



LIFE EXPECTANCY *& Physical/Mental Health*

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WHAT ABOUT THE REST OF ME?

Physical disease within Mental Health

BY JANET MEAGHER AM

Despite unprecedented investment in Australia's mental health system in recent years and the establishment of the National Mental Health Commission to help drive a stronger, more coherent and equitable, response to mental health, it is becoming apparent that many people who use our system are struggling more than was previously acknowledged. The largely under-recognised burden of physical disease is rapidly testing our ability to improve quality of life and recovery outcomes for people who live with mental health issues.

People with a mental illness have a life expectancy that is from 10 to 32 years less than the general population. That statistic will surprise a lot of people. Similarly, the death rate for people with a mental illness is two-and-a-half times greater than for the general population – and the disparity is not attributable to suicide rates.

Mental health consumers are at higher risk of chronic physical health conditions such as diabetes, heart disease, and obesity, and have much higher mortality rates from all main causes compared to the general population. This is due primarily to the effects of mental illness and its medications. However, reduced access to healthcare including timely screening, assessment and treatment, also has an impact.

For people living with mental illness, poor health does not happen in isolation from the effects of the prescribed medications, the person's genetic make-up and the more sedentary lifestyle to which mental illness contributes.

People living with mental illness have a 30% higher chance of dying from cancer compared to the general population, yet the occurrence of cancer is statistically similar to that of the general population. Death rates are higher because access to screening and treatment comes too late in the trajectory of the cancer.

Regrettably, a higher risk of premature death is not confined to those with ongoing mental illness – depression is now known also to increase the risk of death from heart disease.

These health disparities are greater for people living with a psychotic disorder as well as for Aboriginal and Torres Strait Islander Australians (see Pat Dudgeon and Tom Calma's article). People with illnesses such as bipolar disorder or schizophrenia have cardiac problems, metabolic or endocrine disorders (diabetes and obesity) at much higher rates than the rest of the community. For these two groups, cardiovascular disease and mental illness have been found to be the two leading drivers for their unacceptable burden of disease.

The national survey of psychotic illness exposed the extent of physical health problems for people in this group:

- Diabetes rates at over three times those found in the general population.
- One third carrying the risk of a cardiovascular event within five years.
- Half affected by metabolic syndrome, which is associated with an increased risk of cardiovascular disease and diabetes as a side effect of prescribed antipsychotic medications.

Most Australians are not aware that treatment with prescribed psychiatric medications can seriously affect physical health and longevity. Where anti-psychotic medications and treatments increase risks, prescribers need to ensure they respond appropriately in particular with:

- Routine reviews of medication regimes.
- Use of psychosocial/ talking therapies as alternatives to pharmaceuticals alone.
- Screening for known risk elements.
- Avoiding polypharmacy (multiple medications) whenever possible.

As professionals, planners, funders, service users and advocates, we must ask ourselves, how did we omit this for so long, and what can we do about it?


We know from one study that while nearly 90% of people living with psychosis had visited a general practitioner (GP) in the past year, two-thirds reported they did not have a general health check or a cardiovascular-related health check during the visit. It is estimated that only one in five people with a mental illness has a mental health treatment plan from their GP and that those plans usually do not refer to physical health checks or improving physical health.

The persistent and significantly higher levels of cardiovascular disease for people with persistent mental illness indicates a lack of understanding of how to implement interventions and service protocols to reduce risks, such as motivating individuals and introducing and encouraging self-management programs that target weight, blood glucose, lipid control and physical activity.

Barriers to coordinated management

Evidence suggests that there are significant barriers to effective, coordinated management of co-existing physical and mental health conditions, including:

- People with a mental illness being treated solely for symptoms of mental illness.
- Poor recognition of the



UNLESS WE SERIOUSLY REFLECT ON HOW MUCH WE PERPETUATE THE LIFE EXPECTANCY GAP FOR PEOPLE WITH MENTAL ILLNESS, WE WILL NEVER CLOSE IT.

Janet Meagher

National Mental Health Commissioner, mental health consumer activist and advocate for over 30 years

relationship between mental health and physical health.

- Primary healthcare professionals' low-confidence or discriminatory response to whole-person care when working with people who have a mental illness.
- Mental health workers' unwilling or slow response to medical health issues.
- Concerns of people with a mental illness about using the services from transport and access to discrimination.

In its first-ever national report card on mental health and suicide prevention, the National Mental Health Commission (NMHC) found that the low levels of physical health monitoring of people with mental illness made it difficult to know how best to increase that monitoring and close the gap on life expectancy for people with complex and demanding health needs.

Nevertheless, the Commission made several recommendations regarding further research into the metabolic side effects of psychiatric medications, as well as improved primary care service protocols more actively to address the physical health needs of people experiencing mental illness, with particular reference to the disproportionate

prevalence of cardiovascular disease among people with mental illness.

Encouragingly, a national summit held May 24, 2013, discussed how to address increased mortality in the mental health consumer population. The May Summit Communiqué reported that:

The Summit agreed to a new national commitment to reversing the trend of people with a serious mental illness dying early and experiencing disproportionately adverse health outcomes with this to be based on the following principles:

- People with severe mental illness should have the same expectations of a rich and contributing life as the general population. This includes having good mental health, physical health and wellbeing as well as the same access to timely and quality healthcare and the other supports and services critical to a contributing life.
- To achieve these improvements, there is a need for the active engagement of all relevant portfolios across governments, noting the importance of a rehabilitation and recovery framework.
- Any action to reverse this trend must be informed by the experience and knowledge of individuals living with mental illness and also that of their families and carers.

- Improving the physical health of people with severe mental illness requires the active engagement and participation of all levels of healthcare and across all specialities particularly with regard to primary healthcare.

To progress action, it was agreed that immediate attention would be given to developing a series of commitments across jurisdictions, with further detail on implementation including targeted outcomes to be provided in due course.

Where does this leave us?

We must continue to support action on more effective service delivery for dealing with the unacceptable levels of morbidity and mortality linked to poor physical health among people affected by mental illness. This work is urgent. Acknowledging that it will take time we must, in accelerating our responses, ensure that our approaches are consistent, based on sound consumer empowerment and health promotion principles, and are tailored to meet the real needs of mental health consumers and those who support their efforts to get health equity and an all-round better deal.

With government interest and policy development and planning approaches

underway, it is timely that we address the largely unspoken dynamic that underpins much of the historic oversight in this area of mental health – that people experiencing mental illness are still primarily defined by their mental illness, as needy and to be managed, rather than seen as a whole person with potential and a right to have a healthy, worthwhile contributing life.

It is time we shone some light on attitudes in clinical practice and challenge the shroud that a psychiatric diagnosis brings to other symptoms and markers.

How often do medical people pass off physical symptoms as psychosomatic? Why do not we undertake routine cardiovascular and metabolic investigations in mental health practice? Do we listen and observe, do we offer or refer to appropriate screening and health promotion services?

We can, and must, do better. Better practice is driven as much by progressive attitudes as by clinical protocols. Mental health consumers can tell the difference, and are much more likely to work in partnership with services that acknowledge their broader health needs in meaningful ways.

Unless we seriously reflect on how much we perpetuate the life expectancy gap for people with mental illness, we will never close it.

BRIDGING *the* GAP by EMPOWERING



CONSUMERS

Over the past two centuries clean reticulated water, mass health screening, immunisation and antibiotics have revolutionised physical public health. In this century, the parlous state of public mental health has the potential, likewise, to be transformed by the delivery of mental health mass screening, public awareness, prevention, treatment and recovery programs direct to the public via the internet, mobile and other new technologies. Indeed, it is already happening, and Australia is one of a handful of countries leading the way in these new developments.

e-mental health environment now

Much of the e-mental health service innovation in Australia has originated within universities where researchers have not only developed online and mobile applications to deliver mental health services but have also carried out rigorous research to demonstrate their effectiveness.

This development work is within the context of Australia's high internet use. According to the latest figures from the Australian Bureau of Statistics, as many as 79% of households in Australia have internet access and 92% of these are connected by broadband (ABS: 2012). Moreover, most households access the internet every day (ABS: 2012).

To their credit, successive federal governments have been quick to recognise the potential of e-mental health. As a consequence, the Department of Health and Ageing has partly or fully funded the ongoing delivery of a number of e-mental health services. A key driver here has been the evidence that these programs work and are cost-effective especially given consistent findings that only one-third of Australians receive mental health help from the conventional health system.

In 2006, the Australian government established the Telephone Counselling, Self-Help and Web-based Support Programme, which provided funding to maintain existing internet-based mental health services

and to develop new e-mental health programs. These services range from education and automated self-help prevention and treatment programs to internet-based, peer-to-peer support forums and clinician-guided programs. These e-mental health tools have proved popular. For example, one program funded under the initiative is the well-known MoodGYM.anu.edu.au prevention and treatment program, which was launched in 2001. In its current version, the third, MoodGYM receives approximately 34,000 unique visitors per month, has 670,000 registrants from 222 countries and has been translated into Chinese, Dutch and Norwegian with German and Finnish translations underway. Of MoodGYM users, 22% globally are from rural and remote regions and 22% of the Australian registrants are referred by general practitioners.

In 2012, the Department of Health and Ageing released the e-mental health strategy for Australia. This strategy identifies a need to promote the growth of the e-mental health sector, to provide a 'new layer of service in the health system' that was integrated into existing services, and to assist consumers to identify high quality online services. In particular, the strategy aims to deliver effective e-mental health services to Australians with less need for intensive face-to-face services and to those not currently accessing formal treatment.

To this end, the government continues to fund the services established under the original 2006 initiative and has provided additional funding to support new services. Consistent with the e-mental health strategy, it has also established a mental health portal, MindHealthConnect.org.au, to provide consumers with information about available Australian e-mental health and other services. The visitor to MindHealthConnect can select their own pathway through the site or be guided through the portal based on the findings of a brief screening questionnaire.

The strategy has also established a national virtual clinic, MindSpot.org.au. This clinic operates on a stepped-care-model, is designed to reduce the barriers to help-seeking among Australians by delivering services via the internet, telephone and postal services, and by facilitating referral to face-to-face services where required.

Each visitor to MindSpot is first screened and assessed. The intensity of the services delivered (e.g. low intensity self-help via the internet; referral to high intensity face-to-face treatment) depends on the individual consumer's assessed need. A final initiative, designated by the e-mental health strategy as The E-Mental Health Support Service, is expected to commence soon. It involves the delivery of training to general and allied healthcare practitioners to make it easier to incorporate and take up e-mental health services in the conventional primary healthcare system.

CONSUMERS

Keeping at the forefront

While Australia's service policy and funding track record in the e-mental health arena is impressive, it is critical that we do not rest on our laurels.

In his foreword to the national e-mental health strategy, the former Mental Health Minister Mark Butler emphasised that MindHealthConnect will provide consumers access to high quality and trustworthy information. However, this portal has no explicit quality assurance mechanism for determining the services it incorporates. MindHealthConnect does indirectly link to Beacon.anu.edu.au, a portal that incorporates such a mechanism, but the government has ceased funding this initiative.

Significantly, the e-mental health strategy identifies The E-Mental Health Support Service as being responsible for providing 'advice on quality assurance and new innovations' in the field. With the disbandment in September 2012 of the E-Mental Health Expert Advisory Committee, which informed the development of the e-mental health

strategy, this expert role will be critical if Australia is to continue to capitalise on developments in e-mental health and maintain high quality services. Equally, if the government is serious about its commitment to consumers and carers, the consumer and carer sectors must establish a mechanism to ensure both sectors are formally and actively incorporated into the advisory process.

The government's integration of e-tools into the current healthcare system is important. However, it ignores the huge potential of people and systems outside this conventional system to promote and deliver these programs. These include consumer and support groups, teachers, sports environments and the workplace. The possibilities are extensive as evidenced by the establishment of bibliotherapy book clubs in Scottish libraries.

The E-Mental Health Support Service is charged with delivering training programs to individual practitioners. Again, clearly this is important. However, there is also a need to change organisational systems. Programs that have been demonstrated effective within these systems need to be implemented in practice.

For example, MoodGYM has been demonstrated effective when integrated into Lifeline telecounselling. Callers who were referred to MoodGYM showed decreased depression and reduced alcohol use compared to those with usual access to Lifeline services (Farrer et al: 2011, e28099; 2012, e68). Similarly, in a study conducted in almost 30 schools in metropolitan and rural and remote Australia, MoodGYM has been shown to prevent new cases of anxiety, and new cases of depression (boys) (Calear et al: 2009, 1021-32). Despite this, MoodGYM has not been implemented in Lifeline nor systematically rolled out in schools across the nation.

Both are lost opportunities. We know that current treatment techniques optimally delivered to all who could benefit would avert only 34% of the burden of depression (Andrews et al: 2004, 526-33). This suggests that it is critical to implement evidence-based prevention interventions. Clearly schools provide an ideal setting in which to deliver such programs. Prevention programs are well established in the domain of physical health. It is past time to implement prevention programs in the mental health domain using

e-mental health tools delivered en masse, at low cost and with high fidelity.

Finally, the science of the development, evaluation and delivery of e-mental health programs is fast-moving. Other countries, such as the United Kingdom and the Netherlands, have funding programs which support the development of new interventions and their research evaluation. Australia has no such research and development funding programs and innovative and pragmatic e-mental health research is not favoured by standard funding bodies such as the National Health and Medical Research Council. There is a real danger that we will slip from the forefront of these developments and that future governments will be forced to buy technological solutions at inflated prices from commercial operations located overseas. Even more serious is the risk that, in the future, Australians will continue to suffer high levels of avoidable mental ill-health problems. Consideration is needed to preserve the geese that have until now laid the close-to-free golden e-mental health eggs.

by PROF KATHY GRIFFITHS

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the
**SOCIAL &
EMOTIONAL
WELLBEING of
ABORIGINAL
& TORRES
STRAIT
ISLANDER
PEOPLES**

article by

PROF PAT DUDGEON

*Inaugural chair and now
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Over half a million Aboriginal peoples and fifty thousand Torres Strait Islanders live in Australia (ABS: 2011). This figure includes people who identify as both. They are a relatively young population, with a median age of 21 years, compared to 37 years for other Australians (ABS: 2012a). There are many varied Aboriginal and Torres Strait Islander language groups, cultures and traditions but also collective elements: a shared cultural history and ancestry in populations that suffered invasion by a colonising power; and racism, social exclusion and intergenerational poverty that are all too common as contemporary lived experience.

Across a range of indicators there is a gap between the mental health of Aboriginal and Torres Strait Islander peoples and other Australians. Particular population groups face further challenges. Among Stolen Generations' survivors, mental health conditions occur at twice the rate as among those who had not been removed from their families (ABS: 2012b).

Improving mental health remains a critical challenge for Aboriginal and Torres Strait Islander leaders, communities and policy makers in Australia, and not just for its own sake. Mental health conditions influence or impact upon many other forms of disadvantage, as, indeed, social, political, historical and cultural conditions determine mental health.

Up to 22% of the overall health gap between Aboriginal and Torres Strait Islander peoples and other Australians has been directly attributed to mental health conditions (Vos, Barker, Begg, Stanley: 2007, 2). Over one-quarter of all prisoners at June 2012 were Aboriginal and Torres Strait Islander peoples (AIHW: 2011, 29), with very high rates of mental health conditions reported among them (Heffernan, Andersen, Dev et al: 2011, 37-41).

Social and emotional wellbeing

Aboriginal and Torres Strait Islander peoples have consistently asserted that their physical and mental health should be understood in holistic terms (National Aboriginal Health Strategy Working Group: 1989), with a foundation for both in social and emotional wellbeing – a positive state of existence within a network of healthy relationships that includes between the individual and their family and kin, community, traditional lands, ancestors and the spiritual dimension of existence (Social Health Reference Group: 2009, 4, 7-8).

Social and emotional wellbeing is a protective factor against the stresses of life that can impact on mental health. As an example, a positive cultural identity and Aboriginal spirituality has been reported to assist Aboriginal children and young people to navigate being an oppressed minority group in their own country (Department of Education and Early Childhood Development: 2010, 45); and provide meaning in adversity (Centre for Rural and Remote Mental Health: 2009, 9, 11, 19)

Conversely, negative challenges to social and emotional wellbeing can undermine resilience and leave individuals

and communities exposed to stressors, psychological distress and trauma that can lead to mental health conditions. In this context, protecting and promoting families, communities, cultures, languages and identity can be understood as preventative mental (and indeed physical) health measures.

Trauma across the life cycle

Supporting social and emotional wellbeing is particularly important because stressors, psychological distress, trauma, and associated and compounding factors, are reported at high rates across the life cycle of Aboriginal and Torres Strait Islander peoples, particularly on young persons.

Stressors reported include: illness, disability, accidents, pregnancy, divorce or separation, death of a family member or close friend, witnessing violence, racism and abuse or violent crime. Some are associated with poverty: overcrowding at home, losing a job and unemployment (ABS: 2010). Exposure to multiple stressors is associated with psychological distress – reported by Aboriginal and Torres Strait Islander peoples at 2.5 times the rate of other Australians (ABS: 2012c).

Trauma refers to the potential mental health impact of a major stressor, such as violent assault, disasters, severe automobile accidents and life-threatening illnesses. Further, Aboriginal and Torres Strait Islander peoples' experience of trauma has been linked to repeated exposure to multiple, repeated severe and sustained stressors (such as racism) over time (Galma: 2009, 153-154). A 2008 survey in Queensland among Aboriginal and Torres Strait Islander prisoners reported 12.1% of males and 32.3% of females with post-traumatic stress disorder (Heffernan, Andersen, Dev et al: 2012).

Access to mental health services

Mental health services designed with non-Indigenous Australians in mind do not always fit with Aboriginal and Torres Strait Islander peoples' cultures and communities' lives, nor with their lived experiences. This lack of cultural and other fit can act as a barrier to using these services, or benefitting from them.

There are other access barriers. Services and professionals may not be available locally in remote areas where a quarter of Aboriginal and Torres Strait Islander peoples live. But even for the majority who live in, or near, urban centres, the cost of working with psychologists and psychiatrists can be prohibitive. On average, Aboriginal and Torres Strait Islander peoples earn significantly less income than other Australians (AIHW: 2011, 29).

The way forward

There are several approaches to consider:

- Protecting and promoting social and emotional wellbeing.

As discussed, strong culture and identity and healthy families and communities help protect Aboriginal and Torres Strait Islander peoples against the stresses that life can deliver, including some of the unique challenges they face.

Empowerment, ownership of problems, and leadership by Aboriginal and Torres Strait Islander individuals and communities is critical here; just as disempowerment is part of the problem, so empowerment must be part of the solution (Dudgeon et al: 2012).

Australian governments must support, and work in partnership with, Aboriginal and Torres Strait Islander communities to tailor culturally appropriate solutions that protect and promote social and emotional wellbeing as critical preventative responses to mental health conditions.

- Mental health services tailored for Aboriginal and Torres Strait Islander peoples.

For many decades now there have been calls for mental health and social and emotional wellbeing services within Aboriginal Community Controlled Health Services. These health services, operated by and for Aboriginal and Torres Strait Islander communities, offer many advantages. They are uniquely placed to offer traditional and innovative contemporary mental health and holistic social and emotional wellbeing services. Critically, they also have a history of improved health outcomes in their communities where other services have not, or simply did not exist, as examples, in relation to diabetes management and mothers and infants health services (Robert Griew Consulting: 2008).

In particular, it is vital that suicide prevention services are culturally tailored and that trained Aboriginal and Torres Strait Islander staff are available for people at risk of suicide.

Overall, it is critical that all mental health services are able to provide culturally competent mental health workers and professionals and a culturally safe service overall. In a nutshell, these concepts mean that professionals and

workers can work across cultures when necessary, and that services overall are welcoming to, and respectful of, Aboriginal and Torres Strait Islander peoples (Hayman, White and Spurling: 2009, 604-06).

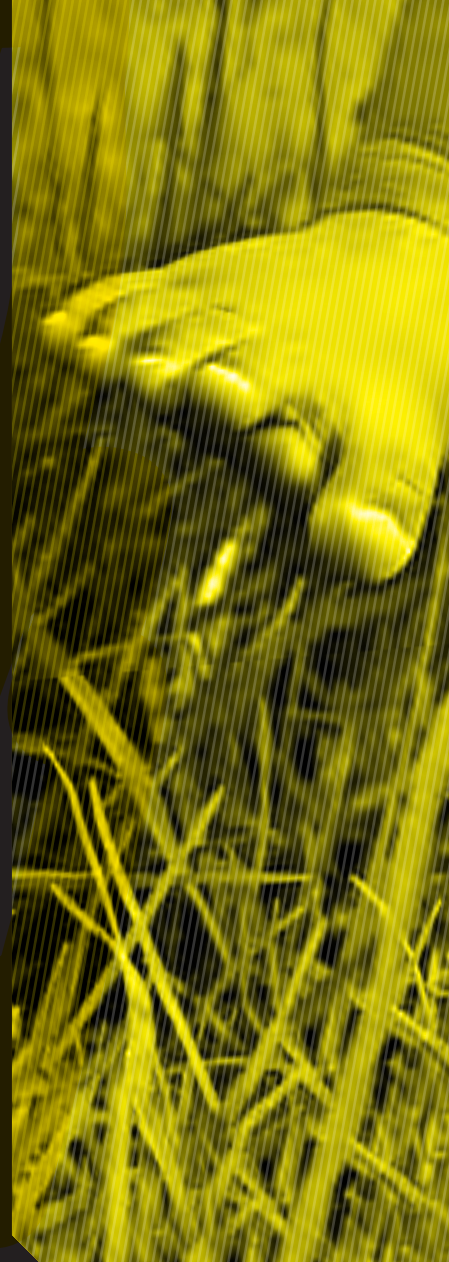
- An integrated and whole-of-government policy response.

At the time of writing, significant national mental health reform processes are taking place alongside the development of a plan to close the gap in Aboriginal and Torres Strait Islander health outcomes and life expectancy. These include the release of a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and the renewal of the Aboriginal and Torres Strait Islander National Strategic Framework for Mental Health and Social and Emotional Wellbeing as well as the existing drug and alcohol strategy.

It is vital that the opportunities in the space are grasped. To that end, in 2012 the National Mental Health Commission, echoing calls from Aboriginal and Torres Strait Islander peoples, called for a mental health target to be included in the Council of Australian Government's (COAG) Closing the Gap National Reform Agenda, and a dedicated Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan (National Mental Health Commission: 2012) that integrates the responses discussed above into a coherent, holistic and whole-of-government policy response.

In particular, the high levels of stress and trauma reported cannot

be reduced through the actions of the mental health system but through the combined work of many agencies and all Australian governments working in partnership with, and under the leadership of, Aboriginal and Torres Strait Islander peoples. In that regard, the COAG Closing the Gap National Reform Agenda provides a good starting point for integrating mental health responses into many areas of government activity.





THE HIGH LEVELS OF STRESS AND TRAUMA REPORTED CANNOT BE REDUCED THROUGH THE ACTIONS OF THE MENTAL HEALTH SYSTEM – BUT THROUGH THE COMBINED WORK OF MANY AGENCIES AND ALL AUSTRALIAN GOVERNMENTS WORKING IN PARTNERSHIP WITH, AND UNDER THE LEADERSHIP OF, ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES.

Dr Tom Calma AO

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