



NMHCCF submission to the Australian Commission on Safety and Quality in Health Care Consultation on Patient Safety in Primary Health Care

October 2010

The National Mental Health Consumer and Carer Forum (NMHCCF) is the combined national voice for consumers and carers participating in the development of mental health policy and sector development in Australia.

Introduction

Mental health consumers and carers face a range of barriers to effective, quality mental health service delivery and care. These barriers include stigma within services and in the community, inadequate access to appropriate services, inadequate community mental health supports, lack of service coordination, poor service culture resulting in discrimination and substandard care, lack of appropriate evaluation and continuous quality improvement in services and lack of leadership for appropriate change management. In addition, consumers and carers do not receive appropriate support to assist them access services around housing and employment.

All of these issues regularly impact on patient safety with often severe consequences, ranging from the potential for immediate injury or disease to severe long term health effects caused by lack of access to, or falling through gaps in service provision. This often leads to a vicious cycle where mental health consumers become increasingly unwell, leading them back to acute hospital based care, which could have been averted with adequate access to treatment options and community supports.

Carers describe being forced to watch consumers wait until their mental health conditions become sufficiently florid to demand the attention of the largely hospital based acute care system currently in place. This is often despite repeated calls from carers for help and assistance prior to the issues escalating into more dangerous, unhealthy and long lasting situations.

The situation seems hopeless for many mental health consumers, carers and those working in the sector. These issues have been the subject of numerous submissions from the NMHCCF,¹ reports,² senate inquiries³ and recent ministerial advice.⁴ The significant financial commitments made under the COAG National Mental Health Plan 2006-2011 were welcome but comprised a group of loosely related projects, as opposed

¹ See www.nmhccf.org.au/submissions

² Mental Health Council of Australia, 2005, *Not for Service experiences of injustice and despair in mental health care in Australia*, a report of the MHCA and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission, Mental Health Council of Australia.

Mental Health Council of Australia, 2003, *Out of Hospital out of mind, A Report Detailing Mental Health Services in Australia in 2002 and Community Priorities for National Mental Health Policy for 2003-2008*, Mental Health Council of Australia.

³ Parliament of Australia, 2008, *Towards recovery: mental health services in Australia*, a report from the Senate Standing Committee on Community Affairs, Commonwealth of Australia.

Parliament of Australia, 2006, *A national approach to mental health – from crisis to community*, a report from the Senate Select Committee on Mental Health.

⁴ National Health and Hospitals Reform Commission, 2009, *A healthier future for all Australians - Final Report June 2009*, National Health and Hospitals Reform Commission.

to a strategic approach to reform. With a lack of any real data on mental health outcomes in Australia, the effects of this plan are not able to be effectively monitored.

Yet there is evidence to support good practice models and demonstrated areas of excellence do exist. Many of these are also documented in the reports outlined above. What is urgently needed now is serious consideration of why such services are not the norm in Australia's mental health system. This analysis will be extremely important in informing the implementation of a patient safety framework in mental health and primary care.

The mental health consumer and carer experience of primary care

Case Study

One of my sons who has schizophrenia was diagnosed with diabetes 4 years ago. We struggled for 3 years, even with the intermittent assistance of mental health service and a GP. He was hospitalised in general and psychiatric wards many, many times over three years. "His own choice" was an often repeated phrase we heard!

Then 1 year ago, he was taken on by the Royal District Nursing Service after a hospital admission, who realised immediately he could not manage his illness himself.

They have been fabulous. They installed a special telephone with a screen in his home. They phone him every night and observe him injecting his insulin and he can also see them. They talk briefly with him and check his blood sugar levels, which he keeps a records of in a booklet they have given him.

His keyworker, who is a nurse from RDNS, visits him every Monday at the same time and talks to my son (and his father who is his main carer) about what has happened this week, adjusts his medication if necessary, and reminds him of the food he is supposed to eat.

This is a fabulous example of how people with cognitive impairment as a result of severe mental illness and physical health issues should be cared for. RDNS are consistent, reliable and assertive, when it is necessary to be so!! My son has never responded so well to workers. He is described by RDNS as "motivated" and one of their "star" clients, despite being described by previous mental health workers as "difficult to engage".

It is not that difficult to provide a good service and also not that expensive. It only takes 10 minutes a day for the phone call, plus one meeting once a week.

It is all about someone being accountable and having the right attitude - and actually caring about people. If people with schizophrenia were all receiving a service such as this, we could probably alter those appalling early mortality rates!

Anonymous carer, 2010

In the mental health sector, primary care can involve general practice, community health centres, community mental health services, ambulance and police services and hospital emergency units. As already outlined, these busy services are often placed under strain meeting the crisis needs of mental health consumers and carers, whose crises could have been averted with appropriate care available and supports in place.

Ambulance and police services are often a first port of call for mental health consumers who are so unwell that they are unable to access appropriate care themselves. The lack of alternatives for many mental health consumers to adequately manage their illness in the community means that after the police, hospital emergency departments are also a significant point of contact.

One alarming statistic is that two thirds of people with mental illness, who attended hospital emergency departments, reported that they did not receive mental health care in 2006-07, and that they had unmet needs in counselling, social intervention, information, skills training and medication.⁵ Other evidence shows that one in four people who made a suicide attempt did not access services for mental health problems in the previous twelve months.⁶

These figures are a major concern given the evidence for early intervention to assist individuals in managing mental illness.⁷ The figures should also be of concern to policy makers who are seeking to relieve funding pressures on the hospital system, remove access block and prevent episodes of serious mental illness which require acute care.

Further, under the COAG agreed National Health and Hospitals Network plan it is proposed that 'medicare locals' will be used to coordinate and deliver primary care mental health services. While it is not clear what this will involve, medicare locals are likely to open up new roles and organisational structures around the mental health and primary care interface which have not existed up until now. It will be very important that these are established to manage the risks for mental health consumers and carers in primary care and carry out best practice in coordination and delivery of services.

Physical health

The often neglected physical health of mental health consumers is of particular concern to consumers and carers and should be a focus of any initiatives in patient safety in primary care.

Mental health consumers experience higher rates of diabetes, heart disease, and obesity, and have considerably elevated mortality rates from all main causes compared to the general population.⁸ They are often not in contact with mental health services, have no GP and can lack the skills to manage, or lack a focus on, their physical health. If they are in contact with these services, there are often inadequate supports to ensure that their daily needs are met, such as following up with medication.

The NMHCCF has developed an Advocacy Brief on the *Physical Health Impacts of Mental Illness*, which is at Appendix 1 to this submission. It includes the recommendations:

- state and territory governments undertake to educate all stakeholders on 'Physical Health Impacts of Mental Health Problems and Disorders'

⁵ Australian Bureau of Statistics, 2007 *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, accessed from the ABS website on 20 May 2010.

⁶ Slade T, et al, 2009, *The Mental Health of Australia 2. Report of the 2007 Survey of Mental Health and Wellbeing*, Department of Health and Ageing.

⁷ McGorry P, Killackey E and Yung A, 2007, *Early intervention in psychotic disorders: detection and treatment of the first episode and the critical early stages*, *Med J Aust* 2007; 187 (7 Suppl): S8-S10

⁸ Lawrence D, Holman CDJ, Jablensky AV, 2001, *Duty to Care – Preventable Physical Illness in People with Mental Illness*, University of Western Australia.

- state and territory governments enable appropriate screening, assessment and physical health checks for all persons with identified mental illness, including attention to dental health
- the Australian Government takes leadership on these issues by requiring all identified mental health funding to be accountable for physical health maintenance
- all mental health programs and policy areas report on physical health screening, assessment and monitoring for all mental health consumers in receipt of services
- given the nature of mental illness, service providers need to innovate and respond creatively to address the physical health impacts of mental health disorders and their treatment
- doctors take responsibility, when prescribing medications for people with mental health issues, to treat them holistically and monitor their physical health changes and needs.

The case study above shows that after a number of hospitalisations, the mental health consumer serendipitously found a service provider who could meet his needs. Patient safety in primary care needs to be set up so that this sort of service provision is a standard part of care.

Medication Safety

Medication safety risks are particularly relevant to the mental health sector where mental health consumers manage numerous symptoms and health conditions with medication.

In 2006 the NMHCCF participated in a national stakeholder workshop on mental health and the quality use of medicines. The final report of this workshop documented a range of practical solutions to improve accessibility and quality use of medicines for mental health consumers and carers.⁹ These included strategies for:

- improving information around medicines to consumers, carers and professionals in such areas as
 - the development of easily accessible consumer medicine information
 - the development and maintenance of a central repository of information such as educational materials, clinical evidence and practice guidelines etc on specific mental health medicines for use by professionals and consumers
- improving behaviours around prescribing by providing consumer and carer input into training for professionals about medicines
- undertaking better post market monitoring including investigation of serious health events around medicines use
- providing a stronger role for the provision of input from consumers and carers on national medicines policy.

It is also clear that national medicine policy needs to consider improving the cost burden associated with medicines for the treatment of mental illness. This should include analysis of the effects of disincentives for the purchase of mental health medicines under the current PBS arrangements, as well as accessibility of the current Medicare safety net system for people with mental illness. New medicines policy should also ensure that pricing of current and new mental health medicines remains accessible to people with low incomes.

⁹ Mental Health Council of Australia, 2006, *Report of the National Stakeholder Workshop on Mental Health and the Quality Use of Medicines*, Mental Health Council of Australia.

Other patient safety priorities in mental health

Some work has already been undertaken in the area of patient safety in primary care in the mental health sector. In 2003, the Safety and Quality Partnership Group of the Australian Health Ministers Advisory Committee (AHMAC) Mental Health Standing Committee and the Australian Council for Safety and Quality in Health Care developed the *National Safety Priorities in Mental Health; a national plan for reducing harm*¹⁰. The plan included consideration of primary care and it highlights a range of urgent issues in mental health. The Plan was endorsed by the AHMAC and focussed on a number of urgent priorities for safety in mental health:

- reducing suicide and self harm
- medication safety
- reducing and eliminating the use of seclusion and restraint
- reducing adverse medication events
- improving the safety of transport of people with mental illness.

The Plan also reveals that there is little national consistency in the appropriate identification and monitoring of adverse safety events and more needs to be done nationally to improve these areas and assist services to be able to address them.

This report resulted in the National Seclusion and Restraint Project which piloted initiatives to reduce and eradicate the use of seclusion and restraint in mental health services. While this project was undertaken in acute care settings, some of the learnings including the use of trauma informed care will be extremely useful in a primary care setting.¹¹

In 2009 the NMHCCF published its own position statement on seclusion and restraint *Ending Seclusion and Restraint in Australian Mental Health Services* which has been taken up as an information source for this project.¹²

It will be important that both the mental health and primary care sectors build on these initial steps in improving the safety of mental health services to ensure that gains in patient safety are effective and sustainable. To do this, a strategic approach is needed to improving service quality and based on addressing the human rights of mental health consumers and carers in health care.

The *Fourth National Mental Health Plan*¹³ and the newly released *National Standards for Mental Health Services*¹⁴ go some way to meeting this need and need to inform patient safety in primary care. Both of these documents summarise policy directions that mental health consumers and carers think will be useful, and relevant to the primary care sector. The national mental health *Standard 2: Safety* will be particularly relevant to the development of any guidelines in patient safety in primary health care.

A specific guideline document for implementing the *National Standards* is also proposed to be developed for community organisation settings and private office based mental

¹⁰ National Mental Health Working Group, 2003, *National Safety Priorities in Mental Health; a national plan for reducing harm*, Commonwealth of Australia

¹¹ See the National Seclusion and Restraint Project website www.nsrp.gov.au.

¹² See the NMHCCF website www.nmhccf.org.au/Publications-info.

¹³ Australian Health Ministers, 2009, *Fourth National Mental Health Plan*, Commonwealth of Australia.

¹⁴ Australian Health Ministers, 2010, *National Standards for Mental Health Services 2010*, Commonwealth of Australia.

health services. These guides will be relevant to many primary care services and it will be important that they are cross referenced by primary care patient safety documentation.

Conclusion

While the *National Safety Priorities in Mental Health* plan targets some specific urgent priorities and the *Fourth National Mental Health Plan* and the new *National Standards for Mental Health Services* and guidelines will provide good policy direction, mental health consumers and carers remain concerned about the effectiveness of these strategies. Since the *First National Mental Health Plan* was released in 1992 and the first *National Mental Health Standards* were released in 1996, consumers and carers have been disappointed by the extent to which these policies have been taken up in mental health services. There are a range of barriers to implementation such as stigma, inadequate funding for community mental health supports, conflicting priorities in health services, culture of mental health services and lack of leadership. Until these barriers are addressed, special projects targeting urgent safety priorities for mental health consumers and carers should be included in any strategy to address patient safety in primary care.

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NMHCCF Advocacy Brief

Issue: Physical Health Impacts of Mental Illness

Outline

The appalling health and early mortality rates of people with persistent mental illness is unacceptable. The physical health impacts of mental health problems or disorders have a significant effect on a person's wellbeing and contribute to their social exclusion.

These impacts may occur as a direct or indirect result of the disorder, treatment or psychotropic medication, that is, they are iatrogenic, (occurring as a direct result of the disorder or its treatment, for example, diabetes, weight gain, heart disease).

The physical health-related effects of mental illness can also be impacted on by poverty, neglect, discrimination, symptomatology, smoking, substance abuse, dietary habits, etc.

People with mental illness have more physical health problems than the general population and evidence shows the instance of coronary heart disease, metabolic disorders, respiratory disease, cancer, infection, obesity, endocrine disorders and dental disease is significantly greater in this group. In addition, these physical health problems in people with mental illness are less likely to be screened for, identified and treated.

Background

People with mental illness are among the most socially and medically marginalised people in our community. Ironically, these same people are frequently monitored and treated by qualified health professionals for their mental health problems, whilst their physical health issues are not addressed.

The life expectancy of people with schizophrenia, for example, is at least 25 years less than those in the general population. Whilst people with persistent mental illness do not have higher rates of diseases such as cancer and heart disease, they do die from those diseases between two to three times more often than those with the same health problems in the general population. This is due to people with mental illness not receiving appropriate preventative screening or treatment.

Psychiatrists, general practitioners and any other prescribers of psychotropic medication have a responsibility to monitor the effects of medication on a person's physical state as well as its impact on their mental wellbeing.

In the words of the UN Convention on the Rights of Persons with Disabilities (2006):

Persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination...States/Parties shall take all appropriate measures to ensure access ...to health services...with the same range, quality and standard....as provided to other persons.

People who experience mental illness have the right to live long and healthy lives just like the wider population.

Key Points for Consumers and Carers

The National Mental Health Consumer Carer Forum (NMHCCF) finds this state of affairs alarming and totally unacceptable. More has to be done to address this problem. These issues must be placed in the public domain to initiate discussion and to promote understanding and action.

National, state and local policies, procedures and structures need to be improved and clarified in order to raise awareness as well as to change health monitoring and attitudes.

Iatrogenic and health effects of mental illness can seriously affect:

- personal recovery journeys
- self image
- people's futures.

Consumers can often expect to:

- have significantly reduced life expectancy
- experience a greater burden of ill health
- suffer delayed diagnosis and treatment of many disorders or diseases.

Studies¹⁵ have shown that:

- people with mental illness are 30 per cent more likely to die from cancer, despite having no higher occurrence of the disease than the wider population
- people with mental illness have an overall death rate 2.5 times that of the general population
- forty-four per cent of all hepatitis C cases occur in people with mental illness
- people with mental illness have life expectancy reduced by between 15 to 25 years
- people with mental illness who also have alcohol and drug related disorders have the worst survival rate.

Recommendations for Change and Key Issues for the Future

The NMHCCF recommends that:

- state and territory governments undertake to educate all stakeholders on "Physical Health Impacts of Mental Health Problems and Disorders"
- they enable appropriate screening, assessment and physical health checks for all persons with identified mental illness, including attention to dental health
- the Australian Government takes leadership on these issues by requiring all identified mental health funding to be accountable for physical health maintenance

¹⁵ Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001) *Duty to Care: Physical Illness in People with Mental Illness*.

Perth: The University of Western Australia.

- all mental health programs and policy areas report on physical health screening, assessment and monitoring for all mental health consumers in receipt of services
- given the nature of mental illness, service providers need to innovate and respond creatively to address the physical health impacts of mental health disorders and their treatment
- doctors take responsibility, when prescribing medications for people with mental health issues, to treat them holistically and monitor their physical health changes and needs.

Other Resources

NSW Health (2009) *Physical Health Care of Mental Health Consumers - Guidelines*. NSW Department of Health.

Lambert, T & Chapman, L (2004) *Diabetes, Psychotic Disorders and antipsychotic therapy: a consensus statement*. MJA Vol 181(10), p 544-548.

Seymour, L (2003) *Not all in the Mind: the Physical Health of Mental Health Service Users*. Mentality, UK.

NCCF (2004) *Diabetes and Psychotic Disorders- A Guide for Consumers and Carers*. 3 parts : Looking after your Health, Companion Document for Consumers and Carers and accompanying resource CD. NCCF, Canberra.

- (2005) *Academic Highlights: Advancing the treatment of People With Mental Illness: a call to action in the Management of Metabolic Issues*. Journal of Clinical Psychiatry, Vol 66 No. 6, p 790-798.

Brown S, Inskip H & Barraclough B (2000) *Causes of the excess mortality of schizophrenia*. British Journal of Psychiatry, Vol 177, p 212-217.

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