



Australian Government
Department of Health and Ageing

**SUBMISSION TO THE SENATE COMMUNITY AFFAIRS COMMITTEE
INQUIRY INTO COMMONWEALTH FUNDING AND ADMINISTRATION OF MENTAL
HEALTH SERVICES IN AUSTRALIA**

Introduction

Many of the determinants of mental health and mental illness are influenced by factors beyond the mental health system and a cross-sectoral and whole of government approach is essential.

This submission has been prepared by the Department of Health and Ageing (DoHA), in consultation with the Departments of the Prime Minister and Cabinet (PM&C); Families, Housing, Community Services and Indigenous Affairs (FaHCSIA); and Education, Employment and Workplace Relations (DEEWR). It should be read in conjunction with the Ministerial Budget statement, *National Mental Health Reform 2011-12*.

The submission starts with a contextual overview of the prevalence of mental illness and the structure of the current mental health system, before addressing each of the items in the inquiry terms of reference, with a particular focus on the 2011-12 Budget *Delivering National Mental Health Reform* package.

Context

Mental illness is the largest single cause of disability in Australia, accounting for 24 per cent of the burden of non fatal disease¹. The prevalence of mental illness is increasing globally, with the World Health Organization reporting that depression will be one of the biggest health problems worldwide by 2020². About one fifth of Australians will suffer from a mental illness this year, and nearly half the population experiences a mental health problem at some time during their lives³.

The Australian Government plays a national leadership role in improving the lives of Australians with mental illnesses, their families and carers. It achieves this through articulating a vision for reform for Australia's mental health system; driving collaborative effort across the different levels of government, non-government organisations (NGOs) and the private sector; engaging consumers, carers, service providers, stakeholders and experts; developing the strategies, policies and systems to support its vision of reform; and funding a range of mental illness prevention, early intervention and treatment services and mental health promotion activities.

The major funders of mental health services in Australia are the Commonwealth, state and territory governments and private health insurers⁴. In 2008-09, total expenditure on mental health services by the Commonwealth and state and territory governments was \$5.6 billion. This figure includes expenditure under the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS) in addition to Commonwealth managed programs and initiatives, grants to states and territories, private health

¹ National Mental Health Report 2010, p18

² What is Mental Illness? 2007

³ Mental Health Statistics Fact Sheet, p1

⁴ National Mental Health Report 2010, p24

insurance premium rebates, research and the National Suicide Prevention Program. In 2008-09 the Australian Government was the largest single funder and was responsible for 37.9 per cent of the nation's total mental health services (\$2.1 billion). The states and territories combined were responsible for 62.1 per cent of mental health spending (\$3.5 billion)⁵.

State and territory governments are responsible for the delivery of specialised public mental health services, such as community based services and hospital care, primarily for those with severe mental illnesses. The Australian Government complements these by directly funding a range of services for people with mental illnesses, including through the MBS, the PBS and programs administered by DoHA, FaHCSIA, DEEWR and the Department of Veterans' Affairs (DVA).

In the 2011-12 Budget, through the *Delivering National Mental Health Reform* package, the Government recognised that more needs to be done to help Australians who have a mental illness get the care they need, when and where they need it and to support their families and carers.

This package builds on existing investment in mental health, including funding for mental health under the MBS and PBS. Australian Government funding for mental health specific programs (including Indigenous programs) in the four year period 2011-12 to 2014-15 has increased by 357 per cent to around \$2.4 billion; compared to \$516.3 million provided in the four years 2004-05 to 2007-08. This investment will continue to grow to around \$3.1 billion over the five years to 2015-16.

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

The *Delivering National Mental Health Reform* Budget package provides a \$1.5 billion investment in both health and community services over the next five years and a structure to continue reform in the long term.

The reforms also build on the investments already made by the Government in the past eighteen months – in suicide prevention, expanding headspace and underwriting more subacute beds, for example – and spanning multiple areas of government, including homelessness, carers, disability and broader health reform. When combined with the 2010 Budget and election commitments which provide \$624 million over the same five year period, the Government has committed \$2.2 billion in funding over the next five years for new and expanded mental health services.

This mental health reform package has been designed as a finely balanced package of cross-sector initiatives. Both in their implementation and monitoring, the various components are intended to work together to close current system gaps, diversify and enhance the service offer and improve consumer outcomes. A summary of each of the package measures, funding and which agency is leading implementation is at [Attachment A](#).

The package also recognises the diverse impact of mental illness and lays down the foundations for a new systematic approach to support people with mental illness:

- helping to prevent and detect mental illness early, and building the capacity for early intervention (particularly for young Australians);
- ensuring the majority of Australians with mental illness (ie those with less severe illnesses) continue to have access to care, including by expanding the available e-mental health service offer, while better targeting primary mental health care to ensure that the most disadvantaged, who continue to miss out, receive the right care;

⁵ Report on Government Services 2011, p12.40

- providing additional support for families and carers of people with severe mental illness to help them cope with their caring role, and ensure that they have opportunities to participate socially and economically;
- delivering joined-up services for the smaller number of Australians severely affected by mental illness and having complex care needs (including an incentive for states and territories to fill key gaps in their systems);
- increasing social and housing support and economic participation for all people with mental illness – acknowledging that mental health is about more than simply health care; and
- improving accountability and quality, and thus building into the mental health system structural enablers of further reform.

These reforms will have two main effects. One is to start reorienting the mental health system towards prevention and early intervention. The second is to help people to stay well in (and connected to) the community, irrespective of the severity of their mental illness.

A Ten Year Roadmap for Mental Health Reform will set out what Australia’s mental health system should look like in ten years, and the main steps involved in reaching this goal. A new National Partnership with states and territories aims to provide more supported accommodation for people with severe mental illness and better admission and discharge planning in hospitals.

The package was informed by the Government’s consultations with stakeholders operating in the health and non-health fields, including through a time-limited Mental Health Expert Working Group and a national program of consumer and carer meetings directly with the Minister for Mental Health and Ageing, The Hon Mark Butler MP. The Government also established an APS200 project Deputy Secretary group that spanned across a wide range of relevant portfolios and which reported to the Secretaries’ Board in developing early policy thinking on the package.

The development of the package was informed by a thorough review of the evidence, and reflected successes and areas for improvement in existing programs – for example:

- models of youth-friendly mental health services;
- the clinical effectiveness and accessibility of e-mental health services;
- the ability of the Access to Allied Psychological Services (ATAPS) program to meet needs in hard to reach groups that the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) program evaluation found were still missing out on treatment offered through Medicare;
- the success of social support services to reconnect people back in the community;
- and the growing body of evidence for early intervention in childhood development.

In line with the Government’s fiscal rules and strategy, the new investments in the *Delivering National Mental Health Reform* Budget package are offset by genuine savings, which include a redirection of \$580.5 million from the Better Access program to new and expanded measures.

b) Changes to the Better Access Initiative

From 1 November 2011:

- **Payments to General Practitioners (GPs) will be linked to the time spent on developing a Mental Health Treatment Plan, with the addition of an incentive for special training to maintain the high quality of care provided**
 - For GPs who have completed Mental Health Skills training, the rebate for a GP Mental Health Treatment Plan consultation of between 20 and 39 minutes will be \$85.92 and the rebate for a consultation of 40 minutes and more will be \$126.43 (currently \$163.35, regardless of duration).

- For GPs who have not completed Mental Health Skills training the rebate for a GP Mental Health Treatment Plan consultation of between 20 and 39 minutes will be \$67.65 and the rebate for a consultation of 40 minutes and more will be \$99.55 (currently \$128.20, regardless of duration).
- The rebate for GP Mental Health Review item 2712 and the GP Mental Health Consultation item 2713 will be \$67.65 (currently \$108.90 and \$71.85, respectively).
- **Medicare rebates for eligible people with a diagnosed mental disorder under Better Access will be capped at 10 individual allied mental health services per calendar year, from 12**
 - Following the initial course of treatment (a maximum of six services) consumers will be able to access four more sessions (to a maximum of 10 services per calendar year). They will also be eligible for a total of 10 group sessions per calendar year in addition to individual sessions.
 - Consumers currently receiving allied mental health services will still be able to access up to 12 individual and/or up to 12 group services up to 1 November 2011. In exceptional circumstances an additional six individual services may be accessed before 1 November 2011 by consumers who are currently receiving treatment. Individuals who have already accessed 10 or more individual and 10 or more group services by 1 November will not be eligible for additional services until 1 January 2012.

Evaluation of Better Access

The Better Access initiative has been instrumental in encouraging collaboration between GPs and allied mental health providers for the benefit of Australians with common mental health conditions such as depression and anxiety. After almost five years of operation, and a comprehensive and independent program evaluation released in full in March 2011, the Government now has a much clearer understanding of how the program is being used by both consumers and private providers. A summary of the Better Access evaluation and its key findings is at [Attachment B](#).

The evaluation, found that the program is increasing the community's access to mental health care. The percentage of Australians with a mental health disorder in the previous 12 months accessing treatment for mental illness rose from 35 per cent to an estimated 46 per cent between 2007 and 2010⁶. Over two million people have benefited from services since the commencement of Better Access in 2006, and many of those receiving treatment had not previously sought help for their mental illness.

However, while the evaluation shows that access for hard to reach populations has improved to some extent, those groups traditionally less well served by Medicare continue to miss out on the mental health services they need. As a universal scheme delivered through Medicare, Better Access provides fee for service rebate services with no targeting.

In particular Better Access continues to struggle to adequately service hard to reach and vulnerable groups like young people, men, people living in rural and remote regions, Indigenous Australians and people living in areas of high socio-economic disadvantage. The evaluation confirmed that its distribution of services across the community is relatively poor: the further people live from a GPO, the fewer services they receive. In rural Australia – and especially in remote Australia – service levels drop off dramatically. The use of services is approximately 12 per cent lower for people in rural areas and approximately 60 per cent lower for people in remote areas, compared to people living in capital cities.

The evaluation data also showed a clear difference in access according to socio-economic status: use of Better Access services were approximately 10 per cent lower for people living in the most socio-economically disadvantaged areas (48.5 persons per 1,000 population in 2009) compared to people living

⁶ Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: Summative Evaluation. <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-sum>

in relatively more advantaged areas (between 52.4 and 53.6 persons per 1,000 population in 2009). In 2009, the richest quintile of Australians, accessed two and a half times the number of services, attracting three times the Medicare dollars in rebates compared to the poorest quintile of the community.

Coupled to this is the rapid growth in outlays on the program. Better Access commenced in 2006 at a (then) estimated cost of \$442.5 m over the first four years. Actual expenditure totalled \$2.02 billion in the first five years (from its introduction in 2006 to June 2011). Growth in outlays may slow down as a result of the 2011-12 Budget changes, but uptake and costs of this demand driven program will continue to rise. In the context of the evaluation findings and other data about Better Access item usage, and the current fiscal environment, the Government will redirect a proportion of the more than \$4 billion which is otherwise projected to be spent on this program over the next five years, to services which are targeted to those people most in need.

Reinvestment of savings

Savings generated from these changes are enabling additional mental health services to better serve some of the most disadvantaged people and their carers, through services provided at low to no cost to the consumer and through innovative and expanded services delivered in a primary care setting. For example:

- Nationally, ATAPS will grow from \$36.1 million in 2010-11 to \$108.7 million in 2015-16 and a total of \$432.7 million over the next five years. This expanded funding will be directed at addressing imbalances in access to Medicare mental health services and will particularly target children and their families, Indigenous people and those in lower socioeconomic areas.
- A single portal for online therapy and clinical support will bring together and improve awareness of and access to existing services. An additional 45,000 people will have access to web-based therapies over five years, particularly benefiting those in areas with limited access to face to face services or who fear stigma and discrimination.
- The successful headspace model is being expanded to achieve 90 fully sustainable sites across Australia by 2014-15. Once all 90 sites are fully established, headspace will help up to 72,000 young people each year.
- Funding will also support better coordinated care for people with severe, persistent mental illness and complex needs by providing a single point of contact – a care facilitator – and flexible funding to plug service gaps for around 24,000 people with severe and persistent mental illness and their families.

As flagged above, these changes are also made in an environment where Australian Government investment in mental health specific programs – excluding mental health expenditure through the MBS and PBS – in the four year period 2011-12 to 2014-15 has increased to around \$2.4 billion compared to \$516.3 million provided in the four years to 2007-08.

(i) the rationalisation of general practitioner (GP) mental health services

(iii) 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

Introduction of time-tiered rebates for GP Mental Health Treatment Plans

As at 30 June 2011, over 2.8 million GP Mental Health Treatment Plans have been provided since Better Access commenced on 1 November 2006. Time-tiered rebates for the GP Mental Health Treatment Plan items will be introduced from 1 November 2011 to bring them into line with GP activity of similar duration, based on self-reported survey data on how long GPs are actually taking to develop a mental health treatment plan. Further details on the changes to the Better Access GP Mental Health Treatment Plan item rebates are given above.

Bettering the Evaluation and Care of Health (BEACH) and Medicare data showed that, compared to a standard consultation, GPs providing Better Access treatment plans receive two thirds more money for one third less time (on average)⁷. The current untimed Mental Health Treatment Plan item rebate is \$163.35 for an average consultation of 28 minutes. For a standard consultation under Medicare that lasts more than 40 minutes, a GP receives \$99.55.

The Budget therefore brings the Better Access rebate back into line with a standard timed consultation under Medicare but gives GPs an additional 27 per cent premium if they complete six hours of mental health training – consistent with the Government’s ongoing commitment to ensuring that high quality mental health services are being delivered. An estimated 72 per cent of GPs using Better Access have completed mental health skills training and are eligible to claim the higher rebates for consultations.

The Government has stated it is confident that these changes will not affect the clinical assessment and preparation of care plans by GPs given that the rebate is, at least, equivalent to a standard timed consultation and GPs’ desire and responsibility to provide ongoing whole patient care. Instead, the changes will put in place a funding structure that reflects the actual time GPs currently spend with clients, while providing incentives to GPs who invest in mental health professional development.

Funding for GP mental health training

The Commonwealth has made significant investments in a range of GP mental health training initiatives, including:

- \$1,515,658 to the Royal Australian and New Zealand College of Psychiatrists in the period 2007-2009 to undertake Phase One of the Mental Health Interdisciplinary Networks project. This involved an environment scan about how the professions collaborate to inform strategies in education and training; and a multidisciplinary training package targeted at all professional groups, providing case studies, information on the Better Access and related initiatives, role definition, guidance on communication between providers, consideration of the public and private sector interface with primary mental health care delivery and networking.
- \$14,680,478 to the Mental Health Professionals Network (MHPN) for the period 2008-2011 to undertake Phase Two of the Mental Health Interdisciplinary Networks project and deliver national multidisciplinary workshops for mental health professionals. Workshops concluded on 30 June 2010 with a total of 1,169 workshops held and attended by over 15,000 mental health clinicians.
- \$1,329,355 in 2007 to the Australian General Practice Network (AGPN) to develop and deliver locally based national information and orientation sessions on Better Access initiative.
- \$512,300 for the period 2007-2009 to the Australian College of Rural and Remote Medicine to pilot and deliver on-line Mental Health Skills Training (Level 1) and Focused Psychological Strategies Skills Training (Level 2) training packages to GPs in rural and remote areas.
- \$2,102,503 to the General Practice Mental Health Standards Collaboration (GPMHSC) for the period 2009-2012 to develop, monitor and promote quality standards for GP education and training in primary mental health care.
- \$35,000 to Genesis Ed in 2009 for six one hour Level 1 mental health skills training modules online via the Thinkgp website. More than 2,000 GPs undertook this training.
- \$552,581 in 2010-11 to the Royal Australian College of General Practitioners to encourage GPs to undertake Focussed Psychological Strategies Skills Training. Grants have been provided to accredited training providers to deliver training courses with a focus on regional, rural and remote areas. It is expected that up to 250 GPs will benefit from this training.
- \$408,925 in 2010-11 to the Australian Psychological Society to develop online cognitive behavioural therapy continuing professional development training for psychologists, social workers and occupational therapists who provide services under Better Access.

⁷ Analysis of 2010 Bettering the Evaluation and Care of Health (BEACH) and unpublished MBS data.

(ii) the rationalisation of allied health treatment sessions

(iv) 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

Design and intent of Better Access

As the above Term of Reference acknowledges, the Better Access initiative aims to provide allied mental health services for people with mild to moderate mental disorders, in a primary care setting.

The scheme was designed and introduced in 2006 in response to low treatment rates for high prevalence or common mental disorders, like anxiety and depression, of mild to moderate severity. The impact of these disorders on the individual and their functioning can range from relatively mild effects to more severe episodes, but with the right short term, evidence-based interventions people can generally recover and live productive lives.

This is in contrast to more severe and persistent forms of mental illness such as bipolar disorder and psychosis which affect a much smaller proportion of the population. These people need intensive and ongoing clinical and non-clinical services. Better Access was not designed to provide long term services for this group, who are predominantly clients of state and territory government specialist mental health services.

Instead the Better Access Medicare items provide a structured framework for GPs to undertake early intervention, assessment and management of patients with less severe and enduring mental disorders, as well as providing referral pathways to clinical psychologists, registered psychologists, and appropriately trained social workers and occupational therapists.

According to the Better Access evaluation, the majority of consumers accessing mental health services under the program were experiencing depression and/or anxiety; and the program is providing treatment to people with severe symptoms and relatively high levels of psychological distress. Consumers experienced clinically significant reductions in levels of psychological distress and symptom severity upon completing treatment. In addition, in the 2007 National Survey of Mental Health and Wellbeing, it was estimated that only 35 per cent of people who experienced a mental disorder in the previous 12 months accessed treatment, while in 2010 this has grown to an estimated 46 per cent. This is consistent with the original aim of the initiative, which was to improve access for people with common mental disorders who historically had low treatment rates.

Treatment courses under Better Access

A standard course of evidence-based psychological treatment under Better Access is six sessions. At present, eligible patients may be referred for a course of six sessions and, following a review by their GP, another course of six sessions if they need it – that is up to 12 individual allied mental health services – per calendar year. Currently a GP may provide a new referral to enable a patient to access a further six individual sessions in the calendar year in exceptional circumstances (up to a total of 18 services in a calendar year). Exceptional circumstances only apply where there has been a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services.

The recent, comprehensive and independent evaluation of the Better Access program found that almost three-quarters of people who access services only needed between one and six sessions a year and the average number of mental health services received after a GP Mental Health Treatment Plan is five⁸.

Implications for consumers

From 1 November 2011 consumers will be eligible for a six session treatment course, and a further four sessions following a GP review in a calendar year. They will also be eligible for ten group sessions per calendar year. According to usage data, the majority (87 per cent) of Better Access users will be unaffected by this change.

As indicated above, the number of Medicare subsidised mental health care services are highly likely to continue to grow. No cap has been put in place on the number of people who are treated by Better Access and, as a demand driven program, all services that are clinically required will continue to be subsidised in line with the program's parameters.

The number of services available under the significantly expanded ATAPS program will not change (that is six sessions, and a further six sessions if required on clinical review, with up to 18 sessions available in exceptional circumstances).

People who currently receive more than ten allied mental health services under Better Access are likely to be patients with complex needs and would be better suited for referral to more appropriate mental health services. GPs can refer those people with more severe and persistent mental disorders to Medicare-subsidised consultant psychiatrist services, where 50 sessions can be provided per year, or to state/territory funded specialised mental health services.

To help make psychiatrist services available in more areas, from 1 July 2011 the Government is providing new Medicare rebates for online psychiatrist consultations for patients living in regional, remote and outer metropolitan areas. GPs, specialists and other health professionals will be provided with financial incentives to help deliver these online services and funding will also be provided to support training and supervision for health professionals.

In addition, and as part of its balanced and integrated Budget package, the Government will also invest \$571.3 million over the next five years in new and expanded services for Australians with severe and persistent mental illness – through the new Coordinated care and flexible funding measure; and significant expansions of the Personal Helpers and Mentors, Mental Health Respite and Support for Day to Day Living in the Community in the Community programs. Other measures that will benefit this group include the additional Early Psychosis Prevention and Intervention Centres and the addition of 40 new Family Support services nationally.

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

ATAPS program

Medicare subsidised mental health services provide a universal service platform, but hard to reach groups are more successfully reached through more targeted fundholding programs such as ATAPS. Better Access subsidises a range of mental health services provided by private practitioners who, in a free market environment, choose where they practice.

⁸ Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) Administrative Data - <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-b>

ATAPS is a national program funding Divisions of General Practice and established Medicare Locals to broker and provide short term focussed psychological services to people who have been diagnosed with a mental disorder of mild to moderate severity. For the period 1 July 2003 to 30 June 2011 more than 247,300 client referrals have occurred and over 982,800 services have been provided.

In contrast to Better Access uptake data, between July and December 2010, 40 per cent of ATAPS services were provided in rural and remote areas, and 66 per cent of total referrals were for people on low income, 30 per cent were male and three per cent were Indigenous. Significantly, the majority of ATAPS services are provided at no cost to consumers – in the period 1 July 2003 to 30 June 2011, around 80 per cent of services were provided free of charge with an average co-payment of \$15.79 for the 20 per cent of services that attracted a co-payment. By comparison, in the period 1 January 2007 to 31 December 2009, 56.7 per cent of all Better Access services were bulk billed and attracted no co-payment. Of the 43.3 percent of services that attracted a co-payment the average payment was \$34.97 (when averaged across all Better Access services, the average co-payment was \$15.16).

A review undertaken between 2008 and 2010 found that ATAPS is an important primary mental health initiative which complements the Better Access initiative, achieving improved consumer outcomes in more than 86 per cent of cases. However, one of the key policy directions the review identified was better addressing service gaps. The value of ATAPS as a flexible service delivery model with the capacity to address unmet need both geographically and for subpopulations was also highlighted.

Expansion of ATAPS

The 2011-12 Budget committed \$205.9 million over five years to expand ATAPS, doubling funding and closing service gaps for around 184,000 additional people. This includes 50,000 children and their families; 18,000 Indigenous Australians; and 116,000 people from other hard to reach groups or locations, with a particular focus on lower socioeconomic areas. Importantly, the expansion will also support the up-skilling of allied health providers in child mental health and Indigenous service provision and the development of linkages between health care and community organisations and workers.

Extra ATAPS funding for people living in lower socioeconomic areas and other hard to reach groups was rolled out from 1 July 2011 under existing arrangements with Divisions of General Practice, transitioning to Medicare Locals as they are established and demonstrate capacity to deliver mental health services. These transition arrangements will focus on service continuity.

To ensure a more equitable distribution across the country, a new needs based distribution formula was applied in the allocation of 2011-12 ATAPS funding. The formula allocates funds on the basis of relative needs assessed by population size weighted for socioeconomic disadvantage, rurality and access to Medicare subsidised allied mental health services.

The Government's Budget package also invests in approaches which will diversify treatment options and improve access through service expansion, re-engineering and innovation. An investment of \$14.4 million will establish a single mental health online portal and to expand the services provided by the 'virtual clinic' announced the previous year. People, regardless of where they live, will have access to a range of evidence based online and telephone treatments as an alternative to traditional face to face services. This will particularly benefit people living in rural, regional and remote Australia, young people who often prefer online modalities, and people who are worried about stigma and being identified.

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

Key data and issues

People with severe, long term mental illness remain among the most marginalised and disadvantaged people in Australia. Many are not receiving the right mix and quality of community based services to remain clinically stable, avoid hospitalisation and to have a reasonable quality of life. Approximately 3.1 per cent of the population, or 676,000 individuals, experience severe mental illness. Most people (approximately 93 per cent) with severe mental illness are in contact with health services. For this group the problem is more about the quality and coordination of services, particularly in the community setting.

A proportion of those with severe mental illness (around 60,000 individuals) also experience persistent symptoms and have complex, multiagency care needs. Their need for linked up clinical care, appropriate recovery-focused social support and stable accommodation is particularly acute. They can often fall between gaps in acute and community based mental health services, between the specialist and primary mental health care systems and between health services and community support services.

Commonwealth funding for services for people with severe mental illness

The Australian Government funds clinical services to people with mental illness through primary care and Medicare subsidised private psychiatrists, with most of these services designed for and directed to people with the more common and less enduring mental illnesses.

Arising from initiatives under the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011, the Commonwealth now also funds community support services for people with severe illness delivered through NGOs that previously have been solely funded through state/territory mental health budgets. FaHCSIA's Targeted Community Care (Mental Health) Program includes three community mental health initiatives aimed to assist people with mental illness and their families and carers to manage the impact of mental illness: Personal Helpers and Mentors, Mental Health Respite: Carer Support, and Family Mental Health Support Services.

It is estimated that the Australian Government provides 30 per cent of funding to NGO managed programs for people with severe mental illness. More recently, the Commonwealth entered the field to fund Early Psychosis Prevention and Intervention Centres and sub-acute mental health beds, both areas that have been the traditional province of states and territories.

Through the 2011-12 Budget, the Government is making an investment of \$549.8 million over five years to bring together services for 24,000 Australians with severely debilitating, persistent mental illness and complex multiagency needs.

The *Coordinated care and flexible funding for people with severe and persistent mental illness and complex needs* measure is described in more detail in the Ministerial Budget statement, *National Mental Health Reform 2011-12*, but will help those benefiting to stay well in the community through:

- a nationally consistent assessment framework and multiagency care plan;
- one point of contact for eligible consumers, their families and carers on all of their care needs; and
- a 'no wrong door' approach to accessing the full range of services required and a flexible funding pool to help close service gaps.

This measure will be implemented through community based organisations that have the skills and connections to assume these functions. Medicare Locals and other non-government organisations are expected to participate. Auspicing organisations will seek to work closely with states and territory services – both clinical and non-clinical.

More broadly, the 2011-12 Budget delivers access to a wider range of care options designed specifically for the needs of people with severe mental illness, building on the foundations of existing successful programs. With allocated funding of \$571.3 million over five years, increased service capacity in housing, social support and clinical care will complement the structural changes of the *Coordinated care*

and flexible funding for people with severe and persistent mental illness and complex needs measure, including through:

- more support services through the Support for Day to Day Living Program to assist an extra 18,000 people over five years;
- an additional 425 community mental health workers to work one on one with 3,400 extra individuals. They will join the 1,000 workers already providing intensive, practical support in Personal Helpers and Mentors (PHaMs) services across the country;
- additional mental health respite services will give about 1,100 families and carers of people with a mental illness access to flexible respite and support services;
- \$2.4 million to increase economic and social participation. This will be supported by the \$50 million for more personal helpers and mentors to support a return to employment, plus almost \$26 million over three years to support the very long term unemployed with a mental illness through the *Building Australia's Future Workforce* package; and
- \$201.3 million to encourage the states and territories to invest more in priority areas and address service gaps, including in accommodation support and presentation, admission and discharge planning in emergency departments.

e) Mental health workforce

(i) Two-tiered Medicare rebate system for psychologists

Since its inception in 2006, Better Access has provided different rebates for clinical and registered psychologists. This design was based on advice from the psychology profession.

Clinical psychologists receiving fee-for-service payments through the MBS are required to have training and qualifications that are consistent with international benchmarks. In accordance with the *Health Insurance (Allied Health Services) Determination 2011* psychologists who wish to provide Medicare rebatable psychological therapy services, which are at the higher MBS schedule fee level, must be either:

- a member of the College of Clinical Psychologists of the Australian Psychological Society (APS); or
- assessed by the APS as meeting the requirements for membership of the College and continues to meet those requirements; or
- endorsed by the Psychology Board of Australia (PBA) to practice in clinical psychology.

The credentialling standards applied by the APS and the PBA for clinical psychologists ensure that eligible providers meet heightened requirements with respect to education, length of work experience in the field, and clinical supervision in relation to the provision of psychological therapy services for people with a diagnosed mental disorder.

The purpose of credentialling is to ensure that clinical psychologists eligible to claim a higher MBS fee have the appropriate education, skills and experience to provide psychological therapy services. A higher fee recognises the higher level of clinical knowledge, skills and experience required to deliver specific services under Medicare for people with an assessed mental disorder.

(ii) Workforce qualifications and training of psychologists

The 2009-10 Budget introduced mandatory continuing professional development (CPD) requirements for registered psychologists, social workers and occupational therapists providing focused psychological therapy services under Better Access. From 1 July 2011 any allied mental health professional registered with Medicare Australia to provide services who has not undertaken the required ten hours of CPD is no longer eligible to attract Medicare rebates for their services. Eligibility can be re-instated on the completion of the CPD requirements.

This measure promotes good clinical practice for the large number of Medicare registered Better Access providers, and is an important step to ensure Commonwealth-funded mental health services are of a suitably high quality. This requirement also provides a quality assurance mechanism for consumers who will know that all Better Access services are delivered by highly qualified practitioners who have maintained their clinical skills and knowledge base.

The measure was designed to ensure that accredited CPD activities become uniform across each profession so there is consistency in the quality of services delivered and the CPD activities meet the needs of all professions who provide focused psychological therapy services.

DoHA also funds projects which focus on workforce training and development, including:

- **Rural Allied Health Locum Scheme.** From 2010-11 this scheme will provide 100 locum placements per year in rural locations to enable allied health workers in rural areas to take leave to undertake training and organisations to back-fill their positions to support ongoing service delivery. Also included in the health reform commitments was \$6.5 million for an additional 100 rural allied health clinical placement scholarships each year from 2010-11, available under the Nursing and Allied Health Scholarship and Support Scheme.
- **Nursing and Allied Health Scholarship and Support Scheme (NAHSSS).** Through the NAHSSS, the Government is continuing to support allied health students and professionals with scholarships to support undergraduate and postgraduate study, clinical placements and CPD activities.
- **Mental Health Professional Network (MHPN).** The MHPN supports collaboration and expand referral paths in Australia's primary mental health sector by fostering local, sustainable interdisciplinary networks of mental health professionals. Since February 2009, MHPN has established 500 networks across Australia, of which 40 per cent are located in regional, rural and remote areas and set up professional networking platform, [MHPN Online](#).
- **Mental Health Professional Online Development (MHPOD).** Based on the national practice standards, MHPOD is a learning resource for mental health practitioners that provides approximately 70 hours of online training material covering 50 topics, with an additional thirteen topics currently in development.

(iii) Workforce shortages

Workforce is a critical enabler for mental health service delivery and reform. While according to the component of the Better Access evaluation designed to consider workforce issues⁹, the numbers of full time equivalent psychologists, social workers and occupational therapists providing care in public sector mental health services have risen steadily since 1995-96, many public, private and non-government mental health services experience shortages in workforce supply, and difficulties with recruitment, distribution and retention. As services expand to meet demand, they need to be staffed by people with the skills, knowledge and experience to provide effective and appropriate mental health treatment, care and support.

All governments have worked together to create a National Mental Health Workforce Strategy and Plan with the aim of developing and supporting a well-led, high performing and sustainable mental health workforce delivering quality, recovery-focused mental health services. Final endorsement of the Strategy and Plan will be sought from all Health Ministers at their meeting on 4-5 August 2011.

The Strategy and Plan acknowledge that:

- growing and developing the mental health workforce is a priority for Australian governments;

⁹ Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: Component C - An analysis of allied mental health workforce supply and distribution.
<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-c>

- workforce supply cannot always meet demand, and socio-economically and geographically disadvantaged areas continue to be underserved; and
- there is a need to further refine and clarify the data collected to allow a better understanding of the size and distribution of the workforce across the different sectors, settings and levels of government.

The Strategy and Plan will provide an overarching framework for the ongoing development of the mental health workforce in Australia. It will direct current activity, and inform future decisions on where government can make strategic workforce investments to further develop workforce capacity and contribute to improved consumer outcomes over the next ten years.

Subject to Health Ministers' endorsement, a more detailed implementation plan is being developed by the Mental Health Workforce Advisory Committee.

Health Workforce Australia (HWA) has identified mental health as an important priority. Work on the National Training Plan for Doctors, Nurses and Midwives, led by HWA, will recommend optimal entry levels to each professional group to meet future demands, including moving to self sufficiency in supply by 2025. Psychiatrists and mental health nurses are separately identified within these activities. HWA is currently consulting with relevant national professional bodies, medical and nursing colleges, education providers, government agencies and the non-government sector.

Through national health reform measures in 2009-10, \$1.2 billion was invested in workforce programs. A key measure was the expansion of the Specialist Training Program from around 360 posts per annum to over 900 per annum by 2014. In 2011 this includes 96 additional dedicated Psychiatry training posts.

f) The adequacy of mental health funding and services for disadvantaged groups

Several elements of the Australian Government's 2011-12 Budget package are designed to reorient and better target the system to improve access to services for the most disadvantaged Australians with mental illness.

The Australian Government, through DoHA and FaHCSIA funds a number of specific and targeted programs.

(i) Culturally and Linguistically Diverse Communities

People from a Culturally and Linguistically Diverse (CALD) background have a significantly lower level of access to mental health care and support in the wider community. This can result in much greater responsibility being placed on family members without adequate support or education. A transcultural project has been funded by the Australian Government since 1995. The Multicultural Mental Health Australia (MMHA) project has operated from March 2003 and aims to address these issues. The project provides a range of national coordination, communication and information activities. It is not funded to provide clinical services. Clinical services for people from CALD backgrounds are provided through a variety of mainstream and special purpose services across Australia and are funded at the Commonwealth and state and territory levels.

Following an independent review and financial review of the MMHA project, and consistent with the recommendations of the independent review, DoHA undertook an open, merit based Invitation to Apply process and a new three year funding agreement valued at \$2.7 million was executed in June 2011 for the delivery of a revised and refocused multicultural mental health project.

The project will be delivered by the Queensland Transcultural Mental Health Centre in partnership with the University of Melbourne's Centre for International Mental Health, the Victorian Transcultural

Psychiatry Unit and the University of South Australia's Mental Health Nursing Group, Human Rights and Security Cluster. The Queensland Government's Mental Health, Alcohol and Other Drugs Directorate is the fund holder and will offer management and executive support for the project.

The new consortium will deliver the project to provide national leadership in and improve awareness of mental health and suicide prevention in CALD communities and promote better mental health and wellbeing for these diverse groups through the:

- promotion of development of culturally competent mental health services;
- increased support and information for culturally and linguistically diverse mental health consumers, their families and their carers;
- increased awareness in multicultural communities of mental health issues and reduced stigma associated with mental health illness; and
- development of resources, information and training for mental health professionals.

The 2011-12 Budget will also expand a number of existing services that have a strong track record in reaching CALD communities:

- Funding of \$205.9 million over five years doubles the current ATAPS investment, meaning over 180,000 extra people will receive psychological services. All ATAPS services are targeted to give priority to population groups which have particular difficulty in accessing mental health treatment in the primary care sector, including people from CALD communities. Service delivery costs associated with clinical services are supported, including interpreter services.
- The Support for Day to Day Living in the Community program offers structured social, recreational and educational activities to improve the quality of life for individuals with severe and persistent mental illness, including individuals from CALD communities. The 2011-12 Budget provides \$19.3 million over five years in additional funding for existing providers to support an estimated 3,650 extra people a year.
- \$208.3 million over five years will expand and integrate PHaMs and respite services. The expansion will see more people with severe mental illness supported, including the targeting of vulnerable groups like CALD communities. This will provide greater access to intensive, one-on-one support for individuals to aid recovery and reduce social isolation, with a focus on employment and educational outcomes. It will also provide improved access to respite for their families and carers.
- \$61 million over five years will double the capacity of existing Family Mental Health Support services to ensure a specific focus can be placed on vulnerable groups like children from CALD communities; and enable wrap around service to be provided in a 'whole of family' approach. This will help over 30,000 vulnerable and at risk children, young people (up to 16 years) and their families.
- The establishment of a single mental health online portal providing assistance to an additional 45,000 people over five years will particularly benefit people from CALD backgrounds, who often want to remain anonymous, face added levels of stigma, and are also often reluctant or face barriers to using face-to-face services.

DoHA also administers the Program of Assistance for Survivors of Torture and Trauma (PASTT), which offers services for people requiring support for psychological and psychosocial issues arising from pre-migration experiences of torture and trauma. In 2011-12 \$13.6 million is provided to PASTT agencies to deliver services including:

- direct counselling and related support services, including advocacy and referrals to mainstream health and related services to a minimum of 5,914 individuals, families and groups who are survivors of torture and trauma;
- education and training to a minimum of 264 mainstream health and related service providers;
- community development and capacity building activities to at least 53 community groups;

- rural, regional and remote outreach services to enable survivors of torture and trauma to access comparable services outside metropolitan areas; and
- provision of resources to support and enhance the capacity of specialist counselling and related support services to a minimum of 44 groups.

Since April 2011, PASTT has been consolidated with the Short-Term Torture and Trauma Counselling Support service which was previously funded by the Department of Immigration and Citizenship (DIAC). This consolidated service has been welcomed by the sector and now offers an integrated and seamless service for the target group.

PASTT agencies are all members of a network of specialist rehabilitation agencies that work with survivors of torture and trauma, known as the Forum of Australian Services for Survivors of Torture and Trauma. Clients can be referred through a wide range of sources including DIAC's Humanitarian Settlement Services, other settlement services, GPs and other health services, education providers, legal services, community services, family, friends and through self referral.

The 2010 *Mental Health: Taking Action to Tackle Suicide* package includes \$22.5 million for community prevention activities that target groups and communities at high risk of suicide, including Indigenous and CALD communities. This measure, which commenced roll out on 1 July 2011, encourages linkages and connections within and between communities, mental health service providers and government for improved outcomes in suicide prevention.

The Government also supports, under the National Suicide Prevention Program, two suicide prevention projects that focus on people from CALD communities. Funding for the two years to 30 June 2013 has been provided to Phoenix: Migrant Resource Centre in Tasmania (\$492,814) and Nexus: Queensland Program of Torture and Trauma (\$467,725).

(ii) Indigenous communities

The 2011-12 Budget provided additional new funding of \$39.1 million over the next four years for existing counselling, family tracing and reunion services to Indigenous communities, including the Stolen Generations, and consolidated services under a cohesive Social and Emotional Wellbeing Program.

The new Social and Emotional Wellbeing Program, which offers a flexible package of service delivery with national coordination and support, now has ongoing total funding of \$182.5 million over four years from 2011-12 to 2014-15. Services will include:

- counselling, family tracing and reunion services to members of the Stolen Generations, through the existing network of Link Up Services across Australia;
- social and emotional wellbeing services, particularly counselling services, to Indigenous Australians, through existing mental health and counselling staff based in Aboriginal Community Controlled Health Organisations across Australia; and
- national coordination support to services and staff, through initiatives that include workforce support units, innovative practice, research and governance support, national coordination and communication forums, electronic client records and data collection, support for peak bodies, program support and program development and evaluation.

In addition the ATAPS expansion will mean a significant expansion of psychological support services for Indigenous Australians. Specific funding of \$ 36.5 million over the next five years will provide services for 18,000 people.

Implementation planning is underway to establish a virtual clinic that will provide online support for people with mental illness, and a central support centre to ensure evidence based treatment programs are

available via the virtual clinic. The central support centre will also focus on supporting Aboriginal Health Workers and other health professionals working in Indigenous communities, on mental health issues.

The Mental Health Services in Rural and Remote Areas (MHSRRA) program will provide up to \$125 million from 2006-07 to 2014-15, including \$32 million from 1 July 2011 to 30 June 2013. Fundholders under the MHSRRA program include two Aboriginal health services, and the program complements ATAPS by reaching into rural and remote Australia.

A new Indigenous mental health expert advisory group and a suicide prevention sub group will be established to advance the Australian Government's mental health and social and emotional wellbeing, and suicide prevention reforms for Aboriginal and Torres Strait Islander people. To maximise the impact on Aboriginal and Torres Strait Islander people, the mental health group will advise DoHA on the design and implementation of measures in the Government's mental health reform Budget package, as well as guide the Commonwealth in the development of its Ten Year Roadmap for Mental Health Reform and a new national Social and Emotional Wellbeing Framework.

The suicide prevention sub group will guide the development of Australia's first national Indigenous Suicide Prevention Strategy. It will also advise on the best methods to invest the \$6 million in funding prioritised and allocated to Indigenous communities from the *Taking Action to Tackle Suicide* package.

An investment of \$150,000 – targeted to Indigenous communities in the Kimberley – has been provided for enhanced psychological services and for the associated education and training of allied health workers delivering them. Boab Health Services will deliver the psychological services, including linkages with the Kimberley Aboriginal Medical Service Council and local Aboriginal health providers, while the APS will develop and implement the education and training support to health workers.

In recognising the need to provide services specifically targeted to Indigenous communities, the National Suicide Prevention Program (NSPP) has Aboriginal and Torres Strait Islander Australians as a priority target group for funding, with an investment of over \$11 million over the next two years. Examples of community led activities funded through the NSPP are:

- the Koori Kids Wellbeing project on the South Coast of NSW which provides cultural awareness and whole-of-school mental health promotion at local primary schools. The program also provides intensive counselling and support for Aboriginal children with existing problems and a parent education program (funding of \$466,00 from 2011 to 2013);
- the Sustainable Personal Development for Aboriginal Men project in Port Augusta (SA), which equips Indigenous men aged 15-45 to more effectively manage challenging life situations through culturally appropriate personal development resources and training modules (funding of \$298,904 from 2011 to 2013); and
- the Hope, Opportunity, Purpose, Education and Employment project run by the Mildura Aboriginal Corporation provides psychological and coordination services to students (funding of \$310,078 from 2011 to 2013).

(iii) People with disabilities

For some people living with a physical or mental disability, the severity and duration of a co-morbid mental illness can be significantly disabling and impact on their social and economic functioning. As a result, this group is often dependent on a range of government assistance, including income support and employment support services.

Income support payments through the Disability Support Pension (DSP) are the single largest outlay of benefits for people experiencing mental illness. In the last ten years the proportion of DSP recipients with

a primary psychological or psychiatric condition¹⁰ has grown by 76.1 per cent. Of the 792,581 DSP recipients in June 2010, 28 per cent (227,420 recipients) had a psychiatric or psychological condition recorded as their primary condition. Many of these also have other co-morbid conditions creating additional challenges and barriers for them.

As part of the expansion of PHaMs services under the 2011-12 Budget, \$50 million has been allocated to provide personal helpers and mentors to specifically help people with mental illness on, or claiming, income support or the DSP who are also participating in employment services. This intensive support will help up to 1,200 people with a mental illness stay engaged with employment services while they look for work, or participate in work or training.

g) The delivery of a national mental health commission

Through the 2011-12 Budget, the Australian Government is investing \$32 million over five years to establish Australia's first National Mental Health Commission as an Executive Agency within the Prime Minister's portfolio. The Commission will have a strong working relationship with the Minister for Mental Health and Ageing.

The Government's decision to establish a Commission recognises the need for greater transparency and public accountability and an independent body with strong oversight of system performance. Its location in the Prime Minister's portfolio will also harness cross sectoral linkages.

The Commission will produce an Annual National Report Card on Mental Health and Suicide Prevention. This will strengthen public accountability and transparency by monitoring whether services deliver lasting outcomes for people experiencing a mental illness, and help inform future investment in mental health. The Commission will also facilitate partnerships and work closely with mental health organisations, associations and consumer groups, and will report on its activities through an annual report to be tabled in Parliament.

It will provide cross-sectoral advice with a focus on the design, implementation and evaluation of mental health initiatives. In performing this role, the Commission will monitor the ongoing implementation of the Government's proposed Ten Year Roadmap for Mental Health Reform.

PM&C are establishing the Commission, and the Government will consult mental health stakeholders, carers and consumers on aspects of the Commission, including through a workshop facilitated by the Mental Health Council of Australia, scheduled for September 2011.

The Prime Minister announced on 1 June 2011 the appointment of Ms Robyn Kruk as Chief Executive Officer designate. The role of the CEO will be to guide the Commission in providing strategic and practical advice to Government on mental health reform, based on evidence of the mental health system's performance across all jurisdictions. Ms Kruk has almost 30 years of significant public sector experience, including as Director General of NSW Health and Director General of the NSW Department of Premier and Cabinet.

The Commission will have nine Mental Health Commissioners, including a Chair, who will be appointed to provide a broad range of expertise and experience across the mental health sector and to inform the work of the Commission.

The establishment of the Commission will be complemented by focused applied research in priority mental health areas nominated by the Government through the 2011-12 Budget initiative: *Mental Health*

¹⁰ Indicates a range of mental illness conditions – does not include intellectual disabilities.

Research - Strategic investment in mental health research priorities through the National Health and Medical Research Council (NHMRC). The NHMRC has allocated \$26.2 million over five years for this measure.

The Commission will also be assisted by the continuation of funding for national surveys and datasets, and the establishment of a new national mental health consumer body, which will contribute to more responsive and accountable policy and program directions within the sector.

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

The Australian Government is committed to expanding its world leading telehealth and e-mental health programs. This includes the development of flexible models using existing and new technologies and innovative services, both as adjuncts and substitutes for other more conventional forms of treatment. Telephone and web based therapies are particularly appropriate for and encourage help seeking in: people in rural and remote areas who face barriers in accessing face-to-face services combined with a strong culture of self-reliance; those who fear stigma and/or who wish to preserve their anonymity; and those who prefer to access psychological assistance outside clinical settings.

E-therapy is a clinically proven and cost-effective way of treating mild to moderately severe depression and anxiety disorders – the bulk of mental illness affecting about 3.1 million Australians each year. For some people, e-therapy is enough to put them back on track and assist them with coping strategies, without needing any or many face-to-face services.

An evaluation of the *Telephone Counselling, Self-Help and Web-Based Support Programmes* measure, undertaken by Healthcare Planning and Evaluation Pty Ltd on behalf of DoHA, found that the deployment of the range of e-mental health initiatives under the measure has enhanced access to information related to different mental health problems, particularly for people living in rural and remote areas. Data provided by participating organisations suggested that approximately half of those accessing sites were from non metropolitan areas.

The evidence base for the efficacy of e-mental health programs is continually expanding:

- A 2002 *National Review of Tele-counselling and Web Counselling Services* by Urbis Keys Young¹¹ found that web-based counselling was accessible to a range of clients who were either unable or unwilling to contact conventional or face-to-face counselling and/or mental health services. As such, it was playing a significant role in information provision, early intervention, crisis management and referral to specialist or mainstream services.
- Studies by the Australian National University in April 2007¹² confirmed that depression, self-help and information programs can be delivered effectively by means of the Internet.
- In July 2008, the School of Psychiatry at the University of New South Wales published a paper on treating social phobia with Internet and email-based treatment programs.¹³ The results of the study compared favourably with outcomes reported in benchmarking studies from high-quality face-to-face treatment programs for social phobia, and provided further positive data about the utility of Internet-based guided self help programs for people with social phobia.

¹¹ Urbis Keys Young, *National review of tele- counselling and web counselling services* (22 October 2002)

¹² Griffiths, K., & Christensen H, 'Internet based mental health programs; a powerful toll in the rural medical kit', April 2007

¹³ Titov, N., Andrews, G., & Schwencke, G 'Shyness 2: treating social phobia online: replication and extension', Australian and New Zealand Journal of Psychiatry, vol.42, no.7, July 2008

Despite this strong evidence base, the uptake of e-mental health programs is relatively low. Current treatment websites are poorly signposted and not well connected with the broader health system. To address this, the 2011-12 Budget initiative, *Establishment of a single mental health online portal*, will:

- bring together and consolidate the various dispersed websites and telephone services currently available and provide an additional avenue to traditional face-to-face services; and
- guide people to programs most suited to their needs, from self directed programs and clinician assisted support through a ‘virtual clinic’.

As a result, over 45,000 additional people will have access to therapies over five years.

Training and resources for the delivery of e-treatment within general practice will also be established together with electronic mental health training and support for Aboriginal Health Workers and clinicians in remote areas.

Access to and the performance of telehealth services and e-mental health services, in particular, will be greatly enabled by the National Broadband Network. E-mental health programs now operate in an environment characterised by: ongoing technological development; increasing use of SMS; mobile internet devices and mobile applications; social interaction internet sites; and new gaming technologies and platforms.

i) Any other related matter

Focus on early intervention and prevention

The 2011-12 Budget mental health reforms, along with other investments in areas of Commonwealth responsibility, were designed to help move the mental health system towards prevention, early intervention and care in the community, and away from expensive crisis-driven activity. The Government is strengthening its focus on prevention and early intervention, especially for children and young people, through creating partnerships between family support and health services and expanding on a significant scale proven models of mental health care such as *headspace*.

Inadequate prevention and early intervention investment can contribute to a lifetime of disadvantage caused by chronic mental illness. When the signs of mental illness are identified early in very young children and they and their families are supported with appropriate services, children are more likely to develop resilience and learn life skills that support them to participate fully in society as they grow up.

The Government will approach mental illness for children and young people on two fronts. One is through additional, proven mental health models aimed at youth, covering the spectrum from prevention and connection to treatment for less severe conditions, to dedicated Early Psychosis Prevention and Intervention Centres to improve the lives of young people experiencing psychotic illness. These measures will also complement the expansion of the ATAPS program and access to e-mental health psychological therapies.

Secondly, by providing greater opportunities to assess children’s social and emotional development and helping their families access assistance through a universal three year old health check, providing training for a variety of professionals in education and early childhood, providing additional targeted early intervention services.

Collaboration with state and territory governments

The Australian Government recognises that national reform will take time and will involve cooperation between all governments. Since the announcement of the 2011-12 Budget package, several cross-

portfolio and cross-jurisdictional processes have already been established. Additionally, the Prime Minister has written to Premiers proposing that COAG consider mental health during 2011.

To support this, a new, time-limited working group through the COAG Senior Officials has been established to negotiate the new National Partnership (NP) on Mental Health and consider the Ten Year Roadmap on Mental Health Reform. This working group is being co-chaired by Ms Jane Halton, Secretary of the Department of Health and Ageing, and Ms Rebecca Brown, Executive Director of the Western Australian Department of the Premier and Cabinet. It first met on 28 June 2011, with a second meeting arranged for 8 August 2011.

The Commonwealth's offer of a NP is intended to help states and territories to fill major service gaps in their systems to particularly benefit people with severely disabling, persistent mental illness, who are frequent users of emergency departments and need stable accommodation as a cornerstone to keeping well and breaking the cycle of hospitalisation and homelessness.

Accordingly the Commonwealth has nominated two priority areas for funding under the NP:

- Supported accommodation; and
- Better presentation, admission and discharge planning in hospitals and emergency departments.

States and territories will be invited to bid for funds from a total funding pool of \$200 million over five years through a 'competitive federalism' model. This approach recognises that service gaps are not uniform across states, allowing areas of greatest need to be targeted by this funding. Funding is not intended to fully fund all of the existing gaps, but to provide an incentive to address known shortfalls and increase accountability. The Commonwealth will also be seeking co-investment from states and territories in order to leverage greater investment in mental health. The intention is to have the NP signed by all governments by the end of 2011.

Developing a Ten Year Road Map for Mental Health Reform

The Australian Government will also work further with the states and territories, mental health consumers, carers, NGOs and other providers and experts in the preparation of a Ten Year Roadmap for Mental Health Reform which will be completed later in 2011.

The Roadmap will set out what Australia's mental health system should look like in ten years, and the main steps to reach this goal. It will provide a framework for and guide future investment, as the measures funded through the 2011-12 Budget are bedded down and their effects evaluated.

As outlined above, discussion with the states and territories has commenced through the COAG Senior Officials working group, and consultation will take place with the sector, including through the Mental Health Expert Working Group and via an implementation workshop hosted by the Mental Health Council of Australia in September 2011.

Consumer and carer engagement in mental health reform

All Australian governments recognise and support the need for mental health consumers and their carers to contribute to mental health reform and improved mental health service delivery. Consumer and carer input was an important part of developing the 2011-12 Budget package.

On 30 June 2011, the Minister for Mental Health and Ageing announced \$4 million for a new national mental health consumer organisation which is being established as part of the Budget package. The establishment of the new organisation will be informed by, and build on, mental health consumer consultations and feedback including:

- the Scoping Study conducted in 2009-10 to inform the establishment of a new peak national mental health consumer organisation;
- the information gathered from mental health consumers and others through a broad range of consultative mechanisms such as the 14 face-to-face forums attended by Minister Butler in November and December 2010; the on-line youth forum held in December 2010; and seeking public comment via the Commonwealth's Mental Health and Wellbeing website; and
- expert input and advice from the National Advisory Council on Mental Health and the Mental Health Expert Working Group.

DoHA has engaged the Consumers Health Forum (CHF) to auspice the new organisation. This arrangement is intended to provide the new organisation with a good foundation for its operations and to get it up and running as quickly as possible. CHF has well-established infrastructure, public profile and credible experience to provide a suitable first 'home' for the new organisation. This arrangement will provide a sound foundation for the new organisation and will assist in the transition to an independent organisation following a readiness assessment. So that mental health consumers are involved from the outset of the establishment of the organisation, an interim advisory group will be established by CHF.

DoHA provides about \$400,000 per annum for the Mental Health Council of Australia to auspice the National Mental Health Consumer and Carer Forum (the Forum), and to operate the National Register of mental health consumer and carer representatives. States and territories also contribute funding to auspice the Forum. The Forum is the endorsed mechanism through which the Mental Health Standing Committee seeks consumer and carer representatives to inform the development of government policy and programs at a national level.

Conclusion

In summary the Commonwealth's investments in and administration of mental health services in Australia, now spearheaded by the 2011-12 Budget *Delivering National Mental Health Reform* package aims to deliver a system that gives Australians with mental illness timely access to clinical and non-clinical support, and the best chance to recover, stabilise and stay well in the community.

ATTACHMENTS

- Attachment A *Delivering National Mental Health Reform* package summary of measures, funding and lead agency
- Attachment B Summary of the Better Access evaluation and its key findings

2011-12 COMMONWEALTH MENTAL HEALTH PACKAGE

Measure title	Lead Agency	<u>2011-12</u> (\$m)	<u>2012-13</u> (\$m)	<u>2013-14</u> (\$m)	<u>2014-15</u> (\$m)	<u>4 year total</u> (\$m)	2015-16 (\$m)	<u>5 year total</u> (\$m)
Improving outcomes for people with severe and debilitating mental illness		-15.8	69.2	125.1	181.4	360.0	211.4	571.3
<i>Coordinated care and flexible funding for people with severe and persistent mental illness</i> Provide support to around 24,000 people with severe and persistent mental illness and complex care needs through Care Facilitators, a nationally-consistent assessment framework and multiagency care plans.	DoHA	-25.4	35.5	69.1	117.6	196.8	146.9	343.8
<i>Expansion of Support for Day to Day Living in the Community program</i> Additional funding to the 60 existing service providers to enable them to provide social support and structured rehabilitation to an additional 18,000 people over five years with severe and persistent mental illness.	DoHA	2.4	4.1	4.2	4.4	15.0	4.2	19.3
<i>Additional personal helpers and mentors and respite services</i> Additional services to 3,400 people with severe mental illness, and 1,100 of their carers and families over 5 years.	FaHCSIA	7.3	29.6	51.9	59.4	148.1	60.2	208.3
Strengthening primary mental health care services		18.0	34.0	46.7	56.4	155.1	65.2	220.3

<p><i>Expansion of Access to Allied Psychological Services</i></p> <p>Additional psychological services to over 180,000 people from hard to reach groups through the expansion of the Access to Allied Psychological Services (ATAPS) initiative, including:</p> <ul style="list-style-type: none"> • 50,000 children and their families; • 18,000 Indigenous Australians; and • 116,000 people from other hard to reach groups or locations, with particular focus on lower socioeconomic areas. 	DoHA	16.1	31.1	43.7	53.1	144.0	61.9	205.9
<p><i>Establishment of a single mental health online portal</i></p> <p>Increase access to telephone and web-based treatment programs for about 45,000 additional people with common mental disorders, such as anxiety and depression, and provide online support for mental health professionals.</p>	DoHA	1.9	2.9	3.0	3.3	11.1	3.3	14.4
Strengthening the focus on the mental health needs of children, families and youth		19.7	61.0	94.0	151.6	326.2	165.5	491.7
<p><i>Health and wellbeing check for three year olds</i></p> <p>Include emotional wellbeing and development in the existing Medicare Healthy Kids Check and changes the target age of the check from four years to three years. Expert Group to advise on item and map child health services.</p>	DoHA	1.0	6.7	0.9	1.3	9.9	1.1	11.0
<p><i>Expansion of youth mental health (headspace)</i></p> <p>An additional 30 <i>headspace</i> sites, bringing the total number of sites to 90 to achieve national coverage by 2015-16. This initiative will support up to an estimated</p>	DoHA	13.5	22.5	34.9	61.4	132.3	65.0	197.3

72,000 young people each year once all 90 sites are operational.								
<i>Early Psychosis Prevention and Intervention Centre (EPPIC) model – further expansion</i> Additional funding which, with funding provided in the 2010-11 Budget and state contributions, will establish 16 EPPICs that at full capacity will be able to provide services to up to 11,000 young people experiencing first episode psychosis, or at very high risk of psychosis.	DoHA	2.9	23.0	44.9	70.8	141.6	80.8	222.4
<i>Additional Family Mental Health Support services</i> Doubles the number of Family Mental Health Support Services from 40 to 80, assisting over 32,000 children and young people over 5 years.	FaCHSIA	2.3	8.9	13.3	18.0	42.5	18.5	61.0
<i>Australian Early Development Index (AEDI) – ongoing national implementation</i> \$29.7 million over five years, at no net cost to the Budget, to fund ongoing three yearly cycles of the AEDI – a population based measure of how children have developed by the time they start school across five areas of early childhood development.	DEEWR	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<i>Social Engagement and Emotional Development survey of children aged 8 to 14 years</i> \$1.5 million over five years, at no net cost to the Budget, to develop and conduct a survey of young people in their middle years.	DEEWR	0.0	0.0	0.0	0.0	0.0	0.0	0.0
National Partnership on mental health *		22.3	43.6	44.4	45.1	155.3	46.0	201.3

<i>National Partnership on Mental Health</i> Establish a new National Partnership to help fill major service gaps in state and territory mental health systems, with a focus on accommodation support and presentation, admission and discharge from emergency departments.	DoHA	22.3	43.6	44.4	45.1	155.3	46.0	201.3
Increased economic and social participation by people with mental illness		1.0	0.3	0.3	0.3	2.0	0.3	2.4
<i>Increased employment participation for people with mental illness (+ substantial investment in Building Australia's Future Workforce package)</i> Build capacity of employment services providers and Department of Human Services staff to identify and assist people with mental illness to gain employment; provide more support to employers; and review the Supported Wage System	DEEWR	1.0	0.3	0.3	0.3	2.0	0.3	2.4
Ensuring quality, accountability and innovation in mental health services		2.1	2.6	2.4	2.6	9.6	2.5	12.2
<i>Establishment of a National Mental Health Commission</i> Establish a National Mental Health Commission as an executive agency within the Prime Minister's portfolio, with a strong working relationship with the Minister for Mental Health.	PM&C	2.1	2.6	2.4	2.6	9.6	2.5	12.2
<i>Leadership in mental health reform – continuation</i> \$56.8 million over five years, at no net cost to the Budget, to continue the Commonwealth's leadership role in driving mental health system and service improvement through evidence-building, infrastructure and advocacy	DoHA	0.0	0.0	0.0	0.0	0.0	0.0	0.0

arrangements.								
<i>Research funding</i> The National Health and Medical Research Council will dedicate \$26.2 million over a five year period (a minimum of \$5 million per year) from the Medical Research Endowment Account to build capacity within the Australian mental health research sector and encourage and fund quality research projects.	NHMRC	0.0	0.0	0.0	0.0	0.0	0.0	0.0
SubTotal		47.3	210.6	312.9	437.5	1,008.3	490.9	1,499.2
Savings Measures		-62.8	-107.0	-120.3	-135.6	-425.6	-154.8	-580.5
<i>Better Access Initiative – two tiered rebate for treatment plan session</i> Payments to General Practitioners (GPs) will be linked to the time spent on developing a Mental Health Treatment Plan, with the addition of an incentive for special training to maintain the high quality of care provided.	DoHA	-50.1	-80.5	-85.4	-90.9	-306.9	-98.9	-405.9
<i>Better Access Initiative – cap allied health sessions to 10 from 12</i> Cap the number of allied mental health services available at 10 sessions per patient per calendar year from 12 sessions per patient per calendar year (current average is 5). 87% of current users unaffected.	DoHA	-12.6	-26.5	-34.9	-44.6	-118.7	-55.9	-174.6
SubTotal		-62.8	-107.0	-120.3	-135.6	-425.6	-154.8	-580.5
TOTAL		-15.5	103.6	192.6	301.9	582.7	336.1	918.8

* Indicative costs – final phasing of funding to be negotiated with the states

Key findings from the program evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative

Background

The *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative was introduced in November 2006 in response to low treatment rates for high prevalence mental disorders like anxiety and depression.

The aim of Better Access is to improve outcomes for people with clinically-diagnosed problems by providing evidence-based treatment.

New item numbers were added to the Medicare Benefits Schedule (MBS) to provide a rebate for selected mental health services provided by GPs, psychiatrists, psychologists (clinical and registered), social workers and occupational therapists.

The Department of Health and Ageing commissioned an independent and wide-reaching evaluation of the program, overseen by experts in the research and mental health fields, which began in January 2009 and was completed at the end of 2010.

This program evaluation aimed to assess the overall appropriateness, effectiveness and impact of the initiative.

The following table summarises the separate components of the evaluation which are all available at www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval

Component	Title
A	A study of consumers and their outcomes
A2	A study of consumers and their outcomes (focusing on the occupational therapy and social work sectors)
B	An analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) administrative data
C	An analysis of allied mental health workforce supply and distribution
D	Consultation with stakeholders
E	Evaluation of projects conducted under the education and training initiative to support Better Access
F	Analysis of the Second National Survey of Mental Health and Wellbeing
Overall	Summative Evaluation

Key Findings

According to the evaluation...

1. Better Access has improved access to mental health care for people with common mental disorders such as anxiety and depression

Use of services under Better Access has been high and has increased over time. In 2007, more than 700,000 Australians (one in every 30) received at least one Medicare rebatable mental health service under the initiative. In 2008, this figure was more than 950,000 (one in every 23), rising to more than 1.1 million people (one in every 19) in 2009.

Australians received a total of 2.7 million Better Access services in 2007, 3.8 million in 2008 and more than 4.6 million in 2009.

After accounting for some people who received services in more than one year, this equates to over two million individuals who received more than 11.1 million services over the three year period 2007 to 2009.

2. Better Access is reaching groups who are traditionally disadvantaged in their access to mental health care although there are still some groups not accessing the services they need

People in hard to reach groups are using Better Access but they continue to use these services at a lower rate than the general population and miss out on the mental health care they need. This is particularly the case with young people under 15 years old, men, people living in rural and remote regions and people living in areas of high socio-economic disadvantage.

However all groups are using the services more each year, with the biggest increase for those who have traditionally been the most disadvantaged. For example, the relative growth in uptake between 2007 and 2009 was considerably greater for young people under 15 years than for all other age groups.

More than two-thirds of people who used Better Access (65.5% in 2009) live in capital cities. The evaluation shows that geographic disadvantage continues to be an issue - compared to capital cities, people living in rural areas used the services 12% less and people living in remote areas used the services 60% less

Use of Better Access was around 10% lower for people living in the most socio-economic disadvantaged areas, than in all other areas. People with the greatest levels of financial need were the biggest beneficiaries of bulk-billed services. The proportion of services that were bulk-billed increased from 68% in rural centres to 72% in remote areas. Bulk-billing levels also increased as the level of relative socio-economic disadvantage increased.

3. Better Access has contributed to an increase in treatment rates for people with mental illness

In the 2007 National Survey of Mental Health and Wellbeing, it was estimated that only 35% of people with a mental disorder in the previous 12 months accessed treatment, while in 2010 this has grown to an estimated 46%.

4. Better Access is reaching people who have not previously accessed mental health care

Around half of all Better Access consumers may be new, not only to Better Access but to mental health care more generally (see Component A report).

Of the more than 950,000 consumers who had received at least one Better Access service in 2008, more than two thirds were first-time Better Access users. In 2009, more than half of the 1.1 million consumers served by Better Access were first-time users (see Component B report).

5. Better Access is providing treatment to people in need

Better Access is providing treatment to people with severe symptoms and high levels of psychological distress.

The majority of consumers accessing mental health services under Better Access were experiencing depression and/or anxiety. This is consistent with the aim of the initiative, which is to improve access for people with common mental disorders who historically had low treatment rates.

Among consumers who received Better Access allied mental health services, close to 73% received between one and six services. The average number of services received was five.

6. Better Access has resulted in improved mental health outcomes for consumers

The evaluation indicates that consumers experienced clinically significant reductions in levels of psychological distress and symptom severity upon completing treatment.

The same outcomes were achieved whether the consumer was male or female, young or old, or more wealthy or financially disadvantaged.

7. Better Access is a cost-effective way of delivering mental health care

While it was difficult for the evaluation to assess cost-effectiveness directly, findings show the typical cost of a Better Access package of care delivered by a psychologist is estimated to be \$753.31. Based on cost modelling for optimal treatments for a population with common disorders, it is estimated that optimal treatment for anxiety or depressive disorders costs about \$1,100 in 2010 dollars.

Further information

The evaluation reports are available from www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval

If you have any difficulty accessing the PDF printable versions of the Better Access evaluation reports, please email mentalhealth@health.gov.au

For all media enquiries, please contact the office of the Minister for Mental Health and Ageing on (02) 6277 7280.