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Applying the World Health Organization Mental Health Action Plan to evaluate policy on addressing co-occurrence of physical and mental illnesses in Australia

Brenda Happell[1,2,12] RN, RPN, BA(Hons), DipEd, BEd, MEd, PhD, Professor of Nursing and Executive Director

Chris Platania-Phung[1,2] BA(Hons), PhD, Research Fellow

Stephanie Webster[3] BBus, Graduate Diploma in Vocational and Workplace Learning

Brian McKenna[4,5] RN, BA, MHSc(Hons), PhD, Professor of Mental Health Nursing

Freyja Millar[6] RN, MNP, Project Officer

Robert Stanton[7] BHMSc(Hons), ESSAM, AEP, Research Officer

Cherrie Galletly[8] MBChB, DPM, FRANZCP, PhD, Professor of Psychiatry

David Castle[9] FRCPsych, DLSHTM, MD, MSc, MBChB, FRANZCP, Chair of Psychiatry

Trentham Furness[4,5] BHlthSci, BExSci(Hons), MExSci, PhD, Research Fellow

Dennis Liu[10] MBBS, FRANZCP, PhD, Clinical Lead, Senior Consultant Psychiatrist

David Scott[11] BHM(Hons), PhD, Research Fellow

[1]Research Centre for Nursing and Midwifery Practice, University of Canberra, Faculty of Health. Building 6, Level 3, Canberra Hospital, PO Box 11, Woden, ACT 2606, Australia.
[2]ACT Health, Research Centre for Nursing and Midwifery Practice, Building 6, Level 3, Canberra Hospital, PO Box 11, Woden, ACT 2606, Australia.
[3]Independent Consumer Academic, Life Expectancy Advocate (Mental Health).
[4]School of Nursing, Midwifery and Paramedicine, Australian Catholic University, 115 Victoria Parade, Fitzroy, Vic. 3065, Australia.
[5]NorthWestern Mental Health, The Royal Melbourne Hospital, Level 1 North, City Campus, Grattan Street, Parkville, Vic. 3050, Australia. Email: Brian.McKenna@mh.org.au; Trentham.Furness@mh.org.au
[6]Eastern Health, Melbourne, Vic. 3128, Australia. Email: freyja.millar@easternhealth.org.au
[7]School of Medical and Applied Sciences, Central Queensland University, Rockhampton, Qld 4700, Australia. Email: r.stanton@cqu.edu.au
[8]University of Adelaide, School of Medicine, 30 Frome Road, Adelaide, SA 5000, Australia. Email: cherrie.galletly@adelaide.edu.au
[9]St Vincents Hospital, PO Box 2900, Fitzroy, Vic. 3065, Australia. Email: David.CASTLE@svhm.org.au
[10]Northern Mental Health Service, 7-–9 Park Terrace, Salisbury, SA 5108, Australia. Email: Dennis.Liu@health.sa.gov.au
[11]NorthWest Academic Centre, Sunshine Hospital, PO Box 294, 176 Furlong Road, St Albans, Vic. 3021, Australia. Email: d.scott@unimelb.edu.au
[12]Corresponding author. Email: brenda.happell@canberra.edu.au

Abstract

Objectives. The aim of the present study was to document Australian policies on the physical health of people with mental illness and evaluate the capacity of policy to support health needs.

Methods. A search of state and federal policies on mental and physical illness was conducted, as well as detailed analysis of policy content and the relationships between policies, by applying the World Health Organization Mental Health Action Plan 2013–2020 as an evaluative framework.

Results. National policy attention to the physical health of people with mental illness has grown, but there is little interconnection at the national and state levels. State policies across the country are inconsistent, and there is little evidence of consistent policy implementation.

Conclusions. A coherent national health policy framework on addressing co-occurring physical and mental illnesses that includes healthcare system reforms and ensuring the interconnectedness of other relevant services should be prioritised.

What is known about the topic? People with mental illness have a lower life expectancy and poorer physical health than people who do not have a mental illness. Government policy is critical to reducing inequalities in physical health and increasing longevity.

What does this paper add? Evaluating policy developments against the World Health Organization's Mental Health Action Plan 2013–2020, this review identified a lack of cohesive national-level policy on how to improve the physical health of people with mental illness. Although there are some state-based policies regarding strategies for better prevention and management of the physical health of people with mental illness, evidence of policy implementation is either scarce or inconsistent. The capacity of current policy to translate into reforms that increase the physical and overall health of people suffering mental health difficulties seems very limited.

What are the implications for practitioners? This paper outlines major policy gaps and an overall need for a national-level policy. National-level leadership on integrated health care is required, with monitoring to ensure health care reforms are genuinely informed by consumer and clinician views and are effective.

Additional keywords: inequality, service evaluation.

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Introduction

The poor physical health experienced by people with mental illness is a major and yet under-acknowledged public health inequity in Australia. For this group, lower life expectancy is commonly reported[1] and, just as for the wider population, chronic illnesses such as cardiovascular disease (CVD) are the major cause of death.[2] Mental illnesses, such as depression, schizophrenia, anxiety, post-traumatic stress disorder, eating disorders and bipolar affective disorder, are associated with an increased prevalence of a range of physical illnesses, including CVD, diabetes, respiratory disorders, dental problems and infections.[2–9] Higher rates of physical illnesses in people with mental illness are found in psychiatric hospitals in the private sector,[10] publicly provided units and community out-patients,[11,12] as well as in general population studies.[13–15] Furthermore, preventable inequalities in life expectancy are getting larger.[16] For example, based on mental health service data for Western Australia (WA) from 1985 to 2005, Lawrence *et al.*[16] found that discrepancies in the life expectancy between people with and without mental illness had increased during that period, with over three-quarters of excess death in the former group (77.7%) being attributed to CVD, respiratory disorders and other physical illnesses.

Determinants of mental illness and physical illness are multiple and likely to be interactive. Medication side-effects, including obesity, are regularly reported.[17–19] Factors contributing to the co-occurrence of mental and physical illness include a high prevalence of smoking,[20] low rates of physical activity and poor diet.[21] Coupled with these poor health behaviours are socioeconomic conditions and symptoms of mental illness, which make changing health behaviour very challenging.[22] Contact with general practitioners (GPs) and specialists[23] and the development of integrated care in mental healthcare settings[24] are cited as approaches to addressing the increased risks of CVD, diabetes and other physical illnesses. Yet, access to health care and standards of care within these services are often found to be wanting.[25–27] Consumers, carers and health professionals report being treated with disdain when voicing physical health problems;[28] with their somatic concerns misinterpreted as being about mental health problems, they also experience diagnostic overshadowing.[29] In mental health services, screening and follow-up of risk factors for the range of physical illnesses that consumers may encounter is *ad hoc*,[30] even for what are known to be the most acknowledged problems by clinicians, such as metabolic syndrome.[31] Carr *et al.*[23] reported that for 1185 people with psychosis surveyed around Australia, physical health problems were the most common health-related 'challenges over the next year' at 27.4%, closely followed by 'uncontrolled symptoms of mental illness' at 25.7%.

Policies to address mental and physical illness and access to quality health care are clearly vital to reducing inequalities in health in Australia. It is important to consider what policies are available (federal and state), their level of integration and implementation and their potential to effect change in light of the substantial challenges. These challenges include the complexity of the policy environment, such as multi-tiered governance of healthcare,[32] non-health policy areas relevant to health needs of people with mental illness,[23] the variety of government and non-government services[33] and policies specific to primary health and mental health.[34,35] People with mental illness are not a homogeneous group and live in diverse social and cultural situations. Furthermore, the cultural and institutional stigma of mental illness impact on service delivery.[23,36]

International policy pertinent to mental and physical health care integration in Australia is the World Health Organization's (WHO) Mental Health Action Plan for 2013–2020 (hereafter referred to as the WHO Action Plan),[22] established during the

66th World Health Assembly. Australia is a member of the WHO. The WHO Action Plan acknowledges the elevated rates of physical illnesses experienced by people with mental illness and proposes that member states 'Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting *both mental and physical health care needs*...' (emphasis added).

The overarching WHO Action Plan offers 'six cross-cutting principles and approaches' for member states,[22] which are presented in Table 1. Although less detailed, the Action Plan also acknowledges connections to plans relevant to the physical health needs of people with mental illness, such as on alcohol, social determinants of health and prevention and management of non-communicable diseases.[22] The WHO Action Plan has been acknowledged within health care integration policy in other regions, such as Britain.[37]

Although reviews and commentaries have considered health policy in Australia with respect to co-occurrence of mental and physical illness,[23,26,34] there has not been a comprehensive review of the content and implementation of relevant policies in Australia at state and national levels. The purpose of the present paper is to review Australian policy in order to facilitate progress on integrated care, such as to reduce physical health care inequality for mental health consumers. This review is guided by evaluating the Australian policies identified against the WHO principles laid out in the Action Plan.[22]

Methods

The present review involved identification of relevant policy material and then qualitative evaluation of policy against the general principles of the WHO Action Plan. Mental illness was defined in line with Chapter 5 of the WHO International Statistical Classification of Diseases and Related Health Problems (10th revision),[38] Mental and Behavioural Disorders, in accordance with the WHO Action Plan.[22] Because the Action Plan endorses a 'multisectoral approach' (Table 1), the review encompassed government, non-government public health and health professional bodies. Federal and state government websites were navigated to locate relevant policy and related documentation. This included major national bodies, organisations that focus on specific physical illnesses, policy advisory bodies and websites of state health departments and Ministers of Mental Health. Electronic searches using Google on health policy were conducted using combinations of the following search terms: 'mental illness', 'comorbidity', 'physical illness', 'chronic disease', 'integrated care', 'policy'. The searches took place from May to June 2014. This review also draws on policies identified by the authors in their clinical practice, health advocacy and via attendance at conferences and seminars.

Each policy was evaluated in terms of its attention to each of the six principles set out in the WHO Action Plan[22] (Table 1). This involved qualitative analysis of the content of policy, including location of all occasions where mental illness and physical illness were referred to together in documentation (e.g. depression and CVD), followed by matching all relevant content to the WHO Action Plan. For example, for human rights (Principle 2), we examined whether the policy made reference to human rights and, if so, in what ways.

Results

Overview

There has been increasing attention given to physical health care of people with mental illness in the past 10 years with positive development of policies, signalling an overall movement towards alignment with the WHO Action Plan. Recent developments include: local cross-sector initiatives for specific areas such as dental care,[39,40] change of diet, physical activity[41,42] and smoking;[43,44] identification and management of cardiovascular or cardiometabolic disorders;[31,45,46] and assistance in accessing GPs and effective GP–consumer consultations.[47] Several of these programs for improving services, and studies for ascertaining service needs, have been funded by government at either federal or state level.[39,48] Randomised controlled trials have been conducted for smoking[49] and diet,[50] and several lifestyle programs have been evaluated using other methods.[51,52] These developments have followed emerging consensus on policy and care management approaches to mental and physical illness co-occurrence where the mental health system is viewed to be

Table 1. The six principles, as stated in the World Health Organization (WHO) Mental Health Action Plan[22]

Principle	Statement by WHO
1. Universal health coverage	Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.
2. Human rights	Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.
3. Evidence-based practice	Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.
4. Life course approach	Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.
5. Multisectoral approach	A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.
6. Empowerment of persons with mental disorders and psychosocial disabilities	Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy planning, legislation, service provision, monitoring, research and evaluation.

Table 2. National-level policy challenges and actions required to align with the World Health Organization (WHO) Mental Health Action Plan[22]
HeAL, Healthy Active Lives; MI, mental illness; PI, physical illness; SANSP, Second Australian National Survey of Psychosis; GP, general practitioner; MBS, Medicare Benefit Schedule; NGO, non-governmental organisation

WHO principle	Policy gaps and challenges	Actions
Universal health coverage	Uneven integrated care coverage across states and territories. No national-level policy on integration. Apart from the SANSP study,[23] a paucity of national-level inquiry into service access, utilisation by people with MI and PI, including Medicare. Unknown access and quality of health services as a function of different cultural and ethnical backgrounds. Little policy on whether generic health promotion campaigns and programs are suitable and effective for people experiencing MI. Generalisability of the National Tobacco Campaign appears to be limited.[69] Little consensus on national targets for improved physical health.	National-level policy on care integration of mental health and physical health services, such as clarification of responsibilities between and within primary care and mental health services. Take into account perspectives of consumers and health professionals regarding implications of the proposed GP co-payment. Develop integrated care policy that is respectful of different cultural perspectives on health and ensure cultural competency of healthcare practitioners.[70] Fund research on inclusiveness, suitability and effectiveness of health programs. Ensure program developers consider the needs and unique challenges of people with MI. Through a partnership approach, come to a set of targets and ensure state–national alignment with them. Need for recognition of HeAL[61] at national government level.
Human rights	Little articulation of what human rights are affected by fragmented services,[71] and how human rights frameworks are applicable to integrated care policy.	Involve the Australian Human Rights Commission in policy debate and reform.
Evidence-based practice	Inadequate identification, monitoring and follow-up on cardiometabolic and other risk factors in mental health systems.[34]	Further evaluation, integration and mainstreaming in clinical care of the standards, protocols and guidelines developed thus far.[54,70,72–77]
	No policy direction on what integrated care models (GP incentives via MBS, co-location, consultation–liaison, nurse or case manager coordination of integrated care) are most appropriate, and in what contexts.	Funding of trials of integrated care models in Australia[23] and systematic evaluation of outcomes derived from each integrated care approach. Policy practitioners consult national-level debates on integrated care from other countries.[37]
Life-course approach	Little recognition of life-course dynamics of MI and PI in policy and research, other than recognition that PI onset is earlier in people with MI compared with general population.	Ensuring continuity of recent advances on youth prevention and management,[31,61] with care for older age groups. Policy highlighting higher PI and lower life expectancy of people who have experienced early trauma.
Multisectoral approach	Multisector linkages (e.g. public, private, NGO, employment) developing at state level[53,70] not evident at national level.	Connecting policies outside of health system that impact people's health (e.g. housing, employment) to physical and mental health care integration policy.[57]
	Minimal policy attention to social and economic effects on people's mental and physical health.	Research: integrating empirical research on social determinants of health[78,79] with current research on co-occurring MI and PI.
Empowerment of persons with mental disorders and psychosocial disabilities	Little policy detailing how reforms in major areas (such as recovery)[57] coincide with changes needed on integrated care. Support for consumer involvement and leadership yet to be extended to national level.	Lessons from consumer participation policy and programs in mental health recovery can be drawn on to inform consumer participation in integrated care. Research on consumer experiences and views on level of integration of mental and physical healthcare services and suitability of health promotion programs. National-level attention to the work of physical health advocates.[80] Partnership building between consumers, NGOs and national government agencies.

important (not primary care alone),[53] the side-effects of psychotropic drugs are acknowledged[54,55] and the physical health risks encountered more by people with mental illness are better understood.[56]

Notably, targets, goals and requirements for reporting progress on reduction of physical ill-health and improved life expectancy have been recently formulated in government policy, advisory bodies, international declarations and in the

academic literature.[57–64] These new measures increase the capacity to establish public awareness and evaluate progress of strategies for reducing inequality, especially in accordance with WHO Action Plan Principle 1, Universal Health Coverage.

National-level policy

The Fourth National Mental Health Plan (FNMHP)[57] places greater emphasis on addressing mental illness and physical illness together than previous mental health policy frameworks. In particular, the FNMHP includes two key priority areas: (1) prevention and early intervention (Priority Area 2); and (2) service access, coordination and continuity of care (Priority Area 3).

A national summit 'addressing the premature death of people with mental illness',[63] hosted by the New South Wales (NSW) and federal governments, took place in May 2013 and was attended by a cross-section of stakeholders. Present analysis of the two-page summit communique[63] indicated attention to matters tied to all but Principle 4 of the WHO Action Plan. The National Mental Health Commission (NMHC),[62,65] which has recognised physical ill-health and shortened life expectancy of people with mental illness as a major public health issue, noted that after the Summit there was 'no known progress from public reporting'.[62] It was similarly the case in the present policy review that no policy developments or reports following this Summit could be found.

National-level policy has yet to formally recognise and endorse an international consensus statement, namely Healthy Active Lives (HeAL),[61] which highlights the rights of young people and their central role in improving services, minimisation and closer regulation of medication, and pathways to address stigma and socioeconomic barriers, as well as setting 5-year goals for physical health outcomes for young people with psychotic disorders. HeAL has been endorsed by nine Australian organisations, the UK Royal Colleges of Surgeons, Physicians, Psychiatrists and Nurses, and two international associations;[61] however, it is notable that this has not included state or national Australian governments directly responsible for the provision of health services.

Relevant to Principles 1 and 6 of the WHO Action Plan (universal coverage and empowerment, respectively), the latest national policy on recovery from mental illness[59] cites Victorian policy on recovery that includes physical health.

Table 2 outlines policy gaps identified at a national level. Table 2 illustrates that significant policy work is needed to accord with each of the WHO principles. After reporting of the findings of this review, actions for aligning Australia with the WHO principles, as stated in Table 2, are discussed.

Having a GP is a mainstay of primary healthcare in Australia and this has become a policy focus for people with co-occurring mental and physical illness.[23,53] However, people with mental illness continue to encounter barriers at all major steps in healthcare utilisation.[66] Although the views of GPs and consumers regarding the outcomes of policy development in this area are lacking, nurses who work in mental health report that policies such as the Mental Health Nurse Incentive Program (MHNIP), which is focused towards mental health service improvements in primary care, may also be successful in facilitating integrated care.[67]

In the 2014–15 budget, the Federal government proposed a Medicare co-payment for GP consultations and pathology services from July 2015. These proposals need to be considered in light of their potential impact on people experiencing mental health difficulties and the economic situation of people in those life situations. People with mental illness already report considerable difficulties in accessing GP services, and a decrease in bulk-billed services has been reported to be a barrier to primary care.[68]

State policies

Infrastructure for policy development through partnerships between state government, regional services and consumer groups seems to be most well established for states and territories with the largest populations: Victoria, NSW, Queensland and WA. The greatest change in policy has been state based and subsequent to the findings of the Duty to Care Report[35] in WA. In WA, changes included the introduction of the HealthRight Advisory Group, cross-sector partnerships (university–non-governmental organisations (NGOs)–state government linkages), lifestyle programs (Healthy Body Healthy Mind) and consumer participation.[70,75,81,82] It is unclear whether these initiatives have extended beyond Perth to regional WA, or the remainder of Australia.

A Ministerial Advisory Committee on Mental Health was established in Victoria and, following consultations with consumers and GPs, assembled a report detailing roles for the primary and mental health sectors. Principles were 'affirmative action' and a 'whole of system approach'.[53] The policy reform proposals were broad and integrative: recognising the potential of the MHNIP[83] for providing more comprehensive care, considering recreational opportunities for physical activity outside the healthcare system and locating state-based systems within a national reform process led by the Council of Australian Governments. Although the Report[53] provided detailed actions and recommendations to the State Government, no follow-up policy development by the Victorian Government could be found. Such a failure to translate policy proposals into action has not occurred in all states. In NSW,[84,85] Queensland[86] and WA,[70] similar proposals have led to the development and partial implementation of physical health guidelines for mental health consumers. Some state governments have funded programs to support consumers in participation and advocacy in evolving physical health services, such as the Peer Advocacy and Support Service in WA.[82]

Insofar as behaviours affect physical health, research informing policy is most visible in response to banning or restricting smoking in mental health facilities.[69,87] This has included a review of policy implementation, where it was argued that to support continuity in cessation and readiness to quit, specific antismoking support is needed in both community care and inpatient care.[88,89] Contrary to stereotypes of people with mental illness as self-neglectful, efforts to quit tobacco continue after engagement in cessation programs.[90,91]

Discussion

Given the disparities in physical ill-health and life expectancy between people with and without mental illness, one may

anticipate an aggressive policy approach to reverse these inequalities. Such an approach would include paying close attention to ensuring adequate access to and good-quality health care. However, in the present evaluation of Australian policy from the point of view of the WHO Action Plan, the policy framework on how health care is arranged to ensure physical and mental health needs are met is inconsistent. In particular, there was transient attention at national level, uneven attention across states and territories and significant gaps between policy and implementation.

There has been some progress in national policy on integrated care, as evidenced by the attention given to co-occurring physical illness in the FNMHP. However, there is a lag between the evidence base of staggering physical health problems of people with mental illness in Australia[16,23,92] and policy implementation. Further, there is minimal development of a central national policy to provide strategic direction. Recent budgetary and other policy proposals will see less emphasis on prevention of illnesses at a national level.[80] In addition, there is no minister for Mental Health at this level. Overall, there is a shortage of pathways for key concerns of consumers (such as physical health) to have political influence.

The greatest clinical consensus is on the need for cardiometabolic monitoring of consumers on antipsychotic medication as minimum care.[73] Just as in other countries,[93] the availability of physical health screening guidelines has not ensured minimal screening standards are met for physical health problems such as CVD. Screening and monitoring protocols and guidelines are available in Australia[45,46,54,70,75,77,94] (see Table 2) and overseas.[47] Further, although screening is important, this should be followed by effective, evidence-based interventions.[61]

People experiencing mental illnesses other than psychosis, such as anxiety, depression and trauma, encounter heightened rates of a range of physical health problems and chronic diseases, such as CVD.[2,15,95] In light of this, there needs to be more consistency in Australian physical health care of people for a wide spectrum of mental illnesses while retaining a whole-of-person approach, consistent with the WHO Action Plan.[22]

As found in a literature review by Chadwick *et al*.[96] of consumer views on healthcare, numerous barriers mental health consumers face derive from healthcare providers, such as attitudes and organisation of care. As indicated in Table 2, there needs to be much more research into the views of mental health consumers regarding physical health, and genuine direction of reforms based on consumer viewpoints and recommendations. Strengthening of research and policy centred on consumer perspectives will be recognition of the diversity of groups of mental health consumers. These steps would ensure progress across all principles of the WHO Action Plan.

The present review is not without limitations. We did not analyse local and regional policies and service arrangements. There may be policy developments underway that are yet to be made public that may have been missed in this review. However, because the research team represents different states in Australia, we are reasonably confident we have identified most of the relevant policies.

Conclusion

A highly visible national-level policy framework on improving the physical health of people with mental illnesses is required. Health policy could be greatly strengthened by drawing on special knowledge of consumers, policy makers, health practitioners and carers.

Competing interest

None declared.

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