The peak organisation representing the non-government mental health sector in Tasmania at a state and national level

Submission

Joint Select Committee Preventative Health Care Inquiry

The Mental Health Council of Tasmania has a vision for a vibrant and effective mental health sector in Tasmania.

www.mhct.org

Suite 5 Mayfair Plaza
236 Sandy Bay Road
Sandy Bay TAS 7005

Phone: (03) 6224 9222
Fax: (03) 6224 8497

Email: ceo@mhct.org

Contact: Darren Carr
Chief Executive Officer

Prepared by: Elida Meadows
Policy and Research Officer

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The Mental Health Council of Tasmania (MHCT) is the peak body representing the interests of consumer, carer and community mental health sector organisations, providing a public voice for people affected by mental illness and the organisations in the community sector that work with them.

The MHCT advocates for effective public policy on mental health for the benefit of the Tasmanian community as a whole and has a strong commitment to participating in processes that contribute to the effective provision of mental health services in Tasmania.

The Council recognises that for people who experience mental health problems and mental illness, it is vital that they are able to easily access to services for the provision of the right care, at the right time, by the right people. All too often mental health problems and illness reach crisis point before appropriate care is received, despite the evidence that, with early identification and treatment, mental illnesses may be less severe, shorter in duration and less likely to recur, making a significant difference to the impact of mental illness on an individual and assisting them in their recovery journey.

We welcome the opportunity to make this submission to the Senate Select Committee on Preventative Health Care and would equally welcome the prospect of appearing before the committee

RECOMMENDATIONS

1. Support greater priority given to mental health and well-being, better public understanding and awareness (SDoH: Freedom from discrimination and violence; valuing diversity, physical security, self-determination and control of one's life)

Recommendations

- Work for a culture shift to make public mental health "everybody's business", starting with a public anti-stigma campaign.
- Legalise same sex marriage to improve the mental health outcomnes for LGBTI communities.
- Investigate the potential benefit of mental well-being impact assessments for all new major legislation
- Advance the field of mental health by developing the concept of population mental health, and fund research projects to target gaps in mental health data.
- Pioneer an interdisciplinary approach to addressing mental health.

2. Promote meaning and purpose and social connectedness (SDoH: Social inclusion supportive relationships, involvement in community and group activity; and civic engagement)

Recommendations

- Adopt the implementation of inclusive policies as routine practice.
- Promote skill development of mental health service staff on what real involvement means and the contributions support people can make.
- Provide more opportunities for social inclusion programs such as those provided by organisations like The Eureka Clubhouse and Richmond Fellowship.
- Recognise and act to increase access to arts programs which are shown to achieve positive outcomes in social connectedness.
- . To make a difference we need to measure how well inclusive approaches are reflected in service programs and what outcomes are being achieved.

3. Ensure a positive start in life (SDoH: Equitable start in life)

Recommendations

- Increase enhanced and personalised support for parenting through culturally relevant forms of home-based visiting (ante-natal and in the first few years of life) provided at a local or regional level.

- Active follow-up where a family is under stress or experiencing tough financial or social difficulties.[1]
- Support for parents, particularly those with mental health problems through, for example, parenting programs, perinatal support and closer links between children's and adults' mental health services.
- Emphasis on childhood prevention and the extension of early intervention services to young people with any type of mental health problem.
- Provide opportunities for affordable holidays for parents and children who are unable to take breaks due to financial pressures.
- Respite centres for children to help during crises.
- Greater input in schools in terms of mental health education, stress reduction and providing counselling and other interventions.
- Ensure provision of services for young people with particular needs or vulnerability, for example children in care, children at risk of violence, and disabled young people making the transition to adulthood, especially those with learning disabilities.
- Adequately fund child and adolescent mental health services (CAMHS), to support for wider CAMHS initiatives for the provision of those services that have a specific remit to provide specialist mental health care for children and young people, and their families.
- Investigate suicide "hotspots" in Tasmania and apply for funding under the Federal Government's Improving safety at 'hotspots' measure to address this issue.

4. **Build resilience and a safe, secure base** (**SDoH:** Access to economic resources: work, education, housing, money)

Recommendations

- Identify areas where policies and practices across government agencies can support positive mental health and develop an interagency action plan to support cross government linkages.
- Strengthen collaboration and partnerships across a range of sectors, including housing, employment, community services, disability, justice, education and health to ensure an integrated approach to health promotion, prevention, early intervention and recovery.
- Promote access to employment, income support, education, disability, accommodation and other community support services for consumers as part of an integrated approach to mental health care and recovery. Support employment strategies that promote employment and vocational programs linked to clinical and community support services.
- Support collaborative partnerships between non-government organisations, health care providers and government agencies.

[1] The first 2 dots points are quoted from National Mental Health Commission, (2012) *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, Sydney: NMHC, p.12.

- Increase the capacity of the non-government sector to provide psychosocial rehabilitation and support services. Increase the capacity of the non-government sector to provide advocacy and information services to mental health consumers and carers.
- Promote the role of consumer and carer organisations in collaborative partnerships.
- Support and acknowledge the key role of general practitioners in providing primary health care services, including mental health care, for both metropolitan and country communities.
- Promote strong collaboration between hospitals, community mental health services and general practitioners to facilitate continuity of care for consumers.
- Promote a shared care approach to service provision.[2]

5. Integrate physical and mental health and well-being across population groups and settings (SDoH: Access to health care services)

Recommendations

Focus needs to be placed on a strong primary care approach to delivering health services for people living with a mental illness, to

- to be responsive to the person's living circumstances, their complex health needs and the changing nature of their mental health requirements;
- to provide early intervention when symptoms first arise in adolescence and prior to that for early childhood and family support.

[2] The recommendations for this section were sourced from the south Australia Government's document - South Australia, Mental Health Policy Unit Policy and Inter-Governmental Relations Division, (2010) *South Australia's Mental Health and Wellbeing Policy: 2010-2015*, Adelaide: Department of Health, Government of South Australia, p.14.

Background

For those in the community mental health sector the priorities are to:

- Recognise that mental health is everybody's business and that mental health is more than the absence of mental illness – mental health is vital to the wellbeing of individuals, families and societies;
- identify factors that impact on mental health and wellbeing and implement strategies to reduce barriers to mental health – including initiatives to reduce poverty, discrimination and inequalities and to promote access to education, meaningful employment and housing, as well as services and support for those who are vulnerable; and
- create flourishing and connected communities through the promotion of well-being and resilience and the reduction of inequalities.

The federal government also recognises the importance of these issues to the future mental health of our communities and has outlined actions for prevention and early intervention in its Fourth National Health Plan, Priority Area 2.

The Fourth National Health Plan Priority Area 2: Prevention and early intervention
Summary of actions

- Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience.
- Implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations.
- Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services.
- Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage.
- Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.
- Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors.
- Expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with a mental illness.
- Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma.[3]

[3] Australian Health Ministers, (2009) *Fourth national mental health plan: an agenda for collaborative government action in mental health 2009–2014*,Commonwealth of Australia, p.32. Website: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09

The greater vulnerability of disadvantaged people in each community to mental illnesses may be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health. In contrast, persistent anxiety, insecurity, low self-esteem, poor self-efficacy, social isolation and lack of control over work and home life can have powerful negative effects on mental health (Wilkinson and Marmot, 2003). These psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. These factors also interact in complex ways with social and economic factors. For example, the lower people are in the social hierarchy of industrialised countries, the more common are these problems (Wilkinson and Marmot, 2003). Depression, for example, is 1.5 to 2 times more prevalent among low-income groups of a population.4

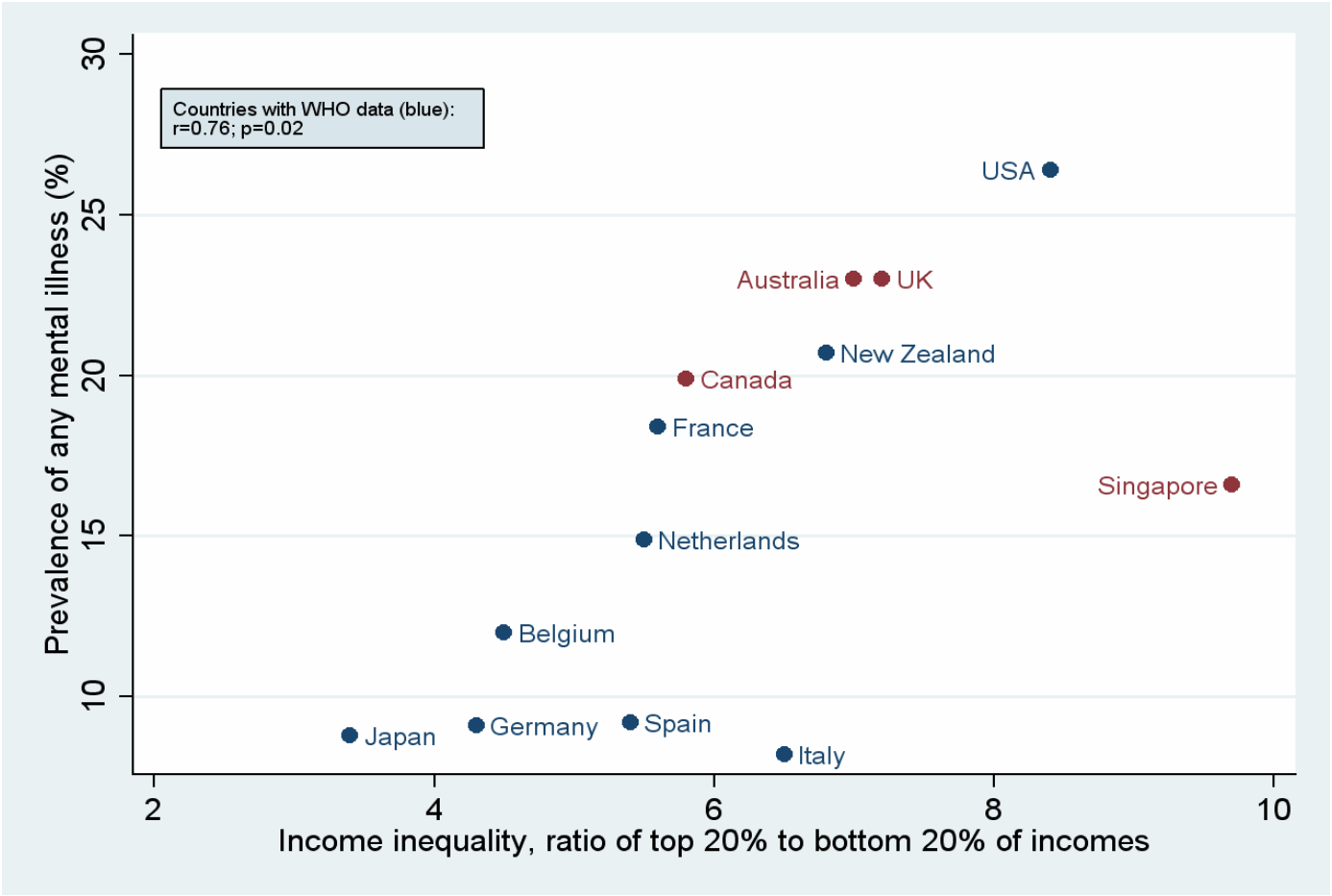
Mental health and mental illnesses are determined by multiple and interacting social, psychological, and biological factors, just as health and illness are in general. The clearest evidence for this relates to the risk of mental illnesses, which in the developed and developing world is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and low income as demonstrated in the graph below. Given the evidence that Tasmania has some of the lowest socio-economic indicators in the country, the evidence for Australia as a whole is equally relevant to the situation in this state.

According to the ABS, the 2011 Census shows that the unemployment rate in Tasmania is 6.4% as opposed to the national average of 5.6%. Median Weekly income for a person over 15 years of age iss $499 as opposed to the national average of $577; for families it is $1,203 as opposed to the national average of $1,481 and household median income is $948 as opposed to national average of $1,234.[5] ABS data also show that almost one third of households in Tasmania receive Government income support payments as their principal source of income, which is higher than the national average.[6]

The following graph makes clear the association of income inequality and incidence of mental illness in the developed world.

[4] Professor Margaret Barry and Dr Lynne Friedli, (2008) *The Influence of Social, Demographic and Physical Factors on Positive Mental Health in Children, Adults and Older People*, (Mental Capital and Wellbeing: Making the most of ourselves in the 21st century) UK Government Foresight Project, p.7.
[5] ABS (2012), *2011 Census Quickstats: Tasmania.*
[6] ABS (2011) 1338.1 - *NSW State and Regional Indicators*, Dec 2010.

Graph: Mental Health in Relation to Income Inequality[7]



In a recent article, Lynn Todman, Vice President, Leadership in Social Justice and the Executive Director of the Institute on Social Exclusion (ISE) at the Adler School of Professional Psychology in Chicago, noted that "There is growing consensus that daily living conditions and the distribution of power, money and resources shape the incidence of physical health outcomes such as respiratory, cardiovascular and infectious diseases; cancers; obesity; and diabetes. By comparison, there is far less focus and collective agreement on the role of social conditions in shaping mental health outcomes. Mental health prevention and intervention efforts concentrate overwhelmingly on affecting individual, family and/or community change, while changing the broader social, political and economic conditions that impact mental health is often neglected."[8]

It is clear that health promotion and prevention of illness have gained strong acceptance within public health, but it is noteworthy as noted by Lynn Todman that they have often

[7] Developed from: Pickett KE, James O, Wilkinson RG. Income inequality and the prevalence of mental illness: a preliminary international analysis. Journal of Epidemiology and Community Health 2006; 60: 646-7 http://www.equalitytrust.org.uk/why/evidence/mental-health

[8] Lynn Todman, (2011) *The social determinants of mental health*, American Psychological Association website: http://www.apa.org/pi/ses/resources/indicator/2011/08/lynn-todman.aspx

failed to incorporate mental health components within their framework. Considering the evidence of strong linkages between mental and physical health it is surprising that this is still a deficit. A greater understanding of the links between mental well being and physical health is needed by policy-makers, program and service providers and the community at large.

While the socioeconomic determinants of mental health require more study, research so far indicates that in general, people who are more socially isolated and people who are disadvantaged have poorer health than others; more socially cohesive societies are healthier, with lower mortality; and there are strong positive health outcomes associated with social connectedness.

Explaining the social gradient: mental illness journeys...distribution & causes of population patterns of health, disease & wellbeing

- Socio economic status – parental income, tenure, education, occupation, employment
- Adverse life events: violence, abuse, neglect, illness
- Contact with criminal justice system
- Racism and other forms of discrimination
- Institutional care in childhood[9]

Getting it Right

Based on the available evidence and ongoing consultation with members and stakeholders, the Mental Health Council of Tasmania believes that the basis for the promotion of good mental health and the prevention of mental illness in our society entails the development of sustainable, connected communities, the reduction of risk factors, the promotion of protective factors, and necessitates addressing the following crucial points:

1. Support greater priority given to mental health and well-being, better public understanding and awareness (SDoH: Freedom from discrimination and violence; valuing diversity, physical security, self-determination and control of one's life)

Issue/s

The increasing interest in positive mental health and wellbeing needs to be accompanied by an investment in research on the determinants of positive mental health across the life course, as distinct from studies on the determinants of mental disorders. To fully capitalise on the potential of mental health promotion, our 'roadmap to mental health' needs to be

[9] Dr Lynne Friedli (2012) *Reflections on the social determinants of mental health*, Public Mental Health Seminar Wolfson Institute, London 13th December 2012.

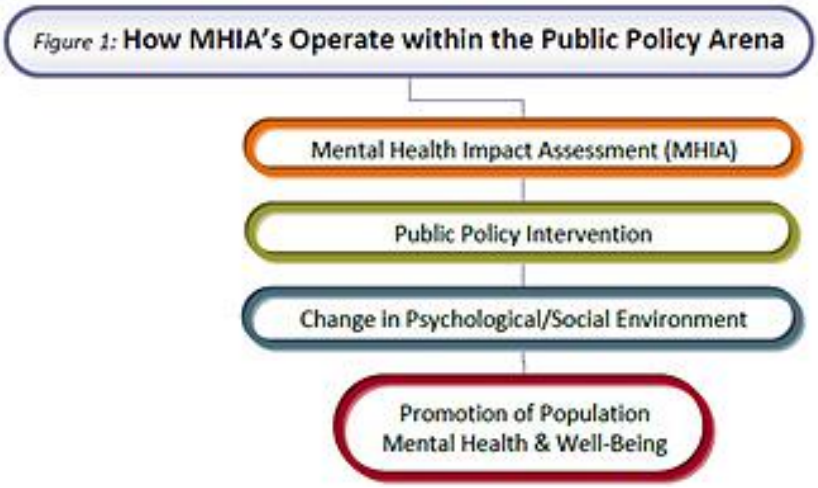
driven by a clear understanding of the nature of positive mental health and the factors that determine its maintenance and promotion across population groups and settings.

Stigma and discrimination were clearly key issues for consumers and carers and often raised in consultations with the MHCT. Public education and tackling stigma and/or discrimination is a prerogative to improve public understanding of mental health. Such a public campaign can result in people caring for their own mental health, seeking help earlier and being more aware of issues for people with mental health problems. This is a whole of community enterprise that needs to reach the broadest sector of society including employers, teachers, the police, service providers and diverse communities in general.

Stigma is also an issue across different population groups, for example Culturally and Linguistically Diverse (CALD) groups and the Lesbian, Gay, Bisexual, Transsexual and Intersex (LGBTI) communities, with the latter having higher suicide rates in this country than Indigenous people. Evidence has shown that jurisdictions that have legalised same sex marriage report a better mental health outcome amongst these communities.[10]

Another issue is the desirability of mental health impact assessments designed to promote population mental health and well-being within the local environment. The MHIA expands the notion of Health Impact Assessment practice beyond its usual emphasis on physical health issues to address mental health concerns that often have been left out of public policy discourse. It is a preventative practice that can be used to help ensure that legislation, policy, and other public decisions reflect an understanding of their implications for the mental health of vulnerable communities. It advances the prevention of mental ill health by developing the concept of population mental health. More importantly, the process of constructing the MHIA gives voice to vulnerable people, whose interests historically have been omitted from the national/statewide conversation on mental health.

[10] There is abundant evidence available including Paul Martin, *Statistics & Research regarding Lesbian and Gay Mental Health Issues and Same Sex Marriage Summary Shee*t, Brisbane: Centre for Human Potential – Brisbane, Website: www.australianmarriageequality.com/.../Marriage-equality-me...



[11]

Successful and meaningful mental health impact assessment depends on, among other things, the availability of good evaluative evidence on the nature, size, and likelihood of predicted mental health impacts. Various sorts of evidence are clearly important to promotion, prevention, and early intervention programming and information is often scarce. Data from qualitative studies, for example, can be used to identify the existence, nature, and possible mechanisms for unpredicted negative or positive impacts of interventions. Longitudinal life-course data can examine the long-term health effects of exposures to poor social and economic conditions and can identify aspects of the social environment or indeed populations where interventions may be most appropriately targeted. Cross-sectional epidemiological data can be used to inform and prioritise proposed interventions based on the strength of observed associations, for example existing data on unemployment and mental ill health.

Evidence

In a 2000 SANE Australia survey, people with mental illness and their families said "less stigma" was the number one thing that would make their lives better.[12] More recently SANE research found that "The distress and discrimination many people with a mental illness experience because of stigma associated with their illness is just as widespread as it was five years ago, according to new research by SANE Australia.

Three quarters (73%) of the 400+ people recently surveyed by the national mental health charity said they had experienced stigma or discrimination in the last 12 months because of their mental illness. A survey by SANE in 2006 found that 74% of respondents said they had personal experience of stigma."

This is unacceptable and contributes to a domino effect of negative outcomes for people living with mental illness: possibly not seeking treatment until the situation escalates; fear

[11] J. Sherrod Taylor, (2011) *Mental Health Impact Assessment and public policy*, The American Psychological Association, Website: http://www.apa.org/pi/ses/resources/indicator/2011/08/mental-health.aspx

[12] SANE Australia. (2000) *What's your view?* Website:: http://www.sane.org/campaignsbluesky.html

of going out therefore not undertaking any social activities and becoming more isolated; increasing stress and mental illness; worsening situation for the consumer and carers.

Although this submission refers good research being done in the area of mental health, ore research is also required in to other aspects of mental health issues. In particular we need to share the research that has been done in order to maximise the potential for better informed policy and programs across sectors. We should also be than able to identify gaps and the need for further research.

Few epidemiological studies have focused on analysing the determinants of positive mental health among whole populations. The existing evidence regarding the factors that enhance mental health is derived mainly from intervention studies and extrapolations from community epidemiological studies of psychiatric morbidity. Keyes (2007) articulates this situation as the 'roadmap to health is through illness'. The paucity of research on positive mental health and its determinants across populations limits our capacity to monitor the full impact of policies and practices that seek to promote mental health and wellbeing. The scope of epidemiological studies and national health surveys needs to be expanded to include indicators of positive mental health so that we can achieve a greater understanding of the determinants of mental health and how they unfold across the lifespan.[13]

In particular, the capacity to determine the potential ramifications of governmental action upon the social determinants of mental health is very important. Impacts upon disadvantaged populations are of special concern to community stakeholder organisations and public officials alike which is why the Mental Health Impact Assessment would be a value addition to the public policy toolkit.

Recommendations

- Work for a culture shift to make public mental health "everybody's business", starting with a public anti-stigma campaign.
- Legalise same sex marriage to improve the mental health outcomnes for LGBTI communities.
- Investigate the potential benefit of mental well-being impact assessments for all new major legislation
- Advance the field of mental health by developing the concept of population mental health, and fund research projects to target gaps in mental health data.
- Pioneer an interdisciplinary approach to addressing mental health.

[13] Professor Margaret Barry and Dr Lynne Friedli, (2008) *The Influence of Social, Demographic and Physical Factors on Positive Mental Health in Children, Adults and Older People*, (Mental Capital and Wellbeing: Making the most of ourselves in the 21st century) UK Government Foresight Project, p.7.

2. Promote meaning and purpose and social connectedness (SDoH: Social inclusion supportive relationships, involvement in community and group activity; and civic engagement)

Issue

There is abundant evidence that mental health status is strongly correlated with levels of participation in social and community life. The amount of emotional and practical social support people get varies by social and economic status and poverty can and does contribute to social exclusion and isolation. People who receive less social and emotional support are more likely to experience more depression.

Evidence

Good practice: Gardening project in Milan, Italy

A few years ago, 12 patients were discharged from a psychiatric hospital in Milan, Italy, to be followed up as outpatients. They all found accommodation either with their families or in apartments with some supervision close to the hospital. They tended to be somewhat passive until a formal work training program was offered to them in gardening by a cooperative that had been recently created and subsidized by the regional government. After an apprenticeship of a few months, the cooperative obtained a formal, year-round contract from three suburbs of Milan. This included seeding, planting, looking after flower arrangements and grass, and general maintenance of public gardens. Within 4 months of initiating their work, all ex-patients had moved to the areas where they were working. The project includes two monitors who are professional gardeners. All employees are paid the regular rate corresponding to their job.[14]

A national survey conducted by the Australian Bureau of Statistics in 2001 found rates of mental and behavioural problems and 'a very high level of psychological distress' were higher amongst adults who lived alone compared with adults living in a household with at least one other person.[15]

The link between social inclusion and mental health & wellbeing

A study of 2000 people in Finland found that social support strengthened mental health in all respondents (Sohlman 2004).

Young people reporting poor social connectedness (that is, having no-one to talk to, no-one to trust, no-one to depend on, and no-one who knows them well) are between two and three times more likely to experience depressive symptoms compared with peers who reported the availability of more confiding relationships (Glover et al, 1998).

A large meta-analysis of routinely collected data from 1952-1993 found a significant increase in mean levels of anxiety among US college students and school children which was correlated with reduced social connectedness (Twenge, 2000).

[14] Gaston Harnois, Phyllis Gabriel, (2000) Mental health and work : impact, issues, and good practices, (Nations for Mental Health), Geneva: WHO and ILO, p.54.

[15] Australian Bureau of Statistics (2001) 4811.0 - National Health Survey: Mental Health, Australia.

Evidence of significant and persistent correlations has been found between poor social networks (weak social ties, social connectedness, social integration, social activity, and social embeddedness) and mortality from almost every cause of death (Seeman 2000; Berkman & Glass 2000; Eng et. al 2002). Studies have consistently demonstrated people who are socially isolated or disconnected from others have between two and five times the risk of dying from all causes compared to those who maintain strong ties with family, friends & community (Berkman & Glass 2000). Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health. Supportive relationships may also encourage healthier behaviour patterns (Wilkinson & Marmot 2003).[16]

Recommendations

- Adopt the implementation of inclusive policies as routine practice.
- Promote skill development of mental health service staff on what real involvement means and the contributions support people can make.
- Provide more opportunities for social inclusion programs such as those provided by organisations like The Eureka Clubhouse and Richmond Fellowship.
- Recognise and act to increase access to arts programs which are shown to achieve positive outcomes in social connectedness.
- To make a difference we need to measure how well inclusive approaches are reflected in service programs and what outcomes are being achieved.

3. Ensure a positive start in life (SDoH: Equitable start in life)

Issue

There is now ample evidence that the early stages of life - from birth to age three – are more critical for development in mental, social, and physical functioning than in any other period across the lifespan and that what happens during this period influences how the rest of childhood and adolescence will unfold. (UNICEF 2002). A healthy start in life greatly enhances the child's later functioning in school, with peers, in intimate relations, and with broader connections with society. Additionally, backing this up with high quality education and interventions throughout the school years to support children and families in stress is shown to increase resilience and reduce the longer term need for crisis services. Programs which target the well-being of families, including the alleviation of economic hardship, family-friendly policies at the workplace, or access to child care, can lead to overall mental and physical health improvements in children and future adults.

Evidence

[16] VicHealth Mental Health & Wellbeing Unit, (2005) Social inclusion as a determinant of mental health and wellbeing, Research Summary 2: The link between social inclusion and mental health & wellbeing, p.3.

A recent NZ study found that individuals from the lowest childhood socio-economic backgrounds have significantly greater odds of reporting high to very high psychological distress compared to those individuals from the highest childhood socio-economic backgrounds. The authors conclude that "this research addresses an important life course issue regarding the pathways between childhood socio-economic position and mental health in adulthood. Our results suggest that disadvantaged social environments during childhood may have particularly adverse consequences for adult mental health status, because of their effects on educational achievement and subsequent socio-economic status."[17]

There is also strong evidence from a US study that "home-visiting interventions during pregnancy has shown health, social, and economic outcomes of great public health significance, including the improvement of mental health outcomes both for the mothers and, in the long-term, for the newborns. An effective example is the Prenatal and Infancy Home-visiting Program (Olds 1998; Olds 2002)[18], a 25-year program of research that has attempted to improve the early health and development of low-income mothers and children and their future life trajectories with prenatal and infancy home visiting by nurses."[19]

The report *Promoting mental health : concepts, emerging evidence, practice*, (2004) produced by the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne, provides references to ample evidence of universal programs to groups of students influencing positive mental health outcomes and types of interventions in schools that have been identified as achieving improved competence and self-worth, as well as decreasing emotional and behavioural problems. This report also points to the value of a positive psychosocial environment at school ("child-friendly schools") to positively affect the mental health and well-being of young people. The components of positive psychosocial environment at school include providing a friendly, rewarding, and supportive atmosphere; supporting cooperation and active learning; and forbidding physical punishment and violence. The focus on a range of generic risk factors and mental health problems, such as academic failure, aggression, and bullying, and have demonstrated increased individual competence and resilience as well as reductions in depressive

[17] Sarah K Mckenzie, Kristie Carter, Tony Blakely, Sunny Collings, (2010) The association of childhood socio-economic position and psychological distress in adulthood: is it mediated by adult socio-economic position? *Longitudinal and Life Course Studies*, Vol.1, Issue 4, p.354.

[18] The study referred to is documented in Olds, D.L., (2002) Prenatal and infancy home visiting by nurses: from randomized trials to community replication, *Prevention science: the official journal of the Society for Prevention Research*, Vol.3, No.3, pp. 153-72.

[19] Promoting mental health : concepts, emerging evidence, practice : summary report, (2004) World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne, p.37.

symptoms. As students get older and are faced with new challenges, such as peer pressure to engage in delinquent behaviour or substance use, social-emotional skills become particularly important to maintaining health and positive development.

Early signs of emotional disorders frequently appear during adolescence, yet they are often undiagnosed and go untreated. Young people with mental health disorders are at a greater risk for dropping out of school, ending up in jail and of not being fully functional members of society in adulthood.

- Approximately 4 million adolescents attempt suicide around the world each year – of these at least 100,000 are successful. Three times more females than males attempt suicide, but three times more men than women are successful.
- In the United States, 1 in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment. Fewer than 1 in 5 receive treatment.[20]

As far as suicide- in particular youth suicide - in Australia is concerned, according to the Hunter Institute of Mental Health:

- In recent years (2006-2010) the Northern Territory (20.2 per 100,000) and Tasmania (14.5 per 100,000) have had the highest rates standardised death rates by suicide, followed by Western Australia (13.2 per 100,000). In Tasmania it is notable that no suicide "hotspots" have been recognised and this prevents any prevention measures to be put in place in those areas where suicides are more likely to occur. This is an issue that requires further investigation.
- Considering all causes of death, suicide accounted for 23% of deaths among 15-19 year old males and 24.5% of deaths among 20-24 year old males in 2010. The corresponding percentages for females in both of these age groups are 16.6% and 25.7% respectively.
- Mental disorders such as major depression, psychotic illnesses and eating disorders are associated with an increased risk of suicide especially after discharge from hospital or when treatment has been reduced.[21]

In Tasmania it is notable that no suicide "hotspots" have been recognised and this prevents any prevention measures to be put in place in those areas where suicides are more likely to occur. "A 'suicide hotspot' has been defined as 'a specific, usually public, site which is frequently used as a location for suicide and which provides either means or opportunity for suicide.'"[22] The MHCT believes that several sites warrant further investigation and is aware of one site where the rate of suicide is 3 times greater than the notorious Gap in Sydney.

[20] *Adolescence: A time that matters* (2002) New York: UNICEF, p.35

[21] Hunter Institute of Mental Health, (2012) *Facts and stats about suicide in Australia*, Website: http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats

[22] Preventing suicide at suicide hotspots, (2012) Centre for Health Policy, Programs and Economics, University of Melbourbne, p.5

Although international studies show that nearly 20% of children and adolescents will have an emotional and/or behavioural disorder at some time during their youth regardless of where they live or the family income (Division of Mental Health, WHO. 1994), there have been limited studies designed to ascertain the prevalence of mental health disorders in Australian children and young people. The national report *Mental Health of Young People* in Australia (Sawyer, 2001)[23] indicates that 14% of children and adolescents suffer from a diagnosable mental health problem … In this report only three disorders were examined in detail: conduct disorder, mood disorder and attention deficit hyperactivity disorder. Co-morbidity amongst these three was common: 23% of the children and adolescents with one disorder had at least one other disorder … The National Survey showed that only 25% of the children and adolescents with mental health problems had attended services seeking help in the six months prior to the survey. Most commonly they attended their family doctor, school-based counsellors or private paediatricians. Of the children who met criteria for a disorder and whose parents thought they needed help, only 50% had attended any service and less than 20% had attended a psychiatrist, Child Adolescent Mental Health Service (CAMHS) or hospital psychiatry department. [24]

Recommendations

- Increase enhanced and personalised support for parenting through culturally relevant forms of home-based visiting (ante-natal and in the first few years of life) provided at a local or regional level.
- Active follow-up where a family is under stress or experiencing tough financial or social difficulties.[25]
- Support for parents, particularly those with mental health problems through, for example, parenting programs, perinatal support and closer links between children's and adults' mental health services.
- Emphasis on childhood prevention and the extension of early intervention services to young people with any type of mental health problem.
- Provide opportunities for affordable holidays for parents and children who are unable to take breaks due to financial pressures.
- Respite centres for children to help during crises.
- Greater input in schools in terms of mental health education, stress reduction and providing counselling and other interventions.

[23] M.G Sawyer *et al*, (2001) *The mental health of young people in Australia: Key findings from the Child and Adolescent Component of the National Survey of Mental Health and Well-Being*, Australian and New Zealand Journal of Psychiatry, Vol.35, Issue 6, pp.806-814.

[24] *CAMHS & Schools Project: a partnership between the Victorian Mental Health Branch and the Victorian Student Wellbeing Branch,* (2004) Melbourne: Mental Health Branch, Dept. of Human Services of Victoria and Dept. of Education & Training, pp.4-5.

[25] The first 2 dots points are quoted from National Mental Health Commission, (2012) *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, Sydney: NMHC, p.12.

- Ensure provision of services for young people with particular needs or vulnerability, for example children in care, children at risk of violence, and disabled young people making the transition to adulthood, especially those with learning disabilities.
- Adequately fund child and adolescent mental health services (CAMHS), to support for wider CAMHS initiatives for the provision of those services that have a specific remit to provide specialist mental health care for children and young people, and their families.
- Investigate suicide "hotspots" in Tasmania and apply for funding under the Federal Government's Improving safety at 'hotspots' measure to address this issue.

4. Build resilience and a safe, secure base (**SDoH:** Access to economic resources: work, education, housing, money)

Issue

A whole-of-government approach is required to bring together a range of sectors that impact on the mental health of individuals, such as housing, education, welfare and justice. Partnerships with these other sectors must be fostered, in order to develop a broader, whole-of-government approach to mental health that promotes positive reforms. Additionally, intersectoral linkage has been identified as fundamental to mental health promotion**.** Improving mental health outcomes requires policies and programs in government, NGO and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as specific activities in the health field relating to the prevention and treatment of ill-health.

Evidence

Numerous studies demonstrate that programs which address the determinants of mental health and support consumers towards recovery are more likely to succeed in this goal. Furthermore it is also becoming clear that an integrated, whole of community, whole of government approach is essential to promoting mental health and wellbeing. A collective effort from all sectors to promote social inclusion and social and economic participation assists in promoting positive mental health and a community environment that supports the recovery process.

The fundamental building blocks of good mental health include a positive start to life, strong and supportive relationships with friends and family, stable housing, employment, education, income security, social inclusion and participation in community life. On the other hand, people who experience social isolation or disadvantage, unemployment, family breakdown, violence, abuse, poor educational attainment, income or housing insecurity or who have substance abuse problems are more vulnerable to mental ill-health. In turn, people with mental illness or a mental health problem are more likely to suffer social and

economic disadvantages, including discrimination, with reduced opportunities to participate in the life of the community, inhibiting the recovery process.

The determinants of health and wellbeing are complex and inter-related, and there must be a commitment to supporting and developing partnerships with both government and non-government organisations in the general health, housing, disability, employment, education, family and community services, justice and drug and alcohol services sectors. This includes respecting the specialist knowledge of each of these sectors and working across sectors to build awareness about how everyday activities and services can promote positive mental health in the community and facilitate the process of recovery for those experiencing mental ill-health.

The role of carers and consumers in supporting and informing intersectoral collaboration is essential at all levels of policy, planning, research, service development and delivery in order to ensure the best possible health outcomes.

Recommendations

- Identify areas where policies and practices across government agencies can support positive mental health and develop an interagency action plan to support cross government linkages.
- Strengthen collaboration and partnerships across a range of sectors, including housing, employment, community services, disability, justice, education and health to ensure an integrated approach to health promotion, prevention, early intervention and recovery.
- Promote access to employment, income support, education, disability, accommodation and other community support services for consumers as part of an integrated approach to mental health care and recovery. Support employment strategies that promote employment and vocational programs linked to clinical and community support services.
- Support collaborative partnerships between non-government organisations, health care providers and government agencies.
- Increase the capacity of the non-government sector to provide psychosocial rehabilitation and support services. Increase the capacity of the non-government sector to provide advocacy and information services to mental health consumers and carers.
- Promote the role of consumer and carer organisations in collaborative partnerships.
- Support and acknowledge the key role of general practitioners in providing primary health care services, including mental health care, for both metropolitan and country communities.
- Promote strong collaboration between hospitals, community mental health services and general practitioners to facilitate continuity of care for consumers.

- Promote a shared care approach to service provision.[26]

5. Integrate physical and mental health and well-being across population groups and settings (SDoH: Access to health care services)

Issue:

The National Report Card on Mental Health and Suicide Prevention informs us that "The physical health of people living with a mental health difficulty is worse than the general community. For people living with a severe and enduring mental illness their health is much worse – people with illnesses such as bipolar disorder or schizophrenia have heart-related problems, diabetes and obesity at much higher rates than the rest of the community."[27]

The Report Card also notes that, "To reduce these shocking levels of physical ill health, we need to ensure that health services work to prevent, identify and effectively treat those conditions. However, we know that this will be difficult whenever the barrier of the 'overshadowing effect' in medical care exists – where treatment of a physical ailment is overshadowed and sidelined by the presence of a mental illness, and the whole person's health and wellbeing are not considered."[28] 28

Evidence

A study conducted at the University of Western Australia in 2001 showed that people living with a mental illness had an overall death rate that was two and a half times greater than the general population.[29]

Mental disorders accounted for 13% of the total burden of disease in Australia in 2003 (Begg et al. 2007) and ranked third for morbidity and mortality after cancer and cardiovascular diseases. Mental illnesses were the leading cause of the non-fatal burden of disease in 2003 (24%).
In 2009, mental disorders were responsible for 686 deaths, excluding suicide and dementia, with most deaths due to substance abuse involving alcohol and heroin (AIHW 2012).
According to the 2010 National Survey of Psychotic Illness, people with psychotic illness also frequently experience poor physical health outcomes (Morgan et al. 2011). For example,

[26] The recommendations for this section were sourced from the south Australia Government's document - South Australia, Mental Health Policy Unit Policy and Inter-Governmental Relations Division, (2010) *South Australia's Mental Health and Wellbeing Policy: 2010-2015*, Adelaide: Department of Health, Government of South Australia, p.14.
[27] National Mental Health Commission, (2012) A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC, p.23.
[28] National Mental Health Commission, (2012) A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC, p.28.
[29] R. Coghlan, D. Lawrence,C.D.J. Holman, A.V. Jablensky, (2001) *Duty to care: Physical illness in people with mental illness*, Perth: University of Western Australia; 2001.

more than a quarter (26.8%) of survey participants had heart or circulatory conditions and one-fifth (20.5%) had diabetes. The prevalence of diabetes is more than three times the rate seen in the general population.[30]

The issue of burden of disease is interesting in that although, as noted above, mental illness accounts for around 13% of burden of disease in Australia, with regards to mental health funding, the AIHW points out that, "About two-thirds of total regular health spending can be allocated to disease groupings. Of the broad groups shown, cardiovascular diseases accounted for the greatest spending ($7.9 billion or 11%) followed by oral health ($7.1 billion or 10%) and mental disorders ($6.1 billion or 8%)."[31]

The National Mental Health Report Card notes that although, in "Australia and internationally, guidelines have recommended that people with severe mental illness have their physical health monitored on a regular basis", there is evidence that this is not the case. The Report Cites evidence that demonstrates that "while nearly 90 per cent of people living with psychosis had visited a GP in the past year; two thirds reported they did not have a general health check or a cardiovascular-related health check. Additionally, it is estimated that only one in five people with a mental illness has a GP mental health treatment plan"[32] and this leads to worsening outcomes including lower life expectancy, increased hospitalisation, stress on families and carers leading inevitably to a greater burden on the health system and higher costs to government.

Recommendations

Focus needs to be placed on a strong primary care approach to delivering health services for people living with a mental illness, to

- to be responsive to the person's living circumstances, their complex health needs and the changing nature of their mental health requirements;
- to provide early intervention when symptoms first arise in adolescence and prior to that for early childhood and family support.

[30] AIHW, (2012) *Background to mental health services in Australia*, Website: http://mhsa.aihw.gov.au/background/

[31] AIHW, (2012) How much do we spend on health? Website: http://www.aihw.gov.au/australias-health/2012/spending-on-health/

[32] [32] National Mental Health Commission, (2012), p.30.