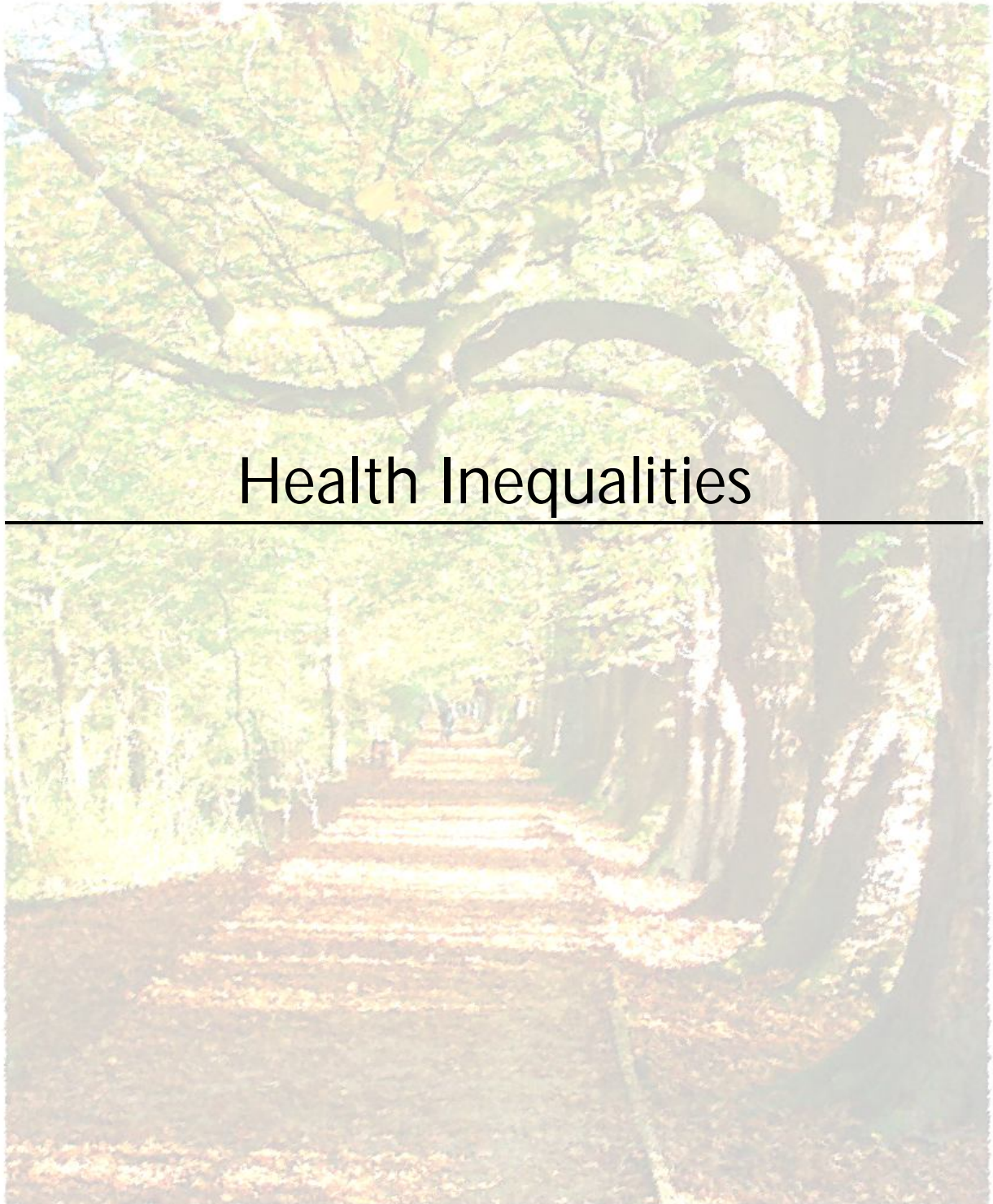




**Psychiatric Disability Services**  
of Victoria (VICSERV)



Health Inequalities



## VICSERV Pathways to Social Inclusion

# Health Inequalities: policy and practice failure

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### Facing the facts

- People with mental illness have a higher death rate across each of the main physical causes
- Their death rate is 2.5 times greater than that of the general population
- People with mental illness are 30% more likely to die from a cancer diagnosis
- The death rate from heart disease has increased substantially for women with mental illness.

### Better outcomes are possible

- Opportunities include tailored prevention and early intervention strategies
- Building linkages between mental health and primary and sub-acute/acute care
- Formally highlight the need for knowledge to be built in order to provide the appropriate supports and develop a carer health agenda
- The specific experiences and needs of people living with severe mental illness must be considered if we are to support their engagement with health interventions and address their profound health inequalities.

### Our call for action

- VICSERV proposes the immediate establishment and funding of a prioritised (ill-) health and mental illness research agenda
- Sector self-review of all PDRSS program types for 'whole of person health approaches'
- 'Beyond Mental Illness' training program for clinical mental health professionals and GPs
- Targeted health promotion and secondary/tertiary prevention strategies.

## The disturbing facts<sup>1</sup>

- People living with severe mental illness have an overall health status that is far lower than that of the mainstream population, resulting in significant health inequalities.
- The death rate of people with mental illness is 2.5 times greater than that of the general population, which is equivalent to a life expectancy of 50 - 59. People with schizophrenia have a mortality rate that is up to three times higher than that of the general population.
- People with mental illness have a higher death rate across each of the main physical causes, with heart disease causing the highest number of 'excess' deaths. The death rate from heart disease has not declined for this group in recent years, in stark contrast to the general population and has actually increased substantially for women with mental illness.
- The number of deaths in people with mental illness, due to main physical causes, far exceeds the number of hospital admissions for related conditions. Conditions such as heart disease are not being picked up or treated until it is too late. Whilst the incidence of cancer appears to be no different for people with a mental illness and the general population, people with mental illness are 30.0% more likely to die from a cancer diagnosis.
- Coexisting physical conditions found in patients with severe mental illness include diabetes, hyperlipidaemia, cardiovascular and respiratory disorders, obesity, malignant neoplasms, HIV/AIDS, Hepatitis C, hyperprolactinaemia, osteoporosis, irritable bowel syndrome, Parkinson's disease, accidental poisonings (related to prescribed and illicit substance use), injuries inflicted on the person, and poor nutrition.
- An estimated 20-50% of new clients of adult mental health services in Victoria present with a coexisting substance abuse problem; and the prevalence rate is even higher for young adults.
- People living with severe mental illness have poor oral health. Experience indicates these people require 23.0% more dental treatment services and have 36% more extractions than other low-income consumers.
- People living with severe mental illness often experience high rates of co-morbidities due to high-risk health behaviours interacting with mental illness and vice versa. These behaviours include cigarette smoking, alcohol and other drug abuse, obesity, poor diet, and lack of exercise.

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<sup>1</sup> Please refer to *Health Inequalities – Policy and Practice Failure. Background Paper* for details and references.

## **Is it them or is it us?**

People living with severe mental illness literally suffer the consequences of policy and system failure to address social determinants of health (housing, employment, income, education, social inclusion, etc.) and to ensure access to health services that are able to effectively address their needs.

Practitioner responses to people living with severe mental health illness often fail to demonstrate an awareness of the connections between physical health conditions and their contributing factors.

## **We have created a disjointed service system where there is:**

- Poor inter-sectoral collaboration, knowledge transfer and resource sharing between the mental health service sector and primary care and (non-psychiatric) acute care sectors.
- A tendency (likelihood) for specialist mental health, clinical and PDRSS workers to overlook and/or under-address the physical health issues of their patients/clients.
- Reluctance on the part of other health providers to engage and treat clients whose behaviours are affected by mental illness.

People living with severe mental illness 'fall between the cracks' of service systems leaving a range of physical conditions ignored and untreated, resulting in tragic health outcomes.

## **The health costs of caring**

Carers can spend over 100 hours a week 'on the job'.<sup>2</sup> The experience can, for at least some periods, be fraught with difficulty and stress. As with many aspects of the carer role, necessary questions have neither been asked nor answered. Given both the rights and role of carers, it is time to consider their health and wellbeing as part of a comprehensive response to the impact of mental illness.

VICSERV is not yet making specific propositions in this area but considers it important to formally highlight the need for knowledge to be built in order to provide the appropriate supports and develop a carer health agenda. VICSERV plans to explore with carers (and key carer organisations) questions related to their health experiences and needs in the next phase of proposition development. VICSERV invites interested stakeholders to engage in dialogue and a partnership approach to this work.

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<sup>2</sup> See *Social Inclusion – An Outcome Measure for the Mental Health Service System. Notes on Context, Definition and Evidence* for details.

## **Addressing health inequalities: moving forward together**

The specific experiences and needs of people living with severe mental illness must be considered if we are to support their engagement with health interventions and address their profound health inequalities.

### **Opportunities include:**

- Integrated, multi-disciplinary approaches – new models and ways of thinking, funding and working.
- Tailored prevention and early intervention strategies.
- Building linkages between mental health and primary and sub-acute/acute care.
- Making improvements in referrals (with an emphasis on supported referral) and other aspects of service coordination.

### **Capturing these opportunities requires:**

- Authentic engagement of consumers and carers in setting their own health agenda.
- Building the evidence for practice.
- Utilising the PDRSS sector as a platform for engagement and linkage.
- Innovation supported by policy and investment.
- Partnerships.

### **The VICSERV propositions: A multi-faceted strategy**

The evidence indicates an urgent need for a comprehensive response to address the substantial health inequalities experienced by people living with severe mental illness. To this end VICSERV proposes a multi-faceted action strategy comprising four strategy elements. These are:

- Research.
- Practice Innovation.

- Workforce Awareness and Development.
- Targeted Policy and Investment.

### 1. *Research*

A key to making long-term difference is knowledge and using that knowledge to raise awareness and change policy and practice. There is a need for a comprehensive (ill-) health and mental illness research agenda that includes:

- Exploration of the relationship between physical wellbeing (illness) and recovery (social inclusion).
- Health status analysis with a focus on age, gender, length of time living with a mental illness, and other factors. This may include studies that quantify the costs of physical ill health borne by individuals with severe mental illness and society (including government).
- Better understanding of health promotion models appropriate for people living with severe mental illness.

VICSERV proposes the immediate establishment and funding of a prioritised (ill-) health and mental illness research agenda in Victoria that is built on active collaboration between key stakeholders including:

- Government as co-leader, (part) funding body and partnership broker.
- Consumer representation.
- VICSERV as sector agent and co-leader.
- Research expertise; health promotion expertise.
- Representation from clinical mental health, primary and acute health sectors.

Investment required: \$150,000 in the first year for establishment of the prioritised research agenda and seed funding for at least one of the agreed research priorities. It is expected that a realistic three-year funding proposal (including funding models) would be developed in Year One.

## 2. *Practice Innovation*

- (a) Pilot integrated PDRSS and primary health responses. This practice innovation involves the Department of Human Services (DHS) funding six pilot sites—across inner city, outer suburban, regional and rural Victoria—to integrate primary health and PDRSS service responses. It is proposed that the pilots are funded to operate for a three-year period initially. Pilots would reflect different models in order to enrich sector learning, although it is expected that all would:

- Include multi-disciplinary teams.
- Be informed by the experience of primary health services developed for injecting drug users, RDNS Homeless Persons services and other relevant practice models.
- Integrate, in some way, the concept of health self-management and health coaching (including peer coaches) using adaptations of the Flinders, Wagner or other evidence-based models.

It is proposed that funding be a joint initiative of the Government Mental Health and Primary Care Branches and that funding allows for a substantial evaluation. VICSERV would expect to make a significant contribution to informing the design of the pilot.

Investment required: \$300,000 per pilot site per annum for three years (\$5.4 million) plus \$150,000 for pilot evaluation.

- (b) Targeted health promotion and secondary/tertiary prevention strategies. Fund at least one sector-wide health promotion initiative that includes secondary and tertiary prevention strategies—specifically designed to target consumers living with severe mental illness and address risk factors related to one or more of the chronic illnesses demonstrably impacting on the population e.g. cardiovascular diseases or diabetes.

It is proposed that the overarching strategy be developed collaboratively between DHS, VICSERV, consumer representatives and key health promotion bodies. It is anticipated that implementation would occur through partnership approaches involving PDRSS, clinical mental health services, primary health and health promotion agencies and, potentially, Mental Health Alliances and Primary Care Partnerships.

Evaluation of this practice innovation could be usefully linked to the proposed research agenda.

Investment required: \$100,000 in the first year for the design of the strategy and to support engagement in and coordination of implementation partnerships. It is expected that implementation costs, funding options and requirements would be developed in Year one as part of the design process.

- (c) Sector self-review of all PDRSS program types for 'whole of person health approaches'. VICSERV will lead the sector in a process of internal review of all PDRSS program types to identify opportunities for integrating 'whole of person health approaches', good practice models, and practice gaps. This initiative will form part of VICSERV's quality improvement agenda and is intended to be implemented over a two-year timeframe.

Investment required: the cost of this initiative would be fully absorbed into VICSERV's operating costs.

### 3. *Workforce Awareness and Development*

- (a) Health awareness training program for the PDRSS workforce. The VICSERV Training Unit will develop a Health Awareness Training Program that includes training for new, longer-term staff and management across the PDRSS sector on:

- Health issues for consumers i.e. prevalence, risk and protective factors, gender analysis.
- Health risks, side effects, medication (psycho-pharmaceuticals) and informed choice.
- Working with consumers to identify and manage health issues and navigate/access the health system.
- Designing PDRSS program activities that support physical wellbeing.

It is anticipated that training modules will be readily adapted for use in other sectors and VICSERV would aim to make the product available through Mental Health Alliances.

Investment required: DHS is requested to provide once-off funding of \$40,000 to assist VICSERV in designing the program and developing quality resources (hard copy and online). Implementation of the training across the PDRSS sector will be resourced through VICSERV's training budget.

- (b) Beyond Mental Illness Training Program for clinical mental health professionals and GPs. This training initiative will assist in bringing about the attitudinal change across the necessary sectors to make a difference to the health outcomes of people living with severe mental illness. The training is intended for clinical mental health professionals and GPs—those positioned to make a substantial difference to consumers in identification and follow up of physical vulnerabilities and illness.

It is proposed that the work undertaken by VICSERV in developing training for the PDRSS workforce (see above) will inform this initiative. It will, however, be necessary to

assure broader engagement and ownership, and it is proposed that DHS take an active 'sponsorship role' in establishing the right platforms and partnerships for the Beyond Mental Illness Training Program.

Investment required: To be determined.

#### 4. *Targeted Policy and Investment*

Immediate and specific policy responses are required to address the profound health inequalities experienced by people living with severe mental illness. Policy must include targets to reduce the burden of disease carried by this population group, address access issues, coordinate systems, and support responsive models of service.

It is vital to ensure both the primary health (including dental) and chronic illness agendas, at both state and federal levels, specifically address the health needs of people living with severe mental illness. The interface between state and federal mental health funded programs and primary and chronic illness policy, programs and funding, needs to be conceptually mapped and practically built as a matter of urgency.

The PDRSS sector provides a critical and stable point of engagement for people living with severe mental illness and their carers. The sector offers a platform from which to build (or integrate) responses to health needs through targeted investment and partnership approaches.

#### **VICSERV advocates for:**

- Policy and funding support for an intelligent set of targeted, largely partnership-based strategies (described above).
- Recognition of and support for the potential of the PDRSS sector to play a key role in promoting health responses and access to health services.
- Reform to funding through MBS that allows either block funding for primary health and chronic illness responses for this group or substantially incentivised payment schedules.
- Inclusion of a physical health focus and goals in the Victorian *Because Mental Health Matters* agenda.

VICSERV is committed to playing a leadership role and working in active, broad-based partnerships to ensure integrated health system reform that addresses the health needs of mental health consumers.

## Summary of proposed investments

Strategy Element	Initiative	Year 1	Over 3 Years	Funders	Outcomes
<b>Research</b>	Research partnership(s), prioritised agenda, seed funding	\$150,000	To be determined	DHS and/or C'wealth	Better evidence of need, and impact; guide to effective practice
<b>Practice Innovation</b>	Pilot integrated PDRSS/ primary health responses (x 6 plus evaluation)	\$1,950,000	\$5,550,000	DHS Mental Health and Primary Care branches and/or explore potential partnership with C'wealth	Improved primary health response to target group, better linked sectors, good practice, evidence
	Targeted health promotion/prevention initiative	\$100,000	To be determined	DHS with possible VicHealth partnership	Targeted health promotion model; enhanced consumer engagement, better linked sectors and extended partnerships
	Review of all PDRSS program types for 'whole of person health approaches'	Existing resources	Existing resources	VICSERV	Good practice evidence, gap analysis, better integrated program design
<b>Workforce Awareness and Development</b>	PDRSS sector Health Awareness Training Program	\$40,000 plus existing resources	Existing resources	DHS/ VICSERV	Increased awareness and changed mindsets, improved health needs identification and better integrated PDRSS program design features
	Beyond Mental Illness Training Program for mental health clinicians and GPs	To be determined	To be determined	To be determined	Increased awareness and changed mindsets, improved health needs identification and service responsiveness

See also 'Targeted Policy and Investment' – MBS funding options (p. 4).

## Health Inequalities: policy and practice failure

### ***Background paper***

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#### **Introduction**

People living with severe mental illness have an overall health status that is far lower than that of the mainstream population, resulting in significant health inequalities. However, their poorer health status cannot be explained solely by their mental illness. There is evidence to show that people with severe mental illness are also at increased risk for a range of chronic physical health conditions such as cardiovascular diseases, diabetes mellitus, respiratory diseases, obesity, and infections.<sup>3</sup> Having any (or several) of these physical health conditions adds further complexity to their lives; and the compounding effects of physical health and mental health issues demands effective responses from governments and health services alike.

This paper explores the health status of people living with severe mental illness through three indicators: their mortality rate, morbidity experience, and high-risk health behaviours. The paper also discusses the barriers to accessing services for good health, with particular focus on 'traditional' health services—primary, specialist and acute care. The main barrier identified is a fragmented and disjointed health service system that commonly neglects the physical health needs of people living with severe mental illness until a medical emergency occurs, or it is too late.

Before exploring these issues, it is important to briefly contextualise health inequalities within a social model of health framework given the degree to which socio-economic factors contribute to overall health status. According to VicHealth, health inequalities are the result of two key factors.<sup>4</sup> The first relates to barriers to resources necessary to achieve and maintain good health. Critical resources identified are: secure housing, stable employment, adequate income, education, and social inclusion. A person may experience barriers to one or more of these resources for a range of reasons, and not having access to these resources results in marginalisation, socio-economic disadvantage and poorer health. The second factor relates to barriers to accessing services that support health—not only 'traditional' health services but services in the broad 'social model of health' context e.g. transport and community-based supports. A person may experience barriers to services because of cost, inaccessibility, inappropriateness, unawareness, discrimination, or a combination of these issues. Services may exist; but not being able to use them means unmet needs and poorer outcomes.

The lack of critical resources for health amongst people living with severe mental illness is well documented in the literature and is not the focus of this paper. Some key statistics are, however, worth mentioning. These figures are drawn from the findings of a census of 3,800 Australians aged 18 to 64 with psychotic disorders undertaken by the Low Prevalence Study Group of the *National Survey of Mental Health and Wellbeing*.<sup>5</sup> The research method included

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<sup>3</sup> See for example Lawrence D, Holman CDJ and Jablensky A (2001) *Duty to Care: Preventable Physical Illness in People with Mental Illness*, Perth: University of Western Australia. This report is discussed further below.

<sup>4</sup> Victorian Health Promotion Foundation (2008) 'Burden of disease due to health inequalities' and 'Key influences on health inequalities', Melbourne: Victorian Health Promotion Foundation.

<sup>5</sup> Jablensky A, McGrath J, Herrman H, Castle D, Gureje O, Morgan V and Korten A (1999) *People Living with Psychotic Illness: An Australian Study 1997-98*, National Survey of Mental Health and Wellbeing Report 4, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing. This study was part of the first National Survey of Mental Health

interviews with 980 participants using a specifically designed instrument covering a range of socio-demographic details including occupation, income, education, housing and relationships.

The study found that 72.0% of respondents were unable to describe a regular occupation (broadly defined to include paid work as well as study, home duties, parenting and other vocational roles) and 85.2% were reliant on a government pension or social benefit (in particular the disability pension) as their main source of income. Almost half (47.8%) had not completed their schooling or gained any post-school qualifications; and whilst many lived in relatively stable forms of housing (e.g. public/private rental properties, family homes, their own homes, or supported housing) a concerning proportion (42.0%) were housed in tenuous accommodation types (e.g. institutional settings, hostels, boarding houses, rented rooms, crisis accommodation, shelters) or were homeless. Almost one-third (31.3%) lived alone and only 9.3% had a person at home they could describe as a carer.

More information on the lack of critical resources amongst people with severe mental illness can be found in the companion papers: 'Housing and Support', 'Economic Participation: employment and education' and 'Social Inclusion'.

### **Mental illness and chronic disease: the policy context**

The extent of physical illness experienced by people with severe mental illness is even more concerning when set against the backdrop of contemporary public health discourse and the focus on preventing major chronic diseases at the population level—or at least intervening as early as possible. Included here are key policy directions and initiatives such as:

- The *National Chronic Disease Strategy*. This strategy was endorsed at the Australian Health Ministers' Conference in 2005 and provides a framework for all jurisdictions to improve chronic disease prevention and treatment through a population-based approach to health inequalities and an emphasis on integrated and multidisciplinary care planning. The self-management of chronic disease also gained prominence through this strategy, and is named as one of four key action areas along a continuum from prevention to care. The *Sharing Health Care Initiative* currently invests in a range of self-management of chronic disease education interventions.<sup>6</sup>
- The new *National Preventative Health Care Strategy*. This strategy will provide a 'blueprint' for further tackling the burden of chronic disease through an explicit focus on early intervention in the primary care setting (rather than later intervention in the acute setting). The recently announced *National Primary Health Care Strategy* is part of this 'blueprint' and

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and Wellbeing. The second National Survey of Mental Health and Wellbeing was conducted in 2007 with preliminary results available in late 2008.

<sup>6</sup> Evidence suggests that consumers with effective self-management skills make better use of health care professionals' time and acquire enhanced self care. Further study, however, is required to validate the use of self-management tools for specific groups such as people living with severe mental illness. The *Sharing Health Care Initiative* currently offers grants to fund research aimed at expanding the range of evidence-based self-management of chronic disease interventions. Hard-to-reach groups such as Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse populations, and people experiencing socio-economic disadvantage are particularly identified as the focus for research.

includes a review of Medicare Benefits Schedule (MBS) items to better support general practitioners in the prevention and management of chronic conditions.

Also central to the *National Primary Health Care Strategy* is the development of GP-centred primary care models (e.g. GP 'super clinics') for communities with high unmet needs for services and/or high levels of (or risks for) chronic diseases.

- The recently-established National Health and Hospitals Reform Commission (NHHRC). This Commission will provide expert advice on performance benchmarks and practical reforms to meet current and future health challenges (e.g. the growing burden of chronic diseases). The Commission reports to the Federal Health Minister (and through her to the Prime Minister), the Council of Australian Governments (COAG) and the Australian Health Ministers Conference; and has been directed by Cabinet to develop a long-term national health reform plan (interim by the end of 2008 and final by mid 2009). A central part of the reform includes revising the Australian Health Care Agreements to accommodate funding focus beyond acute care to include prevention.
- The Victorian *Care in Your Community* initiative. This initiative has long recognised the impacts of a handful of chronic disease causes on the total burden of disease, including conditions that are either preventable or capable of being managed in community-based rather than bed-based hospital care. The *Chronic Disease Management Program Guidelines for Primary Care Partnerships and Community Health Services* underscore the importance of self-management in integrated chronic disease management framework.

Mental illness is often included in the group of chronic diseases targeted by these interventions, along with cardiovascular diseases, cancers, injuries, diabetes and asthma. But there is very little focus on people with mental illness—in particular, severe mental illness—as a distinct population group at high risk for a range of other chronic (physical) health conditions. It is as if people with mental illness need only to deal with their mental illness and nothing else. This suggests that despite all of this swimming 'upstream' by decision makers to prevent chronic diseases or intervene as early as possible, the development of specific responses that can effectively address the physical health problems (and poor health status) of people living with severe mental illness is yet to be seen.

## **Health status of people with severe mental illness**

### *Mortality rate*

The mortality rate of people with mental illness (both low and high prevalence) was revealed in a major population-based record linkage study in Western Australia.<sup>7</sup> The study reviewed the physical health experiences of over 240,000 people registered on the Mental Health Information System for a period of almost two decades. The study found that the death rate of people with a mental illness is considerably higher than the population in general. Overall, the death rate of people with mental illness is 2.5 times greater than that of the general population, which is equivalent to a life expectancy of 50 - 59.

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<sup>7</sup> Lawrence et. al. op. cit. p. xi.

The study found a higher rate of death across each of the main physical causes, with heart disease causing the highest number of 'excess' deaths.<sup>8</sup> Indeed, the death rate from heart disease has not declined for this group in recent years, in stark contrast to the general population where health promotion and early intervention efforts seem to have made a difference. The rate of death through heart disease has actually increased substantially in the case of women with mental illness.

The study also found that the number of deaths in people with a mental illness, due to main physical causes, far exceeds the number of hospital admissions for related conditions. This suggests that conditions such as heart disease are not being picked up or treated until it is too late, and raises serious questions about the adequacy of the level of care received by this group. Cancer is another example: whilst incidence rates appear to be no different for people with mental illness and the general population, people with mental illness are 30.0% more likely to die from a cancer diagnosis (later detection means poorer prognosis).

Studies show that people with schizophrenia have a mortality rate that is up to three times higher than that of the general population.<sup>9</sup> Whilst a high number of deaths in this group can be attributed to suicide, an excess mortality is nonetheless associated with a range of physical health conditions. A Victorian study has established that patients with schizophrenia are 2.9 times more likely to die of causes such as cardiovascular disease than people in the general population.<sup>10</sup> According to the WA linkage study, people with affective psychoses have an excess mortality associated with pneumonia, influenza and chronic obstructive pulmonary disorder. The study also shows that people with other psychoses, experience consistently elevated mortality rates across all main physical causes.<sup>11</sup>

### *Morbidity experience*

Living with a severe mental illness already carries significant morbidities. However, these are often amplified through the coexistence of morbidities associated with physical health issues. Detection of chronic conditions and early intervention (not to mention prevention) remain problematic for people with mental illness who generally receive far too little attention from health service providers for their physical health needs. When considered alongside the excess mortality figures, the picture that emerges is of a group of people with complex health needs experiencing a range of morbidities for longer than necessary before being addressed (if ever) and often dying earlier as a result.

Scanning the literature, Lambert et al. provide a list of physical conditions found in patients with severe mental illness.<sup>12</sup> These include diabetes, hyperlipidaemia, cardiovascular and respiratory disorders, obesity, malignant neoplasms, HIV/AIDS, Hepatitis C, hyperprolactinaemia, osteoporosis and irritable bowel syndrome. Some conditions are related

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<sup>8</sup> 'Excess' deaths are the number of deaths above what can be expected in the general population.

<sup>9</sup> Lubman D and Sundram S (2003) 'Substance misuse in patients with schizophrenia: A primary care guide' in *MJA Supplement*, 178, 71-5.

<sup>10</sup> Ruschena D, Mullen PE and Burgess P (1998) 'Sudden death in psychiatric patients' in *British Journal of Psychiatry*, 172, 331-6 as cited in Lambert JR, Velakoulis D and Pantelis C (2003) 'Medical comorbidity in schizophrenia' in *MJA Supplement*, 178, 67-70.

<sup>11</sup> Lawrence et al., op. cit., p. 36.

<sup>12</sup> Lambert et al. op. cit., p. 67.

to the side effects of medications; others derive from health behaviours that carry high risks for poor outcomes (see further below). The connections between physical health conditions and their contributing factors appear to be well documented in the literature, and practitioner awareness and response to consumer needs should be high. But they are not.

The authors of the WA linkage study similarly provide a list of physical health conditions associated with low-prevalence disorders. Added to the list by Lambert et al. are Parkinson's disease, accidental poisonings (related to prescribed and illicit substance use) and injuries inflicted on the person (whether in response to violent behaviour or victimisation). There is evidence of poor nutrition through inadequate diet as well.<sup>13</sup>

Lambert et al. note further that people with severe mental illness often experience elevated rates of comorbidities due to high-risk health behaviours interacting with mental illness and vice versa. Cigarette smoking, for example, is not only a risk factor for cardiovascular and respiratory conditions. By reducing available plasma levels of anti-psychotics, smoking may also influence a patient's behaviour and treatment outcomes. The cognitive and behavioural deficit symptoms of schizophrenia, compounded by the effects of certain drugs, may orient patients towards selecting certain foods that are high in fats and low in fibre (e.g. 'fast foods'), in turn, leaving them even more de-energised and unable to address their obesity or poor nutrition.<sup>14</sup>

Problematic substance use is common in people with schizophrenia and many have a dual diagnosis of mental illness and alcohol/other drug related disorders.<sup>15</sup> In Victoria, it is estimated that 20-50% of new clients of adult mental health services present with a coexisting substance abuse problem; and the prevalence rate is even higher for young adults.<sup>16</sup> According to Teeson et al., when compared to people with a single condition (that is, either a mental illness or an alcohol or other drug disorder) those experiencing dual diagnosis have higher rates of violence, suicidal behaviour, suicide, anti-social behaviour, and physical health problems such as infections.<sup>17</sup> Having a dual diagnosis can also increase the symptom severity of both conditions and impact adversely on treatment and recovery. Drug use and symptoms of withdrawal can either mimic or conceal some psychiatric symptoms making diagnosis and treatment of mental illness more complex; cognitive impairments resulting from both disorders can increase the difficulty of identification and management of a dual diagnosis.<sup>18</sup>

People living with severe mental illness experience persisting poor levels of oral health e.g. poor gingival health and decaying teeth. Poor oral health adds to the overall morbidity experience of this group and is associated with a range of factors including side effects of certain medications, neglect of personal oral care, poor diet (see further below) and irregular use of dental services until emergency care is required.<sup>19</sup> According to one community health

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<sup>13</sup> Lawrence et al. op. cit., p. 65, p. 93 and p. 95.

<sup>14</sup> Lambert et al. op. cit., p. 68.

<sup>15</sup> Lawrence et al. op. cit., p. 95.

<sup>16</sup> State Government of Victoria (2008) *Because Mental Health Matters: A New Focus for Mental Health and Wellbeing in Victoria*, Consultation Paper, Melbourne: Victorian Government Department of Human Services, p. 32.

<sup>17</sup> Teeson M and Proudfoot H (eds) (2003) *Comorbid Mental Disorders and Substance Use Disorders: Epidemiology, Prevention and Treatment*, Report for the National Drug Strategy, Canberra: Commonwealth Department of Health and Ageing as cited in State Government of Victoria (2007) *Dual Diagnosis: Key Directions and Priorities for Service Development*, Melbourne: Victorian Government Department of Human Services, p. 5.

<sup>18</sup> State Government of Victoria (2007) op. cit., p. 7.

<sup>19</sup> North Richmond Community Health Centre, Oral Health Program, 'Mental illness and oral health' available at <http://www.nrchc.com.au/oralhealth/> and accessed 04/07/08.

service in inner Melbourne, it is common to find people with severe mental illness missing several or all of their teeth, and gum disease is more pronounced in this population.<sup>20</sup> It is noted that full extraction was often performed on inpatients in the days of institutionalisation as a protective measure against biting carers. Another community health service offering dental services to Health Care Card holders in Melbourne's western suburbs reports that on average it provides 23.0% more treatment services to their mental health clients than all other clients, with this group requiring 10.0% more restorations and 36.0% more extractions than everyone else.<sup>21</sup>

### *Health behaviours*

There is ample evidence in the literature that living with severe mental illness is associated with a range of health behaviours that carry high health risks. These include smoking, alcohol and other drug use, obesity and poor diet, underactivity and lack of exercise: all contributing factors to the morbidity experience and mortality rate.

As noted in the WA linkage study, smoking—a major risk factor for cardiovascular and respiratory conditions and lung cancer—is a common activity of people living with severe mental illness.<sup>22</sup> The research by the Low Prevalence Study Group found that 73.2% of male patients with psychotic disorders and 56.3% of female patients were current smokers. Moreover, of those who smoke, over one quarter (27.6%) reported a daily consumption of 30 or more cigarettes.<sup>23</sup> It is further noted that whilst the high smoking rates can be explained by a range of reasons (including self-medication), cigarettes are expensive and place a high financial burden on this group. Those who smoke are often least able to afford it; but smoking cessation devices, such as nicotine patches, are even less affordable.<sup>24</sup>

Alcohol and illicit drug use is common amongst people living with severe mental illness. In the Low Prevalence Study Group research, 11.5% of respondents described themselves as lifetime abstinent. Of those who had ever used alcohol, more than one-third (37.7%) reported drinking either daily or on several days a week in the 12 months prior to the interviews. A lifetime diagnosis of alcohol abuse or dependency was made in 30.0% of the sample. Meanwhile, 48.5% of respondents reported illicit drug use on one or more occasions. The most frequently used substance by far was cannabis. Amphetamines, LSD, heroin and tranquillisers were also reported by respondents, with the use of cocaine, phencyclidine and inhalants/solvents less prevalent. Poly drug use was, however, a recurring theme in 19.1% of respondents. A lifetime diagnosis of cannabis abuse was made in 25.1% of the sample, and a lifetime diagnosis of other substance abuse/dependence was made in 13.2%.<sup>25</sup>

There are several reasons identified in the literature for substance use amongst this group.<sup>26</sup> These include social-environmental factors, e.g. socio-economic deprivations that place people

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<sup>20</sup> Burchell A, Fernbacher S, Lewis R and Neil A (2006) "Dental as anything" Inner South Community Health Service dental outreach to people with a mental illness' in *Australian Journal of Primary Health*, 12:2, pp. 75-82.

<sup>21</sup> Correspondence with the CEO at the Western Regional Health Centre.

<sup>22</sup> Lawrence et al. op. cit., p. 7.

<sup>23</sup> Jablensky et al. op. cit., p. 41.

<sup>24</sup> Access Economics (2007) *Smoking and Mental Illness: Costs*, Report for SANE Australia, Canberra: Access Economics, p. iv.

<sup>25</sup> Jablensky et al. op. cit., pp. 41-42.

<sup>26</sup> Lawrence et al. op. cit., pp. 7-8.

with severe mental illness in close proximity to others using alcohol and illicit drugs. There may also be a biological disposition to substance use. There are self-medication reasons behind substance use as well, (adverse states induced by either the mental illness or its treatment can be mediated by psychoactive substances).

People living with severe mental illness have high rates of obesity and poor diet, e.g. consumption of foods that are high in saturated fats and low in fibre.<sup>27</sup> The WA linkage study provides evidence of weight gain as a side effect of certain medications; however, it is highly likely that the experience of obesity and poor diet is associated with lower socio-economic status, inadequate living conditions, and food insecurity experienced by this group.

## **Barriers to Accessing Health Services**

### *Disjointed service system*

Despite the excess mortality caused by physical illness and the morbidity experience arising from a range of physical health issues and high-risk behaviours, it is all too common for the physical health needs of people with severe mental illness to go unmet by health professionals. At the core of this problem is a disjointed service system. There is poor intersectoral collaboration, knowledge transfer and resource sharing between the mental health service sector and other health services such as primary care. The location of clinical mental health services in the acute/sub-acute setting further distances sections of the mental health sector from the rest of the service system. There is also a 'silos within silos' effect, with different parts of the mental health system disjointed from each other. Lack of continuity of care *within* the mental health system and *between* mental health and health services combine to create fragmented service delivery—not to mention frustration, dissatisfaction and ultimately poor outcomes for service users. As noted by the Mental Health Council of Australia, consumers end up shifting between mental health services and other health services without receiving truly effective (holistic) treatment from anyone.<sup>28</sup>

### *Blinkered mental health policy*

Currently in Victoria there is a significant process in place to review and reform the mental health service system. *Because Mental Health Matters* is a consultation paper that explores new directions for mental health in Victoria, building on the COAG *National Action Plan on Mental Health 2006-2011* and the report, *Improving Mental Health Outcomes in Victoria*, commissioned by the Victorian Government in 2006. The paper makes a strong case for changing a currently overburdened and crisis-driven mental health system, which has a capacity to provide care only to those in most urgent need of it. As noted in the paper, many consumers have experienced severe symptoms of mental illness by the time community-based clinical care is provided—often in an acute inpatient service via the police, ambulance, a crisis team and/or a hospital emergency department. The paper goes on to state that this situation:

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<sup>27</sup> Lawrence et al. op. cit., p. 76.

<sup>28</sup> Mental Health Council of Australia, 'Access to health services by people with mental illness', available at [http://www.hreoc.gov.au/disability\\_rights/health/mhca.doc](http://www.hreoc.gov.au/disability_rights/health/mhca.doc) and accessed 04/07/08.

*Can be compared to not treating a person with cardiovascular disease until they are experiencing a heart attack. Such a response is now generally regarded as unacceptable in respect to a physical health problem, and the same should apply to mental health treatment and care.<sup>29</sup>*

What the paper fails to acknowledge is that mental health consumers are not being treated for cardiovascular disease, as well as a range of other chronic physical conditions, until it is too late, and that this is unacceptable. Whilst the paper does mention the increasing 'complexity of client needs' in those with comorbid substance misuse and/or physical health problems, there is little mention anywhere—not even in the named focus area of partnerships—of a new direction towards an integrated and comprehensive mental health and health service response to meet such need (the exception being in the case of Indigenous people with mental health and physical health issues).

### *Practitioner factors*

A disjointed service system creates a huge divide between practitioners. On one side are mental health specialists, e.g. clinical workers and, to some extent, PDRS workers, who typically overlook the physical health issues of their patients. The WA linkage study cites a number of studies showing why this happens.<sup>30</sup> Some specialists may regard physical complaints as psychosomatic symptoms (referred to as 'diagnostic overshadowing') or may be focused solely on the presenting psychiatric problems. Others may regard smoking and other substance use as self-medicating and so do nothing to address the physical health consequences associated with these high-risk behaviours (and even tacitly encourage it). Still, others feel they lack competence in undertaking physical examinations, or that, as specialists, they shouldn't have to deal with primary care issues, or that their patients are too troublesome for physical examinations to be done. There are also time and resource limitations to conducting physical examinations in the mental health services setting.<sup>31</sup>

On the other side are primary care providers who are also reluctant to treat people with severe mental illness for their physical health issues, this time due to lack of knowledge, misconception, fear and stigma related to mental illness. There are some practitioners who dislike psychiatric patients and feel they are disruptive in the primary care setting.<sup>32</sup> According to Lubman and Sundram, dual diagnosis clients seem to evoke particularly powerful unpleasant feelings in health professionals who can be overwhelmed by the complexity of presenting problems and unclear about which issue to tackle first.<sup>33</sup> Other practitioners feel they lack adequate training in mental health issues to provide an appropriate service to this client group.<sup>34</sup> Still, others believe that too much extra effort is required to obtain a full medical history and informed consent, or that patient compliance to treatment courses will be too difficult to achieve, and so leave physical health needs unaddressed.<sup>35</sup> There are also significant time and resource limitations within current funding models to providing quality primary care services to this

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<sup>29</sup> State Government of Victoria (2008) op. cit., p. 77.

<sup>30</sup> Lawrence et al. op. cit., pp. 8-10.

<sup>31</sup> Lambert et al. op. cit., p. 69.

<sup>32</sup> Lawrence et al. op. cit., p. 9.

<sup>33</sup> Lubman and Sundram, op. cit., p. 72.

<sup>34</sup> Lawrence et al. op. cit., p. 9.

<sup>35</sup> Lambert et al. op. cit., p. 69.

group, and often the real costs of delivering services need to be borne elsewhere (e.g. by the provider). This can act as a major disincentive on the part of providers to undertake consultations for people with severe mental illness.<sup>36</sup>

Whatever side of the equation, the results are the same. People living with severe mental illness 'fall between the cracks' of two service systems leaving a range of physical conditions ignored and untreated.<sup>37</sup> The most distressing part about this is that many of the conditions contributing to the morbidity experience and excess mortality of this group are avoidable through prevention or early intervention strategies; and that such strategies are actively promoted and applied to the general population. People with severe mental illness are therefore being denied the same level of health care provision enjoyed by the rest of the community in what effectively amounts to discrimination.

### *Patient factors*

There are some barriers to accessing health services that lie on the side of the patient.<sup>38</sup> There may be a higher threshold to pain due to the effects of certain medications leaving consumers unaware of physical health issues. There may be an inability to describe/communicate problems, wait for/keep appointments, and follow treatment instructions due to cognitive and behavioural deficit symptoms. Consumers of mental health services may not be linked into the primary care system or may actively avoid contact with general health care services due to lived realities of stigma and fear of discrimination. Some patients may feel too overwhelmed by the thought of carrying out the changes required to improve their physical health.

The cost of accessing health care is a significant barrier and low-income consumers are limited to the ever-diminishing pool of providers who bulk bill. Allied health practitioners not covered by MBS subsidies can limit access to options for physical health issues. There are associated costs with getting to appointments as well.<sup>39</sup>

### **What is good practice?**

This discussion has demonstrated that there is an urgent need to bring together mental health care and physical health care into an integrated and multidisciplinary approach for people living with severe mental illness. This will not only make their experience of health care better; it will reduce existing health inequalities by attending to physical health needs earlier and more effectively. Indeed, there is a need to see specific chronic disease prevention and early intervention strategies developed and implemented for this group. Such strategies would need to be accompanied by assertive outreach and proactive health care in all parts of the service system to ensure that people living with severe mental illness receive attention to their physical health needs.

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<sup>36</sup> Consultation with VICSERV Reference Group.

<sup>37</sup> Lambert et al. op. cit., p. 69.

<sup>38</sup> Ibid.

<sup>39</sup> Mental Health Council of Australia, 'Access to health services by people with mental illness', available at [http://www.hreoc.gov.au/disability\\_rights/health/mhca.doc](http://www.hreoc.gov.au/disability_rights/health/mhca.doc) and accessed 04/07/08.

A dearth of good practice models exists; however, Lambert et al. suggest the following elements as helpful for improving service provision:<sup>40</sup>

- Routine use of a standard checklist and collection of core information concerning physical health amongst *all* health professionals.
- Adequate resourcing of psychiatric services to carry out physical health tasks.
- Refresher training for psychiatrists (and key members of multidisciplinary community psychiatric teams) that includes elements of detection, management and prevention of physical health conditions.
- Specific multidisciplinary teams with broad medical and psychiatric expertise and training as the basis for enhanced models of shared care.
- Formalised programs to address training and other issues at regional or state levels.

Internationally, elements of good practice can also potentially be drawn from the UK Department of Health's *Choosing Health: Supporting the Physical Health Needs of People with Severe Mental Illness Commissioning Framework*.<sup>41</sup> These practice guidelines are part of the national mental health policy agenda, which focuses on the core themes of integration, recovery and social inclusion. The framework includes many examples of programs established to support people living with mental illness attain and maintain positive physical health outcomes, such as:

- Employing physical health staff in inpatient wards and developing in-reach services.
- Investment in linkages between primary and sub-acute/acute care e.g. the development of dedicated 'physical health link' workers.
- Improvement in referrals and other aspects of service coordination.
- Specific programs that deliver individual or group interventions such as smoking cessation for people with schizophrenia, walking groups, Yoga and Pilates sessions, health and wellbeing days.

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<sup>40</sup> Lambert et al. op. cit., p. 69.

<sup>41</sup> UK Government (2006) *Choosing Health: Supporting the Physical Health Needs of People with Severe Mental Illness, Commissioning Framework*, London: Department of Health.