The peak organisation representing the non-government mental health sector in Tasmania at a state and national level

Submission

Inquiry into Commonwealth Funding and Administration of Mental Health Services

The Mental Health Council of Tasmania has a vision for a vibrant and effective mental health sector in Tasmania.

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Mental Health Council OF TASMANIA

Submission

The Mental Health Council of Tasmania (MHCT) is the peak body representing the interests of consumer, carer and community mental health sector organisations, providing a public voice for people affected by mental illness and the organisations in the community sector that work with them.

The MHCT advocates for effective public policy on mental health for the benefit of the Tasmanian community as a whole and has a strong commitment to participating in processes that contribute to the effective provision of mental health services in Tasmania.

The MHCT welcomes the opportunity to provide comment to the Senate Community Affairs Committee for inquiry into the Commonwealth Funding and Administration of Mental Health Services.

We have extensively consulted with its members and are pleased to make an informed response to the Senate Committee to the Terms of Reference (TOR) below.

Terms of Reference

a. The Government's 2011-12 Budget changes relating to mental health;

The MHCT would like to congratulate the Commonwealth Government on the following specific budget highlights:

- *The expansion of the Day to Day Living Program*. In Tasmania there is currently only one funded Day to Day Living Program. The MHCT sees this as an opportunity to expand further programs across the State to enable Tasmanians living with a mental illness obtain assistance in managing their day-to-day activities.

- An increase to the *Personal Helpers and Mentors* program and the *mental health respite services*. The MHCT supports the increased investment into these vital services. The MHCT recommends the $50 million allocated to support people with a mental illness receiving a Disability Support Pension, be directed towards specialist mental health employment support services, as these organisations have the knowledge and skills to assist people gain and maintain meaningful paid employment.

- *The expansion of ATAPS.* The MHCT commends this area of growth, if it targets the most vulnerable and marginalised in our community. Specifically, the MHCT recommends the Government targets people from culturally and linguistically diverse backgrounds, to ensure they have access to this valuable service. One avenue of achieving this outcome is to ensure funding is quarantined for the use of interpreters.

- *Increased employment participation*. 'Work is a fundamentally important part of everyone's life, no less the lives of people with a mental illness. As such, it is seen by many, including people with a mental illness, their carers and their treatment providers, as an essential measure of recovery. At the individual level recent research shows that working can lead to less frequent admissions to hospital, lower symptoms of psychosis, lower treatment costs, improved quality of life, improved social functioning and enlarged social networks.'[1] The MHCT applauds the investment of funding to employment service providers to build their capacity to work with people with a mental illness to access meaningful employment.

- *A National Partnership Agreement on Mental Health*. The MHCT supports the States and Territories working to identify and address gaps in service delivery, particularly around accommodation support, hospital admission and discharge procedures to and from the community mental health sector.

- *Establishment of a National Mental Health Commission*. The MHCT is excited about the establishment of a Mental Health Commission. We anticipate playing a progressive role in strengthening accountability and transparency in the mental health system, resulting in better outcomes for people with a mental illness, their families and carers.

b. Changes to the Better Access Initiative, including:

1. The rationalisation of general practitioner (GP) mental health services,

The MHCT supports the rationalisation of GP mental health services. The MHCT welcomes the reinvestment of savings generated from these changes to alternative programs that will target people living with severe and persistent mental illness, their families and carers. This will deliver better outcomes for people with a mental illness, their families and carers.

From 1 November 2011, the rebate for the development of the GP Mental Health Plans will reflect the actual time spent preparing the Plan. The rebates will vary depending on the length of consultation, and whether a GP has completed Mental Health Skills Training (MHST). For example, the rebate, for a GP who has completed MHST is currently $163.35. This will reduce to $85.92 for a consultation lasting between 20 and 39 minutes, and $126.43 for a consultation lasting longer than 40 minutes.

The MHCT recognises that this rationalisation may impact negatively on GPs with the reduction in rebates, particularly given some GPs bulk bill the preparation of a Mental Health Treatment Plan. The MHCT would not like to see a situation where GPs charge well above the scheduled fee, in order to maintain the current level of income, as this would be detrimental to the most vulnerable in our community.

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[1] J.Leff & R.Wagner, *Social Inclusion of People with Mental Illness*, Cambridge University Press, Cambridge, 2006, p. 113

2. The rationalisation of allied health treatment sessions,

The MHCT supports the rationalisation of allied health treatment sessions. The MHCT welcomes the reinvestment of savings generated from these changes to alternative programs that will target those living with severe and persistent mental illness, their families and carers. This will ensure delivery of better outcomes.

The MHCT is aware that from 1 November 2011, Medicare rebates for allied health practitioners under the Better Access Initiative will be capped at ten individual sessions, and ten group sessions per calendar year. Currently, people with a diagnosed mental illness can receive up to 12 individual and/or group sessions in a calendar year, with the allowance of six additional sessions if required.

The MHCT acknowledges that this rationalisation could impact negatively on people with a mental illness. In reviewing the Evaluation of the Better Access Initiative, [2]we note that almost three quarters of people who had an allied health treatment intervention, accessed between one and six sessions. The median number of Better Access sessions accessed by people was five, whilst the maximum they could access was 12.

The MHCT suggests that people who are eligible to receive these services not be restricted to the number of sessions available to them, rather they are free to access timely, affordable and suitable service provider. The MHCT also understands that this program may not meet some people's needs, thus suggest alternative programs, such as the ATAPS Program, that targets people with severe and persistent mental illness.

3. The impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and

Please refer to the above response.

4. The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;

Please refer to the above response.

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[2] Piriks, J., Harris, M., Hall, W. & Ftanou (2011) *Evaluation of the Better Access to Psychiatrists, Psychologists and Practitioners through the Medicare Benefits Schedule Initiative – Summative Evaluation*, Centre for Health Policy, Programs and Economics, Melbourne.

c. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services Program;

In Tasmania there are several services that provide the Access to Allied Psychological Services Program (ATAPS) to people living with a severe mental illness. The MHCT would like to inform the Government that generally the ATAPS providers are concerned about the reduction in the maximum number of sessions which the community can currently access. From their experience, in delivering the Better Outcomes Integrated Care Service (ICS) program, they have found Tasmanians entering the program are exhibiting higher scores on the Kessler Psychological Distress Scale (K10). This is an evidenced based, self reporting tool which measures people's level of distress, anxiety and depression. The higher scores are an indication someone is experiencing a moderate to severe mental illness.

The MHCT would like to inform the Government the Tasmanian ATAPS providers are concerned that the proposed reduction in ATAPS sessions from 12 to ten could impede on the recovery process for a person experiencing a mental illness. If the Government decides to follow through on this proposal the MHCT recommends the savings from this service be redirected to other community mental health services, such as the Personal Helpers and Mentors Program.

d. Services available for people with severe mental illness and the coordination of those services;

The MHCT applauds the budget announcement to support coordinated care and flexible funding for people experiencing severe and persistent mental illness. However, the MHCT does have some concerns about the 'nationally consistent assessment process'. We are concerned that it may duplicate existing processes without adding value, and that significant resources may be consumed in the development of the assessment tool. There is also a risk that such a tool may become another barrier to service access, rather than achieving the goal of the initiative, which is to facilitate access. We also believe that such an assessment process may focus too much on medical issues to the exclusion of social factors. To ensure against this, the MHCT envisages a range of relevant Departments contribute to the development of the tool with a focus on achieving access, rather than assessing needs. We are happy to work with the Commonwealth and the Tasmanian community mental health sector to guide this work.

e. Mental health workforce issues, including:

1. The two-tiered Medicare rebate system for psychologists,

The MHCT notes that the evaluation of the Better Access programme found no difference in the clinical outcomes for those who saw a 'clinical psychologist' versus those who saw a 'registered psychologist'.[3] Both kinds of psychologist saw people with the same severity of symptoms and over the same period of treatment they both performed equally well in measurable terms.

[3] Pirkis, J. *et al* (2010), *op. cit*., pp 27–32.

Moreover, according to this new research clients were just as satisfied with seeing registered psychologists too.[4] These findings align with earlier surveys of psychologists in the Medicare system that identified that clinical and registered psychologists saw clients with the same types of conditions with similar levels of symptom severity and that an equivalent proportion of people improved as a result of psychological treatment.

These findings are important because clinical psychology services for Tasmanians living in rural and regional areas are extremely scarce for any aspect of practice.[5] Moreover, as Australia is largely self-reliant for its psychology workforce, Tasmania faces significant challenges in relation to skills in this area. The Tasmanian Department of Health and Human Services own *Allied Health Professional Workforce Planning Status Report* acknowledges that although the Australian labour market for psychologists – which includes Clinical Psychologists – appears to be in balance, there remains recruitment and retention problems in rural and some speciality areas. The report establishes the difficulties in recruiting psychologists with suitable specialist clinical qualifications for positions in the North and North West of Tasmania. This was of special concern in services that did not have established professional supervision structures in place.[6]

Although the impact of the introduction of MBS rebates for psychologists on the psychology labour force is not yet fully clear, the uptake of psychological services has been very high. As such, the provision of rebates may well increase overall demand for psychologists, and particularly clinical psychologists, thereby putting further pressure on supply. Another potential consequence is a shift in the ratio of public to private sector employment, with a greater proportion of psychologists opting for private sector work.[7] This has the potential to expand the stress on public mental health services, and thus the pressure of those services based in community sector organisations. Similarly, it (potentially) further complicates referral pathways and the co-ordination of care between government, non-government and private mental health services. The MHCT believes that additional monitoring and analysis of information on the psychology labour force is warranted to assess developments.

Whatever the conclusion of the definitional division of psychologists from the perspective of the Medicare system, the two-tiered system has seen the most vulnerable and distressed members of the Australian public bear the brunt of a policy decision that discriminates against many psychologists with advanced training in mental health care. This is felt more strongly in Tasmania where access to psychologists is already limited, and any further boundaries to that subsidised access are disadvantageous.

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[4] Pirkis, J. *et al* (2010), *op. cit*., pp 33–53.

[5] Department of Education, Employment and Workplace Relations (2010), *Skill Shortage List, Tasmania*, December 31, p 2. The list rates the profession of Clinical Psychologist as subject to a "State-wide shortage".

[6] DHHS (2003), *Allied Health Professional Workforce Planning Project: Psychology Information*, Agency Health Professional Reference Group, Allied Health Professional Workforce Planning Group, p. 5. [Online: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/38074/ah-psychology.pdf.]

[7] Mental Health Workforce Advisory Committee (2008), *Mental Health Workforce: Supply of Psychologists*, February, pp 3-4.

2. Workforce qualifications and training of psychologists, and

The MHCT believes that training and work placements across broad community settings (including non-government mental health services, which are also referred to as Community Managed Organisations, CMOs) contribute to both an increased skills mix at a practitioner level, as well a more collaborative and fluid mental health service system.

Such exposure in the training of psychologists complements the many new models of collaborative mental health service delivery through a coalition of providers – clinical, psychiatric disability rehabilitation and support services and primary health – that are being developed to provide better integrated and more comprehensive service responses to people experiencing mental health issues. A key goal of all national and state plans has been about better coordination of services to prevent those experiencing acute mental illness from falling through the care 'net'. A critical element needed to achieve this is related to the coordination and linking of care across primary, acute and community providers, and the role that the training of psychologists has in achieving this.

In addition, we note that the National Preventative Health Taskforce has strongly advocated or workforce strategies to be part of a comprehensive strategy specifically advocating the need for "a skilled and motivated workforce, especially in the public health and primary healthcare sectors, will be essential to support delivery of health promotion and preventative health measures across the community".[8]

This has implications for the training of health care workers and how the different types of health care workers interact, "bringing primary healthcare providers such as general practitioners, community pharmacists, nurses, psychologists and other allied health professionals together for community-based training and support, providing a way of ensuring a comprehensive and well-coordinated approach to preventative health care".[9] Thus, there is a strong need not just for more psychologists but also for changing distribution, role and work practices of health care workers, including workers in the CMOs, as part of a strategy to combat the growing burden of disease.

3. Workforce shortages;

As noted above, NGOs provide a range of community-based treatment and support services specialising in early intervention, prevention and recovery. In the past, these services have been grouped under the term 'non-clinical' but this term is increasingly inaccurate and unhelpful as many NGOs are involved in providing psychosocial treatment and many employ psychologists, mental health nurses and other university qualified workers with experience in clinical care.

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[8] KPMG (2009), *Health Workforce in Australia and Factors for Current Shortages*, National Health Workforce Taskforce, April, pp 20–21.

[9] National Preventative Health Taskforce (2008), *Australia: the healthiest country by 2020 A discussion paper*, p 44.

The Department of Education, Employment and Workplace Relations identified regional shortages for psychologists in 2007. It found that NGOs reported difficulties in attracting suitable applicants for psychologist vacancies because the public sector offered more attractive remuneration, while the public sector found it hard to compete with private practice and industry. Some employers reported that changes to Medicare funding had led more psychologists to establish their own practices rather than seek paid employment.[10]

A significant feature in the pay structure of the mental health sector is the disparity between what the NGO and government sectors are able to pay for similar work. This was a particular barrier to retaining degree-qualified staff within the NGO sector, reinforcing the dualistic labour market described above.[11] There are some who see the NGO sector as a development opportunity, to "get their hands dirty" with high levels of direct consumer contact. This helps those workers to gain entry to higher paid government work, where they then transition out to private sector. In this way, there is a systematic structural deficit in terms of the psychologist workforce available for NGO agencies.

f. The adequacy of mental health funding and services for disadvantaged groups, including:

1. Culturally and linguistically diverse communities,

Information released by the Australian Bureau of Statistics (ABS)[12] indicates 11.3% of Tasmanians were born overseas and 3.7% speak a language other than English at home. The Department of Immigration and Citizenship recently made a decision to house asylum seekers in and around Hobart. The plan includes housing up to 400 single men in a detention centre in Pontville, and housing women and children in the greater Hobart area.

Many studies have found asylum seekers are survivors of torture and trauma, and associated with this are numerous and complex mental health disorders.[13] In ensuring the mental health needs of this population are met, the MHCT recommends the Government provide adequate funding and services in the following areas:

- Expand the funding to the Personal Helpers and Mentors Program to include employing workers from culturally and linguistically diverse (CaLD) backgrounds.

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[10] DEEWR (2008), *State and Territory Skills in Demand Lists*, Department of Education, Employment and Workplace Relations, Canberra, May 2008.
[11] Community Services and Health Industry Skills Council (2009), *Mental Health Articulation Research Project Services and Workforce Study*, p 28.
[12] Australian Bureau of Statistics (2006), National Regional Profile of Tasmania, www.abs.gov.au
[13] See, for example, Keller, A.S. et al, 2003, *Mental Health needs of asylum seekers*, Lancet, 362 (9397), 1721-1272; Newman, L.K., Dudley, M., & Steel, Z, 2009, *Asylum, detention, and mental health in Australia*, Refugee Survey Quarterly, 27(3) 110-127; *The National Inquiry into Children in Immigration Detention*, 2004, Australian Human Rights Commission.

- Designated CaLD mental health workers employed in the existing Headspace services and in State Government Mental Health Services.

- Provision of training for interpreters in the area of mental health.

- Expand funding for natural therapies including massage, acupuncture and other evidenced based natural therapies, for newly arrived refugee and humanitarian entrants.

- Funding needs to reduce stigma associated with having a mental illness, which the CaLD community experiences. This recommendation aligns with priority area 1(Social Inclusion and Recovery) under the *Fourth National Mental Health Plan*.[14]

2. Indigenous communities, and

The MHCT is aware of the high levels of non-specific psychological distress reported by Indigenous Australians.[15] Of particular concern are the high rates of serious psychological distress, which are twice that of non Indigenous Australians. Serious psychological distress is considered to be a global indicator of poor social and emotional wellbeing.[16]

3.7% of Tasmanians identify as being Indigenous[17] and anecdotally there are low levels of access to the community mental health sector by this group. The MHCT thus would advocate increasing the uptake of services by Indigenous Tasmanians. To address this, we would recommend a specialist integrated service be established in Tasmania, to ensure that Indigenous Tasmanians have access to social and emotional wellbeing and primary mental health care services, when and where they need them.

3. People with disabilities;

The MHCT acknowledges that people who have multiple complex needs have significantly greater difficulty accessing services than those people who fit neatly into a single service system. People who experience both a mental illness and an acquired brain injury are among Australia's most disadvantaged people, who usually cannot access treatment and support for their mental illness and their acquired brain injury. People living with these issues will encounter

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[14] *The Fourth National Mental Health Plan*, An agenda for collaborative government action in mental health 2009 – 2014

[15] Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009) *Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People,* Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

[16] Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009) *Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People,* Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

[17] Australian Bureau of Statistics (2006), National Regional Profile of Tasmania, www.abs.gov.au

a range of barriers, which stem from the service system, rather than the individual with the disability.[18]

To address this service system issue the MHCT advocates for all service providers, across the health, housing and justice systems, to regularly engage in cross sectoral meetings to discuss how best to break down these service system barriers. This will facilitate an increased awareness of the needs of people experiencing both mental health illness and an acquired brain injury, as well as an increased awareness of the role of service providers within each sector. The MHCT want to ensure that funding bodies and service providers see this group of people as a priority, rather than a problem group that no-one provides a service to.

g. The delivery of a national mental health commission;

The MHCT welcomes the establishment of a National Mental Health Commission. We envisage the Commission's core functions to provide cross-sectoral leadership drive transparency and develop and monitor the implementation of the 10 Year Roadmap for Mental Health Reform. We believe there is significant potential for greater accountability and increased priority given to mental health with the creation of this agency.

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; and

According to the ABS 54.8% of Tasmanian households utilise the internet at home and 35.2% of the population reside in the remote and outer regions.[19]Even though this figure is low the MHCT supports the promotion and use of online services to support people living with a mental illness and their families and carers. To align with the *Fourth National Mental Health Plan*, the MHCT encourages these online services to include promotion, prevention and early intervention.

i. Any other related matter.

No comment.

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[18] Lamont, M., 2011, 'Alcohol Related Brain Injury', *Alcohol, Tobacco & Other Drugs Council Tas Inc Co morbidity Symposium 2011,* Hobart, Tasmania.
[19] Australian Bureau of Statistics (2006), National Regional Profile of Tasmania www.abs.gov.au