

Submission the Productivity Commission on Mental Health

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I was pleased to see that physical comorbidities associated with mental illness are identified as important in the Issues paper. There is a great need to care for the whole person, physically, psychologically and socially in the context of mental illness. However I would like to propose that the perspective taken on physical comorbidity is limited and that this limitation has potential significance for cost of care and effectiveness of care. The limitation arises from the position that physical illness is conditional on the mental illness, thus the issues paper focussed on the presence of physical comorbidities in persons with mental illness. This is also reflected in Figure 7 that reports on the probability of having a physical illness in persons with mental disorder. I would suggest that the prevalence of mental disorder in those with physical illness is at least as important. It might be argued that these are the same individuals, however many persons with mental illness in the context of physical illness will never be identified with the mental illness, let alone receive intervention. Furthermore the service environment in which detection, assessment and intervention for mental illness in persons with physical disorder are likely to be very different in this alternative.

How significant a problem is this? In comparison with those reported in Figure 7 from Harris et al (2018) it is useful to consider the rates of comorbidity of mental disorder for persons with a physical illness. As a specific example the rate of diagnosed major depression in women with type 2 diabetes is 23% (Nichols and Brown, 2003) compared to the rate of type 2 diabetes in women with mental health disorder of 6.7% (Harris et al, 2018). In another sphere the rates of PTSD in children six months after discharge from ICU is 25% (Dow et al, 2013). High rates of mental illness have been reported for the physical illnesses described in the Issues paper.

Why is this different perspective important?

As identified in Harris et al (2018) there is likely to be a lack of understanding and competence in the detection, assessment and integrated management of physical health in mental health settings and this is compounded by perceived or real barriers. That is likely to hold true for the detection and integrated management and promotion of mental health in physical health settings. In a recent study of the full range of healthcare professions in a major tertiary children's hospital it was found that lack of knowledge, lower skill levels and perceived barriers were associated with a generally lower level of mental health care for patients with physical illness (Moss et al, 2018).

Physical and mental health care needs to be integrated both in mental health and physical health settings. Often the boundaries of scope of practice are used to separate physical from mental health care. Whilst specialised skills for treatment of mental health disorder do require a specialised workforce, management of mental health should not necessarily be partitioned in this way. This is because in the management of physical illness the healthcare professional needs to be aware of and understand that role of mental health in the overall management process, especially where effective management of physical illness is impacted by mental health (for example adherence to self-management in a person with depression or anxiety). Also provision of simple mental health care and facilitation of better mental health should not be partitioned because such care can be undertaken effectively and with better physical and mental health outcomes for patients by healthcare professionals from non-mental health specialties. Two examples of this come from work with physiotherapists. In study by Bennell et al (2016) trained physiotherapists provided an integrated basic psychological intervention in the context of physical care for patients with arthritis

which yielded better physical and psychological outcomes than either alone. In a recent study by Sterling et al (2019) training physiotherapists provided a brief stress-focused intervention integrated with a physical intervention for persons with traumatic neck injury. The study found that the integrated treatment yielded significantly better physical and psychological outcomes than physical intervention alone. Both studies indicate that integrated care is feasible and effective. They also indicate that rather than having separate skilled professionals each respectively delivering the physical or mental healthcare, this can be done effectively by a single healthcare professional. This approach has the potential to revolutionise care by reducing cost, improving access and also improving outcomes.

Integration of mental health with physical health care in physical health settings provides an opportunity to identify and intervene to promote better mental health at a very early stage (King et al, 2009). Physical health care settings provide a point of significant and convenient access to support persons in distress or adversity. It provides the opportunity for detection of need, simple mental health care, and assessment and triage if needed to more intensive or specialised support and intervention.

What might be required to achieve this?

The primary requirements would be effective and accessible training for staff, connected escalated mental health support systems, and an all-of-organisation commitment to promoting better mental health as part of healthcare. Training would include:

1. Provision of knowledge about indicators, signs and symptoms of mental health problems, especially in the context of physical health problems and management,
2. Effective communication skills with individuals to promote better mental health within the context of physical illness presenting a physical healthcare setting,
3. Simple stress and distress management skills key skills,
4. Selection and application of tools to assist in assessing need for escalated care.

Training must also include promotion of confidence in application of skills via supported application and ideally simulation training. Also there should be recognition of structural and organisational barriers including the recognition of an integration of promotion of better mental health is a necessary part of all effective healthcare, addressing real or perceived threats to professional identity and challenges in performing outside of scope of practice (Mitchell et al, 2011). Therefore training would ideally include healthcare staff at all levels, from executive leadership to administrative staff. Training would not just occur in the workplace but also as part of tertiary-level undergraduate and postgraduate training. The ultimate goal would be for every healthcare contact, no matter how small and no matter the context, to be more likely to promote and better mental health as well as physical health outcome for all persons.

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