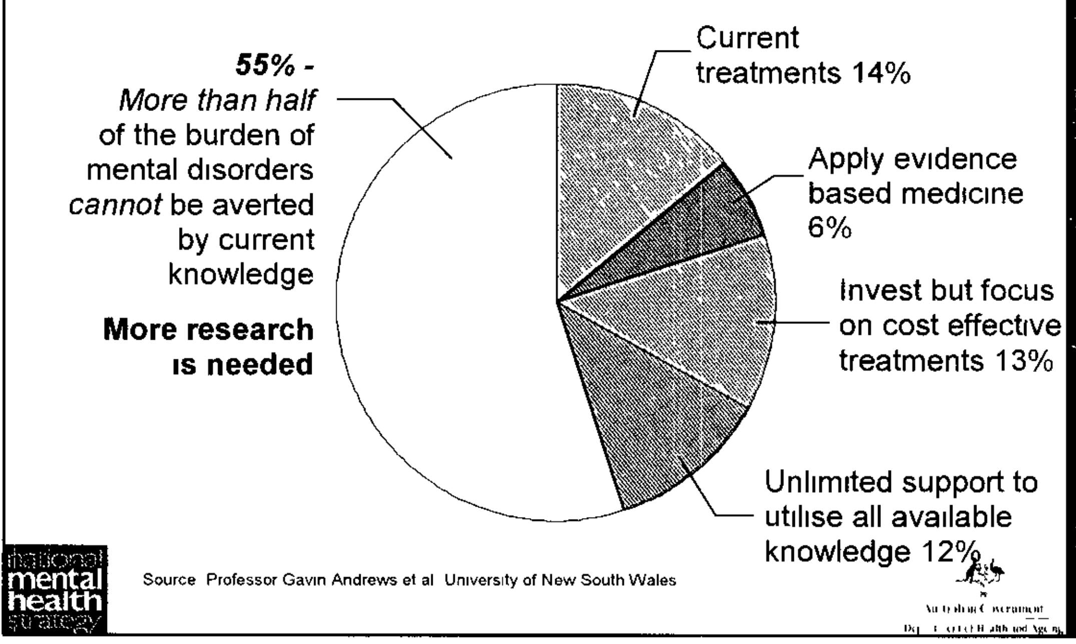
Improved Health Care Alone is Not the Answer



Mental health as a risk factor for physical disease

THE AGE MONDAY, MARCH 17, 2003
theage com au

Depression link to heart disease

Judy Skatssoon

Depression and loneliness are bigger risk factors for heart disease than stress, ranking alongside smoking, high blood pressure and cholesterol

The finding is included in a new position statement released by the National Heart Foundation yesterday after a comprehensive review of evidence by an expert working group

of health, medical and scientific affairs Andrew Tonkin, said the new position represented a big shift in thinking about heart disease He said during the 1970s the type A personality typified by the driven businessman was seen as most at risk of heart attack This had now been replaced by the stereotype of a lonely old man or woman without family or friends

"Certainly the evidence about

A different understanding of 'mental health'

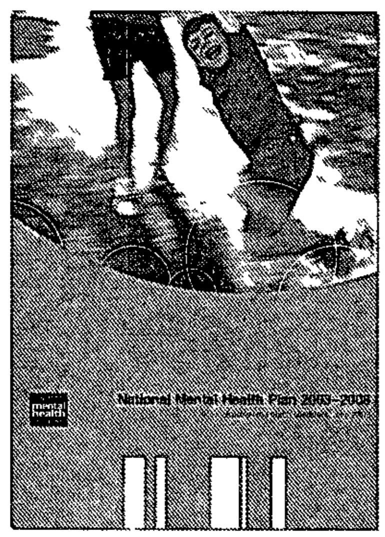
- Recognition that 'getting mental health right' is fundamental to the well being and economic health of our society
- Recognition that community partnerships are essential – Governments cannot do it alone
- Mental health's position in the health system, as well as its profile in the community, is changing
- For the first time, the theme of 'mental health is everybody's business' is being embraced by community leaders in industry, politicians and others who have great influence in our society
- The need to give high priority to mental health is now recognised worldwide

Australia's National Mental Health Strategy:

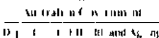
PART 3: *Current themes and initiatives*

The next set of slides summarise the key current aspects of the National Mental Health Strategy and give examples of new developments in the fields of prevention and promotion, service quality, and population mental health

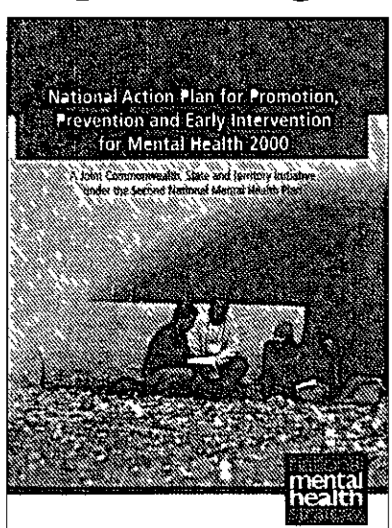
The National Mental Health Plan 2003-08



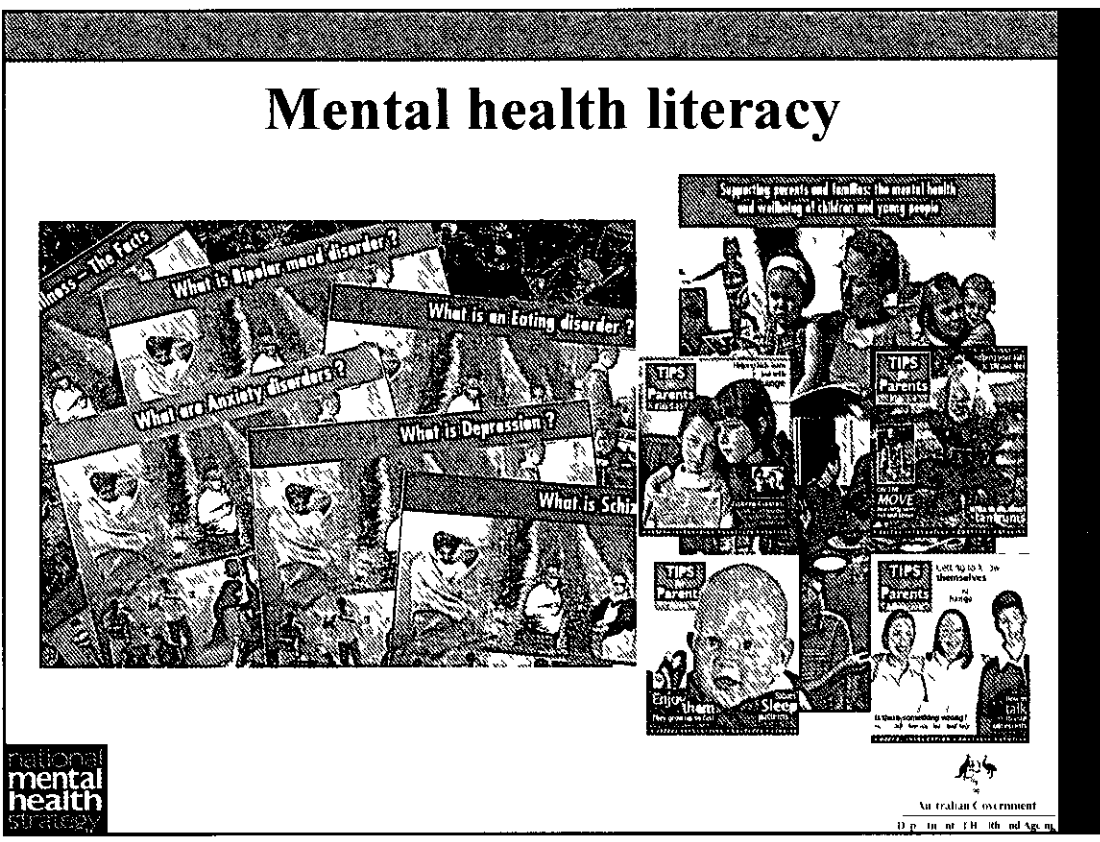
- Agreed by all Health Ministers
- Aims to consolidate service reforms while also extending the new paradigm for mental health
- Four priority areas
  - *Promoting mental health and preventing mental health problems and mental illness*
  - *Improving service responsiveness*
  - *Strengthening quality*
  - *Fostering research, innovation and sustainability*
- The Plan will continue to be monitored and reported publicly



THEME: Promoting mental health and preventing mental health problems

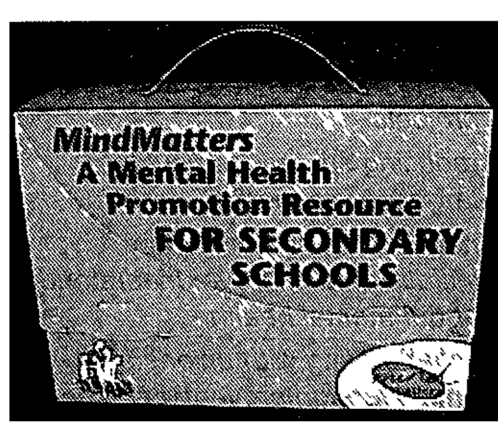


- Continuing effort required to position mental health as a 'whole of community' matter by
  - *consolidation of successful pilot projects*
  - *reducing stigma, particularly targeting the media*
  - *new mental health literacy initiatives to improve understanding about mental health*
  - *collaborating with unions and employers on prevention in the workplace*



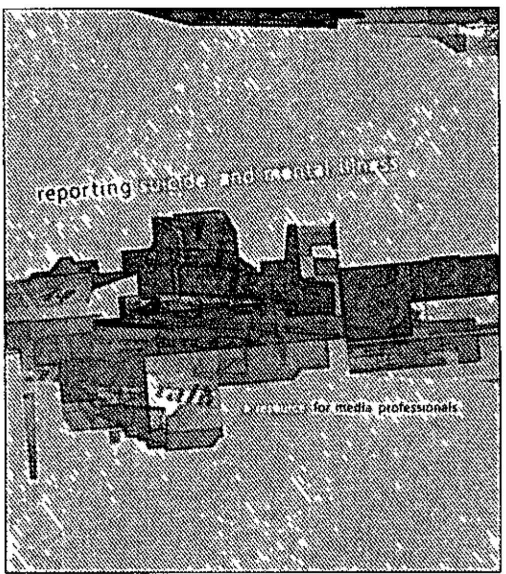
Mindmatters

Mental health promotion program for secondary schools



- *7,000 MindMatters resource kits produced, distributed to all Australian secondary schools*
- *Professional development training provided to 17,000 teaching staff*
- *Covers 65% of Australia's 3,200 secondary schools*
- *Complementary products under development for primary schools*

Resources for the Australian Media

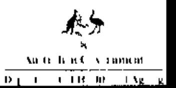


Supported by additional initiatives including

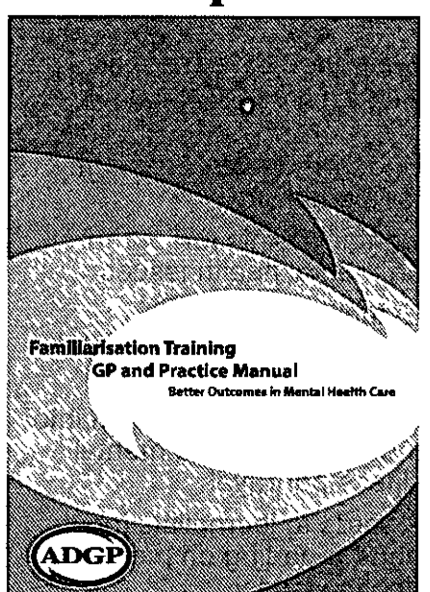
- Undergraduate curriculum for journalism
- Contact points for journalist on mental health issues
- Establishment of the National Media and Mental Health Group
- Monitoring and research into media suicide and mental illness portrayal
- Awards to journalists for good reporting on mental health issues

THEME: Improving service responsiveness

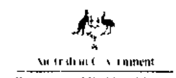
- Aims to sharpen the focus on responsiveness of the specialist mental health service system
  - *Access to care, especially acute services, early intervention*
  - *Improved continuity of care*
  - *Support to families and carers*
- Respond to the ongoing and emerging gaps within the service continuum
- Enhance rehabilitation and recovery-oriented programs
- Strengthen primary mental health care



Emphasis on General Practice



- Incentive Payments for GPs
- New Fee for service Counselling Item for GPs
- Access to Psychology services
- GP education and training
- Restructure payments for private psychiatrists



THEME: Improving Service Quality

- Emphasis on consumers, families and carers as 'customers'
- Aim is establishing a culture of continuous quality improvement
- Substantial investment in information infrastructure has been made – to provide the foundation for quality improvements
- Key initiatives
  - *Implementation of national practice and service standards*
  - *Comprehensive 'roll out' of routine consumer outcome measures for all people under care*
- The future Benchmarking against performance standards

Multiple national strategies, 'whole of government' involvement

National Suicide Prevention Strategy – Living is For Everyone (LIFE)

National Drug Strategy

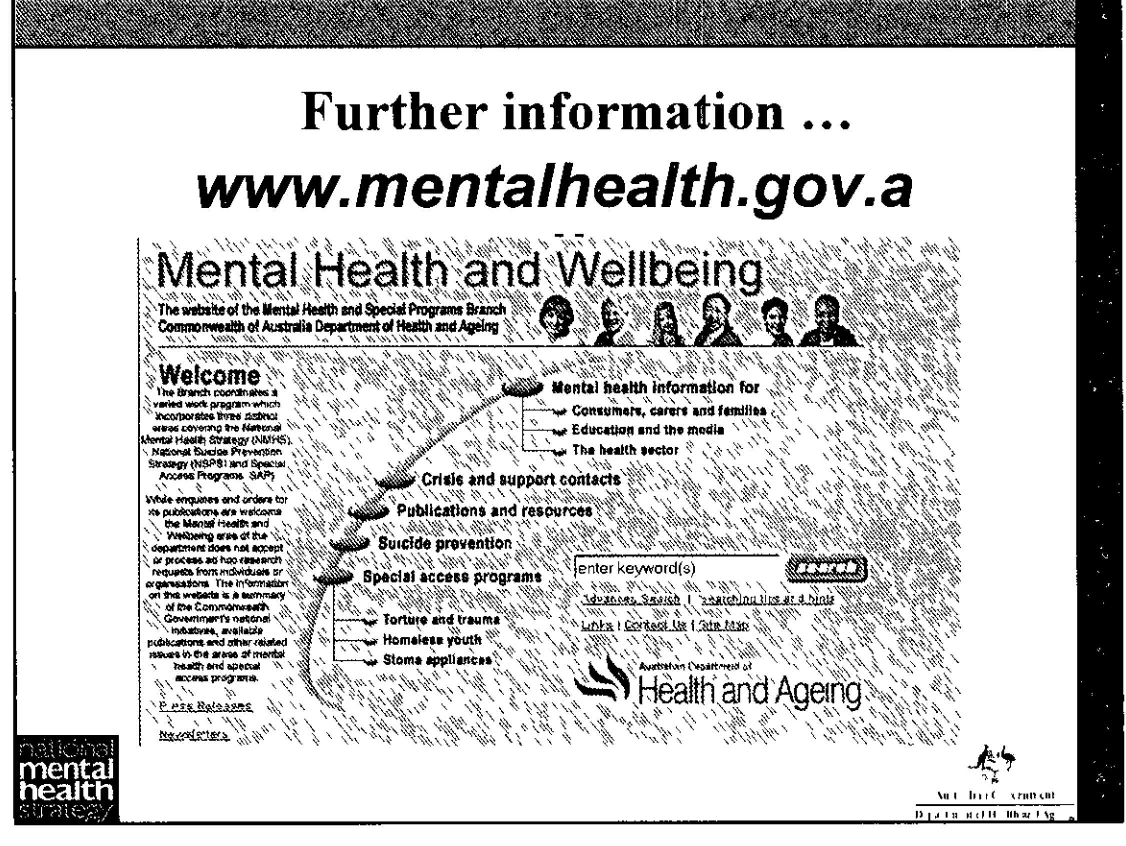
LIFE

Living is For everyone

Australian Government
Department of Health and Ageing

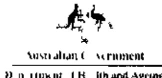
Further information …

www.mentalhealth.gov.a



APPENDIX 1: How the National Mental Health Strategy is monitored

The next set of slides provide details of how the National Mental Health Strategy is monitored This was a specific question asked in the notes from NIMH Japan



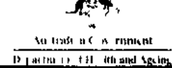
The National Mental Health Report

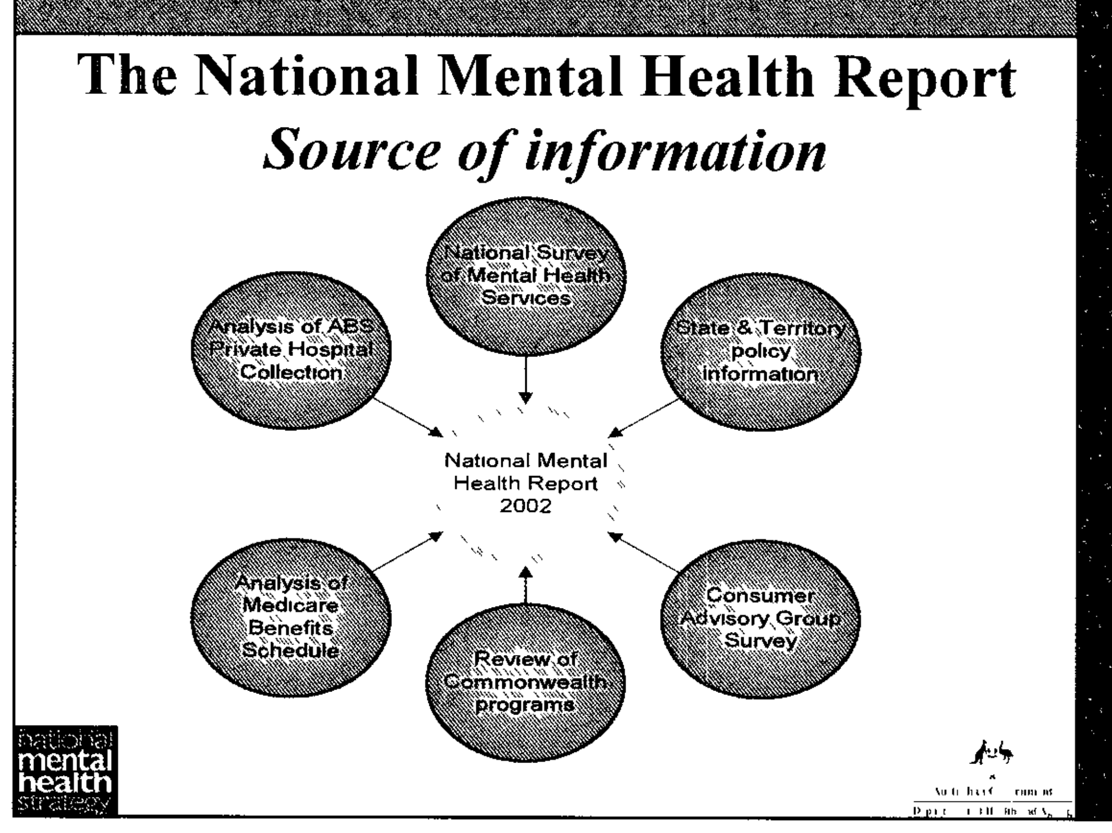
- Australia's Health Ministers agreed

  "To develop nationally agreed measures of performance in relation to each of the objectives in this policy and to report annually and publicly on the progress of the Commonwealth and each State and Territory in relation to these performance indicators "

  (National Mental Health Policy)

- This report is known as the National Mental Health Report, and is the primary vehicle used for monitoring the National Mental Health Strategy
- 7 reports have been published, the eighth is near completion





National Survey of Mental Health Services

Information categories collected

- Resource data
- Type and volume of services available
- Indicators of service activity
- Funding and accounting practices
- Quality of arrangements for monitoring service delivery and financial performance
- Consumer and carer participation in services

National Survey of Mental Health Services

Information categories collected

- The National Survey is conducted on annually on all public sector mental health services, it is the primary information source for the National Report
- Information covered includes
  - *Range, type and level of services available*
  - *Service activity indicators*
  - *Expenditure by service type*
  - *Workforce profile*
  - *Consumer and Carer participation mechanisms*
- Specific Survey instruments have been developed for service organisations, regional management and central administrative/policy units

National Survey of Mental Health Services

Information categories collected by level

National Survey of Mental Health Services

- Mental health service delivery organisations
  - Range type & level of services
  - Service activity indicators
  - Recurrent expenditure by service type
  - Quality of monitoring systems
  - Revenue sources of funds
  - Accounting practices
  - Workforce profile
  - Consumer participation
- Regional Administration
  - System level expenditure
  - Revenue sources of funds
  - Regional accounting practices
  - NGO funding
- Central Administration
  - Budget appropriation allocation
  - Revenue sources of funds
  - Annual reporting
  - State level accounting practices
  - System level expenditure
  - NGO funding

APPENDIX 2: Background to mental health literacy initiatives

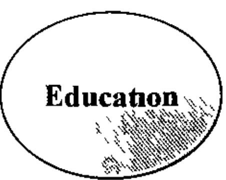
The next set of slides responds to the NIMH Japan request for information on mental health literacy initiatives Some examples are given earlier in the presentation but this section gives background information

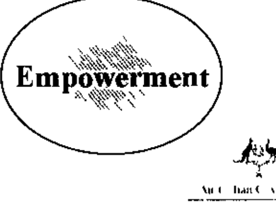
Promoting Awareness: Early efforts

- Community Awareness Program (CAP) - early initiatives taken under the First Plan
- Time-limited, mass media campaign
- Aimed to
  - *Position mental health on the public agenda*
  - *Promote a greater understanding and acceptance of those experiencing mental illness*
  - *Dispel myths and misconceptions about mental illness*

Community Awareness Program

- Three phases
  - Awareness *reduce stigma and discrimination through mainstream mass media*
  - Education *strategies to educate and inform particular groups in a more targeted way eg schools, media and employers*
  - Empowerment *strategies to empower and better equip consumers to advocate*





Community Awareness Program

- Key messages included
  - *all people have a dimension of mental health which can be protected and promoted*
  - *'ordinary people' experience mental health problems*
  - *It's just like any illness*
  - *mental health problems are curable*
  - *help is available*

What was achieved?

- Positives
  - *increase in awareness*
  - *improved attitudes to mental health disorders*
  - *tolerant attitudes reinforced*
  - *contributed to improved consumer self esteem*
  - *increase in awareness of help services*
- Effects were small
- But strong support for the campaign, high level of demand for educational materials

The current approach

- Continue to pursue the original CAP aims but
  - *emphasise a **positive approach** to mental health*
  - ***build capacity**, both in the specialist mental health sector and broader human services*
  - ***focus on partnerships**, build community ownership*
  - *adopt a broader **population health framework***

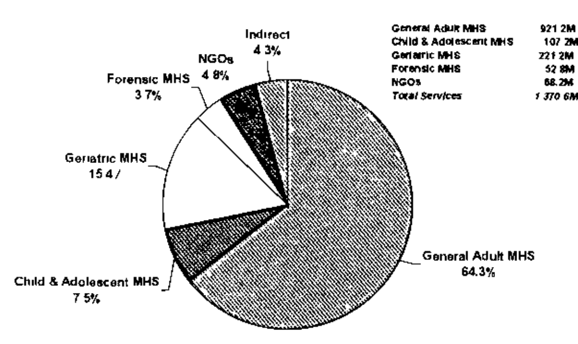
APPENDIX 3: Other specific issues raised by the NIMH Japan

The next set of slides responds to other specific issues raised in the notes provided by the National Institute of mental health Japan

Mental health population survey

- The National Survey of Mental Health & Wellbeing was conducted in 1997 It involved 3 components
  - *A general population survey involving 10,000 households, covering people aged 16-64 years*
  - *A child & adolescent population survey*
  - *A 'low prevalence disorders' survey, targeted at enumerating the prevalence of psychotic illnesses in the population*

Child & Adolescent psychiatric services



Total Expenditure 1997 98 = $1 432 Billion

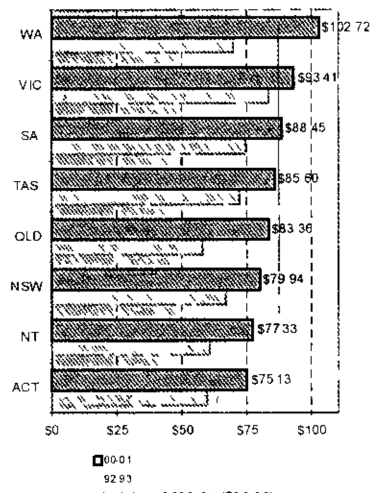
- The level of child & adolescent services in Australia is widely regarded as insufficient and requiring considerable development
- Child & adolescent services account for approximately 8% of specialist mental health expenditure
- Young people aged 0-17 represent 24% of the Australian population

Aged Care, dementia in particular

- Years ago, many people with dementia were admitted to Australia's stand alone psychiatric hospitals as the first treatment option This is no longer the case
- Separate Aged Care residential services are funded by the Federal Government and comprise nursing homes (high level care) and hostels (low level care) Total beds = approx 152,000 This far outnumbers the number of psychiatric beds in Australia (7,500 approx)
- Expenditure on these services = $2 billion (approx)
- However, in several States, specialised mental health residential services for the aged are provided for 'complicated dementia', where the person has severe behavioural disturbance that cannot be managed in a general aged facility
- Most States and Territories also provide specialist 'psychogeriatric' assessment teams in the community to assess and treat older people with mental disorders Specialist psychiatric acute units are also available where admission is required
- However overall the availability of specialist aged mental health services is very variable across the States and Territories

Are there differences between States?

- In short, yes!
- These differences are based in
  - *different levels of resourcing*
  - *different demography*
  - *different approaches to service development and innovation*



Differences between States and Territories in per capita expenditure on specialised mental health services 1992 93 and 2000-01

Ⅲ. 資　　料

社会福祉学科倫理委員会申請書

申　請　日　10月22日
職名　氏名　教　授　中根　允文
助教授　綿　祐二
講　師　吉岡久美子

研究課題	精神保健についての知識に関する日豪共同研究
研究目的	本研究は、1998年に開始された日豪保健福祉協力の共同研究の一環であって、2001年から第二段階の「精神保健」に入り、2002年から「自殺防止」及び「地域の精神疾患への態度の改善」をテーマに実質的研究が始まった。 今回の研究では日豪両国にとって共通した重大にして緊急の課題である、自殺防止対策を含む精神保健に関わる啓発活動を、地域住民を対象に検討するものである。精神保健の啓発活動というとき、近年の精神保健上の様々な話題を前提に、そのニーズは極めて増大してきているが、その背景となる情報は殆ど無く（特に日本では）、今回の大規模な調査を通して初めて把握される。 近年の自殺者数の増加傾向に歯止めをかけるためには、自殺に関わる心理社会的要因の解明と共に実践的な防止策の開発が肝要であり、そのための基礎資料として、そうした知見の確立を日豪が共同して推進したいと考える。
研究方法の概要 （具体的に） （例） 調査実施期間 調査実施対象 など	現在、オーストラリア側提案の草案をもとにした調査票のオーストラリア版および日本版が完成している。調査票は、IDセクション、症例に関わる理解・認識に関わる認識のありよう、対象者自身における心身の健康状態、幾つかの精神疾患や精神保健に関する知識の程度などを問う約120項目からなっている（別添資料）。これらを、必要に応じてカードを利用しながら、所定の訓練を受けた調査員が面接して調査し、情報収集を行う。 面接調査は、委託業者（山手情報処理センター、東京都北区中里）によって一般地域住民を対象に行われる。調査対象住民は、全国から調査地点（市町村単位に）を選択して、2000人を抽出する。年齢幅は20－69歳とし、1世帯から複数の抽出は行わないこととする。面接調査は被験者宅を訪問して行い、1回の面接調査時間はおおよそ30分で終了できると考える。 日豪両国で得られたデータをまずそれぞれに集計解析して、各国別の特徴を明らかにする。特に両国間でデータに影響する心理社会的・文化的相違点の関与を検討していく。得られた知見をもとに、日豪それぞれ、あるいは両国における精神保健行政への具体的なフィードバックを提案していく。 倫理的配慮として、地域住民には今回の研究の主旨を口頭、紙面両方で説明して協力を依頼し了承を得た上で実施し（協力拒否の保証）、さらに個人の情報が漏洩することが無きように厳重に守秘する。データ公表にあたっては、個人名は全く表示されることなく、集団的数値のみが出てくる。 平成16年以降は、専門職を対象とした調査を行い、今回の基礎資料との比較検討を行っていく。
判定結果	社会福祉学科倫理委員会 委員長 山岸利次（印） 社会福祉学科長　高橋信幸（印） 上記の通り承認する
委員会からのコメント	

METHODOLOGY FOR MENTAL LITERACY PROJECT

Door to Door Methodology

Interviews are to be completed using a door to door methodology

Interviewers will be issued maps or start points and are to use the standard method of moving around the mapped area or working from the start point that they have been trained in

Qualifying Respondent

The person in each household that we need to speak to is the person in that household who, of those who are 18+ years of age, had the most recent birthday

Leaflet

Each interviewer will be issued with a number of leaflets that explain the general 'health' (not specific) nature of the survey, that it is being carried out by the company for the institution and emphasising that it is an important study that we hope will benefit the community as a whole It will also detail the person who qualifies in each household (most recent birthday) and the importance of speaking to that person to get a valid sample universe

House by House

At each house make your normal approach and if the door is answered introduce yourself and read the introduction Explain the general purpose and importance of the survey and then screen the person at the door to find out if they are the person we need to speak to (most recent birthday) If the required respondent is available and is willing to talk to you may do the interview on the spot

If the required respondent is there but not available re-introduce yourself, hand the respondent the leaflet, explain the nature and importance of the survey etc and attempt to make an appointment for another time

Should the required respondent (RR) not be at home at this time hand the leaflet to the person who answered the door and ask them if they would be able to pass it on to the RR Tell the person at the door that you will be returning (in so many hours / days - write this on the leaflet) and that you would very much like to speak to the RR at

that time If you are able to get a phone number to help arrange an appointment that would be helpful

Should no-one answer the door at this time leave the leaflet in the mail box to warn the RR that you have called, would like to speak to them and will be returning at some time (write the day and rough time on the leaflet) to try to do so

Call Backs

In the metro areas (Cap cities) we will be making 5 call backs to each house or until we receive a final result (a refusal, or an unavailable for the survey period) One of these may be done by phone (for metro interviewing only) if you have managed to get a phone number

In ex-metro areas we will be making 3 call backs or until we receive a final result

Obviously, the best approach is to make your series of calls over a short period like two weeks in the case of metro areas and one week including both weekends for ex-metro interviewing You should also vary you hours so that if you intend on making two calls on successive weekends you should also make a call during the week day evenings

Call Sheets

You will need to keep accurate records of the calls that you have made to each house in the area that you have been assigned These will be used to calculate a number of relevant statistics later on

So for each call to a house you will need to record whether or not your visit resulted in an interview, a refusal, an appointment, a 'not available for duration', a no contact, language barrier, respondent incapable (blind or deaf etc) or whether you skipped the building due to it being a shop or other not applicable building

Obviously, once you have received a final result (refusal, not available, language, incapable, shop, or an interview) you can stop recording for that building but subsequent visits to other residences should be recorded until you have reached 5 or 3 call-backs (depending on location) or you receive a final result

The Topic of the Survey

For the purposes of this survey we need to keep the exact nature of the survey from the respondent till the end of the interview If the respondent asks about the topic we are able to tell them that "We are