

Submission to the Productivity Commission (PC) draft Mental Health

From Bret Hart, previous WA Dept of Health child health medical officer receiving referrals from Community Health child and school nurses for the assessment and management of children and adolescents including mental health issues, suicidal ideation and intent.

Established a Youth Suicide Prevention task force with recommendations to prevent suicide.

Convened 'Promoting Optimism WA' to emulate the Penn Depression Prevention Project developed by Prof Martin Seligman. This led to the Aussie Optimism

Program: <https://healthsciences.curtin.edu.au/schools/psychology/aussie-optimism/programs/>

Previously an editor for the International Journal of Mental Health Promotion

Trialled the Early Development Index in North metro Perth which became the AEDC.

Currently chair of the Board of Wellbeing in Schools Australia: <https://www.wisawellbeing.com.au/> with comments made by WISA CEO Jac Van Velsen at a public forum endorsed.

The Draft report is dominated by the challenges of meeting demand and whilst there are valid recommendations in relation to prevention, they were devised prior to the publication of more comprehensive reports produced by the National Academy of Sciences, Engineering and Medicine (NAS) which include many relevant evidence based recommendations. Even though these are from a United States perspective, they are motivated by more pressing circumstances than our own. Nevertheless there are signs that we are following the same path as indicated in the attached unpublished draft document: Australia's Midlife Crisis.

The reports that warrant serious consideration include;

[Promoting Positive Adolescent Health Behaviors and Outcomes](#) Thriving in the 21st Century (2019)

[Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth](#) A National Agenda (2019)

[Vibrant and Healthy Kids](#) Aligning Science, Practice, and Policy to Advance Health Equity (2019)

To ensure opportunities for prevention are not missed, it is prudent to consider the levels ranging from primordial to quaternary as defined here: <https://jech.bmj.com/content/55/7/452.short>

In so doing there would have been less likelihood of jumping straight to a secondary prevention strategy ie "...screening of social and emotional development should be included in existing early childhood physical development checks to enable early intervention."

Whilst this recommendation makes intuitive sense, when there are insufficient resources to meet demand as indicated several times elsewhere in the report, it is unethical to identify more children needing interventions and therapy when these services are unavailable in a timely fashion. This reinforces the need for more investment in upstream initiatives to prevent children needing investigation and management in the first place.

As indicated in the US reports, there are many more opportunities for prevention including prior to conception. However, the word "preconception" does not appear, the word 'prenatal' appears only once in volume 1 and there is passing reference to the antenatal period in volume 2. There are many more examples of interventions such as this one in WA to prevent subsequent problems in childhood; <https://www.sciencedirect.com/science/article/pii/S0002937816320634>

The most comprehensive case for investing in the first 1000 days in Australia has been argued by Dr Tim Moore; <https://www.rch.org.au/uploadedFiles/Main/Content/ccchdev/The-First-Thousand-Days-A-Case-for-Investment.pdf> following his evidence

paper; <https://www.rch.org.au/uploadedFiles/Main/Content/ccchdev/CCCH-The-First-Thousand-Days-An-Evidence-Paper-September-2017.pdf>

The predominant medical model in the PC report may account for the limited references to 'upstream' especially when it is most crucial as indicated in this commentary: <https://link.springer.com/article/10.1007/s10995-016-1970-8>

Another well informed report from NAS suggests how to move upstream to improve a nation's health ; [Integrating Social Care into the Delivery of Health Care](#) (2019)

The Prime Minister has emphasised the need for an upstream approach by suggesting the need for a “a whole-of-government approach to suicide prevention”. This is consistent with Mental Health in All Policies (MHiAP):

<https://www.sciencedirect.com/science/article/abs/pii/S0924933814786092>

Nevertheless MHiAP is not mentioned in the draft report.

These comments emphasise the importance of before and during the first few years of life as being crucial in reducing mental illness but there is also the need to investigate the contribution and cause of mental illness in the slowing in increasing life span as suggested in my draft paper as follows:

Australia's midlife crisis

By Bret Hart

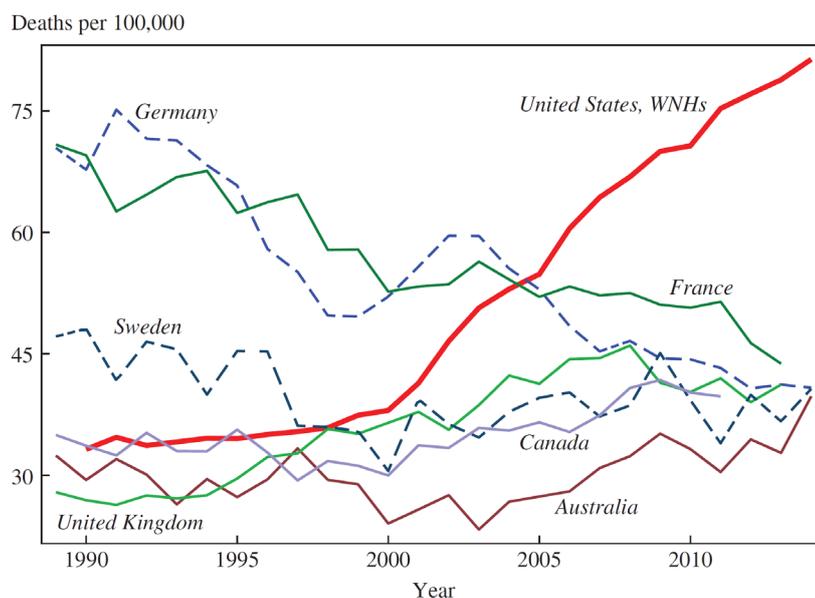
In May 2017 University of Melbourne (UM)'s Laureate Lopez with Adair alerted us to the fact that Australia's increase in life expectancy is slower than in other high income countries.¹ Similar trends in the US and the UK² precipitated debate³ and a review⁴ in Britain suggesting austerity contributes to what has been coined in the US 'shit life syndrome' (SLS).⁵ However, apart from one editorial citation, a blog produced by the Gratton Institute⁶ and limited media coverage,⁷ Lopez & Adair's analysis did not receive the attention that is warranted given the implications of their research findings.

Attracting more interest in England, Watkins et al estimated that there were 45,368 more deaths in England than was expected compared with pre-2010 trends and blamed the reduction in public spending on social care.²

Also timing is everything in relation to media attention. Lopez & Adair's results were published around the time of Australia's "shock" Federal election result.

In 2017 Nobel Laureate Professor Sir Angus Deaton warned via UM's multi-media platform, Pursuit, that Australia should be alarmed from the fact that within a decade to

Figure 5. Deaths of Despair by Country for Age 50–54, 1989–2014^a



Reproduced with permission from Case and Deaton 2019

2014, the suicide rate among Australians aged 55 to 64 surged by 54 per cent.⁸

The mode of displaying data is another influence on the potential response. For example, Deaton with his economist wife, Professor Anne Case, measured mortality rates of 50-54 year olds from accidental or intent-undetermined alcohol and drug poisoning, suicide, and alcoholic liver disease and cirrhosis for U.S. White non-Hispanics. The trend in increasing 'deaths of despair' published by the Brookings Institute provided a warning flag for Australia.⁹ By graphing the results to compare the trends with mortality rates in other countries it is apparent that Australia experienced increasing mortality of 50-54 year olds during the last few years of the 25 year study period. This is consistent with the results of UM researchers Clarke & Erreygers. Using Australia's Household, Income and Labour Dynamics (HILDA) survey data they explored the correlation between the income and health of 24,820 individuals and found that for the 40 per cent of them on the lowest income their life expectancy-related health poverty rates had not improved. Also the gap between top and bottom widened by about 50 per cent especially since 2009, as life expectancy improved for wealthier Australians.¹⁰

Research discovering early trends is not as headline-grabbing as revealing that life expectancy has been declining in the US since 2014.¹¹ This justified describing the situation as a "public health crisis" prompting a call for action by "...policy makers to deal with the social determinants of health (SDOH), and by researchers to intensify investigation of the causes and solutions."¹²

This motivated the US to implement social health interventions as key strategies for organizations to address the SDOH with a return-on-investment (ROI) calculator recently developed to assist organisations with their business cases.¹³ They should also benefit from the collaboration between UnitedHealthcare and the American Medical Association (AMA) to better identify and address SDOH by expanding the current 15 SDOH-related ICD-10 'Z' codes to about 23 key areas which will be available in October 2020.¹⁴

There are extravagant claims for a ROI by tackling a SDOH.¹⁵ For example the Montefiore Health System in the Bronx claimed that by investing in housing reduced ER visits and unnecessary hospitalizations for an annual ROI of 300 %.

In England the approach to SDOH has been to promote the implementation of Marmot's six policy objectives:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

This challenge was accepted in 2013 by Coventry. Within three years the outcomes included; narrowing the life expectancy gap between the most affluent and the most deprived from 11.2 years to 9.4 years for men; improvements in educational development, health outcomes, life satisfaction and employment, and reductions in crime in priority locations.¹⁶

Meanwhile Lopez and Adair find it "difficult to explain" the slowing in life expectancy of Australians occurring to greater degree than in Western Europe. Rather than await clarity, it would be prudent to emulate the Marmot City model in Australia. This is especially pertinent as Lopez and Adair surmise that it will be difficult to further reduce mortality from ischaemic heart disease, cerebrovascular diseases, and cancer so "...future gains in life expectancy will increasingly depend on controlling other risk factors".

Is despair a risk factor? The answer depends on the definition and whether it leads down a road to premature death. It is a hypothesis that Shanahan et al argue deserves conceptual mapping with empirical studies using longitudinal multilevel data.¹⁷

Despair is a construct sadly familiar to the First Nations people of Australia with a view that despair is responsible for their intractably high suicide rates.¹⁸ It also helps explain the challenge in bridging the gap in life expectancy. This challenge can be met with higher educational attainment according to Hart et al.¹⁹ This is consistent with the findings from Case and Deaton's analysis with higher degrees providing immunity to deaths of despair compared to midlifers with no tertiary qualifications.

Arguably 'despair' was discovered in Western Australia in 1990 by Professor D'Arcy Holman. He conducted a review of Community Child Health services and discovered that staff "...felt under siege from the community demand for pastoral care, counselling and social welfare services...to render assistance to persons suffering from psychosocial morbidity (PSM)." His definition of the latter could apply to despair – "a state of human distress resulting from personal conflict within an individual, and/or from an adverse social environment." He also observed that "...the need and demand for human services staff to render assistance to persons suffering from PSM had greatly increased since the late 1970s..."²⁰ In response, he suggested a community debate on "family, work and personal well-being." Along with his 172 recommendations for reform, there was no action. This idea is, therefore, long overdue being implemented not only in Western Australia but also this discussion needs to occur nationwide with options such as the Marmot City initiatives being promoted for Australian communities to consider adopting.

In the despair discussion, there is scant regard to the influence of adverse childhood experiences (ACE) or impact of toxic social environment²¹ on the higher risk of future mental illness, substance use and violence which also puts the next generation at risk of ACE.²² This is one of many reasons it is important for clinicians to use the ACE checklist to help identify the burden of exposure to trauma, violence and abuse of children so that supportive action can be taken.²³

It is surprising that Lopez did not give his co-author and himself credit forecasting that a risk factor would increase by 2020.²⁴ He and his colleague predicted that depression and heart disease would fast replace the traditional enemies, such as infectious diseases and malnutrition, as the leading causes of disability and premature death. However, these predictions had global application and it is questionable from reviewing 2001-2014 data whether the incidence of depression has been increasing in Australia or whether the diagnosis rate has increased.²⁵ But, since 2014, there has been an increase from around 4 million Australians (17.5%) with a mental or behavioural condition, to one in five (20.1%) or 4.8 million Australians in 2017 -2018. This rise was predominantly due to more people reporting anxiety-related conditions and depression or feelings of depression.²⁶

Either way, the problem is expensive. The Productivity Commission (PC) estimates that mental ill-health and suicide are costing Australia up to \$180 billion per year and treatment and services are not meeting community expectations. Also, the prevalence rate of mental illness in Australia is above the OECD average - hence the PC's current inquiry.²⁷

The inquiry provides a great opportunity for the PC to consider the wealth of evidence based recommendations developed by US expert practitioners with the recently released consensus study reports published by the National Academies of Sciences Engineering and Medicine; 'Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth'²⁸ and 'Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity'.²⁹ With many implications for primary and community based interventions and healthcare, these reports will also be valuable in informing Australia's 10 year Plan for a Better Health System launched in August 2019.³⁰ The Federal Minister for Health's support for the latter is encouraging and so is his commitment with the Prime Minister to drive a whole-of-government approach to suicide prevention as a "key priority". This political will is vital in achieving progress. However, there is

another priority that seems to subsuming others; returning the budget to surplus. See alternative <https://www.abc.net.au/radionational/programs/bigideas/for-us-and-our-children-after-us/5782952>

This aim is shared by the UK which managed to reduce its deficit to pre-crisis levels after a decade of austerity.³¹ But at what cost? In the book edited by Bambra, 'Health in hard times: Austerity and Health Inequalities' it is clear that "austerity kills" and had a negative impact with health practitioners rendered powerless by the undermining of their efforts to mitigate against the pathogenic impact of fiscal restraint on their patients.³² A cure for the consequent despair is not therefore going to come from the healthcare system with its limited influence on SDOH. It is economists who appreciate that economic and social forces since the middle of the 20th century that facilitated advances in life expectancy.³³ Any faltering in those advances should prompt an urgent examination of those forces³⁴ just as a doctor would with a patient showing early warning signs of cancer. It is a theme likely to be echoed in Case & Deaton's forthcoming book, 'Deaths of Despair and the future of capitalism'.³⁵

The Prime Minister rightly indicated that a whole of government response is needed to address suicide. The same applies to stopping the slowing in Australia's improving life expectancy. A key member of cabinet to assist is, not so much the Health Minister, but the minister who develops and implements economic policy because "...population mental health is intimately connected to societal economic conditions. The (poor) mental health of modern societies offers a stark indication of the consequences of not taking action: 'economic growth at the cost of societal recession'".³⁶

The highly esteemed Oxford epidemiologist the late Professor Geoffrey Rose said "Much can be done by individuals themselves to improve their own health prospects, but whether or not they will actually take such action depends substantially on economic and social structures for which governments are responsible." To shirk this responsibility will cause Australians who should be enjoying their most productive prime of life to continue to vote with their lives.

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