Improving the physical health of people living with mental illness in Australia and New Zealand

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Author Contributions

RR and HL conceived of the paper and its initial structure. RR HL and CB contributed equally to the writing of the paper, CM contributed to social policy context and the lived experience sections and MH contributed to description of the RANZCP activities.

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RR and MH are both on the Australian Equally Well Implementation Committee. HL is the Strategic Policy Advisor for the Wise Group and has a strategic leadership role for Equally Well in New Zealand.

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Abstract.

People diagnosed with mental health issues have relatively poor physical health and die earlier than their counterparts in the general population. People living with mental illness in rural Australia have three times the risk of premature death than the total population. This paper reviews recent international, Australian and New Zealand research, identifies the increased risk of early death of people living with mental health issues in rural settings and looks at the need for policy and practice responses. Two national initiatives are described in Australia and New Zealand which seek to systematically address this inequity as a matter of priority. Finally, it argues for co-design and consumer participation in policy development, program implementation and research. Improved understanding of the perspectives and priorities of people with experience of mental health issues is vital if change is to be fully realised.

Key Words. Mental health, Physical Health, Equally Well, Comorbidity

What is already known

- People with mental illness die, on average 20 years earlier than the total population average life expectancy.
- Eighty percent of people living with mental illness have a mortality-related physical health condition

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- The major causes of early death for people with mental illness are cardiovascular disease, respiratory disease and cancer.

What this paper adds

- For every one person living with mental illness who dies of suicide, 10 die prematurely due to cardiovascular disease, respiratory disease and cancer.
- This paper describes the Equally Well initiatives of New Zealand and Australia to improve the physical health of people living with mental illness
- A model of collective action is used to inform and describe initiatives in Australia and New Zealand to improve the physical health of people living with mental illness.

1. Introduction.

Many people living with mental illness have excellent physical health and live long and productive lives. Unfortunately, this is not the experience for all. People who are diagnosed with a mental illness, are more likely to experience poorer physical health and die earlier than their general population counterparts. There is a large body of research, spanning many decades, which supports a clear link between mental illness diagnosis and poor physical health. Large studies and meta-analyses in the USA [1, 2] and Europe[3, 4] have reported between 20 and 28.5 years of life lost for people diagnosed with mental illness.[5]

New Zealand research has confirmed international findings that that people using mental health services have a significantly higher risk of shortened life expectancy. Māori mental health service users were found to have a higher mortality rate than Māori with no diagnosed mental illness.[6]

Likewise, an analysis of a large Western Australian data set showed that life expectancy of people accessing public mental health services was reduced by approximately 12 years for women and 16 years for men.[7] An Australian Bureau of Statistics (ABS) report found that while persons accessing Medical Benefits Scheme (MBS) or Pharmaceutical Benefits Scheme (PBS) mental health-related treatments represented only 15% of the total population, they comprised half of all premature

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deaths due to physical health conditions.[8] The highest risks of premature death were from respiratory disease, cardiovascular disease, prostate cancer, breast cancer, lung cancer and diabetes (Fig. 1).

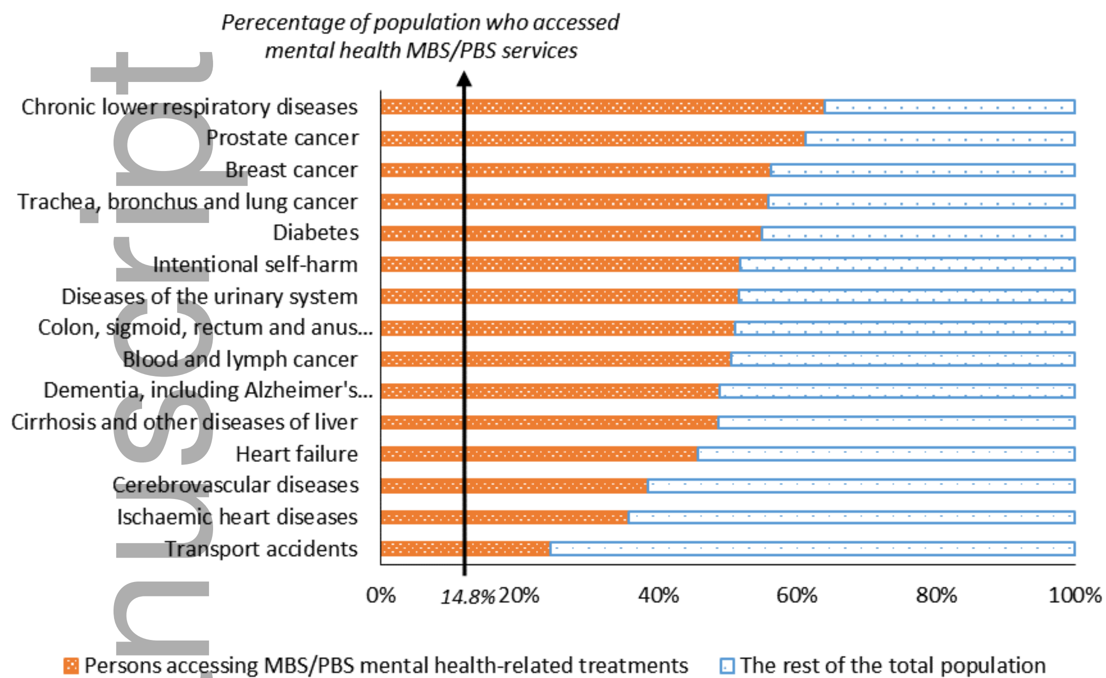

Figure 1: Percentage of total deaths of persons (age 15-74 years) accessing MBS and/or PBS mental health-related services by cause of death[8]

An Australian Bureau of Statistics (ABS) survey of mental health and co-existing physical health conditions found that 80% of people diagnosed with mental illness have a co-existing, mortality-related physical illness.[9] Between 77% and 94% of the causes of early death in people living with mental illness relate to physical illnesses.[7, 10] People living with mental illness had six times the risk of respiratory disease,[8] four times the rate of cardiovascular disease,[11] and two times the risk of diabetes.[12] Death by suicide does contribute to the premature mortality of people diagnosed with mental illness but ABS data indicates that for every one person living with mental illness who dies due to suicide, 10 die prematurely due to cancer, cardiovascular or respiratory disease.[8]

Based on a clear understanding of the importance of co-production and co-design with consumers, Australia and New Zealand have both launched collaborative initiatives, to improve the physical health and life expectancy of people living with mental health issues. This paper briefly describes the rationale for taking a collaborative approach, before introducing and describing the two initiatives.

The experience of rural communities

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People living in rural settings have shortened life expectancy of between one and three years, and an increased burden of disease (Disability Adjusted Life Years) of between 9 and 26%.[13] In Australia, people living in remote and very remote areas have mortality rate 1.4 times higher than those living in major cities and higher rates of comorbidity.[14] The diabetes mortality rate is four times higher, and the suicide rate two times higher for those living in very remote settings than the rate in major cities (Fig. 2).[15] People in rural areas are more likely to experience poor health and comorbidities, greater risk of alcohol dependence, smoking, obesity and lack of exercise.[16]

The social determinants of poor health as they relate to rural communities in Australia are well-documented. They include unemployment (5% in major cities, 7% in rural, regional and remote, and 12% in very remote) and low income (9% in major cities, 11% in inner regional, 12% in outer regional, 14% in remote and 26 % in very remote areas).[17] In Aboriginal and Torres Strait Islander communities the interaction alone between social determinants and behavioural risk factors contributes 15% of the health gap.[14] The higher disease burden and social disadvantage in rural communities exists in the context of a shortage of medical and allied health professionals. Compared to the major cities in Australia, rural communities only have 63% of the GPs,[18] and fewer psychologists, occupational therapists, medical imaging clinicians, and physiotherapists (45, 47, 54 and 58% respectively).[19]

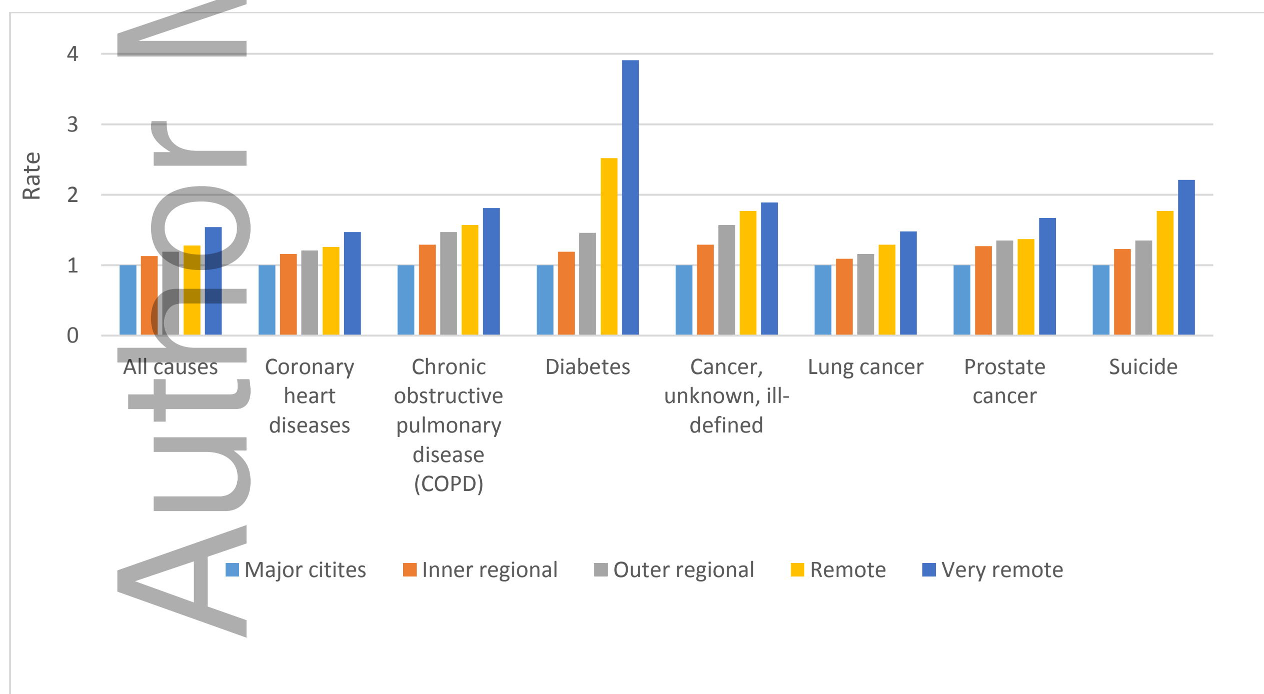

Figure 2: Number of Australian deaths, by cause, in each area, in excess of the major cities rate, for the 3 year period 2009-2011[15]

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When mental illness is added to this mix, the risk of poor health outcomes is even higher, although good data is limited. While the population levels of psychological distress in rural settings is equivalent to that in the major cities,[20] those living with mental illness in rural Australia have over three times the risk of early death due to physical health conditions.[8] There is little research investigating causes of the elevated risk of early death for people living with mental illness in rural communities, but they are likely complex and inter-related. Happell et al., highlighted higher levels of stigma in rural areas, compounded by lack of access to services, geographical distance, poor cross-cultural communication, administrative burdens and role definition issues all contribute to the worse health outcomes of people living with mental illness in rural communities.[21]

The physical health of people living with mental illness in rural New Zealand has received minimal attention in published research. However, concern about high rates of suicide in rural New Zealand led to the establishment in 2015 of Farmstrong,[22] a wellbeing program run by a partnership between the Mental Health Foundation of NZ and the farming industry, which aims "to give farmers access to the tools, resources and information needed to take better care of themselves and in turn, their farming business, their families, staff and community". [22]

Policy and practice responses

There have been several reasons posited to account for physical health comorbidities and early death of people diagnosed with mental illness. The issues are perhaps best viewed as a complex system of compounding factors such as impacts of medication,[23] stigma,[24] smoking,[25] past experience of trauma, and poor access to care[26] where each has an impact on the other.

Despite this complexity, there are barriers which can be addressed by policy makers and practitioners. One such barrier is in accessing medical care.[27-29] When people living with a mental illness do access health services, their physical health needs are often seen as a part of their mental health condition. This 'diagnostic overshadowing'[30] can lead to physical conditions not being investigated or treated, which can prove fatal.[28, 31] Research indicates that delayed cancer diagnosis and cardiovascular disease diagnosis for people with a diagnosed mental illness is a major problem.[32, 33] In rural communities this is compounded by a lack of supporting primary and allied health staff, limiting screening and treatment opportunities.[30, 34]

There is a clear need for policy and practice responses which target whole systems. The perspectives provided by mental health service users are crucial in mapping appropriate responses. The

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contributing factors are numerous and the mental health service system is complex. The World Health Organisation has developed a model to conceptualise and structure interventions to improve the physical health of people diagnosed with mental illness[35] (Fig. 3). Service planners and those looking to make a difference should consider where and how to prioritise actions, based on local issues and opportunities.

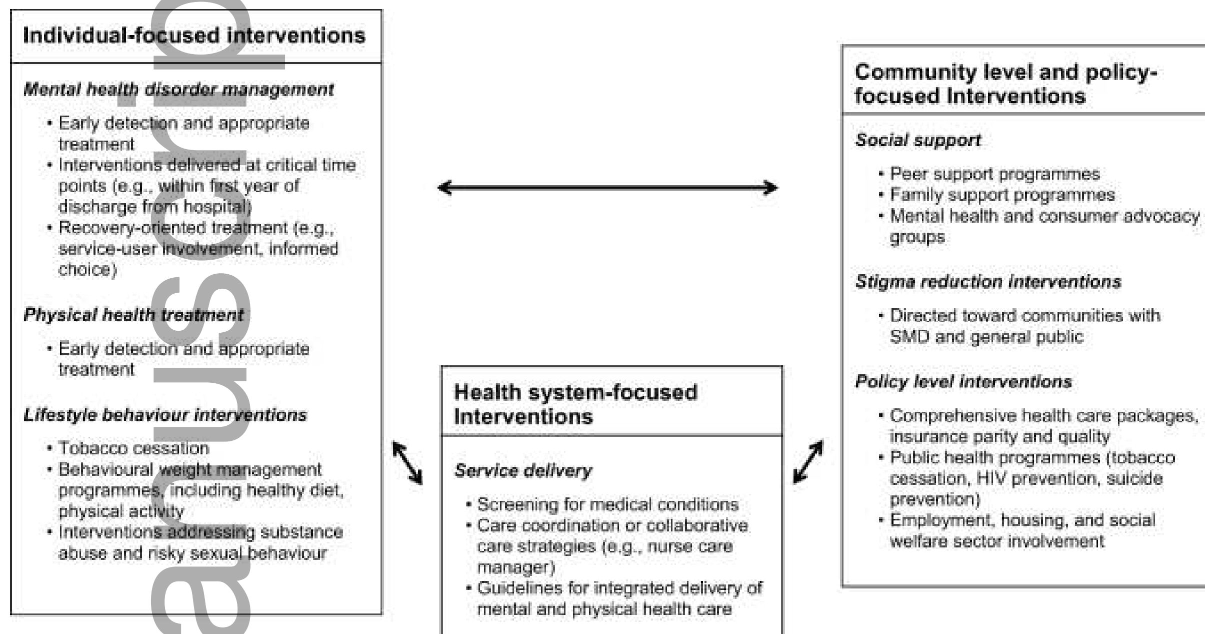

Figure 3: Multilevel model of interventions to reduce excess mortality in people living with mental illness (taken from Liu et al, 2017)[35]

Despite extensive research evidence on the early mortality of people diagnosed with mental illness,[36] not enough progress has been made in addressing this problem. In fact, the evidence suggests the life expectancy gap is increasing.[5, 7, 33] In response, both Australia and New Zealand have embarked upon national collaborative initiatives to improve the physical health of people living with mental health issues. Both of these initiatives have been entitled 'Equally Well', emphasising the goal of people living with mental health issues to experience equity in access to, and quality of health care.

New Zealand

Equally Well was established in New Zealand by national Non-Government Organisations Platform Trust and Te Pou o te Whakaaro Nui (Te Pou) during 2013, as a collaboration of individuals and organisations working to improve physical health outcomes for people who experience mental health conditions and addiction. It draws on the principles of collective action to effect and sustain

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whole systems change, in recognition that no one person or organisation can solve these 'wicked issues' alone.

An evidence review[37] was used to inform discussions with health and social sector leaders, including a national summit in 2014 where a program of action was initiated, and a consensus position paper[38] was developed. This paper called for a concerted and sustained effort by all those in positions to effect change, which has now been signed by over 100 professional peak bodies and health and health-related agencies. Leaders in health policy and professional development, funding and planning, universities, primary care and mental health and addiction treatment services have agreed to work in partnership with people with lived experience of these challenges, to effect change.

Prior to the 2014 summit, an online conversation between stakeholders was generated. The online discussion forum has continued to identify and debate issues, put people in touch with what's happening, and assist in planning for change. A model of collaborative action[39] was developed, based on work done in Canada[40] (Fig. 4).

Figure 4: The New Zealand Equally Well collaborative model[39]

Australia

The National Consensus Statement, *Equally Well: Improving the physical health of people living with mental illness in Australia*[41] was launched in July 2017. The consensus statement was the result of

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broad consultation during 2015 and 2016 including a national consensus workshop of health and mental health stakeholders. Over 70 national organisations, including all state and territory governments and key organisations have so far signed-up to 'making the physical health of people living with mental illness a priority at all levels: national, state/territory and regional'.[41: p.7] Equally Well in Australia benefitted from the prior experience of Equally Well New Zealand whose members have provided generous advice throughout these initial phases, and since.

The Australian mental health system is a complex mosaic where the eight state and territory governments fund approximately 90% all public health services. In addition, services are also provided by Commonwealth funded mental health services, community managed organisations, private health providers and Primary Health Networks (PHNs), who are charged with service planning and coordination at a regional level. There are many examples of excellence, however, too frequently opportunities for shared learning and collaboration are missed. It is in this context the Australian Equally Well consensus statement was developed. As with its New Zealand counterpart, implementing a national initiative in this complex system presents a challenge.

The Equally Well implementation gives regard to several considerations. In Australia there already existed a high level of commitment to improve the physical health of people living with mental illness, evidenced by the range of initiatives already underway. However, there is still a need to increase awareness of the range and nature of initiatives underway and planned, as effective, successful initiatives operating in some regions are virtually unknown elsewhere. It is also iimportant to set public targets and measure implementation progress nationally, across the health sector, and by rurality. Based on these premises, Equally Well seeks to: promote awareness, facilitate collaboration, showcase examples of innovation and curate a repository of resources available to promote and support best practice. Underlying all of this is the commitment to ensure the equal participation of consumers, their supporters and carers in design, production and evaluation of this initiative.

To date the strategy to address the physical health of people living with mental illness in rural communities has been to direct governments and regional health services to address the issue locally as a matter of priority. Action 16 of the National Mental Health and Suicide Prevention Plan requires governments to work with:

> "*…PHNs and LHNs to build into local treatment planning and clinical governance the treatment of physical illness in people living with mental illness by:*

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16.1. including it as part of joint service planning activity between PHNs and LHNs

16.2. including it as part of joint clinical governance activity

16.3. requiring roles and responsibilities to be documented as part of local service agreements."[42]

Australia and New Zealand

Across both countries the Royal Australian and New Zealand College of Psychiatrists (RANZCP) continues to run an advocacy campaign and have produced a number of reports[43] examining the economic cost of mental illness and comorbidities,[44] the evidence base,[45] barriers to health care for people with mental illness and other physical illnesses, and what can be done to reduce these barriers. The RANZCP has also produced publicly available information and fact sheets about the side effects of medications.[46] Useful national and international resources for psychiatrists and trainees have been collated on a new webpage[47] to support the treatment, management and monitoring of physical health of people with mental illness. As well as this new webpage, each of the RANZCP clinical practice guidelines and the physical health consensus statement includes recommendations for mental health clinicians to consider physical health of people with mental illness.

By looking at initiatives which had been effective in achieving substantial impact, the Stanford Social Innovation Review identified five success factors for collaborative action.[48] This approach has informed Equally Well activities in New Zealand and Australia. Table 1 outlines examples of key Equally Well actions against each of these five conditions of collective impact.

Table 1. Equally Well actions across the five conditions of collective impact

Five conditions of collective impact	Progress in New Zealand and Australia
Common agenda	170+ organisations from both countries have signed-up and endorsed consensus statements
Shared measurement	Work is underway in both countries to consider the best way to develop shared measurement evaluation for collaborative, and individual initiatives.
Mutually reinforcing activities	• Partnership approach across activities, including research projects, and presentations at workshops and conferences • Comprehensive wellness programmes encouraging peer support • The development of a wellbeing-focused prescribing toolkit for prescribing clinicians • Metabolic screening audits undertaken in some mental health services • Inclusion of Equally Well in health quality and safety standards frameworks • Equally Well prioritised in national policy documents e.g., Living Well with Diabetes (NZ);

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	National Mental Health and Suicide Prevention Plan (Australia). • District Health Boards (DHBs) annual plans include Equally Well priorities (NZ). • Some Local Health Districts (LHDs) and Primary Health Networks are including Equally Well in their planning priorities (Aus.) • Mental health is included as a risk factor in CVD risk management guidelines for primary care (NZ) • Some regions are funding better access to primary care for mental health service users (NZ) • The RNZCGP developed an Equally Well policy brief providing guidance to GPs and practice nurses
Continuous communication	• Continuous communication with stakeholders is encouraged through open access programmes and via a regular electronic news update • Development of digital and social media strategies and campaigns • Ongoing communications and advocacy with stakeholders
Backbone support	Te Pou in NZ and Charles Sturt University in Australia provide backbone support to the collaboratives, including circulating regular Equally Well e-news, publishing examples of innovation and good practice online, synthesising and disseminating the latest research, regularly speaking to target audiences, coordinating partner activities, encouraging connections across partner members, and building an informal network of Equally Well champions.

4. Conclusions

Both countries have chosen a collective, ground-up movement to affect change, coupled with strategies to influence policy, strongly influenced by the growing evidence base on collective impact. The collaboratives include governments, community-managed organisations, carer and consumer organisations, peak bodies and professional societies/colleges. The diversity of membership in the two collaboratives highlights the importance of a backbone function, to keep a guiding vision and strategy, support aligned activities, establish shared measurement practices, build public will, advance policy and mobilise funding.[40] It is early days, with both programs focussed on long-term implementation and sustained change.

In both countries, there has been a better understanding of the importance of recovery in clinical practice, as reflected in the RANZCP clinical guidelines.[47] In New Zealand, this is partly due to the anti-stigma programme *Like Minds Like Mine*, which has for many years funded service user organisation activities and created service user positions in mainstream services. Television

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campaigns, combined with service user activities, have been successful in shifting attitudes in both the general population and amongst clinicians over the last 20 years.[2] In Australia, reducing stigma and discrimination against people living with mental illness is now a national priority in the Fifth National Mental Health and Suicide Prevention Plan.[42]

Most published research on the physical health of people living with mental illness has been conducted using large databases of people with a diagnosis of mental illness. However, the lived experience of people living with mental illness has received little attention from researchers. New research reveals valuable insights from the perspective of service users[49, 50] and their experience of mental, physical and primary health care, especially the way they approach, navigate and attempt to manage these systems. More research is needed on the impact of rurality on the physical health of people living with mental illness especially from the perspective of people living with mental illness and their carers. Equally Well will be making a difference when people's experience of support and services changes and they participate in quality care in a stigma-free environment. Co-design and consumer participation in policy development, program implementation and research is vital. Acceptance of the premature death and poor physical health of people living with mental illness needs to be replaced by commitment to addressing this international scandal as a matter of priority.

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