Submission to the Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services

1.1 *Overview*

From the position of this submission's author recent changes in mental health funding have been decided which appear incongruent to Department of Health and Ageing asserted objectives of Better Access, ATAPS and other relevant mental health service provision. An analysis of the Better Access program including criticisms, analysis of EPPIC and headspace initiatives and the process of "mental health reform" will be discussed. Proposed reforms appear to have a political rationale according to health reform agenda and recommendations about management of these issues are made.

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1.2 *Better Access Program Background*

Better Access to Psychiatrists, Psychologists and General Practitioners through Medicare (Better Access) is a universal primary health initiative introduced in November 2006 in response to extensive consultation of the mental health sector which culminated in the National Action Plan on Mental Health 2006-2011. This plan recognised that the Federal government had a responsibility to extend mental health services in the community to health consumers requiring responsive mental health intervention for high prevalence disorders that were not eligible for, or not requiring, team based treatment within the various State and Territory public mental health services.[1] Better Access was expected to meet certain goals in it's implementation by i) improving treatment rates of mental health disorder by facilitating access to mental health services, ii) establishing pathways of referral and collaboration between health professionals within a primary health setting and iii) produce good clinical outcomes for identified treatment recipients. Independent evaluation indicates that all objectives have been met in the incomplete five year period. The World Health Organisation makes several recommendations in the consideration of health expenditure, stating in review

of their international survey of mental health, *"As health care spending continues to rise (World Health Organization, 2006), resource allocation decisions will need to be based increasingly on information about prevalence and severity of disorders and cost-effectiveness of interventions."* [2] This submission will consider Better Access delivery outcomes in terms of resource expenditure value for the Australian public before an analysis of the criticisms of Better Access and discussion of the mental health political climate.

2.1 Better Access Context & Rationale

The Australian Bureau of Statistics tell us that as of 2007, 45% of Australians aged 16-85 years had experienced a mental health disorder at some point in their lifespan and one in five had experienced a mental health disorder in that year. This would represent nearly 7.5 million Australians who have a personal story about mental health impact overall or 3.2 million in the past twelve months. [3] Beyond the personal toll of mental disorders is the financial impact with various estimates taking account of different factors yet a commonly cited figure of annual cost of mental illness in Australia is an estimated $20 billion to the national economy as inclusive of service provision, productivity loss, labour non-participation and morbidity from suicide.[4] National Surveys of Mental Health and Wellbeing data indicated that only approximately 35% of Australians with a current mental health disorder sought and received treatment prior to Better Access establishment. [5] The subsequent National Survey of Mental Health and Wellbeing to more completely inform upon the impact of Better Access is pending yet Department of Health and Ageing modelling indicates that treatment rates of mental disorders had *increased to an estimated 46%* with the Better Access program being the main vehicle of this improvement in treatment rates. [6] This can be read particularly favourably if the base treatment uptake rate of the National Survey of Mental Health and Wellbeing is considered parallel to the statistics which showed that 86% of those who indicated presence of mental health disorder (including substance disorders) *and* did not access services said that "they had no need for any type of assistance." [5] Consumer evaluation of Better Access indicated that Better Access had removed barriers to mental health services with consumers reporting previous obstacles of costs (approximately 50%), accessibility (13%) and stigma concerns (12%) with traditional service delivery across all psychological therapy provider consumer groups. [7]

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2.1 Better Access Context & Rationale

Australians have used their Medicare rebates in accessing the Better Access program in high numbers across all demographic groups. 710, 840 people used Better Access in 2007, in 2008 at least one Better Access service was used by 951 454 people and in 2009, 1 in every 19 Australians or a total of 1,130, 384 people used Better Access. Controlling for Australians who received care in more than one year of service, this equates to 2, 016, 495 people in the three year period using Better Access Medicare rebates.[5] Better Access was designed to treat high prevalence disorders in a primary health capacity to improve service accessibility and this objective has been met. Better Access as a program provided treatment to 24% of all those treated for mental health disorder in Australia in 2006-2007 and this has continued to increase until 2009-2010 with *Better Access providing 53% of overall treatment for mental health disorders.*

2.2 *Better Access Report Card*

The World Health Organisation state that mental health needs to be established as a universally available health priority [8] and General Practitioners continue to reinforce the need for mental health to remain within the scope of primary health with clear referral pathways with recognition that 12% of all General Practice presentations were primarily of a psychological basis (11 million encounters) with a large percentage more having psychosocial complication. [9] Stakeholders including General Practitioner and specialist psychological therapy providers within Better Access indicated that Better Access had been instrumental in enhancing overall professional collaboration and the integration of mental health care into mainstream services .[6] In providing General Practitioner assessment and removing obstacles to community based psychological treatment, professional stakeholders have indicated increased capacity to provide early intervention by providing response in early stages of symptom onset regardless of consumer age. [10] [11]

Better Access has been subjected to independent evaluation by the Centre for Health Policy, Programs and Economics, University of Melbourne as the successful tender with the Department of Health and Ageing ("Better Access evaluation"). This evaluation collated over twenty different data sources to indicate that Better Access had met the third objective in matching treatment to identified gaps with sound consumer outcomes as consequence. The independent review showed i) that *90% of those using Medicare rebates to use Better Access had a (high prevalence) depression or anxiety diagnosis, ii) approximately 80% of those treated recorded pre-treatment high or very high levels of distress on Kessler 10 assessment and iii) 47% of those using Better Access met the criteria for a severe disorder, 45.5% reported a high level of disability.* The Better Access evaluation found that the level of severe, moderate and mild disorders as rated by severity and disability reported by Better Access consumers was comparable to consumers of other Australian mental health services (including those of the State and Territories.) *[6] [7]*

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2.2 *Better Access Report Card*

The Better Access evaluation including the consumer study also showed that all types of psychological therapy provider treatment i) showed *improvement from high or very high levels of psychological distress pre-treatment to much more moderate levels of psychological distress at treatment completion* as assessed by Kessler-10, ii) consumers across treatment provider groups showed *improvement from moderate to severe depression to normal or mild depression levels* as measured by Depression Anxiety Stress Scales and iii) consumer evaluation showed *"almost universal" satisfaction* with the clinical care received reporting "significant improvement in their mental health and their ability to cope through stressful situations. [6] Research completed by Australian Psychological Society in 2008 corroborated these findings with 2,223 Better Access consumers, 90% of these consumers reporting "significant" or "very significant" improvement in their condition. [12]

2.3 *Better Access Summary*

Better Access has been and remains the only public program situated to provide universal psychological therapy treatment for all age groups and high prevalence disorders not indicating need for centre based team care. There appears to be solid, independent evidence that Better Access has met program objectives as established for a universal mental health program with target outcomes of increasing treatment rates of high prevalence mental health disorders, establishment of referral pathways and enhancement of professional partnerships within the professional sector and positive treatment outcomes on observed measures.

3.1 Better Access Criticisms

Better Access has been subject to widespread criticism by critics within the sector who have taken exception to fee-for-service, universally accessible mental health care. Some of the active critics published papers criticising Better Access from implementation and prior to review.[13] [14] Criticisms of Better Access will be considered in this section including allegations that Better Access will create a budget "blow-out," Better Access has been an uneconomical program, Better Access failed to deliver services to those most needing service, Better Access provided care to people not needing service, Better Access was not well monitored or regulated including disparagement of service provider training or qualification or that Better Access was not an evidence based program.

3.2 *Budget Blow-out Claims*

From the first year of delivery critics claimed that Better Access was a budget "blow-out," [15] this claim has continued through numerous media releases from the Brain Mind Institute. [16] [17] The total cost of Better Access services to government, in terms of benefits paid, has in fact increased from $288.9 million in 2007 to $389.4 million in 2008, and to $478.1 million in 2009. [6] The Brain Mind Research Institute and Orygen Health released modelling in March, 2011 stating that Better Access will cost "3 billion dollars over 4 years" with the use of Medicare uptake figures and a growth rate of 10% .[18] This would appear to be an improbable conclusion based upon disparate sources of information. The uptake increase in the first two available years of Better Access was indeed near 25% and 15% yet Better Access uptake growth can not be expected to continue to increase in such increment due to a "ceiling effect." As observed in the Melbourne Better Access review, also within the Post-Implementation Review (PIR) of Better Access conducted by the Department of Health and Ageing in 2009, "*the Better Access initiative has significantly increased access to affordable mental health services in the primary care sector and to many patients who previously could not afford these services, thereby meeting a previously unmet need."* [19]

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3.2 *Budget Blow-out Claims*

As stated, one of the objectives of Better Access implementation was to open access to mental health treatment for Australians who had previously not accessed mental health treatment. The government's Post-Implementation Review stated further, "*this strong increase in uptake is in line with expectations based on the increased consumer and provider awareness about the initiative and greater provider familiarity with the Better Access MBS item requirements over time."* [19] Predictions of large compounding uptake of Better Access services would need to be interpreted with caution as universal mental health programs previously not available to the Australian public mature, particularly as the differential between mental health disorder incidence and treatment seeking behaviour remains unchanged.

Furthermore, evaluation of the availability of Better Access workforce by the National Institute of Labour Studies at Flinders University in 2010 made two points relevant to the provision of

services regardless of demand. "*Better Access was not viewed as having an impact on the numbers of psychologists re-entering the (Better Access engaged) workforce,"* alongside observation that "*most of the Better Access mental health occupations are already working at their full capacity*." [20] This observation of the limit of availability of Better Access workforce was also referenced by the Department of Health and Ageing's Post–Implementation Review which did not raise concerns about Better Access growth but instead expressed concerns about *possible waiting lists, delays in treatment and mental health professional skill accessibility*.[19] For these reasons, it is not a credible claim that Better Access will or could continue to grow unchecked.

3.3 Better Access Treatment Cost

Better Access as a fee-for-service program has also been shown to be a cost-effective method of delivering treatment as relative to both service based methods of delivery and relative to other mental health Medicare based services. The Better Access review indicated that "*the typical cost to government of a package of care from a clinical or registered psychologist is $566*." With the addition of medical assessment, development and implementation of a treatment plan by the General Practitioner, treatment under Better Access costs the government only $753.31. Using the benchmark of $1,100 as set by referenced scholarly works indicating good value parameters, the Melbourne review was able to demonstrate that Better Access was able to provide treatment at a low per incidence of treatment cost to tax payers. [6]

3.4 Better Access Treatment Cost Relative to Alternatives

2011-2012 Budget proposals include the concept that Better Access rationalisations will be compensated by continued access to psychiatrists under MBS items and with doubling the capacity of the Access to Allied Psychological Service (ATAPS). The suggestion that these mechanisms could compensate for the rationalisation of Better Access in service delivery will be discussed later yet the concept that mental health costs would be reduced by use of psychiatry MBS and ATAPS is deeply flawed. Medicare Items attached to a 45 minutes or more review by a Consultant Psychiatrist as of July 2011 for Item 291 is $195.50. [21]

3.4 Better Access Treatment Cost Relative to Alternatives

ATAPS, by their nature, are also a funded service with administration costs. The Australian National Audit Office within their 2011 audit report, "Administration of the Access to Allied Psychological Services Program" for the Department of Health and Ageing indicated that ATAPS administration within General Practice Divisions exceeded the capped 15% of budget in various Divisions. [22] There are good reasons tied to flexibility of targeted service expenses that administration costs may be high yet an independent review of ATAPS completed in 2008 showed that for 2007-2008 unit costs varied between $57 to $1,155 per session, [23] with an average cost of $219 per session compared to the Better Access cost of approximately $80 for most service providers under Medicare.[24] Furthermore, for all of the targeted criticism about out-of-pocket expenses within Better Access more than half of the consultations were bulk billed to consumers despite the heavy predominance of extended consultations of over 50 minutes. Psychological therapy providers average co-payment, when charged, is

approximately $35 [6] and psychiatric gap payment averages of $63.69 in urban areas and $80.33 in rural areas. [19]

Better Access provides more cost effective service for the government and as a (rebate plus gap) aggregate than the services the government are currently positing as cheaper alternatives so it may be considered that any cost saving would occur by limitation of service accessibility via capped services or psychiatric unavailability. The Better Access budget must also be framed in the context that the National Mental Health Report 2010 showed that the Australian government have only committed 7.5% of the total health budget to mental health which is an unchanged proportion since 1993. Of those funds the State and Territory hospital services accounted for the largest share of national mental health spending (28%), followed by state and territory ambulatory care services (24%) and psychiatric medicines subsidised through the Australian Government Pharmaceutical Benefits Scheme (14%). [25] This low proportion of funding relative to health budget expenditure is at odds with the findings that high prevalence mental health disorders are the third leading specific cause of health loss as measured by disability-adjusted life years lost in Australia (after heart disease and diabetes)[26] Furthermore high prevalence mental health disorders account for 13% of overall health burden of disease in Australia. [27] This is a morbidity trend predicted to become worse by the World Health Organisation which reports that depression is becoming a worsening problem and is likely to become the second leading cause for morbidity by 2020.[28] This is a health challenge Australia needs to prepare well to meet and Better Access has been shown to be a program which meets World Health Organisation criteria for meeting disorder prevalence, severity and superior treatment unit costs over alternatives.

3.5 Disadvantaged Groups - Men

Critics of Better Access (Professor Ian Hickie, Brain Mind Research Institute) have also criticised Better Access as "Medicare as usual" for failing delivery of services to men, people under 15 years, rural Australians and the socially disadvantaged.[15] [29] This criticism of Better Access fails to take into account both global mental health incidence and treatment utilisation differences. The Word Health Organisation, for instance, completed cross-national associations between gender and mental disorders in the "World Health Organization World Mental Health Surveys" and reported that women across all continents were both more likely to report high prevalence mental health disorder symptoms and to seek treatment. [30] Australian research has also shown that the suggestion Better Access "fails" men is based upon flawed premise as Australian males also do not identify symptoms of mental health disorder or identify as requiring treatment (at any service) at the same rate as women. [31] [32]

3.5 Disadvantaged Groups - Youth

Analysis of the findings of the National Survey of Mental Health and Wellbeing 2007 per young people, 13-17 years, did indeed find that only 31% of those identified by parents as having mental health problems and 20% of adolescents who identified themselves as having problems, had attended a professional service (of any kind) during the 6 months prior to the survey. [5] Again, the distinction between experiencing mental health disorder and treatment seeking behaviour can be made [31] yet instead of Better Access "failing" Australians under 15 years the Better Access evaluation has shown that lower rates of uptake of the Better Access service in this age group in 2007 have shifted considerably with the under 15 year age group showing the *highest relative growth of uptake of all age groups, with young people rates of growth of 109.4% for Focussed Psychological Strategies and 121.4% for Psychological Therapy Items*.[6] This trend was noted by the University of New South Wales Headspace

Evaluation Report of 2009 which states, "*Medicare data for the two years from November 2006 to November 2008 does suggest that young people are not only accessing mental health services in greater numbers, but that they are doing so at higher rates than the Australian population in general. It was expected that mental health service usage would steadily increase as a result of the changes to the MBS system, and there has been a steady increase nationally in the numbers of people accessing mental health services."* 33 The magnitude of service uptake by Better Access can not be largely explained with reference to headspace numbers as of 2009 as i) it is unclear what percentage of headspace attendees accessed mental health items (as provided under Better Access) ii) attendance was spread between 2007 to 2009, yet if all 13,917 headspace attendees to 2009 accessed at least one Better Access MBS this would have only represented less than 5.5% of the over 253,000 Australians aged under 25 years who accessed Better Access rebates in 2009. 33 6

3.5 Disadvantaged Groups - Rural

The Better Access evaluation is also able to inform criticism about Better Access capacity to meet rural needs, although definitions of "rural" categorisation vary across research, there is evidence which predictably shows that remote uptake of Better Access was behind other categories yet as in the case of youth above, the *relative growth in remote access was higher than other groups between 2007-2009 as may be expected as a program matures.6* Better Access uptake actually increased in non-capital metropolitan cities and rural centres from 2007 to 2009 to the point that these groups now have higher usage rates than capital cities per 1,000 population. 6 As with preceding demographic groups, Better Access appears to have increased access to mental health services in more ruralised areas 34 35 *despite* observed differences in mental health awareness and attitudes between rural and urban groups. 36 Notably these gains in provision of mental health services in a primary care setting would have benefits in ameliorating problems with the transfer of rural consumers to urbanised tertiary health settings as people are treated in their local community within social and medical supports and without the need to travel distances. 37 These gains have been made in conjunction with the $51.7 million Mental Health Services in Rural and Remote Areas program providing targeted services such as Aboriginal and Torres Strait Islander primary health care services. 1

3.5 Disadvantaged Groups – Socio-economic Disadvantage

Criticism of Better Access not reaching people from lower socio-economic regions is also not as clear-cut as critics infer. This is partially due to the complication involved in measuring disadvantage by Index of Relative Socio-economic Disadvantage which is an inexact measure taking into consideration various variables of the postcode where a consumer lives which may not reflect individual circumstances. 38 The Better Access evaluation showed that the uptake rates of Better Access were approximately 10% lower for people living in the most disadvantaged areas (48.5 persons per 1000) to least disadvantaged regions (53.6 persons per 1000) yet the *relative growth in uptake between 2007 and 2009 was highest for people in disadvantaged areas.* Data also indicated that bulk billing was highest and co-payment when charged was lowest across all item groups in Better Access for people in areas of greatest socio-economic disadvantage rating. Increased referral to a psychologist for treatment of

mental health disorders in areas of high socio-economic disadvantage has also been noted since Better Access commencement. [6] The Department of Health and Ageing Post-Implementation Review simply stated, "*The Better Access MBS items have increased access to affordable mental health services for patients who previously could not afford these services".*[19] The criticism of Better Access failing certain groups will also be considered with analysis of the criticism that Better Access provided care to people not needing a service in Section 3.6.

3.6 Service Provision Trends

Mental health critics associated with the Brain Mind Research Institute and Beyond Blue have used the media to claim that Better Access provided care to people not needing a service with claims that Better Access was "welfare for the wealthy" and provided care for the "worried well" or "people not even worried." [39] [40] This is the point at which this submission must respond to points which are factually untrue not debateable premise. Better Access is established with clear pathways of referral which require General Practitioner's to provide assessment, diagnose a mental health disorder and refer to shared care within a Mental Health Treatment Plan. [41] This submission has also already shown that; i) 90% of those using Medicare rebates to use Better Access had a (high prevalence) depression or anxiety diagnosis, other 10% are substance use, personality or other disorders ii) approximately 80% of those treated recorded pre-treatment high or very high levels of distress on Kessler 10 assessment and iii) 47% of those using Better Access met the criteria for a severe disorder, 45.5% reported a high level of disability. [6] [7] The criticism that Better Access is only treating mild and moderate disorders due to the fact that it is funded to treat high prevalence disorders also seems to be confusing the idea that mood or affective disorders are less serious than other forms of disorder such as psychosis which is a premise not supported by international (WHO) onus of morbidity evaluation. [2] [29] [42]

The assertion that Better Access services were duplicating services or seeing over-serviced consumers [43] has also been refuted by the evidence that in *2008 Medicare data showed that 87.2% of consumers received a Better Access Mental Health Treatment Plan for the first time and in 2009, a significant 77.1% of consumers were provided first time Better Access Plans.*[6] Furthermore, analysis of the 2007 National Survey of Mental Health and Wellbeing revealed that 62% of Better Access consumers were totally new to using psychological therapy services of any type. [5]

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3.6 Service Provision Trends

The Better Access evaluation brought together data from Medicare Benefits Schedule and the 2007 National Survey of Mental Health and Wellbeing and aggregated them with Divisions of General Practice to observe whether Better Access services were distributed appropriately across Divisions according to levels of mental health treatment need. Better Access evaluation findings were that Better Access showed higher uptake rates in Divisions with higher levels of mental health need.[6] Epidemiological analysis of the 2007 National Survey of Mental Health and Wellbeing also showed "(*a)mong people with a 12-month affective or anxiety disorder, Better Access service use, as compared to other service use, or no service use, was predicted by clinical factors (ie. more severe disorder, having an affective disorder) but not by urbanicity (ie .living in a major urban area versus a rural or remote area), level of socio-economic disadvantage (ie. living in areas of less disadvantage) or other socio-demographic factors (such as age, gender, education or employment status)."* [44] In other

words, clinical need as defined by having identified more severe or complex needs was the predictive factor of Better Access rebate utilisation not demographic or socio-economic factors. These findings were corroborated by General Practitioner data collected by the BEACH program. 9 These findings would indicate that the Better Access program was meeting perceived need for treatment which is the role of accessible treatment programs. There may be other variables involved in the differences of service usage between population groups including differences in willingness to identify psychological issues, different perceptions of treatment seeking and as stated with gender, differences in mental health disorder incidence.

3.7 Better Access Service Provider Professional Standards

The same critics have in different forums suggested that practitioners within Better Access were not of appropriate standard. One vocal critic went so far as to say via "The Age" on June 10, 2010, "*But a surge in the number of counsellors, therapists and psychologists offering the rebate and bulk-billing has raised concerns among several (mental health) council members about the quality of the service being provided. "Someone can hang a shingle out the front of their place and provide these services under Medicare, but we have no idea of the standard of care*." 40 This again is a factual untruth. As stated in 3.2 of this submission there has not been a surge of practitioners registering with Better Access and only health professionals registered with their relevant registration body have ever been able to provide services under Medicare and apply for a Medicare provider number.45

Better Access practitioners must meet minimum standards of education and professional competency including ongoing professional development requirements which are set and monitored by relevant professional registration bodies and associations in consultation with the government.46 Medicare Australia has also engaged in 2009 audit of the Better Access scheme with a focus upon the diagnosis of a mental health disorder acting as the activation of Better Access treatment amongst other measures. 47 Disparagement of mental health engagement or need for treatment of high prevalence disorders within the media would predictably increase stigma 48 attached to using Better Access Medicare rebates and is likely to serve as an obstacle to Australians receiving early identification and treatment for their health concerns as evidenced by World Health Organisation Surveys 49 and Australian research. 50

3.8 Evidence Base

Over the span of Better Access there have been claims by the Brain Mind Research Institute that Better Access failed to deliver on providing evidence based treatment. In 2007, there was complaint that Better Access treatment was substandard due to departure from team based care 14 and in 2010 the same group claimed that the evaluation of Better Access failed to meet their standard for treatment evaluation. 51 Media have reiterated claims that Better Access fail to deliver on evidence based practice without evidence to support these claims 52 As stated, the Centre for Health Policy Programs and Economics, University of Melbourne (Better Access review) used 20 different data sources to evaluate the Better Access program with positive conclusions as per treatment outcomes and consumer satisfaction ratings as measured by psychometric assessment, consumer and stakeholder feedback. 6

Better Access treatment has been developed and administered according to a Department of Health and Ageing funded initiative conducted with assistance of the Australian Psychological

Society (APS). The APS were commissioned to complete a very extensive review of the evidence informing brief psychological intervention, a meta-analysis. The scientific literature review process is regularly updated to include new international research findings and to guide Better Access policy and implementation. Better Access Medicare Items are constructed so that Australian Medicare rebates are contingent upon delivery of the most evidence based therapies available including Cognitive Behavioural Therapy and Interpersonal Psychotherapy. The recommendations of treatment delivery in terms of treatment types and duration are derived from best practice analysis, "Evidence-Based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review, Third Edition (2010)."[53]

Extrapolating from Better Access policy, critics could be suggesting that individual practitioners are failing to provide evidence- based and Medicare endorsed psychological treatment. The Department of Health and Ageing completed a Post-Implementation Review of Better Access which did not identify evidence of competency issues which would form a serious allegation in reference to individual practitioners failing to meet professional standards and Medicare requirements [19] In fact, need for compliance with Medicare Items could arguably be a regulatory factor in ensuring that Australians seeking psychological treatment receive evidence based treatment as health practitioners are audited for program compliance and professional standards as set by Medicare.

3.8 Better Access Criticism Summary

Both formal and informal scrutiny of Better Access has been more assertive and vocal than any other program evaluation the author of this submission has ever witnessed or observed in widespread research of Australian mental health services within Federal or State and Territory health. In analysis of Better Access criticisms with reference to research and the known data relating to Better Access it can be seen that Better Access is meeting objectives of increasing treatment rates for high prevalence disorders which are not eligible for, or requiring, resource intensive team based treatment approaches. The assertion that Better Access will represent a budget "blow-out" has been considered from the perspective of unmet need "ceiling" and the known facts about mental health skill shortage in Australia which self-limits Better Access growth. The criticism that Better Access is a costly method of providing treatment has been answered particularly in reference to other known forms of service delivery. Evidence about Better Access meeting clinical needs of Australians as a universal treatment program has also been considered in response to criticisms of Better Access failing vulnerable groups. Criticisms of Better Access professional standards and evidence based practice have also been refuted from the perspective of examination of professional and Medicare requirements.

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3.8 Better Access Criticism Summary

The inference that Better Access only treats mild and moderate disorders due to focus upon mood and affective disorders has also been shown to be incorrect both i) in terms of disorder severity Better Access manages and ii) in terms of global awareness of the burden of high prevalence disorder morbidity. Better Access program role diminishment, with the inherent mild disorder assumption, relative to other spending priorities will be the focus of the remainder of this Submission. It is posited that Better Access has been criticised for agenda based reasons.

4.1 Recommendations toward Mental Health Budget 2011-2012

The 2011-2012 Mental Health Budget follows on from recommendations made by the National Health and Hospitals Reform Commission Report as released in June 2009 [56] and recommendations made by the Independent Mental Health Working Party which culminated in a paper written by a group called the 'Independent Mental Health Reform Group' using the University of Sydney server called, "Including, Connecting, Contributing: A Blueprint to Transform Mental Health and Social Participation in Australia" released in March 2011. [54]

The first two major recommendations of expenditure made by the National Health and Hospitals Reform Commission Report were;

1. We recommend that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service.

2. We recommend that the Early Psychosis Prevention and Intervention Centre (EPPIC) model be implemented nationally so that early intervention in psychosis becomes the norm.

No further recommendations were made about specific Federal mental health services.

The "Independent Mental Health Working Party" likewise made recommendations for funding in eight priority areas as follows;

1. Prevention and early intervention services for children, young people and emerging adults (i.e. 0-25 years), with specific emphasis on increased access to both better primary care and more specialised community-based services ($988m);
2. New integrated community services that use innovative contracting systems to drive real social inclusion and enhanced economic participation ($710m);
3. New collaborative health services that are consistent with national health reform and promote primary and specialised mental health care in community-based settings ($203m);
4. Collaborative medical and psychiatric services for maintenance of the elderly in community settings and to promote healthy ageing ($100m);
5. A National Mental Health Commission to report annually ($50m);
6. Use of new technologies, particularly e-mental health services to increase access to services as well as support ongoing self-care and traditional clinical care ($160m);
7. Strategic research, development and evaluation to promote health service reform, investigate new and enhanced treatments and trial new models of service provision ($139m); and
8. Reform and develop the mental health workforce, with a specific emphasis on promotion of flexible and responsive team-based care ($150m).

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4.1 Recommendations toward Mental Health Budget 2011-2012

The funding recommendations made by the Independent Mental Health Reform Group are stated to be guided by the following principles:

• The services presented here are ready for immediate implementation
• These services are in areas where autonomous Commonwealth activity is possible and desirable
• The services recommended must be genuinely transformational
• The Blueprint does not make specific recommendations regarding other key services which are currently within state/territory jurisdiction, such as community mental health services, judicial and police services etc.
• The Blueprint recommends services and programs which are grounded in evidence, demonstrated to have a positive impact on the lives of people with a mental illness.[55]

Note again that the COAG National Action Plan on Mental Health 2006-2011 first recommendation of key areas of funding responsibility, "services delivered by private psychiatrists in the community, General Practitioners, psychologists, mental health nurses and other allied health professionals" [1] was omitted from the Independent Mental Health Reform Groups recommendations.

4.2 Mental Health Budget 2011-2012

The Budget 2011-2012 as outlined in Budget 2011–12: Mental health—centrepiece of this year's health budget, Parliament Library:

- *$419.7 million over five years to establish up to 12 new Early Psychosis Prevention and Intervention Centres (EPICC), and 30 new headspace sites to help young people with or at risk of mental illness*
- *$343.8 million over five years to provide more coordinated care services to people with severe mental illnesses*
- *$269.3 million over five years for community mental health services, in particular to expand Family Mental Health support services and increase the number of personal helpers, mentors, and respite care services*
- *$201.3 million over five years for a National Partnership Agreement on Mental Health. Funds from this agreement would be made available to state and territory governments on a competitive basis for projects designed to address major gaps in mental health services and*
- *$205.9 million over five years to expand access to the Access to Allied Psychological services programs in hard to reach and low socio-economic areas.*

"Other important initiatives include the establishment of a Mental Health Commission and an online portal to make it easier for people to find and access mental health services.

The initiatives outlined in the Budget broadly accord with the priorities for investment outlined in a blueprint for mental health reform published by an Independent Mental Health Reform Group in March this year." [56]

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4.3 Analysis Budget 2011-2012 –Better Access

This submission will consider directly the decisions to rationalise Better Access and rationales provided for this rationalisation process, the decision to invest in EPPIC and Headspace age and disorder specific services and the increased ATAPS investment in particular before providing information about the recommendation process.

In a Fact Sheet released by the Department and Health and Ageing called, "Rationalisation of allied mental health services under Better Access: 2011-2012 Budget Measure" key points made included; *"From 1 November 2011 Medicare rebates for eligible people with a diagnosed mental disorder under the Better Access initiative will be capped at 10 individual allied mental health services per calendar year, from 12."* [57] This is a factual distortion failing to relate that the Better Access program previously had a concession which provided for six (6) additional rebates as clinically indicated under "exceptional circumstances" providing eighteen (18) rebates per year for eligible Australians.

As noted in 3.7, Better Access was developed and implemented in accordance with extensive review of available evidence informing psychological treatment including a matching of available rebates per calendar year to evidence which shows that psychological therapies such as Cognitive Behavioural Therapy require fifteen (15) to twenty (20) sessions to complete toward positive outcomes. 53 The consequences of providing rebates for an artificially abbreviated treatment course for people with high prevalence disorders has not been well researched yet the provision of incomplete treatment can not be considered ethical or evidence based practice. Department of Health and Ageing rationale for the cuts have identified the usage patterns of Better Access citing that many Better Access users utilised only six (6) rebates in the year.7

Leaving aside issues with methodology including lack of follow-up evaluation, failing to control for return to treatment and treatment occurring over different calendar years, using service usage statistics to develop Better Access rebate policy is a flawed premise. This would incorporate a mental health program policy of capping Medicare rebates at an arbitrary, economically-set point for the Better Access consumer regardless of the known psychological treatment duration efficacy. Rationalisation of the Better Access according to usage statistics would also appear to have very limited cost saving benefits due to the purported relative scarcity of consumers using more than ten (10) Medicare rebates yet removes Better Access capacity to treat the consumer who has complicated psychological issues. Recent APS research indicates that Better Access has reached over 260,000 Australians who have used more than ten (10) treatment sessions with Better Access. 58

The Department of Health and Ageing's "Rationalisation of allied mental health services under Better Access: 2011-2012 Budget Measure" Fact Sheet mentioned above continues to provide some departure from the findings of the Department commissioned Better Access evaluation for people requiring more than ten (10) Medicare rebates for treatment of their mental health disorder. "*It is important that people get the right care for their needs. People who currently receive more than 10 allied mental health services under Better Access may have more severe or complex needs and would be better suited for referral to more appropriate mental health services. People with severe and persistent mental disorders who require over 10 allied mental health services are still eligible for up to 50 Medicare Benefits Schedule consultant psychiatrist services per annum, or to access the specialised mental health system in each State or Territory. To help make psychiatrist services available in more areas from 1 July 2011 the Government will also provide new Medicare rebates for online psychiatrist consultations for patients living in regional, remote and outer metropolitan areas"* 57

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4.3 Analysis Budget 2011-2012 – Better Access

As stated in 1.2, Better Access was established in 2006 as a key funding responsibility, as identified by COAG, for the Federal government to provide funding for treatment to address very low treatment rates in high prevalence disorders which were not eligible for, or needing access to the community mental health services provided by State and Territory services. Better Access is a unique, universal access program which Departmental Post-Implementation Review 20 assessed as meeting hitherto unmet need of treating high prevalence disorders. The Department of Health and Ageing's Better Access evaluation, as stated in 3.5, also shows that Better Access provides good outcomes for predominantly *severe and moderate* mood and affective disorders. Better Access is *not* engaged in providing care for mild and moderate mental health disorders as some government briefs have reported since "mental health reform." 58 This is particularly problematic as Better Access evaluation demonstrates that Better Access reaches and provides treatment to Australians with severe high prevalence disorders not treated elsewhere, Better Access is in high demand and current budget proposals would provide subs-standard treatment duration which would result in

inevitable mitigation of evidence-based practice for Australians with disabling and distressing high prevalence disorders.

Analysis in 3.3 provided an appraisal of relative cost of Better Access to other methods of providing mental health treatment. The accessibility of other forms of mental health treatment delivery also remains problematic. Better Access was developed, in part, as a response to the limited accessibility of psychiatric services generally and particularly within rural areas or for new patients [19] Accessibility of other forms of service delivery including telephonic or internet means will not solve the problem of psychiatric workforce working capacity.

4.3 Analysis Budget 2011-2012 – ATAPS

A Department of Health and Ageing media release entitled " 2011-12 Budget Provides Greater Access to Psychological Support" of May 16, 2011 quotes the Minister for Mental Health and Ageing as stating, "the doubling of funding in this year's Budget will allow subsidised treatment for about 185,000 extra patients, over five years," [60] The addition of this treatment would mean that 370, 000 would have access to ATAPS services using ATAPS Audit figures [23] although there is no indication as of yet whether ATAPS consumers would be subject to the same truncated treatment duration of ten (10) sessions. The premise that additional ATAPS funding would "enhance mental health delivery in the primary setting" [61] as stated in Mental Health Reform is flawed in two major ways. The rationalisation of Better Access General Practitioner Items are likely to reduce General Practitioner Mental Health Plan formulation which would reduce the primary health benefit of early intervention and restrict many more Australians from receiving care than the modest ATAPS enhancement will compensate, ATAPS capacity to remain a targeted service in a climate of reduced Better Access capacity is also dubious. Analysis of these issues will be examined with reference to Department of Health and Ageing information.

Surveys of general practitioners have indicated that one in four general practitioners will stop drafting General Practitioner Mental Health Plans due to rationalisation of Better Access remuneration of mental health plans as relative to physical health plans and one in two General Practitioners believe that rationalisation of the Mental Health Plan component of Better Access would reduce the time which could be spent with each patient. [61] This would represent a very significant reduction in assessment and referral of mental health disorder by deliberate avoidance of the program which by 2009 Better Access uptake standards (not mental health disorder figures) would represent over 275,000 Australians per year not receiving treatment. [6] The hidden and incalculable impact of missed mental health disorder early identification opportunity associated with time constraint is likely to be even more considerable. This can not be seen as a progressive step in primary health assessment and treatment of mental health disorder or early intervention outcomes.

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4.3 Analysis Budget 2011-2012 – ATAPS

Department of Health and Ageing publicity releases suggest that via ATAPS "*the Government will provide a major boost to primary mental health services, by targeting additional resources to groups that are hard to reach and currently underserviced, such as people in rural and regional Australia and low income areas, Indigenous Australians, men, young people under 25 and other disadvantaged groups."* [57] Previous ATAPS Reviews have also stated that "*ATAPS and Better Access must be complementary. ATAPS can focus on areas and populations where Better Access may not be as flexible in it's service delivery.*" [24]
The 2011 ATAPS audit further states, "*the Government now views the ATAPS program as an important and necessary program to complement the much larger Better Access initiative, in particular through the targeting of groups with low usage of Medicare-funded services*." [22]

The premise of ATAPS, as a Better Access complementary service, which may assist in mental health engagement and perception change within groups not accessing services now is one echoed within Australian evaluation of primary mental health programs. [34] [35] This premise occurs however within a history of ATAPS often exhausting their annual budget resulting in capping of General Practitioner referral within General Practitioner Divisions or establishing waiting lists pending end of budget year. [23] The rationalisation of Better Access in a climate of no means testing of any mainstream mental health service will inevitably lead to increased demand or "overflow" from one program into other no-cost or low-cost programs particularly in a potential climate of Better Access practitioner attrition, The most probable consequence of proposed mental health funding changes therefore would be the reduction in any targeted focus gains that may have been available in terms of specialist attention toward changing perceptions of treatment seeking. In other words, this submission, would suggest that the strengths of both Better Access and ATAPS will be considerably mitigated.

4.3 Analysis Budget 2011-2012 – Early Intervention Services EPPIC & headspace

As stated in 4.3, the mental health budget allocated *$419.7 million over five years to establish up to 12 new Early Psychosis Prevention and Intervention Centres (EPICC), and 30 new headspace sites to help young people with or at risk of mental illness.* An analysis of EPPIC according to World Health Organisation mental health service criteria will proceed before an analysis of headspace. Both EPPIC and headspace are described as clinical programs of Orygen Youth Health which, in turn, describes itself as "*a world class facility for the comprehensive treatment of young people experiencing a first episode crisis in mental health"* on the Orygen Health website*. [62]*

The author of this submission was unable to find an independent evaluation of EPPIC services comparable to the Better Access evaluation which would provide an overview of EPPIC cost per treatment unit, accessibility, prevalence of "early psychosis" as defined by EPPIC, alternative services capacity or consumer outcomes for analysis. EPPIC's website states that EPPIC originated in 1988 and became a community based service in 1992. EPPIC describes itself as a "dedicated early psychosis service in a dedicated youth service." [63] EPPIC appears to be a community health service similar to those offered in state public community health services as provided by a multi-disciplinary team consisting of case manager staff including nurses, clinical psychologists, occupational therapists, and social workers working with consultant psychiatrists, or psychiatric registrars working under senior consultant psychiatrists. In terms of accessibility, EPPIC provides services to 12-25 year old Australians with symptoms of psychosis. EPPIC are tertiary centres and are in select metropolitan areas only yet they do state that consultation services exist from their base.

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4.3 Analysis Budget 2011-2012 – Early Intervention Services EPPIC & headspace

'headspace' services can be evaluated with reference to the Headspace Evaluation Report: Independent Evaluation of headspace: the National Youth Mental Health Foundation (2009) as completed by a research team associated with the Social Policy Research Centre, University of New South Wales. [33] This "headspace Evaluation Report" was completed in November 2009 in reference to data collected by June 2009. This evaluation report would represent the initial stages of headspace establishment, implementation and administration as headspace originated in 2006, ten (10) of thirty (30) headspace centres were announced in February 2007 and the remaining twenty (20) were announced in January 2008. All centres were operational by December 2008. Some of the evaluation findings and omissions may be understood from the context of program infancy yet this evaluation remains the only source by which independent analysis of headspace can be made.

From the headspace evaluation report it can be understood that the headspace service model is one which "*aims to provide multidisciplinary services to young people with mental health issues in 30 (centres) throughout Australia across four key areas: primary health, mental health, alcohol and drug use, and social and vocational support"* 33. In operational terms this has occurred through headspace becoming a company by limited guarantee with charitable status in 2009. According to the headspace evaluation report, headspace is currently funded by the Department of Health and Ageing and governed by the headspace board largely consisting of organisations who originally tendered for the National Youth Mental Health Foundation namely Orygen Research Centre, University of Melbourne, Brain Mind Research Institute, Australian Psychological Society and the Australian General Practice Network, alongside board members from the Australian Indigenous Doctors Association & Principals Australia and a chair nominated by the Department of Health and Ageing.

headspace centres are established by participation in a competitive tendering process administered by the headspace Grants Committee. The headspace Evaluation Report states, "*the centres collectively received $34.2 million between 2006 and mid-2009, and will be receiving at least $500,000 each per year between 2009 and 2010 as ongoing core funding. Service delivery is supported by the Youth Mental Health Initiative (YMHI) Allied Health Worker (AHW) program which assists in the payment of practitioners, such as psychologists, social workers, mental health nurses, occupational therapists, Aboriginal and Torres Strait Islander health workers, AOD counsellors, and youth workers."* The Youth Mental Health Initiative is a Department of Health and Ageing program of an additional $50 million established in order to provide staff for headspace initiatives. 64

In explaining local set-up the headspace Evaluation Report explains that each centre "*is directed by a lead agency on behalf of a consortium of government agencies and non-government organisations (NGOs) from a range of sectors. This arrangement is intended to encourage a whole-of-community approach and engage key stakeholders in the development, establishment, implementation and coordination of headspace services."* At initial stages of implementation, the local Centres were guided by a headspace national office which was administered within the University of Melbourne; the Centre of Excellence (research arm) was established within the Orygen Research Centre at the University of Melbourne; the community awareness program was funded and run by the Brain and Mind Research Institute (BMRI) at the University of Sydney; and the service provider education and training program was undertaken by the Australian Psychological Society and the Australian General Practice Network. These services, with the exception of the role of Orygen Research Centre, have now been assumed by headspace National Office which governs and supports all headspace centre activity.

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4.3 Analysis Budget 2011-2012 – Early Intervention Services EPPIC & headspace

The headspace model thus is aiming to bring together local centre human resources to deliver services as promoted by Brain Mind Research Institute community awareness initiatives, supported by Orygen Research Centre research, facilitated by human resource training by psychological and medical professional association, administered by headspace national office and local consortiums in a role similar to the management committee. The headspace evaluation report explains that the headspace centres themselves are designed to assist young people to engage with help seeking by drop in centre engagement, self or agency referral whereupon the young person's details are collected, information or referral may also be provided. The young person may proceed to assessment as provided by a salaried worker such as a Youth Mental Health Initiative Allied Health Worker who would provide referral according to need to any or all of the services available including; co-located mental health workers, State or Territory funded mental health workers, co-located (State or Territory funded) Alcohol or Other Drug Workers, co-located Vocational Assistance Workers,

Youth Mental Health Initiative funded or MBS paid Allied Health Clinicians and Youth Mental Health Initiative salaried or MBS funded General Practitioners.

The headspace Evaluation Report indicated that as of June 2009 the idea of bringing these services together as a hub has been frustrated by some difficulties with recruitment which would be indicated by reference to mental health skill shortages as discussed in Section 4.3. Psychiatrists and General Practitioners have been particularly difficult to recruit within headspace centres with the headspace Evaluation Report stating that only one third of operational headspaces were able to provide all four intended services as of date of report. 33 headspace centre funding was also seen to vary across centres with headspace core funding required for physical establishment, payment of administration and management duties, Youth Mental Health Initiative funding provided core service delivery, administration and linkages between services yet factors such as charging rent, salaried versus Better Access remunerated practitioners models, consortium donations, philanthropic donations and gap payment policy appeared to vary across headspace centres. 33

The headspace evaluation report experienced difficulties in providing a full evaluation of headspace services as of June 2009 due to only 7,022 young people from 22 of 30 (Wave 1, 2008) and 26 of 30 (Wave 2, 2009) headspace sites being connected to headspace database. From the 26 centres only 24 headspace centres were included in data and the headspace Evaluation Report states that 29% of the data available was produced in two headspace sites. The headspace Evaluation Report cites that there was "*substantial missing data from some sites and for certain variables"* particularly for demographic information, occasions of service, referral source, diagnosis and available psychometric data such as the Kessler 10 psychological distress scale results. headspace data sets ultimately included data for 2222 service users between baseline and second assessment so information about the impact of headspace intervention across different headspace centres and types of young people are not known. 33

Further sources of data about headspace used in the Headspace Evaluation included; two waves of interviews with young people, Wave 1 (2008) included 91 young people, Wave 2 (2009) included 93 young people, 16 participants were interviewed in both Wave 1 and 2, ii) 69 headspace users were surveyed in 10 in-depth headspace centres in both Waves 1 and Waves 2 yet survey response in Wave 1 was so poor (48 surveys) surveys were combined, iii) 21 carers were interviewed in Wave 1 and 31 were surveyed in Wave 2 (4 repeated interviews between Waves 1 and 2), iv)surveys of 232 headspace service or consortium providers in Wave 1 and 2 and v) interviews of 36 headspace service affiliates in Wave 1 and 31 in Wave 2 (15 interviewed in both Wave 1 and 2).

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4.3 Analysis Budget 2011-2012 – Early Intervention Services EPPIC & headspace

The headspace evaluation report has stated, "*due to the limitations of the data at this stage in the evaluation, it is not possible to draw any firm conclusions about the outcomes for the population of young people accessing headspace."* Longitudinal data showing improvements over time was also not available. 33

headspace statistics to June 2009, indicated that the 30 sites had collectively seen approximately 13,917 young people and had provided over 95,000 occasions of service. An equal split of 10 centres each were seen to have had high, moderate or low usage figures with the busiest headspace centres seeing upon average 57.6 service users per month, moderate use centres seeing 27 and low use centres seeing 17.1 service users per month. 33

headspace dataset, where available, has produced results unsurprisingly similar to Better Access usage and improvement figures considering headspace relies heavily upon Better Access providers under MBS to provide the mental health services within headspace centres. The most frequently occurring disorders for young people attending headspace (n=811) were anxiety and depressive disorders. 93.2% of 147 young people surveyed reported an improvement in their mental health since coming to headspace. Improved mental health outcomes were uniformly spread across all demographic groups. The K-10 sample showed modest reduction of psychological distress subsequent to treatment.

47% of service users demonstrated a high level of distress as measured by the Kessler 10 which is significantly less than the Better Access 80% of service users with high levels of psychological distress yet this ratio was noteworthy to headspace evaluation providers as indicative that headspace is registering a large proportion of service users who may not meet criteria for early intervention. 44% of the K10 dataset showed medium levels of distress and 9% reported no or low levels of psychological distress. 78% of available dataset sample of 145 service users surveyed indicated that relationships with families had improved and 67% of surveyed service users believed their use of Alcohol and Other Drugs had improved. 33

The headspace Evaluation Report stated that they considered the positive responses in their very truncated sample to be "*suggestive of positive outcomes*" obtained within headspace centres. This submission would argue there is reason for profound concern that such a small and arguably selective representation of overall headspace performance and the differential between distinct headspace centres with their own local lead agencies, consortiums, policies and method of operating leaves questions about performance variation unanswered at this stage of headspace development. This is particularly of concern when interviews of headspace managers indicated "*tension existed between managers and headspace National Office when the managers felt they were being criticised for not complying with the headspace model, despite the lack of an explicitly defined model to conform to."33* The headspace feature of co-location of services has also been raised by the headspace evaluation as there were concerns that "*co-location does not automatically result in effective coordination of services and care. Where co-location occurs, (centres) need to ensure that there is collaboration and that the co-located service(s) are coordinated as part of the headspace model."* 33 Service mix and professional recruitment issues as experienced within headspace centres could contribute to confusion about how headspace as a service would differ from other service user experiences with the finding that, only 68% of the survey sample had seen at least two headspace practitioners, most commonly a GP and psychologist to access Better Access Medicare provisions. 33

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4.3 Analysis Budget 2011-2012 – Early Intervention Services EPPIC & headspace

This difficulty with headspace centre differences in model ambiguity, compliance and data adherence may be resolved or resolving yet this has resulted in a context where analysis of headspace must remain inconclusive in terms of evaluating service consistency and service objective outcomes. The comparison of headspace to already existing State and Territory Child and Youth Mental Health Services who place emphasis upon child-appropriate access and service linkage is also frustrated although headspace access would appear to have a different profile and lower threshold than most State and Territory mental health services. Access by different demographic groups remains inconclusive due to data compliance issues yet headspace is definitively limited by demographic to Australians aged from 12 to 25 years willing to be treated within a centre model of care. headspace centres are also restricted to select metropolitan areas and are accessible largely within normal working hours. 33

Cost of headspace services in totality and in per treatment cost unit are likely to be higher than a fee-for-service model due to heavy use of administration yet the headspace Evaluation Report also indicated that it was unable to provide a cost analysis of headspace services. The Evaluation Report indicated that insufficient information about headspace finances had been furnished to their evaluation *"(T)he evaluation intended to conduct a cost analysis*.*The data from this analysis was not included because it did not properly reflect the true establishment and recurrent cost of the program. Only budgeted revenue and expenditure data for the 2008-2009 financial year and the actual revenue and expenditure for the six months from 1 July to 30 December 2008 was available to the researchers for analysis."* [33]

This submission to the Senate Inquiry would argue that it is disconcerting that the general public have no potential method of conducting a proper analysis of either the EPPIC or headspace programs which have been recommended to receive considerable diversion of mental health program funding. Mental health funding is effectively being diverted away from established, transparent mental health service delivery shown to produce good outcomes for the Australian public. The remainder of this Submission will be dedicated to an analysis of the mental health reform process which has also raised concern for many commentators.

5.1 Background to Mental Health Reform

This submission asserts that the recent Budget 2010-2011 proposals and shift toward "Mental Health Reform" has not been based in fair or open analysis of mental health treatment programs upon merit yet is designed to further the goal of wider, largely covert health reform. This part of the submission must make connections which are based upon publicly available facts and make informed commentary without the expressed intentions of people, bodies and departments involved due to the closed, secretive and non-consultative processes involved. Prior to stepping forward in analysis of mental health reform processes certain stakeholder history and descriptions are required.

British United Providential Association (BUPA) is a multi-national insurance company specialising in health insurance with a presence in 200 countries and insuring over 10 million people globally. BUPA has been extending it's presence in Australia. BUPA bought HBA Insurance in 2002 and purchased MBF for $2.4 billion in 2008. BUPA insures over 3.2 million Australians as MBF, SGIO, HBA, ANZ Insurance, NRMA Insurance and Mutual Community. BUPA also has investments in health provision including Health Eyeware (Blink), Peak Health Management and private cardiology group Genesis Heart Care, with an agreement which involves monitoring of patient results and higher remuneration of desired outcomes. 65 BUPA Foundation currently is sponsoring perinatal mental health research by St John of God Health Care as well as Brain Mind Research Institute (Hickie) work on Healthy Ageing. 66

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5.1 Background to Mental Health Reform

St John of God Health Care is a leading health care provider, with private hospitals, home nursing, pathology and Social Outreach and Advocacy services throughout Australia, New Zealand, and the wider Asia-Pacific region. As a Catholic, not-for-profit group, St John of God Health Care, as a part of Catholic Health Australia, employs more than 9,300 staff and are Australia's largest not-for-profit private health care group and the third largest operator of private hospitals. St John of God is also involved in the provision of inpatient and outpatient mental health services across Australia including St John of God Hospitals in NSW and Victoria, Pomegranate House (community psychology), Bloomsbury House (dual diagnosis service), Raphael House (perinatal and infant mental health) plus an array of Social Outreach and Advocacy Services. 67

Orygen Youth Health Research Centre (OYHRC) is a charitable organisation and Australia's largest youth mental health research centre. Orygen states that it is "*one of the pre-eminent psychiatric research institutes in Australia and has developed key collaborations across the diagnostic spectrum for research and treatment of disorders with peak onset in the 12-25 year period*." [68] Orygen Youth Health Research Board members include representatives of the University of Melbourne, Melbourne Health, the Australian Institute of Company Directors and the Colonial Foundation (chair). [69] Orygen Youth Health Research Centre have been the beneficiaries of $46 million dollars from the Colonial Foundation (a philanthropic initiative of Colonial Ltd with the Commonwealth Bank) in 2010 after a series of other large grants. [70] Orygen Youth Health Research program, headspace hosted Heads Up!, an international youth mental health conference in July 2010 "*with the support of its key partners, Orygen Youth Health Research Centre, Youth beyondblue, Australian General Practice Network, VicHealth, St John of God and BUPA."* [71] BUPA literature has also indicated the health partnership with headspace. [72] EPPIC is also a program under auspice of Orygen Health.

Beyond Blue, is a charitable organisation backed by the Beyond Blue Depression Research Ancillary Fund Trust Deed and describes itself as an independent, not-for-profit organisation working to increase awareness of depression, anxiety and related disorders throughout Australia. Beyond Blue has strong affiliation with Orygen Health initiatives due to the role of Professor Ian Hickie as both Orygen consultant with EPPIC and headspace and Clinical Advisor (former CEO 2002-2003) of Beyond Blue. Beyond Blue have an extensive history of running programs with assistance from the MBF Foundation, now the BUPA Foundation. [73] [74] [75] Currently, this partnership is being repeated as Beyond Blue rolls out the National Perinatal Depression Initiative which has basis in BUPA sponsored research of a St John of God initiative.[76] Beyond Blue is also currently funding Brain Mind Research Institute 45 and Up research into internet based treatments for depression. [77] Professor Hickie is also currently a BUPA Australia Medical Advisory Panel Member and has represented BUPA Australia at conferences discussing health reform in Australia. [78]

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5.2 National Health Reform

As stated in Section 4.1, the Third Mental Health Plan defined early intervention in a much broader manner than subsequent policies with investment in early symptom identification. The first time early intervention was defined in the narrow age-band way was with recommendations made by the National Health and Hospitals Reform Commission Report as released in June 2009 which indirectly yet clearly serve to include Orygen specific services;

1. We recommend that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service.

2. We recommend that the Early Psychosis Prevention and Intervention Centre model be

implemented nationally so that early intervention in psychosis becomes the norm. [54]

The recommendations of the National Health and Hospital Reform Commission also included as follows; *"(a) design element in redesigning the health system to meet emerging challenges is concerned with the 'next generation' of Medicare. There are four important points here. First, the Commonwealth Government will be responsible for bringing together state-funded primary health care services and medical services under Medicare to create a comprehensive primary health care platform. This will include a focus on promoting good health, early intervention and better managing chronic disease. Second, the Commonwealth Government will need to consider the scope of services under the 'universal service entitlement' in a 'next generation' Medicare. The broader range of services included could be funded through a range of different payment mechanisms involving, for example, a mix of salary, fee-for-service, grants, payments for performance and quality, and payments for episodes of care.Third, we have recommended that the scope and structure of existing safety net arrangements be reviewed. There are currently multiple safety nets and a patchwork of government programs that partially meet the costs of some services. We need a simpler, more family-centred approach that improves the affordability of health care. Fourth, we have recommended that in reshaping the Medicare Benefits Schedule (one core element of the 'next generation' of Medicare), the Commonwealth Government must first decide the scope of services to be included. A framework is then needed to define the competency and scope of practice within which health professionals can provide certain services. This reshaping should be driven by a robust evidence base, and also promote continuity and integration of care through collaborative team models of care."* [54]

The government appointed Chair of the National Health and Hospitals Reform Commission was Dr Christine Bennett, Chief Medical Officer, BUPA Australia. [79] In writing an Introduction to the BUPA Foundation Report in 2009, Dr Christine Bennett documents that the Australian health system "*is a system that increasingly finds itself under pressure. Indeed, the health needs of our population are changing and the case for health reform in Australia is compelling."* Dr Bennett continues stating, "*The (BUPA) Foundation is determined to play an active role in exploring health policy initiatives that will ease the financial burden on healthcare services and strengthen the sustainability of Australia's mixed private and public health system. Much of the Foundation's work aligns with the national health reform agenda*." [79] The mental health reform process commenced alongside recommendations for Australia's health system including the concept of Medicare Locals (who will administer headspace and ATAPS), Super-clinics, the portable e-health record, the establishment of new bureaucracy strata involved in outcome measurement and reporting, maintenance of private health insurance rebate and proposal of consideration toward Medicare Select, a compulsory universal private health insurance scheme [54] [80] [81] [82]

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5.3 National Health Reform

A similar process of public health devolution, rationalisation of universal fee-for-service primary health, privatisation of polyclinics, remuneration of health service provision by tender and remuneration according to outcomes is already in place with BUPA as a major player in the UK. [83] [84] [85] [86] [87] The process toward "managed competition" in the UK was a secretive and closed one. [88] [89]

In the absence of governmental "managed competition" policy disclosure observation of reform processes must be made by using evidence of the inclusion and preparation of stakeholders. Catholic Health Australia held their "Ten Years From Now" National Conference on August 23-25, 2010 in Adelaide as sponsored by Catholic Church Insurances Ltd which acted as a forum of discussion of Catholic Health role in health reform agenda. The Conference Opening session was entitled, **'**Where do we want to be 10 Years from Now' and the session description was "*The Australian Government is in the process of reforming Australia's health system - something many Australians have been seeking for years. Health*

Minister Nicola Roxon will outline progress on the Government's reform agenda, and (Catholic Health Australia) Chairman Tony Wheeler and CEO Martin Laverty will outline the role likely to be played by Catholic organisations in the reform process." 90

The Mental Health Session at the Catholic Health Australia Conference was presented by Professor Ian Hickie, CEO Brain and Mind Institute and Professor Brett McDermott, Queensland Mater (CHA) and Beyond Blue. This session was named 'Catholic presence in Mental Health in the next 10 years,' it was described as involving "*Two of Australia's most respected mental health experts… will identify the current barriers in access to mental health services, and suggest the role that Catholic services could play in overcoming these gaps in the decade ahead*." Another notable inclusion at the Catholic Health Conference was Monsignor David Cappo, Vicar General of the Archdiocese of Adelaide who conducted a Plenary Session called "A 10 year plan to deliver care before it's needed.' 90 Another contributor to the Catholic Health Australia Conference was the Executive Director of Catholic Social Services who has recently resigned from that position to assume a CEO role with the Mental Health Council of Australia. 91

The Catholic Health Australia National Conference was closely followed by the Australian General Practitioner Network National Forum, "Connecting Care: Big ideas/Local solutions" as sponsored by BUPA and held in Perth from November 3-6, 2010. Quoted by professional media leading up to the conference was AGPN CEO David Butt who said, "*now is the time for all primary health care advocates and enthusiasts to take this national opportunity at the AGPN Forum to influence the primary health care agenda* ***that has been set for this minority Labor Government.*** *Keeping the primary health care reform momentum fresh and valid for this multi-faceted government is essential for those within the health sector and for the broader community."* 92 Professor Ian Hickie attended the AGPN conference as representative of BUPA Australia 78 and presented a session "*2010: Does it end well? Health Reform or (DIY) Health Renovations? (does anyone know where we are headed?)"* with Professor Hickie arguing the need for health reform in the form of the National Health and Hospital Network Plan as recommended by the National Health and Hospital Reform Commission particularly in terms of introducing early intervention services in terms of age rather than symptom onset. 93 This Forum was informed previously by an October "AGPN and Beyond Blue roundtable" which had discussed reforms in primary mental health care within Medicare Local structure including expansion of ATAPS, the Personal Helpers and Mentor Scheme, headspace and a Doncaster model of care for high prevalence disorders which reduces access to psychological care of high prevalence disorders by the introduction of a frontline strata of non-professional information sharing and support workers. 94 95 Both the Hon Nicola Roxon, Minister for Health and Hon Mark Butler, Minister for Mental Health and Ageing attended the AGPN Forum. 94

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5.4 National Health Reform

The Fourth Mental Health Plan was delivered in November 2009 amidst criticism of the drafting process. Commentary about the management of the drafting process of the Plan as described by Mental Health Consumer groups and mental health sector representatives included the comment that the Federal Health department had developed a "culture of secrecy." 96 97 A submission to the Development of the National Mental Health Plan written by peak NSW consumer group, NSW Consumer Advisory Group provided an account of very poor consultative processes including incidental notification of the discussion paper and consultation process by communication with a NSW government department, NSW CAG distributing the Plan Discussion Paper themselves to other non-government stakeholders and tokenistic feedback mechanisms not welcoming idea exchange but rather a "yes," or "no" response set. 98 This Fourth Plan for Mental Health delivered a focus upon service targets, accountability, standard monitoring and a shift from broad view of health to a narrow focus upon identified "at risk" populations only. The focus upon enhancement of linkages and *innovative service and funding models* with very little reference to actual service delivery left

the Department of Health and Ageing and Treasury with discretionary space to create political answers to profoundly important health policy and funding decisions. [99]

5.3 Socio-Political Context

In the first half of 2010, Orygen Youth Health, Orygen Youth Health supporters and media campaign team executed a broad and successful public relations campaign culminating in candle-light vigils and petitions with GetUp! members across Australia. GetUp's petition was put forward to the Prime Ministers Office in June 2010 with over 84,000 signatures after GetUp! raised in excess of $50,000 to support media messages for the Early Intervention campaign. [100] [101] [102] The petitions signed by GetUp! members were worded;

"I call on the governments of Australia to act urgently and effectively to reform mental healthcare in Australia so that: - there is no longer inequality of access to effective treatments between physical health and mental health
- early intervention is the norm;
- community based treatments are the norm; and
- quality services are the norm." [103]

Better Access was maligned within the media by people associated with Orygen Youth Health and Beyond Blue preceding and during this timeframe with refutable or false claims as can be evidenced in Section 3 of this submission. The Mental Health Council of Australia became a vocal critic of Better Access also re-iterating concerns about access equity as posited by Beyond Blue and Orygen Youth Health which have been strongly challenged by Better Access data and evaluation. [104] [105] Almost all other mental health consumer groups have remained silent in this context.

5.4 Mental Health Expert Advisory Group

The Federal Minister for Mental Health and Ageing, Mark Butler suspended the National Advisory Council on Mental Health and selected a new "Mental Health Expert Advisory Group" which was convened on December 23, 2010 with the purpose of making recommendations toward "mental health reform" and Budget expenditure. The membership of the group is as follows;

Dr Christine Bennett, Chief Medical Officer, BUPA Australia, Previous Chair of National Health and Hospital Reform Commission, Sponsor of headspace, Brain Mind Research Institute

Professor Patrick McGorry AO, Executive Director of Orygen Youth Health (EPPIC & headspace), University of Melbourne

Professor Ian Hickie AM, Executive Director, Brain Mind Research Institute, Board of Directors of headspace, co-researcher Early Psychosis, Clinical Advisor Beyond Blue, Medical Advisory Board BUPA

Monsignor David Cappo AO, Vicar General, Archdiocese of Adelaide, member of Board of Beyond Blue, Chair of Social Inclusion Board, member of SA Economic Development Board

Dr Andrew Fuller, Clinical Psychologist, Department of Psychiatry, University of Melbourne (works with Professor Pat McGorry), Consultant on Beyond Blue partner program, MindMatters for youth mental health.

Dr Pat Dudgeon, Clinical Psychologist, School of Indigenous Studies, University of Western Australia, co-authored with McGorry on 2009 headspace resource sheet for Borderline Personality Disorder, Sponsored by St John of God for attendance at 2008 Indigenous Conference, Engendering Leadership Through Research and Practice

Dr Christine McAuliffe, General Practitioner, General Practitioner Spokesperson for Beyond Blue

Professor Frank Oberklaid OAM, Director, Centre for Community Child Health, The Royal Children's Hospital, Melbourne, Campus Partner of the University of Melbourne

Ms Janet Meagher AM, Divisional Manager (Inclusion), Psychiatric Rehabilitation Australia, Consumer advocate with strong affiliation with Beyond Blue (photo in 2001 Beyond Blue Annual Report), founding partner of Mental Health Council of Australia, Director of Development, Psychiatric Rehabilitation Australia, registered rehabilitation provider in mental health employment and housing programs,

Ms Sally Sinclair, Chief Executive Officer, National Employment Services Association, Alumni, Neuropsychology, University of Melbourne

Mr Toby Hall, Chief Executive Officer, Accountant & CEO, Mission Australia. Chairman of Sterihealth (major medical waste company) Board, Director of UK based recruitment agency, Working Links, Director of Goodstart Childcare Ltd (owners of ABC Learning Centre).

Mr Anthony Fowke AM, President of Association of Relatives and Friends of the Mentally Ill (ARAFMI) Australia, Mental Health Council of Australia Board Member, BaptistCare Board Member

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5.4 Mental Health Expert Advisory Group

This submission refutes the defence that this group are independent and impartial including proffered explanation that the group are picked from a small academic mental health sector. There are nearly forty Australian Universities who could make solid contribution to a mental health policy expert panel. The absence of any (predominantly) clinical practitioners in a panel established by the Department of Health and Ageing in the identified context was not a disingenuous move with unintentional cost of credibility. This advisory group inclusions, purpose and outcomes were almost certainly pre-determined by a health reform agenda supporting private health and employment providers within a non-consulted health transformation process conforming with health reform. The conclusions of this Mental Health Expert Advisory Group are however not known as this group was required to sign confidentiality contracts which prevent Australians from knowing the process or outcomes of this group except as they may have been included in the drafting of the “Including,

Connecting, Contributing: A Blueprint to Transform Mental Health and Social Participation in Australia" document.

5.5 *Blueprint To Transform Mental Health*

The health recommendations or termed "*The Top 30 Best Buys"* listed by the Blueprint showcased the unevaluated EPPIC services, insubstantially evaluated headspace, development of National Autism early intervention, specialised assessment of child behaviour disorders and the national rollout of Beyond Blue perinatal program through enhanced Commonwealth funding as the first six recommended reinforcing the developmental definition of early intervention ignoring symptom onset. As stated, this definition was first articulated in the National Health and Hospital Reform Commission (NHHRC) report and is contrary to the Royal Australian and New Zealand College of Psychiatrists Submission to the NHHRC which articulated concern that "*the nation has a responsibility to offer equivalent access to mental health care to all Australians. The reform direction must focus on mental health across the life span with associated targeted early interventions measures for each relevant group*. *Similarly, the College is concerned that investing in one disorder only, psychosis, neglects other more common mental health disorders such as anxiety, depression and older onset disorders that can have a greater impact on the burden of disease and cost to society" 107*

The blueprint for mental health services prepared by the self-termed Independent Mental Health Reform Group was drafted by; Monsignor David Cappo, Professor Patrick McGorry, Professor Ian Hickie, Sebastian Rosenberg, Senior Lecturer at Brain Mind Research Institute, John Moran, General Manager at Orygen Youth Health, Founding Executive Committee of headspace and Matthew Hamilton, Senior Policy Advisor at Orygen Youth Health and the "Social Change Strategist" behind Orygen Youth Health's launch of headspace and mental health reforms."

This issue is considerably more significant than concerns about conflict of interest. The mental health reform agenda is intrinsically based in closed, non-consultative and exclusive process which is part of the larger imposed shift of health reform.

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6.1 Recommendations

Submission recommendations include;

1) Senate Committee initiates an intensive investigation of mental health reform processes including the selection of the Mental Health Expert Advisory Group, recommendations of the Mental Health Expert Advisory Group, recommendations by the Department of Health and Ageing staff to Treasury resulting in recent mental health budget decisions and any other matter relevant to the proposed Mental Health Budget 2011-2012 and

2) Rationalisation of the Better Access proposal should be reviewed as informed by such an investigation.

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