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Committee Secretary  
Senate Community Affairs Committee  
PO Box 6100  
Parliament House  
Canberra ACT 2600

**Catholic Social Services Australia submission on the Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services**

Catholic Social Services Australia (CSSA) is the national network of Catholic social services across Australia. The 70 CSSA member agencies provide a diverse range of community services to children, young people and their families across all regions of Australia.

The 2011 Federal Budget announcements indicate a substantial commitment to mental health funding in certain areas, and the current reform agenda is an opportunity for decisive government leadership in mental health policy.

This submission indicates support for the general directions of these reforms and funding measures, and reflects on the implications of funding and administrative changes for people experiencing mental illness, their families and carers, the agencies that support them and the broader community. In commenting on selected parts of the Terms of Reference, we note current gaps in service delivery that will still need to be addressed and emphasise the importance of a 'whole of life' approach to service delivery.

Thank you for the opportunity to provide comment.

Yours sincerely,

Paul O'Callaghan  
Executive Director

# **Catholic Social Services Australia (CSSA) submission to the Senate Community Affairs Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services**

This submission comments on selected parts of the Inquiry Terms of Reference.

## ***(a) the Government's 2011-12 Budget changes relating to mental health***

### *General comment on National Mental Health Reform*

Federal Budget announcements for 2010-11 and 2011-12 indicate a substantial commitment to mental health funding in certain areas. The Government's 'Ten Year Roadmap' is an opportunity for fostering significant systemic and attitudinal reform so that prevention and early intervention are the norm, and more intensive support and care are readily accessible across all domains of wellbeing – health and safety, emotional and social wellbeing, material and environmental security, education and work, community participation and peer and family relationships.

A key to successful reform will be service integration and the breaking down of program and policy silos, especially between health and community portfolios. A major task of the new Mental Health Commission will be to ensure that policy development and rollout of new and expanded programs are supported by whole-of-government policy within a social justice and social inclusion framework:

- The key issues that act as barriers to recovery from mental illness are poverty, social isolation, financial hardship (including insecure housing), stigma and discrimination. Policy responses need to be built on respect for the rights of the person and focus on capacity, not deficits
- A fundamental shift is needed toward an emphasis on health promotion and recovery – enabling individuals to gain control over their lives, wellbeing and health, building on existing strengths, networks and capacity and promoting whole of community responsibility for social inclusion. While there is a place for treatment and formal services, mental health consumers are not passive recipients of care but active agents on their own behalf. Policy needs to reflect a holistic, all-of-life approach, not only 'better service delivery'. The gap between treating 'illness' and addressing social exclusion needs to be reconciled – recognising the paramount need to treat the illness *and* support the person to be resilient, build on strengths, connect with community support and achieve optimal wellbeing

*In particular, CSSA is supportive of the following 2011-12 Budget measures:*

- The targeting of investment to early intervention programs for children in the early years with particular reference to the universal 3 year old health check.
- Expansion of ATAP services to provide services to families, young people and children. It is recognised that ATAPS has been successful in reaching populations that have difficulty in accessing mental health services. CSSA agencies experience difficulty in retaining providers of ATAP services in rural and remote regions given the funding models. CSSA advocates for the targeted provision of ATAP services for hard to reach and hard to engage populations, particularly ATSI and CALD, and consideration of alternative funding models to those currently used.
- The expansion of Family Mental Health Support Services, which have proven effective for enabling 'wrap around' support to help consumers and families access both clinical and non-clinical services in a systemic and integrated way. Future service establishments need to meet the needs of rural and remote communities that continue to be underserved.

- The expansion of Personal Helpers and Mentors Services, again with the recognition that priority be given to the establishment of services in rural and remote locations. While the commitment of \$50 million under PHaMS to specifically support individuals to gain employment and move off Disability Support Pension is applauded, CSSA would like to see such investments directed to specialist mental health employment support services.
- The expansion of the Support for Day to Day Living program. However, the funding per place remains grossly inadequate to sustain ongoing quality service provision, and the 2009 reduction in the proportion of funds allocated to discretionary spending further reduces the capacity of services to connect clients with mainstream community engagement options<sup>1</sup>. This needs to be addressed.
- Provision of funding for coordinated care and flexible funding for people with severe and persistent mental illness. In developing this model, we urge greater emphasis on partnering with community managed mental health/NGO service providers.
- CSSA supports the expansion of early intervention services for adolescents and young people. We would, however, prefer to see a more flexible approach to Headspace and EPPIC services. At least some of the proposed new services should be placed in rural and remote locations. In addition, the model needs to be flexible enough to be responsive to local needs and priorities, rather than being developed and imposed in accordance with what has worked in a metropolitan area.
- CSSA is strongly supportive of the establishment of a National Mental Health Commission and believes that its success will depend on active participation by community managed services and NGOs.

**(b) changes to the Better Access Initiative**

The findings of the 2011 Review of Better Access<sup>2</sup> support the general principal of capping mental health services for the majority of consumers.

CSSA supports a better targeting of resulting savings to community based services, hard to reach populations and coordination of services for people with complex needs, severe and persistent mental illness. However, we do have concerns that some people will still fall through the cracks – especially where there are long waiting lists for services and a lack of bulk billing for therapeutic options. Access to GPs irrespective of rationalisation continues to be a significant barrier to seeking help in regional, rural and remote communities due to long waiting lists, non-existent GP services and GP practices not taking new or transient consumers. These shortcomings in GP access often mean NGO and Community Managed services must shoulder the burden of assisting consumers to seek help.

The 2011 Better Access Program evaluation found that the average number of sessions for users is five. Almost 90% of users utilise 10 or less sessions and close to 73% utilise six or less. The 2011 evaluation also shows that support for disorders of anxiety and depression is most prevalent. The evaluation also indicates that two thirds of people utilising Better Access are capital city based and that geographic disadvantage continues to be an issue.

Where individuals are in need of 10 or more sessions, it is likely that they are experiencing more severe symptoms and needs than can be dealt with in an early intervention program such as Better Access. Where alternative services are available, re-allocation of funds makes good sense. However, alternative programs are not always available, and the extra Better Access sessions (in particular, the additional six exceptional circumstances sessions)

<sup>1</sup> Healthcare Planning and Evaluation Pty Ltd, *Evaluation of Support for Day to Day Living in the Community: A structured activity program: Final Report*, Department of Health and Ageing, September 2010

<sup>2</sup> Reifels, L., Bassilios, B., King, K., Fletcher, J., Kohn, F. Blashki, G., Burgess, P., Pirkis, J. *Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program: Fourth interim report for the evaluation of the Specialist Services for Consumers at Risk of Suicide: Improving access to and outcomes from mental health care*, February 2011, Centre for Health Policy, Programs and Economics, Melbourne University

have been essential for some enduring and complex situations. The capping fails to address the challenges of providing quality therapeutic services in under-resourced areas, including how to encourage professionals to service these areas. A key question therefore is just *how* (and *where*) savings generated from this change will be reinvested in additional services for particularly vulnerable and hard to reach groups.

***(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program***

CSSA applauds the increase to Access to Allied Psychological Services (ATAPS) funds. ATAP services are seen to be successful in reaching hard to reach populations with needs. the 2010 review<sup>3</sup> indicated that 45% of services are provided to rural communities, with 68% of services delivered to consumers on low incomes and 86% of consumers experiencing improved outcomes.

However CSSA's position is that ATAPS does not adequately deliver to marginalised groups and remote rural communities, with about 2% of services going to individuals of Aboriginal and Torres Strait Islander descent, and limited numbers servicing consumers for whom English is a second language. A substantial percentage of ATAPS consumers are seeking assistance for high prevalence disorders (Depressions 76%, Anxiety 59%); a small percentage of consumers seek assistance for severe and persistent mental illness.

The 2010 review<sup>4</sup> quite clearly identifies that:

*Service provision should be supplemented for consumers in areas where access to private Medicare services is limited due to geography or locality, such as in rural, remote and some outer metropolitan areas.*

*Appropriate service models should be provided for hard to reach groups in all areas of Australia who are currently not accessing, or cannot afford, psychological services (including Aboriginal and Torres Strait Islander people, children and young people, services for parents when children are identified as having a mental health problem, people at high risk of suicide and people experiencing or at risk of homelessness) and for whom more flexible models of care are needed.*

CSSA supports the position that non-government and community-managed organisations be engaged to deliver ATAP services in addition to Divisions of General Practice in order to better meet the needs of marginalised and difficult to service populations.

CSSA maintains that work force availability remains a critical issue for consumers particularly in rural and remote communities. Clinical Services in regional centres are often unable to attract staff to fill existing FTE and there are extended periods of 'vacant positions'. The 2010 review identified<sup>5</sup> that:

*Respondents noted there were a number of challenges to recruiting and retaining the ATAPS workforce including competing with other Government programs and providers preferring to work under the Medicare system through Better Access. In rural and remote areas there is often difficulty attracting providers due to social and professional isolation*

***(d) services available for people with severe mental illness and the coordination of those services***

CSSA welcomes the announcement to provide support for coordinated care and flexible funding for people with severe, persistent mental illness and complex needs. However, we have some concerns about the possible service model, where funding and location of Care Facilitators appear to be aligned with Medicare Locals, and would urge a greater emphasis

<sup>3</sup> Department of Health and Ageing, *Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010,

<sup>4</sup> Ibid, page 4

<sup>5</sup> Ibid, page 13.

on partnering with community managed mental health/NGO service providers. CSSA is also concerned that the establishment of a national assessment process may duplicate existing tools and processes without adding any further value and place a further reporting burden on providers.

**(e) mental health workforce issues**

*(i) the two-tiered Medicare rebate system for psychologists*

Professionals often argue that gap fees improve outcomes and increase client commitment towards intervention. However, evidence<sup>6</sup> shows that gap fees (averaging around \$35 a session), do not impact on outcomes, and are a deterrent for certain groups to access services (particularly young people and those experiencing co morbid conditions). Gap fees have increased by 50% over the last 10 years, and remain a significant barrier for people seeking assistance.

The differential between the rebate for a clinical psychologist (\$119.80) and a general psychologist (\$81.60) may impact on the level of gap payment consumers are required to pay. Clinical psychologists and psychiatrists remain the most expensive services to access for treatment, and clients are often unfamiliar with the differences in fee schedules across professions. This finding was supported by the Senate Community Affairs Committee in 2008<sup>7</sup>, which found that the current gap fees charged by all professions (GPs, Psychiatrists and allied health professionals) continue to be barriers to access and utilisation, particularly in the rural and regional areas of Australia.

The existence of gap fees ensures that Better Access services will target populations with the greatest ability to pay, and be out of reach of those who are most disadvantaged. This is a serious access and equity issue which needs to be reviewed.

*(iii) workforce shortages*

Analysis of the mental health workforce under Better Access<sup>8</sup> indicates that over the course of the ATAPs program there has been a steady increase in the numbers of allied professionals delivering services. However, the CSSA position is that there remains a fundamental shortfall in the broader mental health workforce such as social workers, occupational therapists, respite and community support workers.

**(f) the adequacy of mental health funding and services for disadvantaged groups**

*(i) culturally and linguistically diverse communities*

Resourcing for the provision of services to CALD communities continues to be inadequate, particularly for recent arrivals including refugees, and emerging cultural groups many of whom have experience homeland and migration trauma.

*(ii) Indigenous communities*

CSSA recognises the high level of need for Indigenous Australians. "The 'Close the Gap: National Indigenous Health Equality Targets, 2008' report provides a National Framework for addressing the national life expectancy gap of 17 years for Aboriginal people. That service

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<sup>6</sup> Pirkis, J., Harris, M., Hall, W. & Ftanou, M., *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative Final Report*, 22 February 2011

<sup>7</sup> Standing Committee on Community Affairs, *Towards recovery: mental health services in Australia*, Canberra, September 2008

<sup>8</sup> King, D., Tan, Y., Wainer, J., Smith, L., Fitzpatrick, D., Sun, L. & Owada, K., *Evaluation of the Better Access Initiative Component C: Analysis of the Allied Mental Health Workforce Supply and Distribution*, National Institute of Labour Studies, Flinders university, Adelaide, September 2010

model development and delivery is to be done in a culturally responsive way. As noted in a recent consultation report from SA Health<sup>9</sup>:

“Fundamental to Aboriginal people is a holistic perspective of mental health which encompasses the social, physical, emotional and cultural wellbeing of not just the individual but of the whole community.

*“Social and emotional wellbeing problems are distinct from mental illness, although the two interact and influence each other...Social and emotional wellbeing problems can result from: grief, loss, trauma, abuse, violence, substance misuse, physical health problems, child development problems, gender identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism and social disadvantage”.*

In particular CSSA recognises the need to develop and expand service that address high rates of suicide and psychological distress for urban, rural and traditional lands peoples, and current rates of targeted funding are inadequate.

*(iii) people with disabilities*

As stated above CSSA is very supportive of the commitment to funding for employment support through the PHaMS programs, but believes there is a need for dedicated employment programs. However, access to supported employment options remains limited. The current system is directed towards people with a physical disability. It is inflexible for someone with a mental health illness as it does not cater for the cyclic nature of the illness.

CSSA welcomes the change in policy that will allow people to work up to 30 hours a week for two years without impacting on DSP eligibility and increased incentives for employers to hire people with a psychosocial disability. However, small financial incentives alone will not be sufficient. Employer and employee mindsets and attitudes will need to change over time if workforces are to be truly inclusive and supportive. Employers need to be supported with educational and information resources, and governments need to show leadership through an active Mental Health Commission, integrated Commonwealth/State/ Territory action and inclusive economic and social policies.

*(iv) Other*

Other disadvantaged groups not well served by current programs are people who are being detained, or have been released from, correctional facilities such as prisons, remand centres and detention centres.

***(g) the delivery of a national mental health commission***

CSSA supports the overall aim of the Commission, to oversee the delivery of the government’s mental health reforms and a more accountable and transparent mental health system, but is concerned that the Commission’s powers are insufficient to actually *drive* quality improvements and ensure a ‘joined up’ approach to integrated care and support. In the absence of clear terms of reference, it is hard to comment on the Commission’s potential as an effective ‘watchdog’ and advisory body.

The Commission will need to represent a broad spectrum of consumer, carer, service provider and community interests in order to guide realistic long term planning and coordination. A very real challenge for the Commission will be to demonstrate leadership for systemic and policy change that transcends jurisdictional and portfolio silos.

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<sup>9</sup> SA Health, *Summary Report: Statewide Aboriginal Mental Health Consultation*, July 2010, Adelaide, with citation from *National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2004-2009*, Page 3

***(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups***

CSSA does not have independent evidence as to the efficacy of online services however experience suggests that use of technology is advantageous in reaching remote and rural communities and engaging socially isolated individuals.

Online services may serve to fill some gaps in services, particularly for people living in isolated areas, but must *complement*, not replace, high quality face-to-face services. We believe that online service must embrace a wide range of technologies and modalities and include promotion, treatment and recovery support, early interventions and de-stigmatisation. Online services must be more than health literacy strategies.

***(j) any other related matter***

*CSSA recommends that Government provide funding and support processes for building agency and staff capacity to meet community needs*

- Greater flexibility to allow program providers to go beyond program guidelines, many of which have been modelled on urban contexts. With greater flexibility, workers will be enabled to 'go the extra mile' to address complex problems that are exacerbated by remoteness, rural challenges and stress, and lack of support services
- Build capacity of locally based agencies to develop responses appropriate to the context – suicide prevention in rural and remote areas, staff training, assistance to supplement community education costs, funding for Mental Health First Aid training
- Support for the assessment process and care for mental health carers and teams
- Enhanced capacity for brokerage of services/supports that enable holistic care that focuses on recovery and community engagement
- Ongoing training for local staff in more isolated regions to ensure a consistently high quality of service; along with access to professional supervision that is not readily available in rural and remote communities
- Funding to collaborate with local universities to assist in the training and development of highly skilled psychologists through placements and supervision

*CSSA recommends greater funding and program flexibility to enable timely and adaptable responses to those experiencing grief, loss and psychological distress as a result of natural disasters*

The impacts of natural disasters such as the recent floods, periods of drought and extensive bushfires are never short-term; but funding usually is short-term which makes it difficult to plan for ongoing mental health and other community support. Cessation of critical support services because the disaster is deemed to be over comes at a cost – to the individuals whose recovery may take years, and to the agencies trying to support them and maintain a hard-won level of trust in the absence of an assured funding stream.

*CSSA recommends a national public education campaign be developed and implemented*

Despite vastly improved public awareness about the prevalence of mental illness over recent years, much misinformation, misunderstanding and stigma remains. Concerted action is needed to change attitudes and remove the barriers that currently prevent people from living fulfilling lives in the community. Ill-informed perceptions and attitudes are often the first hurdle for people to overcome as they try to access housing, employment, financial support, education, supportive relationships, social networks and community activity at the same time as managing their illness and undergoing clinical treatment and specialised support services.

Ideally, specialised mental health services would link seamlessly with mainstream and other specialised services, with information and referral pathways easily identifiable.