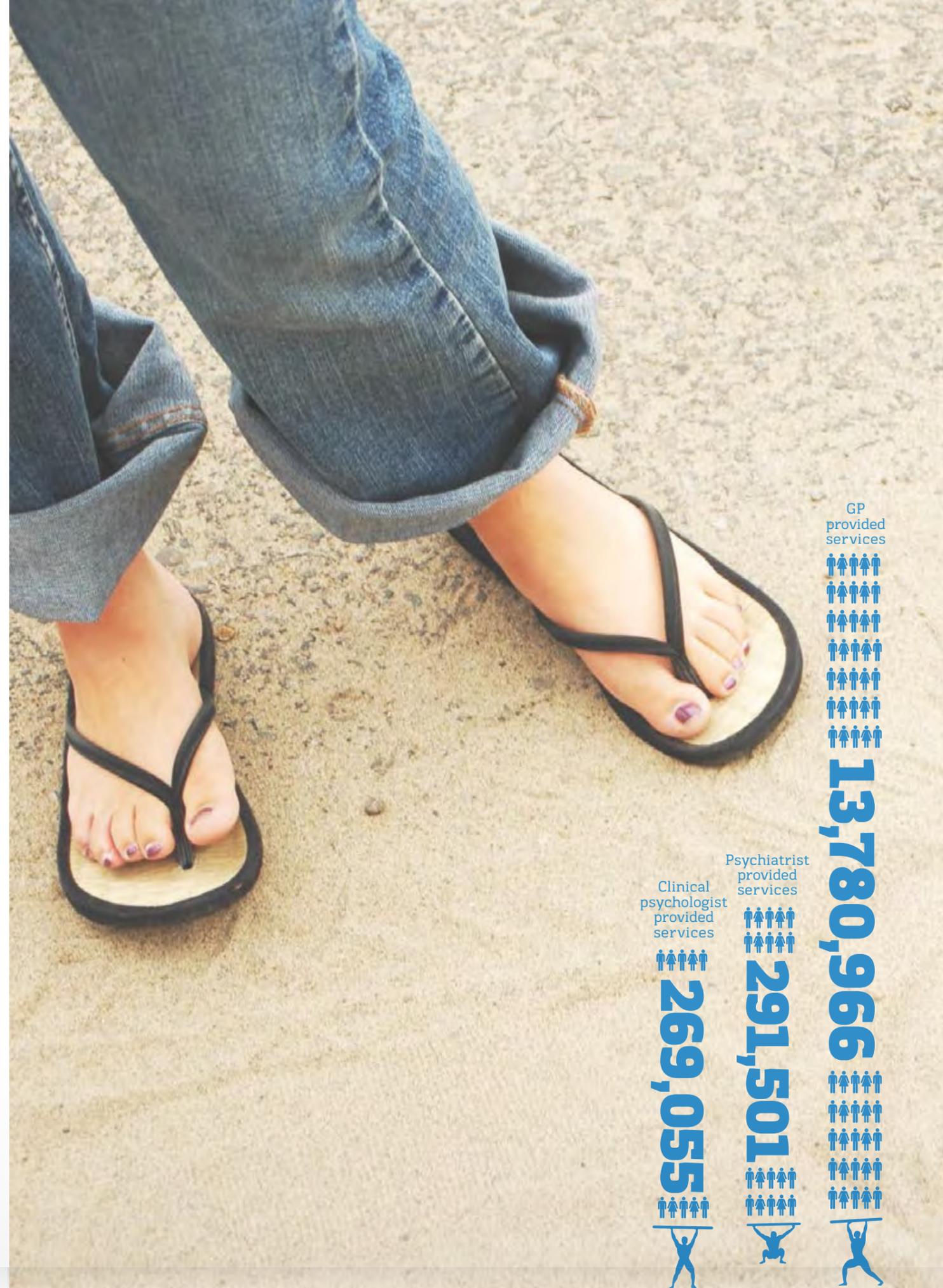
While 35% is far too small a proportion, it's still more than one million people accessing mental health services. The impact on Australia's health system is already significant. People experiencing depression, anxiety, and other common mental health problems usually go first to their GP for help, and then via referral to a mental health professional such as a psychiatrist or clinical psychologist. In 2013 this meant that the combined workforce of 36,300 GPs, psychiatrists and psychologists provided 14.3 million mental health related services.



More than **ONE MILLION** people access mental health services



36,300 GPs, psychiatrists and psychologists provided 14.3 MILLION mental health related services

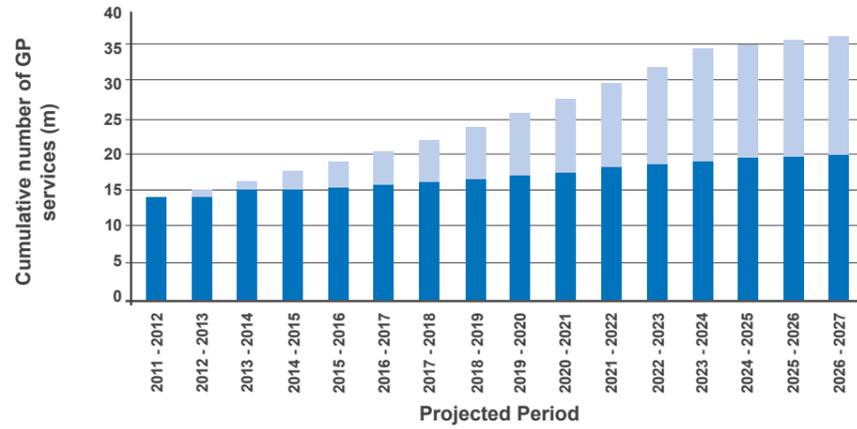


The modeling on which this report is based shows that in the absence of any systemic changes, forecast population growth, combined with an increase in the proportion of people seeking help from 6% to 12% of the total population (as advocated for by the National Mental Health Commission) would lead to a further increase in demand for, and use of, services of between 135% and 160% over the next fifteen years across the three mental health professions.

This significant increase in turn presents substantial challenges to the overall capacity of the mental health services workforce. Taking into account the maximum number of services that can be provided by a single professional in a year, an additional 8,800 health professionals would be required over the next fifteen years across just three key groups of service providers – general practitioners, psychiatrists and clinical psychologists - in order to meet the projected demand.

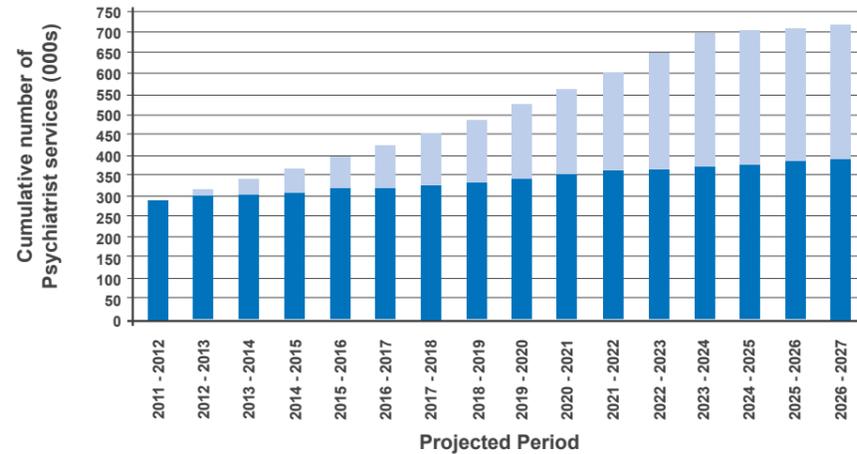
Mental Health Services Provided by GPs

Impact of increase in utilisation
Impact of population only



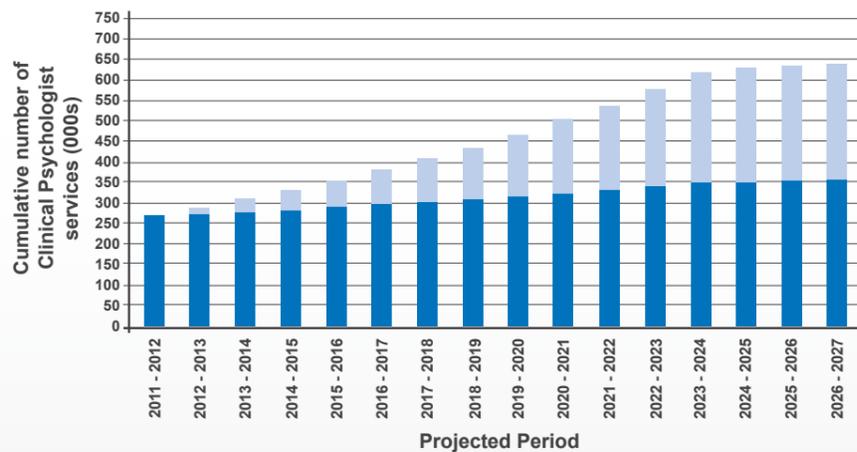
Mental Health Services Provided by Psychiatrists

Impact of increase in utilisation
Impact of population only



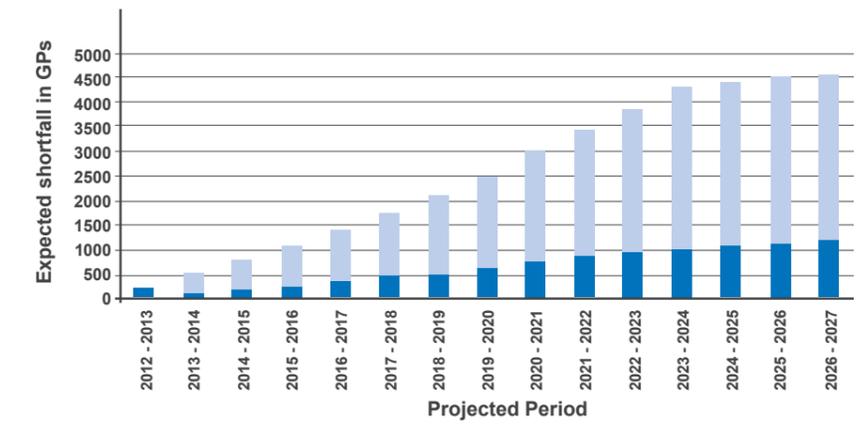
Mental Health Services Provided by Clinical Psychologists

Impact of increase in utilisation
Impact of population only



Shortfall of GPs for Mental Health Services

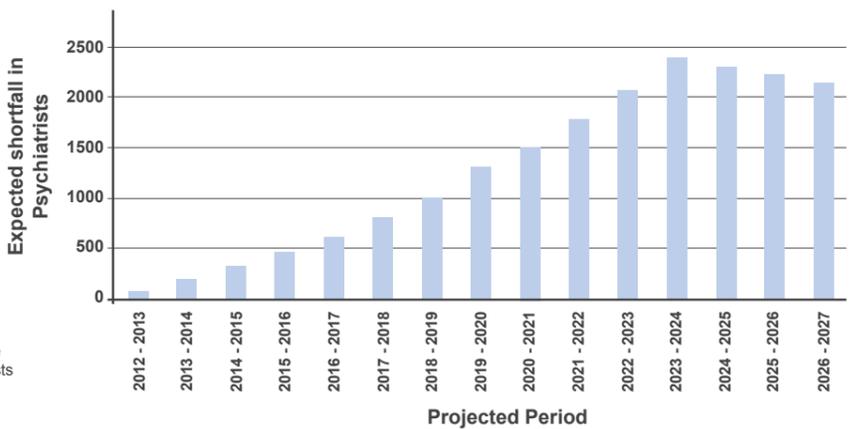
Impact of increase in utilisation
Impact of population only



Shortfall of Psychiatrists for Mental Health Services

Impact of increase in utilisation
Impact of population only*

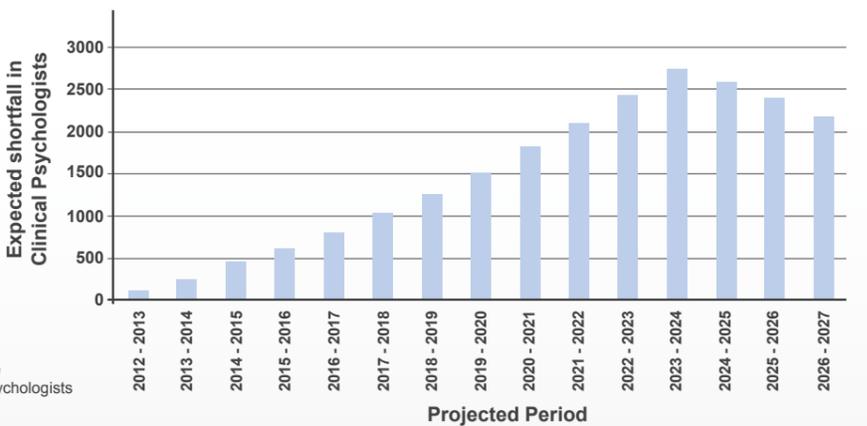
*assuming population growth, there would be no shortfall in psychiatrists



Shortfall of Clinical Psychologists for Mental Health Services

Impact of increase in utilisation
Impact of population only*

*assuming population growth, there would be no shortfall in clinical psychologists



Achieving this growth in the mental health workforce would require taking decisive action immediately. Both psychiatrists and GPs typically require around nine years of training in order to qualify at a basic level, whilst for clinical psychologists the typical minimum period of training and development is six years. Given these long lead times, an effective and wide-spread strategy to grow the number of mental health professionals would need to be implemented within the next 12 months. Historical experiences in Australia suggest that this is unlikely. Indeed, the 2013 report *Obsessive Hope Disorder* notes that no coherent strategies to address mental health workforce shortages have been implemented in the decades since the first National Mental Health Strategy was developed in 1992.

Adding to the challenge, the mental health services workforce is facing the same issues of an ageing workforce that demographic shifts have created across the Australian community. Simultaneously, an ageing population will have increased need for health services across the spectrum, while a proportionately smaller working-age population will be available to meet the employment needs of all sectors. Even under current circumstances, there is a wide disparity in mental health service availability between different areas, rural and regional communities are badly under-resourced already. While our model examined only three key professions - GPs, psychiatrists, psychologists – it is clear that other mental health professions such as mental health nurses are also likely to experience the same issues and the same shortfall in meeting demand.

Even assuming that such a workforce development project could be successfully implemented within the next 12 months, the cost implications of such significant workforce growth would be prohibitive.

These factors make resourcing this projected shortfall likely to be an unachievable challenge.

Salaries alone – for just those three health professions – would rise to \$1.75 billion per year in 2027. Training and development costs, and the need for other, mental health professions to also expand, would increase that cost significantly.

The 2013 Medibank Private/Nous Group Review of Expenditure found that Australia spends at least \$13.8 billion per annum on direct health expenditure in the mental health area.¹⁶ These costs have been rapidly rising over the previous years, with programs such as 'Better Access' - which blew out from a forecasted \$538 million to a predicted \$2 billion (over four years) - demonstrating how quickly services addressing unmet demand can face cost over-runs. Indeed health expenditure overall has grown rapidly in Australia, rising by 74% in the last decade alone¹⁷. Perhaps unsurprisingly then, Accenture predicts that the gap in the ability to pay for in-demand services in 2025 in Australia will be US\$50 billion.¹⁸

In this context then, the projected cumulative increase of \$9 billion (in today's dollars) over the fifteen-year time line of our model presents serious concerns. These concerns become more acute given the fact that this estimate is extremely conservative. Our model took into account the cost of salaries and on-costs across just three professions. Training and development costs, incentives and capital expenditure are not accounted for, nor are support staff or allied health professionals.

It's clear, then, that there are serious questions about the sustainability of our current system of delivering mental health services in circumstances of a growing population and increasing demand for, and use of, mental health services within that population. The affordability, and the practical possibility of expanding the mental health workforce to meet the needs of a substantially greater number of people seeking help, are both doubtful.

Even in the unlikely event of a successful resolution to both financial and demographic challenges, this model is based only on a doubling of the number of people getting help and support - leaving one third of all Australians with mental health issues still without the assistance and services they need.

Not business as usual

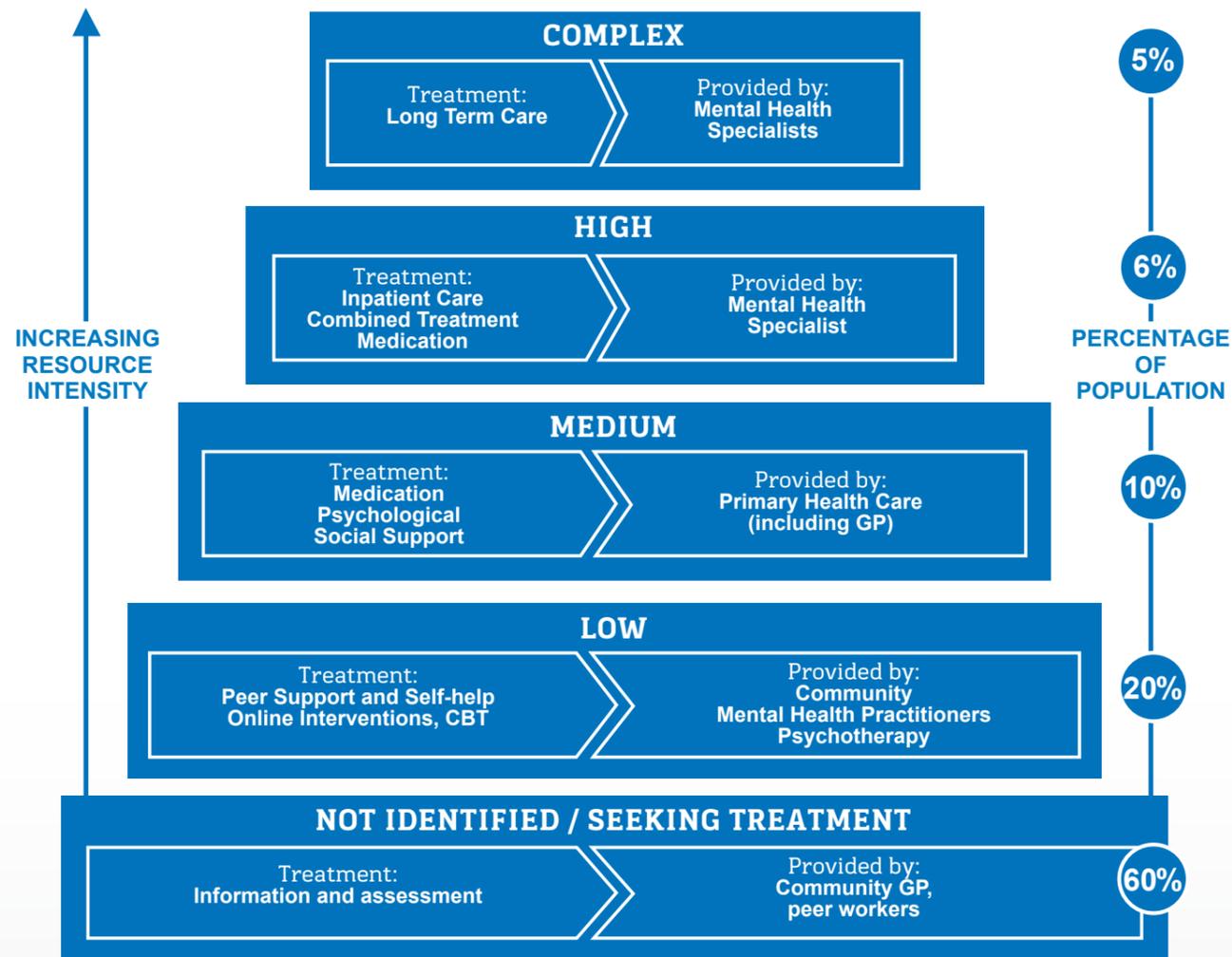
If increasing the proportion of the population who can access mental health services will strain the current mental health system and workforce beyond capacity, and expanding the workforce to meet increased need is neither economically sustainable nor practically possible, our only viable option is to shift the way that mental health services are conceived, developed and delivered in Australia.

We need a greater focus on prevention¹⁹, the development of new workforce models and the exploration and integration of more effective, efficient and accessible service delivery approaches²⁰ that genuinely support user self-directedness and empowerment.²¹ Happily, Australia already leads the way in the development of alternative approaches, including the use of online services, the trialling of community based care, and the growing attention to developing a peer workforce.



21ST CENTURY MENTAL HEALTH CARE

Over the last decade, stepped care has been increasingly suggested as an appropriate model for efficient and cost-effective provision of needs-based mental healthcare services.²² Stepped care is a model for delivering and monitoring interventions and treatments so that the most effective, yet least resource intensive treatment is delivered to patients first, only stepping up to more intensive treatments as clinically required. The model is designed to make effective use of available (and often limited) resources, and is dependent on streamlined transitions at the different steps in the pathway, requiring services to work together cohesively.²³ It is an approach to the delivery of services and allocation of resources that has been especially recommended as an appropriate framework for the treatment of depression and anxiety, two of the most prevalent mental health disorders in Australia.²⁴



Constructing Australia’s mental health system around a stepped care framework gives us the opportunity to deliver a high volume, open access service focused on delivering support and information in the most efficient way possible.²⁵

In and of itself, a stepped care approach offers significant alleviation of existing and future workforce pressures. This benefit could potentially be even greater, however, through expanded utilisation of peer workers to provide lower-intensity support, thus freeing up clinicians to assist those in greater need.

“Peer workers” are people employed in mental health support roles that require them to identify as being a current or previous mental health consumer or carer.²⁶

Peer-based programs provide an alternative to traditional clinician-led care, and may break down barriers to help seeking by providing informal support, while allowing people to remain autonomous and in control of their help-seeking journey.

Peer support programs have been widely used in health promotion and risk reduction initiatives due to their capacity to engage with at-risk young people who are hard to reach by conventional support services, and have shown high levels of acceptability by young people in particular. Over the past decade there has been a large growth in the number of peer support led mental health programs in the US, New Zealand, Australia and the UK, and in late 2011, the Community Services and Health Industry Skills Council recognised a mental health worker peer worker qualification.²⁷ A growing body of research has found multiple benefits from this model of service delivery, with a recent Cochrane review²⁸ finding that “rather than being seen as a lesser trained health worker, lay health (peer) workers represent a different and sometimes preferred type of health worker. The often close relationship between lay health workers and their recipients is a strength of such programmes.” Furthermore, a US multisite research initiative carried out between 1998 and 2006 with 1827 people²⁹ found that participation in consumer led services increased both wellbeing and subjective components of wellbeing when compared to the outcomes achieved through participation in traditional mental health services³⁰, whilst another cross sectional survey found that individuals involved in consumer led services had improved social functioning compared to individuals involved in traditional mental health services³¹.

Considerable further efficiency and scale can also be added to a peer-worker approach through the use of technology, with the adoption of online technology by young people in particular an important reason for an increased focus on providing information and support through this medium for the mental health difficulties that commonly arise in this age group.³²

Online interventions for a range of mental disorders and problematic health behaviours have been demonstrated to be effective. For example, recent Australian research found that information about depression, and interventions that used cognitive behaviour therapy and were delivered via the internet were effective in reducing symptoms of depression in a community sample, more effective in fact, than a credible control intervention.³³ Online interventions - which can span self-help, peer-support, and virtual groups and clinics using assisted professional care - have the potential to reduce contacts at all levels of care within a stepped care model, as well as supporting people in seeking treatment in the first place.³⁴

Moreover, the anonymity and 24/7 availability of many online interventions can help to overcome some of the barriers to help-seeking (such as physical access and concern about confidentiality) that exist for some. Finally, they are highly cost-effective and have a shorter lead time to develop the work force compared to mental health clinicians.

Australia has been at the forefront of international innovation in the development, delivery and evaluation of e-mental health services for over a decade. However these approaches are still yet to be fully understood and embraced by the mental health workforce as a whole, integrated properly into the mental health system, or funded in a way that is sustainable and enables them to operate at scale. There is a need to both train and support the existing mental health workforce

to use and refer to online services, and to better integrate and fund existing services that have demonstrated their effectiveness over many years.

It is thus apparent that developing a stepped care system that integrates effective but low-cost and highly scalable interventions (such as those provided online) with existing 'traditional' services whilst better utilising peer workers to provide support at the lower-intensity end of the system, will be the most effective and efficient way to boost overall capacity and ensure that help and support can be provided to all those who require it. In addition by embracing e-mental health, and better utilising the peer workforce, we potentially have the opportunity to improve help seeking rates by overcoming geographical and attitudinal barriers, providing much greater reach and accessibility. A commitment to the use of technology and a focus on alternative health care professionals must therefore be the foundation for any effective response to a resource constrained mental health workforce and a potential increase in the number of people accessing help.

More efficient service delivery, minimising the need for face-to-face contact as a precondition for getting help and requiring clinical professional consultation only as needed, would also offer considerable cost savings. If a stepped care, integrated system of mental health care reduced the annual increase in the number of services provided by mental health care professionals (GPs, psychiatrists and clinical psychologists only) by only 1%, \$2.4 billion would be saved over the next 15 years. If that reduction was 4%, the savings would be \$7.2 billion and there would be no workforce shortfall for psychiatrists and clinical psychologists.

CASE STUDY: 21ST CENTURY MENTAL HEALTH SYSTEM IN ACTION

Jayden has been feeling pretty down for the last couple of months. He wants to get a good high school result but doesn't feel very motivated and is having difficulty concentrating. His job at the pizza shop can get really stressful, and he feels tired all the time but can't sleep at night. As a result he's becoming increasingly socially withdrawn, and argumentative with some customers. His marks are also suffering. Jayden's Mum has noticed that something isn't right and suggested that he talk to someone, but embarrassed to admit how he's feeling, and unable to see how talking will help, Jayden resists these suggestions.

One night at 3:00am as Jayden is unable to sleep, he goes on to Facebook to kill time and sees an advertisement for ReachOut.com - a service that provides information and support to young people going through tough times. Feeling pretty bad at that moment, Jayden clicks on the link and is taken to ReachOut.com. There he finds a questionnaire that he can complete online, and that, based on his results, will provide him personalised recommendations for help and support. There is also the option for Jayden to have his results reviewed by a peer support worker from an associated organisation who will contact him within the next 48 hours to provide additional support. Jayden signs up, puts in his email address and fills out the questionnaire, glad that he can keep this private from his family and friends and curious to see what his results will be.

The next day, walking home from school, Jayden notices that he has an email from the mental health peer support worker who has reviewed his results. Craig, the peer support worker, suggests that there may be some mobile phone apps that might help Jayden with his sleep and concentration problems and that they can discuss this if Jayden would like.

They set up a time for 9:30 that night.

In an online chat with Jayden, Craig explains that the services within ReachOut.com are part of a broader system that can offer different levels of support depending on what Jayden needs. Craig suggests that Jayden could start by trying out some self-help programs on his own, or with ongoing support from Craig if he feels like it would help motivate him. Craig further explains that if after a while Jayden feels like things are not improving, then Craig can introduce Jayden to a psychologist or psychiatrist online or face-to-face.

Jayden feels like Craig understands how he is feeling because Craig himself has been pretty low at times. Together they come up with a plan of action that involves Jayden using a sleep and wellbeing mobile phone app specifically designed for young men over the next six weeks, and checking in with Craig online once a week to see how things are going. Craig emphasises that the option is there for Jayden to ask Craig for an introduction to a psychologist or psychiatrist at any time if he needs some extra support.

Over the next six weeks, Jayden uses the suggested app and chats online to Craig once a week. Jayden's sleep, and therefore his mood improves. He still finds work stressful however, so Craig introduces him to a clinical psychologist in his local area that he sees for a single brief intervention session to discuss strategies for coping with stress. By the end of eight weeks Jayden is sleeping better and feeling happier. He feels better able to respond to customers when they get impatient without getting angry, and is concentrating better at school, which is reflected in improved exam results.

EARLY HELP, BETTER THAN LATE HELP

Investing in mental health promotion and prevention helps to reduce demand for more resource-intensive services, thus also reducing workforce pressure and overall health costs³⁵. In spite of this, and the endorsement by the Council of Australian Governments of the Roadmap for National Mental Health Reform 2012-22 in December 2012, that prioritised prevention and early detection and intervention, the majority of State and Federal mental health spending continues to be disproportionately concentrated in downstream mental health interventions, in treating mental health problems that have become severe, rather than in catching them early, or even preventing them in the first place. Between 2010 and 2011 for example, of the \$6 billion spend on health care, hospital services (26%), ambulatory care services (24%) and psychiatric medicines subsidised through the PBS (13%), accounted for the largest proportion of spending on mental health.³⁶ This must change. The World Health Organisation Pyramid Framework shows that mental health hospitals and specialist care present the highest cost. A greater focus on mental health care models targeting early intervention will potentially reduce future cost and demand on the acute sector. As little as a 1% increase in the mental health sector's productivity gain from fewer acute mental health conditions needing treatment would save \$2.4 billion over the next 15 years.

Early intervention also minimises the long-term economic costs of poor mental health, especially for the one in four young people experiencing a mental health disorder, the effect on education and the transition to the workforce of untreated mental health problems can be lifelong, even after recovery. Strong evidence particularly exists to demonstrate that interventions focused on the prevention of suicide, adult and childhood depression and childhood anxiety, are of particularly good value.³⁷

Since investing in mental health promotion and prevention and in early intervention is an effective way of reducing the economic costs of mental health, Australia's mental health system will be best served by building a strong promotion and prevention strategy that targets those most at risk of developing mental health problems and makes full use of all available channels to reach them. These at risk groups include young people, particularly Aboriginal and Torres Strait Islander young people (who are four times more likely to die from suicide than their non-Indigenous peers), lesbian, gay, bisexual, transgender and intersex young people (who are eight times more likely to attempt suicide), and young men, who are under-represented among those who seek help. Effective initiatives to help those most at risk of developing mental health problems will only be developed through processes which are open and consultative, listening *to*, rather than lecturing *at*, young people at risk.

In addition to targeting key at risk groups, Australia's prevention efforts should be widely delivered through a number of settings. Australia's current investment in programs such as MindMatters and KidsMatter that promote mental health literacy in schools, for example, should be continued. International experience has demonstrated that building resilience in young people at key points of transition – starting school, starting high school, and finishing compulsory education – has lifelong benefits.³⁸ Online avenues should be further explored, with the internet increasingly being a preferred medium for people – in particular young people – to access health information and resources^{39,40}. Social marketing campaigns conducted online, including via social networking services can now reach a large population, at a fraction of the usual cost. The flexibility of mobile devices and the expanding development of apps offer new opportunities for innovative campaigns and new ways to deliver information and support.

CONCLUSION

Meeting the demand for mental health help and support in Australia is not a new challenge, nor is it one that shows any sign of disappearing in the near future. Indeed, if we are actually successful in lifting rates of help-seeking among the Australian population, the projections in this report suggest the problem will only get worse.

It is clear that our existing models of service planning and delivery will simply never be able to meet this demand without a truly massive injection of financial and human resources, an investment that would impose a very significant cost-burden across society and, in all reality, is unlikely to ever materialise.

Despite this, there is reason for optimism.

Right now, we have the opportunity to create a new mental health care system that can deliver the right support, at the right time, to whoever may need it, regardless of who and where they may be. We could transform mental health services, creating a 21st century model that expands access, increases flexibility and improves outcomes – if we have the foresight to make the right investments and policy decisions now.

We need to create a system of stepped care, where accessing help does not necessarily require physical contact with a mental health professional, and where support and assessment can be provided by peer workers. We need a system that reconceptualises

help to encompass self-help and peer-support, managing and diverting the demand on clinical services and professionals so that they are free to assist those in greatest need of a higher level of support. We need to reorient our service systems from being expert-led, to being person-centred and driven, whilst harnessing the power of technology to deliver massive efficiency and scale. And beneath all this we must prioritise, and fund, mental health promotion and prevention to keep people mentally healthy in the first place.

This is all achievable, provided adjustments are made to funding priorities and planning frameworks. For the sake of millions of Australians who, every year, need mental health support and don't get it, and for the sake of the future economic sustainability of the health system, we must find the will to make this happen.



APPENDIX 1

REACHOUT.COM BY INSPIRE FOUNDATION

ADVISORY COMMITTEE MEMBERSHIP

The Committee was made up of a range of mental health experts who provided insight into the available datasets, the model designed, the assumptions made and final model outputs. Membership included:

Mr Jonathan Nicholas	CEO, ReachOut.com by Inspire Foundation
Mr Carlton Quartly	Principal Advisory, Accountability and Review, NSW Mental Health Commission
Mr Sebastian Rosenberg	Senior Lecturer in Mental Health Policy Brain and Mind Research Institute, Sydney Medical School, University of Sydney
Ms Kylie Wake	Director, Consumer and Carer Programs Mental Health Council of Australia

APPENDIX 2

THE MODEL COMPONENTS

The model was designed with the following components guided by the desired outcome, advice from the ReachOut.com by Inspire Foundation Advisory Committee and the available data.

Component	Data Source
Population	Base population as at August 2011 with information available at the following level: <ul style="list-style-type: none"> • By state • By area (metro/non-metro) • By age-band • By gender
Service types	Focus on non-admitted patient services only. Services included: <ul style="list-style-type: none"> • General practice • Medicare subsidised services (see subcategories below) • Psychiatric disability support • Emergency departments • Community Care Medicare subsidised service categories <ul style="list-style-type: none"> • General practice • Psychiatrist • Clinical psychologist • Other psychologist • Other allied health
Utilisation	For all service types outlined above, utilisation rates (e.g., per 10,000 population) were obtained at the following level: <ul style="list-style-type: none"> • By state • By area (metro/non-metro) • By age-band • By gender

Workforce	The current and projected healthcare professionals were reviewed and analysed for the following type of healthcare professionals: <ul style="list-style-type: none"> • General practitioners • Psychiatrist • Clinical psychologist
Cost	Cost associated with the increase in projected healthcare professionals were estimated by the Advisory Committee for the following: <ul style="list-style-type: none"> • General Practitioners • Psychiatrists • Clinical Psychologist

APPENDIX 3

THE DATA SOURCES

The data sources used in the development of the model are presented in the table below.

Component	Data Source
Population	2011 Census of Population and Housing from Australian Bureau of Statistics (ABS)
Service types	Based on mental health related service categories and data available from the 2011/2012 Australian Institute of Health and Wellbeing (AIHW) report. Services defined in the Medicare Benefits Schedule (MBS). National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD). National Community Mental Health Care Database (NCMHCD). The BEACH survey of general practice activity for 2011–12 and previous years was conducted by the Family Medicine Research Centre, University of Sydney.
Utilisation	2011/2012 AIHW utilisation data for the following services: <ul style="list-style-type: none"> • General practice • Medicare subsidised services • Psychiatric disability support • Community care 2009/2010 AIHW utilisation data for the following service: <ul style="list-style-type: none"> • Emergency department
Workforce	Fourth National Mental Health Plan – An Agenda for Collaborative Government Action in Mental Health 2009 – 2014 Health Workforce Australia database Health Workforce Australia – Health Workforce 2025 Medical specialities Volume 3
Cost	Average salaries are not readily accessible and so a desktop review was conducted followed by health sector enquiries to obtain salary figures for General Practitioners, Psychiatrists and Clinical Psychologists. As an initial guide these were discussed with the Inspire Advisory Committee and figures were confirmed as appropriate and applied to the model.

APPENDIX 4 ASSUMPTIONS

In order to perform the projections, assumptions needed to be made with respect to various components of the model. Inputs from the Inspire Advisory Committee as well as data available from multiple sources were used to determine the future outcomes of the mental health workforce. The following summarises the assumptions used in the development of the model:

Component	Data Source
Population	<p>The base population as at August 2011 was projected using the ABS projection factors using the medium levels of fertility, mortality, net overseas and interstate migration. The projection factors were available at the following level:</p> <ul style="list-style-type: none"> • By state • By area (metro/non-metro) • By age-band • By gender
Utilisation	<p>Recommendation by the Advisory Committee suggests that for all mental health related services, the increase in utilisation (excluding the impact of the increase and ageing of the population) is expected to be between 4-6% per annum.</p> <p>For all service types outlined above, the base utilisation rates (e.g., per 10,000 population) for 2011/12 (2009/2010 for emergency department) were projected using an estimated growth in utilisation of 6% per annum.</p> <p>The utilisation projections were applied uniformly at the following level:</p> <ul style="list-style-type: none"> • By state • By area (metro/non-metro) • By age-band • By gender
Workforce	<p><u>General Practitioners</u></p> <p>Using the Health Workforce Australia – Health Workforce 2025 Medical specialities Volume 3 released in November 2012, we have used the following information and assumptions to project the future workforce and determine the shortfall to meet the projected increase in utilisation:</p> <ul style="list-style-type: none"> • Current number of General Practitioners in 2009 and projected number of General Practitioners for 2012, 2018 and 2025 (uniformly distributing increases in between years) • 2010/11 average number of services per General Practitioner • Productivity improvement of 1% per annum <p>Using the above, we have determined the expected number of services that the projected workforce would not be able to provide and have translated the excess number of services into number of general practitioners required to meet the demand.</p> <p><u>Psychiatrists</u></p> <p>Using the Health Workforce Australia – Health Workforce 2025 Medical specialities Volume 3 released in November 2012, we have used the following information and assumptions to project the future workforce and determine the shortfall to meet the projected increase in utilisation:</p>

Workforce (cont.)	<ul style="list-style-type: none"> • Current number of Psychiatrists in 2009 and projected number Psychiatrists for 2012, 2018 and 2025 (uniformly distributing increases in between years) • Determine the 2011/12 average number of mental health related services per Psychiatrists • Productivity improvement of 1% per annum <p>Using the above, we have determined the expected number of services that the projected workforce would not be able to provide and have translated the excess number of services into number of psychiatrists required to meet the demand.</p> <p><u>Clinical Psychologists</u></p> <p>Using the Health Workforce Australia database, we have used the following information and assumptions to project the future workforce and determine the shortfall to meet the projected increase in utilisation:</p> <ul style="list-style-type: none"> • Current number of Clinical Psychologists in 2012 meeting the following criteria: <ul style="list-style-type: none"> ▶ Endorsement: Clinical Psychologist ▶ Principal role: direct client care role • Determine the 2011/12 average number of mental health related services per Clinical Psychologist • Productivity improvement of 1% per annum <p>Using the above, we have determined the expected number of services that the projected workforce would not be able to provide and have translated the excess number of services into number of clinical psychologists required to meet the demand.</p>
Cost	<p>A conservative approach to the cost of the workforce was taken by only using the average salaries for General Practitioners, Psychiatrists and Clinical Psychologists.</p>

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ABOUT REACHOUT.COM BY INSPIRE FOUNDATION

ReachOut.com by Inspire Foundation is the organisation behind Australia's leading online youth mental health service. Established in 1996, ReachOut.com was the world's first online mental health service and attracts an average of 1.4M unique visitors each year. The critical role for ReachOut.com in the Australian mental health system is prevention and early intervention, ensuring young people have a 24/7, evidence based and anonymous online environment to seek help. Outcomes of ReachOut.com are helping young people to improve their mental wellbeing, increase their mental health literacy and follow pathways through to clinical and emergency care for those who need it.

ABOUT EY

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ABOUT THE EY/REACHOUT.COM PARTNERSHIP

ReachOut.com by Inspire Foundation is EY Australia's first national strategic community partner. Launched in 2012 the three year relationship aims to:

1. Contribute to and challenge the national dialogue around mental health through reports such as this and the previous Counting the Cost report.
2. Provide information and support for EY staff to enhance their own mental health and wellbeing.
3. Support the service that ReachOut.com directly provides to hundreds of thousands of young people each year.

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