THE AUSTRALIAN NATIONAL UNIVERSITY

Depression & Anxiety Consumer Research Unit
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Research is Everybody's Business! Seminar Series

Transcript of lecture by Prof. Ian Hickie (University of Sydney, beyondblue) at the ANU, 16th October 2003. "Is there an epidemic of Depression?"

Professor Marie Carroll (introducing)…

The Consumer Research Unit is the first of its kind that's been set up by the ANU Centre for Mental Health Research and the wonderful aim of this new unit is to bring news of breakthroughs and developments in research in mental health to you, the consumer, to keep you in touch with what's happening in universities and research institutions.

The consumer research unit is so vital in making that all important link between the universities and the communities that they serve.

All too often the things that matter to you and me in our everyday lives are not properly communicated and all too often, too, the researchers themselves or the government determines what gets researched. And the consumers often find that the important practical issues in their lives are ignored. So the consumer research unit wants to ask consumers what's important to them - to focus on the issues that consumers identify.

In psychological research we're just as guilty of this as any field of study is. Apart from being a direct consumer of our services through professional clinical services the average person knows very little of the important psychological research that's been done in areas such as depression and anxiety which of course touch us all to greater or lesser extents either directly or indirectly. But still less does the average person get to determine what aspects of depression and anxiety will be researched.

The consumer research unit will be presenting a series of seminars bringing the latest research to the general public and engaging in a dialogue with the public today's seminar 'Is there an epidemic of depression?' will be followed in later seminars by topics such as the side effects of medication and the latest research on the effectiveness of non-medical treatments for anxiety and depression including lifestyle treatments and alternative treatments. After today's presentation we'll have time for some questions from the audience and this is the chance for the public dialogue about depression and anxiety that the unit so earnestly seeks

Please join me now in welcoming the director of this innovative consumer research unit, Dr Kathy Griffiths, who will introduce today's speaker - Kathy.

Dr. Kathy Griffiths:

Thanks very much Professor Caroll.

Welcome everybody, its my pleasure to welcome Professor Ian Hickie to the ANU. Many of you here will probably know about Prof. Hickie. He's a director and an advisor to beyondblue the national depression initiative and was the CEO of beyondblue until recently when he took up a position of Professor of Psychiatry and Executive Director of the new Brain and Mind Research Institute at the University of Sydney. Now Ian has actually said 'please don't say too much" but I do want to say a few things about him so he'll just have to bear with me.

He's got a strong clinical and research expertise in the area of depression and in fact he's written more that 140 articles in scientific journals. His academic and other excellence has been recognised in many, many awards from organisations like the Royal Australian and New Zealand College of Psychiatrists, the Australasian Society of Psychiatric Research and also the THEMHS gold award to mental health services research. Personally, I think Ian's greatest achievement has been the area of advocacy and making a real difference for mental health consumers. Depression is now on the public map so to speak in Australia and I think Ian has a lot to do with that.

I was in a meeting last year with Ian and after he left, (and Ian is often at one meeting when he should simultaneously be at several others), a GP at the meeting leaned over and he said ' Ian Hickie's a genius you know?' and well, if achieving remarkable things is a sign of genius then I think he was right.

Ian's tireless work on behalf on each and every one of us who has depression or could have depression in the future sometime, is absolutely remarkable in my opinion. What's more it's a clear sign of Ian's genius that as CEO of beyondblue he authorised funds to assist in the establishment of the Depression and Anxiety Consumer Research Unit – so thank you very much for that Ian.

Without further ado I'd like to hand over to Ian:

Professor Ian Hickie:

Professor Carroll, Kathy and the general public, thanks for coming. Some of you have heard me before so thanks for coming again because there is a need at one sense to give this talk as I do in some ways over and over again because in a sense a talk that can't be given too often in our public environment, and given what I'd really like to talk about is the size of the health issues that surround depression and anxiety so that more and more people and perhaps more than once, and certainly every time I come to Canberra, I think that there are people here that need to hear this talk more than once so that they get in their heads that actually mental health represents the big health challenge in our society in the future.

As a consequence of that we might see the appropriate investments in services and research in those aspects of community support that will really make a difference to the lives of people who have been affected by depression and anxiety. It is actually a great pleasure to accept Kathy's invitation, even though she's running out the door, to actually give this talk and actually as she said, the consumer research unit I think is a major innovation in the way in that we conduct research in this area and hopefully make a difference to people's lives in the future and so through my time with beyondblue it was one of the projects that we supported and hopefully continue to support. To actually see the establishment of a consumer research unit within the Centre for Mental Health Research, within one of the major mental health research

entities in this country and I think it's a credit to Tony Jorm and his colleagues that they supported that development and to Kathy and her colleagues in particular that they've brought that great idea into life.

Now if you do tune into the odd ABC program or you see some of the media that we've been able to attract through beyondblue you might, as people in my family do, ask is there really an epidemic out there or do you just talk a lot about the same thing you know what is the notion, what is the size of the problem with regards to depression and common disorders in our country.

Well I am keen to say actually, it's not that we over-talk, we actually under-talk it, particularly for all mental disorders and if you just go to the AIHW type figures, mental disorders in this country are number one when it comes to disability. We're always up the top. I think a lot of people do these charts and they actually sort of lob us off and leave us out and start with the serious things like heart disease and cancer and urological disorders but mental disorders constitute 27% of total years of life lost to disability in this country. They are the disabling disorders.

I was at a great health meeting last night actually with major health figures. And we got into an argument about death and disability because you know in fact we emphasise the disability in particular associated with mental disorders although our disorders are associated with premature death, and we were having an argument about whether death actually matters in the health system or not. Some people argue actually death is quite a good outcome in the health system as you stop costing the system and I have been to the odd meeting in Canberra at times where I've heard the odd politician express the idea that nothing is reliable as a dead voter – which lets you know their intentions.

And while on health spending a lot of the time a lot of the public actually think that premature death is quite important but actually in our society it is the economic and social contribution ongoing disability is our major issue. And as we become healthier in the general physical health sense people whose lives affected by disability is a major concern and mental disorders really do matter. Earlier this year the neurosciences group in Australia got to present to the Prime Ministers' Science Engineering and Innovation Council about where Australia should make it's future investments in bio-technology, in health, in science in general. And this particular slide was used for particular emphasis. Many of you particularly in Canberra, may be aware of the extent which the intergeneration report is being used to get governments to think about the future cost of health care, particularly for those with neurological brain degenerative disorders at the later part of the life cycle - the really important part of a disability in our society.

But there's been almost no serious government consideration that in fact for 15-34 year olds, 60% of disability costs are accounted for by common mental disorders. So there are people completing education, training, entering the workforce, paying tax they are the tax payers of the future to take care of that group, prime minister and his friends, who may be at the other end of the cycle who are worried about who is going to pay and take care of them as they age. Now there has been some degree of attention and certainly through the efforts of Fiona Stanley, the Australian of the Year, to emphasise how important mental disorders are amongst children and how important the developmental years are, but there has been a relative understatement of the extent to which actually mental disorders come into their own during that teenage and early adult life period and the potential implications for us of 60 % in the age group being accounted for by mental disorders.

We are lucky that Scott Henderson here at ANU in association with Gavin Andrews, Wayne Hall and others insisted that we actually have a mental health survey in Australia and has been largely the top line of that, that over 800,000 Australian adults have a depressive disorder which has certainly justified my public existence for the last few years but importantly to say that those 800,000 Australians are part of over 2 million Australians and that roughly an equal number of men and women that have the common mental disorders of anxiety and depression or associated alcohol or substance abuse - big numbers.

I personally prefer the death and disability statistics to just the disability statistics. One of the problems in mental health is that we are well aware of the contribution to disability but in the general health world and in terms of the hearts and minds of the voters out there, and I'll come back to this continuously, until we have the hearts and the minds of the voters voting for us and actually saying that mental health matters that we tend to be ignored in the wider health debate. We do contribute to death as well as disability.

In fact when WHO and Harvard University got together and set up the competing charts of who contributes to the most premature death and disability, unipolar depression finished fourth but in the statistics that they used they didn't really account for the depression contributing to death, suicide and depression's contribution to physical outcomes wasn't really factored in.

When AHIW did the same thing here in Australia and depression finished equal third on the death and disability charts, it was largely due to the overall amounts of disability. If you actually factor in depression's contribution to death through suicide and the premature deaths through its contribution to heart disease and to poorer outcomes of a range of other medical conditions we would probably already finish second.

As most people already know we are projected to go to number two in the next twenty years if we don't do anything further about it.

And the reason that we would go to number two is not so much that we are shooting up the charts but of course all those ones that are up the top at the moment are going down. Which is of course good news for blokes like me because men of my age are on the whole are going to live 15 years longer than their dads in one generation which is a remarkable change in the physical health profile of our community through public health and some degree of improvement in health services in those areas but its largely the diet, exercise, smoking and attention to other risk factors which has had such a dramatic effect on heart disease, stroke and lung disease.

Of course our investment in preventative strategies, early intervention strategies and improved health services for any of the significant mental disorders has been minimal on an ongoing basis and it is really interesting to ask why is that the case.

I have the good fortune as often is in my work to be debating this with a 60 Minutes reporter just the other day and he said "well, there's nothing you can actually do" and I said " there's quite a lot we can do but there's the public perception that there's nothing we can do" and I was having a kind of interesting discussion with him because it's our failure to communicate to the wider public that we actually can do stuff that works, that reinforces the idea that in mental health that there's not much that can be done. It's very sad for those people that have got those problems but that there's not much that can be done to prevent it or not much that can be done to treat it.

The other big challenge for us is actually the essentially changing epidemiology of depression. Now I like to put up this particular chart and highlight an empty space because this is the good

news empty space for people like me. If you went back about 40-50 years and you look at the patient statistics you would seen a big bump up here in increased depression rates in blokes between the ages of 50-70 where they had quite poor mental health in association with quite poor physical health, and particularly in association with vascular disease, heart disease, stroke etc as well as lung disease.

So men between the ages of 50-70 have poor physical health, also had high rates of depression and quite high suicide rates. They have largely disappeared. Now I know you know this in Canberra because we have a Prime Minister who had talked about retiring at age of 65, as men of his generation are supposed to except that he found he was in excellent health and having the time of his life and had no intention of retiring. In fact we now have a society as he tells others that we expect you to go on looking after yourself quite into your 70's if you're independent and you're physically well.

So whatever else his other characteristics may be he's a great role model for actually what we now expect in that age group. We don't expect blokes like him to be miserable, we expect them to be out there walking every morning in that Vodafone tracksuit having a great time and actually making some sort of contribution. They've disappeared. Of his father's generation they would have occupied a large part of the chart.

Unfortunately what has happened within the same forty year period is that the mental health of younger people has declined. Rates of depression, anxiety, alcohol and substance abuse and suicide have all gone up over the same fifty year period in young people. It's not a reporting artefact, we see it across those various sets of disorders a substance abuse in addition to other mental health disorders and in harder statistics like suicide rates. Something's fundamentally gone wrong in our society over that 50 year period.

Now we don't think it's a physical health or welfare or education issue because all those things have largely and dramatically improved for younger people across that particular period. It certainly implies that something more intrinsic to the social fabric has changed and has adversely impacted on younger people rather than older people. Certainly most of the theorising these days is around social connection, or in our case rather in social disconnection to the extent where we just don't take care of each other in the same way that we used to.

We just don't have the same the more rigid and fixed social structures that people could access whether they were churches, community groups, social groups, RSLs, schools, your people over the back fence, your local neighbourhood , that children don't seem to have to access to that large range of functional adults that you really require to learn coping skills to get through life, to cope with adversity to be there when you're going through tough times.

Unfortunately I think its often reduced in our society to artificial debate about one parent families vs two parent families as distinct from the whole range of grandparents, aunts, uncles, the lady next door, the bloke who runs the local footy team, the person down the local shop that you know who represent that whole wider group of adults in which children were previously enmeshed so if your parents were duds, or not very helpful, as my kids tell me regularly, you have a whole range of other aunts and uncles and other people who can actually help you out and you don't see yourself as being isolated or having no-one to turn to .

Of course if that is the case, if that is the explanation, it is quite a challenge to us, on an ongoing basis as to in what ways are we going to establish the sort of social networks that will be protective and critical to the development of younger people.

As I say you see these effects not just in things that involve going and knocking on people's doors and counting actually who's got which particular disorder but people always worry about whether differences in reporting styles are having an effect. You see it in pretty hard statistics like suicide and so you see that dramatic fall in rates of suicide in people over the age of 65 across the course of the last century.

Most people would be aware of the extent to which particularly in the last half of the century, and particularly in the 70's and 80's, rates of suicide amongst people in the 15-24 year old age group really took off, what people are less aware of is that in fact rates of suicide in 25-44 yo have continued to increase as well. That is, those people, who were teenagers in that particular period are now in their early adult life and they are taking their high rates of suicidality with them, they're not growing out of it. Whatever went wrong during those particular generations is continuing with those people. The maturing of their brains, the moving into other social roles, isn't fixing the problem.

Whatever were the fundamental sets of abnormalities that occurred and have impacted adversely on their mental health are continuing to see that. And this now remains one of the most worrying aspects of our suicide statistics and I think appropriately we've seen a switch in the naming of our national suicide strategy from the National Youth Suicide Strategy to just the National Suicide Strategy.

That there are particular issues, particularly for that 24-45 year old age group, and there is a group particularly still of older men, men over the age of 75 that continue to have high rates of suicide, where their physical health starts to go bad.

So where men's physical health used to start to go bad at age 65 now it starts to go bad at about age 75 and you start to see the increasing rates of depression and you still see quite high rates of suicide in that age group. But it is a challenge to us. I'll come back to this because there are opportunities here. There are issues about 25-44 year olds because they do start to use health services. The issues of 15-24 yo remains a real challenge to us, what sets of social structures, what sets of social interventions may be open to us to potentially affect suicide rates in that group and there certainly has been some degree of plateauing at least in the rate of rise of suicides in that age group.

This other group however raises the other possibility - may we be able to do something through improved heath services in that group in which we already have health services they access that provide a better deal. The combination of the change in suicide stats is pretty well summed up in this one lined graph.

When you look at the shift in who actually suicides from older people to younger people over the last half of the last century you see a dramatic rise particularly in the 1990 onwards in the years of total life lost to suicide.

Now, a lot of things about our National Mental Health Survey would be otherwise boring if it weren't that people set up the surveys Scott Henderson, Gaven Andrews and others said "perhaps we should ask people what they actually do rather than whether they've just got this problem. What do they actually do about health services, where do they go , what sorts of treatments do we provide", and the really awful bit, and I guess I always feel reluctant about discussing this particular statistic amongst health service providers, they always already fell overwhelmed with who's already in health care, only 38% of people who actually have the problem are in care, there are more people sitting out there not actually into care.

If you think you're having a bad day already and feeling overwhelmed, there's probably twice as many sitting out there not coming to care. Many with anxiety disorders, many with degrees of substance abuse, but even for issues like depression which are pretty clear cut in terms of their effect on people's life and the degree of disability. Over half of those cases don't come forward.

I think some of the most interesting research in depression and where like the consumer research unit and other groups contribute, is to go ask why? Because these are people who have volunteered significant psychological symptoms on questionnaires, they are clearly disabled by their illness but in the last year they haven't come forward for any treatment. Why not?

Then you have to ask yourself do you really want to know the answer to that question because it isn't very nice. The two overwhelming issues are the stigma – we live in a society which is fundamentally intolerant of these disorders and if you go to a doctor or you go to a health service and someone says you've got it then you really have got it. Its an interesting cognitive shift - you can have the problem, you can have the symptoms, you can be at home but you can pretend you haven't got it.

You're actually going to work, you're going to school, you're driving your partner nuts, the kids can't stand you, you're drinking too much but you still haven't got a problem – you can still say it will go away. Its not really a health problem, it'll be there next year, it's the boss, its finances, its work, its relationships, it will pass even when it doesn't. People are able in a sense to maintain that and you say well why would you want to do that and you say well, what's the health system look like that I' m going to come forward to seek treatment in. It doesn't look very attractive.

People are extremely reluctant about the nature of the treatment that they will receive, both being fearful of the treatments particularly the medical treatments, but in addition fearful of the responses they will receive from health care systems if they enter into them with a pretty smart idea that many of those systems are not well suited and they may run into sets of attitudes that in fact discourage them from seeking care.

In addition, to the obvious social problem, that if you go in there and the doctor says it is depression then what are you going to tell your family, what are you going to tell your employer, what are you going to tell your insurer next time you apply for life insurance, what are you going to say on all those questionnaires.

Anyone who's ever entered the United States recently - are you a criminal and do you have a mental illness? Like these are the questions you get asked at immigration everywhere else – you never get asked if you have heart disease or diabetes, you get asked whether you are a criminal or got a mental illness, these are things that are a fundamental threat in society. We live in societies that are fundamentally intolerant of these sorts of disorders and fundamentally unknowing about the nature of the disorders.

So a lot of people sit outside care because of the stigma and because of the health care systems. That represents part of the problem, part of the reason there are levels of disability associated with mental health. Of course it reinforces the community stigma. If what you see a lot of the time, are people with untreated illnesses you are going to have a pretty negative view about the outcome of those illnesses.

I mean if you look at the history of de-stigmatisation for other disorders in society, stigma tends to fall when those disorders are successfully treated. Epilepsy is a great example. If you see

people with epilepsy falling around having fits all the time, then its very hard to de-stigmatise that disorder. Its very hard to talk about its easy to live with epilepsy. Its not easy to live with untreated epilepsy but actually once epilepsy is successfully treated people are able to resume their roles in life even go out and say I've got epilepsy and essentially people can see them functioning normally, see them contributing to society and go OK epilepsy is just an illness and don't have to worry and be afraid of it anymore.

What most people see most of the time in our society is people with untreated or poorly managed mental health problems which reinforces the whole stigma about the ideas of unpredictability, unreliability, people not making a contribution and that's one of our major challenges.

Of those people who do come forward for treatment in Australia, we largely have a primary care, a general practice based system. There are a couple of advantages in that, or what have been advantages, in our system as we all know our system is fundamentally up for renegotiation at the moment. Whether at the end of the day whether we have a fairer Medicare or not, I think remains to be seen but the issue in Australia has been and quite different to a lot of other countries in that we have a relatively accessible health care system where most mental health care work is done in primary care settings.

However that does mean on the whole that there is very little specialist input into that and the chances up until recently that you get an evidence based intervention as a consequence of not coming forward or largely being treated in primary care system are unfortunately only about 1 in 6. So its not very good in terms of a wealthy country like ours only treating about 1 in 6 people effectively with one of these sets of disorders. End result – a lot of days lost out of work and role.

There is a difficulty in the whole mental health field and health in general, of course, to talk about individual illnesses and then to gauge advocacy just on behalf of your own particular thing. That's kind of difficult because people say well, you know it's hard to see that depression thing or its hard to know what it means and you seem to be in competition all the time with other sets of disorders.

One of the things which we've learnt about in recent time is that we need to emphasise the extent to which depression and anxiety co-occur with other problems that people really do worry about and that they contribute to those problems. And the bottom line is often people need an integrated health system, they need a health system where psychological mental issues are dealt with, they need welfare systems, they need support systems, income support systems where things come together.

In young people in our country there is a great deal of concern about drug and alcohol issues and it is really important to emphasise the extent to which depression and anxiety are co-associated with those issues that we really worry about, and I'll return to this continuously, but the three big substances for young people and their health and social effects.

In older people we need to play up and recognise, in the sense in making it very public and overt, the extent to which depression is an serious illness and contributes to other serious illnesses either as a consequence of being associated with the illness itself, things like small vessel, cerebrovascular disease in older people may under pin some of the presentations of depression or extent to which the depression is a risk factor to other things we really do worry about like heart disease.

From beyondblue's point of view being involved in reviewing the literature with the Heart Foundation earlier this year and getting the Heart Foundation to make a major public statement that depression was a risk factor of equal magnitude to tobacco, hypertension and high lipids was a really major issue.

Its amazing how much more seriously people have taken the discussion as a consequence of taking thirty years of research and putting it together and having it come out through the mouth of the Heart Foundation in the wider hub of public health debate. But to emphasise depression as part of people's physical health – the extent to which depression is associated with cognitive impairment in older people is a critical issue. Overwhelmingly I think we have to be careful not just to emphasise disability but people do care about premature death even if health planners don't. People in terms of their own lives do in the extent to which people with these disorders die prematurely.

There's some really interesting dichotomies going on in our health system at the moment. I've always been ambivalent about coming to Canberra, on many trips to Canberra I always felt I've always left empty-handed - you come down here with some really important message, gone to see someone really important and they've gone "yeah, sure, put it on the agenda, get back you in five years or so".

There was the National Health Summit, kind of the alternative health summit, down here a little earlier this year, you may remember when the Commonwealth and States were fighting about money, and there's some really interesting perspectives presented through that really, clinicians, non-government organisations, other people talking about what was going on. One of the people who presented was John Meninger, he has a paper which I'd recommend to you, its just come out in the Medical Journal of Australia, talking about health priorities, he has just done reviews of health in NSW and SA for two governments in trouble about their mental health services in particular.

He makes a particularly interesting comment, about the third page into it, there's a really long paragraph about real health priorities which are not health financing and not necessarily the traditional ones. So he talks about mental health as being a number one community priority. But unfortunately most discussions of health are about hospitals, emergency departments, surgical waiting lists and which doctors have quit the system this week. They tend not to be about actually the health priorities and there's something of an increasing discrepancy between about what the community thinks is important and what politicians believe is important and believe they need to fund for the next election or what you as voters are going to care about when you vote federally next year or when you vote in each of your own states or territories every year, as it seems to me.

I have got to say in my three years of being CEO of beyondblue, eight out of nine health ministers changed in Australia during that period and on the whole more junior people came in, more senior ministers left saying "thank god, I've survived being health minister, now I'll get on with something else important." I'm not sure what the important in the community actually thinks is more important than health and education because actually if you ask the community what it really thinks is important, health and education come out all the time, but for politicians these are both definitely [hard] portfolios .

At the same time this year, my colleague, Dr Grace Groom, and I from the Mental Health Council of Australia did a review of mental health services around the country, which was provocatively titled 'Out of Hospital, Out of Mind'. One of the big problems for mental health is that we've successfully moved out of hospital environments. The only danger when you move out of hospital environments is people go 'great, you're not health anymore you're social

welfare, we don't have to spend any money' and new money, if you ask any state health minister goes into hospitals, it goes into new technologies, new hospitals, new pharmaceuticals, big operations and big technology cost money.

By it's nature it soaks up the dollar first. Stuff that just devoted to people that doesn't have very high technical or pharmaceutical expenditure costs heaps and we're in danger of missing out. Despite the fact that it would be our contention, Dr Grace Groom and I, that we have had a National Mental Health Strategy for a decade, we actually haven't gone anywhere in terms of health investment. Over that ten-year period that we had an agreement between governments in Australia to increase spending, and they said that overtly, and certainly improve our game in mental health, total health spending went up 46%. The cost of providing health care in Australia went up 43% in the same period so the net effect was about nil.

If you look at who spent extra money during that period the states on the whole spent 29%, they actually spent less that the cost of health care during period. So mental health services did move out of hospitals - end result we spent less money, not more money. The Commonwealth did actually significantly invested, it's spending went up 80%. But two thirds of that went up in new pharmaceutical expenditure and the thing about new pharmaceutical expenditure is that it is a fixed process.

Companies develop new products, they apply to the government, it goes through a regulatory process, if you succeed you get the money. It doesn't require a really political decision up until recently. So two thirds of the actual increase in expenditure quite rightly went into new products that are all quite good but it wasn't actually increased investment by governments in a whole range of other services and social investments that might actually improve the health of the nation.

It's really interesting there's almost an inverse proportion between the number of health ministers you have and the number of health outcomes you get. In New Zealand they have one health minister, they had the same sorts of royal commissions and enquiries into mental health in the mid 1990's that we had in Australia in the early 1990's but they set up one commission, one independent commission, and they had one health department, so the health department for mental health, they have an independent commission to review what the department does.

During the same period their health spending went up 120% and New Zealand now spends twice per capita on mental health what we spend having started in approximately the same place. And you can tell I reside in NSW now because NSW has the lowest spending of the states, our biggest state, it's the lowest spender, it now spends a third per capita.

For any of who attempt to use mental health services and wonder why every day of the week you don't feel like you're going anywhere then I think anyone, be it a provider of services, be it a researcher, be someone who uses those services, just stands in bewilderment at times that we've had a national mental health strategy, that we've had nine governments so called committed but we've actually gone backwards. The proof of the pudding is our ministers have just decided, they've all signed off on July 31 on another five years of a new national mental health plan.

There was a lot of conjecture whether this was a good thing – people in government think this is a good thing. Its good that we have a national strategy – means that there is a national emphasis. Those of us in the non-government sector are far more sceptical about whether this is a good thing or not.

The first decision about mental health made in any jurisdiction after the signing off on our new 2003-2008 plan was in WA where the state health minister has just pulled $12m out of community organisations, most of which are related to mental health, indigenous health and child health. So in fact what we see is governments in trouble over our health spending because health is expensive and the first major set of decision after we've agreed to do it again as a nation is for one of the states to pull money out of mental health.

That's the conundrum that we face, that is the political issue that we face. Kathy was very generous in her introduction but I reckon you could say that for advocates like me we've been hopelessly unsuccessful. Because we're making this argument all the time about the health, what the community cares about but somehow our political process arrives at a point where it becomes at the hard end of things that we return to the fact that health is hospitals and doctors and operations and don't invest in what the community really cares about.

Now as part of the review that Grace and I did do, because its easy in the advocacy business and the presenter of epidemiology/mental health to simply whinge. There's a lot of people out there not getting services and the services aren't very good, so we said to people in part of this survey we were doing 'ok if we're going to have a new national mental health plan we have to decide, and were going to have limited budgets, what would you really care about?'.

It's very interesting to us that the community said our two highest priorities are early intervention and coping with drug and alcohol abuse – they're the two things that we really want our government to invest in. We want services to arrive early, we want people to come to services and for that we need a more educated community who knows what its problems are and assists people to get the care and you've got to have services which are orientated to taking care of people at lower levels of severity and earlier in the course of their illness.

Secondly this issue of drug and alcohol abuse and its relationship to mental health was prioritised Interestingly within the drug and alcohol area the people who were commenting on this were pretty cluey - that means not specialised drug and alcohol services, it means things out there at a primary care level. It means staff who work in both mental health and drug and alcohol and general practice having a good idea how all these things going together and it means it would be really helpful if some of our national strategies went together.

Association with beyond blue we've had a series of publications. This is one as a supplement to the medical journal of Australia in May 2002 – I just want to highlight in a sense some of the underlying problems. When you ask people 'what about major health problems?'

One of the problems when you talk health people tend to talk cancer and heart disease. People really fear cancer. You've got all these death and disability charts. Cancer isn't near as overwhelming for society as people think – people obviously fear it a great deal and I always think of the politics - you can work these things out from the politics – you can do national surveys or you can just watch elections - somebody may remember the last federal election, you may remember Labor Party talked about a national cancer initiative. What can we do in health - lets have a national cancer initiative. In NSW - we've got a new minister for medical research whose established a new $200 million cancer research entity in NSW. He's got a personal interest, he had a close relative die of cancer, we now have a major new cancer initiative, $200 m - now that's great at one level in Australian research terms.

But it tells you about politicians and the interaction with some public perceptions – heart disease always figures highly.

We endlessly hope, and I think it being the business we're in, we're being hopeful. I have a talk at the Heart Foundation recently, it was a bit like this, doesn't anyone care about us, someone at the end – you know don't you get totally miserable about this? No-one takes your area seriously? Well in fact I've got to say , in fact, I'm the son of a cardiologist and I actually remember when the Heart Foundation was established but the Heart Foundation and people with heart disease went through the same issue about 30 or 40 years ago - would they build more coronary care units, would they build more acute hospitals, coronary artery surgery had just started at the time and there was quite a divide in the profession between to build more hospitals, do better specialised services and the public health side which lead to the establishment of the Heart Foundation .

No – we actually had better start to invest in the community long term about getting them to care about the sets of issues and heart disease does extremely well at that - most of our cancer services around the country we see this information particularly breast cancer, prostate cancer, lung cancer have been incredibly successful.

We have a long way to go. We ask people about the major health problems facing Australians. If we put it in health terms as a threat to their life we tend not to rate. Its really interesting, you have go long way down here and you might have to get out your binoculars, but for suicide, we have had a national youth suicide strategy for almost a decade, almost no-one rates suicide as a health problem. When you go and ask them about younger Australians, we all care about our kids and we hope that politicians care about their kids, because there tends to be some issue gauge, in you know mental health doesn't figure that highly even though it's the overwhelming cause of disability and gonna cost us – suicide barely rates.

We have a national youth suicide strategy out there - barely rates. Even more staggering when you come and ask about older Australians, there is an assumption that older people never kill themselves. There's just really no public recognition out there – not in health terms anyway. It doesn't lead the issue about how to people see these sorts of problems, certainly often not in health terms.

Another set of research that we have done is to really more qualitative research to look at the experiences of people who actually do enter the health system with one of these sets of problems – again published in the MJA last year.

Now some of these are predictable as alluding to the daily experiences of stigma in some ways are predictable if you live in a society that doesn't really get what is wrong with you. On the one hand they think its nothing, its trivial, we all get depressed, we all get sad, and on the other hand they thinks is chronic intractable, nothing can be done. You know public attitudes are very fluid around these issues and for lack of the fundamental understanding is not a surprise that people run into problems in their workplace with insurance, with their family, everyday of the week.

The second one of these really stood out and we think should be a focus of national attention - negative attitudes of health professionals. Why it happens with people with depression and anxiety common mental disorders, turn up at their GP, their local emergency department, their local community health facility, youth health facility, etc they are running into people who say "oh my god do I have to deal with you? Couldn't you come on a day when we were less busy with real health problems, couldn't you use up less time, couldn't you wait" and then if you've done something like try to kill yourself, for gods sake, "couldn't you stop doing that, couldn't you actually stop wasting our time and our precious resources on these sets of issues?" It is really disheartening to find the extent to which people who have had significant mental health

problems have run into not just one of, or not just not odd, or occasional experiences of really negative attitudes.

Also really negative attitudes about whether treatment will help which offers rather miserable side - I can kinda understand at times within the general health systems that people with poor mental health training often have negative attitudes about health - as I say they are used to seeing people who are poorly treated. Often health professionals express very negative views about the value of treatment on offer.

At this point in the lecture, the tape stopped due to an equipment failure. However, the talk continued for another 20 min, and a long question time.

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