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PO Box 668 Rozelle NSW 2039

T 02 9555 8388
F 02 9810 8145
E info@mhcc.com.au
W www.mhcc.org.au

ABN 59 279 168 647

Dr Rohan Hammett
Deputy Director-General, Strategy and Resources

NSWPHCC@doh.health.nsw.gov.au

**Subject: Submission National Primary Health Care Strategic Framework: Consultation Draft**

Dear Dr Hammett,

The Mental Health Coordinating Council (MHCC) thanks the NSW Ministry of Health for the invitation to provide feedback into the consultative process concerning the *National Primary Health Care Strategic Framework: Consultation Draft.*

In the first instance MHCC state their support for the vision for a national primary health care framework, and strongly support the four strategic outcomes requiring further focus:

- Build a consumer-focused integrated primary health care system;
- Improve access and reduce inequity;
- Increase the focus on prevention, screening and early intervention; and
- Improve quality, safety, performance and accountability.

However, in our view, the draft paper seriously omits to consider the breadth of services, skills and competencies necessary to achieve the stated outcomes, except expressed in very general terms. Each area of health requires quite different engagement with primary health care. Mental health for example requires primary health care to play a very different role than for other conditions such as diabetes or skin disorders.

Despite references in the draft paper to Australians generally enjoying some of the best health outcomes in the world, with the fifth highest life expectancy in OECD countries in 2009, the story is a very different one for people who experience mental illness and coexisting psychosocial difficulties in Australia who can expect to live 20/25 years less than the general population (a comparable statistic to the United States and Europe).

Dr Joe Parks Director, Missouri Institute of Mental Health and Distinguished Professor of Science, University of Missouri (who was recently in Australia and spoke at a MHCC forum on the relationship between mental and physical health) – he stated that:

> *People with serious mental illness (SMI) die, on average, 25 years earlier than the general population. Studies document recent increases in death rates over those previously reported. This is a serious public health problem for the people served by our mental health systems. While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia* (for example) *are due to medical conditions such as cardiovascular, pulmonary and infectious diseases. Compounding this problem, people with serious mental illness have poorer access to established monitoring and treatment guidelines for physical health conditions.*[i]

The impact of mental illness within the Australian population has become increasingly apparent. The 2007 National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics found that an estimated 3.2 million Australians (20% of the population aged between 16 and 85) had a mental disorder in the twelve months prior to the survey. The Burden of Disease and Injury in Australia study indicated that mental disorders constitute the leading cause of disability burden in Australia, accounting for an estimated 24% of the total years lost due to disability.

Internationally there is increasing recognition that stronger primary care systems are associated with better health outcomes and lower costs. Particularly in the sphere of mental health - when improved primary health care is holistic and person centred, delivered by a workforce well versed in mental health issues that is well connected to a diversity of community managed psychosocial support services, primary health care has the potential to prevent hospital admissions. It also can prevent inappropriate and unnecessary use of acute hospital resources, residential aged care services and ambulatory services and interactions with the criminal justice system.

In the context of the National Health and Hospital Reform agenda, primary health and community delivered services face unique challenges. Over the past three decades primary health services have come under significant pressure to address a more complex and diverse range of community mental health needs. Several important trends have contributed to these pressures. [ii]

- Support for the social rights of people with mental illness and coexisting problems to receive care and treatment in the community.
- A greater appreciation of the social context for health has seen the development of services that address mental health, indigenous health, cultural and linguistic diversity and consumer and carer participation. Health promotion focused on social, economic, organisational and social determinants of health has emerged a significant area of activity for primary care services.
- More recently, there has been a significant expansion of same day procedures, hospital in the home, rehabilitation in the home and community based care and support for people with chronic health care needs.

Many problems exist in relation to access, equity, efficiency and quality. Whilst there has been a significant expansion of community based services to support people experiencing mental health issues in the community, there is a poor understanding in the primary health sector about what actually helps people with mental health problems recover in the community. It is not just about medication and management by a clinician with community services sitting on the periphery.

The community managed sector provides a range of clinical and nonclinical psychosocial services critical to prevention, early intervention and staying well in the community. Community managed services provide care coordination with the consumer at its centre. The Framework as it presents primary health care is a further expansion of the role of the GP as 'gatekeeper' for all aspects of health care. MHCC propose that it is necessary for the system to recognise the different roles and competencies necessary to provide good mental health outcomes, and how the primary health sector can partner and collaborate effectively with mental health public providers and community managed services.

Whilst the draft paper alludes to the diversity of services necessary to provide a seamless model of care, it clearly demonstrates in the detail a model of care that has the GP at its core and which is a medicalised approach to care. This is a model that fails to meet best practice standards in terms of

people experiencing mental health problems who require a coordinated recovery orientated approach to care and support in the community.

When most Australians think about mental health services they think of hospital-based care for those few people who are extremely unwell and/or experiencing a psychiatric crisis at any given time. The contributions of private providers such as psychiatrists and psychologists, and increasingly GPs, might also come to mind. However, sound knowledge of community mental health services – both public (i.e. government) and community managed (i.e. non-government)—is often quite limited. [iii]

This thinking about Australian mental health services has in part been created by a mental health system that continues to be based on a medical model with its focus on illness, symptoms, hospital beds and medication. The social determinants of health, the principles of mental health recovery, the importance of social inclusion and trauma informed approaches are now well understood. Yet the restructure of mental health services to reflect this knowledge base has not been well targeted.[iv]

The National Health and Hospital Reform currently underway in Australia, including the important emerging role of Medicare Locals in strengthening primary healthcare responses for people with complex and diverse health and social needs, provides an opportunity to strengthen social determinants and human rights based approaches to mental health care that better supports prevention of, and recovery from, mental illness. However, this will not be achieved without a much greater awareness and knowledge of the community managed mental health sector and the services and programs it provides.[v]

A key challenge relates to the risk of increasing fragmentation in service delivery as new providers enter the scene, including Medicare Locals and private health professionals delivering Medicare reimbursable mental health services. Health and community service providers are increasingly asked to work as part of interdisciplinary teams and to provide integrated services. Unfortunately, the evidence base related to service coordination and achieving integrated care is not well understood or established. This includes an important gap regarding the views of people affected by mental illness and service providers in identifying the knowledge, skills and attitudes (i.e. competencies) required to achieve integrated care.[vi]

Australia has a rich, complex and diverse non-government community managed mental health sector that has been delivering services that keep people well and out of hospital for more than 100 years. Unfortunately, the sector is not well understood or recognised beyond the many Australian's fortunate enough to have received services from it. The community managed mental health sector has a critically important but marginalised role in ensuring the well-being of the many Australians affected by mental illness. Community managed mental health services need to be recognised, valued and further developed as a core provider of services to people affected by mental health problems.[vii]

Under the National Health and Hospital Reform agenda the Medicare Locals (MLs) should primarily be taking on a co-ordination rather than a service delivery role . There is a strong risk of duplication occurring in this dynamically changing service delivery environment if MLs take on the role of delivering services that are already being delivered by an experienced community managed mental health sector. This is an area that needs to be monitored so that, in relation to people with mental health problems, we do not see a creep away from recovery orientated community based care approaches, back to a medicalised model delivered directly by MLs.

In relationship to these discussions about models and approaches to service delivery, it is important upfront that the National Primary Health Care Strategic Framework clearly define the language and terminology of 'Primary Health Care'. Different service systems and sectors have very different views as to what constitutes Primary Health Care, and MHCC strongly recommends that this is a vital element to ensuring all the parts of the health care system are on the same page at the outset.

The community managed mental health sector is uniquely placed to facilitate recovery and social inclusion opportunities for people living with — or at risk to develop — mental health problems, as well as their families and carers as part of the primary health care system.

A number of priority areas relating to mental health and well-being have been identified by the Australian Social Inclusion Board. These include:

- Supporting people with a mental illness to find appropriate employment/education
- Tackling the social exclusion resulting from homelessness and the lack of affordable housing
- Supporting early intervention and prevention for those at greatest risk of long-term disadvantage through health education and family relationship services. [viii]

For the National Primary Health Care Strategy Framework to provide effective service delivery to people with mental health problems it must fully consider the contribution and situation of the community mental health sector. For this reason, an increased understanding of who the sector is, the services it provides, the workforce that provide them and the developing evidence base for the effectiveness of community managed mental health services is critical.

MHCC recommend that the National Primary Health Care Strategy Framework refer to the publication, *Taking Our Place — Community Mental Health Australia: Working together to improve mental health in the community,* which has been developed toward closing that knowledge gap, authored by Community Mental Health Australia (CMHA) a coalition of community mental health peak bodies in all eight states and territories. CMHA was established in 2007 in recognition of the shared activities, challenges and potential to effect change of the state and territory community sector mental health peak bodies and their respective memberships of more than 800 non-government community managed organisations (NGOs/CMOs) nationally). These organisations offer a broad range of services to people affected by mental illness. The primary goals of CMHA are to build a viable and sustainable community managed mental health sector and to promote the value and outcomes delivered by community managed mental health services based on a philosophy of recovery and social inclusion. [ix]

This paper is attached and is also available at:
http://www.mhcc.org.au/documents/Projects/CMHA%20Promotions%20Paper%20FINAL-WEB.pdf

Access to community based services varies significantly and people with very similar needs have inequitable access depending on evolution of programs and eligibility criteria in a particular location. Frequently, people with mental illness, often with chronic coexisting physical health and other complex needs such as post-acute care, substance abuse problems and intellectual disabilities have variable access to publicly funded primary health and community care services across jurisdictions.

Local responsibility for population health and the coordination of services and costs for specific populations is often diffuse and fragmented. In this context it is not surprising that local health promotion, prevention and early intervention remain relatively under developed. There are also significant concerns about the continuity of care for individuals over time and across service types

and sectors, particularly between acute, sub- acute and other human service sectors in the community.

Governance, organisational, payment and accountability arrangements sometimes present difficulties for integration and continuity of services for individuals or population groups with specific needs across agencies and providers (e.g. people with mental health needs and coexisting chronic physical illness, post-acute care needs, alcohol and drug problems, survivors of long-term trauma and abuse and ageing people with lifelong mental illness).

MHCC also note that there is poor evidence in the framework as to how individual primary health providers will collect data and be made accountable in terms of performance measurement and consumer outcomes and experience of service delivery. Nor is there and clarity about data collection on referral patterns and collaboration between services and feedback loops. These problems are exacerbated by having different performance reporting and accountability requirements for similar services and target populations.

The Framework lacks a clear and consistent and comprehensive approach to improving and monitoring the quality of primary health and community care for people with mental health problems in the Framework. Whilst the Quality Improvement Council runs a national scheme that accredits over three hundred primary health and community support agencies (http://www.qic.org.au/) and there is now a national approach to GP accreditation (http://www.agpal.com), in general, there has been a proliferation of models for primary health and community care service often with variations across jurisdictions. At the same time there is a proliferation of standards and approaches to monitoring quality across jurisdictions and sectors.

**Directions for reform**

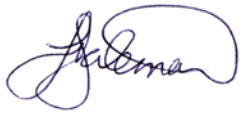
In the context of National Health and Hospital Reform initiatives, development of a national framework for primary health should include consideration of the following elements to address the issues which have been discussed earlier:

- National primary health and community care goals and objectives that set out equity, efficiency and quality criteria.
- National performance indicators used to report on and benchmark the quality, access, efficiency and utilisation of the primary health and community support system and its impact on acute, sub- acute and residential care.
- Population based planning, allocation and monitoring.
- Coordinated service pathways including consistent best practice models linking prevention, early intervention, primary care, acute-care and community managed support services should be developed for all illness, and co-existing illness ,health care needs.
- National workforce planning and analysis for primary health and community managed support services.
- A national evaluation, research and development program in primary health and community managed support services.

- Notwithstanding the need to strengthen overall system capacity, it is clear that there are significant opportunities to strengthen integration across primary health and the community managed service sector and between these services and the acute and residential aged care sector.

MHCC have embarked on a Service/ Care Coordination Strategy that investigates the system reforms necessary to provide improved care coordination across mental health related service sectors, and the workforce competencies necessary to undertake care coordination roles. This work is shortly to be completed and MHCC will be pleased to forward the Ministry a copy. Service/ Care Coordination is central to the many issues that need to be taken into account in developing a National Primary Health Care Strategic Framework in Australia. Improvement to Australian primary health care will only eventuate if the national framework embraces a person centred approach to service delivery and promotes service and care-coordination across the public, primary and human services community managed service systems.

We thank you for your interest and look forward to further discussion in the near future. For more information on this submission please contact Jenna Bateman, CEO at jenna@mhcc.org.au or Corinne Henderson, Senior Policy Officer at corinne@mhcc.org.au



Jenna Bateman
Chief Executive Officer

[i] Morbidity and Mortality in People with Serious Mental Illness. 2006. Editors: Joe Parks, Dale Svendsen, Patricia Singer, Mary Ellen Foti, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

[ii] Swerissen, H. 2004. The importance of primary and community care.

[iii] - X. Community Mental Health Australia (CMHA: 2012). Taking Our Place — Community Mental Health Australia: Working together to improve mental health in the community. Sydney: CMHA, p.2 - 6.