Mental Health Council of Australia

ABN 67 592 218 493

Mental Health Council of Australia Response to the National Preventative Health Research Strategy (2012-2016) Consultation Draft, 31 August 2012.

Background

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector. The membership of the MHCA includes national organisations of mental health services, consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

The current focus of the Australian National Preventative Health Agency (ANPHA) is

> …to lead, facilitate and promote policies and programs that keep people healthy and out of hospital…The initial focus of ANPHA will be on obesity, tobacco and alcohol – all significant lifestyle risk factors associated with chronic disease. ANPHA ion approaches in primary care….[1]

This includes increased efforts to discourage smoking among people living with, or at risk of, mental illness and providing more effective interventions around all risk factors for disadvantaged groups, such as Indigenous peoples and people living with mental illness.[2]

This recognition of the increased risk factors for physical disease amongst people with a mental illness is welcome. However, MHCA is disappointed that the value of mental health promotion and the prevention of and early intervention for mental illness do not have a greater focus in the current National Preventative Health Strategy.[3] This contributes to the risk that this important area will not be a focus for future research or prevention initiatives.

In this submission the MHCA argues that the burden of disease and cost to the economy from both mental illness and co-occuring physical health conditions cannot be ignored. We recommend that the National Preventative Health Agency identify the prevention of mental illness as an issue of growing importance in the community and include it as a research priority in the proposed *National Preventative Health Research Strategy 2012-16*.

Mental health promotion and mental illness prevention

According to the World Health Organisation, mental illness is already the leading cause of years lost due to disability worldwide and projections indicate the problem is increasing.[4]

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[1] Australian Government. (2012) *Portfolio budget statements 2011-12: budget related paper no.1.10: Health and Ageing Portfolio :Australian National Preventative Health Agency resources and planned performance.* Accessed from the Department of Health and Ageing website on 29 August 2012. http://www.health.gov.au/internet/budget/publishing.nsf/Content/2011-2012_Health_PBS.

[2] Australian National Preventative Health Agency Bill 2010. Commonwealth of Australia, Canberra.

[3] National Preventative Health Taskforce. (2009). *Australia the Healthiest Country by 2020, National Preventative Health Strategy – the roadmap for action*. Commonwealth of Australia, Canberra.

[4] World Health Organisation. (2009). *Global Health Risks – mortality and burden of disease attributable to selected major health risks*. World Health Organisation, Geneva.

There have now also been several international longitudinal studies which demonstrate the profound and lifelong impact of untreated mental illness and behavioural problems that appear in childhood. The results can have significant social and economic consequences for adults, including reduced levels of employment, lower salaries when employed, personal relationship difficulties and increased contact with the criminal justice system.[5]

The International Labour Organisation estimates the costs of mental illness account for up to 4% of the gross domestic product in developed countries.[6] With a $1.4 trillion dollar economy in Australia in 2009, this would equate to $55 billion per annum.

These figures should be a major concern to policy makers who are seeking to relieve funding pressures on the hospital system by preventing episodes of serious mental illness which require acute care and free up access to hospital services.

Nowhere are the costs of lack of preventative strategies more clearly demonstrated than in the mental health sector where the bulk of funding spent on mental health is in the area of hospital based acute services.[7] Many people with mental illness do not have access to appropriate medical and other supports to enable them to live independently and maintain their health for extended periods of time. This results in a vicious cycle that leads people to relapse, often requiring hospital admission, experience more frequent periods of illness, disability and social exclusion, thus slowing their recovery even further, all of which could have been averted with adequate access to appropriate treatment and community supports.

These problematic funding issues in the mental health sector were acknowledged in the report of the National Health and Hospitals Reform Commission, which also advocated the importance of a national preventative health approach as a key element of health system reform.[8]

Further, there is now good evidence that early intervention can assist individuals in managing their mental illness.[9] And recent data shows that as many as 19% of all new cases of mental illness can actually be prevented using appropriate interventions.[10] Emerging meta-analyses also show that promotion and prevention strategies reduce the individual and social impacts of mental illness when it does occur.[11]

It is clear that in addition to treatment, promotion and prevention should be seen as important new ways to reduce the enormous burden of mental disorders over coming decades. As a consequence there has been a growing international recognition of the need to promote positive mental health and wellbeing and to prevent the onset of mental illness.[12,13,14]

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[5] Scott S, Knapp M, Henderson J, Maughan B. (2001). *Financial cost of social exclusion: follow up study of antisocial children into adulthood.* British Medical Journal, 323, (7306); 191.

[6] Gabriel P, Liimatainen MR. (2001). *Mental Health in the Workplace*. International Labour Organisation. World Health Organisation, Geneva.

[7] Department of Health and Ageing. (2007). *National Mental Health Report 2007: Summary of twelve years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005.* Commonwealth of Australia, Canberra, p2.

[8] National Health and Hospitals Reform Commission. (2009). *A Healthier Future for all Australians Final Report of the National Health and Hospitals Reform Commission – June 2009*. Commonwealth of Australia, Canberra.

[9] McGorry P, Killackey E and Yung A. (2007). *Early intervention in psychotic disorders: detection and treatment of the first episode and the critical early stages.* Med J Aust 2007; 187 (7 Suppl): S8-S10.

[10] Cuipers P, Van Straten A, Smit F. (2005). *Preventing the Incidence of New Cases of Mental Disorders: A Meta-Analytic Review.* Journal of Nervous and Mental Disease, 193 (2): 199-125.

[11] Ibid.

[12] World Health Organisation. (2005). *Mental Health Action Plan for Europe, Facing the Challenges, Building Solutions.* World Health Organisation, Copenhagen.

[13] Commission of the European Communities. (2005) *Improving the mental health of the population; Towards a Strategy on mental health for the European Union.* Commission of the European Communities, Brussels.

[14] Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJL. (2006). *Global Burden of Disease and Risk Factors.* The World Bank, New York.

With mental health promotion and prevention in its infancy in Australia, it is timely that the proposed National Preventative Health Research Strategy 2012-16 includes mental health as a key research priority.

The mental health needs of the Indigenous sector is another area where more research urgently needs to be undertaken and this would complement proposed ANPHA activities to support initiatives under *Close the Gap*. This includes research into the specific requirements of Indigenous people living with the effects of intergenerational trauma as well as identification of appropriate ways to ensure that mental health services are more accessible to them.[15]

Physical health needs of people with mental illness and their carers

For over a decade, Australian and international research has demonstrated that people with severe mental illness are more likely than others to have significant physical health risks and major health problems.[16, 17, 18, 19, 20] This includes a high level of health risk factors commonly found in people with mental health conditions such as obesity, smoking, poor nutrition, limited opportunities for physical exercise which result in serious illness such as strokes, respiratory disease, cancer, diabetes and coronary heart disease.[21, 22, 23]

People with mental illness are also more likely to experience serious illnesses earlier and before the age of 55, are less likely to survive for more than five years following diagnosis and are less likely to receive evidence-based checks and treatments.[24, 25]

Australian data indicates that people with mental illness have life expectancies 15 to 25 years lower than the general population.[26] This is now backed up by recent UK data which shows life expectancy across all mental illnesses is well below the UK average for both genders.[27]

The experience of caring for a person with mental illness can also have major negative health impacts on carers, who frequently neglect their own health requirements. The focus of

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[15] Atkinson J et al. (2010). *Trauma, trans generational transfer and effects on community wellbeing*; and Wilkes E et al. (2010). *Substance misuse and mental health among Aboriginal Australians*. Both in Purdie N et al. (2010). *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Commonwealth of Australia, 2010.

[16] Brown, S., Barraclough, B. & Inskip, H. (2000). *Causes of the excess mortality of schizophrenia.* British J Psychiatry, Vol. 177, pp. 212-217.

[17] Connolly M., & Kelly C. (2005*). Lifestyle and Physical Health in Schizophrenia.* Advances in Psychiatric Treatment, vol. 11, 2005, pp. 125-132.

[18] Harris, E.C. & Barraclough, B. (1998). *Excess mortality of mental disorders.* British J Psychiatry, Vol. 173, 1998, pp. 11-53.

[19] Lawrence D.M, Holman C.D, Jablensky A.V. And Hobbs M.S. (2003). *Death rates from ischemic heart disease in Western Australian: 1980-1998*, British Journal of Psychiatry, Vol. 182, 2003, pp. 31-36.

[20] Woo, V., Stewart, B.H., Houlden, R.L. (2005). *Canadian Diabetes Association Position Paper: Antipsychotic medications and associated risks of weight gain and diabetes.* Canadian Journal of Diabetes, Vol. 29, No. 2, pp. 111-112.

[21] Newcomer J.W. (2007). *Antipsychotic medications: Metabolic and cardiovascular risk.* Journal of Clinical Psychiatry, Vol. 68, Supplement 4, 2007, pp. 8-13.

[22] Osborn D.P., Nazareth I and King M.B. (2006). *Risk for coronary heart disease in people with severe mental illness, cross-sectional comparative study in primary care.* British Journal of Psychiatry. Vol. 189, 2006, pp. 285-289.

[23] Osborn D.P. et al. (2008). *Relative risk of cardiovascular and cancer mortality in people with long term conditions.* BMC Psychiatry, Vol. 8, 2008, p. 84, http://www.biomedcentral.com/1471-244X/8/84 accessed on 27 August 2012.

[24] Government of Scotland, (2005). *National Programme for Improving Mental Health & Wellbeing: Addressing Mental Health Inequalities in Scotland*, access from the website http://www.scotland.gov.uk/Publications/2005/11/04112909/29100 on 27 August 2012.

[25] UK Disability Rights Commission. (2006). *Equal treatment: Closing the gap. A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems,* accessed from http://psychminded.co.uk/news/news2006/sept06/drcreport.pdf on 27 August 2012.

[26] Coghlan R, Lawrence D, Holman CDJ, Jablensky AV. (2001) *Duty to Care: Physical Illness in People with Mental Illness*. Perth: The University of Western Australia.

[27] Chang C-K, Hayes RD, Perera G, Broadbent MTM, Fernandes AC, et al. *Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London* 2011, PLoS ONE 6(5): e19590. doi:10.1371/journal.pone.0019590.

carers and clinicians is entirely centred on consumer health, while carer needs are often not considered.[28]

The costs of these burdens on the individuals concerned, the community and the health system make it clear that the physical health needs of mental health consumers and carers should also be a priority for preventative health research.

Conclusion

Preventative action in mental health is critically important for two reasons. First, the large and growing burden of disease associated with mental illness means we must identify areas where prevention is possible. Second, the high prevalence of risk factors for physical disease among people with a mental illness means that prevention in mental health will have flow-on benefits for physical health. Therefore, investment in prevention, promotion and early intervention in mental health will deliver payoffs for both the mental health service system and the wider health system.

The Australian community desperately needs a model of preventative health which includes mental health as a key aspect of community wellbeing. Such a model would link mental health promotion, prevention, early intervention, treatment and ongoing recovery in a seamless, cost effective approach to research, policy and service provision.

[28] House of Representatives Standing Committee on Family, Community, Housing and Youth. (2009) *Who Cares…? Report on the Inquiry into Better Support for Carers.* Parliament of the Commonwealth of Australia, Canberra, pp.ix, 191.