

CANBERRA MENTAL HEALTH FORUM

THE CASE FOR INCLUDING PEOPLE WITH CHRONIC MENTAL ILLNESS IN THE 2019 ACT AUDIT OFFICE'S PROPOSED PROGRAM REVIEW OF CHRONIC DISEASE SERVICES

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25 January 2019

Who are we? The Canberra Mental Health Forum is a community-based advocacy and support group. It is the independent voice advocating for mental health reform in the ACT and surrounding area. Our membership is made up of people who are carers, people with lived experience of mental illness, community members who have a general interest in improving mental health services and others who have work experience in various capacities in the health and community sector. The group enhances its members' knowledge and understanding of mental illness and mental health services. We have a special interest in challenges from a caring perspective.

What do we do? We have monthly meetings as a U3A group and run a lively on-line chat forum, open to all.

Our members regularly meet with decision makers in the mental health arena, serve as carer or consumer representatives on mental health committees, actively contribute to current debate by inputting into government consultations, prepare formal submissions to government and liaise on a day to day basis with carers and people with a mental health/psychosocial disability. We also provide support to our members who request assistance with a family member in crisis.

Why did we write this paper? In September 2018 we became aware that the ACT Auditor-General was planning to do a performance audit in 2018-9 of the ACT Health Directorate. This audit would focus on services for people with chronic illnesses and, in particular, coordination of such services where comorbidities were present. At that time the Auditor-General's Office had not defined the parameters of its proposed audit and could not say whether chronic mental illnesses would be included.

People with chronic mental illnesses are amongst the most vulnerable and most complex to care for. There are very serious, well documented concerns about their physical health. All the evidence points to the physical health of this group being neglected and that they are more likely than others in the community to have other chronic illnesses, to die prematurely from these diseases and to have high levels of risk factors associated with these other chronic diseases. The health disadvantages for this group are unacceptably high. It is therefore vital that they are included in the **proposed audit**.

"People experiencing mental illness are likely to live 14 to 23 years less than the general population, largely due to cardiovascular disease and cancer rather than suicide; and the gap is widening."

This paper provides the Auditor-General with evidence supporting the above statements and will help him to understand the importance of including, in the proposed audit, services for people who have both chronic mental illness and other chronic diseases.

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THE CASE FOR INCLUDING PEOPLE WITH CHRONIC MENTAL ILLNESS IN THE 2019 ACT AUDIT OFFICE'S PROPOSED PROGRAM REVIEW OF CHRONIC DISEASE SERVICES

SECTION ONE

WHY INCLUDE PEOPLE WITH MENTAL ILLNESS IN THE PROPOSED PROGRAM REVIEW?

This section outlines reasons why the proposed review should include people with chronic mental illness. Section 4 provides further evidence to support this position.

The proposed review intends to focus on the coordination of care for people with chronic health conditions. Mental illness is a common chronic illness, often associated with other chronic conditions. Mental illness is not a single disease, but a broad category encompassing a range of conditions. These conditions include substance use disorders which:

- are internationally recognised as a chronic, relapsing mental health condition;
- can be associated with schizophrenia type conditions
- commonly co-occur with other mental illnesses;
- often develop in people with other mental illness, especially anxiety;
- are associated with criminality, adding stress, causing or increasing the severity of other mental health disorders and complicating access to appropriate treatment.

There are strong reasons why all types of chronic mental illness should be included in the Auditor-General's proposed review.

Firstly, mental illnesses are a major contributor to the burden of disease and occur at earlier ages than physical chronic diseases.

"Mental illness is a leading cause of chronic disease in the ACT, with anxiety disorders and depressive disorders contributing to 5.1% and 2.7% of the burden of disease, respectively".ⁱ

The ACT burden of disease figures above appear not to include the more debilitating mental illnesses such as psychosis, eating disorders, drug and alcohol use disorders, and some other less common mental illnesses. Hence the total contribution to the burden of disease from mental illness is even higher than suggested above.

Mental illness is the most common chronic disease for people in the age range 0-44 years.ⁱⁱ

These years are crucial for people's early development, education, employment, family life and so on. Disruption through mental illness and possibly other chronic disease can have a lifelong negative impact. For example:

- for people aged 16-30 years, 79% of people with mental illness are in secondary or tertiary education or employed compared with 91% for those withoutⁱⁱⁱ; and
- for people aged 16-64 years, 62% of people with mental illness are employed, compared with 80% for those without mental illness.^{iv}

Secondly, people with enduring debilitating mental illnesses frequently have comorbidities, including both physical and other mental health chronic conditions. They should be included in the review as they are amongst the most vulnerable and most complex to care for:

“Severe and persistent mental illnesses, such as psychotic disorders, have a relatively low prevalence but have a substantial impact on individuals, their families and society due to the ongoing and sometimes extensive care needs required to support the individual”.^v

The patterns of comorbidity vary, depending on the nature of the mental illness and other factors.

For example, having a mental health condition is a potent risk factor for experimenting with substances and subsequently developing a substance dependency. The link is particularly strong with anxiety disorders.^{vi} The proportion of people with one mental illness who also have drug and alcohol use disorder, appears to be increasing.^{vii}

“People with co-occurring drug use and anxiety disorders often have a more severe level of disability over time, and poorer treatment response.”^{viii}

This combination of mental health disorders is particularly common amongst the prison population.

In 2016, detainees at the Alexander Maconochie Centre (AMC) had high levels of a wide range of mental health conditions, common chronic diseases and disabilities and risk factors for chronic diseases. Their mental health conditions included depression (30%), anxiety disorder (22%) substance use disorder (16%), schizophrenia (14%), personality disorder (12%), ADHD (10%) and bipolar disorder (10%). Approximately 27% of respondents indicated that they also currently experienced other, less common illnesses, including hepatitis C, multiple sclerosis and ulcers.^{ix} These figures suggest many detainees have a complex mix of care needs.

Thus, caring for their health needs in prison and managing their transitions in and out of prison provides special challenges.

The ACT Health Directorate is responsible for providing health services to AMC detainees, many of whom have serious mental disorders and other health problems. It is important that, as part of its proposed review, the Audit Office examine Health’s performance in this important area.

People living with psychotic illness 2010, a national survey^x, found that for one quarter of participants, their physical health was one of the biggest challenges. A recent ACT study reported that factors such as poverty, neglect of public services and being treated as second class citizens because of a diagnosis of mental illness and/or psychosocial disability “were connected with significant barriers in accessing physical health care”.^{xi}

Thirdly, “there is a large body of research, spanning many decades, which supports a clear link between mental illness diagnosis and poor physical health”.^{xii} People with mental illness, especially those with serious and enduring mental illness, are more likely than the general population to:

- die younger;
- have comorbidities ie other types of mental illness and/or physical chronic diseases;
- have a high level of risk factors for chronic health conditions (eg smoking, excessive weight, lack of exercise, poor diet, side effects of the medication for their mental illness, unemployment, poverty, social isolation, homelessness, poor education levels;
- have more advanced physical chronic disease before being diagnosed and treated; and
- have longer hospital stays for episodes of their other comorbidities.

Fourthly, ACT compares unfavourably with Australian averages on some measures of physical health and wellbeing for people with mental illness. For example, for cancer and CVD, the ACT has a substantially larger gap than the Australian average between the proportions of the population with

and without mental illness with these diseases. Similarly, the gaps in the proportion of its residents with and without mental illness with certain health risk factors are much higher than the Australian average, including being overweight, smoking and at risk of long-term alcohol damage.

The four issues above demonstrate there would be substantial potential benefits in the ACT for the individuals, their carers, families and friends, the broader community and the health system from having an effective, whole person, coordinated approach to caring for people with mental illness and comorbid conditions. The proposed Auditor-General's review could highlight strengths and weaknesses of the current arrangements, potentially leading to better outcomes for this very vulnerable group and consequent substantial cost savings.

SECTION TWO

ROLE OF GENERAL PRACTITIONERS (GPs)

The Audit Office's preliminary description of its proposed program review of chronic disease services refers to the possibility of including the effectiveness of the current arrangements to coordinate care with community and other agencies also involved in the care of those with chronic health conditions. GPs play a substantial role in managing mental illness, including providing services to those with serious and enduring mental illness such as Schizophrenia. A study by the Royal Australian College of General Practitioners indicated that:

- over 88% of people with psychotic illnesses visited a GP at least once a year;
- for at least 30–40% of people living with schizophrenia in Australia, ongoing management is provided by their GP alone.^{xiii}

In Australia, 70 percent of antipsychotic medications are prescribed by GPs.^{xiv}

Thus, it is vital that the Audit Office include GPs' roles in caring for people with chronic mental health conditions and other comorbidities in its proposed program review.

SECTION THREE

RECENT ATTEMPTS TO IMPROVE THE SITUATION

In recent years there have been attempts to encourage a more preventative approach and more effective care and treatment of people with both chronic physical and mental health problems. See for example:

- The recently issued World Health Organisation's "Guidelines for the Management of Physical Health Conditions in Adults with Severe Mental Disorders".^{xv}
- 5th National Mental Health and Suicide Prevention Plan 2017. Priority Area 5 recognises the importance of improved approaches to reducing premature mortality and the prevalence of chronic physical health conditions for people with mental illness.

- National Mental Health Commission. *Equally Well: the national consensus statement for improving the physical health and wellbeing of people living with mental illness*. Sydney. NMHC; 2016. This has been ratified by all states and Territories and a large number of other organisations. A leaflet outlining NSW's response to this initiative is attached.
- NSW Mental Health Commission, *Physical Health and Mental Wellbeing, An Evidence Guide* 2016;
- Australian Health Policy Collaboration, *Beyond the fragments - Joining up Physical and Mental Health, the case for a new approach in policies and services*, Issue Paper No 2015-05, Dec 2015, Maria Duggan

The Audit Office would find these documents useful to provide benchmarks to measure the degree to which ACT Health has in place services and processes to achieve the best possible outcomes for people with comorbid chronic mental and physical illnesses.

SECTION FOUR

WHAT IS THE EVIDENCE TO SUPPORT THE STATEMENTS IN SECTION 1?

Statistics from both from Australia and overseas demonstrate the poor physical health of people with severe mental illness. The NSW Mental Health Commission cites documents back to 2000 raising concerns about this issue, but little seems to have changed.

See Reference ^{xvi}

There is a common picture across a wide range of reports and research papers of substantial People experiencing mental illness are likely to live 14 to 23 years less than the general population, largely due to cardiovascular disease and cancer rather than suicide; and the gap is widening. disadvantage. Precise figures vary as they are based on different combinations of chronic illness, include varying types of mental illness or refer to different time periods. Examples are given below.

4a Premature Mortality

“There can be no greater illustration of how the health system has failed people with mental illness than the life expectancy gap, mostly caused by preventable, and treatable, diseases”, Professor Harvey Whiteford, National Mental Health Commission Commissioner^{xvii}

People experiencing mental illness are likely to live 14 to 23 years less than the general population, largely due to cardiovascular disease and cancer rather than suicide; and the gap is widening.”
The highest risks of premature death were from respiratory disease, cardiovascular disease, prostate cancer, breast cancer, lung cancer, and diabetes.

See references ^{xviii} and ^{xix}

Over 690,000 Australians are affected by psychosis each year. Those experiencing psychosis are 2-3 times more likely to have comorbid cardiometabolic illness, and die 10-25 years

prematurely compared to the general population^{xx} ^{xxi}. These physical comorbidities alone are responsible for 12,000 early deaths and a cost of \$15 billion each year^{xxii} ^{xxiii}. Consumers continue to receive rates of cardiometabolic assessment, monitoring and treatment as low as 3%^{xxiv}.

People using MBS and PBS services for mental health conditions were 13% of the population, but constituted 50 % of premature deaths^{xxv}

Between 77% and 94% of the causes of early death of people with a mental illness relate to physical illness. Suicide contributes to premature mortality for people diagnosed with mental illness, but for every one person living with mental illness who suicides, 10 die prematurely due to cancer, cardiovascular or respiratory disease.^{xxvi}

Both addiction to substances and acute intoxication are contributory factors to suicides. Australian 2016 opiate overdose deaths are at their highest level since 1999. The ACT had the highest rate of overdose deaths of any capital city: 7.9 per 100,000.^{xxvii}

On 9 November the Australian Institute of Health and Welfare released an analysis of opiate overdose deaths revealing a surge to levels not seen since 1999.^{xxviii} Not all overdose deaths are people with substance use disorders or other mental illnesses, but many are. There is a close association between substance use disorders and other mental illnesses. It is therefore likely that these overdose deaths include a relatively high number of people with mental illnesses other than substance use disorders

Suicide rates have recently increased dramatically in the ACT. Many of these are people with mental illness. Effective coordination between various agencies is essential if this unacceptable rate of suicide is to be reduced.

See reference ^{xxix}.

4b Higher than expected prevalence of other chronic health conditions

80% of people diagnosed with mental illness had at least one co-existing, mortality-related physical illness. Compared with the general population, people living with mental illness are:

- twice as likely to have cardiovascular disease;
- twice as likely to have respiratory disease;
- twice as likely to have diabetes;
- twice as likely to have metabolic syndrome;
- twice as likely to have osteoporosis;
- 50% more likely to have cancer; and
- six times more likely to have a dental health issue.^{xxx}

Other research points to even greater disadvantage for some people with mental illnesses.

“People living with mental illness had six times the risk of respiratory disease and four times the rate of cardiovascular disease” ^{xxxi}

Further, comorbid substance use disorders are the most prevalent psychiatric conditions associated with severe mental disorders (SMD).

“The pooled prevalence for comorbid substance use disorders in SMD has been noted to range up to 42% (for alcohol use disorders), 69% (for cannabis use in schizophrenia), and just

over 50% (for affective disorder amongst those on a methadone maintenance programme)^{xxxii}

A recent Productivity Commission^{xxxiii} report compares relative proportions of specified chronic health conditions for people with mental illness (MI*) and those without (NMI). The table below illustrates these proportions for people with mental illness in the ACT and compares them with Australia wide figures (unpublished ABS data).

ACT's figures are substantially worse for Cancer and CVD and somewhat lower for Arthritis and Asthma.

Table 1: Comparison of proportions of physical chronic disease for people with MI compared with those without, ACT v Australia, 2014-15

Condition	Category	ACT %	Gap %	Au %	Gap %
Cancer	MI	4.6	+187	2.6	+44
	NMI	1.6		1.8	
Diabetes**	MI			8.8	+63
	NMI			5.4	
Arthritis	MI	25.7	+53	26.4	+61
	NMI	16.8		16.4	
CVD	MI	9.4	+114	8.6	+54
	NMI	4.4		5.6	
Asthma	MI	18.4	+86	17.4	+93
	NMI	9.9		9	

* self-reported condition lasting or expected to last for 6 months or more

** ACT figures unreliable

4c Risk Factors for Chronic Diseases

Research demonstrates that people with mental illness tend to have a high level of risk factors for chronic physical illness. Examples from the NSW Mental Health Commission include:

“Prevalence and relative risk of modifiable cardiovascular disease risk factors in schizophrenia and bipolar disorder compared to the general population”

Modifiable risk Factor	Schizophrenia	Bipolar
Obesity	45-55%; 1.5-2 times increased risk	21-49%; 1-2 times increased risk
Smoking	50-80%; 2-3 times increased risk	54-68%; 2-3 times increased risk
Diabetes	10-15%; 2 times increased risk	8-17%; 1.5-2 times increased risk
Hypertension	19-58%; 2-3 increased risk	35-61%; 2-3 times increased risk
Dyslipidemia	25-69%; 5 times increased risk	23-38%; 3 times increased risk
Metabolic Syndrome	37-63%; 2-3 times increased risk	30-49%; 1.2-5 times increased risk

Antipsychotic-induced weight gain can affect more than 80 per cent of people treated with a psychotic medication.

People experiencing mental illness spend less time being physically active, and more time being sedentary, compared with the general population.

Evidence demonstrates that people experiencing mental illness have poorer diets than the general population, due in part to increased hunger, cravings and faster eating as side effects of antipsychotic medication.

The oral health of people with severe mental illness is often poor and untreated. Oral disease is highly related to chronic diseases that contribute to premature mortality.” xxxiv

The Productivity Commission compared proportions of people with mental illness for 3 health risk factors with those without. ACT results were substantially worse for having a high level of risk factors for chronic physical illness than Australian averages for all three factors.

See reference xxxv

Table 2: Comparison of proportions of selected health risk factors for people with mental illness compared with those without, ACT v Australia, 2014-15

Risk Factor	Category	ACT %	Gap %	Au %	Au Gap %
Overweight/obese	<i>MI</i>	69.9	+14	63.7	+2
	<i>NMI</i>	61.2		62.6	
Daily Smoker	<i>MI</i>	18.4	+79	21.8	+65.9
	<i>NMI</i>	10.3		12.9	
At long term risk from alcohol	<i>MI</i>	21.7	+47	18.2	+7
	<i>NMI</i>	14.8		17	

4d Delays in/non- existent in diagnosis and treatment for physical illness in people with mental illness

A RACGP study of the care of people with schizophrenia found that such patients were less likely to seek help early for physical health problem, so that conditions were more advanced^{xxxvi}, perhaps a part explanation for shorter life expectancies and poorer outcomes.

People with severe mental illness are less likely to receive high quality medical care than those without severe mental illness.^{xxxvii}

It is widely recognised that consumers receive low rates of cardiometabolic assessment and monitoring, limited referral and access to appropriate healthcare, and a lack of care coordination and follow-up, even for life threatening conditions.^{xxxviii xxxix xli xlii}

Consumers frequently experience discrimination, stigma and a culture of hopelessness and low expectations by healthcare providers, which inhibits help seeking.

See reference ^{xliii}

4e Longer hospital stays

A recent Tasmania study^{xliv} compared hospital lengths of stay for people with mental illness and those without for 5 chronic health conditions (lung or colorectal cancer, chronic obstructive pulmonary disease (COPD), type II diabetes, ischaemic heart disease (IHD) and stroke). Findings included that those patients with mental illness were younger and had longer lengths of stay.

“In cancer and stroke cohorts, co-morbidity of mental illness unfavourably affected the LOS variation by as high as 97% (CI: 49.9%–159%) and 109% (78%–146%), respectively”

The researchers concluded that there were potentially substantial savings in bed-days from improved approaches to in-patient care for people with serious mental illness with these comorbidities.

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