Australian Government
National Mental Health Commission

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Good afternoon.

I acknowledge the Ngunnawal people, the traditional custodians of the land and pay my respects to their Elders past and present.

I'd also like to pay my respects to people with lived experience of mental health issues, their families and other supporters.

I also thank the National Press Club for its continuing support for speakers about mental health.

Mental health is the weak point of Australia's generally good health system. Today I am going to talk about one of the more visible, and, to a degree, fixable parts of mental health - the poor physical health and wellbeing of those with mental illness.

And in doing so on behalf of the National Mental Health Commission, I am proud to launch *Equally Well – the National Consensus Statement on improving the physical health and wellbeing of people living with mental illness,* a statement of over 50 major organisations concerned with mental health.

About the NMHC

A quick overview of the National Mental Health Commission.

It plays a key role in mental health reform in Australia.

How?

First, we monitor and report on the performance of the mental health system.

Second, we engage with all stakeholders in the mental health system (especially people with a lived experience and their carers).

Third, we also provide advice to the governments and the community, particularly about evidence-based ways to improve outcomes for people living with mental illness.

I'd like to single out two significant contributions the National Mental Health Commission has made:

- First, it has promoted the concept of a contributing life. Essentially, this asserts that people living with a mental health difficulty should be able to expect the same rights, opportunities and health as the wider community. Simply put, it means having a stable and secure home (not a temporary one), meaningful work, opportunities for education and training, good healthcare and support when needed, and connections to family, friends and community, all without experiencing

discrimination due to having a mental health problem. In short, it embodies a life where people with mental illness are thriving, not just surviving!

- This concept highlights the need for a whole of government approach to reform – that is, reform cannot just come from within health departments alone, or housing departments, or employment or education departments for that matter. Rather, to achieve the contributing life vision, we need a wider approach - a whole of government approach - to the strategy and governance of reform. Sadly, that is not what we currently have in Australia. We need to have an approach at national and state level that involves all parts of government not just health departments. We need leadership from the top.

- Second, in 2014 the Commission reviewed the mental health system as a whole. We found that whilst there is a substantial level of investment in mental health related services in Australia, the service system is fragmented, siloed, hard to navigate and with too little spent on investment and especially on prevention and early intervention

- In 2015, the government announced major mental health reforms drawn from our recommendations.

- These reforms aim to fundamentally change the way services are planned and delivered, and focus on delivering a more person-centred, locally-based, stepped-care approach to mental health and suicide prevention services.

Reflecting the value they place on the role of the National Mental Health Commission, the Coalition Government made a commitment prior to the last election that it would strengthen the Commission. We look forward to an announcement about that - I believe it is imminent.

The need to embrace *Equally Well*

Today, I want to discuss the physical health and wellbeing of people living with mental illness.

It's shocking that even now – in the 21st century - with all our capabilities and one of the best health systems in the world - people with a mental illness have poorer physical health outcomes than those without mental health issues – particularly those with a chronic mental health condition.

What is most distressing is that, on average, people with a serious mental illness die younger – between 14 and 23 years earlier – than the general population.

And of great concern the gap seems to be widening rather than narrowing over the past three decades.

There are some alarming statistics to consider.

Firstly, four out of every five people living with a mental illness have a co-existing physical illness.

Compared to the general population, people living with mental illness are:

- two times more likely to have cardiovascular disease;
- two times more likely to have respiratory disease;
- two times more likely to have metabolic syndrome;
- two times more likely to have diabetes;
- two times more likely to have osteoporosis;
- 65% more likely to smoke; and
- six times more likely to have dental problems.

They comprise around one third of all avoidable deaths.
People living with severe mental illness are particularly at risk.

They are:

- five times more likely to smoke;
- six times more likely to die from cardiovascular disease, even if aged between 25 and 44 years;
- four times more likely to die from respiratory disease;
- more likely to be diagnosed with diabetes or have a stroke under the age of 55 years;
- 90% more likely to be diagnosed with bowel cancer if they have schizophrenia; and
- 42% more likely to be diagnosed with breast cancer if they have schizophrenia.

Why do people with mental health problems have poorer physical health and excess mortality?

It is not suicide – it only makes a small contribution.

Medications can, in many instances, lead to weight gain, obesity, cardiovascular disease, metabolic syndrome and type 2 diabetes. Often no action is taken to actively prevent or manage these damaging side effects despite clinical guidelines to the contrary partly because it is unclear who is responsible – the physical or mental health people.

Poor access to services also contributes. That can be due to a lack of knowledge or ability or motivation to locate or access or travel to appropriate services. New models of proactive integrated screening and health care would address these concerns.

Affordability of high out-of-pocket costs can also limit access to screening, investigations, medication or other prescribed treatments.

Stigma and discrimination which is still widespread, particularly towards those with serious mental illness, can also discourage an individual from seeking help.

And health professionals still all too regularly demonstrate stigma and discrimination against those with mental illness - by ignoring them or by dismissing or diminishing the symptoms they report, by not investigating as frequently or by not treating as assertively as they otherwise might if the person did not have a mental illness.

There is so called ‘diagnostic overshadowing’. In simple terms if I have a sore back then I am taken more seriously than a person with mental illness with the same complaint with the consequence

that physical conditions can go undiagnosed and untreated which can prove fatal.

The quality of care can also suffer because health professionals do not feel comfortable in knowing how to relate to persons with mental illness or how to explain treatment options or medications in a way that maximises understanding and compliance with treatment.

Adding to that, physical health teams may struggle to help people with mental illness whilst mental health professionals may not pay enough attention to physical health care.

Of particular concern is evidence of the inequalities in access to treatment in some of the most critical areas of health care, with individuals with schizophrenia at most disadvantage. For example, some patients with serious mental illness and diabetes are less likely to receive standard levels of care for their condition, just as patients with mental illness and cardiovascular disease are the least likely to receive specialised interventions and some medications. This differential can extend into the surgical realm as well, with studies demonstrating that people with serious mental illness have higher rates of postoperative complications and higher postoperative mortality.

So called ‘health risk behaviours’ are particularly high amongst those with mental disorders. Known risk factors such as smoking, alcohol and drug use, poor nutrition, higher sedentary behaviour and lower levels of physical activity contribute to poorer physical health.

We know that when someone with a mental illness smokes, there is often no effort made to encourage them to stop smoking. This may be due to a view - perhaps well-intentioned but misinformed - that you should not expect too much from people with mental illness. Sometimes it is because smoking is perceived to be their only pleasure in life. In my view however, this is yet another form of discrimination – not offering a treatment that could improve health and wellbeing and increase life expectancy simply because someone has a mental illness is unacceptable.

There are many other factors that also contribute to poorer health outcomes as well – inadequate housing, lack of education, social exclusion, low income, unemployment, exposure to violence and abuse, and intergenerational trauma – to name a few.

Is it inevitable that people with mental illness will have poor physical health? The answer to that is a very big and clear “No” - because we know that much of the link between mental illness and poor physical health is preventable. We just need to do more to prevent it!

Health and wellbeing is a basic human right and it is being denied to many in our community because they have a mental illness.

The disparities in health outcomes for people living with mental illness that I have detailed to you today – with lower life expectancy and higher rates of physical ill-health – are unacceptable.

That's why the Commission aided by 53 mental health organisations and countless individuals - many here today – and whom I want to thank - led the development of *Equally Well – the National Consensus Statement*.

We are all committed to putting health care for people living with mental illness on an equal footing to that of people without a mental illness.

Now if we are to achieve improved health outcomes for people living with mental illness, it clearly will require a change in how the system works.

The *Equally Well Statement* calls for better collaboration and coordination between governments, professional bodies, social and community services and other leaders in mental health to make the physical health of people living with mental illness a national priority, and to address the many factors that place people living with mental illness at risk.

One of the core reforms we have called for is person-centred care rather than provider-centred care. If that is done it will be easier to combine physical health care as well as mental health care.

The *Equally Well Statement* challenges the low expectations that pervade the health system in terms of health outcomes for people with serious mental illness. Not only can people with mental illnesses benefit from evidence-based interventions, just like everyone else, but more fundamentally, they have the same right to high-quality appropriate health care as everyone else.

Our Statement sets out practical approaches to addressing the problem of poor physical health of the mentally ill including better prevention services, early treatment, better equity of access, improved quality of health care, care coordination and better integration across physical health, mental health and other services.

Aboriginal and Torres Strait Islander

Regarding Aboriginal and Torres Strait Islander mental and physical health I make three points:

1. The life expectancy of Aboriginal and Torres Strait Islander people with mental illness is much less than for Aboriginal and Torres Strait Islander people without mental illness;

2. The emotional social and wellbeing framework stemming from Aboriginal and Torres Strait Islander culture is holistic and brings together physical and mental health in a way mainstream approaches don't;

3. I want to mention a passion of mine: that the Council of Australian Governments (COAG) ‘closing the gap’ targets should include mental health targets.

Economics

The OECD estimates the average overall cost of mental health to developed countries is about four per cent of GDP.

There is scope for more or better investment in, and for much improvement in the operation of, the mental health system.

Martin Wolfe, the world's leading economics commentator has said that "Given the economic costs to society, including those caused by unemployment, disability, poor performance at work and imprisonment, the costs of treatment would pay for themselves."

As to the total cost to the Australian health system of physical illness for people living with severe mental illness it has been estimated at $15 billion per annum (about 1 percent of GDP). That includes the cost of health care, lost productivity and other social costs.

I would like reform of mental health to be seen as an important part of the economic reform agenda. The potential economic gains dwarf most of the gains that might be made from standard reforms being discussed currently and is more politically achievable. Last week a start was made. The Australian Conference of Economists made it a keynote session.

There is a strong case for a reference to the Productivity Commission to get mental health on to the economic agenda.

The importance of carers

I would also like to highlight the incredible contribution that carers of people with mental illness make.

An estimated 240,000 Australians care for an adult with mental illness but are not registered to receive carer benefits.

According to a recent study by Mind Australia it would cost $13.2 billion to replace informal mental health care with formal support in Australia.

The Fifth National Mental Health and Suicide Plan

There is not time to discuss the forthcoming Fifth National Mental Health and Suicide Plan except for one observation.

One of my great disappointments at the NMHC over 5 years has been the slowness and resistance by governments to give enough priority to the production of measures of performance or outcomes in relation to the mental health system recommended by us since 2012.

One exception namely the collection and recent public reporting on rates of seclusion, has seen a reduction in this restrictive practice – it shows the value of publishing data.

It is also important for the National Mental Health Service Planning Framework to be publically available. The reticence to publish this framework has held back public and political understanding of what is needed to address mental health.

More broadly, we in the mental health community know that sadly, when push comes to shove, that when budgets are made, mental health, the poor cousin of health and social welfare, does not get

the priority it needs. What I find especially disappointing, however, is the failure to publish data and information that lets the community know the truth about mental health and that could help make it a higher priority.

National Disability and Insurance Scheme (NDIS)

The NDIS is a good thing, and mental health should be included.

There is early anecdotal evidence that for many people with severe and persistent psychosocial disability, participation in the NDIS is resulting in more effective services and supports, better tailored to the diverse and specific needs of individual consumers.

The Commission, however, has heard from multiple stakeholders across Australia of many very serious issues and concerns expressed about its implementation.

Today I refer to two issues.

First, there is concern about the estimated number of people with mental illness and psychosocial disability who will not be eligible for support under the NDIS.

Bear in mind that the Australian Bureau of Statistics (ABS) data show there are about 700,000 people with severe or psychotic mental illness.

The initial estimate was that 64,000 people with psychosocial disability would qualify to receive Individually Funded Packages

(IFPs) by full rollout in 2019-20. The Department of Health has estimated that it's more like 92,000 people.

However, the Commission thinks that both of these figures vastly underestimate the number of individuals with mental illness who need psychosocial support, and that there may be up to or more than 200,000 people who will miss out on much needed psychosocial support because they will be deemed as not eligible under the NDIS.

Incidentally I discount claims that current enrolment numbers show the estimates were on target. The Victorian submission to the Productivity Commission shows why.

More people need to get in. Equally worrying is the fate of large numbers of people who are deemed to qualify at best for a lower tier of support. There are grave fears as to whether they will receive any significant support at all and we deeply fear many people will fall into a big hole between the NDIS scheme and mental health schemes.

The Commission has raised this discrepancy with the Government. We were pleased that a funding commitment of $80 million was given in the Federal Budget to help bridge this gap.

The $80 million is a good start. But it may not be sufficient to meet the need and it still needs to be matched by states and territories, who in some instances appear to have been withdrawing funding for psychosocial disability services as part of the transition to the NDIS.

It's not just the NDIS we have to worry about. It is also the capacity of mainstream mental health service systems to support and complement the NDIS. If the NDIS is too restrictive there will be a flood of people needing mental health services at great cost to federal and state governments.

The second big and related issue is the assessment process for determining eligibility. The NDIS is principally designed for people with a physical or intellectual disability. Assessing their level of disability and the supports they require is relatively straightforward. In contrast, assessing the eligibility of people with a mental illness and their level of psychosocial disability and the supports they require is frankly proving to be a major problem for an assessment process dominated by physical and intellectual disability. The assessment process requires radical review.

Just to take one problem. Many prospective participants are not able to collect the evidence required to complete NDIS access and review processes. People with severe mental illness (particularly those on compulsory treatment orders), the homeless, people with a dual disability, and those with little informal support network, are often unable or reluctant to engage with formal service systems or have no treating health professional.

For individuals with mental illness and an associated psychosocial disability there is a need for additional effort and outreach to help them access, understand and provide the information necessary for them to participate.

Despite the NDIS trials commencing over three years ago, there is still no published eligibility criteria for people with psychosocial disability. Added to that, anecdotal reports indicate that the outcomes from the assessment process are somewhat unpredictable and seem quite variable for people with similar levels of psychosocial disability.

All of these point to a need for the scheme to build much better the specialist skill capacity needed to deal with people with mental illness, and also to consider whether a special gateway is required for people with mental illness to facilitate their entry to the scheme. At the moment the big risk is that mental health becomes the poor cousin of the scheme, and is squeezed between an imperfect NDIS and a contracting mental health system.

I also believe the NDIS fails to adequately address the housing support needs of people with a mental illness despite provision in some cases for payment of so called ‘user cost of capital’ - which makes a limited contribution in this area.

Equally Well

In this speech I will not go into detail of our action plan but I want to acknowledge there is some promising and substantial work in this area from groups that are with us here today.

To pick two from many there is the Healthy Active Lives Programme (the HeAL Programme) developed by Dr Jackie Curtis and others at the Bondi Psychosis Programme.

The Royal Australian and New Zealand College of Psychiatrists has also produced an excellent report *Keeping Body and Mind Together*.

On behalf of the National Mental Health Commission, I am honoured to officially launch *Equally Well* and in doing so to thank all stakeholders who have been involved in its development and all organisations that have shown early support for it.

I would like to acknowledge members of the *Equally Well* Implementation Committee who are here with us today. The Committee will be co-chaired by Associate Professor Russell Roberts from Charles Sturt University and Elida Meadows the Carer Co-Chair of the National Mental Health Consumer and Carer Forum. They are joined by representatives from key stakeholders in the private, public and community sectors.

We also call on individuals and organisations across Australia to take action in your area of influence.

Equally Well truly is a national statement of consensus. Today, there are 53 logos on the website showing the support that already exists from the Australian Government, all State Governments, all Mental Health Commissions, PHNs, professional colleges and many high profile mental health sector organisations.

In launching *Equally Well,* we wish to inspire a commitment to putting health care for people living with a mental illness on an equal footing with people with physical problems.

Thank you.

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