Mental Health: From individual stigma to societal issue

Asia and Oceania edition

Introduction

ASIA

Asia is a large region with vast diversity in culture and levels of human development. Access to health resources varies significantly between countries. Accessing mental health resources, despite ongoing stigma in many Asian cultures, is even more challenging. Furthermore, cultural beliefs around showing a "brave face" may obscure the true burden of mental illness.
For instance, in Thailand, depression is the number one cause of years lost due to disability for women.[1] In Japan, a country that is known for its Zen philosophy — a synonym for calmness and tranquility — claimed more lives in October 2020 due to suicide than COVID-19 had from January-October 2020.[2] In South Asia, the word depression does not exist in Punjabi, a language by one of the major ethnic groups of both India and Pakistan.

Against this backdrop, it is difficult to paint an accurate picture of the mental health landscape in Asia or compare it between countries. However, it is reasonable to say, that like in other regions, access to mental health tends to correlate with access to physical health. As a highly developed country, Japan has a strong national health system and has taken action to combat the country's elevated suicide rate. The government has enacted a mental health policy that provides many inpatient and community-based mental health resources to cater to a range of mental issues. It also provides approximately 146 mental health workers (government and non-government) per 100,000 people (data from 2017, the latest year for which data is available).[3] In Laos, healthcare professionals are concentrated in urban centres, making it challenging to access general physicians for those living in rural areas.[4] Mental health services are integrated into the general healthcare system, with inpatient and outpatient services at the central level. There are limited outpatient services in provincial hospitals and limited community mental health services as mental health is seen as a non-pressing issue compared to many other competing priorities.[5]

There is a strong influence of Buddhism, Taoism, and Hinduism in many parts of Asia that may be a protective factor for mental health. Meditation began as a spiritual and religious practice in India and spread with Buddhism throughout Asia, integrating with existing local practices. Many contemplative practices blending intentional movement with mindfulness originated in Asia, such as yoga, Tai chi,

[1] https://www.who.int/thailand/activities/creating-awareness-on-prevention-and-control-of-depression
[2] https://edition.cnn.com/2020/11/28/asia/japan-suicide-women-COVID-dst-intl-hnk/index.html
[3] https://www.who.int/mental_health/evidence/atlas/profiles-2017/JPN.pdf
[4] https://www.researchgate.net/publication/322374309_Mental_healthcare_in_Laos
[5] https://www.usaid.gov/sites/default/files/documents/1861/USAID_Laos_Health_Strategy_2019-2023.pdf

Qi Gong. The Chinese government is now actively promoting meditation as a key element of its mental health strategy. Moreover, the 9-9-6 culture — working from 9 am to 9 pm for 6 days per week — has driven many young professionals to discover or rediscover such practices, and the pandemic has only accelerated this trend. Mindfulness-based approaches that remove the religious or spiritual element have helped meditation gain popularity with the younger generations. The pandemic has only spurred this increase. Consequently, the number of yoga studios in China increased by 9% in 2020, and the ecosystem of apps around mindfulness geared towards the Chinese market has blossomed. For example, the Chinese app Co-sleep reached 50 million users in 2020.[6] The Chinese turn towards mindfulness shows how the importance of mental wellbeing is becoming more widely recognized as an effective and accessible non-medical approach to achieving greater peace of mind.

In this publication, you will hear from experts based in India and Pakistan who will shed light on approaches to health from a South Asian cultural context. While these countries represent a small sample of the diversity throughout Asia, they shed light on how mental health is emerging as an important social issue and approaches to addressing this issue in the face of stigma.

OCEANIA

Oceania, like Asia, comprises great differences of peoples and cultures. The majority of its population is concentrated in Australia and New Zealand, two highly developed countries. While the other 24 countries and territories in Melanesia, Micronesia, and Polynesia are comprised of islands in the Pacific Ocean that are mainly less developed and much lower in population. Access to mental health resources essentially follows access to resources for physical health, but the extreme remoteness of many Pacific island nations presents a challenge for development and access to many physical and mental health resources.

In Australia and New Zealand, the pandemic has made mental health emerge as a publicly discussed social issue. For instance, in New Zealand, the government has recently set up a 1.2 million New Zealand dollar mental health innovation fund, which will finance one-off proposals for new ideas that do not necessarily fit into current mental health funding schemes.

In this publication, you'll read more about Australia's approach to mental health. Substantial challenges remain to make mental health fully accessible to all while removing stigma. Nonetheless, the country has significant resources devoted to mental health and is working to make mental wellbeing a greater priority.

[6] https://www.sixthtone.com/news/1008287/chinas-stressed-out-workers-are-rediscovering-the-art-of-meditation

Pakistan: Growing awareness and support for mental health resources, from pregnancy onward

By Dr Joanna Maselko & Dr Siham Sikander

A challenging context for mental wellbeing

Pakistan as a country suffers from numerous development challenges and stresses which underlie the need for mental health awareness and treatment. Pakistan is the 6th most populous country of the world, with a growing population of 207 million. Though its approximately 1,100 USD per capita income per capita income puts it in the category of middle income countries, nearly a quarter living below the poverty lineIt has both a relatively high fertility (3.4 children per woman) high maternal mortality rate (140/per 100,000 births), and 40% of children under 5 have stunted growth.- We continue to have In the face of these considerable challenges, less than 3% of the GDP is invested into health[7-10], and literacy levels are low (5.3 mean years of schooling). Overall, Pakistan ranks 154th on the Human Development Index.

Gender and sexual identity issues present additional challenges. Pakistan is ranked 153 of 156 countries on the World Economic Forum's Global Gender Gap Index, indicating low rates of economic participation and opportunity, educational attainment, health and survival, and political empowerment. LGBTQ+ communities have not been recognized so far by the State. However, the recent most census in 2017 included transgender as a third gender option, recognizing transgenders as citizens for the first time[8].

Prevalence of mental health issues and their known social impacts

Against this backdrop, mental health disorders are more prevalent than the global average and are intricately linked to physical issues as well. According to a systematic review, the prevalence of Common Mental Disorders (ie anxiety and depression) among adults, both men and women, is approximately 34%[11]. For women, the situation is particularly severe.

The prevalence rate of perinatal depression is around 32%, is one of the highest rates both regionally and globally[12, 13]. Exacerbating the mental health risk factors, studies and demographic health surveys report high rates of intimate partner violence with up to 53% of women reporting having experienced violence in the past year, and up to 12% reporting it during pregnancy[10, 14, 15]. These risk factors lead to poor outcomes for women and children. Poor maternal mental health not only effects women directly by impacting their social functioning and productivity and leads to increased chances of suicide. Furthermore, poor maternal mental health directly affects all child health outcomes including malnourishment, stunting and socio-emotional and cognitive development[16-18].

Considering the high burden of poor mental health, it is surprisingly under-recognized and under-diagnosed. Possibly due to an overall low health-literacy levels of our population and high levels stigma attached to disclosing mental health issues[19, 20]. However, there is increased recognition of the importance of mental health and policy changes and research are underway to support it.

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Increased government support for mental health

Significant promising developments for mental health are underway. In 2014, Pakistan became a signatory to the World Health Organization's Eastern Mediterranean Framework for Mental Health. The framework is a detailed road-map for countries to follow and implement evidence based approaches to be delivered at different levels (primary care, schools and community settings) to help uplift the mental health status of its populations. The Ministry of National Health Services launched its first time ever NCDs & MH Program 2015-2025. More recently with the launch of UN Sustainable Development Goals in 2016, Pakistan is rolling out its Universal Health Coverage (UHC) and mental health has been included in it as part of the Essential Health Services package. The mental services within the UHC is informed by the WHO mental health interventions (mhGAP) and Disease Control Priorities 3rd Edition (DCP3). Back in 2019, maternal mental health was supported by the Presidential Office[21] and prioritized to be addressed by scaling-up known evidence based psychosocial interventions.

Innovative research on maternal mental health and its impacts

Ongoing research conducted by the private sector organizations and universities on mental health in general and maternal mental health specifically is contributing tremendously to our understanding of which interventions works under which conditions and how best to task-shift within community settings by using community health workers and lay peers to identify and treat maternal depression[22-27]. Of particular note is the ongoing birth cohort called Bachpan Cohort (Bachpan means childhood in Urdu, Pakistan's official language) which was established in 2014-2015. It is currently following up on the mothers and their now 6-year-old children[28]. The Bachpan Cohort is unique in that it is one of the few cohorts from Low Middle Income Country and/or High Income Country settings, solely looking at maternal depression and its longer-term effects on child developmental outcomes (with an equal number of non-depressed women as a reference group)[28]. It is also innovative in that a number of peer-led psychosocial interventions have been embedded in it and evaluated through randomized trials[23,26].

Evidence based policy and practice shift to support mental health

The current ongoing research in Pakistan, is not only informing policy, but also gradually informing practice shift. There are number of other scale-up and COVID pandemic related challenges that require urgent attention moving forwards. The ongoing pandemic and its effect on livelihoods and disruption of social interactions has clearly highlighted the importance of mental health. This warrants in-depth understanding and the opportunity to reimagine global mental health and build-back better from the pandemic[29].

In terms of the LGBTQ+ communities, have not been recognized so far by the State. However, the recent most census, did include transgenders as the third gender option and were first time recognized as citizens of Pakistan[8].

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India: Societal Challenges to Mental Health

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The mental healthcare system of India has always been in a state of neglect and crisis. The COVID-19 pandemic has further widened the gap between mental health needs of the Indian people and the available care or resources. What are the reasons for such a crisis? Why hasn't India been able to address the mental health needs of its people? Are the current professional and policy-based efforts enough? What changes do we need to bring about to address the burden of mental health in India?

The Burden of Mental Health in India

The Global Burden of Disease study collected data globally from 1990 to 2017 and reported, in Lancet Psychiatry, that 14% of the Indian population lives with a mental disorder. The National Mental Health Survey (NMHS) of India (2015-2016) estimated that more than 10% of the Indian population (nearly 150 million Indians) lives with one or the other mental health concern. The most common of these concerns are substance abuse, mood disorders, and stress-related disorders. The NMHS (2015-16) also found that the mental health care gap in India is around 84% which means that only 16% of Indians living with mental illness have access to treatment and mental health rehabilitation. There are several reasons for this disparity. The unavailability and non-affordability of existing mental health services, shortage of adequately trained mental health professionals, low mental health awareness, stigma about mental illnesses, and lack of social support are significant barriers that prevent people from seeking professional help. However, a parallel arc in the Indian mental health scenario is of people's preference for traditional healing rituals and alternative medicines to heal from their mental health concerns. The contradictions between the traditional/alternative healing systems and biomedical practices lead to non-linear patterns of mental health-related help-seeking. WHO Mental Health Action Plan (2013-2020) recommended including traditional and faith healers in the government mental health programs to bridge the treatment gap in low- and middle-income countries. The District Mental Health Programs of some Indian states (like Karnataka and Gujarat) have attempted to collaborate with faith healers. However, the Indian mental health policymakers are majorly divided over the role of faith healers and religious sites in providing mental health care (according to the minutes of a meeting of Core Group on Mental Health at the National Human Rights Commission in 2017). Therefore, India continues to bear the mental health burden with an increasing number of people suffering from mental illnesses, widening mental health treatment gap, and persistent marginalization of traditional healing practices from mental health policies in India.

Impact of COVID-19 on Mental Health Scenario in India

COVID-19 has dramatically impacted the mental health scenario in India and increased our mental health burden substantially. The lockdowns and social distancing practices significantly impacted the accessibility of existing mental health services, thus widening the treatment gap even further. The work-from-home models and pervasive socio-economic uncertainty is taking an enormous toll on people's mental health. Historically marginalized and oppressed groups like migrant labourers, slum dwellers, internally displaced individuals, the elderly, and women have borne and continue to face more significant mental health challenges due to the pandemic. The public healthcare system initiated mental health helplines in 2020 and promoted telemedicine to address the growing need for mental healthcare. Private practitioners and non-government organizations are also adapting to the changing circumstances. India is witnessing a greater interest and funding in the digitization of healthcare services and the development of mental health chatbots. The Insurance Regulatory and Development Authority of India instructed private insurance companies to provide policies for mental health treatment by October 2020. These professional and policy-related changes indicate that the COVID-19 pandemic could prove to be a watershed moment for the mental healthcare system in India.

Societal Challenges to Mental Health

It is noteworthy that mental health looks like a personal endeavour from a biomedical perspective. However, it is not so. Mental health is an intersectional and developmental concern that requires a shift from individual responsibility to a collective change. For instance, NMHS found that mental health concerns in India are more prevalent among males, middle-aged individuals, in urban-metros, among less educated, and in households with lower income. This finding indicates that poverty, compromised education, urban isolation, gender discrimination, occupational demands, and global challenges adversely affect an individual's productivity, the realization of their potential, and interpersonal satisfaction. Thus, it can be inferred from this finding that mental health is a function of the social, political, and economic context. Acknowledging the intersectionality of mental health and societal factors, United Nations identified mental health as an important Sustainable Development Goal (SDG) to "ensure healthy lives and well-being for all at all ages" in 2015. The National Health Policy of India (2017) endorsed the UN's 2030 agenda for sustainable development and identified that non-health related determinants like occupational safety, housing, violence, and urban safety have a significant impact on the prevention and promotion of health.

SDGs focus on Universal Health Coverage. While trying to ascertain universal health, it is crucial to be cognizant that we live in a hierarchical society where inequality is not just economic; people experience discrimination, oppression, and marginalization based on caste, class, gender, sexuality, ability, or religion. Moreover, reducing the mental health care gap requires systemic changes like accessible and affordable education, empathetic workplaces, livelihood and employment support, protection of human rights of vulnerable and marginalized people, and building a supportive and inclusive society. Therefore, an effective mental healthcare system must be affordable, accessible, equity-based, gender-sensitive, affirmative, intersectional, and inclusive.

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Australia

Interview with Dr. Sohel Abu, current Managing Director and Executive Representative, AXA Life & Health International Solutions, former AXA Group Chief Medical Officer

What are the 3 most common mental illnesses in Australia? Where does mental health sit on the spectrum from an individual issue that is stigmatised to an openly treated social issue?

One in five (20%) Australians aged 16-85 experience a mental illness in any year – almost half (45%) of all Australian adults will face mental health issues during their lifetime. The most common mental illnesses are depressive, anxiety and substance use disorder.

The Cov-19 pandemic has caused a considerable degree of fear and concern in the population and triggered a sense of uncertainty and insecurity. As the pandemic wears on, ongoing and necessary public health measures such social isolation, lockdowns and necessary safety measures have exposed many people to experiencing to poor mental health outcomes. Many adults are reporting specific negative impacts on their mental health and well-being, such as difficulty sleeping, eating and increasing alcohol consumption and substance use as a way of coping with stress or emotions related to COVID-19.

Governments and NGOs have increased spending on the de-stigmatisation of mental illness, year on year with the intuition that lower stigma levels will reduce the barriers to treatment, thereby lowering suicide rates, admission and readmission rates. It is a policy priority with both major political parties in Australia to improve mental health outcomes.

The spectrum from stigma to an openly treated issue is largely dependent on the society in which it is evaluated. Most western societies have well-organised campaigns to de-stigmatise mental health conditions. It would wrong though to view a western society as a homogenous entity, with large differences in stigma likely to be found by both location and subculture. In rural and remote areas, it has been difficult to effectively run many pro-social campaigns, perhaps reflected by high suicide rates, substance abuse and violence. Some language, cultural and religious barriers exist in some urban areas making it difficult to lower stigma.

What kinds of mental health infrastructure and resources are available and accessible in Australia?

The resources would best be divided into community, primary, secondary, tertiary and rehabilitation services.

Community services are strong and run by both religious and secular NGOs (e.g., Beyond Blue, Lifeline, Catholic Care). They are often well-funded and provide crisis counselling, pastoral care, triage to other services and liaison with relevant agencies e.g., housing, social security. They are mostly staffed by well-meaning volunteers and tend to follow an algorithmic approach to provide support. With primary care, individuals have the choice of accessing a general practitioner or a psychologist (around AU$250 per hour) with or without a referral. The level of access is usually determined by location and funding. Some locations have low density of service providers (who then are typically expensive). If a general practitioner is motivated by income optimisation, consultations are often brief and unsatisfactory from a therapeutic perspective. There is likely to be a low threshold to diagnose and prescribe simple psychotropic medications. Under mental health care plans, individuals are able to access subsidised psychology consultations. Medications are subsidised by a federal pharmaceutical benefits scheme.

Secondary resources include referral to consultant psychiatrists (around AU$550 per hour) and some outpatient special clinics (e.g., Black Dog Institute). There is a low rate of psychiatrists per capita, with it worse in some regional areas. Many psychiatrists are not taking new patients, with additional demand evidence during the pandemic. The government has funded access to psychiatrists via tele-health, which has benefited some patients in rural and remote locations. Very few psychiatrists bulk bill, meaning that mentally ill individuals are offered services that they cannot afford to access. Those who rely on social security would have practical barriers to accessing these services. Tertiary services are divided into child and adolescent, adult and psychiatry of old age. The services are regionally based. Admissions tend to be difficult to organise unless there is a safety issue or psychosis. The services are mostly operating at capacity and vary by location. Follow up services are by regional mental health teams. They provide services to those with severe mental health conditions. Those with low to medium level impairments often 'fall between the cracks', with private services too expensive and public services out of scope. Private tertiary hospitals often have funding agreements with private health insurers and cater to those with mild to moderate impairments. For individuals with compensable conditions under worker's compensation or CTP (Compulsory Third Party) claims, will have treatment expenses met by the relevant insurer. Rehabilitation for those with mental health conditions is aimed at restoring or elevating the individual to the best level of functioning. These services are critical for

employment, housing, selfcare and social integration. Eligible individuals (ranging from personality disorders to severe mental health conditions) can access the NDIS (National Disability Insurance Schemes) with care packages.

Some of the key initiatives that the national and local governments together with NGOs and public companies have introduced to support people's mental health in Australia include:

- Extra funding for Primary Health Networks to boost existing mental health services, including for vulnerable groups such as older Australians, Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities
- A dedicated Coronavirus Mental Wellbeing Support Service delivered by Beyond Blue
- Emergency Helpline and support services such as Lifeline, Kids Helpline and other digital services to support specific groups
- Doubling the Medicare-subsidised psychological therapy sessions under the Better Access initiative for people with a mental health care plan from 10 to 20 sessions
- Access to 15 HeadtoHelp mental health clinics in regional and metropolitan areas

How does the government approach mental health? How is it approached by private insurers/NGOs?

The federal and state governments share responsibility for the provision of health services, with the federal government supplying GST (Goods & Services Tax) revenue to the states, subsidising outpatient medical services and medications. The state governments are responsible for the provision of hospital services. Both state governments and the federal government have committed to higher levels of funding. There is often conflict about funding, given that hospitals are usually running at capacity.

Private insurers (e.g. BUPA) offer different levels of cover and cover both outpatient psychological (not psychiatrist) services and subsidise (or fully cover) private hospital admissions. There is a high uptake of the outpatient and inpatient services. Non-commercial NGOs like Catholic Care or Beyond Blue, in addition to providing crisis counselling and triage, will also influence policy formation, fund research and in the case of Catholic Care, provide a range of practical emergency services.

In addition to above, some additional initiatives are state-based. The Victorian Government has announced a record AU$3.8 billion investment in mental health following a recent review of the Victoria's Mental Health System by the Royal Commission – this review has set out a 10-year vision for a future mental health system, where people can access treatment close to their homes and in their communities. The Royal Commission's report has outlined 74 recommendations and proposed several changes to create a future mental health and wellbeing system with holistic treatment, care and support for all Victorians – the Victorian Government has committed to implementing all recommendations.

Importantly, people with lived experience of mental illness or psychological distress will be central to the design and delivery of the new mental health and wellbeing system.

Recommendations are grouped around four key features of the future mental health and wellbeing system:

- A responsive and integrated system with community at its heart
- A system attuned to promoting inclusion and addressing inequities
- Re-established public confidence through prioritisation and collaboration
- Contemporary and adaptable services.

A number of the recommendations seek to reform the foundations of the mental health system, and focus on new governance and accountability structures, the leadership of people with lived experience, and a supported workforce. Others focus on ensuring ongoing excellence in the system, including investment in research, digital technologies and innovation. Collectively, implementation of the reforms will create a responsive and integrated system that is contemporary and adaptable. In the future, Victorians will be able to access compassionate services that meet their preferences, strengths and needs.

What, in your opinion are the main challenges to better mental health in your country?

Mental illness in Australia is a large and complex problem like in other developed nations. Mental illness is the single largest cause of disability in Australia. Mental illness accounts for 24 per cent of the burden of non-fatal disease and remains the biggest risk factor for suicide. Around two million Australians with mental illness do not receive any mental health care. And it's the most vulnerable – people in rural and regional areas, Indigenous Australians, men, young people and disadvantaged groups – who are among the least likely to seek treatment.

The biggest challenge is to provide the right mix and level of mental health services when people need them, and to remove the barriers and stigma that prevent people with mental illness, their carers and families from asking for help. Despite previous attempts at reform and investment by governments, too many people with severe and debilitating mental illness are still not getting the support they need, don't know where to find it, and are falling through the cracks in the system. The families and people who care for them struggle with a system which often causes them frustration and even despair. Lack of integration and coordination between services is regularly cited as contributing to people falling through the cracks.

Substance abuse is the low-hanging fruit. Both legal (alcohol) and illegal substances are a major avoidable cause of mental health conditions. This represents the

largest group of preventable mental health condition. The funding for rehabilitation is a bottomless pit and the government is yet to find a way to make this sustainable. Suicide remains a major policy priority. To date, no initiative has been successful in reducing the rates of suicide (that continue to increase). Suicide remains a major policy priority. To date, no initiative has been successful in reducing the rates of suicide (that continue to increase). In the short to medium term, economic pain caused by the pandemic have raised distress levels in the community by 2-2.5 x baseline. This is going to put a major stress on existing resources, with many being unable to access services. Lastly, there are Iatrogenic problems associated with both under-prescribing and over-prescribing of psychotropic medications and narcotic analgesics. The later has been recognised and is being addressed.

Therefore, the main challenges include:

- people with mental illness, families, carers and providers not knowing where to find the support they need;
- services that are either not connected – leading to people falling through gaps – or which overlap and duplicate resources;
- lack of early intervention and prevention services for children and young people;
- the need for more care services for people with severe and debilitating mental illness, including accommodation support services to help prevent the cycle of crisis-driven rehospitalisation and high levels of homelessness for people with mental illness;
- insufficient support for people with mental illness to participate in work or community life and who may be suffering discrimination and stigmatisation;
- inadequate support for mental health carers, who can suffer crippling isolation and are at risk of poor health themselves;
- the need for greater transparency and accountability in the investments governments make.

The impact of mental illness goes well beyond a person's immediate health and wellbeing.
Untreated mental illness can mean reduced employment, family breakdown, homelessness and suicide. And the burden extends beyond the individual to family and friends. Mental illness causes significant economic and social costs. Mental health has a sizeable impact on lost productivity. This includes both those suffering from severe mental health conditions who are outside the workforce and those in the workforce with untreated mental illness.[30]

What, in your opinion, are the most promising solutions emerging?

Though psychiatry is a low-innovation discipline, solutions such as transcranial magnetic stimulation are in their infancy but the empirical evidence for their efficacy is not strong. Psychotropic prescribing e.g., cannabinoids, LSD-like substances, ketamine are shifting from fringe practitioners to the mainstream but do not have convincing efficacy. New psychotropics have not produced improved efficacy, reduced suicide or admission rates. There are different approaches in talk-based therapy that can be efficacious but empirical evidence is not strong. Most disappointingly is any efficacy of clear strategy aimed at illness prevention. We have not been able to prevent the onset of psychosis in first episodes, even though this service remains politically attractive.

The good news is at least a quarter of mental health problems in adults are potentially preventable through treatment, support and other factors e.g. being in a supportive, positive environment. Additionally, short term psychological therapies such as cognitive behaviour therapy are internationally recognised to reduce the impact and duration of common mental illness of mild to moderate severity. Such therapies present an alternative or, for some, an effective adjunct, to pharmaceutical management.
Recently, good progress has been made. The Government's 'Better Access to Psychiatrists, Psychologists and General Practitioners' ('Better Access') initiative through the Medicare Benefits Schedule (MBS) has enabled more people with less disabling mental illnesses to receive affordable treatment. This helps to keep them engaged with friends, family and employment. However, further improvement is needed especially among the most vulnerable groups such as people in rural and regional Australia and low-income areas, Indigenous Australians, men, young people under 25 and other disadvantaged groups.

The best chance of preventing mental disorders or providing early intervention to minimise the impact of mental illness across the lifetime is during childhood. Untreated conduct disorders in childhood significantly increase the social and economic costs to the individual and the community later in life, including through the criminal justice system.

The effectiveness of early intervention is poorly recognised in the current system and schools and early childhood services are generally ill-equipped to identify problems early and intervene effectively. Additionally, the child mental health services in Australia that do exist can struggle to bridge the gaps between health and the settings where children spend much of their time – education or child care.

For adolescents, mental illness is a significant risk factor for not completing secondary school and subsequent study or employment. It is also a risk factor for longer term mental and physical health outcomes, as well as impacting on their families, friends and others around them.

However, only twenty-five per cent of young people with mental illness access services, and for most there is a long delay between the start of symptoms and when they receive help. Young people are hard to reach, as they don't necessarily make regular visits to traditional medical or community health services. Furthermore, young people are not always comfortable with the available models and types of care provision. That's why the Government has been focusing on services such as headspace, EPPIC

[30] https://www1.health.gov.au/internet/publications/publishing.nsf/Content/nmhr11-12~nmhr11-12-challenges~quality

and KidsMatter that are designed to reach out to children and young people.

What if any particular issues do you see for mental health of vulnerable populations: women, poor, minorities, LGBTQI, etc?

There remains a high rate of mental health conditions relative to the rest of the population for LGBTQI. The focus on Gay and Bisexual men with health campaigns for safe sex and PREP, have dramatically lowered the incidence of HIV/AIDS, removing one contributing factor to mental health difficulty. Some specialised services exist for those in this cohort. Otherwise, access issues are similar to those in the rest of the community. Language, culture and location remain barriers for indigenous communities who often have high levels of substance abuse, domestic violence, unemployment and fragmented social structures. This group is a major priority for both main political parties. Women have a much higher incidence of the common mental health conditions with men being over-represented in substance abuse. They face the same access issues as described above. In addition, as the usual victims of domestic violence, they have special needs for emergency housing and support. While this has been a policy priority for many governments, disappointingly there has been little in the way of progress. Many Aboriginal people are economically and socially disadvantaged and they are constantly worried about their finance or how they are perceived by others, that contribute to mental illness. For Aboriginal and Torres Strait Islander people, good health is more than the absence of disease or illness – it is a holistic concept that includes physical, social, emotional, cultural and spiritual wellbeing, for both the individual and the community.

Based on the 2018–19 National Aboriginal and Torres Strait Islander Health Survey among Indigenous Australians aged 15 and over, it was estimated that: 45% (238,600) rated their health as 'excellent' or 'very good', another 32% (168,900) rated their health as 'good' and 24% (128,200) rated their health as 'fair' or 'poor'. This health rating has improved since 2014–15 when 40% of Indigenous Australians rated their health as excellent or very good, 35% as good and 26% as fair or poor.

Risk and protective factors for Aboriginal mental health are interconnected, and a person with mental illness might show any number of them.

- Widespread grief and loss. This includes grief about the loss of culture, land, connection, and many more areas, often connected to the history of invasion.
- Stolen children. The impact of the past Stolen Generations and ongoing removal of children puts a lot of mental pressure on people, especially when government departments just follow procedures.
- Unresolved trauma. Trauma is a huge factor in Aboriginal health and an agent for many health conditions. If unresolved, trauma can debilitate a person and be passed on to the next generation.
- Loss of identity & culture. When Aboriginal people are separated from their culture and identity, for example when they don't live on their traditional homelands or don't know where they are coming from, they don't feel complete or search for who they are.
- Discrimination and racism. Discrimination based on race or culture, as well as racism, can have a huge impact on any person's mental health.
- Few economic opportunities. Due to other factors, many Aboriginal people are economically and socially disadvantaged. If you have to constantly worry about finance or how you are perceived by others, this worry contributes to mental illness.
- Poor physical health. Physical health problems contribute to the feeling of inadequacy and exclusion, and some people might stop socialising or exercising. 23% of Aboriginal people reported having both a mental health condition and one or more other long-term health conditions.
- Incarceration /Being imprisoned has a huge effect on people's mental health.
- Culturally inappropriate treatment. Especially the health area is prone to assess Aboriginal people with non-Aboriginal criteria, or expose them to culturally insensitive environments.
- Violence. Domestic violence, as well as violence in prisons, for example, contributes to poor mental health

Substance abuse. When Aboriginal people misuse substances to ease their inner pain, it can lead to follow-on issues, such as depression.

Despite the risk factors, there are also some positive, or protective, factors that help Aboriginal people deal with mental illnesses:

- Social connectedness and sense of belonging
- Connection to land, culture, spirituality and ancestry
- Living on or near traditional lands
- Self-determination
- Strong Community governance
- Passing on of cultural practices.

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