Mental Health Draft Report
Submission from Cancer Council Australia and the National Heart Foundation
of Australia
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To the Commission,

Cancer Council Australia and the National Heart Foundation of Australia welcome the Productivity Commission's [draft report on Mental Health](#) ("the draft report") and the opportunity to make a submission.

Cancer Council Australia and the National Heart Foundation of Australia are non-government, not-for-profit organisations, with no religious or political affiliations. Both organisations work to reduce the impact of cancer and cardiovascular disease (respectively) in Australia, and both have a proud history of strong action on tobacco control.

The Productivity Commission's report on Mental Health is critical to set Australia on a path for maintainable long term reform of its mental health system. Cancer Council Australia and the National Heart Foundation of Australia share the concerns outlined in the report and fully support the need for urgent action to improve the mental health services and systems in Australia.

However, our organisations are equally as concerned with the limited recognition of the significant impact of chronic disease on the physical health and life expectancy of people living with a mental illness, throughout such an important report, which will guide future direction for long term reform of Australia's mental health system. The separation of mental and physical health services has been found to contribute to the poor physical health of people living with mental illness, and an integrated approach to the prevention and treatment of co-morbidities is required.

The draft report acknowledges that people living with mental illness experience poor physical health, which can have serious consequences up to and including premature death in chapter nine, 'Physical and substance use comorbidities' (volume 1). The same chapter also highlights the importance of wider systemic reforms as an important enabler for addressing poor physical health. However there is opportunity for greater recognition of the impact and urgent action required to prevent and treat poor physical health among people living with a mental illness throughout the Commission's Final report.

People living with mental illness are more likely to have a number of risk factors that predispose them to chronic disease; however tobacco smoking is the largest contributor to the disease burden. There is a wealth of evidence about the prevalence and impact of tobacco smoking among people living with mental illness, and also effective system-wide interventions.

Therefore this submission focuses on the impact of tobacco smoking as a key contributor of chronic disease among people living with a mental illness, and as a contributor to poor mental health. It also discusses the benefits of addressing tobacco smoking in people living with a mental illness, as a rationale for greater and

urgent action to address tobacco smoking systematically across all mental health services, to improve the health and productivity outcomes of people living with a mental illness. The submission reinforces the importance of, and provides best practice examples of embedding a systematic approach to smoking cessation across all mental health services and developing and implementing tailored, evidence-based interventions for people living with a mental illness to address smoking

With this mind, this submission strongly recommends the following inclusions as a significant part of the Commission's Final report:

1. An in-depth account of the impact of tobacco smoking on the physical health of people living with mental illness.
2. Actions required by mental health services and systems in Australia to address tobacco smoking in people living with a mental illness based on current best evidence and practice. This includes embedding a systematic approach to smoking cessation across all mental health services and; developing and implementing tailored, evidence-based interventions for people living with a mental illness to address tobacco smoking as a means of preventing chronic disease.

The impact of tobacco smoking as a key contributor of chronic disease among people living with a mental illness.

People living with a mental illness are at an unacceptably higher risk of chronic disease compared to the general population, in fact nearly 60% of people living with a mental illness have at least one or more chronic diseases.[1] Evidence suggests that people living with a serious mental illness are:[2]

- More likely to die from cardiovascular disease
- Two to three times more likely to be diagnosed with type 2 diabetes
- More likely to be diagnosed with a respiratory disease and type 2 diabetes or have a stroke at a younger age (under 55)
- 90% more likely to be diagnosed with bowel cancer (particularly if they have schizophrenia)
- 42% more likely to be diagnosed with breast cancer (in women with schizophrenia)

High rates of chronic disease are predominantly due to the higher prevalence of risk factors such as tobacco smoking, as well as obesity and overweight, poor diet, inadequate physical activity and alcohol consumption. Preventing the development of chronic disease in people with a mental illness, by addressing these risk factors, particularly tobacco smoking, has clear economic, social and productivity benefits.

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[1] Harris B, Duggan M, Batterham P, Bartlem K, Clinton-McHarg T, Dunbar J, et al. Australia's mental and physical health tracker.
[2] Keeping Body and Mind Together: Improving the physical health and life expectancy of people with serious mental illness. Melbourne. The Royal Australian and New Zealand College of Psychiatrists. 2015.

The life expectancy gap between people living with a mental illness and the general population is estimated to be 10 to 20 years less, with tobacco smoking as one of the largest contributory factors in this difference.[3] For every one death attributable to suicide among people living with a mental illness, ten deaths are due to chronic disease.[4] In large part, this is because two out of three smokers die prematurely because of their smoking.[5]

Smoking rates specifically remain much higher in people living with a mental illness, compared with the general population. Women living with a mental illness are nearly 70% more likely to be smokers, and men living with a mental illness are nearly 40% more likely, compared to the general population.[6] In addition, smoking prevalence tends to increase alongside the severity of the mental illness[7] and rates also vary by diagnosis, with 25% of people with depression being daily smokers and up to 47% of people with schizophrenia[8] (compared with 12.2% of the general population[9]). Co-morbid mental illness and drug or alcohol use sees smoking prevalence rates at up to 70%.[10]

More broadly, the social costs attributed to chronic disease among people living with a mental illness are significant. A report by the Royal Australian & New Zealand College of Psychiatrists shows the cost of premature death in people with serious mental illness with a comorbid physical illness at $A15 billion annually.[11] Treatment costs dramatically increase for co-morbid physical and mental illness, with one study identifying a significantly higher (33% to 169%) cost of care in people with co-morbid depression and a chronic physical illness compared to the physical illness alone (and excluding mental health service costs).[12]

Any kind of long-term reform of the Australian mental health system must acknowledge that people living with a mental illness are at much greater risk of chronic disease compared to the general population. To improve productivity for

[3] Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population-based registers. British Medical Journal. 2013;346:f2539.

[4] Roberts R, Lockett H, Bagnall C, Maylea C, Hopwood M. Improving the physical health of people living with mental illness in Australia and New Zealand. Australian Journal of Rural Health. 2018;26:354-362.

[5] Banks E, Joshy G, Weber MF, Liu B, Grenfell R, et al. Tobacco smoking and all-cause mortality in a large Australian cohort study: Findings from a mature epidemic with current low smoking prevalence. BMC Medicine, 2015; 13(1):38

[6] Harris B, Duggan M, Batterham P, Bartlem K, Clinton-McHarg T, Dunbar J, et al. Australia's mental and physical health tracker.

[7] Mendelsohn CP, Kirby DP, and Castle DJ. Smoking and mental illness. An update for psychiatrists. Australas Psychiatry, 2015; 23(1):37–43.

[8] Australian Bureau of Statistics Table Builder, using data from the National Health Survey 2014–15.

[9] Australian Institute of Health and Welfare. National Drug Strategy Household Survey (NDSHS). 2106 key findings tables. Canberra: AIHW, 2017. Available from: https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data

[10] Australian Bureau of Statistics Table Builder, using data from the National Health Survey 2014–15.

[11] Royal Australian & New Zealand College of Psychiatrists and Australian Health Policy Collaboration. The economic cost of serious mental illness and comorbidities in Australia and New Zealand: a report for the Royal Australian & New Zealand College of Psychiatrist and the Australian Health Policy Collaboration by Victoria Institute of Strategic Economic Studies. Melbourne RANZCP 2016.

[12] Duggan M. Beyond the fragments: Preventing the costs and consequences of chronic physical and mental diseases. Australian Health Policy Collaboration. Issues paper No.2015-05. Australian Health Policy Collaboration, Melbourne. 2015.

people living with a mental illness, all facets of their health must be considered, specifically contributing risk factors such as tobacco smoking.

The impact of tobacco smoking as a contributor to poor mental health
As well as increased mortality, smoking in people living with a mental illness has been associated with worsened psychiatric symptoms, increased hospitalisations, and – higher dosages for psychiatric medications (due to accelerated medication metabolism caused by tobacco smoking)[13][14]

Evidence also suggests that, amongst people diagnosed with a mental illness such as psychosis, smoking increases the risk of suicidal behaviour.[15] Evidence has also shown that smoking can increase the risk of anxiety, depression and psychotic disorders including schizophrenia.[16,17]

Furthermore, smoking increases financial stress among people living with mental illness and plays a pivotal role in the cycle of poverty and disadvantage experienced by people living with mental illness.[18] It was estimated that in Australia in 2000, of those with a psychotic illness who smoked and were in receipt of a disability support pension, spent more than one-third of their pension on tobacco products.[19] This is acerbated due to people living with a mental health illness smoking more heavily and intensely than the general population.[20]

Benefits of addressing tobacco smoking in people living with a mental illness
Smokers with co-occurring mental illness (or substance use disorders) have limited access to smoking cessation treatment, have smoked for a longer duration, and have lower rates of successful quit attempts.[21] People living with mental health illness have often cited a lack of support from service providers, stress management and the normality of smoking among their peers as barriers to quitting smoking.[22]

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[13] Prochaska JJ. Smoking and mental illness-breaking the link. The New England Journal of Medicine. 2011;365:196-8.
[14] Banham L, Gilbody S. Smoking cessation in severe mental illness: What works? Addiction. 2010;105:1176-89.
[15] Sankaranarayanan A, Castle D. Burden associated with smoking as a suicidal risk factor in an Australian sample of patients with psychosis. Australas Psychiatry. 2016;24(5):437-40.
[16] Pedersen W, von Soest T. Smoking, nicotine dependence and mental health among young adults: a 13 year population-based longitudinal study. Addiction. 2008;104(1):129-137.
[17] De Leon J, Diaz FJ. A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviours. Schizophrenia Research. 2005;76(2-3):135-57.
[18] Lawn S. Australians with mental illness who smoke. British Journal of Psychiatry, 2001; 178(1):85. Available from: http://www.biomedcentral.com/content/pdf/1471-2458-5-138.pdf
[19] Greenhalgh, EM, Scollo, MM, & Pearce, M. 9.6 Smoking, ill-health, financial stress and smoking-related poverty among highly disadvantaged groups. In Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2016. Available from: www.tobaccoinaustralia.org.au/chapter-9-disadvantage/9-6-smoking-ill-health-financial-stress-and-smokin
[20] Greenhalgh, EM., Stillman, S., & Ford, C. 7.12 Smoking and mental health. In Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2018. Available from http://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-12-smoking-and-mental-health
[21] Greenhalgh, EM, Scollo, MM, & Pearce, M. 9.6 Smoking, ill-health, financial stress and smoking-related poverty among highly disadvantaged groups. In Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2016. Available from: www.tobaccoinaustralia.org.au/chapter-9-disadvantage/9-6-smoking-ill-health-financial-stress-and-smokin
[22] Twyman L, Bonevski B, Paul C, Bryant J. Perceived barriers to smoking cessation in selected vulnerable groups: a systematic review of the qualitative and quantitative literature. BMJ open. 2014 Dec 1;4(12):e006414.

While attempting to quit smoking can be challenging[23] and require intensive support to be successful, there is evidence that people living with a mental illness want to stop smoking and can do so.[24] Even in people who smoke and have been admitted to hospital for a mental illness, 65% had an interest in smoking cessation.[25] However, they are less likely to receive best-practice smoking cessation care, yet by ensuring access to best-practice smoking cessation care, there are mental health, general health benefits and socioeconomic benefits.

While people living with mental illness and mental health workers often perceive smoking to be helpful in relieving or managing psychiatric symptoms,[26] recent evidence suggests the opposite; quitting smoking for at least six weeks actually improves mental health, mood, and quality of life, both among the general population and among people with a psychiatric disorder.[27]

Chapter 20 'Social participation and inclusion' (Volume 2) of the draft report acknowledges that socioeconomic disadvantage is a major barrier to social participation, and is strongly associated with mental ill-health. As above, tobacco smoking exacerbates financial stress and reinforces socioeconomic disadvantage experienced by people living with mental illness. For individuals, stopping smoking can help to alleviate financial stress and enable improved social inclusion. For example, an individual who smokes 20 cigarettes a day can save around $A9855 a year upon quitting,[28] lessening their financial stress, with the potential to reallocate spending to healthier choices. This case study of 'Jack' illustrates the financial relief and greater social inclusion as a result of stopping smoking.

In addition, upon smoking cessation, medication dosages for people living with a mental illness may be able to be reduced.[29,30] This has the potential not only to save individuals money, but also reduce mental health care costs nationally.

Embedding a systematic approach to smoking cessation across all mental health services (as well as the entire health system).
Addressing tobacco smoking and other risk factors in people living with a mental illness, as a means of preventing chronic disease development, needs to occur in a

[23] Cook BL, Wayne GF, Kafali EN, Liu Z, Shu C, et al. Trends in smoking among adults with mental illness and association between mental health treatment and smoking cessation. Journal of the American Medical Association, 2014; 311(2):172–82.

[24] Prochaska JJ. Failure to treat tobacco use in mental health and addiction treatment settings: A form of harm reduction? Drug and Alcohol Dependence, 2010; 110(3):177–82.

[25] Siru R, Hulse GK, Tait RJ. Assessing motivation to quit smoking in people with mental illness: a review. Addiction. 2009; 104:719–33

[26] Mendelsohn CP, Kirby DP, and Castle DJ. Smoking and mental illness. An update for psychiatrists. Australas Psychiatry, 2015; 23(1):37–43. Available from: http://www.ncbi.nlm.nih.gov/pubmed/25512967

[27] Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, et al. Change in mental health after smoking cessation: Systematic review and meta-analysis. British Medical Journal, 2014; 348:g1151. Available from: http://www.ncbi.nlm.nih.gov/pubmed/24524926

[28] Australian Retail Tobacconist. Volume 108 October-November-December 2018. Based on an "average pack" of 20 cigarettes, at an average cost of $27AUD/pack.

[29] Lucas C, Martin J. Smoking and drug interactions. Australian Prescriber 2013;36:102-104.

[30] NHS/Specialist Pharmacy Service/UKMi. Medicines Q&As. (UKMi Q&A 136.4) What are the clinically significant drug interactions with cigarette smoking? Prepared November 2017. Available https://www.sps.nhs.uk/wp-content/uploads/2017/11/UKMI_QA_Drug-interactions-with-smoking-cigarettes_update_Nov-2017.pdf

systematic way across the health sector. Relying on individual practice change at the clinician level alone is not sufficient.

An example of this is the [Tackling Tobacco framework, developed by Cancer Council NSW](). Tackling Tobacco takes an organisational change approach to addressing tobacco smoking in health and community services.[31] The framework consists of six key elements including committed leadership; comprehensive smoke free policies; supportive systems; consistent quit supports; training and follow up; and systematic monitoring and data collection.

Cancer Council has recently undertaken a cluster randomized controlled trial evaluating the effectiveness of the Tackling Tobacco program at changing workplace culture and increasing provision of smoking cessation care by community mental health professionals. Initial results have demonstrated that the Tackling Tobacco program is effective at changing staff practice. Staff within participating services were more confident in addressing tobacco and more likely to offer consumers support to quit after completing the six-month program. A Summit was held at the conclusion of the trial with 55 key stakeholders representing community and clinical mental health, government and peak bodies to co-create a five-year strategic plan to reduce the prevalence of smoking amongst consumers of community managed mental health services. Implementation and monitoring of the strategic plan is led by Cancer Council NSW and informed by the six elements of the Tackling Tobacco framework.

In Victoria, this framework has been successfully embedded in mental health pilot services and wider roll-out is planned. Evaluation of the project is ongoing, however staff audits prior to implementation found that while the majority (91%) believed that offering smoking cessation support should be part of routine care, only 28% felt confident to do so. Early results show 60% of staff now rates their service's capability to provide cessation support as extremely or very capable.[32] Consumers describe the support to quit as being "essential", with increased self-confidence about quitting and better financial situations. This framework is also being used in Western Australia (by Cancer Council WA) to embed a systematic approach to smoking cessation in several mental health services.

This framework highlights the importance of supporting individual practice change to optimise system and organisation-level interventions. A crucial part of this is addressing the perception that people living with mental illness aren't interested in quitting and that quitting is an additional burden.[33]

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[31] Tackling Tobacco. Sydney: Cancer Council New South Wales [cited January 2020]. Available from https://www.quit.org.au/resources/community-services/tackling-tobacco-program/
[32]Quit Victoria and NorthWestern Mental Health. 2019. Unpublished data from the "Tackling Tobacco" project.
[33] Sheals K, Tombor I, McNeill A, Shahab L. A mixed-method systematic review and meta-analysis of mental health professionals' attitudes toward smoking and smoking cessation among people with mental illness. 2016;111(9):1536-53.

Other studies have suggested that while mental health clinicians may be confident to ask about smoking status, a much smaller proportion follow this up with advice to quit and provide best practice treatment (pharmacotherapy and referral for behavioural intervention, such as Quitline).[34] This can be achieved, in part, by providing training and education, resources and evidence-based policies, procedures and clinical guidelines to build practitioner confidence, skills and knowledge to address tobacco smoking.

Ideally, all consumers with a mental illness in contact with mental health services should be asked about their smoking status and provided with an evidence-based intervention. A systems-based approach means this action does not rely on the conscientiousness of individual clinicians, but rather becomes integrated into the holistic care provided to all people living with mental illness.

Internationally, systems-based interventions have been highly successful in reducing smoking rates.[35] For example, the Ottawa Model for Smoking Cessation has been adopted in over 120 hospitals in Canada. Under this model, patients receiving care have been found to have a reduced risk of all-cause readmission at 30 days, with the effect lasting up to two years, and a reduction in mortality at one year (compared to patients receiving "usual care" – which in most cases is the provision of self-help brochures).[36] Beyond the health impacts, the potential cost-savings to the health sector by addressing tobacco smoking systematically are significant.

Developing and implementing tailored, evidence-based interventions for people living with a mental illness to address smoking
The most effective intervention to support quitting smoking is a combination of a multi-session behavioural intervention (such as that offered through Quitline) and pharmacotherapy (nicotine replacement therapy or smoking cessation medications such as varenicline).[37] Many Quitlines offer tailored programs for people living with a mental illness and provide a culturally appropriate service for Indigenous Australians, and culturally and linguistically diverse communities. The Victorian Quitline now offers mental health symptom monitoring, to ascertain if and how quitting may be impacting their mental health. This is an important intervention that could be made available to all people living with a mental illness calling Quitlines across Australia.

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[34] Sharma R, Meurk C, Bell S, Ford P, Gartner C. Australian mental health care practitioners' practices and attitudes for encouraging smoking cessation and tobacco harm reduction in smokers with severe menta; illness. International Journal of Mental Health Nursing. 2018;27(1):247-257.
[35] Thomas D, Abramson MJ, Bonevski B, George J. System change interventions for smoking cessation. Cochrane Database of Systematic Reviews 2017, Issue 2. Art. No.: CD010742. DOI: 10.1002/14651858.CD010742.pub2.
[36] Mullen KA, Manuel DG, Hawken SJ, Pipe AL, Coyle D, Hobler LA, et al. Effectiveness of a hospital-initiated smoking cessation programme: 2 year health and helathcare outcomes Tobacco control. 2017;26(293-299).
[37] Kotz D, Brown J, West R. 'Real-world' effectiveness of smoking cessation treatments: a population study. Addiction. 2014 Mar;109(3):491-9.

Ongoing research into specific interventions for addressing chronic disease risk factors such as tobacco smoking in people living with a mental illness is crucial. This is necessary to ensure interventions are tailored to the unique need of the cohort and are cost-effective.

RECOMMENDATIONS

As a matter of urgency, the impact that physical health, particularly the impact of tobacco smoking on people living with a mental illness should be considered a high priority. Not addressing chronic disease risk factors, such as tobacco smoking in people living with a mental illness undermines just delivery of healthcare and will serve to perpetuate inequalities in this vulnerable population.

In light of the overwhelming evidence of the impact of chronic disease on those living with a mental illness, with tobacco smoking as one of the largest contributing factors, Cancer Council Australia and the National Heart Foundation of Australia strongly recommend the following inclusions as a significant part of the Commission's Final report:

1. **An in-depth account of the impact of tobacco smoking on the physical health of people living with mental illness.**

2. **Actions required by mental health services and systems in Australia to address tobacco smoking in people living with a mental illness based on current best evidence and practice.** This should include:

   a) Embedding a systematic approach to smoking cessation across all mental health services, requiring committed leadership; comprehensive smoke free policies; supportive systems; consistent quit supports; training and follow up of clinicians; and systematic monitoring and data collection. To do so, specifics recommendations for the current draft include, (but should not be limited to) the following to ensure a systematic approach:

   - The draft report acknowledges mental health treatment plans (MHTPs) and reviews must undergo significant change to ensure GPs are delivering best practice care (see chapter 5, *Primary mental health care*, volume 1). Any amendments must and should include clear prompts to identify chronic disease risk factors, such as smoking, and arrange the necessary best practice care for smoking cessation (e.g. as above, a combination of a multi-session behavioural intervention, such as that offered through Quitline, and pharmacotherapy[38]).

   - The draft report includes tobacco smoking as a proposed indicator in table 25.2 (chapter 25, *A framework for monitoring and evaluation*, volume 2). Smoking status is an important indicator to understand the true prevalence in this population. This should be extended to understand what proportion of people living with a mental illness who smoke receive appropriate, evidence-based interventions. This indicator

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[38] Kotz D, Brown J, West R. 'Real-world' effectiveness of smoking cessation treatments: a population study. Addiction. 2014 Mar;109(3):491-9.

will be a driver to ensure services are routinely providing this care. Initiatives in Queensland and Victoria have highlighted the importance of this as a means of evaluating if smoking cessation care has been systematically embedded in routine practice.

- The draft report acknowledges the importance of an effective workforce (see chapter 11, *Mental health workforce*, volume 1). As part of building workforce capability, that provides greater quantity and wider mix of required skills, health professionals working in the mental health system should receive training in smoking cessation support, specifically in the delivery of brief interventions for smoking cessation. Training in smoking cessation should be further extended to tertiary education programs where mental health professionals receive their qualifications including, but not limited to, university and vocational education programs. Building capacity of mental health professionals to address tobacco will aid in creating environments where cessation is truly supported.

b) Developing and implementing tailored, evidence-based interventions for people living with a mental illness to address tobacco smoking as a means of preventing chronic disease.

Health professionals and the health sector have a duty of care to not only manage a person's mental illness but also to optimise their physical health. It's not only the "the right thing to do", it is also of great economic importance, and should be included as a critical component of any long-term reform of Australia's mental health system.