Queensland Alliance
FOR MENTAL HEALTH INC.
Peak body for the mental health community sector

Queensland Alliance for Mental Health Response to Senate Community Affairs Committee

Inquiry into Commonwealth Funding and Administration of Mental Health Services

29 July 2011

INTRODUCTION AND BACKGROUND

Queensland Alliance for Mental Health is the peak body for the mental health community sector in Queensland. Queensland Alliance for Mental Health is an independent charity which represents over 200 community organisations working in mental health. Queensland Alliance for Mental Health envisages a community that values differences, promotes well-being and creates a sense of belonging. We aim to achieve this vision by influencing, connecting, strengthening and collaborating with our communities to improve mental health and well-being. Our membership is made up of a variety of organisations from all regions in Queensland, and ranges from large national organisations, to small, unfunded support groups in the community.

Queensland Alliance for Mental Health developed a draft response to each of the inquiries terms of reference and distributed this to members for comment. This document incorporates the additional feedback and comments provided by members.

RESPONSE TO EACH TERMS OF REFERENCE FRO ENQUIRY

Commonwealth Funding and Administration of Mental Health Services

On 22 June 2011 the Senate referred the matter of '*Commonwealth Funding and Administration of Mental Health Services'* to the Senate Community Affairs Committees for inquiry and report. The Committee has welcomed submissions until 29 July 2011, with the report due 20 September 2011 (extension granted from 16 August 2011). Queensland Alliance for Mental Health has responded to each of the Terms of Reference below.

Terms of Reference

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

Queensland Alliance for Mental Health would like to congratulate the Commonwealth Government, and particularly Minister Butler's office on the following specific budget highlights:

- *Coordinated care and flexible funding for people with severe, persistent mental illness and complex care needs* – Queensland Alliance for Mental Health supports the investment into coordination of services for people with severe mental illness. We hold some concerns about the 'nationally consistent assessment process', given that it may duplicate existing processes without adding value, and that significant resources may be consumed in the development of the assessment tool, with little impact. There is also a risk that such a tool may simply become another barrier to service access, rather than achieving the goal of the initiative, which is to facilitate access. We also feel that such an assessment process may focus too much on medical/clinical issues to the exclusion of social factors. To ensure against this, we would want to see a range of relevant Departments contribute to the development of the tool with a focus on achieving access, rather than simply assessing needs.

  Standard tools are rarely culturally relevant and are typically based on western, medical models of mental health which can exclude or incorrectly report the needs of people from other cultural or languate backgrounds. Also, standard tools result in standard systems of application often not allowing the necessary flexibility to explore differences in understanding or the time for interpretation. For people who have come to Australia as refugees and experienced persecution as part of their refugee experience, they may present with mental health symptoms via a standard assessment tool, however, they may in fact be having normal reactions to extraordinary circumstances.

  Standard tools are often administered at the first point of contact with clients, and this is difficult for people who have experienced persecution or who are new to health services as a trusting relationship will need to be developed first. This can be as true for young people, Aboriginal and Torres Strait Islander people, women

prisoners and others with an experience of persecution or mist-trust of authorities, as well as those from refugee backgrounds. Without a trusting relationship, often there is no meaningful engagement with clients, thus negatively impacting the validity of universal assessment tools. The result can be both exclusion of those who need assistance, or over-estimation of the need for service. This outcome s reflected in state and national statistics with low numbers of people of CALD backgrounds' uptake of mental health services.

While there are benefits of standards assessment tools, such as consistency in data and reporting, the rights of consumers to access a confidential service is essential. Should a nationally consistent tool imply sharing information across professions, this needs to be considered alongside the consumers' rights to a confidential service.

Any tool should be developed to be delivered in the community by staff with experience in mental illness and a range of qualifications rather than a specific clinician such as a psychologist or mental health nurse or within the confines of a GP office. Some members express concerns that if services go to Medicare Locals there will be a strong clinical focus and lack of a community based response to coordination. There is a potential conflict of interest here if Medicare Locals are funded for ATAPS, and similar conflicts may exist with community organisations undertaking assessment that also deliver other mental health community support programs. Any organisation undertaking these assessments must demonstrate their ability to connect with local community services (not just mental health or health services) and most importantly demonstrate an understanding of, and commitment to, principles of Recovery.

The Commonwealth Government must work closely with a diverse range of stakeholder groups and peak bodies over the next 12 months to consider these issues in the development of an assessment tool.

- *Expanding community mental health services via increased investment to Personal Helpers and Mentors and Respite services* – Queensland Alliance for Mental Health supports increased investment into these two highly valued programs. We would argue that consideration be given to ensuring that the $50 million allocated to support people with a mental illness on the Disability Support Pension, be directed to high performing specialist mental health employment support services, as these services and organisations have a specific skill and expertise. At the same time we acknowledge there are not many mental health specialist agencies and many existing PHAMs providers also have employment services within their scope, and could deliver positive outcomes.
- *Expansion of ATAPS* – Queensland Alliance for Mental Health supports the increased investment into ATAPS, as long as measures are introduced to ensure that the program supports the hard to reach, vulnerable and marginalised populations it was intended to reach. We particularly highlight the need for improved access to people from non-English speaking backgrounds, and the establishment of quarantined funds for interpreting services. Please see our comments at c) below.
- *A National Partnership Agreement on Mental Health* – Queensland Alliance for Mental Health supports the push for States and Territories to identify and address gaps in service delivery, particularly around accommodation support, and the process of transition between service providers, most importantly from public mental health services to community-managed mental health services.
- *Establishment of a National Mental Health Commission* – Queensland Alliance for Mental Health strongly supports the establishment of the Commission, which we expect to play a lead role in driving transparency and accountability in the mental health system, resulting in better outcomes for people with a mental illness and their families and carers.

b. Changes to the Better Access Initiative, including:

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

Queensland Alliance for Mental Health supports the rationalisation of GP mental health services. Within an environment of finite resources, we believe the reinvestment of savings generated from these changes, to alternative programs that target hard to reach populations and support the coordination of services for people with severe and persistent mental illness, will deliver better outcomes for people with mental illness and their carers.

From 1 November 2011, the rebate for the development of GP Mental Health Treatment Plans will reflect, more accurately, the actual time spent preparing the Plan. The rebates will vary depending on length of consultation, and whether a GP has completed Mental Health Skills Training (MHST). For example, the rebate, for a GP who has completed Mental Health Skills Training is currently $163.35. This will reduce to $85.92 for a consultation lasting between 20 and 39 minutes, and $126.43 for a consultation lasting longer than 40 minutes.

There will also be changes to the rebates for other GP Mental Health MBS items. From 1 November 2011, the rebate for the GP Mental Health Review (MBS Item 2712) and the GP Mental Health Consultation (MBS Item 2713) will both be $67.65. See table below:

GP Mental Health Item	**Rebate until 30 Oct 2011 (currently untimed)**	**Rebate from 1 Nov 2011 (consult 20 – 39 mins)**	**Rebate from 1 No 2011 (consult > 40 mins)**
GP MH Treatment Plan (MBS 2710) – for GPs with MHST	$163.35	$85.92	$126.43
GP MH Treatment Plan (MBS 2702) – for GPs without MHST	$128.20	$67.65	$99.55
GP MH Review (MBS 2712)	$108.90	$67.65	
GP MH Consultation (MBS 2713)	$71.85	$67.65	

The Commonwealth used data from the 'Bettering the Evaluation and Care of Health' (BEACH) Project and Medicare to support their rationalization. This data indicated:

- The median consultation length for a GP Mental Health Treatment Plan was 28 minutes;
- Over 80 per cent of Plans were being completed in less than 40 minutes; and
- 18.5% were being completed in less than 20 minutes.

The new time-based rebates are consistent with most other time-based items and give billing options to GPs based on how long they need to spend with a patient developing a plan.

Queensland Alliance for Mental Health recognizes that this rationalisation may impact negatively on GPs with the reduction in rebates, particularly given that many GPs bulk bill the preparation of a Mental Health Treatment Plan. Queensland Alliance for Mental Health would not like to see a situation where GPs charge well above the scheduled fee, in order to maintain the current level of income. We would therefore recommend some monitoring of what additional charges may arise and any change in access for people with mental illness to GP services.

ii. The rationalisation of allied health treatment sessions,

Queensland Alliance for Mental Health supports the rationalisation of allied health treatment sessions. Within an environment of finite resources, we believe the reinvestment of savings generated from these changes, to alternative programs that target hard to reach populations and support the coordination of services for people with severe and persistent mental illness, will deliver better outcomes for people with mental illness and their carers.

From 1 November 2011, Medicare rebates for allied health services under the Better Access Initiative will be capped at ten individual mental health services, and ten group mental health services per calendar year. Currently, people with a diagnosed mental illness are eligible for up to 12 individual and/or group services in a calendar, with the allowance of an additional six sessions, in exceptional circumstances.

The proposed cap of ten sessions is made up of an initial course of treatment (a maximum of six sessions), with access to up to four more sessions in exceptional circumstances.

Queensland Alliance for Mental Health acknowledges that this rationalisation may be seen to impact negatively on allied health providers, and more importantly consumers. In reviewing the Evaluation of the Better Access Initiative[i], we note that almost three quarters of people who had an allied mental health service, accessed between one and six services. The median number of Better Access sessions accessed by consumers was five, when the maximum allowable was 12 plus an additional six in exceptional circumstances. Queensland Alliance for Mental Health would like to see an environment where people are not restricted in the number of sessions that are available to them, but instead are free to access the right provider, at the right price, for as many sessions as they need. Within this tight fiscal environment however, this is not possible. We believe that although there are people who are likely to require more than the maximum allowable number of sessions, there are alternative programs, such as the ATAPS Program, targeting people with severe and persistent mental illness and complex care needs, that may be more suitable.

Members of Queensland Alliance for Mental Health, particularly those representing women prisoners and people from culturally and linguistically diverse backgrounds, raised the issue of gap fees, and the challenge many people with low incomes face accessing these services as a result. While it is acknowledged that ATAPS seeks to provide access to people who cannot afford to pay gap fees, ATAPS does not meet all these needs.

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

Already responded above.

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;

Already responded above.

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

Queensland Alliance for Mental Health would like to comment on the access issues that people from culturally and linguistically diverse backgrounds experience when trying to access ATAPS services. Data captured in the National ATAPS Minimum Dataset shows that less than 1% of consumers who accessed services '*spoke a language other than English at home*', or rated their English level as '*not well*' or '*not at all*'. In Queensland, 17.9% of the population are overseas born[ii], with about half of these being from non English speaking countries. In another related statistic, 7.8% of the Queensland population speak a language other than English at home[iii]. With less than 1% of people accessing ATAPS identified as coming from a culturally and linguistically diverse background, there are clearly a number of barriers encountered by this population.

In a paper prepared by a coalition of Queensland non-Government and Government multicultural health and mental health services[iv], a number of barriers to access are identified. These include:

- Lack of specific funding for interpreters. Currently, funding to cover interpreter services must come from the service delivery component of the ATAPS budget. With a finite ATAPS budget, this means that consumers receive less services, which means, in many cases, that fund holders are reluctant to allocate funding to interpreter services.;
- Inconsistent models of ATAPS implementation across Divisions of General Practice means that there is

inequitable access to services across Queensland. Some Divisions of General Practice have identified people from culturally and linguistically diverse backgrounds as a priority for their region, whilst other areas have prioritized other groups;

- Health professionals' (both GPs and allied health providers) lack of knowledge and confidence in assessment, diagnosis and interventions in a cross-cultural context. As an example, GPs are often unable to identify a mental health issue where the consumer is unable to express their needs in a language or cultural framework that is understood by the GP. This may result in: under or over diagnosis; misdiagnosis e.g. psychological symptoms being treated as physical ailments; or treatment inconsistent with the client's wishes or beliefs.
- Health professionals' (both GPs and allied health providers) lack of knowledge and confidence in working with interpreters, particularly within a counseling context. As an example, if an inappropriate interpreter is used, symptoms and experiences may be exacerbated rather than relieved, as trauma may be re-triggered by using an interpreter from an ethnic group associated with persecution.

Queensland Alliance for Mental Health would like to see, at a minimum, that Divisions of General Practice, and Medicare Locals, are required to be more accountable to the communities that they are meant to support. We would also advocate for increased funding to community based mental health services who already provide services to people from culturally and linguistically diverse backgrounds. These services are best placed to deliver mental health counselling, which is incorporated into the other necessary wrap-around services that are provided to their clients.

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

Queensland Alliance for Mental Health welcomes the recent budget announcement to support coordinated care and flexible funding for people with severe, persistent mental illness and complex care needs. As stated in response a) above, we have some concerns about the 'nationally consistent assessment process', but we are planning to work with the Commonwealth, and the community mental health sector in Queensland, to guide this work. Again we would raise the specific needs of particular populations, who may not receive equitable access unless some specialist services are developed.

e. Mental health workforce issues, including:

i. The two-tiered Medicare rebate system for psychologists,

Queensland Alliance for Mental Health is not in a position to comment whether this two-tiered Medicare rebate system for psychologists is fair and based on sound principles, nor can we provide any evidence which suggests that people receive better treatment by those psychologists with additional training (ie clinical psychologists).

We would however comment that anecdotally, people incur higher out-of-pocket expenses when they access services from a generalist psychologist, as compared to a clinical psychologist. Again, anecdotally, we understand this is due to the lower rebate received by generalist psychologists, which in turn dictates that they need to charge a higher fee in order to keep their business viable. As an example, the rebate for a long consultation (> 50 mins) delivered by a clinical psychologist is $119.80, whereas the rebate for a long consultation delivered by a general psychologist is only $81.60. In practice, this means that the general psychologist needs to charge significantly higher than the rebate in order to cover costs, which therefore means that consumers pay a greater gap fee when accessing a general psychologist.

Data collected by the Commonwealth in 2008 indicated that the average out-of-pocket expense for a consumer accessing a long consultation with a clinical psychologist was $25.56 (in capital city and metro areas). The out-of-pocket expense for a consumer accessing a long consultation with a general psychologist was $33.05 (in capital city and metro areas). Keeping in mind that this out-of-pocket expense is incurred for every session, this means that consumers could potentially incur costs of around $198.30 for six sessions with a general psychologist, when they only incur $153.36 for six sessions with a clinical psychologist.

Queensland Alliance for Mental Health would recommend that these rebates need reviewing, to ensure that the rebate system does not create additional costs for consumers who choose to see a general psychologist.

ii. Workforce qualifications and training of psychologists, and

No comment.

iii. Workforce shortages;

No comment.

f. The adequacy of mental health funding and services for disadvantaged groups, including:

i. Culturally and linguistically diverse communities,

Already responded above.

ii. Indigenous communities, and

Queensland Alliance for Mental Health acknowledges the high levels of non-specific psychological distress reported by Indigenous Australians[v]. Of particular note is the alarmingly high rates of serious psychological distress, which are twice that of non Indigenous Australians[vi]. Serious psychological distress is considered to be a global indicator of poor social and emotional wellbeing, and an independent predictor of reduced life expectancy, greater incidence and prevalence of disease, increased behavioural risk factors for ill health, and lower overall health status[vii].

Currently, there are varying levels of access to mental health services for Indigenous communities. Twenty five percent of Indigenous Queenslanders live in rural and remote areas of Queensland, where access to mainstream services is sporadic, and access to specialist services is virtually non-existent. The large majority of the Queensland Indigenous population live in urban centres, which would also benefit from specialist, Indigenous, integrated mental health services.

Aboriginal and/or Torres Strait Islander people comprise 3.27% of the Queensland population[viii]. Given the higher leves of distress and the social determinants of mental illness, it is reasonable to assume a greater need for service from Aboriginal and/of Torres Strait Islander people to mental health services through Medicare. However data from the University of Melbourne identifies that since July 2003 only 3% of those accessing the ATAPS program are of Aboriginal or Torres Strait Islander heritage. This data evidences the more limited access to these primary mental health care programs, even when there is no gap fee to pay.

Queensland Alliance for Mental Health would like to see a number of specialist, integrated services funded across the State, to ensure that Indigenous people have access to social and emotional wellbeing and primary mental health care services, when and where they need them. We believe these services could best be delivered through, or well connected with, Aboriginal Community Controlled Health Services.

iii. People with disabilities;

Queensland Alliance for Mental Health acknowledges that people who have multiple needs or comorbidities have significantly greater difficulty accessing services than those people who fit neatly into a single service system. People with a dual diagnosis of mental illness and intellectual disability are among Australia's most disadvantaged people, who in many cases cannot access treatment for their illness, and also fail to receive support for their disability. People with this dual diagnosis will face a range of additional barriers that other people don't experience, and these additional barriers stem from the service system, rather than the person with a disability.

In order to account for these additional barriers, Queensland Alliance for Mental Health would like to see that service providers, across all health systems, are required to regularly engage in multi-disciplinary and cross-sector education events. This will facilitate an increased awareness of the needs of people with comorbidities, as well as an increased awareness of the role of other service providers within the broader health system. At a basic level, we want to ensure that service providers see this group of people as a priority, not a problem group that they refer onto another provider. On top of this, we would also like to see specific programs established that address these specific issues.

iv. Women prisoners;

Queensland Alliance for Mental Health highlights the increasing rates of imprisonment of women across the state, and in particular the over-representation of Aboriginal women who are criminalised and have serious mental health concerns. There are very limited community mental health services available for women leaving prison, and the lack of access to community support on mental health in the first place can lead to criminalisation of women.

g. The delivery of a national mental health commission;

Queensland Alliance for Mental Health supports the establishment of a National Mental Health Commission. With core functions of providing cross-sectoral leadership, driving transparency and developing and monitoring the implementation of the 10 Year Roadmap for Mental Health Reform, we believe there is significant potential for greater accountability and increased priority given to mental health with the creation of this agency.

Queensland Alliance for Mental Health highglights the need for meaningful consumer and carer participation in the establishment of a National Mental Health Commission and the inclusion of people with lived experience and their families in the composition of Commissioners.

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

Although we have no specific evidence on the impact of online services for people with a mental illness, Queensland Alliance for Mental Health supports the promotion and use of online strategies to support people with mental illness, particularly those living in rural and remote areas across Queensland. We think that online services should cover the entire spectrum of interventions, including promotion, prevention, early intervention, treatment and recovery, and should utilise a number of different social media vehicles. Members of Queensland Alliance for Mental Health also note that on line services do not benefit those with language or literacy issues, and those without internet access. Consideration could be given to funding community outreach activities for those populations to ensure an equitable outcome.

i. Any other related matter.

No comment.

[i] Pirkis, J., Harris, M., Hall, W. & Ftanou (2011) *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative – Summative Evaluation***,** Centre for Health Policy, Programs and Economics, Melbourne.

[ii] Queensland Government (2008) *Queensland Characteristics: A State Comparison*, Office of Economic and Statistical Research, QLD.

[iii] Queensland Government (2008) *Queensland Characteristics: A State Comparison*, Office of Economic and Statistical Research, QLD.

[iv] QPASTT, MDA, Harmony Place, ACCES Services, Multilink, ECCQ, MCCGC, QTMHC, and QH Multicultural services (2011) *Making Mental Health programs Accessible and Effective for People of Culturally and Linguistically Diverse Backgrounds*, Queensland.

[v] Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009) *Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People,* Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

[vi] Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009) *Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People,* Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

[vii] Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009) *Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People,* Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

[viii] Australian Bureau of Statistics *Census 2006* Canberra: ABS.