

SOCIAL INCLUSION AND PRIMARY MENTAL HEALTH CARE

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by

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Good Morning ladies and gentlemen.

Like you I have listened to many speakers yesterday who have informed us and given good insights for the future.

I particularly want to mention the Federal Minister for Mental Health and Ageing, Hon Mark Butler who spoke at this conference yesterday (via video). He has a reform agenda.

He has gone out and listened to communities and he is driving reform and change. He has my confidence and the support of many in the mental health sector who know he is trying hard to move the mental health system forward.

I am here to speak to you today mainly as a social worker. For the past 40 years I have worked within the community and with government on many social issues. For 10 years, between 1970 and 1980 I worked on the front line of family support and juvenile justice in a major geographic area of disadvantage in South Australia. Funding for community programs and innovation was available and fairly generous. So funding wasn't a problem.

But no change occurred.

So why did most of our work fail? The answer is now pretty clear to me. We had no clear plan, no targets, no working to outcomes, no real evaluation, no effective collaborative, and apart from good will, definitely no integration of services.

I will come back to all of this a little later.

The main message I want to give today is about social participation.

When I talk about social inclusion, an area of social policy I am closely involved in, I am really talking about ways to increase the economic and social participation of vulnerable and disadvantaged people in the life of the community.

We have more and more evidence that a person's physical health, mental health and wellbeing are directly linked with their opportunities to access education, training, employment, health and mental health support, stable housing, social networks, hobbies and interests as well as other vital services.

And it is becoming clearer in the orbit of public policy that family support, general health and mental health services increase in their effectiveness when they are connected and integrated with the above foundation stones of social participation. Indeed these are the foundation stones of both increased social AND economic life for citizens.

The current structures of general health, mental health and social participation resources and services to Australians must catch up with this reality!

Only about two years ago when the World Health Organisation put out its report on the Social Determinants of Health, one of the major social determinants of health throughout the world, was education. The link between education and indeed a wide range of areas of social participation and health is being made more and more.

So having said this, I am lead to the question.

How should the world of mental health and indeed the work of primary mental health care connect with the foundations of social participation?

At the moment we have a lack of connection and integration, albeit with a few exceptions of some programs on a relatively small scale.

The issue of connection, integration of services, joined up services, new models of collaboration and coordination of services are all very important if we are going to address social participation as a mainstream issue in mental health reform. And integration within health services is also important.

Let me start with the integration of mental health services with the areas of social participation.

If we can create these integrated connections we will be able to offer the people of Australia a new model of mental health care that goes way beyond the present paradigm. We will have a mental health system geared to outcomes in the range of areas that are crucial for the wellbeing of all Australians in their daily lives.

It is my assertion that Australia's mental health system will only truly be responsive to the needs of people and successful in producing proper outcomes when it has been transformed into an integrated system with the foundation blocks of social participation.

We need to go far beyond what I might call first level cooperation between clinical and non clinical services. And I would suggest that this particular distinction is no longer helpful or relevant.

It should be collapsed into a paradigm of goals around mental health wellbeing that provide access to the wide range of opportunities and services needed, into the one holistic joined up pattern.

It is more than simply 'adding on' social participation services to medical services and what we currently define as mental health services.

A new level of integration of services needs to happen. And this new level of integration places the foundations blocks of social participation at the centre of a new mental health system, not the edges!

We all know that the mental health system is in need of significant increased funding. More than half of people in need of mental health support are not being diagnosed or treated.

This is alarming.

I fully agree that significant increase in funding is necessary. But I don't want to see NEW money going into an OLD system.

We must get the mental health system right with the right services for people in need. And part of the plan to get it right is to create a new focus for the system. A focus of social participation. And to develop the infrastructure and the new connections within the mental health system to bring this about.

I also suggest that an integrated model of mental health and social participation should be inserted into a life stages approach to the mental health system.

And we should have specific goals for the mental health system in its response to individuals at their various life stage.

In a recently released document called a A Blueprint to Transform Mental Health and Social Participation in Australia, produced by the Independent Mental Health

Reform Group, of which I am a member, the report outlined a life stage approach to a reformed mental health system.

It said:

“The goal of mental healthcare in early childhood (0-5) would be to support families and children under five, to focus on early childhood development.

The goal of mental healthcare in early school years (5-12) would be to support children to establish the basic skills to adapt educationally and socially to primary school.

The goal of intervention in adolescence and emerging adulthood (12-25) should increasingly be on the individual, but family, educational and employment environments will also be important. Young Australians should be able to select the type of mental healthcare that best suits their needs (including one stop shops, specialist youth mental health services, e-health portals and centres based in educational institutions or employment services).

The goal of mental health care in middle years (25-65/70) should be to support midlife Australians to effectively manage mental illnesses and to lead a productive life through a stable home, caring relationships and meaningful activity. These people should have a choice whether health, housing, social participation or employment agencies play the lead role in the coordination of care.

The goal of mental healthcare in later life (65/70 plus) should be to support older Australians to enjoy healthy ageing, including the prospect of living in their own homes”.

Within these frameworks of life stages and social participation we need vital services.

But it is a new level of social participation in the mental health system that must be on the reform table.

Mental ill health is a key driver of long term unemployment and we know that a good secure job has a big positive affect on a person’s mental health.

So it would be important in a re configured mental health system to have a significant expansion of community services to enhance social participation, and capacity building for employment services sector targeting people with a mental illness. This will require the re orienting of some services and further skills training in the employment sector to support people recovering from mental ill health to re enter the workforce.

As well, secure and stable housing is also directly linked to good mental health outcomes. So housing support programs targeting people with mental health needs

and providing more alternatives to acute hospitalization must be further developed and directly linked into the mental health system.

I am very affirming of the South Australian government under the leadership of our Premier Mike Rann, who has a social inclusion agenda, in its decision to use significant money from the stimulus package to allocate 262 houses to mental health. This gives South Australia the opportunity to grow the number and types of accommodation available to mental health consumers. It is a massive boost to our resources in our mental health system.

To bring about the integration of mental health services with access to opportunities and services specific to a person's social participation in the community, we need new skills developed for care coordination in many agencies.

This would require specific funding made available by government to bring **integration** and coordination about. And the funding should be for new structures and new incentives in this area.

One mechanism of integration might be to fund a lead agency to be responsible for coordination and integration. Any one agency or organization in the mental health and social participation areas might be able to qualify to take on the role of care coordinator and wrap the services of a number of agencies around the person.

At the end of the day, wherever the locus of co ordination rests, the person must be put first, not a system or systems.

As we have said in the blueprint for reform:

“Increasing the level of social participation in education, training, work, family life, good and stable housing, community networks, with friends and colleagues, neighbourhood groups and local organizations enhances the human dignity of people and builds a strong and resilient community that is able to care for its citizens. This is about social inclusion. People are brought more into the centre of community life”.

That is where the mental health system must go.

Besides the development of new integrated community services, we also need to see a new level of collaboration in health services.

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GP Plus, and Super clinics, and the recently announced Medicare Locals all provide opportunities for integrated and collaborative services.

As the blueprint for a reformed mental health systems says:

“Health care reform, particularly with an emphasis on enhanced care for those with chronic illness, needs to pay particular attention to those with mental illness. The movement towards more meaningful management of long term and complex conditions in enhanced primary care environments is long overdue..... it is essential that relevant medical and psychological care components, as well as primary and more specialized mental health care components are not only well integrated but preferentially co located.

Another major consideration is the need to ensure that primary care based systems actively track the broad health outcomes of those with chronic or recurrent mental disorders (as well as those with overt medical co morbidity or mental disorders that occur secondary to other medical conditions or treatments).

“..... To achieve ... enhanced medical and psychological outcomes, integrated health centres need to reflect key underlying philosophies such as the ‘medical home’ concept and actively promote a willingness to be the optimal point of initial or recurrent health care for people with recurrent or chronic mental disorders.”

Consequently funding needs to flow to areas such as incorporating the ‘medical home’ model into our primary mental health system.

I want to say a little more about the ‘medical home’.

In the blueprint of reform I have already mentioned, we say:

“Extensive work by the Commonwealth Fund of New York on the value of the ‘medical home’ in primary care, particularly for those with chronic ill health, and the related work by the Institute of Medicine on enhancing quality of mental health care, indicate strongly the need to develop specific centres that focus on delivery of highly integrated medical and psychological care for those with recurrent or chronic mental disorders.

Such centres may develop from traditional multi disciplinary based general practice or other primary care based health services or may develop out of existing specialist practice centres or adequately resources community services programs that already have ongoing contact with the population in need”.

There is another important aspect of reform. It goes to the heart of accountability.

And accountability and clearly defined outcomes go together.

At present, our mental health system in Australia is outcome blind.

This must be urgently addressed.

And to focus more forcefully on outcomes and goals, one word becomes very very important. And that word is measurement.

As GPs you work in a world of measurement. Whether it is blood tests or a wide range of specialized testing procedures, or basic blood pressure or temperature, etc. You know the importance of measurement.

Measurement is vital to achieving outcomes.

In the area of mental health, measurement is lacking; we don't really focus on outcomes. There are no nationally set targets and outcomes to achieve that can be measured.

That has to change.

One of the important ways to bring about that change, and a way that I, along with many others, am advocating for, is the establishment of a National Mental Health Commission.

And that such a Commission would have a monitoring, evaluation, assessment and advocacy role. That it monitor and evaluate against national targets and goals. This would assist the mental health system to demonstrate effectiveness in delivering on outcomes. And many of these targets would be social participation targets around education, training, employment and housing. This would be a unique breakthrough and it would drive the integration of mental health services with social participation resources and services.

The Commission could also give advice to the Federal Government on the realignment of goals to serve dual purposes regarding mental health outcomes as well as social participation outcomes. It could also give advice on what is working and what is not working in the mental health system, and it could suggest to the government where and how money could be shifted if higher priority areas emerged.

And the Commission should report annually to government and to the community on these targets and goals.

Data is the eyes and ears of good public policy. A National Mental Health Commission would collect and use data regarding outcomes.

This vehicle would be crucial to the ongoing shaping of mental health systems and services in Australia to meet the needs of so many people. And it would be a voice for people to ensure that governments are listening and responsive.

I want to conclude my remarks with some reflection on my work in South Australia in social inclusion. One of my roles in South Australia is to monitor and evaluate particular social programs against outcomes and to not only report on outcomes but

to intervene in systems and bureaucracy to ensure that programs stay on track to achieve goals and outcomes. It is a mechanism referred to as 'independent advice embedded in government'. It sounds like an oxymoron doesn't it. But it is a most successful mechanism to driving goal and outcome success.

What has 9 years of work in joined up government and joined up services taught me?

That joined up services is not a natural fit!

Services will say NO. Leave me alone! I enjoy being a silo. And if you join me up with other services, I will do all I can to leave the group and go it alone!

This is in the nature of systems.

Joined up services will always require a mechanism in place to ensure joined upness remains in place can effectively achieve its goals.

Recognising this, means that we have to put clear and defined mechanisms in place to bring about joined up services.

In fact I would recommend three responses.

First, clear targets and goals are essential together with the proper funding mechanisms to bring the services together in the one plan. The funding of a lead agency to be the agency designated to assist in the joining up, would be one mechanism worth considering.

Secondly, some type of monitoring of the 'joined up ness' of the group (preferably from an independent source or semi independent), and some mechanism to intervene to sort out blockages and barriers, is also essential.

And thirdly, good ongoing evaluation is essential in order to keep the joined up program as responsive as possible to achieving the targets and goals.

The Commonwealth Government has a big task ahead in addressing the mental health needs of the community. This comes at a time when the demands on public money are huge. Hopefully we will get some new money, but I think it is a time when we are going to need to focus squarely on the realignment if not the reallocation of resources to really develop the system we need.

Thank you for listening. I hope we all see huge developments in the mental health system over the next few years. I hope that in the next few years I am not asking myself the question I put at the beginning of my talk today ... Why did we fail!

I don't think we will. I sense a bright future in Australia for a new mental health and social participation era.

Thank you.