

Debate interrupted.

MATTERS OF PUBLIC INTEREST

The **ACTING DEPUTY PRESIDENT (Senator Moore)**—Order! It being 12.45 p.m., I call on matters of public interest.

Health: Mental Illness

Senator TIERNEY (New South Wales) (12.45 p.m.)—I rise today to inform the Senate of the challenges that face the world in the area of mental health. I have often spoken in this chamber about mental health policy in Australia and the funding challenges that we face. Last year, as the leader of the Australian parliamentary delegation to the United Nations General Assembly in New York, I received an international perspective on many policy issues, including mental health. Over time, the world's nations have taken very different approaches to the plight of people living with mental illness. Not long ago in developed countries such as Australia, our most vulnerable people were locked up in asylums, never to be seen again by their friends and family. Not long ago, mental illness was something that we preferred not to talk about. When we did talk about it, it was seen as a problem in the rich, developed countries. However, one-quarter of the population of developing and developed countries now have a mental or behavioural disorder in their lifetime.

It is quite clear that mental health knows no borders. It is an issue that needs global attention. In fact, people in developing countries are often faced with a greater burden because of exposure to war and conflict, dangerous living conditions, exploitation and physical health problems caused by things such as lack of nutrition. What is more, access to services and medicines in developing countries is severely limited. This impedes an individual's ability to access treatment. As a global community we are also becoming increasingly aware of the interrelationship between physical and mental health and the increasing disease burden that mental ill health is placing on society, sufferers and their families. Mental illness affects and is affected by chronic conditions such as cancer, heart disease and AIDS. Untreated mental illness can result in diminished immune functioning, non-compliance with medication and unhealthy behaviour.

The challenge is almost overwhelming, with 450 million people worldwide affected by mental, neurological or behavioural problems at any one time. Worldwide, about 873,000 people die by suicide every year, with depression contributing to 60 per cent of suicides. In some countries, more people die as a result of suicide than of traffic accidents. Those living with a mental illness are often subjected to social isolation, poor quality of life and increased mortality. One-quarter of all patients presenting to a health service are suffering from at least one mental, neurological or be-

havioural disorder. These disorders are a cause of staggering economic, social and personal cost.

What is most alarming is that the overwhelming majority of people with these disorders go undiagnosed or untreated, which severely limits their ability to lead healthy and fulfilling lives. The burden is difficult to measure, as the effect of lost productivity of family members or carers and the impact of stigma and myths associated with many mental illnesses are very difficult to quantify. What we do know is that there are huge financial and social costs in millions of people not reaching their full potential. We also know that many mental illnesses are treatable and even preventable. The last 10 years have seen tremendous improvements in our understanding of and ability to treat mental and behavioural disorders.

Over the last two decades there has been a growing movement to put mental health on the global agenda. In 1991 the UN General Assembly resolved that persons with mental illness shall be treated with dignity and humanity; shall be free from exploitation, abuse and degrading treatment; and shall be entitled to care and treatment at the same standard as other people who are ill. In 1995 the Secretary-General said:

To secure mental health for the people of the world must be one of the objectives of the United Nations in its second half century ... Our objective is to promote the mental health and well being of all the inhabitants of the planet.

In 2001 mental health was selected as the theme for World Health Day and as the technical subject for the World Health Report for 2001. This was an acknowledgement of the need for increased focus on mental health issues globally. The report focused on the medium-term aim of promoting positive mental health and instituting measures to work towards the prevention of ill health in the longer term.

There is a growing feeling and need for change. From an international perspective, Australia has come a long way in the area of mental health and has seen far-reaching reforms over the past two decades. Yet we still see many people living with mental illnesses who are not receiving the care and support they need. Nationally, we are now in the early stages of the third National Mental Health Plan 2003-08. It is a fine plan, agreed on by all federal, state and territory governments. This plan has received favourable international recognition. The World Health Organisation's 2001 report, *Mental health: new understanding, new hope*, noted that Australia's National Mental Health Strategy 'has demonstrated that changes can be achieved in national mental health reform'. Like many other nations, Australia's National Mental Health Strategy has deliberately shifted our focus from institutional care to community based care. Resources that previously targeted maintaining centralised mental health facilities have now been redirected to provide services delivered

through a spectrum of service models, including general practitioners, community centres, day centres, specialist general hospital wards and small specialist hospitals.

The challenge now is to ensure that appropriate funding follows. Whilst Australia has made significant progress against the national reform agenda, there remain large challenges to be addressed. The number of mentally ill people who are committing suicide is rising, and many families still do not have access to the services they so desperately need. Like many developed countries, Australia needs to further integrate mental health services not only into the community but also into the primary health care system. In particular, we need to balance resources and the disease burden for mental health.

Mental illness in Australia makes up 14 per cent of the disease burden but only 9.6 per cent of health funding. Some experts estimate that funding is as low as 6.1 per cent, depending on how you define mental illness. This imbalance has meant that there are insufficient resources to support a wide spectrum of mental health services. Australia is not alone in this problem. The World Bank's 1993 report, *World mental health*, presented at the United Nations in 1995, showed that mental health is responsible for more than one-tenth of the total disease burden globally, and that is projected to rise to 15 per cent by 2020. Suicide is among the top 10 causes of mortality globally. Five of the top 10 causes of disability globally are mental health problems, and depressive illnesses are expected to be the second biggest cause for the disease burden in 2020. Depression is already the fourth-ranked cause of the disease burden and in 2020 it is expected to rank second, following heart disease. In spite of a growing body of information available pointing to the increasing disease burden of mental ill health, there is a huge gap in funding and the lack of treatment available in developing countries is appalling. In some places 95 per cent of depression cases go untreated, along with 80 per cent of schizophrenia cases.

Around the world, people understand the need to provide high quality health care but their focus is often on physical health. Last October, World Mental Health Day focused on the relationship between physical and mental health. Many people with chronic physical diseases, such as diabetes and cancer, also experience undetected and mistreated psychological and emotional problems. Approximately one quarter of people in the world living with cancer will suffer from depression, and depression can weaken people's immune systems. People with chronic depression are also more likely to develop cancer than those not suffering from depression. This is why the national mental health policy should not be solely concerned with mental illness but should also address the broader issues affecting the

physical and mental health of all sectors of the community. This may mean refugee and settlement programs, training programs for the unemployed, reducing domestic violence and providing support for additional services to the elderly. Policymakers, health insurers and even members of the health profession still discriminate between physical and mental health services.

Mental health treatment requires multisectoral action that not only involves the health sector but also works with education and employment services, community based organisations, industry, churches and other organisations. In the words of Gro Harlem Brundtland, the Director-General of the World Health Organisation in 2000:

Only when a comprehensive strategy for mental health which incorporates both prevention and care elements is adopted, will we see substantial and sustainable progress.

We need to fight against the stigma of mental illness that can act as a barrier to sufferers seeking the kind of help they need. Stigma exists because of a lack of public understanding that could be remedied by a combination of working with the media and designing specific community information campaigns. The advances in understanding of mental disorders and human behaviour are providing reasons to be optimistic about future treatment. The results of studies and breakthroughs should be made available to all people, whether from developed or developing countries.

Research funding for mental illness, particularly in the developing world, should be given a much greater priority. At present, only two per cent of research into mental health occurs in the developing world, with its many different pressures and needs. This disparity is resulting in a large treatment gap for sufferers in developing countries. Twenty-five per cent of nations do not have access to the three most commonly prescribed medications for schizophrenia and depression. Pharmaceutical companies should ensure that the benefits of their research and development flow on to developing countries. They should consider relaxing intellectual property rights and delivering generic products to poorer nations where the need for this medicine is very great.

On World Health Day in 2001, the United Nations Secretary General, Kofi Annan, said:

It is time for governments to allocate resources and establish public policy to meet mental health needs.

And yet more that 30 per cent of countries have no mental health programs and even more have no mental health policy. Mental illness has become one of the world's leading causes of illness and disability affecting one in four people worldwide. Yet with most middle- and low-income countries devoting less than 0.1 per cent of their health expenditure in this domain, governments are still not giving mental health policy and programs the attention and resources they need.

Countries around the world are paying a very high price by failing to provide appropriate mental health treatment and prevention for their people.

In our rapidly changing world, the mental health disease burden is likely to rise. It is more important than ever that we acknowledge the large disease burden of mental illness and know that many of these disorders can be successfully treated and managed. We need to provide care and treatment that is aimed at achieving each individual's own highest attainable level of health and wellbeing, and governments should establish a goal of parity between the disease burden of mental health and the resources that are allocated. Surely, this is a crucial step in ensuring the welfare of some of the most vulnerable in our society—those living with a mental illness.

Veterans: Commemorations Program

Senator MARK BISHOP (Western Australia) (12.59 p.m.)—I rise today to address the commemorations program for veterans in 2005, leading into 2006. It is clear that commemorations will be the major program for the Department of Veterans' Affairs this year. That is no surprise because, it is also fair to say, all attempts to form better policy have failed in more recent years. The Clarke inquiry initiated by the government backfired and was pigeon-holed, failure to support the gold card gave veterans and war widows much unnecessary worry, and in Tasmania access to medical specialists remains a problem because the fee schedules, they say, do not compare with those of the private health funds. We are advised by the government that there are no new policies for implementation and there is no additional legislation to be introduced for the remainder of this term.

There is now little on the government agenda except commemoration. It is fair to say, from past example, that the Howard government is very keen on commemoration. It is a government obsessed with public relations and the reflected glory of others. Photo opportunities have become a major substitute for policy initiatives in this area of endeavour. It should be said that commemoration is in itself a good thing, but not to the exclusion of all else. The government's budget for commemoration of veterans until 2006 will be some \$4½ million plus an extra \$7½ million promised during the election campaign, giving a total of almost \$12 million.

The prime events will be the commemoration of the 90th anniversary of Gallipoli and the 60th anniversary of the end of World War II. From the opposition's perspective, these are fine events worth commemorating. Gallipoli is now deeply entrenched in our national psyche, though only three veterans from World War I remain. World War II is increasingly fresh in our minds. Hundreds of thousands of Australians served both overseas and on the home front during that period of

conflict, and for them World War II is an indelible memory. Their families, too, honour that commitment with pride. However, the Australian community requires balance as the plans for these commemorative events evolve. Historians have a tendency to particularise war into campaigns, theatres and individual battles. The reason for this is simply that they were often significant turning points and often they entailed significant loss. They did not, however, represent the totality of effort that might have been involved through that protracted period.

As we have seen in recent years, the Kokoda campaign continues to attract publicity because of the continuing public interest now much apparent in younger generations. It is gratifying for those who served there to see now recognition of the conditions that they endured. Likewise for Milne Bay, Buna, Gona and Sanananda—though perhaps we still understate the significance of campaigns in those areas of New Guinea during World War II. Together they are an example of a last-ditch effort to defend the Australian mainland. The level of hardship and the loss of so many young Australian lives cause us to remember those days, and as the year goes on we will be increasingly reminded of the significance of those losses. In many cases, as recent writers have noted in detail, lives were unnecessarily wasted. Too many of these lives were lost due to the political imperatives of a remote high command.

It is forgotten by some that the war against the Japanese continued in New Guinea for another two years, until the ceasefire settlement at Wewak on 15 August 1945. Prior to these commemorative activities over the last three years there was some focus on other events—for instance, the fall of Singapore, the tragedies of the Burma-Thailand railway and the campaign in Sandakan. To a lesser extent attention was paid last year to the campaigns of North Africa and Greece, including Crete. The \$11 million memorial in London was also unveiled. Many feats of courage and endurance have been recognised.

It is difficult to do them all justice and avoid offending those whose contributions are often unsung. For example, little comment is made on Australians in Borneo and Burma and many other places. It is noticeable that so many veterans believe that they fought a forgotten war. That is often applied to Korea, but it is more noticeably applied to those British Commonwealth forces who took on the task of occupying Japan between 1945 and 1947, after World War II. Peacekeepers too are continually disappointed at the emphasis placed on military service other than their own.

While commemoration of major campaigns is appropriate, there is a risk of overlooking the breadth and totality of the effort involved, including the effort of those who stayed at home but nevertheless supported