Inquiry into Chronic Disease Prevention and Management in Primary Health Care

beyondblue Submission

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beyondblue
PO Box 6100
HAWTHORN VIC 3122

Tel: (03) 9810 6100
Fax: (03) 9810 6111
www.beyondblue.org.au

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Introduction

beyondblue is pleased to present this submission to the Standing Committee on Health's inquiry into Chronic Disease Prevention and Management in Primary Health Care.

Non-communicable chronic diseases have replaced communicable disease as the leading contributors to the burden of disease in developed countries like Australia. Mental health conditions are among the most prevalent of these chronic conditions. They may occur on their own or they may be comorbid with physical health conditions. Despite their prevalence and significant personal, social and economic impact, they are often overlooked in policy discussions on chronic disease and regrettably, also in clinical practice**. *beyondblue* believes that any efforts to improve chronic disease prevention and management in primary care must ensure that the issues and needs of people affected by mental health conditions, such as depression and anxiety, are given due consideration.** As the World Health Organisation has stated: *"There can be no health, without mental health."*[1]

Recommendations

To prevent and better manage chronic disease, a comprehensive, holistic and integrated approach is needed. This should include the following actions:

1. Include enduring mental health conditions in the National Strategic Framework for Chronic Conditions.
2. Prioritise the physical health needs of people with mental health conditions, by developing incentives and systems to conduct annual physical health screening checks for people receiving mental health treatment.
3. Implement a range of evidence-based chronic disease prevention strategies, which include health financing, legislation and regulation, improving the built environment, advocacy initiatives, community mobilisation and health services organisation and delivery.
4. Develop and publicly report on national targets and indicators to monitor progress in chronic disease prevention and management. These targets and indicators should incorporate measures assessing mental health (for example, prevalence rates of common mental health conditions such as depression and anxiety, and the physical health of people with mental health conditions).
5. Fund and incentivise integrated physical and mental health care treatment models, which are implemented through stepped-care approaches, and include e-mental health programs.
6. Increase the capacity and skills of the health workforce to better meet the needs of people with mental health conditions, and co-existing physical and mental health conditions. This should include:
    a) increasing non-clinical and/or low-intensity support roles as part of a stepped care model. The *beyondblue* NewAccess coaches and The Way Back Support Service support coordinators provide examples of roles that increase access, reduce stigma and enable traditional health workforce practitioners to operate at the top of their skill-set
    b) embedding mental health peer support workers as a core component of multidisciplinary mental health and recovery teams
    c) improving the knowledge, understanding and skills of health professionals working with people with physical chronic diseases, to better recognise and respond to mental health difficulties
    d) developing, delivering and evaluating stigma-reduction programs in primary care settings.
7. Encourage doctors to have their own GP – this is essential as *beyondblue* research shows that doctors report substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professionals.

It is essential that these actions are implemented within the broader context of Australia's national mental health reforms, and be informed by the development of the 5th National Mental Health Plan.

beyondblue is a national, independent, not-for-profit organisation working to promote good mental health. Our vision is that all people in Australia achieve their best possible mental health. We create change to protect everyone's mental health and improve the lives of individuals, families and communities affected by depression, anxiety and suicide.

This submission has been informed by *beyondblue*'s extensive experience in increasing awareness and understanding of depression and anxiety and improving access to mental health treatment and support.

***beyondblue* is keen to work with the Government on ways to prevent and reduce the impact of chronic disease,** with an emphasis on preventing depression, anxiety and suicide, and assisting people who become unwell to access effective self-help, peer-to-peer support, and brief and low-intensity interventions that enable them to recover and remain well. *beyondblue* has developed a suite of resources that can complement, and be used as an adjunct, to primary care practice. These resources are funded by the Australian Government.

Mental health and chronic disease

Mental health conditions are extremely common, with one in seven Australians experiencing depression in their lifetime and one quarter of Australians experiencing an anxiety condition.[2] **Depression and anxiety are often chronic conditions**. While around half of people with depression experience only a single episode, for others depression can be a relapsing-remitting condition. A recent review of the natural trajectory of depression suggests that the risk of recurrence of depression after recovery is extremely high - 36 per cent after one year following recovery, 60 per cent after five years.[3] A significant minority of people with depression will experience enduring problems that respond poorly to treatment. The pivotal Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial, found that even after several successive changes in pharmacological treatment for people who did not respond to first, second or third line treatment, the end remission rate was at best only 67 per cent.[4] Overall, the likelihood of remaining depressed for many years is high (30 per cent are still depressed after one year, 20 per cent after two years, 12 per cent after five years).

In addition to being potentially chronic conditions in their own right, conditions such as depression and anxiety may contribute to, or co-occur with a range of other chronic conditions. The National Survey of Mental Health and Wellbeing (2007) found that one third of people with 12-month mental health conditions also had a chronic physical condition. [5] A review of the relationship between mental health conditions and chronic physical conditions has demonstrated that:[6]

- **Depression is more common in all health priority areas** (heart disease, stroke, diabetes, asthma, cancer, arthritis and osteoporosis) than in the general population
- **Anxiety is more common in people with heart disease, stroke and cancer**, than in the general population
- The causal relationship between depression, anxiety and physical health conditions is difficult to determine, however **there is clear evidence that depression is a risk factor for heart disease, stroke and diabetes**
- **Co-existing depression is associated with worse functional outcomes for people with physical diseases**. It is also associated with increased disease severity, because of non-compliance with treatment and greater complications; longer hospital stays; increased morbidity; and increased mortality.

The high levels of co-existing physical conditions in people with a mental health condition has a significant adverse impact – **people with severe mental illness live between 10 – 32 years less than the general population**.[7] In addition to premature death by suicide, the major factors contributing to this lower life expectancy are the higher rates of health risk behaviours such as smoking, higher rates of physical illness, and inequitable healthcare access. [8,9]

Another key factor contributing towards the poorer health outcomes of people with mental health conditions is the **stigma and discrimination associated with these conditions**. People with depression and

anxiety report experiencing stigmatising attitudes from health professionals, with people often saying they feel patronised, punished or humiliated in dealing with health professionals.[10, 11]

> *"I have...found that some of the young GPs who sit in as a locum tend to not take your concerns in regard to chest pains, pain and weakness in the left arm etc. seriously once they read in your notes that you have mental illness...We are not hypochondriacs or attention seekers. We are just a regular person who has a concern in regard to their health." beyondblue* blueVoices member

> *"A few years ago I began having small seizures and I went to see a doctor about this. The doctor's immediate assumption was that I was having anxiety attacks and that I should see my psychiatrist. I found this to be very patronising, as I know that these were not anxiety attacks...my psychiatrist...referred me to a neurologist. I have since been diagnosed with partial epilepsy. My concern with this is that if my general practitioner had been the sole health care provider with regards to my depression / anxiety then my epilepsy may not have been diagnosed at all."* Person with a mental health condition

The stigmatising attitudes and behaviours of health professionals can have significant consequences, including decreasing the likelihood of seeking help, increasing psychological distress, and reducing treatment adherence. [12,13,14,15] 'Diagnostic overshadowing', in which people with depression and anxiety receive poorer physical healthcare than others, can also be attributed to stigma.[16,17] These negative consequences may contribute to the increased risk of suicide and the higher mortality rates among people with mental health conditions.[18,19]

The significant impact of stigma and discrimination on both physical and mental health outcomes demonstrates the need for targeted stigma-reduction strategies in primary care. These should be incorporated into, and/or accompany initiatives, which improve the identification and treatment of co-existing mental and physical chronic health conditions.

Best practice in chronic disease prevention

To effectively prevent chronic disease, a comprehensive and integrated approach is needed, which focuses on common risk factors for chronic disease, and includes strategies for individuals and their broader social, economic and built environments.[20] The World Health Organisation's (WHO, 2005) guide to effective chronic disease prevention interventions should inform Australia's approach to this area. The WHO suggests the following principles should apply to chronic disease prevention policy:[21]

- **Comprehensive and integrated public health action** – this should cut across specific diseases and focus on common risk factors; focus on the entire population over specific subgroups; work across settings, including health care, schools, workplaces and communities; and link government and community-based organisations.
- **Intersectoral action** – the underlying determinants of chronic disease lie outside the health sector (for example, poverty, lack of education, unhealthy environmental conditions, unhealthy diets and physical inactivity). An intersectoral approach is needed to identify and overcome conflicting priorities and vested interests, and effectively develop and implement policy.
- **A life course approach** – risk factors for chronic disease are present from pre-conception through to adulthood and older age. Life course and population-wide approaches are needed to reduce these risks and protect child and adolescent health.
- **Stepwise implementation based on local considerations and needs** – core interventions that can be implemented within existing resources and in short timeframes should be prioritised, with medium and longer-term strategies also developed.

Although individual information and lifestyle change initiatives are important, they need to be combined with initiatives targeted to the social determinants of health and disease. Within the mental health field, this means targeting risk and protective factors within individuals' home, school, work, community and online environments. While the prevention of mental health conditions has a somewhat shorter history than the prevention of physical health conditions such as infectious disease, cardiovascular disease and cancers, there is now a solid body of evidence that demonstrates that public health initiatives can make a

difference and depression and anxiety conditions can be averted or minimised in many instances. Greater emphasis needs to be placed on mental illness prevention including through primary health care.

In accordance with these priorities, **best practice in chronic disease prevention should include the following health policies and strategies**:[22]

- **Health financing –** the principles of equity and effectiveness should inform funding decisions, and chronic disease prevention should be prioritised in health budgets.
- **Legislation and regulation –** laws should protect people from harm and reduce the risk of chronic disease – as has been extensively demonstrated in effective tobacco control measures. Tax and price interventions should also promote healthy choices and activities.
- **Improving the built environment –** the built environment should facilitate increased physical activity.
- **Advocacy initiatives –** information should be used to influence decision-making and public perceptions, behaviours and support for policy options.
- **Community mobilisation –** interventions should aim to reduce risk factors within communities, schools and workplaces.
- **Health services organisation and delivery** – health services should be reoriented from acute health care to chronic disease prevention and management. Effective clinical interventions to prevent chronic disease include those supporting behaviour change (for example, tobacco cessation, increased physical activity, dietary change) and pharmacological interventions (for example, aspirin, blood pressure and cholesterol-lowering drugs). The delivery of these interventions should be informed by an individual's overall risk of developing a chronic disease.

These initiatives need to be implemented through a **partnership model**, which brings together governments, non-government organisations, the private sector, workplaces, educational settings, health services and communities.[23] There also needs to be **national targets and indicators** established and publicly reported on, to monitor progress and inform policy and program changes.[24] It is essential that these targets and indicators for chronic disease prevention incorporate measures assessing mental health. These could include prevalence rates of common mental health conditions such as depression and anxiety, and the physical health of people with mental health conditions.

Best practice in chronic disease management

Effective management of chronic disease requires a focus on long-term, flexible, continuing, comprehensive, multidisciplinary care that addresses people's physical and mental health needs as well as their social and economic needs. Care needs to be person-centred and collaborative with effective communication between the individual and all parties involved in providing supports and services. The Chronic Care Model (CCM) is an evidence-based approach to manage chronic disease in primary care, and improve health outcomes.[25]

This model includes six key elements:

- **Self-management support –** empowering and preparing people to manage their health and health care. This is achieved through providing counselling on self-management and referring to self-management programs.
- **Decision support –** promoting clinical care that is consistent with scientific evidence and individual preferences. This includes embedding guidelines into daily practice – for example, alerts, flow sheets.
- **Delivery system design –** assuring the delivery of effective, efficient clinical care and self-management support. This involves regularly following up patients and fully utilising non-clinical staff. People with high risks or complex needs are supported through care management programs.
- **Clinical information systems –** organising patient and population data to facilitate efficient and effective care. Data informs outreach services and care planning.
- **Health care organisation –** creating a culture, organisation and mechanisms that promote safe, high quality care. Continuous improvement activities are undertaken and incentivised.
- **Community resources –** helping people access needed services in the community. People are regularly referred to community-based services and resources, and there are partnerships across medical and community organisations.

The needs of people with mental health conditions, either as their primary condition or as a co-existing health condition, also need to be explicitly focused upon. Too often, health care is provided in a linear way. Physical diseases are treated first and people are then referred to mental health care or worse still their mental health care needs are forgotten or neglected.[26] This is not effective or efficient. **Integrated care models need to be implemented, which recognise the complexity of co-existing conditions.** [27]

Within the mental health field, a **stepped-care model of service delivery is ideal**. Some people only require psychoeducation provided through information and education resources which enable them to self-manage their condition and make social and lifestyle changes (for example, through e-mental health programs). Others may benefit from structured or informal peer-to-peer support strategies provided on their own or in combination with other care. Brief and low intensity interventions also have a clear place for many people affected by mental health conditions – the former has proven efficacy for alcohol misuse while the latter has proven value for mild-moderate depression and anxiety conditions (see information on *beyondblue's* 'NewAccess' program below). They can be delivered by appropriately trained and supervised non-health care professionals who can complement existing primary care service providers. These interventions should be considered part of primary care.

Online programs can also be used to facilitate better self-management, and improve physical and mental health outcomes for people with chronic disease. An example of an effective online self-management program is the 'Stepping Up' program (www.steppingup.org.au), developed by Deakin University with funding from *beyondblue*. This six to eight week online program is for people with arthritis, back pain or other musculoskeletal conditions. It supports people to deal with some of the physical and emotional challenges of living with a musculoskeletal condition, such as stress, pain, fatigue, depression, low mood, anxiety, worry, sleep problems and making lifestyle changes. The program has been demonstrated to achieve significant reductions in distress, with participants reporting a 17 per cent improvement in their mental health assessment after completing the program. Initiatives such as Stepping Up have the potential to be expanded to other health conditions, and be integrated as a core component of chronic disease management practices within primary care.

Chronic disease management approaches should also incorporate **e-mental health programs**. E-mental health programs include:

- Information, support and assessment sites – These may include information sites, peer networks, screening and diagnostic assessments. These sites may be stand-alone; facilitate access to face-to-face services; or be used as an adjunct to face-to-face care. For example - www.beyondblue.org.au, Black Dog Institute , Headspace, Reachout - all accessed via www.mindhealthconnect.org.au
- Symptom prevention and management programs – These programs may be designed to prevent or treat depression and anxiety. Effective services are generally based on evidence-based face-to-face delivery models, such as Cognitive Behavioural Therapy and interpersonal therapy, and bibliotherapy. Other online programs are also available and may be used by a person working through his/her own self-help; guided self-help (for example, support from a clinician, automated reminders, assistance from technicians); or as an adjunct to face-to-face therapies. For example – www.mindspot.org.au

E-mental health programs are clinically effective - randomised controlled trials have demonstrated that e-mental health treatment programs are as effective as face-to-face treatment for people with mild to moderate depression and anxiety (including social phobia, panic disorder and generalised anxiety disorder).[28,29,30,31] These program may also be up to 50 times more cost effective than traditional services.[32] **The clinical effectiveness and efficiency of e-mental health programs means that there is a strong role for e-mental health programs in increasing access to mental health treatment**. This mode of service delivery has the potential to significantly reduce the prevalence and impact of depression and anxiety in people with other chronic diseases. These programs also provide an opportunity to reach people who may not otherwise access care – for example, due to stigma, cost, geographical location, transport difficulties, social isolation or a lack of services.

It is essential that this integrated, stepped-care model is supported by a **health workforce that has the right skills and abilities to deliver care across the continuum of needs, with a greater focus on developing non-clinical and/or low-intensity support roles**. This will enable specialist health professionals to operate at the

top of their skill-set, reduce demand on clinical services and ensure that specialist care is delivered to those in greatest need of high levels of support. Practice nurses should be embedded within multidisciplinary teams,[33] and the **role of peer support workers**, who are Certificate IV trained, supervised and renumerated, should be explored. Mental health peer support workers model hope and recovery, and have been demonstrated to improve the experiences and outcomes of people receiving mental health treatment.[34] The benefits of the peer workforce could be improved by integrating mental health peer workers as a core component of treatment teams, and expanding this workforce to other health conditions.

It is also important that **health professionals working with people with chronic physical diseases have a good understanding of mental health conditions**. Given the high prevalence of co-existing physical and mental health conditions, it is important that health professionals can recognise when people may be experiencing mental health difficulties, and make appropriate referrals to specialised treatment if required. Examples of existing health professional training and resources include:

- **'Mental health and diabetes program'** – this is being implemented as part of the National Diabetes Services Scheme - www.ndss.com.au/en/Development-Programs/Psychosocial-and-Mental-Health-Impacts-of-Living-with-and-Managing-Diabetes-Program1[35] As part of this program a handbook for health professionals is being developed which includes information on monitoring and addressing mental health problems, making referrals to mental health specialists, and strategies to facilitate communication between health professionals and people with diabetes.
- **'Cardiac blues'** – a suite of resources for health professionals and patients on distress following an acute cardiac event has been developed - www.heartresearchcentre.org/research/the-cardiac-blues-project. Health professional resources include a one hour online training program and a health professional guide. These are accompanied by a brochure and postcard for patients and a waiting room poster. The resources were developed by the Heart Research Centre, with funding from *beyondblue.*

Education and training programs such as these also need to be supported through ongoing support, the development of professional networks, and incentives to improve the coordination of care and communication between providers.

The role of Primary Health Networks (PHNs) in planning and commissioning best-practice chronic disease management models, which meet the needs of local communities, also need to be considered. The National Mental Health Commission's (2014) review of mental health programmes and services recommended that the scope of PHNs be extended to lead the planning and purchasing of mental health programs, services and integrated care pathways. The Commission further recommended that people with complex care needs receive flexible care packages, which enable them to purchase services that meet their needs, and be empowered to make decisions about their healthcare. Any changes in the delivery and funding of chronic disease programs need to align with mental health reform and potential changes to the role and function of PHNs.

Effective chronic disease management approaches should also be supported by suitably aligned funding models. Activity based and block grant funding could potentially be suitable for service providers assisting some people with chronic conditions, such as those whose conditions are less complex and require input at the lower end of the stepped-care model. Ultimately however the emphasis should be placed on **outcome-based funding models**, which incentivise the delivery of integrated, coordinated, multidisciplinary care tied to demonstrable improvements in people's physical health, mental health and social and economic participation. This approach is likely to help shift the provision of care for people with chronic conditions away from piecemeal, reactive care to comprehensive, proactive care which is central to better outcomes.

beyondblue

beyondblue's programs and services are highly relevant to chronic disease management, given the prevalence of chronic mental health conditions, and co-existing physical and mental health conditions. Improving access to services has been a priority for *beyondblue* since its inception in 2000, and *beyondblue* has a range of initiatives and programs to support mental health and wellbeing, and reduce suicide, in people living with a chronic disease.

Information and resources

beyondblue has an extensive range of free resources which focus on improving the mental health of every person, at every stage of life. These resources aim to increase awareness and understanding of depression and anxiety, and give people the confidence and skills to talk about these conditions. ***beyondblue's* resources include a range of fact sheets, booklets, videos, brochures, case studies and online therapies for people living with different chronic diseases**. This information includes details on who can assist people experiencing depression or anxiety, helpful strategies and tips, and advice for family and friends. *beyondblue's* resources are disseminated to individuals, community groups, health centres, libraries, schools, universities, workplaces and many other settings.

beyondblue Support Service – 1300 22 4636 - www.beyondblue.org.au/getsupport

The *beyondblue* Support Service provides all Australians with the opportunity to talk through their concerns with a qualified mental health professional. The service is delivered via a 24/7 telephone service, a web chat service from 3pm to 12am (AEST), and an email response service**. People with a chronic disease, and their families, can receive one-on-one support focussed on addressing their immediate concern, and receive information and advice on continuing to seek help**. The service has recently been independently evaluated and demonstrated to reduce levels of distress and increase motivation to take action for mental health concerns.

NewAccess – www.beyondblue.org.au/newaccess

NewAccess is a *beyondblue* demonstration project that provides a support service to help people tackle day-to-day pressures. This early intervention program provides easily accessible, free and quality services for people with symptoms of mild to moderate depression and/or anxiety who are currently not accessing mental health services. Trained and clinically supervised coaches operate like personal trainers, providing low-intensity cognitive behaviour therapy and individual, tailor-made support programs incorporating relevant areas such as problem solving, goal setting and dealing with worries. Importantly, the program teaches people self-help techniques, that enable them to lead their own recovery. Additionally, NewAccess links clients into local community networks and engages them with other service providers should they require it - for example, employment, financial or housing assistance.

The program is currently being piloted and evaluated in three regions across Australia – Canberra, metropolitan Adelaide, and North Coast New South Wales. It is the result of four years of research and collaborative discussion in Australia and has been adapted for the Australian context from the highly successful UK Improving Access to Psychological Therapies (IAPT) initiative. IAPT is a National Health Service program rolled out across England and proven to improve mental health outcomes. Before the end of the pilot in 2016, *beyondblue* intends to have proven the effectiveness of New Access for a national rollout. Interim evaluation findings for the New Access pilot have been promising - the non-medical model is encouraging men to seek help in higher numbers (39 per cent of all clients are men) and we are achieving an average recovery rate of 68 per cent - well in excess of the UK IAPT benchmark of 50 – 55 per cent. **This unique service delivery model has the potential to provide preventative and early intervention services to meet the needs of people living with a chronic disease, and their families.**

The Way Back Support Service

***beyondblue's* The Way Back Support Service is an innovative approach to supporting people who have been discharged from hospital following a suicide attempt.** Support coordinators link people into existing health, community and social support services, ensuring they receive the care they require. This non-clinical service is currently being trialled in the Northern Territory, with a second trial site being established in New South Wales later in 2015. It is expected to reduce the reliance on acute and emergency services, by facilitating access to timely support and treatment. The service also expects to improve the quality of life of people who have attempted suicide, and reduce the suicide rate among this high-risk population group.

The Brave Program - https://brave4you.psy.uq.edu.au

The BRAVE Program is a free, online evidence-based program that helps prevent and treat anxiety in young people aged between eight and 17 years. The program is made up of 10 interactive sessions which use

cognitive behaviour therapy techniques to help teach young people and their parents how to manage anxiety. The program was developed by the University of Queensland, with funding from *beyondblue*.

Youthbeyondblue – www.youthbeyondblue.com

beyondblue's website for young Australians aged 12 to 25 includes information on depression, anxiety, bullying, alcohol, self-harm and suicide. A new Youthbeyondblue campaign was launched in late May 2015 on digital and social media channels, to encourage people to find out more about depression and anxiety, reduce stigma, and encourage help seeking through completing a 'Brain Quiz' (K10 checklist) online.

ManTherapy - www.mantherapy.org.au

beyondblue's Man Therapy campaign encourages men to take action against depression and anxiety. At www.mantherapy.org.au men can assess their wellbeing, get answers to frequently asked questions about mental health and receive action-oriented advice on dealing with depression and anxiety. The campaign and website feature the fictional Dr Brian Ironwood, a straight talking 'man's man' who combines humour with serious messages about mental health. To help increase the appeal of the Man Therapy campaign to other segments within the 25 - 54 age range, *beyondblue* has also developed the new 'Davo's Man Therapy' campaign, which targets blue-collar males in regional areas of Australia. The campaign launched on Monday 22 June 2015 and will run for a six month period. In 2014-15, nationally there were 206,151 website visits to the Man Therapy website, and 39,967 people completed a 'Mind Quiz' (K10 checklist).

Family guide to youth suicide prevention

beyondblue has developed a guide to support parents of young people who may be at-risk of suicide. It includes information and videos on the warning signs and risk factors of suicide; how to support a young person, including getting help from a health professional; and supporting young people to be resilient. The guide is available at: www.beyondblue.org.au/resources/family-and-friends/parents-and-guardians/family-guide-to-youth-suicide-prevention

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