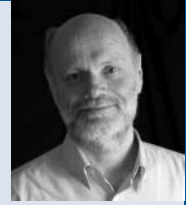


Editorial

The population impact of improvements
in mental health services:
the case of Australia†

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**Summary**

A national survey in 1997 found that Australia had a high prevalence of mental disorders with low rates of treatment. Since then, treatment availability has increased greatly and unmet need has reduced. However, there

is little evidence that the nation's mental health has improved.

Declaration of interest

None.

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In 1997, Australia carried out its first National Survey of Mental Health and Wellbeing.¹ This survey found that mental disorders were common, with close to 23% of adults reporting at least one disorder in the previous 12 months. The most common categories of disorder were anxiety (9.5%), substance (7.7%) and affective disorders (7.2%). However, rates of treatment were low. The survey found that only 35% of people with disorders had received treatment in the previous year, increasing to 56% of those with moderate or severe disability. The main reason that people gave for not receiving treatment was that they saw no need. Similar findings have emerged from national surveys in other high-income countries.

An obvious implication of such findings is that we should be able to improve population mental health by increasing the proportion of individuals that are treated. Using data from the 1997 survey together with burden of disease data, Andrews and colleagues made estimates of the cost-effectiveness of current and optimal treatments.² They estimated that current treatments averted only 13% of the disease burden from mental disorders. The degree of burden averted could be increased by giving existing patients optimal evidence-based treatment and increasing the proportion of individuals receiving treatment. Making some reasonable assumptions, Andrews and colleagues estimated that use of evidence-based treatment at current coverage could avert 20% of mental disorder burden, while evidence-based treatment at a higher rate of coverage could avert 28%. Furthermore, these reductions in disease burden were shown to be achievable at reasonable cost. Greater treatment of anxiety and depressive disorders was found to be particularly cost-effective.

Improvements in service provision since 1997

Since 1997, there have been substantial improvements in service provision in Australia. Data from the National Survey were used widely to advocate for some of these improvements. One area of increase was in the use of antidepressant medication, which

increased by 41% between 2002 and 2007, continuing a trend seen since the early 1990s.³

There have also been improvements in the provision of psychological therapies with the introduction of the 'Better Outcomes in Mental Health Care' scheme in 2001 and the 'Better Access to Psychiatrists, Psychologists and General Practitioners' scheme in 2006. These schemes greatly increased the availability of psychological therapies, particularly those provided by psychologists and other allied health practitioners. The Better Access scheme, in particular, has been very popular with the Australian public and has greatly exceeded its projected budget. In 2007, 1 in every 30 Australians received at least one Better Access service, increasing to 1 in every 19 in 2009.⁴

There have also been major changes in population-based intervention. In 1999, in response to the high rate of suicide, the Australian government set up the National Suicide Prevention Strategy that focuses on promotion, prevention and early intervention strategies. In 2000, the 'beyondblue' organisation was set up by national and state governments to improve the community's response to depression and related disorders. This organisation has increased awareness, improved attitudes to help-seeking and treatment, and supported preventive programmes. Although these population-based interventions did not directly provide health services, they did potentially affect the community's demand for and expectations of mental health services.

Improvements in unmet need since 1997

There is now evidence that unmet perceived need for mental healthcare may have changed in Australia in the decade since 1997. In 2007, Australia carried out a second National Survey of Mental Health and Wellbeing. Although the survey approach was similar in 1997 and 2007, changes to the diagnostic interview used, the Composite International Diagnostic Interview, meant that case definitions were not the same and prevalence rates could not be directly compared. However, there was a component of the interview on perceived unmet need for care that was comparable between the two interviews.

In the current issue of the *Journal*, Meadows & Bobevksi report an analysis of these data, taking care to eliminate possible sources of bias when comparing different surveys.⁵ They restricted their analysis to people who had received mental healthcare from a general practitioner, psychiatrist or psychologist and examined

†See pp. 479–484, this issue

perceived needs in the areas of information, medication, counselling, social intervention and skills training. Meadows & Bobevski found that the perceived needs of service users had increased overall, reflecting changing expectations about what mental health practitioners should provide. However, unmet perceived needs reduced overall, with significant reductions in unmet need for information (from 30.2% in 1997 to 18.0% in 2007) and for counselling (from 19.9 to 12.5%). Although unmet need for medication did not change significantly, this was already quite low in 1997, limiting room for improvement. It was not possible to determine from the survey data why these changes occurred. However, they are consistent with the improvements in service provision that have occurred over the decade.

Evidence on changes in population mental health

Although the reduction in perceived unmet need supports the investment that was made in improved services, the more important indicator is whether population mental health has improved. Unfortunately, because of changes in case ascertainment, it is not possible to directly compare prevalence rates in the 1997 and 2007 National Surveys. Nevertheless, there are several other national and state data sources available that are relevant to this issue. In each of these studies, survey data were collected using similar sampling and survey methodologies at two or more time points.

The first study compared national survey data from adults aged 20–74 years in 1995 and 2003 on psychological distress using the 4-NS (4 Neurotic Symptoms) instrument.⁶ It found an increase in distress in men aged 20–29 years, but no change in women or other male age groups. The second study compared the prevalence of major depression as measured by the Primary Care Evaluation of Mental Disorders (PRIME-MD) in people aged 15 or over in South Australia in 1998, 2004 and 2008.⁷ This study found an increase in prevalence in males aged 15–29 and females aged 30–49, but no change in other age groups. The final study compared psychological distress as measured by the Kessler Psychological Distress Scale (K10) in 1997 and 2007, and for a separate survey series in 2001 and 2004/5.⁸ A significant increase in anxiety symptoms was found for women aged 30–49 between 1997 and 2007, but no difference was found for men or women in other age groups. Depression symptoms did not change. Although the results of these studies vary, none shows an improvement in mental health and all show deterioration for some subgroup of the population.

Another relevant source of data is the suicide rate over the period. The male suicide rate peaked in 1998 and then declined by 44% from 1999 to 2005.⁹ It has been suggested that this decline could be an artefact of misclassification of suicides. However, even making allowance for misclassification, the male suicide rate appears to have declined by one-third or more. Female suicide rates changed little over the period.

Why has there not been a clear improvement?

Although the male suicide rate may have improved, other measures of population mental health do not show an improvement and possibly some worsening. Why then, given the increase in service provision and the reduction in perceived unmet need, has there not been a clear improvement? Some possibilities are as follows.

(a) Services have led to an improvement, but this has been counteracted by increases in other unknown risk factors.

- (b) The number of services may have improved, but the quality is insufficient. Indeed, the analysis by Meadows & Bobevski showed that although unmet need declined, fully met need did not improve, indicating that the number, but not the quality, of services had increased.⁵
- (c) It might be too early to detect any improvement. The 2007 data were collected before the full impact of the greater uptake of psychological therapies had occurred.
- (d) To reduce prevalence substantially may require a two-pronged approach targeting both reduction in incidence through preventive programmes, as well as reduction in duration of disorders through treatment services. In Australia, investment in prevention has not been at the same level as investment in treatment services.

The need for population monitoring

Although these data are specific to Australia, the issue of demonstrating a population impact is not. In the UK, too, it has been pointed out that a largely pharmacological approach to treatment does not seem to have benefited population mental health.¹⁰ There is a clear need for governments to support regular population monitoring in order to assess whether any investment in better services has been worthwhile.

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