4th July 2019

The Victorian Chronic Disease Prevention Alliance (VCDPA, comprising Diabetes Victoria, Cancer Council Victoria, Heart Foundation – Victoria, Kidney Health Australia and the Stroke Foundation) and Quit Victoria ("Quit") welcome the opportunity to make a joint submission to the Royal Commission into Victoria's Mental Health System.

Thank you for your consideration of our responses to the following questions.

5. <u>What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?</u>

There remains an unacceptable gap in life expectancy between people with a mental illness and the general population – estimated at up to 15 years.[1] The vast majority of deaths are not due to mental illness. Concerningly, for every person with a mental illness who dies from suicide, 10 will die due to chronic disease.[2,3] These chronic diseases include cardiovascular disease and stroke, cancer, type 2 diabetes, chronic kidney disease and respiratory conditions such as asthma and chronic obstructive pulmonary disease.[4,5,6] Nearly 60% of people with a mental illness have at least one or more other chronic diseases.[7]

Many of these chronic diseases share multiple risk factors, including tobacco smoking and poor metabolic health (encompassing overweight and obesity, poor diet and physical inactivity, and often impacted by the side effects of some antipsychotic and antidepressant medications) and alcohol use. People with a mental illness have a much higher prevalence of these risk factors compared to the general population, contributing significantly to a disproportionate chronic disease burden. Evidence suggests people with a serious mental illness are:[8]

- Six times 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)

The VCDPA and Quit advocate to the Royal Commission that smoking, poor metabolic health (which includes overweight and obesity, poor diet and inadequate physical activity) and alcohol use in people with mental illness are the most important modifiable risk factors for chronic disease, and embedding best practice support

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[1] 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.

[2] 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.

[3] Australian Bureau of Statistics. Mortality of people using mental health services and prescription medications. Analysis of data. Canberra, ACT: ABS, 2011;2017.

[4] Harris B, Duggan M, Batterham P, Bartlem K, Clinton-McHarg T, Dunbar J, et al. Australia's mental and physical health tracker. Technical paper No. 2018-06. Australian Health Policy Collaboration. Aug 2018.

[5] Iwagami M, Mansfield KE, Hayes JF, Walters K, Osborn DP, Smeeth L, et al. Severe mental illness and chronic kidney disease: a cross-sectional study in the United Kingdom. Clinical Epidemiology. 2018;10:421-429.

[6] Reilly S, Olier I, Planner C, Doran T, Reeves D, Ashcroft DM, et al. Inequalities in physical comorbidity: a longitudinal comparative cohort study of people with severe mental illness in the UK. BMJ Open. 2015;5(12).

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

[8] 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.

into usual care, to enable people with a mental illness to achieve good metabolic health, smoking cessation and reduced alcohol use, is necessary. This requires building the capacity of systems, mental health services and the workforce.

These priority areas also align with those outlined in the Victorian Government's Equally Well framework, released in March 2019.[9]

Tobacco smoking

Compared to the general population, women with a mental illness are nearly 70% more likely to be smokers, and men with a mental illness are nearly 40% more likely.[10] Smoking prevalence tends to increase alongside the severity of the mental illness[11] and rates also vary by diagnosis – with 25% of people with depression being daily smokers, to up to 47% of people with schizophrenia[12] (compared with 10.7% of the general Victorian population[13]).

In addition to increased mortality, smoking in people with a mental illness has been associated with poorer mental health outcomes including more psychiatric symptoms, increased hospitalisations and higher required psychiatric medication dosages[14] (because components of tobacco smoke accelerate the metabolism of some antidepressant and antipsychotic medications).[15] Higher dosages can, in turn, increase the risk of poor metabolic health as a side effect.

In addition, there is some evidence to suggest that amongst people diagnosed with a mental illness such as psychosis, smoking increases the risk of suicidal behaviour.[16] Evidence has also shown that smoking can increase the risk of anxiety, depression and psychotic disorders including schizophrenia.[17,18,19]

There is evidence that people with a mental illness who smoke are motivated to quit. This may be contrary to common misconceptions that people with a mental illness are not interested in quitting, or that it is too difficult. An Australian study of mental health inpatients found that approximately 47% reported making at least one quit attempt in the previous 12 months[20], and similarly people with severe mental illness and substance use disorders make a quit attempt every year.[21] Yet very few receive best practice smoking cessation support[22]; evidence of the need for integration of this into usual care.

[9] Victoria State Government. Department of Health and Human Services. Equally well in Victoria: Physical health framework for specialist mental health services. March 2019. Available from: https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines

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

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

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

[13] Cancer Council Victoria. Victorian Smoking and Health Survey: Daily smoking trends in Victoria among demographic groups (2015 to 2018). May 2019.

[14] Prochaska JJ. Smoking and mental illness-breaking the link. The New England Journal of Medicine. 2011;365:196-8.

[15] Banham L, Gilbody S. Smoking cessation in severe mental illness: What works? Addiction. 2010;105:1176-89.

[16] 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.

[17] 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.

[18] 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.

[19] Prochaska JJ. Smoking and mental illness-breaking the link. The New England Journal of Medicine. 2011;365:196-8.

[20] Stockings EAL, Bowman J, McElwaine K, Baker A, Terry M, Clancy R, Bartlem K, et al. Readiness to quit smoking and quit attempts among Australian mental health inpatients. Nicotine & Tobacco Research, 15(5), 942-949.

[21] Ferron, et al. Course of smoking and quit attempts among clients with co-occurring severe mental illness and substance use disorders. Psychiatric Services, 62(4), 353-359.

[22] Bartlem, et al. Chronic disease health risk behaviours amongst people with a mental illness. The Australian and New Zealand Journal of Psychiatry, 49(8), 731-741.

Please see Question 9 for more information regarding the "what needs to be done" part of this question.

Poor metabolic health

Poor metabolic health (which includes overweight and obesity, poor diet and inadequate physical activity) is an independent risk factor for many conditions including heart disease and stroke, chronic kidney disease, type 2 diabetes and many cancers. People experiencing serious mental illness may be between two and three times more likely to have type 2 diabetes and are more likely to die from cardiovascular disease regardless of smoking status.[23]

Australians living with a mental illness are also more likely to be sedentary. For example, national health survey data has shown that Australian men with a mental illness are 11% more likely and women 8% more likely to have physical activity levels under the recommended guidelines.[24] Similarly, a survey of Australians living with psychosis identified that, in the seven days prior to completing the survey, over 33% of people were sedentary.[25]

Just over one-quarter (28.4%) of Australian men are obese, compared to one-third (33.2%) of Australian men with a mental illness. Similarly, 27.4% of Australian women are obese, compared to 31.3% of women with a mental illness.[26] Alarmingly, in a survey of Australians living with psychosis, obesity rates were as high as 45%.[27]

In addition to population-level policy reforms, such as the introduction of healthy environments, a systematic approach for identifying people with mental illness at risk of poor metabolic health, and facilitating access to evidence-based, tailored interventions, needs to be embedded into routine care. See Question 9 for more information.

Higher levels of alcohol use by people with mental illness

The incidence of excessive alcohol consumption [28] tends to be higher in people with mental illness as compared to the general population. According to National Health Survey data, men with mental illness were 15% more likely to report consuming alcohol at high levels than the general population. Furthermore, women with mental illness were 10% more likely to report consuming high levels of alcohol compared to the general population.[29] The literature has reported that excessive alcohol use by people with mental illness is a major cause of depressive illness. It has also been observed that depressive illness in and of itself may contribute to alcohol use disorder as people with mental illness may use alcohol to self-medicate.[30]

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[23] 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.
[24] Ibid
[25] Jackson CA, Dobson AJ, Tooth LR, Mishra GD. Lifestyle and socioeconomic determinants of multimorbidity patterns among mid-aged women: a longitudinal study. PloS one. 2016;11(6):e0156804.
[26] Australia's mental health and physical health tracker.
[27] Morgan VA, McGrath JJ, Jablensky A, Badcock JC, Waterreus A, Bush R, et al. Psychosis prevalence and physical, metabolic and cognitive co-morbidity: data from the second Australian national survey of psychosis. Psychological Medicine. 2014;44(10):2163-76.
[28] Excessive alcohol consumption is defined as greater than the standard two drinks per day, by the NHMRC Australian Guidelines to Reduce Health Risks from Drinking Alcohol 2009.
[29] Australian Health Policy Collaboration, Australia's Mental Health and Physical Tracker: Technical paper No. 2018-06 (2018), 23.
[30] Fare Australia, Submission: Productivity Commission: the Social and Economic Benefits of Improving Mental Health, (2019), p15.

Exceptionally high levels of alcohol use or dependence has also been found in people with diagnosed psychotic illness. The 2010 Australian National Psychosis Survey found that 50.5% of survey respondents with a psychotic illness requiring treatment also had a lifetime history of alcohol abuse or dependence.[31]

The VCDPA and Quit is concerned that high rates of alcohol use among people with mental illness (as compared to the general population) and particularly in those with a diagnosis of psychotic illness, may predispose these population groups to a disproportionately increased risk of cancer.[32] It has been shown that people with a dual diagnosis of mental and alcohol use disorders typically have more *severe* disease than those with only one disorder and that treatment is frequently more complex and more expensive.[33]

Higher levels of smoking in those with mental illness (combined with higher levels of alcohol consumption compared to the general population) has a synergistic effect on upper gastrointestinal and aero-digestive cancer risk, meaning the combined effects greatly exceed the risk from either one alone. It has been estimated that over 75% of cancers of the upper aero-digestive tract in developed countries can be attributed to this effect.[34] Please see Question 9 for more information regarding the "what needs to be done" part of this question.

Addressing chronic disease risk factors can also improve mental health outcomes

Research has demonstrated that addressing these chronic disease risk factors can assist with recovery from mental illness. For example, stopping smoking for longer than six weeks has been linked to people feeling less stressed, anxious and depressed, with effect sizes similar to using antidepressants to treat mood and anxiety disorders.[35] Similarly, improved physical activity levels have been shown to not only be preventive against some mental health conditions but also be an effective component of treatment.[36,37,38,39,40] Similarly, diets higher in fruit, vegetables, fish and wholegrains have been associated with a reduced likelihood of depression in adults.[41]

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[31] Australian Government, People Living with Psychotic Illness 2010: Report on the second Australian National survey, (2011), 1, defines psychotic illness as including: Schizophrenia, schizoaffective disorders, mania with psychotic symptoms, persistent delusional disorders, acute and transient psychotic disorders and other unspecified non-organic psychotic disorder. Available from:
https://www.health.gov.au/internet/main/publishing.nsf/Content/717137A2F9B9FCC2CA257BF0001C118F/$File/psych10.pdf

[32] In 1988, the World Health Organisation classified alcohol as a Group 1 carcinogen. There is convincing evidence that alcohol use increases risks of cancers of the mouth throat (pharynx and larynx), oesophagus, bowel in men (colon and rectum), liver and female breast. There is probable evidence that alcohol increases the risk of cancers of the stomach and bowel in females.

[33] Foundation for Alcohol Research & Education, *Submission: Productivity Commission Issues Paper: The Social and Economic Benefits of Improving Mental Health* (2019).

[34] Cancer Council Australia, National Cancer Control Policy, Links between Alcohol and Cancer, https://wiki.cancer.org.au/policy/Alcohol/Link_between_alcohol_and_cancer last accessed on 12 June 2019.

[35] Taylor G, McNeill A, Girling A, Farly A, Lindson-Hawley N, Aveyard P. Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ 2014;348:g1151

[36] Schuch FB, Vancampfort D, Firth J, Rosenbaum S, Ward PB, Silva ES, et al. Physical activity and incident depression: A meta-analysis of prospective cohort studies. American Journal of Psychiatry. 2018;175(7):631-648.

[37] Rebar AL, Stanton R, Geard D, Short C, Duncan MJ, Vandelanotte C. A meta-meta-analysis of the effect of physical activity on depression and anxiety in non-clinical adult populations. Health psychology review. 2015;9(3):366-78.

[38] Rosenbaum S, Tiedemann A, Sherrington C, Curtis J, Ward PB. Physical activity interventions for people with mental illness: a systematic review and meta-analysis. Journal of Clinical Psychiatry. 2014;75(9):964-74.

[39] Cooney GM, Dwan K, Greig CA, Lawlor DA, Rimer J, Waugh FR, et al. Exercise for depression. Cochrane Database of Systematic Reviews. 2013.

[40] Firth J, Cotter J, Elliot R, French P, Yung AR. A systematic review and meta-analysis of exercise interventions in schizophrenia patients. Psychological medicine. 2015;45(7):1343-61.

[41] Jacka FN, O'Neill A, Opie R, Itsiopoulos C, Cotton S, Mohebbi M, et al. A randomised controlled trial of dietary improvement for adults with major depression (the "SMILES" trial). BMC Medicine. 2017;15(23)

Management of mental illness in people with chronic disease

Conversely, the VCDPA and Quit also recognise that people with chronic disease are at higher risk of mental illness. Using stroke as an example, one third of stroke survivors will experience depression[42], and between 18 and 25% will experience anxiety.[43]

Four in 10 stroke survivors will go on to have another stroke within a decade, with the risk of secondary stroke highest in the first year.[44] Secondary stroke prevention requires patients to modify lifestyle risk factors such as poor diet and physical inactivity[45] and to comply with prescribed medications. Adequate mental health is required to facilitate the motivation, endurance and planning necessary to engage in regular exercise, plan healthy meals, and consume medications as prescribed.[46] Mental illness post-stroke is associated with a higher risk of secondary stroke.[47]

Currently, our health system is focused mainly on physical recovery after stroke, and many stroke survivors do not have access to services they need for the assessment, diagnosis and treatment of mental health disorders. Victoria is leading the way nationally, and in recent years the State Government has funded a number of innovative pilot projects to improve clinical assessment and management mental health disorders post-stroke.[48]

The VCDPA and Quit strongly support continued State Government investment in services to improve the assessment, diagnosis and treatment of mental health disorders following stroke. These services will improve the lives of Victorian stroke survivors, their families and carers, and reduce the burden of stroke on the Victorian community, health system and economy.

8. **What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?**

Please see Question 9 for regarding the "what needs to be done" part of this question.

In 2018, over 2.4 million Australians were living with both chronic disease and mental illness.[49] A report by the Royal Australian & New Zealand College of Psychiatrists places the cost of premature death in people with serious mental illness with a comorbid physical illness at $15 billion AUD annually.[50] Adding substance use into the mix increases this to $45 billion.[51]

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[42] Hackett ML, Pickles K. Part I: Frequency of depression after stroke: An updated systematic review and meta-analysis of observational studies. International Journal of Stroke. 2014; 9:1017-25.

[43] Campbell Burton CA et al. Frequency of anxiety after stroke: A systematic review of observational studies. International Journal of Stroke. 2012; 8:545-59.

[44] Hardie K et al. Ten-year risk of first recurrent stroke and disability after first-ever stroke in the Perth Community Stroke Study. Stroke. 2004; 35(3):731-5.

[45] Hackam DG, Spence JD. Combining multiple approaches for the secondary prevention of vascular events after stroke: a quantitative modeling study. Stroke. 2007; 38(6):1881–5.

[46] Terrill AL, Schwartz JK, Belagaje SR. Best Practices for The Interdisciplinary Rehabilitation Team: A Review of Mental Health Issues in Mild Stroke Survivors. Stroke Res Treat. 2018: 6187328.

[47] Yuan HW et al. Poststroke depression and risk of recurrent stroke at 1 year in a Chinese cohort study. PLoS One. 2012; 7(10):e46906.

[48] Arthurson L et al. Implementing a teleneuropsychology stroke rehabilitation service in a regional health service. International Journal of Stroke. 2018; 13(1S):29.

[49] Australian Bureau of Statistics. National Health Survey: First Results, 2014-15. Canberra 2015.

[50] 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.

[51] Ibid

Co-morbid physical and mental illness also increase treatment costs dramatically, 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).[52] Almost 40% of potentially preventable hospitalisations are due to chronic conditions.[53] Early detection and management of risk factors can reduce disease risk, slow or reverse disease progression, reduce complications and unnecessary hospitalisations, resulting in reduced expenditure for related hospitalisations.[54]

On an individual level, addressing chronic disease risk factors provides an opportunity for people with a mental illness to improve their social and economic participation. For example, a person who smokes 20 cigarettes a day can save over $9000 a year upon quitting.[55] Not only does this lessen the burden of financial stress, it also enables people with mental illness to reallocate spending to healthier food choices and physical activity interventions and thus improve metabolic health.

> **Jack*, 39, has lived with mental illness for 25 years and has a diagnosis of schizophrenia. Jack smoked between 25 and 30 cigarettes per day for 15 years. With the help of NorthWestern Mental Health, he has been quit for 16 months. He has experienced numerous health and financial benefits since quitting.**
>
> *"It's the toughest thing I ever had to do. Drugs and alcohol, no problem. But ciggies, they have such a hold on ya! In the first 11 months I saved $11,000. I'm on a DSP [disability support pension] so it's hard, money-wise. It's the most money I've had in my bank account in my entire life.*
>
> *Financially, it's been one of the biggest things...I don't have to worry about money anymore. I've got that nice buffer. I can do what I want! Whenever anyone rings me up, before I was always thinking dollar signs. $420 a fortnight on ciggies out of your pension. It's a lot of money to slowly kill yourself, isn't it?"*
>
> **Not consumer's real name*

9. <u>**Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?**</u>

<u>*A systematic approach to chronic disease prevention must be embedded in the mental health service system and across the entire health system*</u>

The "Equally Well Framework in Victoria – Physical health framework for specialist mental health services"[56] ,endorsed by mental health consumers and carers, provides a clear policy direction, and is a positive step, to supporting specialist mental health services to address physical health, including smoking, metabolic health and alcohol use.

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[52] 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.
[53] AIHW Chronic disease overview. Available from: https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview
[54] Australian Chronic Disease Prevention Alliance and Quit Victoria. Submission to the Productivity Commission Inquiry into mental health. https://www.pc.gov.au/__data/assets/pdf_file/0017/240290/sub140-mental-health.pdf
[55] NSW Retail Tobacco Traders' Assocation. Price lists - cigarettes. The Australian Retail Tobacconist; 2016.
[56] Victoria State Government. Department of Health and Human Services. Equally well in Victoria: Physical health framework for specialist mental health services. March 2019. Available from: https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines

But given only a small proportion of people with a mental illness are in contact with mental health services[57], a systematic approach needs to be adopted across the entire health system. Individual practice change at the clinician level alone is necessary but not sufficient. Internationally, systems-based interventions have been highly successful in reducing smoking rates. The Ottawa Model for Smoking Cessation, adopted in over 120 hospitals in Canada, is an example of this. Patients receiving care under this model 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, somewhat suboptimal, "usual care" — which in most cases is the provision of self-help brochures).[58]

Quit has been working with mental health services in Victoria to implement a systems-based framework to ensure that people with a mental illness accessing these services receive best practice smoking cessation support. The framework takes an organisational change approach and consists of six key elements for success including:[59]

- Committed leadership
- Comprehensive smokefree policies
- Supportive systems
- Consistent quit supports
- Training and follow up
- Systematic monitoring and data collection

In Victoria, the framework has been successfully embedded at NorthWestern Mental Health (NWMH) and Orygen Youth Health inpatient, residential and community services pilot sites and wider roll-out is planned across all NWMH services in 2019.

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. 60% of staff now rate their service's ability to provide cessation support as extremely or very capable.[60] People with mental illness describe the support to quit as being "essential", with increased self-confidence about quitting and better financial situations.

In terms of smokefree policies, recent evidence from the UK indicates that implementing these in psychiatric inpatient wards resulted in a 39% reduction in physical assaults per month after the policy was introduced.[61]

It is at this point that the VCDPA and Quit would like to acknowledge and provide our support to the recommendations provided by NWMH in its submission to the Royal Commission relating to the significance of embedding physical health into routine care.

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[57] Mental health services in brief 2018. Australian Government. Australian Institute of Health and Welfare [cited March 2019]. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia/overview

[58] 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).

[59] The Tackling Tobacco Program. Melbourne: Cancer Council Victoria [cited March 2019]. Available from https://www.quit.org.au/resources/community-services/tackling-tobacco-program/

[60]Quit Victoria and NorthWestern Mental Health. 2019. Unpublished data from the "Tackling Tobacco" project.

[61] Robson, et al. Effect of implementation of a smoke-free policy on physical violence in a psychiatric inpatient setting: an interrupted time series analysis. Lancet Psychiatry, 2017;4 540-546; http://dx.doi.org/10.1016/ S2215-0366(17)30209-2

> **John*, 49, is a consumer of a community mental health service. He lives with depression and anxiety. He had been wanting to quit smoking for many years, often smoking up to 50 cigarettes per day. Anxiety and stress were triggers to smoke. By using nicotine patches and with support from the community mental health service, John has now successfully quit.**
>
> *"If I was drinking, I would go through a packet of 50 cigs in one session! I'd fill an ashtray, empty it, and start again.*
>
> *I just got sick of the ashtray-mouth taste, the smoke in the flat, coughing up rock oysters, brown fingers. I tried so many times, but I'd fall off the wagon. I thought to myself, there's got to be a way.*
>
> *I say to myself: 'What do I want a cigarette for?' And then [the craving] goes out of my head. If I've got a patch on, I don't need one."*
>
> **Not consumer's real name*

It is important to also support individual practice change to optimise system and organisation-level interventions. A crucial part of this is addressing the perception that people with mental illness aren't interested in quitting and that quitting is an additional burden on staff in the provision of care.[62] Studies have suggested that while mental health clinicians may be confident to ask about smoking, a much smaller proportion follow this up with advice to quit and provide best practice support (pharmacotherapy and referral for behavioural intervention, such as Quitline).[63] 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 chronic disease risk factors.

Monitoring and data collection are vital

Systems should be integrated into mental health services and the wider health system to record information about chronic disease risk factors (not just "status" but also whether a specific intervention was provided) and ideally included in datasets such as the Mental Health Client Management Interface (CMI) database and the Victorian Admitted Episodes Dataset (VAED).

It is encouraging that the proportion of people with smoking status recorded at discharge and proportion of registered mental health patients with a diagnosis of type 2 diabetes is reported in Victoria's Mental Health Services Annual Report (Outcome 5.1).[64] It is argued that recording of smoking status by mental health services is underreported. In a recent review of patient record files at a mental health service, only 39% had smoking status recorded.[65] It is also not mandatory, nor is there a statewide target for services to have to meet these reporting requirements.

Accurate reporting of data is required to drive practice change. It is recommended that a statewide target for the recording of smoking status and type 2 diabetes diagnosis be developed, as well as the inclusion of

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[62] 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.
[63] 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.
[64] Victorian State Government, Department of Health and Human Services. Victoria's Mental Health Services Annual report 2017-2018. October 2018, Available from https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report
[65] Quit Victoria and NorthWestern Mental Health. 2019. Unpublished data from the "Tackling Tobacco" project.

"smoking cessation and type 2 diabetes intervention provided" be included as an indicator for services to report upon.

Sustained leadership and investment by the Department of Health and Human Services is required to see that the data and the Equally Well Framework truly impact systems and data collection relating to smoking, metabolic health and alcohol use, and to realise the potential to change the lives of people with a mental illness.

People with a mental illness should be offered effective, tailored interventions for chronic disease risk factors as part of comprehensive and routine care

Although attempting to quit smoking can be more challenging[66] and require more intensive support to be successful, there is evidence that people with a mental illness want to stop smoking and can do so.[67] The most effective intervention to support quitting is a combination of a multi-session behavioural intervention (such as the Victorian Quitline) and pharmacotherapy (nicotine replacement therapy or cessation medications such as varenicline).[68] The Victorian Quitline offers tailored programs for people with a mental illness and provides a culturally appropriate service for Indigenous Australians and culturally and linguistically diverse communities.

Tailored interventions to address metabolic health in people with mental illness are also of paramount importance. This is particularly relevant when commencing antipsychotic medications, which have been linked with an increased risk of obesity, and people prescribed these medications need support to manage side effects such as weight gain.[69] Tailored healthy eating and physical activity programs, developed in consultation with the appropriate clinical expertise such as dieticians, should be offered as part of routine care. For example, the *Life!* program delivered by Diabetes Victoria on behalf of the Victorian Government, is an example of a comprehensive program designed to support people at high risk of type 2 diabetes and cardiovascular disease to make evidence-based lifestyle modifications.[70] Similar programs led by an alliance of health organisations to assist Australians to stay well and reduce their chronic disease risk, such as the *My Health for Life* program in Queensland (supported by Diabetes Queensland, Stroke Foundation and the Heart Foundation)[71] could be implemented in Victoria.

Other programs, such as the Achievement Program (supported by the Victorian Government and delivered by Cancer Council Victoria), serve to support schools and workplaces to create healthier organisational environments.[72]

The burden of chronic disease risk factors can also be lessened through population-based policies to support healthy choices

Policy reforms that promote a healthier environment will also positively impact high priority groups – such as people with a mental illness – and should be supported as a population-level approach to tackle chronic disease risk factors.

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[66] 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.

[67] 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.

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

[69] Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia. National Health and Medical Research Council. Department of Health. Canberra, 2013. Available from: https://nhmrc.gov.au/sites/default/files/documents/reports/clinical%20guidelines/n57-obesity-guidelines-.pdf

[70] Lifeprogram.org.au. Melbourne: Diabetes Victoria [cited Jan 2019]. Available from https://www.lifeprogram.org.au/

[71] Myhealthforlife.com.au. Queensland Government [cited July 2019]. Available from https://www.myhealthforlife.com.au/

[72] Achievementprogram.health.vic.gov.au. Melbourne: Cancer Council Victoria and Victoria State Government [cited Jan 2019]. Available from https://www.achievementprogram.health.vic.gov.au/

Healthy Food & Drink Choices

Governments can take a lead on healthy food and drinks provision through a whole of Government healthy food procurement policy. The Victorian Government has comprehensive *Healthy Choices guidelines*[73] which a number of Victorian health services have taken steps to incorporate into their food provision for visitors and staff.[74,75] Implementing *Healthy Choices* throughout all publicly owned and managed facilities including all Victorian health facilities, would benefit people with a mental illness. Adoption of guidelines by sporting facilities, education facilities and workplaces would increase opportunities for people with mental Illness to select healthier foods and drinks. There is strong evidence that good diet quality is an important preventative measure for adolescent mental health.[76] Therefore, increasing the scope of, and compliance with, the Victorian *School Canteens and Other School Food Services Policy* is also an important aspect of creating healthy environments to prevent mental illness in young people.

Education

In our current environment where unhealthy foods and drinks are heavily promoted and unhealthy dietary practices are common, implementing a sustained state-wide public education campaign to encourage healthy eating is vital to increase Victorian's skills and knowledge to purchase and prepare healthy foods. The campaign should focus on population groups with the highest rates of overweight and obesity including being relevant and accessible to those with mental illnesses. In order to make the campaign effective and relevant for those furthest from meeting healthy eating guidelines, initiatives that improve family diets and increase food literacy should accompany the campaign.

Physical Environment

It is recommended that a strategy to get Victorians walking more be developed and implemented. The strategy should emphasise the need for walking infrastructure and urban design to make it safer and easier for people to walk to local destinations like shops, public transport and schools.

Alcohol Use

The VCDPA and Quit is concerned that factors including the alcohol industry's relentless marketing of alcohol products and the rapid increase in new alcohol outlets in Victoria drive high levels of alcohol consumption. VCDPA and Quit advocates for reform of alcohol regulation and policy to support its objective of reducing the contribution of alcohol to cancer, including strengthening alcohol advertising regulation and the Victorian liquor licensing scheme. The VCDPA and Quit would also welcome improvements in Victoria's mental health system that would help address the links between mental illness, alcohol consumption and increased risk of cancer.

11. Is there anything else you would like to share with the Royal Commission?

Addressing chronic disease and physical health in people with a mental illness is of utmost importance in improving life expectancy for this vulnerable population – it is undeniable that the two-go hand in hand – with mental health and physical health impacting on each other. Addressing chronic disease in people with mental illness can improve their quality of life and promote their recovery from mental illness. Not doing so will perpetuate inequalities and the disproportionate burden of disease.

Quit and the VCDPA's key recommendations for the Commission to consider are:

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[73] Healthy Choices Guidelines, Victoria State Government, December 2016. ISBN 978-0-7311-7055-5 (pdf/online) Available from www.health.vic.gov.au/nutrition [cited Jun 2019]

[74] Alfred Health https://www.alfredhealth.org.au/about/healthy-communities/healthy-food/healthy-choices

[75] Barwon Health https://www.barwonhealth.org.au/component/zoo/item/healthy-eating

[76] O'Neil, A., Quirk, S.E., Housden, S., Brennan, S.L., Williams, L.J., Pasco, J.A., Berk, M. and Jacka, F.N., 2014. Relationship between diet and mental health in children and adolescents: a systematic review. *American journal of public health*, *104*(10), pp.e31-e42.

- Smoking, poor metabolic health and alcohol use, as key chronic disease risk factors, need to be systematically addressed as part of the routine care offered by mental health services and the wider health system.
- People with a mental illness should be supported to reduce their risk of chronic disease with tailored evidence-based interventions.
- Mandated statewide data collection regarding chronic disease risk factors, and the inclusion of data relating to whether an intervention was provided in response to these risk factors, is vital.
- The burden of chronic disease risk factors can also be lessened in people with a mental illness through population-based policies to support healthy food and lifestyle choices.

Thank you for considering this submission.

Should you require any further information, please do not hesitate to contact Dr Jasmine Just, Health Systems Project Lead at Quit Victoria on ▮▮▮▮▮▮▮ or email ▮▮▮▮▮▮▮