Senate Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

INQUIRY INTO FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

5 September 2011

Question No: 1

Topic: Inquiry into Funding and Administration of Mental Health Services

Hansard Page: 10

The Committee asked:

The Chair of the Committee asked the Department of Health and Ageing to table Better Access uptake data around specific numbers of people and numbers of services, based on rural and remote areas versus other areas.

Answer:

The recent evaluation of Better Access included an analysis of persons receiving Better Access services by type of geographical region. This analysis is contained within *Component B: An analysis of Medicare Benefits Schedule and Pharmaceutical Benefits Scheme administrative data* and is available from:
http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-b

Regional data was based on the consumers' enrolment postcode and classified according to the Rural, Remote and Metropolitan Areas (RRMA) classification system. The RRMA allocates geographical areas into seven classes: Capital cities (RRMA category (1); Other metropolitan centres (2); Large rural centres (3); Small rural centres (4); Other rural areas (5); Remote centres (6); Other remote areas (7). To facilitate analysis and interpretation, RRMA categories were aggregated into five region types by combining classes 3 and 4 into 'Rural centres' and classes 6 and 7 into 'Remote areas'.

Based on this analysis the table below provides data on persons receiving Better Access MBS services by type of geographic region for the period 2007 to 2009. As outlined in the Department's submission (No. 199) data from the Better Access evaluation shows that more than two-thirds of people who used Better Access services (67.2% in 2007, 66.5% in 2008 and 65.5% in 2009) reside in capital cities.

The evaluation confirmed that in rural areas of Australia and especially in remote areas, service levels drop off dramatically. Compared to the rate of service use in capital cities, 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.

	2007				2008				2009			
	Total services	**No. of persons**	**% of persons**	**Rate (per 1,000)**	**Total services**	**No. of persons**	**% of persons**	**Rate (per 1,000)**	**Total services**	**No. of persons**	**% of persons**	**Rate (per 1,000)**
Region												
Capital cities	1,896,265	477,597	67.2	35.2	2,643,794	632,343	66.5	45.8	3,220,794	740,953	65.5	53.7
Other metropolitan centres	227,686	62,255	8.8	36.7	322,010	83,489	8.8	48.3	406,611	101,922	9.0	59.0
Rural centres	320,730	92,461	13.0	35.0	461,935	127,506	13.4	47.5	577,181	155,054	13.7	57.6
Other rural areas	231,182	71,572	10.1	28.5	334,895	98,863	10.4	38.9	427,534	120,434	10.7	47.3
Remote areas	17,585	6,954	1.0	12.7	23,966	9,253	1.0	16.6	31,828	12,012	1.1	21.5

Data is for all MBS Better Access services which include GP mental health item numbers (2710, 2702, 2712 and 2713), consultant psychiatry item numbers (296, 297, 299, 291 and 293) and allied mental health item numbers (80000-80170).

Region based on RRMA classification.

Source: Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative – Component B: An Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) administrative data.

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INQUIRY INTO FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

5 September 2011

Question No: 3

Topic: E-mental Health Advisory Group

Hansard Page: 24

Senator Moore asked:

Can we get on notice the members of that advisory group as well. We just want to know who is on groups; that is really useful.

Answer:

The members of the e-Mental Health Advisory Committee, which is chaired by the First Assistant Secretary, Mental Health and Drug Treatment Division, Department of Health and Ageing, are:

Professor Helen Christensen
Professor Gavin Andrews
A/Professor Judy Proudfoot
A/Professor James Bennett-Levy
Dr Jane Burns
Professor Pat Dudgeon
Dr Maggie Jamieson
Mr Ryan McGlaughlin
Ms Dawn O'Neil
Mr Evan Bichara
Ms Margaret Springgay
Ms Rachel de Sain (Technical Advisor)

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5 September 2011

Question No: 4

Topic: ATAPS – discontinuity of care

Hansard Page 20

The Committee asked:

CHAIR: If I could add to that, there were also comments about people not being in the zones or the divisions the practitioners were working in and therefore being excluded. They may have been treating somebody and when that person moved to ATAPS they could not continue care. So there is also the argument about discontinuing care where the practitioners were not in a particular area that the division covered.
Senator MOORE: That was in evidence from psychologists at the last hearing as well, so it would be very useful for us as a committee if we could, as quickly as possible—and I apologise for putting that pressure on you—get a specific comment about those statements. We are interested because we have not heard that before.

Answer:

There are two different situations captured in these questions about discontinuity of care, one where a client moves to a new geographic region and the other where a client moves between receiving services under Better Access and ATAPS.

Where a client moves to a new geographic region they may also move into a different Division of General Practice (or Medicare Local) region, which may have a different set of approved providers under ATAPS. In general, Divisions of General Practice are able to accommodate a new person moving into their area who needs continued services under ATAPS, but the person would need to see an allied health provider employed or contracted by that Division. This may lead to an experience of discontinuity of care, even with an appropriate handover from the initial provider to the new provider. On the other hand, the person will be seeing someone who is likely to be closer to their new residence.

The ATAPS operational guidelines do not allow a client to be transferred from Better Access to ATAPS to receive more services once they have reached their full entitlement a year or for the purposes of receiving more services a year. Therefore where a client who previously received services under Better Access is at a later date referred to ATAPS they may have a new referral for a different mental health episode and/or significant change in circumstances and are likely to be seeing a different provider. This may lead to an experience of discontinuity of care, even with an appropriate handover from the previous provider to the new provider.

As a universal Medicare program the scale of service provision under Better Access is significantly greater than that under ATAPS. Consequently there are far fewer providers

employed or contracted by Divisions under ATAPS than there are providers approved to provide services under Better Access by Medicare Australia. This means there is a likelihood that a client who had been seeing a provider under Better Access would not be able to see the same provider under ATAPS.

There is variation across Australia in the business model used by Divisions of General Practice in ensuring the provision of ATAPS services in their area. Many Divisions, particularly in rural areas, directly employ clinicians, making it less likely that they would be able see the same provider under both Better Access and ATAPS.

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HEALTH AND AGEING PORTFOLIO

INQUIRY INTO FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

5 September 2011

Question No: 5

Topic: ATAPS – inability of practitioners to survive on the amount of money they make out of ATAPS, and young less trained psychologists engaged and experienced psychologists not taking part.

Hansard Page 20

The Committee asked:

Senator MOORE: Another complaint is the inability of practitioners to survive on the amount of money they make out of ATAPS. It would be interesting to get some comment from the department about that. We have heard in evidence and in submissions, as recently as this morning from the Butterfly organisation, that they seriously looked at ATAPS as an alternative and that that seemed to be the natural alternative for people who have financial constraints as there is no copayment with ATAPS, but the feedback they get from providers is that they cannot survive on the money they receive out of ATAPS. Does the department have any evidence that practitioners are not participating in the ATAPS scheme because they cannot afford to?

Ms Harman: I am not aware of any, but we will look into that.

CHAIR: You will take that on notice?

Ms Harman: We will.

Senator MOORE: Could you give us any data at all in that area? ATAPS has not been addressed in many submissions but, in the ones where it has, that is the argument put by anyone who is opposed to it. While no-one doubts the effectiveness of providing targeted assistance to people who have financial or locational disadvantage, the argument is that practitioners will not take part and therefore they do not get quality service.

Ms Harman: We will look into that. As I said, there is a significant funding boost going into the program so perhaps that might mitigate that, if that is happening.

Senator MOORE: That would be lovely and, if you would not mind, would you look specifically at the evidence from some of the psychologists—I forget which psychologists gave this evidence at the last hearing; we are hearing from many of them. One of the specific allegations was that young, less trained people were servicing ATAPS and experienced, 'quality' psychologists—whatever that means—were not taking part in the system. If you have any information about the comments people have made it would be very useful for the committee.

Answer:

The Department is not aware of practitioners declining to take part in the provision of ATAPS services because they cannot survive on the money they would receive out of ATAPS. However, the Department does get regular representations from clinicians and clinical services wishing to provide services under ATAPS but who are refused as Divisions already have sufficient providers to meet local needs, or directly employ allied health professionals to provide ATAPS services.

Under the ATAPS program, Divisions of General Practice (transitioning to Medicare Locals as they are established and demonstrate capacity to deliver mental health services) receive funding to purchase the allied health services necessary to deliver ATAPS services. The method of purchase (eg: fee-for-service or direct employment) and the level of funding under these options is a matter for the Division of General Practice as the fundholder. Where there is a contract, the contract rate is a matter between the practitioner and the Division of General Practice.

Divisions of General Practice are required however to ensure that allied health professionals who deliver services under the ATAPS program meet appropriate standards. Under the operational guidelines for ATAPS it is a requirement that allied health professionals should:

- be appropriately qualified,
- registered by an appropriate authority to practise (where registration exists), and/or (where the profession does not have registration), members of a professional body with ethical and professional guidelines;
- have continuing involvement in relevant professional development; and
- must have undertaken rigorous training in cognitive-behavioural therapy and be competent in the delivery of these therapeutic techniques when treating people with mental disorders.

In addition, each Division of General Practice is required to ensure there are relevant clinical supervision, performance monitoring and review arrangements in place for all providers.

In meeting these quality requirements, Divisions of General Practice have adopted a range of locally appropriate ways of engaging suitably qualified and experienced clinicians under the ATAPS program. Many Divisions, particularly in rural areas, directly employ clinicians. This is particularly true in areas where there is low utilisation of the Better Access items, which is often associated with a lack of private providers. It is the Department's understanding that difficulties experienced by Divisions in employing allied health providers tend to be associated with rural areas and areas where there is a small or scarce allied health provider workforce to draw upon. It is in these areas that it is most likely that the available workforce will be younger and less experienced.

In metropolitan and surrounding areas there is more likely to be an established workforce of allied health professionals to draw upon and Divisions either employ or contract a range of providers. While the remuneration under these arrangements is decided between the Division and the allied health professional, there is a natural tension under a capped program between spending more per session and maximising the number of services to these hard to reach groups. The Department supports Divisions in seeking to deliver value for money services while maintaining both effectiveness and quality standards.

Where Divisions of General Practice contract allied health providers, the volume of work has a bearing on provider remuneration as it is dependent on the number of referrals and how many other allied health providers these are spread across. Contracted allied health providers may not find that the volume of referrals under ATAPS meets their expectations. Some Divisions have indicated that some contracted providers have expressed unhappiness with the volume of referrals, though this is anecdotal.

Following the recent ATAPS Review, the Department has put in place further measures to ensure that clinical quality and governance standards are maintained and supported in the program. This year improved reporting on clinical governance and quality arrangements has been introduced under ATAPS contracts, and in the coming year funding has been provided for the development of improved purchasing guidance, and national support structures on clinical governance and quality assurance. Quality of services is important and the Australian General Practice Network (AGPN) has been engaged to develop a nationally consistent

framework to guide the further development of local clinical governance arrangements, resources and supporting materials and to work with Divisions and Medicare Locals to assist them implement the arrangements.

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INQUIRY INTO FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

5 September 2011

Question No: 6

Topic: Inquiry into Funding and Administration of Mental Health Services

Hansard Page: 18

The Committee asked:

Senator MOORE: Is there any evidence that has been given to the department that 18 or between 10 and 18 sessions is enough to cure someone? You have just put on record some information about ongoing discussion about significant acute mental illness and all those things. The argument at the moment is between a maximum of 10 and a maximum of 18 under the Medicare system. What I have been trying to find out, and I am having some difficulty in doing so because it is very difficult question, is: we have evidence that a number of people go to a number of different appointments, but is there any evidence, or are there places we could find evidence, to say that 18 is the right number?

Answer:

In addition to the oral evidence provided (refer p 18 Hansard) which noted that the number of treatment sessions an individual might benefit from would depend on the individual, their diagnosis and other factors in their lives that could affect recovery, the Department provides the following information.

The Better Access initiative was introduced to address low treatment rates for high prevalence mental disorders such as depression and anxiety – particularly presentations of mild to moderate severity where short term evidence based interventions are most likely to be useful.

While some people with more complex or intensive care needs may benefit from psychological interventions under Better Access, the initiative was not designed to provide intensive, ongoing therapy for people with severe, ongoing illness.

The Tolkein II report[1] provides guidelines for optimal treatment protocols for mental disorders including the types of presentations targeted under the Better Access initiative such as depression and anxiety. Tolkein II suggests that the number of treatment sessions required will vary depending on the type of mental disorder, the level of severity, comorbidity and the patient's ability to engage in treatment. All following figures are for a 12 month clinical pathway.

For the high prevalence mental disorders such as depression and anxiety primarily targeted under Better Access, Tolkein II suggests that a combination of GP visits and between 4-10 sessions of Cognitive Behavioural Therapy (CBT) with a psychologist is generally adequate

[1] Footnote: Tolkein II Team. (2006) *Tolkein II: A needs-based, costed stepped care model for Mental Health Services.* Sydney: World Health Organization Collaborating Centre for Classification in Mental Health.]

for people with mild to moderate depression. For people with generalised anxiety between 4-9 sessions of CBT is recommended depending on the level of severity.

The same evidence suggests that people with other disorders such as Borderline Personality Disorder (BPD) or Eating Disorders require significantly more intensive, longer term therapy that is well beyond the scope of the Better Access initiative. Tolkein II suggests that people with BPD require several GP visits, fortnightly sessions with a psychiatrist and referral to state and territory government community mental health services for specialist psychological therapy interventions of up to 26 sessions. The treatment protocol for Eating Disorders suggests that up to 40 sessions of CBT may be required.

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INQUIRY INTO FUNDING AND ADMINISTRATION OF MENTAL HEALTH SERVICES

5 September 2011

Question No: 7

Topic: Cost of Mental Health Package and AMA analysis

Hansard Page: 22-23

The Committee asked:

It seems to be a clear assertion by the AMA that contradicts what you said [total funding provided in the budget for the *Delivering National Mental Health Reform* package] so would you take it on notice?

Answer:

The figures provided by the AMA differ from the Government's announcement of $1.5 billion for the *Delivering National Mental Health Reform* package as:

- in most cases, the AMA does not include 2011-12 measures outside the Health and Ageing portfolio;
- in most cases, the AMA does not include the fifth year of funding; and
- the AMA's figures are net of the redirection of $580.5 million (over five years) from the Better Access program.

The $1.5 billion is in addition to:

- 2011-12 measures that will result in additional spending on mental health, but whose cost were offset within existing resources (a total of $121.5 million over five years);
- measures that will result in additional spending on mental health, announced in the 2010-11 Budget or MYEFO for that year ($624.0 million over five years), which takes the total investment in mental health reform to $2.2 billion over the next five years.

The table at Attachment A sets out the *Delivering National Mental Health Reform* package funding by measure and the responsible agency.

Attachment A

2011-12 COMMONWEALTH MENTAL HEALTH PACKAGE

Measure title	Lead Agency	2011-12 ($m)	2012-13 ($m)	2013-14 ($m)	2014-15 ($m)	4 year total ($m)	2015-16 ($m)	5 year total ($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**
Coordinated care and flexible funding for people with severe and persistent mental illness 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**
Expansion of Support for Day to Day Living in the Community program 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**
Additional personal helpers and mentors and respite services 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**
Expansion of Access to Allied Psychological Services Additional psychological services to over 180,000 people from hard to reach groups through the expansion of the Access to	**DoHA**	**16.1**	**31.1**	**43.7**	**53.1**	**144.0**	**61.9**	**205.9**

Allied Psychological Services (ATAPS) initiative, including: • 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.								
Establishment of a single mental health online portal 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.	**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**
Health and wellbeing check for three year olds 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.	**DoHA**	**1.0**	**6.7**	**0.9**	**1.3**	**9.9**	**1.1**	**11.0**
Expansion of youth mental health (headspace) An additional 30 *headspace* sites, bringing the total number of sites to 90 to achieve national coverage by 2015-16. This initiative will support up to an estimated 72,000 young people each year once all 90 sites are operational.	**DoHA**	**13.5**	**22.5**	**34.9**	**61.4**	**132.3**	**65.0**	**197.3**
Early Psychosis Prevention and Intervention Centre (EPPIC) model – further expansion 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	**DoHA**	**2.9**	**23.0**	**44.9**	**70.8**	**141.6**	**80.8**	**222.4**

high risk of psychosis.								
Additional Family Mental Health Support services 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**
Australian Early Development Index (AEDI) – ongoing national implementation $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**
Social Engagement and Emotional Development survey of children aged 8 to 14 years $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**
National Partnership on Mental Health 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**
Increased employment participation for people with mental illness (+ substantial investment in *Building Australia's Future Workforce* package)	**DEEWR**	**1.0**	**0.3**	**0.3**	**0.3**	**2.0**	**0.3**	**2.4**

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								
Ensuring quality, accountability and innovation in mental health services		**2.1**	**2.6**	**2.4**	**2.6**	**9.6**	**2.5**	**12.2**
Establishment of a National Mental Health Commission 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**
Leadership in mental health reform – continuation $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 arrangements.	**DoHA**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Research funding 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**
Better Access Initiative – two tiered rebate for treatment plan session 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**

Better Access Initiative – cap allied health sessions to 10 from 12 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