

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
5th August 2010

Dear Senators,

Thank you for the opportunity to respond to this important inquiry.

At the outset, Suicide Prevention Australia would like to draw the Committee's attention to some key facts which relate closely to this inquiry. Suicide remains a leading cause of death in Australia, claiming the lives of over 2200 people a year, with thousands more physically and psychologically affected by suicide attempts, suicide ideation and bereavement. The vast majority of these people suffer from some sort of temporary or enduring mental illness. Results from the National Mental Health and Wellbeing Survey indicate that 73.4% of those who made a suicide attempt during the previous year had contact with mental health services at some stage during the 12 month period (Johnson et al 2009). This indicates the high volume of suicidal presentations that mental health clinicians respond to, but also the possibility that some cases of suicidality are not being picked up during mental health assessments. According to the survey over one in four people who attempted suicide had no contact with a mental health service either before or after their attempt. In this context what are we doing to increase service use and improve outcomes to stem this tragic and enduring situation? Many laudable mental health services are available at the State, Federal, private and NGO level, yet typically access and outcomes are based on a combination of geographic factors, SES background and severity of illness, largely mediated by luck and persistence. Those who get left behind by this system deserve more.



Questions have been asked of the robustness of the recent evaluation of Better Access (see Rosenberg and Hickie 2010). Regardless of the evaluation data, Suicide Prevention Australia believes that the proposed changes may be partly motivated by curtailing the runaway costs of Better Access rather than focused on the needs and rights of mentally ill Australians. Cost saving measures can and should be introduced when necessary, but only when the needs of service users are being met and while uncertainty remains about the outcomes of the program, decisions should be cautious.

Please consider our below submission which addresses our supports and concerns for the proposed changes to Commonwealth mental health services funding.

We are happy to provide further comment and information if necessary.

Yours Sincerely,

Dr Michael Dudley AM
Chair, Suicide Prevention Australia

Ryan McGlaughlin
CEO, Suicide Prevention Australia



Commonwealth Funding and Administration of Mental Health Services TOR:

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

Suicide Prevention Australia is very supportive of some new initiatives and increased funding outlined in the 2011 Budget papers. In particular the 2010 Taking Action to Tackle Suicide package provides unprecedented funding for targeted suicide prevention activities. The increased provision of frontline services to those who are at highest risk of suicide or have attempted suicide signals the Government's commitment to those in need. However this funding allocation is playing catch-up with years of underfunding and vastly increased, sustainable systems of funding and efficient administration are still required for the long term health and welfare of Australians.

(b) changes to the Better Access Initiative, including:

- (i) the rationalisation of general practitioner (GP) mental health services,*
- (ii) the rationalisation of allied health treatment sessions,*
- (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, and*

General practitioners are a common first point of help seeking for people who are suicidal. Approximately 60% of people who plan suicide and seek help, do so through GPs, and 20% of people who attempt suicide visit a GP in the aftermath (De Leo et al. 2005). However a large proportion of people seek no help for suicidality, reportedly because they do not feel the need, they don't want to trouble others, they are not confident in the help available, they are concerned about stigma or cost or they are unsure of where to go (De Leo et al. 2005). As people who have attempted suicide are the highest single group at risk of subsequent death by suicide, their lack of service access is concerning. In this context increasing service access and the quality of service provision is essential to preventing suicides. This includes access to properly trained GPs



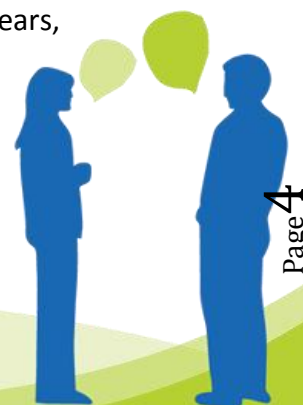
as well as psychiatric and allied mental health care.

The rationalisation of GP mental health services appears to have been designed so that fee's better reflect services currently offered, rather than improving the quality and process of services offered. Should the recommended rationalisations of GP mental health services be introduced, close monitoring of the system must ensure that there are no adverse consequences for patient care. In particular, the reduced Medicare rebate payments available for Mental Health Treatment Plan consultations of less than 40 minutes, risks discouraging GPs from developing plans with some patients. Similarly there is a risk that the reduction in payments available to GPs who complete Mental Health Plan Reviews will result in less reviews being undertaken. The Better Access evaluation found that the requirement for GPs to review the Treatment Plans after 6 sessions was sometimes constrained by the difficulty for patients to get GP appointments quickly, especially in regional areas (Pirkis et al. 2010). This will not be assisted by reducing the rebate available to GPs for these sessions.

GP mental illness and suicide prevention training has been shown to increase the accuracy of diagnoses of depression and other mental illnesses, and leads to a subsequent reduction in suicide attempts (Mann et al. 2005). While the retention of incentives for GP training is welcomed, there is a crucial need to introduce mandatory suicide prevention training for all GPs and health professionals.

(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;

Australia has made significant strides in mental health funding over previous years, however despite advances made, funding still remains critically short of need. The extraction of funds from one area of mental health need to finance



another is a contradiction that could lead to further regression in service delivery.

Suicide Prevention Australia is concerned by the cuts to Better Access sessions for people requiring psychological interventions, from a maximum of 18 sessions in special circumstances to a maximum of 10 with no opportunity for additional sessions if necessary. The majority of clients who currently receive more than 10 Better Access sessions are those with moderate to severe high prevalence mental illnesses – those at highest long term risk of suicide. Alternative referrals to psychiatrists or ATAPS care will not be appropriate for all patients currently requiring greater than 10 Better Access sessions, will break treatment routines and rapport and in some cases will be cost restrictive.

While Suicide Prevention Australia acknowledges that budget savings must be made to provide for other additional services and increases, targeting those at highest risk is neither cost effective nor ethically justifiable.

Suicide Prevention Australia advocates for treating psychologists, like psychiatrists, to be authorised to provide and claim rebates for the number of sessions that they deem necessary for optimum treatment outcomes. Currently only a small percentage of Better Access service users require or utilise more than 10 sessions; this would remain the case under a more flexible system and thus wouldn't have large relative budget implications. Regular monitoring of frequency of sessions undertaken by each psychologist would allow transparency and accountability and discourage exploitation of the system.

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



ATAPS has been refocused on complementing the Better Access program and meeting any service gaps that exists. Evaluation data for ATAPS has been largely positive, especially its provision of services to socio-economically disadvantaged and rural Australians (Department of Health and Ageing 2010). However women remain the overwhelming majority of patients, indicating a gap for males with high prevalence disorders such as depression and anxiety. This does not seem to have been rectified by the recent changes.

The proposed cuts to Better Access will likely increase the numbers of people requiring the services of ATAPS. It is not clear whether the current limits placed on patients who access both schemes consecutively will remain, effectively reducing any potential for patients who exhaust their Better Access session allowance to be referred for ATAPS support within the same calendar year.

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

Suicide Prevention Australia supports the increased investment in Flexible Care Packages for People with Severe Mental Illness to access clinical and non-clinical supports through ATAPS (referred by GP or psychiatrist). This includes \$58.5 million over four years for 25 000 people needing clinical care and \$69 million over three years for non-clinical care. While it is admirable that these packages are being made more widely available, the quality control and training requirements of practitioners within the ATAPS scheme must be prioritised under administration considerations.

Coordination across all clinical and non-clinical mental health services is critical. Most services are designed to address need according to severity of mental illness, however mental illness functioning can fluctuate, thus people may be required to move between services regularly. Pathways to and from care

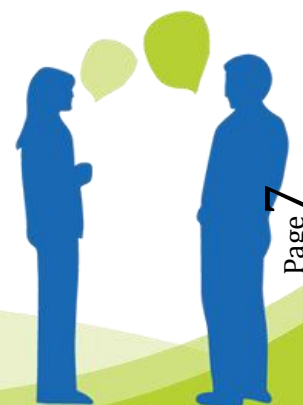


must be prioritised to ensure that those who are experiencing severe episodes of illness get appropriate help immediately, and those who are recovering are fully supported. Education of medical and allied professionals about available referral pathways are necessary to maximise access and optimise treatment pathways, while the general community should also be advised on available services and access points for them and their loved ones.

The expansion of the Additional Support for People at Risk of Suicide or Self Harm project is a welcome investment, as this addresses a previously unmet need for those who are not connected to State or Territory mental health services. It provides additional support and an immediate point of referral for GP's who have patients experiencing suicidality. Such immediate and tailored support is recommended for people who are suicidal and Suicide Prevention Australia advocates for this life saving service to be available through every GP practice to ensure that no-one misses out on services due to their locality. Interventions for people who are expressing suicidality will reduce the numbers and cost of the current volume of presentations to Emergency Departments (which also have unmet resourcing and training needs in the area of suicide prevention).

The potential for reduced availability of clinical psychologists through Medicare (should the tiered system be abolished and clinical psychologists required to work longer private hours to maintain their income) will increase demand on psychiatrists to treat those with severe mental illness. While the government has invested in online psychiatry services, these are not always suitable as a replacement for face to face services. In addition patients who are referred to additional psychiatric support as suggested by the Department will still require psychological therapies either through ATAPS or public mental health services – which are not always accessible.

The primary issue remains the need to provide consistent, accessible and appropriate pathways of care for people with all variances of mental illness.



By removing one avenue which has been shown to be meeting the needs of a small but at-risk population, the Government is increasing the likelihood of people falling through the cracks. Suicide Prevention Australia does not support the rationalisation of Better Access services for this reason.

(e) mental health workforce issues, including:

- (i) the two-tiered Medicare rebate system for psychologists,*
- (ii) workforce qualifications and training of psychologists, and*
- (iii) workforce shortages;*

Concern is raised about the abolishment of the two-tiered system of Medicare rebates for clinical and generalist psychologists. While research has shown similar treatment outcomes for both patient groups, the additional exposure to training received by clinical psychologists better equips them to deal with the range and complexity of mental illnesses and presentations of suicidality. Suicide Prevention Australia does not support any initiative which acts as a disincentive to further training for mental health professionals. Training, professional development and quality control are essential for maximising patient care. The assessment and treatment of people who are suicidal and/or experiencing moderate to severe mental illness is challenging in the best of environments and the training undertaken by practitioners must be maximised. The current system achieves this and should it be changed as proposed then appropriate recognition of training and expertise must be generated in another form.

In addition, patients with moderate to severe disorders and those who are chronically suicidal who require the specialised treatment of clinical psychologists, will be forced to pay inevitable 'gap' fees for this service and will have restricted access as a result. The end result will be increased costs for acute mental health care and tragically lives lost due to inaccessible care.



The lack of consideration given for specialist training evidenced by the proposed abolishment of the two-tiered system is indicative of the disregard for training in mental health and suicide prevention more generally. Few professionals who are responsible or likely to respond to suicidal people are adequately trained, including nursing staff, emergency department staff and GPs.

Suicide Prevention Australia advocates for the an increase in properly trained peer support workers in the mental health workforce. Currently the specialist knowledge and experience of people with lived experience of mental illness are being underutilised, and the wealth of support and treatment that they could provide is being wasted. An effective consumer workforce program should be established with adequate funds.

- (f) the adequacy of mental health funding and services for disadvantaged groups, including:*
- (i) culturally and linguistically diverse communities,*
 - (ii) Indigenous communities, and*
 - (iii) people with disabilities;*

Suicide Prevention Australia supports the recent review of ATAPS which proposes a funding structure that encourages innovation in providing services to disadvantaged and traditionally hard to reach groups. Available to eligible Division of General Practice (future Medicare Locals) the funding pool will allow locally appropriate services and programs to be implemented in consultation with stakeholders and consumers. Potential for suicide prevention initiatives to access expedited funding through this channel is very welcome. Information and advertising of this initiative to the target groups is important so that community-led, needs-driven initiatives receive support.



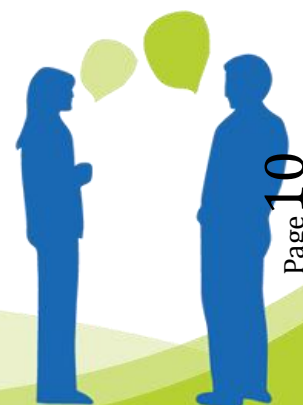
Suicide Prevention Australia would like to call the Committee's attention to other disadvantaged groups who require targeted policies to address service equity issues. These include men, rural and remote communities, sexual minority communities, those with substance abuse issues, homeless communities and the elderly. While some promising initiatives are being undertaken with these groups, as they are with CALD and Indigenous communities and people with disabilities – further policy mainstreaming and targeting of the needs of these communities should be encouraged.

(g) the delivery of a national mental health commission; and

The positioning of the Mental Health Commission within the Department of the Prime Minister and Cabinet will facilitate the mainstreaming and cross-government requirements of mental health improvement, placing mental health care front and centre. The utility of a National Mental Health Commission will be mediated by its governance and accountability capacity. To strengthen these roles and allow the Commission to hold the government and non-government entities accountable for meeting the needs of the community the Commission should have government and non-government appointees. The proposed National Report Card on Mental Health and Suicide Prevention will become the responsibility of the Commission and will provide much needed data on the state of our prevention and care systems.

The involvement of those with lived experience of mental illness and their carers is recommended to facilitate meaningful engagement and representation of those who are the experts in mental health care. This should include Commissioner Posts as well as a separate mental health consumer advisory body.

To ensure that suicide prevention remains a primary consideration in all activities of the Commission, Suicide Prevention Australia strongly



recommends that at least one Commissioner be a specialist in suicide prevention policy.

Suicide Prevention Australia is supportive and optimistic of the potential for the National Mental Health Commission under the leadership of CEO Robyn Kruk.

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

The establishment of an online portal for the full spectrum of evidence based online mental health services is a welcome development. It will add greatly to quality control, ease client access to online services and provide a greater level of choice and confidence in services.

(j) any other related matter.

The provision of mental health services must be supported by maximised access for those most in need. As we have seen a lack of knowledge, confidence and fear and stigma prevent many vulnerable people from accessing services or help when necessary. The implications of this include deteriorating mental illnesses and ultimately suicides. Suicide Prevention Australia urges the Community Affairs committee to reiterate their call for a properly resourced social marketing and public education campaign for suicide prevention, supported by concurrent mental illness campaigns.

Summary

In conclusion Suicide Prevention Australia supports all newly announced funding and initiatives. However we are concerned by some of the proposed cuts to services and funding, not merely because of reduced funding per se, but as these seem to target two areas which are crucial to suicide prevention: specialist training and support for those with moderate to severe mental illness. We hope that the Senate



committee will recommend reconsideration of cuts to Better Access sessions and any initiative which acts as a disincentive for training for health professionals.

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