Effective Mental Health Treatment and Services

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Main Messages

- Mental disorders should be understood along a continuum of symptoms and degree of disability, not diagnosis.
- There are effective (and cost-effective) services for treating (common and severe) mental disorders, but they are widely under-used.
- Models of care are available that may improve utilization and outcomes.
- Both supply-side and demand-side interventions are needed to increase utilization of effective treatment for mental disorders.
17% of Australians experience a mental disorder each year

**SEVERE MENTAL ILLNESS:** 2.5% of Australians (530,000). 0.4% have severe, persistent illness with complex multi-agency needs. Shared Commonwealth-State responsibility. People with severe and persistent disorders primarily a state and territory responsibility.

**MODERATELY SEVERE ILLNESSES:** 4-5% of Australians (900,000). Primarily treated through Commonwealth funded primary health care system.

**MILD TO MODERATE ILLNESSES:** 9-10% of Australians (1.9 million). Primarily treated through Commonwealth funded primary health care system.

Some mental health problems present in the broader population but not sufficient to warrant a diagnosis. But in addition to the groups above, a further 15% will experience a mental illness at some point in their lives.

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**Mild or severe conditions?**

Broadhead et al. JAMA 1990.

www.oecd.org/els/disability
For service planning, two broad groups of mental disorder

- **Common but mostly less severe mental disorders** – e.g. most anxiety and depression
  Treatment is primarily short term psychological and social interventions with pharmacological therapy used where needed. Usually delivered in primary care/referral.

- **Severe, often persistent and complex mental disorders** – e.g. psychosis
  Treatment is pharmacological, psychological and social, often with multiagency involvement. Usually delivered in specialist care.

Supply side

Getting the right therapy to the right person at the right time

- **therapy** =
  - CBT and other psychological therapies
  - Medication
  - Both

If you do this, it will work! (50% of time)
Better than most interventions in medicine for physical illness
### Table 9: Summary of Evidence for the Cost-Effectiveness of Allied Health Provision of Psychological Treatments

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Study Type and Setting</th>
<th>Costs and Outcomes</th>
<th>Results</th>
<th>Q²</th>
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**Note:** All studies were conducted in Australia, with a focus on the cost-effectiveness of CBT for depression. The Q² value indicates the strength of the evidence, with a lower value indicating stronger evidence. The study design varied, with some focusing on education interventions and others on depression treatment, with both showing slight increases in costs and no significant differences in outcomes between groups. The results suggest that CBT may be slightly more cost-effective than usual GP care, but further research is needed to confirm these findings.
Access to effective treatment is important for employment

- Clinical treatment may be a necessary (but not sufficient) condition for some individuals to be able to return to work or keep their jobs.
- But under-treatment is widespread (average 40% treatment rate across countries, across disorders)
  - even among those receiving disability benefits for a mental disorder.
  - Effects not sufficiently studied (cost-effectiveness studies do not include employment)

Evidence from Australia

- Low treatment rates - only 31% receive treatment by the health system, less than half comparable physical illnesses
- The high level of untreated illness is responsible for $6 billion in lost productivity annually in those who are employed.
- Lost productivity arising from people out of the workforce and on disability pensions is estimated at $9.7 billion per year
- Of the six priority health conditions, mental illness is associated with the lowest likelihood of being in the workforce
- 2003 ABS survey - one third of young people aged 15-29 with a mental illness neither in education nor employment

www.oecd.org/els/disability
Barriers to Treatment

**Demand-side**
Lack of awareness of effective treatments
Financial barriers
Stigma

**Supply-side**
Not enough trained personnel
Fragmented system/financing
Variable quality
Stigma

Several studies (Australia, Canada, US) suggest demand side barriers are more significant.

On the supply side, how services are organized matters

- Integrating assessment, diagnosis and treatment into primary care is important for access
- So what does it mean to integrate mental health services into primary care?
- Supply side issues for allied professionals + supervision
  - Effect means replicating good quality psychological services, which are often difficult to scale up.

www.oecd.org/els/disability
Continuum of psychological interventions

Brief, targeted interventions
- e.g. stress management
- Well-suited to primary care

Complete psychotherapeutic interventions
- longer and more intensive therapy; series of sessions with treatment plan
- Require involvement of mental health professionals

Collaborative Care Models: good example

- Multi-professional approach (involving GP or family physician)
- Structured management plan
- Scheduled patient follow-up
- Enhanced inter-professional communication

Good evidence of results superior to “treatment as usual” in primary care for depression, panic disorder and generalized anxiety disorder.

www.oecd.org/els/disability
More creativity is needed for demand-side interventions

- Raising awareness is important but not enough
- Innovative new strategies should be explored:
  - Conditional cash transfers
  - Other demand side interventions
  - Others?
- How to reduce stigma?

THANK YOU.