Interview with The Honourable Mark Butler, MP, Minister for Mental Health and Ageing, Minister for Social Inclusion, Department of Health & Ageing

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You were appointed last year with a specialized portfolio reflecting some of the key priorities on the country's health care agenda. Would you begin by outlining your mission for your tenure?

Prime Minister Gillard announced during the last election in 2010 that both mental health reform and aged care reform would be priorities for this term of government in many important respects that built on the broader primary care and hospital reforms of the first term of the government. The idea was that we would build a foundation of general health reform in the hospital and the primary care sectors, and, on top of that, build some reforms for these two specific areas of need that we identified in mental health and aged care.

After the election, when we formed the government again in late 2010, the Prime Minister created a mental health portfolio for the first time, making me Australia's first mental health minister. The ageing portfolio did exist and they were brought together.

The community sentiment around mental health in the run-up to the election was quite profound. Research was done by British university College in 2010, under which 1000 nationals in eight countries – four developed, four developing – were asked to answer a range of questions, including 'what are the three biggest challenges in your country?' In most countries issues such as the economy and climate change made the list as the top two, including in Australia, but Australia was

unique in putting mental health as the third biggest issue – 35 percent of respondents said that mental health services were one of the country's greatest challenges. These sentiments created real political momentum for a big reform package.

Our reform package has essentially taken three focus points: one is to improve services for adults who have lived with severe and chronic mental illness, often for many years. Some years ago most Western countries as well as Australia went through a process of de-institutionalization: enabling people to move out of psychiatric hospitals to work and live in the community again.

This was a sound policy direction, but it was not followed up with the level of investment in community services that was required. State-governments withdrew services, which led to a higher risk of homelessness and people circulating through hospital emergency departments regularly, often in trouble with the police. The general view was that we needed to do better for these people.

Many of the investments contained in the package announced last year are about 'joining-up' the services that this group is supposed to receive so that they no longer need to go to separate places for housing services, for clinical services, pharmaceutical prescriptions and job applications, for example.

The second focus of the package was around young people, recognizing that two thirds of mental health disorders emerge before the aged of 21, and three quarters before 25. In Australia that part of the population is the least likely to receive treatment, largely because historically we expect them to go to mum and dad's GP to talk about their problems, their sexual orientation and alcohol issues. We are in the process of building youth services which are designed for 12 – 25 year olds, such as primary care, online services and a community based service we call 'Headspace', as well as acute level services, especially for young people who experience their first episode of psychosis.

The third part of our reforms focus on systems reform and trying to lift research in mental health. This includes health services research and biomedical research on what is happening in the brain around schizophrenia for example. Our capacity to research the brain has been transformed by the imaging revolution, so there is a big growth of opportunities there.

We already see that the new generation of anti-psychotics is making life for people with psychosis much easier and gives them a good level of support – provided that other supports are in place as well – to recover to the point where they can live a contributing life in their community.

What research initiatives are you developing to tackle key health priorities and alleviate pressures on the Australian healthcare system?

Last year I initiated a 10-year review of health and medical research. Many things are changing quickly: the mapping of the human genome, the extent to which that is causing research teams to be much larger and often cross- jurisdictional and the shift in disease focus.

A great example of huge interest is the explosion in Alzheimer's and dementia. Dementia will become the largest source of disability in 2016 for the whole of the Australian population. The death rate for people with dementia has grown 140 percent over the past decade, whereas stroke and heart disease continue to follow a downward trend that started over 40 years ago.

The degree to which imaging is changing the fundamentals of our research approach to Alzheimer's is amazing. Traditionally all that we were able to do is to cut someone's head open post-mortem and look at the brain, or treat heavy symptoms. Whereas now we are starting to see the first development of proteins on the brain and checking how we might arrest the development of those proteins. This is incredibly exciting and very important. In my view it (dementia) is the health challenge that will dominate the research and health services sector for the next few decades.

In Australia, there are two challenges that we would like to tackle. One is to deal with the immediate burden of disease associated with dementia – the irreversible burden – and a lot of that work is around health services and not so much traditional biomedical research. For example, how do we build services and facilities that are sensitive to patients and will accommodate their behavioral symptoms that go with dementia?

One key issue today is the vast overuse of antipsychotics for behavioral management issues. In nursing homes as many as 25 percent of patients are on anti-psychotics. There is only one anti-psychotic approved for use on the PBS for use in behavioral management associated with dementia, and that should only be used after non-clinicological attempts have been tried and exhausted. Despite that, the medicine is used widely.

And the next, biomedical challenge is: how do we stop the disease evolution in people who are now at very high risk of getting dementia? We made some significant inroads around 30 years ago in discovering what proteins play a role, but we haven't nailed it yet. We do not even know whether the growth of these proteins is a cause or a symptom of dementia, let alone how to stop it.

We need to get everyone in the health sector rowing in the same direction: we need the entire pharmaceutical industry behind it, we need traditional biomedical researchers behind it, we need the age care sector, GPs and so on all collaborating on the matter. And to do that we need to recognise that the healthcare sector currently operates in silos – the hospital system, primary care

system, GP system – and breaking down those silo’s is a key challenge.

Could you give some examples of successful cooperation between the pharmaceutical industry and the medical research community?

There is a real thirst in the pharmaceutical industry, as there is among other areas of the health sector, to redouble our efforts in dealing with the dementia challenge and that for me is of crucial importance. It is similar to the challenge we faced four decades ago with cardiovascular disease, which led to extraordinary success both for the pharmaceutical industry and for the broader health sector. Tackling the growing impact of dementia is a major challenge in the 21st century, and it is not one we will resolve quickly. It does offer great opportunities for partnerships between the pharmaceutical industry, government, and the health sector, and this cooperation will prove critical in getting the results we are after.

Another area in which we saw such cooperation is in clinical trials. I co-chaired the Clinical Trials Advisory Group (CTAG) which was a partnership with the pharmaceutical industry and the research sector focused on improving the environment for clinical trials – particularly for Phase III – IV. In a federation like Australia such trials often require researchers and pharmaceutical companies to jump through hoop after hoop in ethics & governance approval. The key is to harmonize the degree to which this kind of work has to be done cross-jurisdictionally, while things like how we improve patient recruitment are crucial as well.

Overall it is an important objective of this government to retain a good research sector. We recognize that we live in a highly competitive region with countries like Korea, China and India, quickly moving ahead in this area. We have to identify our competitive advantage and play to it, and as a government we are committed to doing that.

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