Senate Community Affairs References Committee

HEALTH AND AGEING PORTFOLIO

INQUIRY INTO FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

25 September 2011

Responses to questions from Senate Standing Committee on Community Affairs, email 25/10/11

Question:
Can you confirm the committee's understanding that once a patient has received 10 services under the Better Access program, they will not be able to be referred for additional services using the ATAPS program in the same calendar year?

Answer:
Services provided under the ATAPS program should not be used in addition to the ten allied mental health services available under the Better Access initiative per calendar year.

ATAPS has always been a complementary program to Better Access and was not designed to offset or top up services delivered under Better Access. The changes to Better Access announced in the 2011-12 Budget have not altered this relationship.

ATAPS is designed to increase the capacity of Divisions and Medicare Locals to target services to hard to reach groups who are not able to access Medicare subsidised services irrespective of recent Better Access changes. These include: people from low socioeconomic areas; individuals at risk of suicide or self harm; individuals who are homeless or at risk of homelessness; and people in rural and remote areas. ATAPS also focuses on Indigenous people, children, and women with perinatal depression.

Generally, people who access treatment through Better Access do not receive services under ATAPS within the same calendar year unless: their location changes and they are no longer able to access Better Access services due to workforce constraints, or their financial circumstances change and they are no longer able to meet the co-payments associated with Better Access services. In deciding if ATAPS is more appropriate for a client whose circumstances have changed, GPs should consider the focus and target of the ATAPS program.

Question:
If this is the case what alternative programs can a practitioner access to ensure that consumers who need them are being provided with services?

Answer:
Better Access was introduced in November 2006 in response to low treatment rates for high prevalence or common mental disorders like anxiety and depression – particularly presentations of mild to moderate severity where short term interventions are most likely to be useful.

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.

While some people with more complex or intensive care needs may benefit from interventions under Better Access, it was never intended to provide intensive, ongoing therapy for people with severe ongoing illness.

People in this group are generally clients of state and territory government specialist mental health services.

It is important that people get the right care for their needs. As indicated on the Medicare Australia web site, people who currently receive more than ten allied mental health services per calendar year under Better Access are likely to be patients with more complex needs and would be better suited for referral to more appropriate mental health services. This may include the following:

- People with severe and persistent mental disorders who require over ten allied mental health services are still eligible for up to 50 Medicare subsidised consultant psychiatrist services; and
- The specialised mental health system in each state or territory.

The 2011-12 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 in the Department of Health and Ageing's submission to the Senate Inquiry.

For example, the Government is also investing through this year's Budget, $549.8 million to provide coordinated and flexible funding for people with severe and persistent mental illness and complex multi-agency needs. This will provide eligible individuals with a

single point of contact, a care facilitator, and will assist about 24,000 people and their families.

To help make psychiatrist services available in more areas, from 1 July 2011 the Government is also providing new Medicare rebates for video 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.