Response to Australian Government Productivity Commission Draft Report on Mental Health.

Submission from:

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1. The physical health of people living with mental illness is one of the most significant problems in Australian mental health

In 2011, 11,302 people with mental illness **died prematurely** of the top 10 causes of death.[1] This equates to over 30 people a day. Comprising 12.9% of the population, people accessing mental health-related MBS and PBS services constitute over half of the all premature deaths in Australia due to physical health conditions.[2]

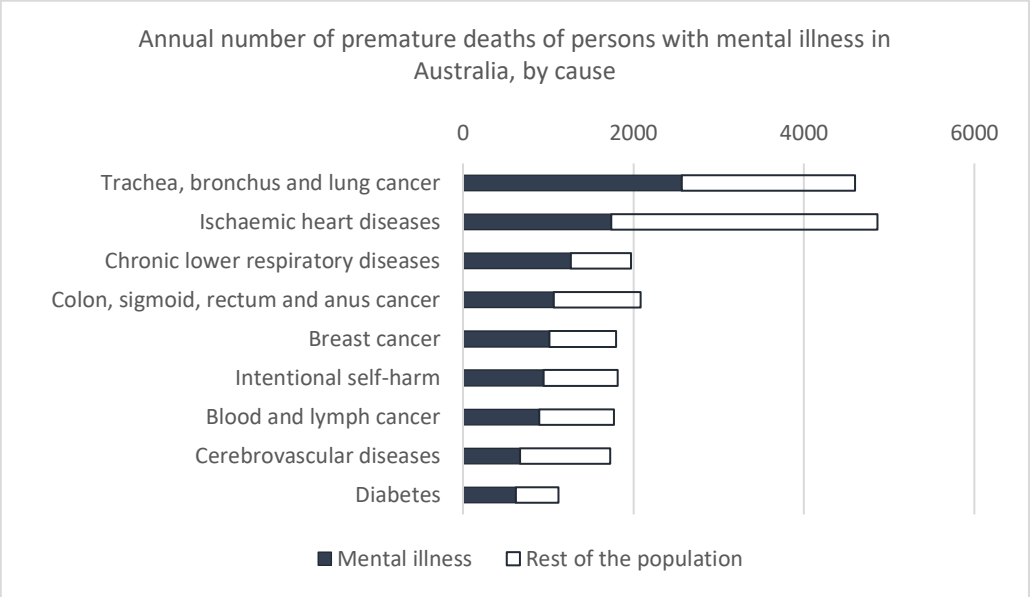

FIGURE 1: *Annual number deaths of persons (age: 15–74 years) accessing medical benefits scheme (MBS) and/or pharmaceutical benefits schedule (PBS) mental health-related services by cause of death[3] (Adapted from ABS, 2017).[2]*

Due to the broad-based membership of the Equally Well Alliance, and potential conflicts of interest, the views expressed in this submission do not purport to represent the views of all of the EWA Committee members, or the 90 organisational supporters of Equally Well.

2. Poor physical health has a cost to Australian productivity

In Australia, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) estimated the cost of premature death of persons with comorbid physical health conditions and severe mental illness at $15 billion per annum.[4] When the cost of substance use is included, this increases dramatically to $45 billion.[4] (This economic study did not include people living with high prevalence disorders such as depression.) For people with a mental illness and an additional two to three coexisting medical illnesses,[5, 6] international research indicates the cost of healthcare increases exponentially.[7] The additional costs of physical health problems in people living with mental illness has been estimated to increase healthcare costs by 70%.[8] The RANZCP report indicates that the cost of care for people living with depression and a coexisting physical health condition is 33% to 169% higher than for depression alone.[9] Frey found that for people living with schizophrenia the direct medical costs increased significantly for persons aged over 65 years, whereas societal costs were higher for persons less than 35 years.[10] A recent US analysis of the burden of comorbid mental disorders argued that the calculation of burden should be expanded to take into account societal impacts and costs.[11]

A Medibank Private study estimated the **total direct cost** of $1.96 billion for comorbid physical and mental health conditions.[12] This is likely to be an underestimate as it only includes the 12 main chronic conditions, and does not include paediatric, physician or General Practitioner (GP) services not recorded with a mental health item number.[12] The annual indirect cost of physical comorbidities in people living with a mental illness has been estimated at $2.1 billion or $451 per household.[12] These estimates do not include the cost of mental illness itself or resultant lost productivity. More work is needed to quantify the significant net economic gains available to society by addressing the physical health of people living with mental illness.[13]

3. Poor physical health is a major contributor to poor mental health and suicidality

McNamara et al.[14] in their '45 and up' study (n=223,405) in NSW concluded that the "markedly elevated prevalence of high distress among older Aboriginal Australians appears largely attributable to greater physical morbidity and disability" (p145). They found that 44% of Aboriginal participants with severe physical limitations experienced high distress. For non-Aboriginal participants, 21% with severe physical limitations reported high psychological distress. For the entire participant group they concluded: nearly all of the medical conditions examined were associated with increased prevalence of high psychological distress as measured by the K10. A collaborative research project in Europe found a dose-response relationship between poor physical health and depression consistent across 11 countries.[15] Likewise, a meta-analysis of effective treatments for depression concluded that improving physical health and increasing physical activity should be a first line treatment choice for depression.[16, 17]

There are several studies linking poor physical health with suicide risk.[18-20] Improving physical health of people living with mental illness is a largely neglected, yet proven effective strategy to reduce suicide risk, particularly in older persons.

4. A large proportion (38% -70%) of these premature deaths are avoidable

A recent AIHW report cited 38% of Australian deaths due to chronic disease are avoidable.[21] In New Zealand, a major study of cardiac disease in people living with severe mental illness found 69% of premature deaths **were avoidable**.[22] No published estimates are available for the percentage of avoidable deaths for people living with mental illness in Australia. However, given the factors listed above, it is safe to assume it would be in the range of 38-70%. Initiatives to improve the physical health of people living with mental illness could **save thousands of Australian lives** each year. The impact of this on a range of economic, social, personal and familial issues affecting the welfare of Australians would be profound (See Table 1).

	Per year	Per day
Annual premature deaths of people with mental illness (top 10 causes)	11302	31
Number of avoidable deaths @ 70%	7911	22
Number of avoidable avoidable deaths @ 50%	5651	15
Number of avoidable deaths @ 38%	4295	12
Lives saved at 50% avoidable if:		
treatment efficacy of 25%	1413	4
treatment efficacy of 50%	2826	8
treatment efficacy of 75%	4238	12

TABLE 1. Projected estimates of avoidable deaths and potential lives saved by treatment efficacy

At the conservative estimate of 50% avoidable deaths, and an intervention success rate of just 50%, investment in this area would save 2,826 lives per year. While premature death due to suicide is tragic and shocking, the premature death due to chronic physical health conditions is also tragic. Of the total number of premature deaths of people living with mental illness 943 died from suicide. For the other 10,359 people with mental illness who die early of physical health conditions, it is also tragic, although not shocking. It is usually preceded by years or decades of poor health. This itself is tragic, and somewhat scandalous given most of these deaths are preventable.

5. Australia had the existing resources, workforce and infrastructure to effectively address this problem

Suicide is a difficult problem to effectively address. “There has been no significant and sustained reduction in the death rate from suicide over the past decade, despite ongoing efforts to make suicide prevention more effective” (Productivity Commission Report, p. 15). The reasons for this are unclear, but are perhaps related to its relationship to broader societal and economic forces and national ennui. On the other hand, the causes, and solutions to the poor physical health and premature death are well-known and amenable to change. Investing in solutions will return positive benefit.

A comprehensive review of the causes of early death is presented in a narrative literature review[1] on physical health and mental illness. The causes of the premature death are complex, dynamic and inter-related. However, the major causes include:

1. Relatively high rates of smoking
2. Lack of physical health screening and treatment
3. Antipsychotic medication side-effects, including metabolic syndrome
4. Lifestyle impacts such as poor diet and low level of physical activity
5. Stigma and discrimination
6. Social economic status
7. Behaviours and conditions associated with the mental illness itself.

The first five of these factors are modifiable and **proven effective, evidence-based interventions exist to address the first four of these factors.**

Australia has the pre-existing resources and infrastructure to address and significantly improve the physical health of people living with mental illness. The main reasons the disparity in physical health outcomes persist for people living with mental illness are related to stigma, 'diagnostic overshadowing'[23] and lack of coordination between mental health and physical health focussed services. People living with mental illness face disadvantages at every point of contact with the health system: screening, diagnosis, and treatment (Figure 2). This disparity results in poor health and needless premature death.

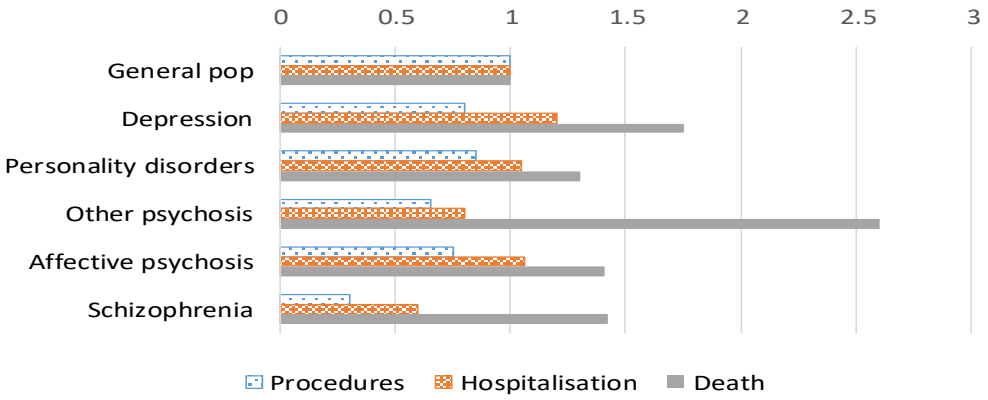

Figure 2: Procedures, hospitalisations and death rates for cardiovascular disease by diagnosis[24]

a. There is widespread commitment to this issue as a policy priority in Australia and internationally

The evidence outlining this extent and seriousness of this problem is comprehensive and compelling. Thousands of studies and scores of meta- and pooled analyses have outlined the extent and nature the poor health and premature death of people living with mental illness.[25]

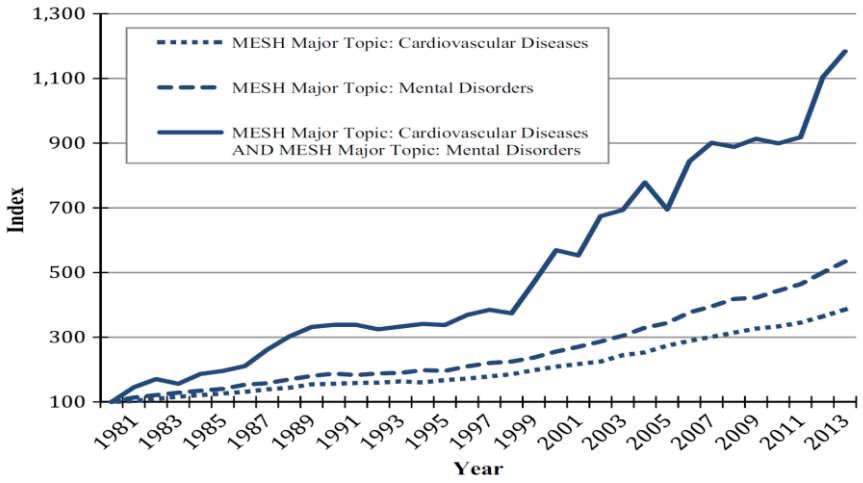

Figure 3 Number of articles published on mortality and physical health of people living with mental illness[25]

Internationally this has summarised in the World Health Organisation's Guidelines[26] and multi-level intervention framework[27] and the Lancet Commission Blueprint.[28] In Australia major data linkage studies in WA[29] and NSW[30] and Australia wide,[2] have consistently demonstrated the life expectancy gap between people living with mental illness and the rest of the population. Many states have made the physical health of people living with mental illness a policy priority, and Victoria recently released its Equally Well strategy[31] for public mental health services.

The importance of this issue is also highlighted in The Fifth National Mental Health and Suicide Prevention Plan[32] and the Equally Well National Consensus Statement.[33] The Equally Well National Consensus Statement has 48 action-oriented recommendations and its implementation is overseen by a broad-based national committee (Equally Well Alliance). In Australia, 90 peak bodies, professional colleges and organisations have formally committed to committing to "*making the physical health of people living with mental illness a priority at all levels: National, state/territory and regional*" (p. 7; equallywell.org.au).

8. Australia is poised to become a world leader in this field.

Equally Well in Australia is working closely with colleagues in UK and NZ, and is leading the development of an international collaboration to help address this issue.

In Australia we have a solid policy framework,[32, 33] strong national commitment[34] and state[31, 35, 36] and local action.[37] However, initiatives and actions in the field are still in their infancy, and further investment in promoting awareness of this issue, fostering collaboration and measuring progress is needed. With the policy framework, the evidence base, existing workforce infrastructure and national commitment, investment in improving the physical health of people living with mental illness would be cost-effective, improve physical health and wellbeing, and save thousands of Australian lives every year. However, additional investment to drive reform, disseminate best practice and support a backbone team necessary for an effective collective impact approach[38] to this challenge.[38]

Comments on draft report recommendations

(**Green text links to relevant sections in the Productivity Commission Report**
Blue text represents comments and annotations
Black text represents original text.)

Reform area 2 (p.2)

Expand and enhance physical health care services, to help close gap in life-expectancy for people living with mental illness. People living with mental illness have a reduced life expectancy of approximately 20 years compared to the total population. The average age of death of people accessing public mental health services is between 50 and 59 years.[29]

Reform Direction (p.7)

For example, mandatory follow up when a person is discharged from hospital after a suicide attempt has been proven to reduce the risk of the person making another attempt on their life; and physical health care screening for all people with diagnosed mental illness and are reforms that could be quickly implemented.

Table 1. (p. 10)

Insert
Physical health care costs of people living with severe mental illness $15 Billion

Early Help for People (p. 12)

But for others, untreated mental ill-health may percolate throughout their life, reducing the wellbeing and standard of living of the affected individuals and often those around them. Likewise, untreated physical ill-health (80% comorbidity)[39] of people living with mental illness, can lead to the development of un-diagnosed chronic health conditions.

Suicide prevention and premature death (p. 15)

The facts on suicide and premature death in Australia are stark. Just over 3000 people are lost to suicide (not all with a diagnosed mental illness) each year in Australia, an average of more than 8 people per day. In addition, 10,359 people living with mental illness are prematurely die due to physical health conditions and average of more than 28 people per day. Suicide is the leading cause of premature death in Australia's young adults, accounting for around one-third of deaths among people aged 15-24. For adults, the three leading causes of early death in Australians between 15 and 75 years are heart disease, respiratory disease and lung cancer (11,434 per year). Strikingly, 5,571 of these premature deaths are of people who access PBS/MBS mental health-related treatments. Suicide rates of Aboriginal and Torres Strait Islander people are more than double that of other Australians, with young males and those in regional communities particularly at risk. For every death by suicide, as many as thirty people

attempt suicide and are hospitalised due to intentional self-harm. And there has been no significant and sustained reduction in the death rate from suicide over the past decade, despite ongoing efforts to make suicide prevention more effective. For every one person with mental illness who dies each year of suicide, 10 people with mental illness die of common chronic physical health conditions. Effective interventions exist for these chronic physical health conditions.

Only a very small proportion of those with mental illness self-harm or have suicidal thoughts, and not all people who suicide had a mental illness. However, up to 25% of people who attempt suicide will re-attempt, with the risk being significantly higher during the first three months following discharge from hospital after an attempt. Half of those discharged from hospital after a suicide attempt do not attend follow-up treatment and responsibility and accountability for follow-up is unclear and inconsistent.

The priority focus on the 1,000 to 2,000 people with mental illness who complete suicide is vital, as is a focus on the 10,000+ people with mental illness who die prematurely each year of chronic physical health conditions. People with co-existing mental and physical illnesses have an equal right to a full and healthy life. Especially when most of these early deaths are preventable with treatments and infrastructure already available in Australia.

For people self-managing or needing low intensity treatment (p .20)

Resources for self-help

Many Australians with mild mental illness are able to manage their mental health themselves without formal clinical intervention and without significant impact on their relationships or engagement in study or employment, so long as they can access relevant information. People needing resources for self-help should have ready access to evidence-based information and assistance through publicly available sources, including pamphlets, telephone services, and online information. There is much already available, but its effectiveness and accessibility would be improved through a well-advertised national phone-line to assist in locating relevant services and supports, and an expansion in online portals to include more information on e-health, telehealth and group therapy services and mental health pathways in local communities.

Resources for consumer and carer advocacy for quality physical health care also merit development. For instance, people living with mental illness are too often denied comprehensive physical health care when visiting the GP due to 'diagnostic overshadowing'.[23] Resources, (endorsed by the appropriate professional colleges) to support people living with mental illness to attain equal access to physical health screening and treatment would be result in a significant enhancement to mental health in Australia.

For people with complex health and social needs

Improving outcomes for people with complex needs is about ensuring they have access to the services needed (both clinical, physical health and broader), when they are needed, with effective information flows and coordination between clinicians and other services.

Clinicians at initial entry points to the health system (p 29)

Proposed changes as a result of the current MBS review (if adopted) would increase the number of ways for GPs to be reimbursed for treating people with mental illness. We have also recommended changes to motivate an increase in care coordination between clinicians and to provide scope for GPs to consult with designated carers and family of a person with a mental illness. The recommended navigation platform and improved access to advice for GPs from psychiatrists should also improve GP links to other health and non-clinical supports for those with a mental illness. To provide more incentive for GPs to improve their mental health training, the merits of introducing a specialist registration system for GPs with advanced specialist training in mental health should be independently assessed.

GPs should also be incentivised to conduct comprehensive physical health screening and care. (This would be one of the best returns on investment in mental health care). For people living with mental illness, for many reasons, the rate of comprehensive physical health examinations is too low. Stigma, diagnostic overshadowing and cost are some of the main reasons for this. Incentives (or the removal the financial disincentives for GPs and their patients) for GPs to conduct regular physical health assessments for people living with mental illness should be considered. In addition, the primary health care guidelines for the major causes of early death for people living with mental illness should be revised in this respect, as has happened in New Zealand.

Draft findings (p 53)

The cost to individuals of the diminished health and wellbeing of living with mental ill-health was a further $130 billion.

The additional cost of physical health comorbidities of people living with severe mental illness is $15 billion.[4]

DRAFT Recommendation 6.1 — supported online treatment options should be integrated and expanded

To aid integration of healthcare services, supported online treatment should have the option for outcomes data to be forwarded to a nominated GP or other treating health professional. Online service providers should annually publish summary output on use of their services, treatment provided, and other measurable outcomes.

Due to the distal nature of on-line treatments, it is very important that these approaches consider, prioritise and help arrange GP appointments to ensure regular physical health checks occur. With an 80% comorbidity rate, most mental health clients will have a co-existing physical health condition. Many of these will be undiagnosed and therefore untreated with tragic consequences. Allied health professionals and online treatment providers are well-place to ensure appropriate physical health care for people living with mental illness.[3, 40]

Draft Recommendation 11.5 — improved mental health training for doctors

In the short term (in the next 2 years)

Continuing professional development requirements for GPs and psychiatrists should incorporate best-practice approaches to managing the side effects of medication prescribed to treat mental illness. To ensure this is the case, the Australian Government should request the Australian Medical Council to review current CPD requirements and make any changes necessary. This should be done in consultation with stakeholders, including the Medical Board of Australia and relevant colleges for GPs and psychiatrists.

Practice guidelines should also be reviewed, to include data on the rate of co-existing physical health conditions, especially the high incidence conditions and those responsible for the greatest number of premature deaths of people living with mental illness. At the moment too many people who see a GP for mental illness, are not screened physical health conditions (due to diagnostic overshadowing). This contributes to premature death of 30 people each day, due to (mostly preventable) physical illnesses such as heart disease

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