RESPONSE TO THE DRAFT REPORT OF THE PRODUCTIVITY COMMISSION ON MENTAL HEALTH

Volume 1
Part II – Re-orientating health services to consumers
Response to Chapter 9: PHYSICAL AND SUBSTANCE USE COMORBIDITIES

The Commission's inclusion of a chapter on the critical issue of physical and substance use comorbidities of people with mental illness in this draft report is welcome. However, it is afforded just 13 pages of the 1,200-page report despite being the primary reason for the large gap in life expectancy (12-15 years) experienced by people with mental illness. Clear supporting evidence for this is provided in section 9.1. Given the importance of this area to the ongoing wellbeing of people living with mental illness, we would recommend that Chapter 9 could be extended where appropriate, to become a more prominent part of your report.

One of the key factors driving the reduced life expectancy among people with mental illness is tobacco smoking. It is the underlying cause of many of the 'causes of death' in your key Chapter 9 reference: Lawrence, Hancock and Kisely, 2013. However, tobacco use itself barely rates a mention throughout this report. Physical illness is responsible for 80% of the life expectancy gap in people with mental illness. The fact that tobacco use is the major contributor to NCD-related early death among this population should have a clear emphasis in this report and not be glossed over.

Our research suggests targeted smoking cessation strategies are warranted for smokers with a mental illness. Why?

- Around one third of Australian smokers have common mental disorders such as anxiety, stress, or depression
- Among this group, smoking rates are highest among young people, especially young females.
- Mental disorders are associated with earlier uptake of smoking, higher uptake of smoking, heavier smoking and longer duration of smoking
- Smokers with mental illness are just as likely as anyone else to want to quit smoking, to try to quit smoking and to use smoking cessation aids
- But, smokers with mental illness have substantially lower quit rates, even those with mild or moderate disorders

A list of references (from authors Lawrence, Mitrou and Zubrick) supporting these statements is provided below.

People living with mental illness smoke at more than twice the rate of other Australians. In 2013/14, Australian adolescents with common mental disorders smoked at more than four times the rate of adolescents with no disorder (Lawrence et al., 2015). Compared to reductions in tobacco use seen in the general population in recent decades, smoking rates amongst adults with mental illness remain

persistently high. For many with a mental illness, tobacco remains their biggest barrier to a long and healthy life as well as imposing an increasingly substantial financial burden. Yet, there is no publicly funded population-level approach targeted at reducing tobacco consumption in people with mental illness. This is despite the enormous contribution to tax excise revenue by smokers with a mental illness, who smoke close to half of all cigarettes sold in Australia. As one of the biggest contributors to the early death of people with mental illness is tobacco related illness, we believe that they deserve an appropriate public health response.

Moreover, standard public health approaches to smoking cessation have been largely ineffective for this population (Lawrence et al., 2011), suggesting the need for targeted strategies. Mental health services and GPs need effective strategies, programs and resourcing to help people with mental illness to manage their tobacco use, but none of this is routinely available in a way that is targeted to the specific needs of this group. More support from the Government in allowing subsidised combination nicotine replacement therapy and extended periods for maintenance therapy on the PBS would be a step in the right direction, along with increased education and support for service providers. At present, the PBS is out of step with the latest (RACGP) clinical guidelines recommending the use of patches in combination with oral forms of NRT, which can be cost-prohibitive for smokers with mental illness, especially if reliant on welfare support, although we acknowledge that other cessation medications are subsidised.

For mental health services, smoking reduction is less of a priority than solving issues around alcohol and illicit drug use which deliver more immediate harms, visible distress, and potentially endanger the lives of others. However, while tobacco use may not be perceived to pose immediate danger for those with mental illness, it represents the single, largest source of modifiable, preventable health and disease risk among this group. The high prevalence of tobacco use, and its over-representation by people with mental illness, comprises an undeniable burden of morbidity and mortality over their lifecourse. Smoking is usually initiated in adolescence and thus targeted intervention for young people with emerging mental health problems and mental disorders is a critical step towards reducing this cumulative burden.

Smoking-reduction initiatives for other high-risk groups provide an example of the importance of targeted strategies. For example, there are high profile publicly funded anti-smoking programs for Indigenous people, some of whom smoke at similar rates to people with mental illness (indeed, mental illness may be a factor in tobacco use among this group). While the Indigenous population is only around 3% of all Australians, around 20% of adult Australians have a 12-month mental disorder, and about 36% of these are smokers – that's over 1 million Australians (Lawrence et al., 2011). We still do not have a large scale publicly funded tobacco management strategy for people with mental illness, despite substantial and irrefutable evidence by us and others indicating this is needed. This is a public health inequity that remains unaddressed, yet it could easily be funded out of tobacco excise revenue.

There are many opportunities for intervention in hospitals and the community along with a growing evidence base for targeted smoking cessation intervention for adult smokers living with mental illness, although still limited in experimental design. Research indicates that individuals with mental illness respond to the same evidence-based treatment as the general population and that cessation medications are generally effective and well-tolerated although less robust for those with serious mental illness. Best practice for all smokers is a combination of behavioural support (including individual and group counselling, Quitlines, brief counselling and motivational interviewing) together with pharmacotherapy.

Best outcomes (either cessation or reduction in tobacco use) tend to be achieved with individually tailored treatment and sustained follow-up including extended periods of pharmacotherapy. Smokers with serious mental illness may face considerable additional barriers to quitting including the use of smoking to manage mental health symptoms, other substance abuse, low confidence in ability to cope with stressful situations, poverty and housing issues, smoking peers, and entrenched health system barriers. Subsequently, although smokers with mental illness want to quit as much as anyone else, relapse is common and quit rates are lower. (See reviews by Prochaska et al., 2017; Stockings et al., 2014; Tidey & Miller, 2015; Zwar et al., 2014). Funding, coordination and support for ongoing research and evaluation is needed for testing and building on targeted strategies across public health settings that can address a varying complexity of needs. There is a particular need for high quality research amongst adolescent smokers with current evidence very limited for all types of intervention (Fanshawe et al., 2017).

We would recommend that the Commission address this clearly in their report.

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