

## RESPONSE TO THE DRAFT REPORT OF THE PRODUCTIVITY COMMISSION ON MENTAL HEALTH

This response to the Draft Report of the Productivity Commission on Mental Health (<https://www.pc.gov.au/inquiries/current/mental-health/draft>) is brief, but I hope will elicit an early response.

As one who has had substantial involvement in this and related areas, I read the report with interest and anticipation. There is clearly much good material and discussion in the report, along with recommendations that merit serious consideration to provide much more focus and support for this critically important area.

It is, however, a matter of serious concern that so far as I can see the Report pays very little attention to issues related to the physical health of people with mental health problems. This has been identified as an area of concern and a priority for further action in a range of reports over many years, not least from the National Mental Health Commission.

From my reading, in a report of 1200 pages, the Productivity Commission report allocates this entire area some four and a half substantive pages, with a further seven pages allocated to substance use comorbidities (although there is nothing in this about smoking), and five pages on “What more should be done to address comorbidities?”.

The discussion is no doubt well-intentioned, but inevitably brief and superficial, as is the commentary on current action relating to physical health and what further might be done. The recommendations are minimal, and while supporting the *Equally Well* statement and initiative, the few lines on “How should physical comorbidities be addressed” (p323) appear to add nothing of substance.

As just three examples among many, beyond two or three very minor incidental references, I can find nothing about major issue for people with mental illness such as smoking, food or oral health, although with all these – as with other areas effectively ignored, there is much scope for intervention.

As noted in the January 2019 *Issues paper*, there is overwhelming evidence that people with mental illness die much younger and experience substantially more physical illness than the rest of the community, from the NCDs to oral health, and consequently have a much lower quality of life. This further results in significant economic costs for both individuals and the community. There is also clear evidence that much of this is preventable, and on the benefits (including to mental health) that known interventions can bring. These matters have thus far not been adequately addressed by the system as a whole, despite praiseworthy efforts by some in the sector and related areas who have sought to show the art of the possible.

A major Australian study published in the British Medical Journal in 2013 concluded that “When using active prevalence of disorder (contact with services in previous five years), the life expectancy gap increased from 13.5 to 15.9 years for males and from 10.4 to 12.0 years for females between 1985 and 2005. Additionally, 77.7% of excess deaths were attributed

to physical health conditions, including cardiovascular disease (29.9%) and cancer (13.5%). Suicide was the cause of 13.9% of excess deaths”.

The 2012 Report of the National Mental Health Commission (“A Contributing Life: The 2012 National Report Card”) noted that, “People with severe mental illness live between 10-32 years less than the general population”, commenting that “People with a mental illness are dying younger – and this is only in part contributed to by people taking their own lives. They have higher rates of physical illnesses, and lower rates of getting the hospital treatment they need, compared to the general population. The reduced life expectancies and ill health of people with the most severe mental illness undercuts their chances of leading a contributing life” and (my bolding) **“It is a life and death issue. It is a national disgrace and it should be a major public health concern.”**

I find it extraordinary that even now, and following the discussion in the *Issues Paper*, this area attracts just five pages out of 1200, no major focus, and no major recommendations. Further, issues relating to physical health and the life expectancy gap are not included among the sixteen topics listed on which responses might be made. This imbalance is likely to have the perverse outcome of reinforcing current paradigms and silos, and leads to an approach that would seem contrary to the systemic change, and coordination and cooperation that the report argues are integral to improvements in the care and health of Australians at risk of or living with mental health conditions. I should stress that if I have misread the report, or missed something, I would be happy to be corrected, although my impressions were confirmed by a ‘phone call to the report secretariat.

I would recommend as a matter of urgency that before the final report is published there be an in depth review of matters relating to the physical health of people with mental illness, a major component of the report relating to this and related issues, extensive consultation with those people who are seeking to do significant work in this area, a recognition of the need for urgent action, and recommendations for the entire health system and those working in it for both immediate action and a long-term program. I would be happy to assist as best I can with advice on this.

Mike Daube

Emeritus Professor Mike Daube AO Hon DSci FPHAA FFPH  
Faculty of Health Sciences, Curtin University

8 December 2019