Private Mental Health
Consumer Carer Network (Australia)
engage, empower, enable choice in private mental health

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SUBMISSION

Senate Community Affairs Committee

Inquiry into Commonwealth Funding and Administration of Mental Health Services

Sent via email: community.affairs.sen@aph.gov.au

Introduction

We thank the Parliament of Australia, Senate Community Affairs Committee for the opportunity to provide input into the Inquiry into Commonwealth Funding and Administration of Mental Health Services.

The *Private Mental Health Consumer Carer Network (Australia)* (hereafter Network) represents Australians who have private health insurance and/or who receive their treatment and care and their carers, from private sector settings for their *mental illnesses or disorders.* As our title implies, the Network is the authoritative voice for consumers and carers of private mental health settings.

The Network is committed to working with the Parliament of Australia, Senate Community Affairs Committee and relevant others in addressing the needs of people with a mental illness and their family or carers. We bring to this Submission, a mental health consumer and carer perspective.

Mental health brings with it many challenges. As a consumer and carer organisation we are in a position to provide direct 'lived' experiences to the Inquiry and would welcome the opportunity to engage in further consultations.

Whilst our Network is primarily focussed on mental health delivered in private sector settings such as private hospitals and private providers in their own practices, we nonetheless consider this an opportunity to focus on the whole of the mental health system far more broadly than just the private sector.

Issues relating to the Terms of Reference

There are a number of issues relating to the relevant Terms of Reference to which we are responding.

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

We congratulate this Government in making mental health a priority in the 2011-12 budget. There are many initiatives associated with significant funding of which we gratefully acknowledge.

(b) Changes to the Better Access Initiative:

Re-direction of $580.5 million from the Better access program to fund alternate services holds significant concerns, especially the rationalisation or reduction of treatment services.

Much has been said in the media and by prominent individuals, but we believe the *Better Access Initiative* is essential if we are to address access to and the needs of people with the high prevalence disorders appropriately. The recently released Australian Government evaluation shows that *Better Access* provides good access to allied health professionals through their GPs, at a reasonable cost, by people who had not previously sought assistance.

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

We understand that the payments under Medicare have been exceptionally high for this program, with the Item Number for GPs to write a mental health plan the most costly.

The Network is concerned that *Better Access* has been singled out for special requirements in order to reduce costs or to redirect the significant reduction in funding to other programs.

GPs are the first and for most people with mental health problems, the **only** point of contact in managing their mental illnesses or disorders. Given the main focus of public mental health services on schizophrenia and psychotic illnesses, without strong support from GPs mental health consumers with high prevalence disorders would receive no assistance, with access to public mental health services essentially precluded.

The Government's evaluation of *Better Access* showed some very important data.

It clearly showed that it has:

- Improved access for many consumers to a mental health services not previously sought or accessed;
- Been overall cost effective in delivering effective treatment;
- Because of the Medicare setup arrangements, very little gaps for consumers; to access GPs and limited out of pocket costs for allied health professionals; and
- It has achieved good outcomes for consumers especially for those with high prevalence disorders

It also showed that a very high number of GPs provided services to consumers in order to access allied health practitioners.

We believe the Government should be doing whatever it can to encourage and support GPs in taking up mental health consultations within their practices.

RESPONSE:
We do NOT agree with the rationalisation.

(ii) The rationalisation of allied health treatment sessions

The people we represent are expressing their concern that the number of consultations are now being reduced to six initially, followed by four, ie a total of ten per person in a given year.

Whilst it has been advised and reported in the media that this is a reduction of **only two consultations**, it actually represents a **reduction of <u>eight</u> consultations** since, under exceptional circumstances, people were able to access up to eighteen

consultations in a given year. The *Better Access* initiative now represents only 10 hours of treatment for depression, anxiety and other major diagnoses a year.

Many consumers are disappointed, since this represents a significant reduction of access for them and has been implemented from what we believe is solely a cost saving or redirection of funds exercise. They value the allied health professionals they see and feel they get good result. This has also been demonstrated within the Evaluation showing good outcomes for people accessing allied health professionals.

With regard to psychologists, their educational requirements fully support their very important role in treating consumers with mental health problems. They are integral to *Better Access* and many consumers believe that they have received very good treatment. Without *Better Access* psychologists were in the main, too costly to access for many people. Consumers value the assistance from psychologists.

We believe that a twelve month delay in the implementation of this requirement should be imposed, to allow current consumers accessing the *Better Access* initiative the time to seek alternative treatment sources. We do not believe that either the ATAPS program, state-based public mental health services or private mental health professionals will be able to expand in such a short time to deal with the needs of people at the more severe end of high prevalence disorders. Consequently, this will result in a large number of vulnerable people without appropriate options for treatment.

Under this Budget measure, the Government anticipates a *saving of $174.6 million* over the next five years.

RESPONSE:

1) We strongly do NOT agree with the rationalisation of treatment session.

2) We request a 12 month delay in the implementation of the reduction from 18 to 10 treatment sessions.

3) We do not believe the public mental health services or private practitioners will be able to expand quickly enough to provide alternate treatment options.

(iii) Impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a Carer Plan by GPs

As referred to in (i) above, we strongly support GPs involvement and engagement in mental health. GPs are the first port of call for all health problems and as consumers and carers affected by mental illness, we strongly support the GPs in this role. We believe that it is essential to encourage GPs to undertake additional training to support their role within mental health, but believe this should be encouragement by way of appropriate remuneration under Medicare.

In real terms, the evaluation also showed a high uptake showing that Australians affected by depression and anxiety in particular welcomed access to allied health professionals for their mental health which they would not have been able to do without *Better Access.* This showed that consumers were accessing treatment which they were not previously able to access, showing that the thrust of the *Better*

Access initiative did actually reach those consumers for which the initiative was designed to reach.

The evaluation also showed that people previously disadvantaged, such as young people were for the first time, able to access mental health services through the allied health professionals.

We understand the need for the Government to continue to provide incentives for GPs to complete specialised mental health skills training and to provide GPs with the encouragement needed for many more to engage with patients with mental health conditions. As stated previously, a great many Australians rely entirely on GPs for their mental illnesses/disorders.

Under this Budget measure, the Government anticipates a saving of $405.9 million over the next five years.

Response:

1) ***We rely heavily on GPs when access to other sources of mental health treatment is not available.***
2) ***We believe the Government should encourage GPs to provide this vital service and are very concerned that the recalibration of the rebates may instead prove to be a disincentive.***

(iv) The impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the MBS

As detailed in (ii) above, consumers are dismayed that the number of treatments have been decreased from 18 to 10 in a given year.

Mild to Moderate mental illness cannot go unacknowledged. We know from various surveys most notably that conducted by the ABS in 2007 – *National survey of mental health and well-being* only 35% of people with a mental illness in the previous 12 months accessed treatment. In 2010 this had grown to 46%, mostly as a result of the *Better Access* initiative.

Whilst the evaluation of *Better Access* showed that most consumers accessed between one and six services a year, it also showed that many consumers had received treatment which they would not ordinarily have been able to access.

The Government concludes that 87% of current *Better Access* users received between one and 10 services and will therefore not be affected by this change. For the remaining 13%, the Government concludes that consumers requiring more than 10 services may be experiencing more severe symptoms and therefore would be better suited for referral to 'more appropriate' mental health services such as Medicare-subsidised psychiatrist consultation or state public mental health services.

We understand that the *Better Access* initiative was designed to allow access for the high prevalence disorders such as anxiety and depression which were (and still are) not considered the core business of public mental health services. Availability, waiting times, access and gap costs associated with accessing Medicare-subsidised psychiatrists are also a major access issue for people.

We know that many consumers access mental health services for severe mental illness through B*etter Access* who would not under normal circumstances be able to receive any sort of treatment otherwise. Diagnoses of people who would fall into this category would be people with Borderline Personality Disorder for example, who are actively excluded from public mental health services.

Response:
We strongly believe that the changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the MBS will be detrimental to the long term health of many Australians

(C) **<u>The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services (ATAPS) program.</u>**

The evaluations of the *Better Access* initiative and the ATAPS programs show that both programs dovetailed or integrated well. ATAPS evaluation showed that this program was effective in providing services to those who seemed unable to access services through *Better Access.* ATAPS has proven to be very effective in addressing the needs of consumers from the rural and remote areas, low socio-economic areas, indigenous Australians and other hard-to-reach populations.

However, under the previous funding arrangements, the constraints limited the ability of this program. Long waiting lists, recent natural disasters and the potential additional numbers of Australians, all compounded access.

Again, we request that a twelve month delay in the implementation of the reduction of treatment sessions from 18 to 10 (as required under the 2011-2012 Budget) to allow current consumers accessing the *Better Access* initiative the time to seek alternative treatment sources.

Under the ATAPS program, GPs can refer people to a similar number and type of psychological services as *Better Access* although we understand that the total number of consultations has remained at 18 per person per year. Under the Budget 2011-2012, the allocation of $205.9 million over the next five years is very welcomed. The Government estimates that an additional 180,000 people will now be able to access assistance for mental health issues or mental health distress.

However, we do not believed that the ATAPS program will be able to expand in such a short time to deal with the needs of people at the more severe end of high prevalence disorders previously seen under *Better Access* but who are not unwell enough to be given services by state-based mental health services. Once again, this will result in a large number of vulnerable people without appropriate options for treatment.

Response:

1) ***We request a 12 month delay in implementing the reduction of treatment services from 18 to 10 under Better Access.***
2) ***We hold grave concerns that ATAPS will be able to expand in such a short time to deal with the needs of current consumers.***
3) ***As a consequence, large numbers of vulnerable people will be without appropriate treatment.***
4) ***We fully support the budget allocation of $205.9 million over the next five years to expand services provided for hard to reach Australians through ATAPS.***

(d) Services available for people with severe mental illness and the coordination of these services.

The 2011-2012 Budget allocated $343.8 million over a 5 year period for these services. We agree that for far too long, people's mental health care has been grossly disjointed, uncoordinated and fragmented.

The public mental health services has focussed largely on people suffering schizophrenia, psychosis and bi-polar disorder, whereas the private mental health system has focussed largely on consumers suffering mood disorders, PTSD, Panic disorder etc.

A single point of contact for people severely affected by mental illness is most welcomed. This will enable a consumer and their family to access timely and appropriate services to address their needs, be that clinical, social, housing, employment etc. This would be the first time that people severely affected can have a 'one-stop-shop' for their needs. The coordination of all services through a specific Care Facilitator will be a bonus.

Previously, the Divisions of General Practice coordinated people's needs through the ATAPS program, and it would seem reasonable that the newly created Medicare Locals would be best placed to handle this task. However, given that significant funding has also been allocated under the Budget to the ATAPS program, we hold concerns as to whether the Medicare Locals will be able to adequately undertake this additional workload.

We do acknowledge that a person referred by the Medicare Locals under ATAPS to a mental health practitioner, who also had a Care Facilitator within the same facility, would enhance the integration and coordination of their care.

We are aware of the existence of a number of non-government agencies able to provide and supervise the Care Facilitator function. For example, the Personal Helpers and Mentors program, is largely overseen by NGOs, yet again we see an increase within the Budget of $208.3 million to the PHaMs Program. We believe that the NGO sector is also able in particular areas or circumstances, to provide the same level of professional assistance to undertaken to fulfil the role.

Response:

1) ***We fully support the budget allocation to fund this service.***
2) ***We hold some concerns that given the increased funding for the ATAPS and PHaMs programs, either Medicare Locals or NGO's currently administering these programs may struggle to additionally act in provision of the role of Care Facilitator.***

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

Hard-to-reach groups

The Network has been advocating for some considerable time for the provision of services using web-based or online technology to provide services to those hard-to-reach Australians. This may be due to location, specific diagnoses, those with special needs &/or indigenous communities.

We are very pleased to see the allocation of $14.4 million over five years to provide e-therapy via a single mental health online portal. This will enhance treatment options for many 'isolated' people.

Mental Health Commission

The Network holds concerns regarding the allocation of $12.2 million over five years for the establishment of the National Mental Health Commission. We would support such a body if, the Commission is charged with examining the adequacy of funding, the distribution of that funding, and determining outcomes. We believe the Commission must be an autonomous body, set up by the Government; to advise and inform, the Government.

The long term viability of such a Commission will be judged by whether the incumbent Government acts on the advice. We also query whether the role of the Commission in the long term, might be the ultimate fund-holders of discrete mental health monies subject to allocation according to their own determination.

We see the makeup of the commissioners as crucial to its acceptability. In recent times, we have seen a number of individuals advocating and receiving very significant funds for their particular areas of interest. This has been noticeably demonstrated within the 2011-2012 budget allocations. Recommendations for funding and implementation of very specific services have been undertaken we understand, without consumers and carers being invited to be a part of any discussions. We are not convinced that the views of consumers and carers are been acknowledged, heard or acted upon.

Further, to have only one consumer and one carer commissioner around a table over-represented by clinicians, 'experts', policy officers, government representatives we do not believe is acceptable. Any Commission must have a consumer from the public sector and a consumer from the private sector to ensure compatibility, integration and integrity. The same must also be mandated for carers, ie. one carer from the public sector and one carer from the private sector. The private sector provides significant treatment and care for a large number of people with health issues generally, and this can certainly be said for mental health. This sector MUST be represented on any Commission.

The establishment of the Mental Health Commission will be fully supported by the Network with an equal, independent and democratic assembly of representatives from both public and private mental health sectors.

Repsonse:

1) ***We support the allocation of funding for hard to reach groups***
2) ***We have concerns about the make-up, appropriated representation of BOTH public and private sectors and the appointment of Commissioners to the new Mental Health Commission.***
3) ***We strongly support the inclusion of the private sector within the make-up of the Commission.***

Conclusion

The Network has been pleased to provide this Submission to inform the Senate Community Affairs Committee. We would welcome the opportunity of providing further input or to discuss this submission directly from a consumer and carer 'lived' experience.

Please contact me on email: jmcmahon@senet.com.au or telephone: 08 8336 2378

Yours faithfully,

Ms Janne McMahon OAM
Independent Chair, 27 July , 2011