



COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Commonwealth funding and administration of mental health services

(Public)

MONDAY, 5 SEPTEMBER 2011

CANBERRA

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SENATE
COMMUNITY AFFAIRS REFERENCES COMMITTEE
Monday, 5 September 2011

Senators in attendance: Senators Boyce, Fierravanti-Wells, McKenzie, Moore, Siewert and Wright.

Terms of reference for the inquiry:

To inquire into and report on:

The Government's funding and administration of mental health services in Australia, with particular reference to:

- (a) the Government's 2011-12 Budget changes relating to mental health;
- (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
 - (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;
- (c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
- (d) services available for people with severe mental illness and the coordination of those services;
- (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;
- (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;
- (g) the delivery of a national mental health commission; and
- (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
- (j) any other related matter.

WITNESSES

BARTLETT, Mr Richard, First Assistant Secretary, Medical Benefits Division, Department of Health and Ageing	7
BLACK, Mr Quentin, Secretary, Psychologists Association (South Australian Branch)	40
BOOTH, Mr Keiran, Carer Co-Chair, National Mental Health Consumer and Carer Forum.....	46
GOLIGHTLY, Ms Malisa, Deputy Secretary, Health and Older Australians, Department of Human Services	7
HAMBLETON, Dr Steve, Federal President, Australian Medical Association	73
HARMAN, Ms Georgie, First Assistant Secretary, Mental Health and Drug Treatment Division, Department of Health and Ageing	7
HICKIE, Professor Ian Bernard, Executive Director, Brain and Mind Research Institute, University of Sydney	65
HUXTABLE, Ms Rosemary, Deputy Secretary, Department of Health and Ageing	7
LOVEGROVE, Mr David, Deputy Consumer Co-Chair, National Mental Health Consumer and Carer Forum	46
LOWREY, Ms Phillipa, Acting Assistant Secretary, Mental Health Early Intervention and Prevention Branch, Mental Health and Drug Treatment Division, Department of Health and Ageing	7
McGORRY, Professor Patrick Dennistoun, Private capacity	65
McMAHON, Ms Janne Christine, Independent Chair, Private Mental Health Consumer Carer Network (Australia).....	53
MIGLIORINO, Mr Pino, Chair, Federation of Ethnic Communities Councils of Australia	58
MORGAN, Mrs Christine, Chief Executive Officer, Butterfly Foundation.....	1
MULLINGS, Mr Benjamin Luke, Chair, Association of Counselling Psychologists	87
NICHOLLS, Ms Fiona, Assistant Secretary, Mental Health Services Branch, Mental Health and Drug Treatment Division, Department of Health and Ageing	7
NIPPRESS, Mr Adrian, Industrial Officer, Psychologists Association (South Australian Branch)	40
PARHAM, Ms Jennie, Principal Network Adviser, Mental Health, Australian General Practice Network	32
QUINLAN, Mr Frank, Chief Executive Officer, Mental Health Council of Australia	81
SINGH, Mr Alan, Assistant Secretary, Mental Health System Improvement Branch, Mental Health and Drug Treatment Division, Department of Health and Ageing	7
SULLIVAN, Mr Francis, Secretary General, Australian Medical Association	73
TOMASIC, Dr Maria, President, Royal Australian and New Zealand College of Psychiatrists.....	25
TUSTIN, Mr Don, Coordinator of Private Practitioners, Psychologists Association (South Australian Branch)	40
WELLS, Ms Leanne, Chief Executive Officer, Australian General Practice Network.....	32

MORGAN, Mrs Christine, Chief Executive Officer, Butterfly Foundation

CHAIR (Senator Siewert): I declare this public hearing open and welcome everyone who is present today. The Senate Community Affairs References Committee is inquiring into the funding and administration of mental health services. Today is the committee's second public hearing for this inquiry. Welcome. Mrs Morgan, I am pretty certain that you know the issues and information about parliamentary privilege and the protection of witnesses.

Mrs Morgan: I do, yes.

CHAIR: If you need a bit of reminding, there is information available. Do you have any comments on the capacity in which you appear today?

Mrs Morgan: I am also the National Director of the National Eating Disorders Collaboration.

CHAIR: We have your submission, No. 190. I invite you to make an opening statement and then—I am sure you know the drill—we will ask you questions.

Mrs Morgan: Thank you very much, and thank you for the opportunity to present to you today. My focus will be on the impact of the recent changes to the Better Access scheme on those seeking treatment for an eating disorder and on our request for the restoration of 18 sessions rather than relying on access under ATAPS.

The Butterfly Foundation is Australia's national non-government organisation representing eating disorders. We seek to raise awareness of this illness, support those who are affected, support research and professional development and advocate for accessible treatment services for all. We are committed to changing the way eating disorders are perceived and treated in the community and to raising the issue as a major health concern.

As I mentioned, Butterfly also manages the federally funded National Eating Disorders Collaboration, which brings together clinicians, researchers, those with a lived experience, teachers, counsellors and others with an interest in eating disorders from across the country. We now have over 250 members of the NEDC, and later this month we will be delivering to the Department of Health and Ageing a national schema for the prevention and treatment of eating disorders. Our charter is to be a nationally consistent, evidence based voice for eating disorders in Australia. Two hundred and fifty does not seem too many, particularly when I know that some of the organisations that have presented to this inquiry represent thousands of members, but we actually see it as being a large number, and that is indicative indeed of those who are involved in the eating disorders sector in Australia. Those involved, particularly at a clinical level and at a research level, are disproportionately small in numbers compared to the incidence of the illness itself, and that is one of the major challenges that we face.

I would like to open with a brief overview of an eating disorder. I think this is relevant as it sets the scene for what I believe are some special needs of our illness and our sector. Contrary to popular belief, eating disorders are not a lifestyle choice. They are complex mental illnesses that cause serious medical complications. They strike at any age and across gender and socioeconomic lines, peaking in adolescence. As such, they strike at the very heart of our youth's potential. How frequent are they? On the most recent estimates, 15 per cent of Australian women will have an eating disorder episode of clinical severity in their lifetime. Across the total population, the incidence is currently reported at around three per cent, but this is increasing, partly due to more people presenting for a diagnosis and partly due to an increase in incidence itself. One in 10 sufferers is male, and anorexia nervosa is the third most common chronic disorder affecting young women.

Eating disorders are diagnosed using psychiatric diagnostic criteria. They include anorexia nervosa, bulimia nervosa, binge-eating disorder and those with an atypical presentation. The causes are still being researched, but we do know that a sufferer is likely to have both genetic and psychological vulnerabilities that, as with other mental illnesses, will be triggered by social and environmental factors. A sufferer of an eating disorder will engage in extreme eating and exercise behaviours that are fuelled by underlying psychological disturbances. They are life threatening. Some of the medical complications they cause include loss of bone density, cardiac abnormalities, infertility, electrolyte disturbance and hypertension. Anorexia nervosa has a lifetime mortality rate up to 20 per cent higher than for any other psychiatric disorder. Eating disorders last for a long time. Even with treatment an eating disorder takes an average seven to nine years before a person is in recovery. They have a high cost. When measured in what is known as disability adjusted years, anorexia nervosa and bulimia nervosa are respectively the 10th and eighth leading causes of burden of disease and injury in young women, if you are looking at the 15- to 24-year range. Most disturbingly, anorexia nervosa has a suicide rate 32 times higher than that for those not suffering, and for bulimia nervosa the rate is 18 to 20 times higher. I will pause there in my statement to say that just last month I had an opportunity to sit with a guy called Barry in Sydney—Barry and his

former wife Judy have given me permission to mention them—and he was talking his daughter, Alana, who from the age of 14 has battled with anorexia nervosa. Barry had only recently been able to bring himself to admit that she actually had the illness; I think he came to grips with that earlier this year. He was reminiscing about her and he said she was a very high achiever who had studied in Japan as well as in Australia. She had been in and out of hospital over the years. At her most recent admission, which was very recently, she had a BMI of less than 15. One of the things she struggled most desperately with was the fact that it would take so long for her to get well and also the fact that it kept coming back. She checked herself out of hospital just a few weeks ago and later that afternoon her mother was called to the police station to identify her. She did not make it.

A disturbing characteristic of someone with an eating disorder is that they are likely to resist diagnosis and treatment. It is their way of coping. It is unlike a physical ailment where, when you get diagnosed with, say, cancer, the first thing you want to do is find a treatment. For those with an eating disorder, part of the whole session of trying to work with them and help them is to convince them that they can let go of it. As such, they require specialist treatment. The national schema that we will be handing to the government at the end of this month will state that at every point of treatment in a continuum of care it is essential that there be access to specialist knowledge and experience. It is not an illness that can be learned from a textbook. It requires specialist training, a patient and compassionate heart and manner, and experience with patients.

At this stage, as I mentioned earlier, there are alarmingly few clinicians working in the sector. We require a multidisciplinary approach, which will include psychiatry, medical, dietetics, psychology, family therapy, specialist nursing and social work. It is critical that we not only retain the current expertise but grow it exponentially. Butterfly's experience working with local communities is that when stigma is reduced and awareness raised, the number of referrals for eating disorders increases. This is not surprising when we know that the current non-disclosure period for bulimia nervosa is still 10 years. For somebody to suffer in silence because they feel such a shame at coming forward and believe that they cannot really be helped, this is just about their willpower.

We recently worked with the local community in Tamworth, which is a regional hub in New South Wales. They only have two clinicians who work in the sector: a GP and a dietician. After six months of working in that sector there was an increased number of referrals but no more clinicians to go to. In New South Wales, which is my home state, we have three adult beds in public health for eating disorders—the current resources are just so scarce. So my appearance today on behalf of all of us in the eating disorders sector is to plead for you to address what we are sure is an unintended consequence of the recent changes to the Better Access scheme.

We currently have two treatment programs offered by specialist psychologists which have opened the way for treatment. Both have been funded under Better Access. They are evidence based programs: Maudsley family based therapy for those suffering anorexia nervosa and CBT for bulimia. They can be fitted into 20 sessions over a six- to 12-month period; we just got there in the 18 sessions under Better Access. Bringing it down to 10 is going to be just too few. We will have a situation where people will access it for half of the treatment, and it is probably better not to go at all than to go for half a session of treatment because you can just be abandoned halfway through.

The other option, I guess people would say, is: why not go under ATAPS? After discussions with ANZAED, which is the clinical peak body representing clinicians and researchers, Butterfly would accept what to us is unpalatable but a truth, and that is that the specialist clinicians who will offer these treatment programs are not permitted under ATAPS, as we know, to charge a copayment and without that copayment they face operating at a loss. They are treating very complex patients and they know they need to commit to them for 18 to 20 sessions at a minimum. They incur a great deal of cost for the courses and workshops et cetera they need to attend in retaining their area of specialisation. As I said, we have done a survey and the unpalatable truth is that if the only option is ATAPS then they will probably cease to offer the service. We need to be increasing what we have available for those suffering from median disorders. We have a long way to go. For us to face the loss of what has been a platform to date would just be shattering to those families that have at least had that access. While we fight for these essential and urgent improvements we would ask, please, that we be allowed to retain the current scheme.

CHAIR: I will just let Senator McKenzie know that Senator Boyce is here. Senator McKenzie was on board until Senator Boyce arrived, so that we could get started.

Senator MOORE: Your opening statement and your submission point out the argument you are making. I just want to clarify for the record who was being surveyed in your survey?

Mrs Morgan: The survey was conducted by the Australian New Zealand Academy of Eating Disorders, which is the peak body representing clinicians and researchers. When I say 'survey', that is probably using it in the

most colloquial sense; it was a request sent out by the president of ANZAED to members asking them about the impact of these changes and for responses received by him.

Senator MOORE: Are the members practitioners?

Mrs Morgan: Yes—

Senator MOORE: Is the survey actually of psychologists and researchers? It was not of people who are working through the issue of eating disorders.

Mrs Morgan: That is correct. The membership of ANZAED was at that stage about 150. I think it has gone up to just under 200. Interestingly, that probably represents the full range of people working in the field. Membership includes psychiatrists, GPs, paediatricians, psychologists, family therapists, dieticians and social workers.

Senator MOORE: I am interested in the fact that Better Access only really covers the psychologists and perhaps the social workers who have a particular interest. Did all the members in that survey had the same view?

Mrs Morgan: The responses were predominantly from those who were practising under Better Access. I think the others have just accepted the reality that there is nothing that they come under. So we just kind of work through that.

Senator MOORE: In terms of the information you have, and I know it is always difficult with numbers—you just have no idea. Your submission indicated that it is very difficult to quantify the issue. In fact, we could talk all day about whether it is increasing or whatever. Is it your understanding that most of the people who have identified and are seeking treatment use the full number of treatments.

Mrs Morgan: Absolutely. They are coming in for these treatments and the reason for that—and the reason we regard them as being evidence based—is that they are modularised. So there are actually two programs. There is a formal program that runs for the 20 sessions, whether it is under CBT for bulimia nervosa or the family based therapy for anorexia nervosa.

Senator MOORE: I am just putting all of this on record.

Mrs Morgan: Absolutely. That is to run it for 10 sessions only. It is so that if a family came forward and said, 'We can only afford to do it for 10 sessions,' you are really running the risk of somebody then being disengaged half way through a program. Perhaps a way of looking at it is that it would be similar to stopping a course of antibiotics halfway through.

Senator MOORE: So under the current process they would be prepared to make financial arrangements for the two extra sessions, and maybe more. You can never say just 20. They are able to financially cover any payment for the extra two, but the eight are what is under discussion?

Mrs Morgan: That is correct. But dropping it down to 10 would mean that they would need to find that cost. I guess it is the same argument as why we cannot go under ATAPS. The clinicians who are providing it are in that sector where they charge—I think the current rate is around \$200—per session.

Senator MOORE: Which is the higher rate?

Mrs Morgan: Yes.

CHAIR: If they charge a co-payment for those sessions, what is the value of the co-payment.

Mrs Morgan: I understand that they will cover \$120 per session under Medicare.

Senator MOORE: So it is about \$100 on average.

Mrs Morgan: Yes.

Senator MOORE: And under ATAPS a standard rate is worked out at each division level—

Mrs Morgan: Correct—

Senator MOORE: and that varies. But the practitioners in your survey have indicated that they would not be able to survive if they continued to operate in that way.

Mrs Morgan: I believe so. I do not have the exact figure. I can come back to you with it if you would like. But I believe it is a hundred and something under ATAPS.

Senator MOORE: That would be great if you would. It would be very useful in terms of boosting up the work that you have done in your organisation on these issues. Your recommendation is that Better Access is not changed for anyone, or that particular consideration is done in your particular area of need?

Mrs Morgan: That is correct. We would ask that it be retained for those who are offering these two programs.

Senator MOORE: So you are looking at a particular focus for the people you have identified through your organisation who have been underserved for a long time. Would that be a fair statement?

Mrs Morgan: Absolutely, while we work to see if we can get better coverage in many other ways.

Senator MOORE: And you are continuing to work with the government about an ongoing particular focus around the whole area of eating disorders. That is an ongoing discussion you are having.

Mrs Morgan: It is, very much so. It is so underresourced at the moment that it is really a case of: where do we start? So we would be seeking just to not go backwards.

Senator BOYCE: You mention the Maudsley family based treatment and its improved recovery rates. Are you able to give us a reference for that? Your submission did not mention where those statistics come from. I am looking at page 3 of your submission.

Mrs Morgan: If you go to the last pages, page 14 and 15, we do have some references there.

Senator BOYCE: Oh, I thought I had done that.

Mrs Morgan: I will certainly take that on notice and make sure we come back to you with the specific reference, but I believe it is included in those references on page 14. I will double-check that for you.

Senator BOYCE: On page 8 you talk about the waiting lists for public health psychology units. Are you able to perhaps put a bit more detail around that comment that the waiting lists are already long.

Mrs Morgan: That is a question that I myself have asked, and I am waiting back to hear back the numbers on it. I anticipated that that might be a question. I do not have a specific number for you, but I think the particular challenge we have with the public health psychology clinics is with both the expertise of the clinicians in relation to eating disorders and just the general waiting lists. I would be guessing at the waiting list numbers, but I can try and find out for you.

Senator BOYCE: Presumably that varies from state to state as well.

Mrs Morgan: It would indeed. For instance, in Sydney we have a clinic at RPA and at Westmead and at Sydney university.

Senator BOYCE: Do any of these public health units have specialists in anorexia nervosa?

Mrs Morgan: I know that the one at Sydney university has, because it is headed by a professor who has got a particular interest in eating disorders.

Senator MOORE: Longstanding.

Mrs Morgan: Yes. Professor Stephen Touyz has a very longstanding interest. So there might be some scattered expertise but, at this stage, within the actual disciplines when they study there are no specific learnings or teachings on eating disorders. It is something that they acquire usually post qualifications.

Senator BOYCE: You told us about your concerns about long-term effects if the Better Access program is removed from patients in this area. What do you see happening in practice? What do you think will happen if the Better Access program is not continued for people with eating disorders?

Mrs Morgan: There are those who are currently offering either of these two programs who have indicated to us that they will not be able to afford to do so, so they will cease offering those programs. That probably means that they will cease dealing in any way with patients with the eating disorders. So the current degree of expertise in the sector will diminish every time we have somebody dropping out. If we work on the basis that the membership of ANZAED is pretty indicative of everyone involved, then everyone that we lose is quite significant. The second potential consequence is that it will continue to be offered by a couple of practices around Australia but it will only be affordable for those who have the financial means to do so. So, once again, we will go back to I think how we were when eating disorders first started being treated back in the seventies and eighties, which is that it is seen as a wealthy person's illness because, unfortunately, those who can afford the treatment are those who have the financial means to do so. But we know that it strikes across all socioeconomic lines, so it will mean once again that those who do not have financial means will not be able to afford treatment.

Senator WRIGHT: In terms of the risk factors of someone only doing 10 sessions rather than the 20 sessions which are the usual component for the programs, you have drawn the analogy with stopping a course of antibiotics halfway through. It is quite a powerful analogy. Given the specific nature of this condition, can you tease out a little bit more why in your view it is not just an inadequate course of treatment but I think you have made the point that it is actually damaging and perhaps better not to have started at all. Can you clarify why that is?

Mrs Morgan: When you are treating somebody with an eating disorder you are dealing effectively with what I believe are three factors. You are dealing not only with the disturbed eating and possibly exercise behaviours, you are also dealing with the psychological disturbances underneath. Most importantly, overlying both of those is the state of change of the patient and their ability to engage with the treatment. I go back to the point I made in my oral submission, which is that a common attribute of somebody with an eating disorder is a disinclination to want to engage in treatment because it is very much a coping mechanism. So part of taking them through, for instance, 20 sessions of cognitive behaviour therapy is working with the patient to engage them and retain them in that appropriate moving through states of change so that they will actually get traction through the course of treatment and stay the full 20 modules, which then takes them to a point where they may have to come back for treatment later but they at least have finished a course of treatment which has helped take them through it. If you stop it after 10 sessions, halfway through, it is quite probable that they will relapse and go back fully into using eating disorders as a coping mechanism, and that also they will potentially then see that as 'I have a failed treatment'. One of the attributes of somebody with an eating disorder is very low self-esteem. They are often perfectionist people and they have very low self-esteem and any perception of failure will actually take them backwards.

CHAIR: I would like to go back to this issue of copayments. If I understand correctly, the families and the patients make a \$100 copayment each time, so we are talking about 20 sessions at \$100, which is \$2,000. I suggest to you that for low income families trying to find \$2,000 is very hard. What I would like to know if possible, if you have the figures, is what is the demographic of the people who are currently accessing the program. I suggest that even \$2,000 puts it way beyond the means of low income families and perhaps even some middle-income families.

Mrs Morgan: It certainly does. I would certainly agree with that. I will come back to you with the demographics as best I can find them. I would like to agree with you, as I say, on that. That is why I think that overall so much more is needed in terms of treatment for eating disorders. I am not by any means saying that this is a perfect situation we have at the moment, just that to take it away would take it away at least from those who have been able to access because of it.

CHAIR: I now go to the issue around ATAPS. To your knowledge, are any patients with an eating disorder accessing ATAPS at the moment?

Mrs Morgan: I do not have any accurate information on that. Once again I will see if I can find that out.

CHAIR: That will be appreciated. I would like to know if patients are accessing it already. To follow up on Senator Moore's question around special funding program, if I understand correctly, what you are suggesting is that there be almost like a specialised program that specifically deals with eating disorders. Are you advocating generally going back to the original process, a team, for everybody or specifically for specific programs? The supplementary question is that if there are other specific disorders that require more time—for example, coming from the evaluation report 87 per cent of people do not need the extra sessions, so would you think for the additional 13 per cent what you do is look at specific disorders that are not accessing it and maybe look at how you could tailor programs for those specific disorders?

Mrs Morgan: I guess there would be a couple of ways. Coming to your first question, which is specifically for eating disorders and what we would look to do there, we would like to think that if we have 10 maybe what we could have is a complementary program with another 10 sessions on the basis that CBT or FBT Maudsley we think can get there for 20 sessions. That is quite specifically driven by those two programs, though I do understand that, with CBT, 20 sessions in a program is generally acceptable, so we would look at that. Interestingly, if we were really looking at what would be needed for those suffering from anorexia nervosa, they probably would be more likely to need 40 to 50 sessions, but we are asking at this point for the additional 10.

In terms of other disorders, it certainly would be a way that it could be looked at. You could do it looking at specific programs that are offered. I guess the only downside to that is that, if a new, evidence based program became available that was slightly different, you would have to apply to bring it out. So to have an appropriate degree of flexibility for those who require more than the 10 sessions would be appropriate.

CHAIR: Thanks.

Senator MOORE: Mrs Morgan, because your organisation does so much work in this area, I am really interested in the issues about the public health services. I am from Queensland, and my understanding is that service is available through the public mental health system for people who are seeking that support. I would really like to hear from your organisation your understanding about what public health services are available. I totally take your point that you put in your submission that there are waiting lists—that is a given—but I am

asking just in terms of the issues about the New South Wales system, where we know one of the great experts in the field operates out of the public health system. In getting a full picture, that would be really useful.

Mrs Morgan: I certainly would be happy to do so.

Senator MOORE: That would be lovely.

Mrs Morgan: I do know that what is done in Queensland has some excellent people working in it.

Senator MOORE: In the public area?

Mrs Morgan: In the public sector.

Senator MOORE: I know some practise privately as well, but, just in terms of getting a snapshot of all the services across the board, that would be very good—and I will follow up with the department as well.

Mrs Morgan: I certainly will do so. That is something that we will be working on under the NEDC banner as well.

Senator MOORE: Thank you.

CHAIR: As there are no further questions, thank you very much. We have given you some homework.

Mrs Morgan: Indeed.

CHAIR: If you could get us the responses when you can, that would be fantastic. We have to report in a fairly short time frame, but we understand that we have asked you for a bit of research—

Mrs Morgan: I am happy to do so, thank you.

CHAIR: so as soon as possible would be fantastic.

Mrs Morgan: Thank you very much. Thank you for the opportunity.

CHAIR: Thank you.

BARTLETT, Mr Richard, First Assistant Secretary, Medical Benefits Division, Department of Health and Ageing

GOLIGHTLY, Ms Malisa, Deputy Secretary, Health and Older Australians, Department of Human Services

HARMAN, Ms Georgie, First Assistant Secretary, Mental Health and Drug Treatment Division, Department of Health and Ageing

HUXTABLE, Ms Rosemary, Deputy Secretary, Department of Health and Ageing

LOWREY, Ms Phillipa, Acting Assistant Secretary, Mental Health Early Intervention and Prevention Branch, Mental Health and Drug Treatment Division, Department of Health and Ageing

NICHOLLS, Ms Fiona, Assistant Secretary, Mental Health Services Branch, Mental Health and Drug Treatment Division, Department of Health and Ageing

SINGH, Mr Alan, Assistant Secretary, Mental Health System Improvement Branch, Mental Health and Drug Treatment Division, Department of Health and Ageing

[09:08]

CHAIR: Welcome. I will do the usual—although I know you all know it—for the record. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. As departmental officers, you will not be asked to give opinions on matters of policy, though this does not preclude our asking questions for explanations of policy or factual questions about when and how policies were adopted. We have your submission in front of us; thank you. It is numbered 199. Both departments or just one may make an opening statement. I invite you to make an opening statement, and then we will ask you lots of questions.

Ms Huxtable: On behalf of the Department of Health and Ageing I would like to thank the committee for the opportunity to present today. The Delivering National Mental Health Reform package injects \$1.5 billion over the next five years, to drive reform of Australia's mental health system. When combined with the 2010 budget and election commitments, this figure grows to \$2.2 billion. This package also builds on existing substantial investment in mental health, through the MBS and PBS, and those elements of social support, housing, education and employment services delivered through a range of Commonwealth portfolios.

In this introductory statement I would like to highlight the unique ways in which this package was developed and will be implemented, which has the potential to make a transformative difference to mental health reform and services. Significant consultations with consumers, carers, experts and service providers, as well as a thorough review of the evidence, highlight the fact that mental health involves a complex system of treatment, care and support requiring the engagement of multiple areas of government.

This package responds with a genuinely cross-sectoral approach, led by DoHA, with invaluable contributions from the Department of Families, Housing, Community Services and Indigenous Affairs; the Department of Education, Employment and Workplace Relations; the Department of Human Services; and the Department of the Prime Minister and Cabinet to improve economic and social participation for people with mental illness, to expand community mental health services, family support and respite services and to establish Australia's first National Mental Health Commission.

Crucially, the package also takes action across the life span and spectrum of mental illness. Potentially transformative elements include a focus on prevention and early intervention, acknowledging the early age of onset of mental illness and current delays in accessing help.

Access to support will be increased through the health and wellbeing check for three-year olds, national coverage of headspace, more family mental health support and early psychosis prevention and intervention centres.

Another innovation will be the investment in a new service delivery channel, e-mental health, through a single mental health online portal. Harnessing technology to overcome barriers to access, whether geographic or stigma based, will contribute significantly to Australia's treatment rates.

Thirdly, we are addressing a clearly identified gap for 24,000 of those most disadvantaged by mental illness. Through Commonwealth support for coordinated care and flexible funding there will, for the first time, be a consistent way of measuring these individuals' needs and linking them to required services. Lastly, the introduction of the National Mental Health Commission will increase accountability and transparency in the system.

Another theme of the budget package is better targeting the government's investment in primary mental health care. As a universal scheme delivered through the MBS, the Better Access initiative provides demand driven MBS rebatable services but has struggled to adequately service those most in need. For example, the program's evaluation confirmed that its distribution of services is not equitable neither in a geographic sense nor in a socio-economic sense. The use of Better Access services was approximately 10 per cent lower for people living in the most socio-economically disadvantaged areas. In 2009, the richest quintile of Australians accessed 2½ times the number of services and received three times the Medicare rebates, compared to the poorest quintile.

After almost five years of operation, from a comprehensive evaluation and analysis of MBS data generated in that period, we know the average number of mental health services received was five, with nearly 72 per cent of people receiving between one and six services. Coupled to this is the rapid growth in outlays that have characterised the program. In 2006, the estimated cost to the Better Access initiative was \$442.5 million over the first four years, whereas actual expenditure totalled just over \$2 billion in the first five years. In this context it has been appropriate to redirect a portion of projected program spending to other mental health initiatives better suited to promoting access to disadvantaged groups. For example, the increased funding in the ATAPS program will help an estimated 180,000 people over five years in underserved areas and from hard-to-reach groups. Headspace will support around 72,000 young people once all 90 sites are established at the end of 2014-15.

The changes to Better Access have been developed in order to minimise the impact on many users of the program. Eighty-seven per cent of current Better Access users will be unaffected by the reduced cap. The changes also mean that payments to GPs will be linked to the time they spend with a patient in developing a mental health treatment plan. Seventy-two per cent of GPs have completed mental health training and are therefore eligible for a higher rebate, which will be larger than standard consultation rebates. Importantly, Better Access will remain a demand driven program. Anyone who needs a course of allied health treatment can still be referred by GPs to receive it and further treatment will be possible after clinical review. Over the next five years it is expected that uptake and costs of this demand driven program will continue to rise, although not at as high a rate as would otherwise have been expected.

I note that, despite the fact that it is not usual practice of governments to consult on specific details of measures in the budget context, this package was developed following extensive consultation, including through national forums with mental health consumers and carers, advice from a mental health expert working group and feedback from more than 1,200 stakeholders consulted as part of the Better Access evaluation. The reform package is also fiscally responsible, funded in line with the government's fiscal rules and strategy.

I note the inquiry has heard about the two-tiered approach to Medicare rebates for psychologists and their workforce qualifications and training. There is significant debate about the pros and cons of this approach. This is essentially a professional issue and, as I understand it, the Better Access rebates were designed on the basis of professional advice at the time. Given there is neither consensus nor overwhelming evidence for either side in the debate, there do not appear to be solid grounds for change.

Lastly, implementation of the budget package is progressing well and is being undertaken in close collaboration with our colleagues, both from other Commonwealth agencies and the states and territories. Later this week a senior officials group of the Commonwealth and states and territories will meet for the third time to progress the national partnership elements of the package and the 10-year road map for mental health reform. In

addition, consultations have commenced with various sectors and stakeholders, including in the areas of care coordination, the National Mental Health Commission, e-mental health strategies and the expansion of headspace.

I would like, again, to thank the committee for the opportunity to give evidence today and would be pleased to answer questions in line with your terms of reference.

CHAIR: We will go through issue by issue, instead of jumping around.

Senator MOORE: I thought I would start with the review of the Better Access program. It has actually been used a lot in terms of the explanation for the changes, as we have heard Ms Huxtable say, and the whole process has also been mentioned in a number of submissions. In various committees and at Senate estimates we talked a lot at different times about geographic and equity access with respect to Better Access. Can you give us any more detail about that review and how the government was able to make argument about there being inequitable access to the program? I have read the review and there are a lot of stats in there. But in terms of the argument about the Better Access program, which was introduced and then reviewed along certain stages of its progress, and the fact that the amount of money being spent was great—and people asked questions about that—an ongoing issue is who has been accessing it. There is the issue around the number of times people access it and that is important. But the other issues include who has accessed it, the geographic spread and the equity process.

Ms Huxtable: I will get Ms Harman to go to the detail. The matters that you raise have been canvassed in the evaluation and that is really the source of the information that we have in respect of the program. However, I would say that because the Better Access program is funded through Medicare, in terms of some of the difficulties we have had with the program they are not dissimilar to the difficulties that you see with Medicare funded programs more broadly, which really go to having an available workforce to provide demand driven services. The fact there has not been equitable geographic coverage is a feature of elements of—

Senator MOORE: All kinds of programs?

Ms Huxtable: That is right. It is common for governments to augment a Medicare delivered service with other funding sources, as is the case with programs like the ATAPS program where you can get better geographic coverage. I will ask Ms Harman to go to the actual evidence that is in the evaluation.

Ms Harman: If I could just run through the main highlights and the main findings of the Better Access evaluation which, as Ms Huxtable said, is the main source of our information about usage. The evaluation showed that access for hard-to-reach populations has, to some extent, improved. But, as Ms Huxtable has just said, those groups traditionally less well served by Medicare continue to miss out on mental health services that they need and that is a feature of any universal fee-for-service rebate type scheme. In particular, we know that Better Access continues to struggle to adequately service hard-to-reach and vulnerable groups such as young people, men, people living in rural and remote regions, Indigenous Australians and people living in areas of high socio-economic disadvantage. The evaluation also confirmed that the usage and distribution of services across the community is relatively poor. In rural and remote Australia service levels drop off dramatically. So, for example, 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 compared to that for people living in capital cities. The evaluation data also showed a clear difference in access according to socioeconomic status, with use of Better Access services approximately 10 per cent lower for the people living in the most socioeconomically disadvantaged areas.

Senator MOORE: Can I jump in there with a specific question. I know that the basis of the data was the Medicare stats, so you saw who was accessing what. How can you make a statement about socioeconomic attributes of people who are using the service? Is it taken on a view about where they lived? Is there any way you can tell that people accessing the services have a particular income or socioeconomic disadvantage?

Mr Bartlett: Senator, it is going to be based on where they live.

Senator MOORE: So it is a geographic decision.

Mr Bartlett: It is a geographic decision.

Senator MOORE: On the basis that if you live in some suburbs you are better off than if you live in others. It is it a generalisation.

Ms Harman: That is correct, yes. As an example, 48.5 persons per 1,000 population in 2009 compared to between 52 and 53.6 persons per 100,000 population in 2009 for people living in relatively more disadvantaged areas. As Ms Huxtable said, the richest quintile of Australians are actually attracting 2½ times the total number of services.

Senator MOORE: Based on geography?

Ms Harman: Exactly, and attracting three times the Medicare dollars and rebates compared to the poorest quintile in the community. Again, balancing that against significant outlays in the program, if you go back to the original estimates for the program those had been exceeded by year 2 of the program. We are now up to over \$2 billion.

Senator MOORE: I think they were exceeded within year 2.

Senator FIERRAVANTI-WELLS: On that point, Ms Harman, that is all very well but the evaluation does not appear to do the comparison. For example, take an area in regional and rural Australia where there are very few practitioners or, in some areas, no practitioners. You can do it on the postcode but when you compare areas that do have practitioners to provide the services then it goes without saying that there will be more people getting services as opposed to areas that do not have practitioners—and I spend a fair bit of time trekking around the countryside, and in regional and rural areas they tell me that there are not too many practitioners. It is all very well to have the services but if you do not have the practitioners you cannot avail yourself of the services. The data does not seem to bring that out. Isn't that one of the key problems with that document—that it does not take into account the actual lack of practitioners in the area? You are not comparing apples with apples.

Ms Huxtable: I think we are. What the data actually shows is the lack of a workforce. One of the issues with Medicare services is that it is a demand driven program. You arrive at the doctor's surgery and you can access a range of services. If doctors are not available then clearly you cannot access those services. Across the Medicare data set—it does not only go to this issue, but if you take any number of cuts through the data—you will find that there is less access to Medicare funded services in rural and remote areas than there is in city areas. If you look at that against what was the RRMA classification or any number of other geographic classifications, you see that impact. I do not know that what we are seeing in respect to the Better Access program is necessarily any different. It will be patchy, so there will be some rural areas where there is greater access to the workforce and you would expect to see services being delivered there. It is more equivalent to in city areas, but it will be patchy, and there will be other areas where that is not the case. So I might be misunderstanding your question, but I think what we are seeing is precisely what you are pointing to—that it does relate to access to a medical practitioner workforce in those areas.

Ms Harman: If I could add to that: that is exactly why the government's budget package diversifies the primary care route into services; for example, through the e-mental health portal, through a massive expansion to ATAPS and a range of other services such as the telepsychiatry items that have recently been introduced. So there are a range of other initiatives that are happening to help overcome the workforce challenges that you have outlined.

Senator MOORE: Ms Harman, I am sorry I jumped in, but it was just one of the core aspects. Were you halfway through giving us your answer? I do apologise.

Ms Harman: I think those are the main headlines. I have got some data around specific numbers of people and numbers of services that were provided, based on rural and remote areas versus other areas, if that is helpful. It might be more useful to table that.

CHAIR: That would be useful, yes. If it is beyond what is in the submission, that would be really useful. Did you have further questions on the review?

Senator MOORE: Yes. You have seen the submissions, I know. There have been some allegations that the review was not conducted in the most effective way, and we have heard evidence from people who were involved in it and the advisory group. They talked about the great scrutiny that the review received in the process going through. Is there any comment you would like to make about the various comments that were put in the submissions about the review not being an effective methodology for looking at the area?

Ms Harman: I think I would just like to reiterate the evidence that we gave at the May estimates hearing, which is that this was probably one of the most comprehensive evaluations of a Medicare item or items ever done, as I understand it. No methodology is ever perfect. I chaired the steering committee and we had a group of experts who were absolutely forensic about testing the veracity of the methodology and questioning the consultants that we had engaged to undertake various components of the evaluation. From my perspective, that was an extremely careful and professional process and we can now stand behind the evaluation.

Senator MOORE: Was there any question of the methodology or the process or the outcomes of that review at the time that it was released? It came out and it was very public and open when the review was finalised; at that time were there any people who were doubting the outcomes, the numbers, the process?

Ms Harman: I think a number of people have raised concerns or issues around the methodology throughout the process of the evaluation. But, as I said, that is countered with those people who were right in there sifting

through the detail with us and providing advice and ticking the veracity of the process along the way. I read the *Hansard* from the first hearing of this inquiry in Melbourne and it seemed to me that there were a number of people who were quite pleased with the way that the evaluation was conducted. Indeed I believe the RACGP noted that we did not often do evaluations that actually measured consumer outcomes, and this was one where we did. I think that was welcomed by the RACGP, from memory.

Senator MOORE: Chair, those are my only questions on the process of the inquiry.

CHAIR: I have another couple of questions, but I think there may be more questions on the review, so let's do those first.

You would be aware that one issue that has been raised is going to the new funding model for GP based on the timing for each consultation. The issue that was raised with us in Melbourne was that that only measured the time with the patient, not the time to develop the plan. Did you take that into account when you were formulating the new approach?

Mr Bartlett: The whole issue of face-to-face versus non-face-to-face time is a longstanding one in terms of the MBS. If you go back and look at the relative value study that was conducted in the 1990s, culminating in about 2000, there was a debate between the AMA and government representatives on the board that managed that about the appropriate measurement of non-face-to-face versus fact-to-face. At that stage the AMA was pushing a line that said, 'For each GP consultation 75 per cent of the time was face to face and 25 per cent was non-face to face. It varies across items. But if you accept that sort of methodology, then in comparing mental health plan items to level C and D consultations, it is not an unreasonable comparison. In effect we are saying that all of them have a non-face-to-face component. That component varies a bit but what you have got there is something that is broadly comparable. The items are not dissimilar, so it is a valid way to look at those.

CHAIR: The point that was made, if I understand it correctly, was that for this particular item it takes longer to generate the plan. Also, I think they raised the issue of consultation with others during that process. In other words, it takes longer in face-to-face time than for normal items.

Mr Bartlett: The description of the item sets out a range of things people can do. One of them is implementation of a management plan. That tends to involve consultation with others on a range of things. So there is not a stark distinction between what is done with a mental health treatment plan and what can be and is done under a level C consultation. There is a comparability there. The number that was cited from the AMA survey, as I remember it, was 18 minutes. It is very difficult to know how accurate that number is. If you go back and accept what they said—that the relative value study reflects what you would expect for a level C consultation—you are looking at something like eight to 10 minutes non-face-to-face time for a standard level C consultation. There is a difference, but again there is also a difference in rebate. Under the new arrangements, I do not think there is anything there that is particularly at odds with anything else. I do not think there is anything that invalidates the approach that is being taken.

Ms Huxtable: The other point to make is that we have detected that there is quite a lot of variability in how general practitioners actually go about generating a plan. Early on in this process, there were some who were citing very long processes. Ms Harman can talk to this more, but there are only certain elements that we would expect in terms of the features of a GP treatment plan, and we are actually doing some work with the RACGP to look to provide a streamlined template that will support GPs in generating the plan. So to the degree possible we will look to make that as streamlined a process as we can. Ms Harman may want to mention the elements.

Ms Harman: There are a number of legislated requirements in respect of the GP mental health treatment plan items. How a GP actually collects the information to support those legislative requirements is really up to them, so we do not have a mandated template as such; we have guidance and, as Ms Huxtable said, we are working with the RACGP to come up with a sector agreed best practice format to capture the information that is required of GPs accessing this item.

The plan allows GPs to assess patients, plan their treatment regime, provide and/or refer them to appropriate treatment and services, and then review the patient's treatment and ongoing management. For example, an assessment must include recording the patient's agreement for the plan, taking the relevant history—biological, psychological and social—including the presenting complaint, conducting a mental health state examination, assessing associated risk and any comorbidity issues, making a diagnosis, which is probably most important, and administering an outcome measurement. In addition to the assessment of the patient, the preparation of a GP mental health treatment plan must also include discussing the assessment with the patient, identifying and discussing referral and treatment options with the patient, agreeing goals with the patient—what should be achieved by the treatment and any actions the patient themselves will take—the provision of psychoeducation, a

plan for crisis intervention and, as I said, making arrangements for required referrals and follow-ups. Those are the requirements of the item.

CHAIR: If I recall correctly, it is not necessarily the requirements that were the problem; it was the time and the recognition of the time that takes and the changes to the fee structure.

Ms Harman: The quality of the interaction is the most important thing, obviously. As Ms Huxtable said, there is great variability in the way that GPs appear to be using these items.

CHAIR: Thank you.

Senator FIERRAVANTI-WELLS: Senator Siewert, how are we going to structure the evidence given by the department? Are we going to start with the evaluation and then—

CHAIR: Then we are going to go issue by issue—so we will go to the broader issue of better access, ATAPS and anything else we want to ask about.

Senator FIERRAVANTI-WELLS: So we are not going to follow the terms of reference? Am I going to be confined to whatever issues—

CHAIR: No, we can cover whatever issues we wish to discuss. But, instead of hopping around, I thought it would be best to deal with it issue by issue. We will try and cover everything.

Senator WRIGHT: The list of things that you have just enunciated in terms of what would be expected in an effective mental health plan is telling. My understanding from the evidence given by the general practitioners at our last hearing is that the process is qualitatively different, in a sense, from some of the other processes that are required in dealing with the patient, forming the diagnosis and doing the follow-up care. One of the things I understood was that in the consultation process, especially if a GP is working with a younger child and has to make contact with the school and parents and make sure that they have done all the background work as well, is dealing with someone who is perhaps in a distressed state or does not necessarily understand the nature of the condition they have, so it is actually qualitatively different from perhaps diagnosing a condition that has objective indications of whether someone has that particular condition. Would you just tease this out a bit more? From what they were saying, my clear understanding is that in order to do this work effectively there is a lot more involved than there might be in many other analogous situations.

Ms Harman: I think that is right, but I think that is also why the item fees have been significantly higher and will remain significantly higher than for a standard consultation, plus the loading of the 27 per cent premium for those GPs who have done mental health skills training to try to maintain the quality of care provided. We understand that 75 per cent of GPs registered with Medicare Australia to deliver Better Access services are fully trained in mental health service skills training, which is great. The point I would make is that, you are right, it can be a very complex interaction and it can deal with some very distressing situations, but I think that is reflected in the fee structure that the government has put around these items.

Senator FIERRAVANTI-WELLS: You may have seen the evidence of Professor Littlefield, who was part of the group that supposedly made and considered the cuts to the Better Access services. It was clear from the evidence given in Melbourne that, whilst Better Access was referred to in passing at these working group meetings, it really was not discussed in detail. I find that at odds with what appears to be your evidence, certainly in your submission, about the dependence on the work of the Mental Health Expert Working Group, Ms Huxtable.

Ms Huxtable: I think our submission referred to the consultative process that underpinned the development of the package. There were a number of mechanisms through which interested parties had an opportunity to engage with government around the evidence about the most effective package of measures that could improve mental health outcomes. One of those was the Mental Health Expert Working Group, to which you referred. That group certainly received a presentation on the findings of the Better Access evaluation, and there was quite a lengthy discussion at that group—I was at the group at the time—around those findings.

It is not correct to say that there was engagement on every element of the package. It would be a very unusual thing for governments to engage on the detail of budget measures, but certainly there was engagement on the structural components of the package. So the engagement that we had with stakeholders did suggest that in the package the themes of early intervention, prevention, focus on children and young people, primary care and access through primary care and, particularly, measures for people with severe and persistent mental illness were the appropriate components of the package that could deliver outcomes across the sweep, if you like. But it is not correct to say, and I do not believe that our submission says, that the precise individual and specific measures were gone through with the stakeholders prior to the budget announcement. That was not the case, and I would say that I do not really know of any cases where governments do that.

Senator FIERRAVANTI-WELLS: It says that the package was informed by the government's consultations with stakeholders operating in the health and non-health field, including through a time-limited mental health working group and a national program of consumer and carer directed—blah blah blah. I find that at odds with just about every submission we have received, starting from the AMA and others, talking about lack of consultation. A number of submissions have focused on the lack of consultation. You have had an evaluation and all of a sudden you are cutting out a major chunk of a program, and the key stakeholders are, in their submissions, telling us that there was no consultation with you. Yet you seem to say that you have based this on consultations with stakeholders. I find the two things do not sit comfortably together.

Ms Huxtable: I think I have probably already responded to that. The statement that the package was informed by consultations is true. It was.

Senator FIERRAVANTI-WELLS: Who actually made the decision to make the cuts?

Ms Huxtable: It was a decision of government in the budget context.

Senator FIERRAVANTI-WELLS: At any stage did this expert working group—Minister Butler's little kitchen cabinet—recommend changes to Better Access? Did they recommend any cuts to the mental health spending?

Ms Harman: No is the short answer. As Ms Huxtable said, the group had a discussion about the main findings of the Better Access evaluation and then had a broad discussion, as I recall it, around what a balanced package of measures to start to reform the mental health system would comprise. That is consistent with the advice that we have given.

Senator FIERRAVANTI-WELLS: Do I understand correctly that no stakeholder recommended to government—as I have read and seen the material—to make major cuts to its Better Access program, yet the government made a decision to take a huge chunk out of this program? This is just so that I can understand, following on from Ms Huxtable's comments. I did get up very early this morning!

Ms Huxtable: I understand where you are coming from. There has been considerable commentary around the Better Access program over many years. While I do not necessarily have the media articles here in front of me, I think if you go back and delve through those there have been concerns of stakeholders for some time that Better Access may not have been the most effective way to provide access to primary care services, particularly in areas where, as we have already discussed, there are pockets of disadvantage. So that is not in and of itself new. It is true to say that there was not a specific consultation with stakeholders around the specific measure that was decided by government in the budget context, but it is not true to say that the program has been universally lauded by all and sundry. There have been concerns over a considerable period about whether the program was a value-for-money intervention, given the fact that—as I think Ms Harman has already said—the original estimates for this program were exceeded in year 2. I think there is a question about whether the program's design would have been as it was initially designed if there had been knowledge about the level of growth that was likely to be seen in that program. I will probably leave it there, but I think it is fair to say that there have been concerns about the program. The evaluation actually provided more focused evidence about where there were areas of concern, and the budget package does still provide a very strong primary care package which aims to focus on those areas where Better Access has not been as effective.

Senator FIERRAVANTI-WELLS: Ms Huxtable, I think the concern is that some of that commentary has also resulted in those people making the criticism. If I can put this in neutral terms, we have seen a situation where we are robbing Peter to pay Paul and those who criticised Peter are now the beneficiaries, receiving the advantage. I want to keep it in neutral terms.

Senator MOORE: I think that it does.

Senator FIERRAVANTI-WELLS: That is really the point, Ms Huxtable. Yes, I am aware of the public commentary, but I am also aware that the criticisms of what the government has done, certainly by organisations and in many of the submissions here, far outweigh perhaps some of that commentary, and I want to put that all into context. Anyway, I will not take it further, but I think you understand where I am coming from in terms of my questions.

Can I go to the criticism of the evaluation itself. You have had, I think, 11.1 million sessions covering two million consumers, yet only about 1,300 consumers were assessed. That is 0.07 per cent. The criticism levelled at the evaluation is that it was not a good data set. But more importantly, going back to the original objectives of the Better Access initiative, what it was intended to do—and perhaps, Ms Harman, you could focus your answer on this—in the evaluation, there was no data on whether collaborative services were actually being provided. One of the objectives was:

... a team-based ... approach to mental health care in the community with psychologists working alongside general practitioners, psychiatrists and other allied mental health professionals.

That does not seem to have been evaluated. In other words, are the professionals working together, what therapies are being provided and are people actually getting better? That does not seem to have come out of this evaluation. You have cut all this money, but these questions remain unanswered.

Ms Harman: If I can just take those issues in turn—and you may need to remind me of what they are. I am just looking for the summary of the evaluation outcomes. There are a number of Q&As and fact sheets on the department's website that talk through the main findings of the evaluation. There was a specific component, from memory, that focused on professional networks. So there was a part of the evaluation that actually did look at collaborative care. From memory, again—I am struggling to find the piece of paper—

Senator FIERRAVANTI-WELLS: Ms Harman, I am conscious of the time. You might like to take that on notice. Also, in the AMA submission—and this may have been canvassed to some extent by Senator Moore's questions—on page 10 they make the criticism, under the heading 'GPs are spending significant time in caring for patients with mental illness':

The Government has cited Bettering of Evaluation and Care of Health (BEACH) data as one of the justifications for its cuts to Medicare rebates for GP mental health services.

It goes on:

Dr Helena Britt, who heads up the BEACH program, has publicly questioned the use of BEACH data in this way. She has confirmed that it does not include the time doctors spent outside sessions on related paperwork and liaising with other healthcare workers.

I think this is the comment that Senator Wright was picking up on earlier. Indeed, at page 11 of the AMA submission, it states:

She directly challenges the Government's interpretation of BEACH data—

and then there is an extract from the *Medical Observer*. Can you comment on that? You have placed a lot of emphasis on the BEACH data, yet this Dr Britt seems to be contradicting what you are asserting.

Mr Bartlett: All BEACH data is face-to-face time. None of it includes non-face-to-face time. All consultations include a non-face-to-face element. There is debate about how much that is. The AMA over a period of time has suggested that you can split it up 75 face-to-face, 25 non-face-to-face. As I said earlier, when you work through that there is a difference between a level C consultation as an example and a mental health treatment plan in terms of non-face-to-face if you accept the AMA's 18-minute response from the survey, but the difference is considerably smaller than something or nothing. So I think that the use of BEACH data in that way is not invalid.

Senator FIERRAVANTI-WELLS: So when Dr Britt criticises you for the interpretation, when she says I have questioned the interpretation, then she is wrong and the government is right?

Mr Bartlett: I believe that the use of the data was a valid use of the data.

Senator FIERRAVANTI-WELLS: The government is right and Dr Britt is wrong.

Senator MOORE: It is an inappropriate question for the department to answer.

Senator FIERRAVANTI-WELLS: You disagree with Dr Britt.

Ms Huxtable: The point Mr Bartlett is making is that the BEACH data has been used to inform an element of this policy which goes to making a judgment about what is the appropriate remuneration for an item where on average it is taking GPs 28 or 28½ minutes—I have not got the figure entirely in my head—to undertake the item. The BEACH data was used for that purpose. There is a number of other elements to the item which goes to the premium that has been added to recognise the mental health skills training that enables a qualitative interaction to occur. I think the issue about the face-to-face versus non-face-to-face is a separate issue and one that I believe we have already responded to.

Senator FIERRAVANTI-WELLS: In the AMA's submission after table 1 they do an analysis and then over the page at page 9 they make this comment: 'The government has attempted to portray the Better Access program as not reaching people in disadvantaged groups.' Then it quotes Ms Perkins, and I will not repeat that. They conclude that the evaluation clearly shows that, rather than implementing savage cuts to Better Access and redirecting this funding to other programs, the government should have looked to maintain its investment and instead found additional funds to support complementary programs. Do you have any comment in relation to the criticisms and that, despite the promising data, you have attempted to portray it in this way? The AMA is being

critical of the way that you put portrayed it, in other words you have manipulated in some way. I withdraw that. They have made certain comments in relation to that. Do you have any comments?

Ms Huxtable: The AMA clearly has a view about the program and I respect their view. However, the decision in regard to Better Access I think is grounded in two things, one of which is an evaluation which looks at its effectiveness in a variety of ways, where it is clear that there are certain groups in the community that are not receiving as equitable an outcome through Better Access as they may receive through other mechanisms. Secondly, data through the BEACH survey in regard to the actual amount of time that GPs are spending with patients in respect of Better Access. I think one of the key things to reflect on is that the fundamental design of the Better Access program has not changed. It is still a program that supports general practitioners working with patients in developing mental health treatment plans. It is still a program that enables a program of treatment to be provided through allied health professionals. It is still a program which continues to grow. It has grown very significantly in recent years and in our view will continue to grow in coming years. It is a program that has been effective in raising the treated prevalence rates for people with mental illness. It was around 36 per cent when the program first began and it is closer to 46 per cent now. There are a lot of positives in the program and it is for that reason that the program's design has been retained. Yes, the AMA have a particular view and they have communicated their view to us. The changes to Better Access retain many of the strengths of that program—I would say retain all the strengths of that program—but enable other primary care solutions to have greater investment in them, which means that people who are currently missing out through Better Access are more likely to be able to receive services, whether that is through an ATAPS service or through the e-mental-health portal.

CHAIR: We are moving on to Better Access in general, which I do not have a problem with, but does anybody else have any questions on the review per se?

Senator McKENZIE: I have got one on data sources.

CHAIR: Go for it.

Senator McKENZIE: Given the issues around the data sourcing, collection and analysis of the evaluation that we have heard about, is the department considering the merit of using a descriptor other than the postcode of who uses the services, how and when? Particularly in regional communities, postcode in itself—and research backs this up—is actually not a great indicator of the socioeconomic status of the individuals within that community. Is there any discussion around using a different descriptor when we are trying to work out the socioeconomic status of an individual accessing a service?

Ms Huxtable: We probably need to differentiate between the evaluation that has occurred, which clearly used a certain methodological approach, and any evaluation that may occur in the future. In any evaluation that may occur in the future, clearly there would be similar engagement with a project steering group and experts around developing methodological underpinnings for that evaluation related to its terms of reference. I do not think I can sit here today and say, 'Definitely the next time we do an evaluation on Better Access it is going to have these features,' because it is not really my decision. The broader question about whether and how to best measure socioeconomic disadvantage is one I am not necessarily qualified to respond to. Richard, do you feel more qualified?

Mr Bartlett: Slightly! I think the point about regional and rural areas is valid, but I think it tends to show the point that was made earlier: there is a significant disadvantage regardless of socioeconomic status in terms of capacity to access medical services. When you average those things, like all averages, it can conceal a significant level of variation, but the fundamental point that it makes is still a valid one. The difficulty for us is that the more we try to refine it, the more we get down to the point where we are starting to provide information at almost an individual level. That is fairly problematic. I think at the moment we have got something that is aggregated to a level where you are commenting on a region; you are not getting down to the level where you are identifying individuals. I think there is some risk that the more we refine that, the more we start to talk about individual circumstances, which are obviously valid but also problematic in terms of people's privacy and a range of other issues.

Senator McKENZIE: Yes, I am not imaging we would itemise it to the individual level.

Senator MOORE: I will just jump in on that. Mr Bartlett, I just want to get this clear. To the best of my knowledge at the moment there is no dataset in our health system which gives information on people's socioeconomic position. I just want to get that clear. I had hoped I was doing that in my first question, but I obviously was not. Under data collection in our health system at the moment, we do not have a system for individualising the socioeconomic status of people. There are sometimes other things done for a particular study,

particularly within the public hospital system, which may ask questions which can then be used. But we do not have a general dataset for any reason.

Mr Bartlett: We do not have that and if we were going to do that we would have to get that dataset. That is a difficulty in and of itself.

Senator WRIGHT: Notwithstanding what you said about the thoroughness of the Better Access evaluation, there are many witnesses who have been highly critical of the evaluation. Indeed, table 1 of the evaluation actually acknowledges some of the shortfalls in the data. Table 1 identifies weaknesses of selection bias or reliance on self-reporting; a lack of potential to track any change or improvement over time, which I think is a significant shortfall; difficulties in inferring conclusive information about better access from the data. Could you comment on that. I suppose the reason I am asking the question is that clearly if significant decisions are going to be made—and those decisions are going to have impacts, as we have heard time and time again throughout the course of the inquiry—it is important to have a really thorough basis on which to be making those decisions.

Ms Huxtable: I think that is a point well made. As I said earlier, no evaluation is ever perfect. We worked an outcome based on the best participation rates that we could get from carers, consumers and providers based on a range of data that we had collected through Medicare. I think the important point to make is that, as Ms Huxtable said, the fundamental design of the better access scheme has been retained. We think it will continue to be a strongly growing program. That growth may slow down slightly as a result of these changes but basically if a person is eligible to meet the policy parameters of the Better Access program going forward they will receive a service. So it is a demand driven program; it has not been constrained in that way. The government has taken a decision, in the current fiscal environment and with the strong growth in terms of outlays in the program, to redirect a proportion of the otherwise \$4 billion that will be expended under Better Access over the forward estimates period, towards other programs that close some of the gaps that we know Better Access will probably never be able to close.

CHAIR: I propose that we spend about another 10 minutes on Better Access. I am particularly keen to spend some time on ATAPS, because we have received quite a bit of criticism of ATAPS that we have not received in the past. I would like to explore that for, say, 10 minutes and then we will have 10 minutes for other issues. We are obviously going to be giving you a lot of questions on notice. That will include the two-tier psychologists which you touched on earlier but if we go there now we will be there for the rest of the time so I propose that we put those questions on notice.

Senator FIERRAVANTI-WELLS: Ms Huxtable, you talked about this primary care et cetera and I go back to the comments made by the AMA. The first thing that the AMA highlighted in their submission, as have other stakeholders, is the lack of consultation undertaken by the government. Surely, Ms Huxtable, when you are taking these sorts of decisions in relation to important aspects of primary care—whether it is cutting Better Access or moving in terms of ATAPS, as Senator Siewert has picked up on—you are dealing with GPs, so why the lack of consultation? It is all very well to listen to their points of view now, but aren't we seeing a repetition of what we saw with the occupational therapists and the social workers? You make the decision, then there is a furore and then you go out and consult, but you have created a problem in the interim. Why didn't you talk to groups like the AMA beforehand? Why are they now so ferociously criticising you for this lack of consultation?

Ms Huxtable: As I said before, it is very unusual for governments to consult in regard to specific budget measures. When it came down to making decisions about the specific measure that would apply to Better Access that was very much in the budget context. I probably have nothing more to add in that regard.

Senator FIERRAVANTI-WELLS: Do you have any comments in relation to the resignation of Dr Christine McAuliffe, who is on the expert advisory group on mental health? It is sort of reminiscent of the spectacular resignation of Professor John Mendoza. Dr McAuliffe has been very critical. She has talked about the step backwards and her reasons for quitting the expert panel. It is very clear that you did not even consult with your own people properly.

Ms Huxtable: I have already responded to that.

Senator MOORE: Shouldn't we leave that as a question for the minister and not for these officers?

Senator FIERRAVANTI-WELLS: One of the comments the AMA has made is that there has been no analysis on the impact of the budget cuts on patients. The AMA made reference to the fact that you did not use the Medical Services Advisory Committee to review the medical rebates for GP mental health services despite MSAC being specifically funded in the 2011-12 budget to conduct rolling reviews of the quality, safety and rebate levels of items listed on the MBS. Do you have any comments in relation to that criticism?

Mr Bartlett: A series of these changes has been informed by the evaluation done of the Better Access program. Whether we get that done under MSAC auspices or someone else's auspices, in effect it is based on a detailed analysis. The requirement to go through MSAC is something that came in after the decision was made.

Senator FIERRAVANTI-WELLS: For the record, was the decision to undertake the evaluation one of government?

Mr Bartlett: To undertake the evaluation of what?

Senator FIERRAVANTI-WELLS: The Better Access program.

Mr Bartlett: It must have been.

Ms Huxtable: That is correct.

Ms Harman: Many years ago. The planning commenced in 2008, I think.

Senator FIERRAVANTI-WELLS: There has also been criticism by the AMA of the injection of this amount of money into ATAPS. Is this an appropriate time to raise it, Chair?

CHAIR: We will finish off Better Access and then go to ATAPS. Are there any further questions on Better Access?

Senator MOORE: If I think of any they will go on notice.

Senator McKENZIE: One of the other submissions we have received today states that reducing the treatment to 10 sessions actually contradicts scientific evidence. Do you have any comments on that?

Ms Huxtable: I am not sure which submission you are referring to and what the context is.

Senator McKENZIE: It is the ACP, Association of Counselling Psychologists, submission. It states that dropping the number of sessions back contradicts scientific evidence. Could you give us your perspective on that?

Ms Harman: It is a question of understanding what that scientific evidence looked like and of having the intellectual capacity to understand what it meant! If we go back to the design of the Better Access scheme, the moment an individual can get a referral from their GP, once they have a mental health diagnosis, they receive a treatment regime of six sessions. That will not change. After that six sessions the person goes back to their GP for a clinical review. If the clinical analysis is such that the person requires further treatment, currently they can access another six sessions in a calendar year. From 1 November that will be reduced to four sessions.

Currently, under the exceptional circumstances provisions of Better Access, another six sessions may be accessed in a calendar year but only if the care or clinical circumstances of that individual changes markedly, so, it is in very exceptional circumstances and it is around that change of circumstances rather than a person just needing ongoing care. I guess the fundamental point I wanted to make was that Better Access, in its original intent and design, was never intended to provide long-term interventions for people who are severely unwell.

CHAIR: Using the Butterfly Foundation as an example—because they were just here—they have presented evidence that the programs they have need 20 sessions. They acknowledge that that is already outside the 18.

Ms Harman: A minimum?

CHAIR: A minimum of 20 sessions. That seems to me to be a rigorously worked out program. They are saying that they think it should be especially funded but ATAPS will not fill that need. There will also be other programs of treatment for other illnesses and disorders that will require the longer time frame. They are saying that the services are not there. The state services and other services you could go to are not going to fill that need. Under the new process, how are we going to deal with programs for which ATAPS is not going to meet the need?

Ms Harman: If we look across the entire package, there are a number of programs that will be coming on stream that will be perhaps more suited to people with those more severe forms of mental illness. I am thinking of, in particular, the coordinated care and flexible funding for people who fall into that category. As you rightly say, these are people who should not necessarily be treated in the kind of primary care program like Better Access or, indeed, ATAPS. We would be encouraging states and territories, through their specialist mental health systems, to be lifting their game and closing service gaps that we all know exist in those kinds of areas—the pointy end of service delivery.

CHAIR: I will put some more questions on notice to follow up on that because I am not convinced that just relying on state services at the moment is going to fix things. It is telling people that is going to fix this issue, particularly with the example we just gave.

Ms Harman: Just to be clear: I do understand the point you are trying to make and I do accept that there are some issues there. But, as I say, we are looking at the package as a whole: a balanced package of services to start to reform the mental health system and close some of the gaps that we know exist. We are working very closely

with the states and territories and will be seeking investment from the states and territories, in respect of the national partnership agreement, for example. And as the government has clearly said through this budget package, they know it is just the start. There is a long-term journey here, and the 10-year road map will articulate that vision of what the government wants the mental health system to look like in 10 years time and the steps that need to be taken to get there.

CHAIR: Thank you. What I am suggesting—

Senator MOORE: Can I have one question? In the same work, Ms Harman, one of the issues is the number, and I can remember sitting in these inquiries several years ago trying to figure out a number. 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?

Ms Harman: I am sorry to be unhelpful but it would really depend on the individual, their diagnosis and the other extraneous factors in their lives that might contribute to whether or not they were going to reach recovery after 10 sessions or 18 sessions, whatever that looks like. And I do not think I am able to provide you with a definitive answer.

Senator MOORE: No-one doubts that people need help and a number of interventions in some way, but the number is what people are focusing on.

Ms Harman: Yes, and what we know from the Better Access evaluation is that, on average, people only need five.

Senator MOORE: Or are only taking five?

Ms Harman: Only receiving five; that is right.

CHAIR: Yes, Senator Wright? I am anxious to move on to ATAPS.

Senator WRIGHT: That leads me to the question: if people, apparently, are only taking, or needing, or using as much as they are apparently taking, needing or receiving, then one would think that there are not greedy practitioners out there trying to get them to do more sessions than they need. That is just a layperson's view of it. If they are entitled to 12 and are only taking five on average—and it is actually quite a small proportion, in my understanding, who are actually taking up to the 18, at this stage—then presumably, based on an evaluation by their practitioner, that is actually what they need in terms of effective treatment. So I have some difficulty in understanding why it is necessary to set the limit at 10, if in fact the majority of people are only taking or using fewer than 10 anyway. Do you understand the point I am making?

Ms Huxtable: Yes, but this decision is taken in the context of constraining the growth in a very rapidly growing program. So, while we anticipate the program will still be growing, it will not be growing at as fast a rate. So the question for government is one around how to vary the design of a program in a way that can constrain that growth and enable moneys to be freed up to provide services in other ways, addressing those areas where we know that there are deficits. So the decision around capping services is part of a context in which a saving is being generated against a forward estimate.

Senator WRIGHT: I understand that and I suppose, then, to put it quite harshly, that one way to constrain the growth is to disallow access to the people who need those extra services, up to the 18. They are just not going to be able to get them, and that is the way to cut back the growth and the costs. I understand there are always decisions to be made, but that is how it looks.

Ms Huxtable: There are any number of decisions that can be made in that regard but one of the concerns we have is that for people who are using large numbers of services through Better Access there is a question about whether Better Access is actually the best program through which those services should be delivered. Better Access was not intended, as Ms Harman said, to be providing long-term treatment for people. We would argue that potentially ATAPS is a better source for providing those treatments. There are any number of other mechanisms whether it be through the state specialist mental health system, consultant psychiatrist appointments, where you can get 50 services a year. So Better Access is not the only option that people have and our view would be that it is not necessarily the option that is best suited for long-term treatment pathways.

CHAIR: Okay. That is a nice segue into ATAPS. I am sure there will be some more questions on notice about Better Access.

Senator FIERRAVANTI-WELLS: One of the comments that is being made is about the recently released evaluation, the ANAO audit report of the ATAPS program, in relation to delivering valued services. There has been some criticism in that report of ATAPS administrative costs. The AMA refer to it in their submission. Basically it looks like many divisions are now using a ratio of 75 per cent service delivery to 25 per cent administration costs as opposed to, and this is the point that the AMA are making, Better Access going directly to the delivery of clinical care. Can you make any comments in relation to that? If you are going to give ATAPS more work does that mean that we are going to see much more moneys going into administration and does that 25 per cent risk going even higher?

Ms Harman: I will take your question in two parts and answer the second part first. For the question as to whether or not we are going to see an increase in administrative costs under ATAPS the answer is no. We have a requirement of divisions of general practice and Medicare Locals, as they demonstrate capacity, to deliver and manage funds for mental health programs of a maximum of 15 per cent of funding that can be used for administration other than for new program streams of funding that are coming in to ATAPS where that can rise to 25 per cent in year 1 to take into account the planning, start up and things like that that need to take place to get that service stream up and running. That 15 per cent requirement is absolutely there to stay. That is a requirement under contract.

In terms of the other point that you made in respect of unit cost, if you like, it does cost more to deliver targeted programs and the point that I would make is that the additional 180,000 people that will receive an ATAPS service over the next five years under the expansion of the program would not necessarily have got a Medicare service at all. So ATAPS is clearly plugging that gap that we know exists in respect of Better Access. People who either could not afford the co-payment under a private practice scheme such as Better Access, who are young, who are living in low-SES areas, who are homeless and do not hold a Medicare card, who are Indigenous, where we are seeing some quarantine funding of \$36.5 million over the next five years specifically for treatment for Indigenous people, or as you mentioned earlier who do not have a private practitioner in their local area. So the point I would make is that ATAPS by its very nature because it is a targeted program does cost slightly more than a universal Medicare delivered service. That is a feature of its success in being able to reach those people that Medicare cannot.

Senator FIERRAVANTI-WELLS: I have questions in other areas. I will put anything more on ATAPS on notice.

Senator MOORE: Ms Harman, some of the evidence we have received indicates that ATAPS is operating very differently from region to region. The negative comments that have been made tend to look at the issues around the availability of funds. Specifically on that issue, I want to make this statement in the committee hearing: we have been asking questions about ATAPS very regularly in different committee hearings and in Senate estimates and we have also been hearing from consumer groups and we had not heard negative information about this scheme. Now people are putting it out, and that is good. I want to get an indication from the department about the understanding of the ATAPS services across the country and the quality of ATAPS up till now, allowing for the fact that everyone wants more money, which is a given.

Ms Harman: We believe it is a very effective program, and that is what the 2009-10 review of the program articulated.

Senator MOORE: Yes.

Ms Harman: There are a couple of points to make here. As a fund-holding program, there is a balance between how much the government interferes and the department interferes in the way that those funds are managed by what is essentially a fund-holding third party. I think if we were to be too vigilant around our management and oversight of those funds—not that we do not do that—we would get strong criticism from divisions of general practice who, to be frank, have criticised us in the past for being too interventionist. So there is a balance there, I think.

What we do under ATAPS is we have some very clear operational guidelines, which we are currently in the process of reviewing and updating with our expert advisory group. Those will be very clear around the parameters for the program and how we expect divisions of general practice and Medicare Locals to manage those funds. They will be things like reiterating the administrative components of the funding.

The issue around funding growth, which is a real one and one that have heard from consumers and carers and from divisions themselves, is that in some areas divisions have run out of funds by the end of the financial year. But I would just like to make the point that in this financial year alone funding will double under ATAPS. I do not have the 2010-11 figure, but \$61.8 million will flow, in fact some has already flowed, to divisions of general

practice this financial year. That is an additional \$31.8 million, so that is double what divisions received last year. So we are really expecting that those issues that divisions have had in the past about running out of money will not be there anymore. In fact, the feedback that we have had from Medicare Locals—we met with them last week or the week before—is that they needed sufficient lead time to make sure they can expend the money, because there is a significant boost of funding going into this program. They are already starting to think about planning.

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.

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.

Ms Harman: Yes.

Senator FIERRAVANTI-WELLS: I would like to ask a couple of questions on EPPICs. There have been criticisms in the various submissions in relation to the Commonwealth proposal that your commitment to additional EPPICs is dependent on states and territories sharing the costs of them. What happens if the states do not contribute to the funding? Does that mean that the Commonwealth will fund them itself, or at what point will the Commonwealth make that decision?

Ms Harman: From memory, I gave evidence about this at the May estimates hearings—

Senator FIERRAVANTI-WELLS: And you told me that you were talking to the states, so I am interested to know if you have made any progress.

Ms Harman: We are talking to them a lot about it.

Senator FIERRAVANTI-WELLS: Good. Have you got a firm commitment?

Ms Harman: To go to your first question, ultimately yes, if the states and territories do not wish to co-invest, the government has said it will fund EPPICs on its own. That will obviously result in a small number of centres, but we are very—

Senator FIERRAVANTI-WELLS: Not the 16? If the states do not come on board then you will—

Ms Huxtable: I do not think there has been any evidence to date in our discussions with the states and territories that that they are not interested in this measure—quite the contrary, in fact.

Senator FIERRAVANTI-WELLS: I did say 'if', and my question was going to Ms Harman's answer that there would be fewer. So my question is: if they do not come to the table, which means there will be less than that figure of 16, have you determined how much less?

Ms Harman: As Ms Huxtable said, there is no indication at this stage that the states and territories do not want to partner with us on EPPICs. Because of the way that the measure was costed and announced, it does rely on a cost-sharing arrangement with the states and territories. So obviously if states and territories do not wish to co-invest then the government would need to put in more money solo for an EPPIC service. But we are in extensive discussions with the states and territories about partnering in the rollout of these new centres.

We have now had three meetings of the senior officials mental health working group, which is chaired by our secretary, Secretary Halton. EPPICs have been discussed at each one of those meetings. We are having a fourth meeting later this week as well and, as I said, we are working with the states and territories through all of these details. We will shortly be consulting with them on some agreed criteria, from the Commonwealth perspective, around what an EPPIC looks like and the participation that we are expecting from states and territories. Following that consultation, the minister will be issuing a formal invitation to states and territories to send proposals to us.

Senator MOORE: On notice, can you tell us who is attending those meetings? I know it is being chaired by the departmental secretary, but for our information we would like to know who is showing up at what level.

Ms Huxtable: The deputy chair is the WA deputy secretary of the Department of the Premier and Cabinet, Rebecca Brown.

Senator MOORE: I think it is interesting to know who is in those discussions.

Ms Huxtable: I will make the point that the group comprises not only health officials but also central agency representatives.

Senator FIERRAVANTI-WELLS: I want to ask some questions on the National Mental Health Commission. It is clear from the various submissions that there is a feeling that the National Mental Health Commission should be a statutory authority, a separate entity, and yet you are going to establish it as an executive agency within the Prime Minister's portfolio. Did you contemplate a statutory authority, Ms Harman? A statutory authority seems to be—certainly in all the literature that I have read on the National Mental Health Commission—what the experts have been calling for. That has been the gist of the evidence we have had thus far. It all seems to be about an independent statutory authority, but that is not what this is.

Ms Huxtable: I am not sure if we can really comment on that. The decision of government was to establish this as an executive agency, and that is what occurred.

Senator FIERRAVANTI-WELLS: Was there consultation about this before it happened?

Ms Huxtable: Along the lines of the answer to earlier questions, there were certainly discussions in the mental health expert working group around mental health commission sorts of ideas, really in the context of increased accountability and transparency and, really importantly, the fact that the mental health response is not just a health response. The thinking behind having the agency housed within the Department of the Prime Minister and Cabinet is really recognising the need for many portfolios to be engaged in improving mental health outcomes. Some of those discussions occurred within the expert working group but not really getting down into the specifics about whether there would be a commission, how it would be constructed et cetera.

Senator FIERRAVANTI-WELLS: Obviously the cost of a statutory authority is greater than the cost of what you are going to do in Prime Minister and Cabinet. Was cost a feature of that?

Ms Huxtable: I probably could not comment on that. I do not have anything in my head around what the cost could or could not be.

Senator FIERRAVANTI-WELLS: Could you take that on notice?

Ms Huxtable: I am not sure that we can really provide a response to a hypothetical costing. We can certainly provide information through the Department of the Prime Minister and Cabinet. I think I can take that question on their behalf—and any other questions you wish to ask about the cost of the agency as decided by government. But I think that is the extent of what we could provide. I do not think that is unreasonable.

CHAIR: I think that is fair enough.

Senator FIERRAVANTI-WELLS: I am just conscious of the time.

CHAIR: Does anybody else have any other questions on the commission before we move on? No? Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: Can I just make some comments and ask if you would mind responding in general. Picking up my point from before, there have been some criticisms that the budget robs Peter to pay Paul. There have been some quite strident comments made by the AMA, amongst others, in relation to the significant cuts, basically criticising you about the sort of headline figure. I am talking most specifically about comments on pages 2, 3 and 4 of the AMA's submission. It effectively says that is all a bit smoke and mirrors—those are my words, not theirs. It tells us that really the net new spending is considerably less than the government seems to be asserting. How much of that \$2.2 billion is actually new money?

Ms Huxtable: One point five billion dollars.

Senator FIERRAVANTI-WELLS: All of that \$1.5 billion is new money?

Mr Singh: That is correct.

Senator FIERRAVANTI-WELLS: Is that \$1.5 billion just health or across government?

Mr Singh: The \$1.5 billion is across government.

Senator FIERRAVANTI-WELLS: Do I understand that previously you said to me that \$1.1 billion was a rollover of the 2006 to 2011 Howard initiatives?

Mr Singh: That is not part of the \$1.5 billion figure.

Ms Huxtable: There is an attachment to our submission which sets out all the funding. I think that is a very good source document.

Senator FIERRAVANTI-WELLS: I have also gone back to my table, Ms Huxtable.

Ms Huxtable: It is not in red but it is a table. It sets out quite clearly the various funding sources but notes that this is not only department of health appropriations but also appropriations for other portfolios.

Senator FIERRAVANTI-WELLS: I appreciate that Ms Huxtable, but all those initiatives that were the COAG 2006-11 initiatives, which were part of the \$1.9 billion announced in 2006, which Better Access was part of, ended on 30 June.

Ms Harman: No, Senator.

Senator FIERRAVANTI-WELLS: Well the funding for most of them ended on 30 June. That then contradicts what you previously told me at the last estimates.

Ms Huxtable: No. Senator, with respect, I think if we go back to estimates that is not what we said. Those programs you were referring to are what we refer to as lapsing programs; therefore, the money for those programs continues to be in the forward estimates. That money is not counted in the table that is attached to our submission.

CHAIR: Can we just be clear. That is funding entirely separate from the \$1.5 billion?

Ms Harman: Absolutely. Of the 16 measures in the latest government package, only six are expanded existing programs. So there are 10 new measures and there are six measures, such as day-to-day living, PHaMS, ATAPS and headspace, that will receive significant funding boosts through this package. But that is not counted in the \$1.5 billion.

Ms Huxtable: But the money that is shown here is the funding boost. It is not funding that already existed in the forward estimates.

Senator MOORE: I would like to make a suggestion. This is a really detailed point Senator Fierravanti-Wells has been following for a while. I found the table useful. Maybe it would be useful if, on notice, Senator, you put some questions of clarification to the table and we went that way.

Senator FIERRAVANTI-WELLS: I will ask my question now, Ms Huxtable. Would you address the specific comments made by the AMA at pages two and three and going over to page four of their submission. They are basically saying that it is only \$650 million in new spending. There seems to be a contradiction between what you have said and what the AMA have said, or are you saying that the AMA is wrong?

Ms Huxtable: There are a number of ways in which figures can be cited and dissected. If you take a four-year figure—

Senator FIERRAVANTI-WELLS: If you—

Ms Huxtable: Not correct in this instance. You can take a four-year figure and you will obviously get a different outcome from a five-year figure. The figures we are citing are five-year figures. You can take a department of health figure only and clearly you will only be showing a subset of what the package is, which incorporates allocations for other portfolios. I do not have the AMA's figure in front of me but, hypothetically, the

figure cited here could be correct and our figure could be correct because that figure is a subset of our figure, both in terms of its four-year—

Senator FIERRAVANTI-WELLS: Ms Huxtable, would you clarify that for me? It seems to be a clear assertion by the AMA that contradicts what you said so would you take that on notice, if it is easier to deal with it on notice. It just seems to be a contradiction; that is the point I am making.

Mr Singh: I will have a very quick attempt to explain. The AMA has said that there is nearly \$650 million over five years which is the net new spend on the package. That is correct if you exclude all the other departments' spending—that is, it is a DoHA only figure—and it also takes into account the effect of the Better Access saves. So, in our view, that figure is incorrect because it does not allow for the cross-portfolio effect. It also does not allow for the fact that this government announced spending last year that contributes considerably to the bottom line of the package, which is an extra \$624 million, and excludes the effect of measures which are being taken forward, which will be spent on mental health purposes but which were absorbed in the budget, and that is another \$121 million. So, as a result of those, the true value of the extra spending in mental health over the next five years is in fact \$2.2 billion, before the Better Access offset.

CHAIR: So the \$2.2 billion is before the offset?

Mr Singh: That is correct.

Ms Huxtable: As is the \$1.5 billion.

Senator FIERRAVANTI-WELLS: Before the offset.

Ms Huxtable: What we have made clear in our thinking and in everything that we have written in regard to this is that this is spending on new initiatives, so it is new money going into new initiatives or growing existing initiatives.

CHAIR: Would you please still take on notice to answer in more detail from going through the AMA's statements.

Ms Huxtable: Sure.

CHAIR: Senator McKenzie has a question.

Senator McKENZIE: I do. It does not involve numbers. I was just wondering about the e-health initiatives that are mentioned as part of the package. My particular question goes to how the department envisages that people will be able to access these online services. Is it going to be by tottering off to their central clinic or in their own homes or community house? Is there some sort of idea about how people get to have their online counselling session?

Ms Harman: There are a range of existing online and phone based counselling services that we are funding currently, and those will continue. Those can be self-referral, referral from a GP or referral from another health professional, as I understand it. Those routes into services will continue to exist. There are basically three parts to the measures announced in this budget. There is the creation of a national online e-portal, or gateway, which will be a single presence on the web and a very well signposted entry point into those existing services and then a range of other services that will come online. We are hoping that we will be able to build accessibility and knowledge about these kinds of interventions and their efficacy and build confidence and trust in the fact that they are an alternative route to service. Again, an individual will be able to access the portal in their lounge room, in their bedroom, potentially in their GP surgery, through their Medicare local—a range of entry points, the point being that it is an interface that anyone can access at any time regardless of where they live.

The second component to the measure is a virtual clinic. One of the entry routes into service will be to this clinic, and that will be linked to the National Health Call Centre Network. The third component is a central support service to support health professionals in delivering these kinds of interventions.

Senator MOORE: Ms Harman, it is my understanding of the ones that are currently operating—and there is a wide range—that one of the initial parts of the discussion with the person coming in is their comfort zone in terms of where they can use it and so on. Certainly, in some of the ones I have been involved in, at the very start there is a bit of an interaction between the provider and the person about comfort, location and all that kind of stuff. Is that true?

Ms Harman: That is exactly right. I think one of the things that we need to take advice on—and we have formed an expert group to provide us with advice on these very matters—is what the right sorts of flags are in the system so that if you do enter and you self-drive, you self-direct treatment, there is a safety net around you so that you can be directed through either warm or cold transfer to an appropriate crisis intervention.

Senator MOORE: 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.

CHAIR: We are over time now. I know Senator Moore wanted to put on notice some questions about the two tiers.

Senator MOORE: There is not much in your submission. I know, Ms Huxtable, you were very clear that this has been ongoingly discussed and there was insufficient evidence—I think those were your words—in that area. I would not mind getting something on notice just about the background to how it happened, because there are differing views about how this two-tier system was introduced, the debate around it and what mechanism there is in the future to look at it. I would just like more about that, because, as you well know, it has dominated the evidence and also the evidence to the committee at the last hearing. Thank you.

CHAIR: Thank you. We will have quite a few questions on notice. You have already taken quite a lot of questions on notice, but we will have some more. We will get them to you as soon as possible. Thank you very much.

Proceedings suspended from 10:43 to 10:59

TOMASIC, Dr Maria, President, Royal Australian and New Zealand College of Psychiatrists

CHAIR: I welcome Dr Maria Tomasic from the Royal Australian and New Zealand College of Psychiatrists to today's hearing. I presume that you have had information on parliamentary privilege and the protection of witnesses and evidence.

Dr Tomasic: Yes.

CHAIR: If you do need some more information, you can get it from the secretariat. The committee has your submission, which is numbered 210. I invite you to make an opening statement and then committee members will put questions to you.

Dr Tomasic: On behalf of the Royal Australian and New Zealand College of Psychiatrists, I would like to thank you for the opportunity to appear before this inquiry. You may know that the college represents psychiatrists who are medical specialists with the broadest and most extensive training in the assessment, diagnosis and treatment of people with mental illness. We use a bio-psychosocial cultural model, which looks at individuals holistically in their physical and mental health, their family and social and cultural contexts. We have a long history of working in collaboration with other professionals in multidisciplinary teams in both in-patient and community settings and with people with mental illness, their families and carers.

I will not repeat the statistics of the extent of mental illness and its devastating impact on people's lives and on their families, carers and on the greater community in terms of emotional and financial impact and lost productivity. I think you are all aware of that and do not need convincing about that. You will also be aware of the drastic lack of services and the limited access to appropriate services. This relates not just to mental health services; people with mental illness also suffer much higher rates of physical illness but have reduced access to physical health services, for a range of reasons.

Many people with mental illness face the challenge of discrimination, multiple disadvantage and marginalisation within the community. First and foremost, the Royal Australian and New Zealand College of Psychiatrists believes that the investment in mental health is significantly inadequate. Mental illness occurs across the whole age group and there is no single entry point. Early intervention into all illnesses that may emerge in any age group is vital to reduce the severity and impact of illness. Services aimed at rehabilitation and recovery are essential. Sadly, many of the most disadvantaged groups with the highest rates of mental illness continue to miss out on services. These include Indigenous Australians, people with intellectual disability and autism spectrum disorders, people from culturally diverse backgrounds and those within the criminal justice system. I know this firsthand from my own personal work in psychiatry as a forensic psychiatrist specialising in people with mental impairment and victims of crime, working in the remote Indigenous communities of the Pitjantjatjara lands of South Australia for seven years, working as a visiting specialist with Disability SA and with people with intellectual disability and autism spectrum disorder, that there are significant lacks in services and people endure significant emotional distress, hardship and discrimination. Any cuts of mental health services, such as GP rebates and better access, is regrettable. We acknowledge that there may have been some problems, but we would advocate for finetuning of the program after appropriate consultation rather than a blanket reduction.

The reduction in GP rebates does not take into account the significant non-clinical time a good mental health plan takes and effectively penalises those GPs with greater mental health skills and interest. Reduction in better access for a maximum of 18 to 10 will mean a reduction in services for some people, as some will fall between the gaps that ATAPS targets a different population from the general Better Access program. Alternative solutions, such as linking the use of a greater number of sessions to increased skills and quality of service in allied health professionals is one option.

Workforce shortage is a major issue for psychiatrists, and we have welcomed the 96 additional expanded settings positions funded by the federal government. This allows more psychiatrists to be trained and increased training in a broader range of settings that better prepares them for the workforce. There is also a need to promote psychiatry as a career for the increasing numbers of medical students currently training and a strategy to address this is welcome and essential to increase workforce capacity in the future. The Royal Australian and New Zealand College of Psychiatrists supports the development of a mental health commission but that this needs to be independent of government to objectively report on the state and progress of mental health services.

CHAIR: Thank you. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: As the college, you are the principal organisation representing psychiatry in Australia and New Zealand and you have got about 3,000 fellows.

Dr Tomasic: That is right.

Senator FIERRAVANTI-WELLS: Were you consulted at all by the government in relation to these changes and these cuts, in particular to the Better Access initiative?

Dr Tomasic: We certainly had several meetings with the minister in the lead-up to the announcement but we were not consulted about the cuts to the program.

Senator FIERRAVANTI-WELLS: There has been reference made to the Mental Health Expert Working Group. Is anybody from your organisation, whether in their capacity because the appointments are to that body personally, on that group?

Dr Tomasic: There are no college representatives. Individual fellows may be on various committees but they are there in that capacity, not in the capacity of representing the college.

Senator FIERRAVANTI-WELLS: So whilst you have discussions with government, there is no formal mechanism whereby your organisation represents to government and you are not formally involved as the college on any mental health body, if I can put it in those terms.

Dr Tomasic: In some. I am now on the ATAPS reference group and that has been for the last two meetings of that committee. That is as a college representative. But that would be the extent of it.

Senator FIERRAVANTI-WELLS: In your submission you make comments that it is obviously regrettable that the cuts to mental health services will result in a reduction in service provision. You make the comment on pages 3-4 that these cuts will result in a significant disincentive for GPs. Obviously the college works very closely with GPs and works very closely with psychologists and other professions. Could you give us a snapshot of that relationship first and then elaborate further on that significant disadvantage that you see will happen?

Dr Tomasic: We have linkages with other colleges at various levels, including at the high level of the presidents of colleges and committee. I have had discussions about this with various people. Also many psychiatrists work fairly closely with GPs in their clinical work and so there is that communication as well. On the mental health plans, there is no doubt that there is a great range of quality in the mental health plans that have been developed by GPs. Some are excellent and some are minimal. I think that is a problem that has been identified and it is something that is worth addressing. However, cutting the rebate is not an adequate solution because to do a very good mental health plan takes an enormous amount of time. It takes more time than the clinical time. The BEACH data focuses on the clinical time that GPs spend to do the plan, but as anyone who works in that area will know, patients come with complex presentations, and those people with mental health problems often do because they have often got physical illnesses and difficult social and family situations. So there is time to write up the plan, time to make phone calls and talk to family and other people, and it is an enormous amount of time. What this is doing is penalising those GPs who have increased their skills in mental health knowledge and assessment and who enjoy the work and want to put the time into the work. That has been a very important part of increasing mental health services within Australia, because GPs are the first point of entry and many people do not get past that point, so having that expertise and rewarding that expertise does make a big difference and will make a big difference.

Senator FIERRAVANTI-WELLS: I am conscious of the time and that other senators want to ask questions, so I am just going to pick up some points from your submission. On page 4, you say, about the Better Access initiative:

One concern is that the system may not be meeting the needs of population that it was originally targeted to benefit ...

You go on:

Psychiatrists have also raised concerns about the lack of communication from psychologists when a patient is undergoing treatment from both professions ...

Could you just tell us a little bit more about those concerns.

Dr Tomasic: We have had quite a number of our fellows write to us and express their concerns about the fact that people are often referred to both a psychiatrist and a psychologist at the same time. Sometimes the gap before seeing the psychiatrist is longer, so they might have started seeing the psychologist. Sometimes that is done as an interim process, while waiting for the appointment with the psychiatrist, but sometimes it is done because the GP has assessed that the person needs both specialists. Many psychiatrists say that, in that situation, they have a great deal of trouble getting any information from the psychologist about what they are doing and how the person is progressing. So quite a number of psychiatrists write in and say they have phoned and they have written letters, but they get no response. That is a real problem because, of course, you could be working at odds. If you have two

treatments going at one time and one person does not know what the other person is doing, that can cause significant problems.

Senator FIERRAVANTI-WELLS: There has been a lot of evidence about that in these hearings. I do not know if you have had the opportunity to look at the transcript of previous hearings, but the issue of psychologists' training has arisen. You have expressed certain views on that, but it comes out fairly clearly from your submission that you think we should be looking at that. Obviously, cutting back on the health sessions is not the way to do it, but do you want to tell us a bit more about how you see that two-tiered system working and whether you think there should be any changes? If you do not have enough time, please take it on notice.

Dr Tomasic: First of all, I would like to say that I think psychologists as a group need to work that out, primarily. I would not want to suggest that I know more about it than they do, but one of the thoughts we have is that, if any change needed to happen, you could make the funding differential, based on people's skills. You could say, for example, if you wanted to limit the use of sessions up to 18 sessions, that that is available only to clinical psychologists because the sorts of people that might need 18 sessions have more complex problems. But they are not necessarily people who are going to fit into the ATAPS program, because that is a very different population. For example, you might have people with chronic depression and anxiety, with some personality disorder issues and perhaps with a background of abuse: they may be functioning on a day-to-day basis, they may be working and doing all those things, but they have enormous amounts of emotional distress and they want autonomy in choosing the service they want. They are not going to fit into an ATAPS model, but they need more than eight or 10 sessions. You really want people who have very high clinical skills dealing with those people and helping those people.

Senator MOORE: I do not know if that is going to help us in terms of resolving that issue, to tell you the truth!

Dr Tomasic: I know. It is controversial.

Senator MOORE: I understand.

Senator FIERRAVANTI-WELLS: I might go to a less controversial area. In your submission, you also say: The most recent National Mental Health Report shows the Australian average for community funded mental health is just 8.3% and most of the increase ... has occurred in the last four years.

Clearly, there could be a far greater role for community funding of mental health. How would you see that developed more, and do you think that the advent of a mental health commission is going to assist in any way in that sector?

Dr Tomasic: The move to community based services is absolutely supported. It is supported by people with mental illness, their families, their carers and professionals in the field. But it is costly. I think hospitals were invented because they are efficient and do not cost as much money as community based services because people come to the hospital. Community services, by virtue of needing to be extensive and varied according to the needs of the population that they are addressing, are costly and there simply is not enough investment in them. We hear on a daily basis from people with mental illness who say that when they need help they do not get it quickly enough, that people do not come to see them early enough, that they do not get the care they need. These services require greater investment, and obviously both state and Commonwealth government need to be involved, so that the system is cohesive and is linked with other systems such as inpatient and rehabilitation and recovery systems. I understand that the role of the commission is to ensure that what is being done is being done appropriately and effectively, so it will be vitally important that they look at the progress in community services.

Senator FIERRAVANTI-WELLS: So you see any commission needing to be an autonomous, independent body that does not just oversee but also evaluates what is done?

Dr Tomasic: Absolutely, and I think that is true of a commission in any area. Any commission looking at a system needs to be independent.

Senator FIERRAVANTI-WELLS: Are your state chapters working with the respective commissions in New South Wales—I know there is now a working group—and in Western Australia, and do you have a relationship with them?

Dr Tomasic: That varies from state to state. Often there is not a very extensive relationship.

Senator FIERRAVANTI-WELLS: You made a reference to early childhood. Whilst there has been a focus on youth, we have not really touched on that. Do you want to tell us a little bit more about that?

Dr Tomasic: I am very happy to reiterate that it is really important to know that mental illness can occur at any time in a person's life and that there are particular ages where there are high rates of the emergence of illness.

Childhood and adolescence are two such areas, but we also see emergence in people in their 20s, in mid life and in old age. Old age is an area that lacks services and will be increasingly in need of services.

Senator FIERRAVANTI-WELLS: Has the college done any work specifically in relation to early childhood?

Dr Tomasic: Yes, there has been some work on early childhood, addressing the need for increased services there.

Senator FIERRAVANTI-WELLS: We would be happy to receive that if that is okay.

Dr Tomasic: I can take that on notice and we can send you that.

Senator FIERRAVANTI-WELLS: That would be good.

CHAIR: We have not really been focusing on the emotional and social wellbeing of the three-year-old stream, and any more comments on that would be really appreciated, Doctor.

Dr Tomasic: All right.

Senator FIERRAVANTI-WELLS: I have one last question in relation to intellectual disability. Unfortunately we have not had any evidence on this, although we have had submissions from people from the intellectual disability sector. Can I ask you—and I think Senator Boyce has a particular interest—

Senator BOYCE: Yes. That was the question I was going to ask.

Senator FIERRAVANTI-WELLS: Why don't I leave it to you, Senator.

Senator BOYCE: Doctor, you have talked about how there must be funding and enhanced training for specialist intellectual disability mental health services. Could you talk a little bit more about what you think needs to be done there?

The other side of the question is the fact that there has not been a lot of take-up of the longer GP consultations—the name of the program currently escapes me—for people with intellectual disability, and how those two mesh together or do not.

Dr Tomasic: There is a very long answer, and I will give an abbreviated one. As you probably know, in Australia the history has been that intellectual disability has been managed by disability services, whereas in the UK it is a subspecialty of psychiatry. There is a long history of that, and I think they have—I have forgotten the number—hundreds and hundreds of psychiatrists who simply work in intellectual disability and autism spectrum disorders. Therefore they have a much greater history of expertise in the area, specialised units that manage that area and research in the area.

Australia has not had that. Part of that responsibility is about services, but part of that is also our college. That has not been something, and it is something we are starting to address. We have formed as a starting point a special interest group, and there has been an enthusiastic take-up of that because we are fortunate enough to have a number of psychiatrists in Australia who have come from the UK with that specialty. We also have a handful of people in Australia who work in that area. So that has started. That will move on. We have structures of special interest groups, then sections and then faculties. Once you get to sections, there is a greater involvement and voice in the college. Part of the reason for setting that up is for them to start looking at things like research and the training of our psychiatry trainees in the area, because currently they do not get training in that area. We are starting to do that, and I think that is really important.

But, because it has been part of disability services, there is a real schism between disability services and mental health services. Mental health services often refuse to take on people because they say they are being managed and case managed by disability services, but of course the case managers there are not mental health trained and they are not mental health case managers. That problem continues and it is a significant problem.

I work in a service. Disability SA employ me in the service I work in, and that is the first time they have employed an adult psychiatrist to work within that setting. That is because they found they could not get psychiatric assessments of people when they needed them.

There is a constant problem in that liaison between the two services, and that is both in general medical services and in forensic mental health services. You probably know that you get large numbers in that setting because often they are found unfit to plead and so, for example, in South Australia, under legislation they are not guilty by reason of mental impairment based on being unfit to plead. They would normally be within forensic mental health services, but forensic mental health services do not feel able to manage.

It is a complex problem, so there is a real need to increase the expertise of people in Australia and also have specialised services for that group, because they need special skills.

Senator BOYCE: Do you have any comments on the current MBS numbers for consultations with people with intellectual disability? I understand they are not being taken up at the rate one would anticipate, partly because of concerns, I gather, of GPs that they will simply become clogged with patients with intellectual disability and that they are not financially viable as they currently are. If that area is improved, does that help feed through to you?

Dr Tomasic: I do not know a lot of details about that and I would have to take that on notice, but that does not help psychiatric treatment of those people.

Senator BOYCE: No.

Dr Tomasic: It may improve access to psychological services within disability services, but I do not know enough about the item.

Senator BOYCE: If you could take that on notice, that would be great.

Dr Tomasic: Will do.

Senator WRIGHT: Dr Tomasic, thank you for a broad-ranging submission. It raised issues that have not necessarily been raised in other submissions, so thank you for that. I think it reminds us of the incredible level and layer of needs that this whole area cries out for, really, in terms of assistance. I am just going to take you back to the issue about the GP rebates in terms of the mental health plan. Representatives of DoHA and the government have been saying essentially that the BEACH data that they relied upon is consistent across the board and that that is only ever going to measure face-to-face consultations in relation to working out reimbursement for sessions. So why would you say that mental health planning or a consultation involving a mental health management plan should be treated differently—or would you say that it should be treated differently? I sense that you are saying that. Why?

Dr Tomasic: I think that the fact is that we need to have GPs with greater skills in mental health and to be motivated to do mental health plans and be involved in that. It is difficult work and it is time consuming. It is hard for anyone, let alone if people do not feel that they have as many skills as they could potentially have. So I think that there have to be incentives of some sort to keep GPs doing that work and to engage those who do spend substantial time. I think that generally it is more complex and it does take more time outside that clinical face-to-face. There are ways of addressing that. There could be a time-based system for the face-to-face and then an extra amount for writing the report. That is similar to one of the item numbers for psychiatrists. A structure like that might be more usable, because I understand that you need to have proof of work for payment. But I think that there are other creative ways of dealing with that. I think that just reducing the rebate is a disincentive.

Senator WRIGHT: I was interested in the gap that you identified in relation to, I suppose, the schism between intellectual disability services and mental health services. Another gap that you have identified, or another area where the college is suggesting that there should be more work done, is in relation to borderline personality disorders.

Dr Tomasic: Yes.

Senator WRIGHT: Can you talk a little bit more about that.

Senator MOORE: Thank you very much for mentioning it.

Dr Tomasic: Personality disorders were excluded from a lot of the services, yet we know that the rates of personality disorder are high. If we look at borderline personality disorder, they are very high, with very high suicide rates and rates of disability and also generational effects. For example, most people with borderline disorders are women, and their mothering skills are impaired by the fact of their having a borderline personality disorder. So if you do not address all those issues then you get multiple generational effects. Yet there is a lack of services. They also have very high rates of comorbid anxiety disorders, post-traumatic stress disorder and depression, and sometimes psychotic symptoms. So the multiple problems have often been considered too hard for services—too hard to manage. They need an organised approach. A lot of the care has been done in private, so up until recently—and there are some states who are providing services—the majority of care was actually provided by private psychiatrists, because public systems found them too hard, took them off the books and said that they did not need services because they did not have an axis 1 diagnosis. So a lot of work has been done, but it has been done privately. I think it is really important that there are services at all levels—adequate and comprehensive services for that population.

Senator WRIGHT: Can I follow up: is there any data that you are aware of in relation to the prevalence or incidence of that condition—whether it is increasing? Are you aware of any evidence?

Dr Tomasic: I am not aware that it is increasing. It has been fairly static for some time, but the rate is—I should know it.

CHAIR: Just take it on notice if that is okay.

Senator MOORE: I have two questions which are more or less on matters. One is about the fact that the aims of the whole Better Access process were not long-term treatment.

Dr Tomasic: Yes.

Senator MOORE: It was supposed to be an introductory process to get some treatment and then have appropriate referral. Can I get some indication from you, on notice, about referrals. I would really like to know how the referral process has been working, on the basis of people being referred to psychiatrists. I am really interested in your comment about duplicate referral and the one mental health plan. That interests me, and I wish there were some way to find out on how many occasions that happened but I do not think there is. I would like to know about the referrals process. I would also like to know about the other intent, which was to have a co-operative multidisciplinary team approach to people's needs—a patient centred approach. I am interested to know, from your perspective as a college, how much psychologists and other people who are treating under Better Access work with psychiatrists. I know that would vary, so that is on notice.

The third thing is a workforce issue. There were some concerns about locations of psychiatrists, which is one of the stimulants of this whole idea of looking at alternative service delivery options. Is there anything from your college about what the current spread of psychiatrists' services are and whether in fact there has been any discernible reduction in psychiatrist referrals and workload as a result of Better Access. From when Better Access started to now—

Dr Tomasic: There are a lot of questions.

Senator MOORE: I am happy to put them on notice. We will give it to you in writing, because they are quite specialised areas. It is to look at the intent of Better Access and what has happened. I am particularly interested in those areas. We will get give those to you in writing.

Senator McKENZIE: I love the word 'maldistribution'. I am sure that will find its way into my linguistic repertoire. You mention frequently the maldistribution of the field of psychiatrists and the workforce supporting the work of psychiatrists throughout your report. I wonder whether the college has any suggestions on what can be done or has any recommendations around improving that maldistribution. I am happy for you to take that on notice as well.

Dr Tomasic: Okay.

Senator McKENZIE: I am sure you have quite a long list. I wonder whether you have any comments about the education and training of psychiatrists here in Australia and of their support staff dealing with the particular issues around working with colleagues from other fields and that sort of thing?

Dr Tomasic: Do you want me to take that on notice?

Senator McKENZIE: I am not sure how pressed we are for time.

CHAIR: We are fairly tight for time.

Dr Tomasic: Okay, I will take that on notice. The short answer is I think we do very well with training, so I think it is easy to criticise. But we can always do better and there are areas where we need to do better. We are currently changing our training program to a competency based program. The expanded settings has been a very good innovation of the federal government because it allows for psychiatry training experiences outside public hospitals. Previously, it had to be done in public hospitals. We do the training but the positions are government positions. So they were all in hospitals. So expanded settings allows for a much broader range of experience, which is a very good innovation. We had 96 extra positions this year and that is very good.

Senator McKENZIE: From a psychiatric perspective, how do you view e-health initiatives and how do you see them working in this space?

Dr Tomasic: I think e-health is really important. Society is changing, but it is not a replacement of other treatment or other information. Psychotherapy is one of the most powerful things in helping someone deal with an illness, no matter what it is—whether it is psychosis or whether you are dealing with grief. A degree of psychotherapy is involved in that treatment. I did read one of the statements that psychiatrists do not do that. I would like to stress that psychiatrists do do that and we do it in every session. It may just be supportive psychotherapy or it may be intensive psychotherapy. There are different kinds. There is no one treatment that is appropriate to every condition or every person. What we do know is that one of the significant things in changing someone is the relationship that forms between the person and the therapist. E-health takes the person bit out. It is

important to give people information, to give them some autonomy in getting that information so that they know where to look, because there is so much on the web now and there is so much misinformation that that is a useful thing. There are some short-term therapies that may help ease people's distress for a time, but I do not think it replaces services. It will never mean that you need fewer face-to-face services.

Senator McKENZIE: What about face to face, like a teleconference?

Dr Tomasic: Teleconferencing is also important, but, again, for example, in the work I do in remote Indigenous communities they do not have teleconferencing, which is a real problem because that would complement the service. If I visit there eight times a year that means, in between, you could have telepsychiatry consultations with the people you know. You need to know them for that to work. If you have never seen them you do not have the same relationship. It would be incredibly effective once you do have that relationship and people know you and the community know you and the families know you. Then it would be very effective at increasing the amount of services. So we certainly support the rollout of telemed.

One of the concerns of course is that there is not going to be just one platform. So there is the issue of compatibility of hardware, if I have got the right terminology. I understand that in Canada they had the same problem, where they use different systems. So they spend enormous amounts of money now trying to make them be able to communicate with each other. That is something where, if it is too hard people will not take it up, because psychiatrists are not looking for work. They will do something if they think it is going to benefit and it is going to be useful, but you do not really have to do it. So I think it needs to be very user friendly for it to be successful.

CHAIR: Thank you. We will have to wind up, although there are probably a lot of questions people would like to ask you. We have given you lots of homework. It shows how interested we are. Thank you for taking the time and trouble to make your submission, to appear today and to take on the homework.

Proceedings suspended from 11:37 to 12:04

PARHAM, Ms Jennie, Principal Network Adviser, Mental Health, Australian General Practice Network**WELLS, Ms Leanne, Chief Executive Officer, Australian General Practice Network**

CHAIR: I welcome representatives from Australian General Practice Network. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I am sure you are used to it.

We have your submission; it is numbered 191. Thank you for that. I would like to invite you to make an opening statement and then we will ask you some questions.

Ms Wells: The Australian General Practice Network—I will use AGPN for short—welcomes the opportunity to speak to the Senate Community Affairs References Committee inquiry into Commonwealth funding and administration of mental health services. Our comments today will relate particularly to the terms of reference related to the adequacy of services provided to people with mental illness under ATAPS, to services available for people with severe mental illness and the coordination of those services, and the changes to the GP Mental Health Care Plan MBS arrangements.

Overall, we welcome the federal government's mental health package. It is a much-needed area of ongoing mental health reform, and these investments, in our view, should build on rather than dilute the successes and strengths of forerunner programs like Better Outcomes and Better Access. As a sector responsible for the implementation of ATAPS and a sector that has also played a role in headspace centres, with many of our member divisions auspicing headspace, we are particularly pleased that both these service platforms are to receive additional funds. It has been all too clear in the past that, while these service models have injected much-needed new services that are complementary to MBS funded services, these are capped programs and it has not been uncommon to see demand outstrip supply.

It is fair to say that ATAPS has had somewhat of an ecological development. It is a flagship program, in our view, and the recent review of the program, which involved input from the field as well as from experts, has rightfully highlighted a number of areas for continuous improvement. Those areas relate particularly to issues such as quality and standards, efficiency and the innovation required to address service gaps, and the steps to ensure that services are most appropriately targeted in order to best complement other services such as the MBS funded services and those that are state funded. We are taking a lead role in working closely with the department and other professional associations to work on those issues and to build the capacity of Medicare Locals in primary mental health care, principally through ATAPS.

We have been funded to develop a clinical governance framework for ATAPS that can be implemented in the Medicare Local environment and also to do a systematic workforce mapping exercise to better understand the status, skills and qualifications of the ATAPS workforce. The thinking behind that is that that will enable us to better understand and work with the field on workforce recruitment, retention and improvement strategies. It will also help provide the field with advice about service models that operate best in a capped funded environment. We are also part of a joint initiative with the Australian Psychological Society which is about developing purchasing guidance, if you like, for Medicare Locals, for services to children and people with serious mental illness.

So we are faced with an expansionary and a challenging environment. ATAPS and related programs make for an opportunity to really embed a robust primary mental health care system. But this also means investment in those functions over and above what you could describe as straight program administration. I am talking about functions such as service planning; service development; partnership and linkage development with other providers, such as state services and those provided by the NGO community; quality improvement; and addressing workforce issues such as supervision and continuing education. We have always had the view at AGPN that these functions are a legitimate part of running a quality nationwide service and that they should be funded appropriately.

Of course, the delivery of the mental health package and the expansion of ATAPS and headspace cannot be divorced from the broader health reform environment and the national health reforms, particularly the introduction of Medicare Local primary healthcare organisations and the role that they are to play in implementing the mental health package.

We have read some of the previous *Hansard* reports and there appears to be some confusion about what Medicare Locals will look like and what they will do. I think the first point to make is that they will be different from divisions of general practice but will subsume and add to the roles and functions delivered through and by

divisions. Put simply, they will be independent companies limited by guarantee. From a membership perspective, they will involve local organisations in a broad range of primary health care providers and, from a board perspective, they will be governed by skills based boards with skills related to the functions of Medicare Locals. The main functions are as regional planners, coordinators and purchasers of services and in some cases they may have an arm that provides services as well so you can see the logic about why they would be built on divisions of general practice in the role that divisions have played in ATAPS. The functions that they will undertake broadly but with respect to ATAPS and primary mental health care include needs assessment, determining local health priorities, planning solutions and implementing those. It is also important to say that those are not exclusive functions. They are often shared with other parts of the system, so collaboration such as with local hospital networks will be important to how Medicare Locals fulfil their role.

We are very conscious of the need to manage the transition from the division's environment to Medicare Locals carefully with respect to ATAPS and related programs to ensure service continuity. We have a transition project at AGPN with a staff of four that has been tasked with assisting divisions with the transition. It is particularly focusing its attention now on supporting establishment and transition with respect to programs and services and working closely with program management staff like Jenny on all aspects of transition.

I would like to close with a few comments now about the changed arrangements to the GP mental health care plans. Under Better Outcomes which commenced a long time ago now, 2001, which was the forerunner to better access, general practice was formally recognised as part of the mental health workforce for the first time. It was quite a watershed initiative. As the RACGP and the AMA have also indicated an essential component of the reform now on the table is the integration of general practice into a broader primary healthcare context providing a mechanism for more integrated services and improved patient outcomes. Why do we say this? There is evidence that shows that the best health outcomes are achieved in systems where there is a well-developed primary healthcare system with general practice at its heart. The recent decision by the government to reduce patient rebates for general practice mental health care plans is not aligned with that.

I close with one of our main points that changes to the mental health rebate for the plans and the expanded measures which are enormously welcome through the budget mental health package are actually interconnected. It is unfortunate that they have become an either/or proposition when maintenance and expansion of funding for primary mental health care overall including services provided through the general practice setting are warranted. Thank you.

CHAIR: Thank you.

Senator FIERRAVANTI-WELLS: Just on that point, Ms Wells, it is really a robbing Peter to pay Paul arrangement where basically what you are saying is that, if they are going to expand services, they need to just expand them rather than cutting one to help fund another. I want to ask a couple of things that arose as a consequence of the last hearing. One was that there were some comments made by various people about the usage of more junior psychologists through the ATAPS program. I think there was some criticism that. Perhaps, Ms Wells, you might like to address some of that at this opportunity.

Ms Wells: I might ask my colleague to address that one.

Ms Parham: I understand that that has been raised in hearings. That is not necessarily normal practice across all the general practice networks. I think they employ a variety of staff. In some cases some general practice networks employ a single discipline, in some other cases there are multidisciplinary staff. At times, because of the funding arrangements and the workforce shortages in many cases that may well be the case. I think it is a real juggling act for the network in terms of trying to get the best people to provide the services in the circumstances with the funding. That is one of the things that we are about to try to look at to get some more substantial and significant information on exactly what the ATAPS workforce looks like because we have some of the workforce that is subcontracted and some that is employed. Many general practice networks find it extremely difficult to actually recruit an allied health workforce, particularly in the rural and remote areas. Sometimes it is a matter of needing to get the best that is available as opposed to having the ideal environment for recruitment.

Senator FIERRAVANTI-WELLS: You suggest at page 5 in your submission that the funding model for ATAPS has not kept up with its expansion. I have two points. One is the reference in the AMA submission—I am not sure if you have seen that; I raised it this morning with the department—about administration costs being more 75:25 rather than the 85:15 that has been delineated. Would you like to make a comment about the accuracy of that 75: 25 ratio? Secondly, with the increased responsibilities you are going to have and the increased numbers that the government is asserting will come through the ATAPS system, that 85:15 certainly will not hold. Is the 75:25 a more accurate reflection of what you are going to be facing in terms of admin costs?

Ms Wells: We have made it clear in our submission that we think the 85:15 ratio is inadequate. Our key point in making that statement, though, is that we would draw a distinction in relation to the sorts of activities that that 15 per cent would cover by way of administering a program, managing a contract with government, entering data into a minimum dataset, which are some of the program administration types of activities that divisions do as a routine undertaking in managing ATAPS. Where we think there needs to be additional capacity is for something that you would not necessarily categorise as administration but it is a legitimate function of service delivery and service design, and that is to have capacity to do the local consultation and work with local hospital networks and state funded services about how this new expansionary funding into ATAPS can be best mobilised on the ground. It is meant to be a targeted program, so you would not want a division to just replicate a state funded service in the region; you would want it to integrate and to target elsewhere. They are quite sophisticated service development and planning functions that you cannot buy with a 15 per cent admin vote.

Senator FIERRAVANTI-WELLS: Were you consulted about these changes before they occurred or did you just hear about it on budget night?

Ms Wells: The changes to Better Access?

Senator FIERRAVANTI-WELLS: Yes.

Ms Wells: We were asked to go to a meeting, about two weeks prior, where there was some indication that the government was looking at the funding envelope for the overall package, but we were not aware of the nature of the changes until budget night.

Senator FIERRAVANTI-WELLS: Were you consulted about the ATAPS changes and the effect that it would have on your network?

Ms Wells: We have been participating in a thing called the ATAPS Expert Advisory Committee. We also work very closely with the department on ATAPS implementation and design directly through our Principal Adviser Mental Health position. So there were elements that we were consulted on and there were elements that we were not, but overall we are comfortable with the thrust of that.

Senator FIERRAVANTI-WELLS: You talk in your submission about the devaluing of the GPs' role in mental health care and the loss of GP engagement in mental health care. Are these propositions that you put to the government as part of those discussions?

Ms Wells: Post the budget announcement, yes, we have.

Senator FIERRAVANTI-WELLS: So it is fair to say that your discussions with government before the budget were in very general terms. You were not consulted or advised; you had no indication before the budget that they were going to make such substantial cuts to Better Access.

Ms Wells: Not prior to the budget, no.

Senator FIERRAVANTI-WELLS: In your submission, in relation to the mental health treatment plans and being the gateway to accessing Better Access as well as ATAPS, you talk about the risk because of the reduced remuneration that GPs will do a management plan instead of a mental health plan. Could you elaborate a bit on that because that is obviously going to have an effect on patients?

Ms Parham: Our belief is that there could be quite significant impacts on ATAPS from the reduction in the Medicare rebates. A lot will depend on the initial reaction of GPs and how they translate that into action, but many of them have said that they may need to charge a fee or a co-payment. We would see this as a very significant barrier to a service that is supposedly free for the client because of the vulnerable state that they are in or the fact that they are of a lower socioeconomic status. All of those are reasons why they should be able to access the ATAPS program. If they had to pay a co-payment, that would be even more of a barrier. We are already finding that many people in the tier 2 categories for ATAPS are not connected with a GP. By the very nature of being in a vulnerable group and at risk, they are not already connected with primary care. It is already a challenge to get a GP treatment plan in those circumstances, so to add another barrier of a co-payment would be significant.

Senator FIERRAVANTI-WELLS: Then you go on to talk about the stigma complicating and compounding the issue.

Ms Parham: That is exactly why tier 2 has been established with ATAPS—to allow more flexible referral pathways and to try and increase and improve access to primary care. So there are already provisions within the ATAPS program now under tier 2 for there to be different referring agents. But there still needs to be a GP as the pivotal person in the overall care of the patient. For example, women in the perinatal period may be able to be referred to ATAPS via a child and maternal health nurse, a paediatrician or a mental health nurse, but we also

need them to be linked to the GP at some point. It is not good for women in the perinatal period, for example, not to be receiving good general practice.

Ms Wells: On the other point about how you best meet the mental health care needs of vulnerable populations, we have read closely the evidence given by headspace, and we were a founding organisational member of headspace, so we support that initiative strongly. But, as Jennie said, GPs need incentives to work in settings outside of what you could classify as mainstream primary care or general practice. The unintended consequence of an initiative like headspace, which is the very service platform we are trying to expand here, needs to be taken into consideration.

Ms Parham: The other unintended consequence is that at the moment GPs undertake additional training to get the increased rebate, and there is going to be a real disincentive for that in the future under these changes.

Senator FIERRAVANTI-WELLS: Overall, though, it is just going to reduce the numbers who are going to be able to get access. There will be less access under Better Access, there are qualifications in relation to ATAPS, and then of course there is the flow-on to headspace. So the overall number of people in Australia who are going to get assistance for mental health issues will be less. That is the bottom line. Ultimately, it is a savings measure and these are just backdoor ways of doing it.

CHAIR: Is that a question or a statement?

Senator FIERRAVANTI-WELLS: I am asking: do you think that there will overall be fewer people accessing mental health services in Australia?

Ms Wells: I think it is hard to predict at this stage. A primary mental health care system needs to be designed around two platforms. One is the Better Outcomes or Better Access design about access to care, early intervention and brief interventions for people with low-prevalence disorders—and that is where the high prevalence in the population is. Equally, we need much more targeted, fit-for-purpose services programs for vulnerable populations which we know are at the pointy end, like young people with early psychosis, young people with comorbidities and mental health problems associated with poor access to employment or poor family relationships. So it is hard to predict, but it is not an either/or debate, which is our main point.

Ms Parham: If I can just add, there are also other programs besides Better Access and ATAPS that provide services to these population groups. Some are Commonwealth funded; some are state funded. You probably would have heard of the Mental Health Nurse Incentive Program. Some of the same MBS item numbers are not needed. That is a Medicare based program. In South Australia the Mental Health Shared Care with General Practice Program is uncapped. It is for people with complex and serious mental illness. Many of those that are seen under the exceptional circumstances elsewhere under Better Access are seen in that program. That is funded to every GPN in South Australia. So there are other models that are state funded that also link and integrate. That is again one of the functions of the GPNs and the Medicare Locals in the future. They have got multiple sources of funding for primary mental health care, and increasingly it is going to be absolutely significant that they liaise with state funded services, not just state funded primary health care programs but state funded services such as A&E departments and crisis support services to support the Commonwealth funded programs through ATAPS under suicide prevention and other areas.

Senator MOORE: Thank you for coming to see us. I only have a couple of questions. In terms of the work that you do in the network, have you heard any comments about the varying quality of medical referrals and medical health plans? Is that something that is discussed?

Ms Parham: We have, yes.

Senator MOORE: Without putting judgment, there is a discussion around there. Obviously with any professional there are varying qualities. In just the quality of the mental health plans, there is discussion?

Ms Wells: Yes, there is. There are solutions: education and training quality assurance.

Senator MOORE: Sure. In your submission there is a comment about the proposed tender process that I would like to tease out a bit more. I would really like you to give us a bit more information, because you are the only person who has so far mentioned that and dedicated time to it in your submission. I would like to hear a bit more about your concern about what is a standard process in government. Some of us have different views about the effectiveness of tendering, but you have made that point. Could you share with us a bit more of your concern there?

Ms Wells: Certainly. Our concern comes from the perspective of the role and function of Medicare Locals, which is principally not to be service providers, versus the role and function in the context of the care coordination measure in the budget package, which would be appropriately delivered by a whole raft of non-

government service providers, because that is what they do well. We would be concerned that Medicare Locals that are a meso-level or a regional-level planning, coordinating entity that need to have productive partnerships, relationships and linkages with the social care sector set off and are pitted against the NGO community in an adversarial or contestable environment. I think the model that works well and that we would advocate for—and I gather the government is thinking seriously about this approach—is the headspace approach, where, sure, you have got to have a lead agency, but the principle of a regionally developed and coordinated local solution to how care coordination could work best needs to be developed in a partnership framework involving all the planning or delivering organisations coming forward with a consortia approach. I think we have seen that work very well in headspace, where the health sector, divisions, the social care sector and the welfare sector have worked together on a headspace model and brought that forward, albeit in a tender environment—that is okay. I just think the principal tenet here is about a partnership approach rather than a contestable one.

Senator MOORE: So the tender environment, which seems to be the model that is used in most distribution of funding?

Ms Wells: Yes.

Senator MOORE: The environment is okay. It is how it would be formed. This consortia model seems to be more and more practical and successful. So it is not the tender as such; it is the methodology of the tender.

Ms Wells: That is right. We certainly appreciate that tendering is a way of procuring services.

Senator MOORE: I have just one other question. We had a little bit of discussion with Senator Fierravanti-Wells about the quality of experience of some of the psychologists that take part in the ATAPS—that is very good. We have had evidence from people to say that, under the ATAPS model, nobody will do anything because they do not get enough money out of it. That is a wide statement but not too wide in terms of evidence we have received about the process such that some people may be better serviced by going through the ATAPS model, as opposed to any further ongoing process through Better Access, due to the nature of where they are and their types of service needs. We had evidence this morning from an organisation and also it has been, if not said directly, pretty clearly indicated by some people who are opposed to the transition to ATAPS that, the way the ATAPS funding operates, no professional will want to be involved in it because it will cost them too much and they will not get as much reimbursement. Have you found in the operations to now that it is not just the experience of the practitioner—it is availability and location and sometimes finding anyone—but some practitioners self-select out of the process because they say they cannot afford to operate in a model where there is no copayment?

Ms Parham: I think fundamentally the first thing is that Better Access is very different to ATAPS. Secondly, there is a plethora of models in the way that ATAPS is delivered. As Leanne said, it has had a very ecological development. One of the things that we really want to see some significant investment in over the next little while is looking at standards, service delivery models, clinical governance and those sorts of things. I think there are mixed models. Some GPNs employ staff, and more and more are going to that model because it is a more effective use of resources, but again it depends on the level of ATAPS funding that a general practice network will get.

Generally those concerns are probably raised by private practitioners who want to work across Better Access and ATAPS. It depends on the subcontracting models. Again, this is an area for future discussion because it is fairly inconsistent across Australia, so what happens in one area does not necessarily translate to another. We really do have to look at standards and consistent practices in the way that the allied health providers are utilised in ATAPS—in terms of standards around whether they are subcontracted or employed and so on—because, again, there are different funding levels going to each network and there are differing constraints. So that may well be an issue that is raised, but I do not necessarily think that it is across the board and universal.

Ms Wells: The other point I would make in response to that is that I do not necessarily think it is a bad thing that some ATAPS services have junior psychologists working within them. As Jennie said earlier, sometimes something is better than nothing. When you are talking about a rural community, if you can get some sort of psychological care, it is better than nothing. That is the sort of work that we want to do through this clinical governance framework. If junior psychologists can be supported through supervision and access to a senior clinician to oversee their work, and the duty of care issues and all those sorts of things are appropriately managed, it is actually a way of attracting and retaining a mental health workforce into the primary care environment.

Senator MOORE: And developing one.

Ms Wells: Yes.

Ms Parham: Because ATAPS is strongly shown in the guidelines to be multidisciplinary. If GPNs only employed the most expensive and highest qualified psychologists, that would probably take up most of the funding and they would not necessarily then be able to provide the level of service.

Senator WRIGHT: Thank you for your time today. I have two questions. One of them is in relation to some points that were made by the Royal Australian College of General Practitioners at the last hearing about some difficulties experienced with the ATAPS program. One that I do not think we have addressed today is the fact that often there are quite bureaucratic hurdles involved and, with mental health interventions, often timing is of the essence to be able to respond effectively and quickly, so that can be a particular issue. Would you like to comment on that?

Ms Parham: Yes, I can comment on that. Again, this is sort of a variance, but in some divisions, for example, GPs need only do a mental health treatment plan; in others they might be requested to do a referral form as well. Most of them are required to do an outcome measure, because that is what the evaluation requires. But, again, it is some of the processes that are in place in some GPNs, which are different across the board. Some have a triage service where they can decide which program is going to best fit the client, and the client can be seen fairly quickly. With others there may be a gap in terms of how soon they can see someone. But, again, I agree that they are some issues that we believe we need to work on in terms of flexible and responsive services, service development and improvements in that way to make it a bit more consistent. Sometimes also GPs are not aware of some of the other flexibilities, so there is a bit of awareness raising and education that needs to happen for them to understand how to better use the system. So it is again a responsibility of the network to do that.

Senator WRIGHT: Thank you for that. The other matter that I found of interest in your submission—although it was tantalisingly brief, really—was the point that you make in terms of workforce shortages into the future. You say:

There is an emerging case for consideration of a new, appropriately credentialled workforce/s that can provide a different level of service.

What do you have in mind there? Can you expand on that a little.

Ms Wells: I am sure Jennie will elaborate on this. What we have in mind there is really modelled on an initiative that is centred around what is termed a 'low-intensity worker' in the UK. This is something on which beyondblue have invested in a feasibility study, and I believe they are looking to support a pilot of it in this country—because we would not for a moment advocate simply importing it. The two systems are very different, so you really cannot take a model of care from one country and implement it universally in the other. So our support for it is tentative. A bit like you, we are tantalised by it, because we think it could fit a stepped model of care. In terms of case identification, supporting early help-seeking and supporting lower level psychosocial interventions, it is a 'horses for courses' approach. You do not necessarily need a highly qualified clinical psychologist to do that but, with a low-intensity worker that is appropriately credentialled against a fit-for-purpose curriculum, there is scope for some workforce development in that space.

The other workforce that, of course, is growing in the primary healthcare environment is practice nurses. They have grown, I think, from about 2,000 to about 9,000 over the last seven years. So again it is horses for courses. You would want to keep interventions within appropriate scope of practice, but again it is another workforce that is front-line care and that we could look to to skill up.

Senator WRIGHT: So watch this space.

Ms Parham: That has been demonstrated with the Mental Health First Aid program, which has trained general citizens and delivered. So, with good assessment by professionals, I think there is a growing case for looking at a whole new workforce that can fill a gap at that end. We know we need specialists at the pointy end, but we can certainly look at it at that early stage, particularly with Australia being a world leader in mental e-health programs, where people can be coached to use those online programs, which is a part of this model.

Senator MOORE: There is also some of this stuff in the PHaMs network.

Ms Parham: Yes, I was just going to mention the personal helpers and mentors.

Senator MOORE: You have workers and that kind of thing in PHaMs.

Ms Parham: I think we have, untapped into, another whole workforce. We are just continually relying on these few disciplines to provide all the face-to-face services. We need to use their specialist skills, but I think we need to be creative and innovative and look particularly at access. Young people are not necessarily looking at face-to-face; they are much more likely to go online and so on as a method of getting help. The evidence is very strong about help-seeking for young people. So I think we have to get a bit more technologically savvy in the way that we think about our programs.

Ms Wells: We would not be advocating a low-intensity service model that is divorced from the primary healthcare system.

Ms Parham: The linking to the high-intensity—

Ms Wells: It would need to be integrated, yes.

CHAIR: We have to move on; I am aware of time.

Senator McKENZIE: I have three questions which I am happy to put on notice or for you to answer. I guess everything you have spoken about today presupposes a model of care from a GP where every person has a GP who case manages a person's health issues across a range of sectors. Am I right that that is the assumption that we are basing this conversation on in terms of GPs' relationship with the patient?

Ms Wells: I do not think that we can assume that everyone with a mental health problem has a GP as a coordinator of care. We are saying that a strong, responsive primary mental healthcare system needs a team based approach and that means a GP working with a psychologist working with a psychiatrist, or a team that is appropriate to the patient's needs. We say that there are different pathways into the primary healthcare service. Again, headspace is a good example where you have a soft entry point, if you like. A young person may not necessarily have a GP but the service is designed in such a way that their access to a GP that can look after their ongoing care, sexual health problems et cetera is facilitated.

Ms Parham: Could I just add that a lot of the programs in tier 2 of ATAPS can be group based programs. Also there are a lot of collaborative models with NGOs. For example, where you do not have a cohort of a client population seeing a GP but being seen in an NGO, there are ways you can put in a resource or work where the population group is. So, even at an individual level you need some GP involvement; it does not mean that that is the entry point. Increasingly we want to work more collaboratively in the service models so that people can be serviced where they are and with the community groups that they are involved in.

Senator McKENZIE: You have spoken a lot today about processes and said that we need to have processes in place et cetera. On page 6 of your submission I have highlighted the sentence:

This will facilitate the implementation of a quality assured program with capacity to support clinical workforce development and data collection among other things.

Were you referring specifically to the mental health plans when you were making that comment or is there a wider issue around data collection?

Ms Wells: I think it was more in the context of ATAPS.

Senator McKENZIE: Do you want to expand?

Ms Parham: There is a whole range of data we would like, I guess, over time. The immediate priority is to get some data on the workforce. The second priority is to begin to get some data on the programs, because there is a degree of service integration that is required. So we want to begin to get a profile, in any Medicare local, of what their mental health programs are looking like, and also what the needs are of their population. We want to know whether the kinds of services they are offering are matching the population need.

Then I think there is a lot more—this is probably a role for the ongoing evaluation of ATAPS—that we can do with the outcome measures in terms of looking at patient improvement. Under the Medicare locals we can look at consumer satisfaction. This is all part of the quality agenda in ATAPS. We can begin to look at whether consumers find the services are getting are of the quality they need and how we can improve that. So we need to have consistent consumer data.

Senator McKENZIE: So at the moment we have the plans and everyone is running around and doing their thing. Does anybody check whether people have dropped out or whether they have recovered? Do we have data on that?

Ms Parham: The University of Melbourne may have some data on that. I would have to check some of their data in terms of tracking. One of the issues—I am going back to an earlier point about contracting versus recruitment—in ATAPS, which is a free service, is DNAs: 'do not attends'. Often people do not attend, particularly if they do not then have to pay for the session. This is a huge issue in terms of demand management strategies. Where you have a subcontractor you would have pay them even if they do not see the person. So there are all those sorts of issues and challenges that are required.

Senator McKENZIE: On page 16 of your submission you discuss online consumer education and training and your strong support of the e-health portal and the consolidation of education modules and information. Do you not support e-health as method of treatment?

Ms Wells: As a method of treatment? Yes, we do support it.

CHAIR: Thank you. You have some homework. Thank you for your submission, your evidence today and your future homework; it is much appreciated.

Proceedings suspended from 12:45 to 13:25

BLACK, Mr Quentin, Secretary, Psychologists Association (South Australian Branch)

NIPPRESS, Mr Adrian, Industrial Officer, Psychologists Association (South Australian Branch)

TUSTIN, Mr Don, Coordinator of Private Practitioners, Psychologists Association (South Australian Branch)

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. We have received your submission, which we have numbered 215. Would you like to make an opening statement?

Mr Black: We have provided a written copy of our opening statement. I would like to talk through some of the key points in the statement. On behalf of our members I would like to thank the Senate for establishing this inquiry and express our appreciation for the efforts of the committee, members and staff for organising the review and inviting us to give evidence today.

Our members have a strong commitment to consumers and their equity, access and participation in specialist psychological services. They were shocked and dismayed by the drastic cuts to psychological services given the positive appraisals of the Better Access programs. The 45 per cent cuts to programs that deliver direct psychological services to consumers is so marked as to render the programs almost unviable. In particular, these cuts marginalise—and this is a major concern for us—the most vulnerable people in our community: people with complex needs and co-morbidities, children and consumers from low socio-economic groups and from regional, rural and remote communities.

Contrary to views that Better Access psychological services are delivered to people with mild mental health problems, the 2006 Tolkien II report suggest that for the treatment of depression by clinical psychologists we would expect to see three per cent mild, 57 per cent moderate and 38 per cent severe cases in a typical spread. A brief examination of my own case load on the last 100 patients screened for depression indicated figures more consistent with one per cent mild, nine per cent moderate and 30 per cent severe cases.

Presently, one of the frequently occurring dilemmas relates to people with more complex needs being seen initially by less-qualified practitioners, who use up most of the Better Access sessions prior to recognising the need for specialist psychological or psychiatric intervention, by which time the consumers' choice has become limited by their means to pay for services.

With respect to the required number of sessions, the Tolkien II report suggests 10, 16 and 24 treatment sessions for mild, moderate and severe depression. Recently, Harnett et al, 2010, suggested a minimum of 20 sessions as necessary for the reliable improvement and recovery of patients with psychological disorders. By comparison the MBS book notes in July 2011 offers the following comment from the Royal Australian and New Zealand College of Psychiatrists:

On the basis of advice from the RANZCP it is expected that it would be generally inappropriate in normal clinical practice for psychiatric treatment performed out of hospital to extend beyond 220 sessions in a calendar year.

The college is suggesting they would not like patients to be seen more than once a day, effectively. There is a wide range of well researched views that would indicate that interventions by psychologists limited to just 10 sessions in a calendar year are less likely to be effective for many of the patients we see and it has really turned, we believe, the Better Access program into more like a limited access program.

Regarding budget expenditure measures, naturally our members would like to see the government's cuts to psychological services reversed in order to receive some small measure of balance in the government's approach to delivering mental health services.

Better Access service shortfalls, compared with the Tolkien II estimates, highlight the need to enhance, not to cut, access to psychological services, especially in rural and remote communities. We were advised in recent discussions that in just one of the 30 remote Central Australian Indigenous communities serviced by GPs and psychologists there have been two fatal adolescent hangings and 13 attempts in the last couple of months. Regarding the trebling of the number of headspace offices at a cost of \$197 million, we oppose this funding initiative. Our experience suggests that the existing funding should immediately be reviewed and evaluated as to its efficient use of taxpayers' money. We would like to provide in camera evidence highlighting the misuse of

headspace, the better access program and ATAPS funding. This has come to our attention as a consequence of our association's GP Assist program. We also have a brief individual story which the individual involved has requested we bring to your attention. It highlights the difficulties facing consumers associated with Medicare accredited, yet minimally trained, unregistered, unregulated, uninsured and unaccountable, service providers.

Finally, regarding the National Partnership Agreement on Mental Health, with \$201 million over five years to address major service gaps, we respectfully suggest that the most prominent service gap now present is in the provision of specialist psychological services. We would like to see some of this money diverted into restoration of those services. Specifically, we would like to see: the reinstatement of 18 being the number of sessions clients can attend under the better access program; rural and remote outreach support for psychologists, to enable them to provide programs and outreach services such as MSOP and telemedicine initiatives; the creation of an assessment and treatment care plan item number for specialist psychologists, which we believe could save the government considerable funds; and the creation of a consultation item number for specialist psychologists to consult with parents and carers of children. Finally, we would ask that the government return to a policy formulation based upon consultation with consumer groups and a broad range of people working in the area and upon objective and well-conducted evaluative research and outcomes.

CHAIR: Thank you. Dr Tustin, do you want to make an opening statement or are you happy for us to go to questions?

Mr Tustin: I am happy to make a few more expansions on the opening statement. Psychology is a science, and we respect decisions that are made based on evidence. We recognise that the better outcomes program has been evaluated with very positive outcomes, which are listed on the written version of the paper I have submitted. The ATAPS program has also been evaluated, by the Australian National Audit Office. On page 15 of their report they say, about the ATAPS program:

... the administrative arrangements established by DoHA have not consistently supported the achievement of program objectives ... there has been variable administrative performance ... in relation to a number of important program elements including: the allocation of program funding on the basis of identified need; monitoring compliance with program requirements; and the administration of new ATAPS initiatives.

We are very concerned to learn that the government plans to transfer money out of a program that has been well administered and has had good results with clients into another program that does not have a good background reputation. We see that as a risky strategy. We think it is especially likely to disadvantage a middle group of clients. We believe that there is a need for support for people with severe disability from mental health issues. We believe the better access program, as revised, will support people with a mild condition; we are very concerned about the middle group of people, those with a moderate condition. In the paper there is some detail about what those individuals look like at a demographic level. We believe that cutting back the number of sessions available to clients from 18 to 10 will make it almost unethical to commence treatment with those people, because that is an insufficient number of sessions to complete effective treatment. That middle group, those with moderate severity, is the group that benefited most from the first version of the better access program, so we are highly concerned about the impact of this cut on them.

CHAIR: Mr Nippress, did you have any further comments?

Mr Nippress: No, I am happy for the committee to move to questions.

CHAIR: Okay. Senator Moore.

Senator MOORE: Thank you, gentlemen. Your arguments are specifically about the cutback to the Better Access psychologist services. I am interested, Dr Tustin, in your concerns about ATAPS. I think you used the words 'ineffective system'. Can you tell me on what basis you say that?

Mr Tustin: I think it is best if Quentin answers that question.

Senator MOORE: Okay.

Mr Black: In part of the background research that we looked at, Don reviewed a number of documents, including the Australian National Audit Office's review of the ATAPS program. We have also drawn on the experience of many of our members in formulating our views. The ATAPS program is very variable, and that is one of the issues, I guess.

Senator MOORE: Mr Black, are you making the statement, or is your group making the statement, that ATAPS are more variable than other services? Are you making the statement that the quality of the ATAPS program is variable and the quality of the Better Access initiative is not? Is that your statement?

Mr Black: That it is the view that we understand from our members and from our own experiences in the area, as well as from our reading of the Australian National Audit Office report.

Senator MOORE: Can we have access to the members' statements on which you base that?

Mr Black: Certainly, we are happy to compile some feedback from our members. We have done two major consultation exercises with the last two Medicare review processes, where we received over 250 written submissions from members about—

Senator MOORE: And the question that you asked?

Mr Black: We would be happy to provide you with further information, including direct quotes, from our members' feedback.

Senator MOORE: You make such a strong statement in your submission, which is of course your right. I can totally take the reference to the ANAO, but without having seen the documents which led to the statements from members—

Mr Black: Sure. Absolutely.

Senator MOORE: And are these members who have worked in both areas?

Mr Black: Yes. Yes, certainly.

Senator MOORE: Because your submission does not tell me—

Mr Black: Yes, fair enough.

Senator MOORE: that is why I am asking. So these were consultations you did with your own members for their views on the two programs?

Mr Black: On Medicare reviews that were done in recent times, yes. The Australian National Audit Office is quite a conservative body, so I think for them to make those sorts of statements indicates—

Senator MOORE: They did not compare the services, Mr Black; they were looking specifically at ATAPS.

Mr Black: Yes.

Senator MOORE: So what I am interested in is the basis on which you have made the comparison between the two services.

Mr Black: Sure.

Mr Tustin: I add that the University of Melbourne's centre for health policy has conducted a large number—I think, 16 now—evaluations of the ATAPS program, and I have read through those. I do not think there is time now to go through those details—

Senator MOORE: No, no.

Mr Tustin: but that also points to the variability in the performance of the different programs.

Senator MOORE: Sure. The other element that has taken up a fair bit of time in these hearings is the two levels of psychology services. Can you tell me, for the record, whether your association has taken a position on that? I know it is touched on in the terms of reference and it has been a particular interest of many witnesses. Has your organisation come up with a view about that?

Mr Tustin: I think we offered a slightly different view from some of the other submissions. We would actually suggest that the unregistered end of the spectrum utilise the lower tier of funding. We are happy to support the continuation of the two-tier system, although we tend to see it more as a three-tier system and possibly a four-tier system if you include GPs providing similar sorts of services. Certainly, there are a range of item numbers that are utilised by psychiatrists for providing cognitive behavioural therapy and interpersonal therapies, and we believe that those item numbers could be utilised by specialist psychologists and, in fact, that the government ultimately should be paying the second tier of rebates for counselling psychologists as opposed to the current situation—

Senator MOORE: Which is in the second paragraph of your written submission. So you are actually supporting an extended change, more than we have heard from other areas?

Mr Black: Well, that is what our members would like to see.

Senator MOORE: I do not think—but I am not sure, because submissions have continued to arrive until now—that I have seen anyone else ask for this particular change. It is great that you have, but I just have not seen it from anyone else.

Mr Black: It is possibly because we are a union!

Senator MOORE: That could be a whole inquiry in itself, Mr Black!

CHAIR: Yes, let's not go there!

Mr Tustin: I might add a little bit to that point. The Tolkien report recommended dividing clients into three levels of severity—mild, moderate and severe—and the information that has come through a number of therapy sessions is that moderate and severe people need a higher number of sessions than the 10 that are currently allocated. I think there is a strong argument that therapists who are able to deal with the moderate and severe end of the spectrum of clients are in a position to have both access to more item numbers and a higher level of remuneration. Those people should be skilled therapists who are able to cope with the wide range of issues that the more complex clients present.

Senator MOORE: Linking the level of skills to the level of severity?

Mr Tustin: Yes.

Senator MOORE: I have one last question, to do with the numbers for Better Access. At the moment, the Better Access initiative is looking at a 6-12 session review, up to the maximum of 18. Why 18?

Mr Black: As I alluded to in my opening speech, 20 sessions is what the current evidence is pointing to across the broad spectrum. However, I would say that there are arguments to be made for additional sessions for different types of conditions. I think that is something that some people have raised, and we would like to support those sorts of calls as well.

Senator MOORE: Sorry, I had a little bit of trouble hearing that, Mr Black. What was that last bit?

Mr Black: Sorry. Just as with the item numbers that apply to psychiatry, there are some item numbers that extend to 50 sessions in the calendar year—

Senator MOORE: That is right, yes.

Mr Black: and others that extend up to 160 for particular types of conditions, and I think that sort of model could be equitably and usefully applied to psychological interventions also.

Senator MOORE: So, once again, looking at the type of session rather than the actual number?

Mr Black: Yes. I think that is well established by research. There are certain conditions that require—

Senator MOORE: Thank you, Mr Black.

CHAIR: Senator Fierravanti-Wells, did you have further questions?

Senator FIERRAVANTI-WELLS: Yes. I would like to pick up on something in your opening statement, the Budget Paper No. 2 expense measures. You talked about the number of consultations per annum to deliver the required number of psychological therapeutic sessions for the 15 most common mental health conditions. Where did you get the figure of 1.7 million sessions per annum?

Mr Black: This is from the review that was conducted from 2006-08, which looked at the number of sessions—a post-implementation review. We were comparing that with the predicted need based on the Tolkien II 2006 report, which looked at 15 common conditions and said, 'This is how many sessions would be required to deliver appropriate services.'

Senator FIERRAVANTI-WELLS: The other statistic that is floating around is the roughly 11 million sessions that have happened under Better Access, I think between 2006 and 2010, which reinforces that point.

Mr Black: Yes.

Senator FIERRAVANTI-WELLS: In fact, if we are talking about 11 million sessions over a period of four years, that is 2.5 million, almost three million, per annum—

Mr Black: Yes. So there is a clear shortfall on the original predictions, isn't there?

Senator FIERRAVANTI-WELLS: There is a clear shortfall. Just looking at that figure, you are talking about 4.8 million sessions being required, and, if we do a back of the envelope calculation on that 11 million figure, it is about 2.75 million per annum.

Mr Black: Yes, and those were the figures provided by Professor Gavin Andrews of the University of New South Wales in preparing the Tolkien II review and predating Medicare's Better Access.

Senator FIERRAVANTI-WELLS: So we are meeting only half the sessions that are required?

Mr Black: Yes.

Senator FIERRAVANTI-WELLS: In this other document you talk about criticism of the ATAPS program. Of course you are referring to page 15 of the ANAO report. You have picked up page 15, but I understand that

littered throughout this document there are other references to deficiencies with the system. At page 7 of this document you talk about 'complementary'. Can you elaborate a little bit more on the point where you say a sense of competitiveness seems to have been introduced between the two programs and then go on to talk about a suggested complementary format for the two.

Mr Tustin: The ATAPS program began before the Better Access program. It was running for some time. Round about 2006 both programs were taking the same group of people, the high prevalence group. The government then reasonably decided that the Better Access program should cater for the high prevalence anxiety and depression group and that the Better Access program be adjusted, as I understand it, for hard to reach but more severe groups of people, which is reasonable. That runs the risk that we would then have a dual system, and the proposal, as I understand it, from the department is that Better Access caters entirely for the milder group and that ATAPS provides the various needs of therapy or clinical and nonclinical services for the people with more severe conditions. One concern is that the middle group, the moderate group, then might miss out altogether, and there are other concerns that having a dual system could lead to a double standard and make it really difficult for everyone to judge which group a particular client should be in. That, I think, would be quite a difficult judgment to make in the beginning.

So the proposal I have there is that Better Access, which is now a universal therapy program, remain a universal therapy program for all Australians regardless of level of disability and that the ATAPS program be developed as a disability support service providing practical psychosocial supports and generalised counselling for people who are severely disabled by a mental health condition. The Commonwealth already runs that sort of approach for aged care and does it well, and roughly the same sort of thing could be done for the mentally ill people.

I think the two programs would be complementary if Better Access continued to provide universal psychological therapy and the ATAPS program were developed to provide the more practical psychosocial supports for people who are sufficiently disabled to require them. I would then suggest that, on cost-effectiveness arguments, therapy be provided as a first option and ongoing disability support be provided as a last resort so that we do not get into a position where we are prematurely putting people who do not really require it onto a disability support system which is then hard to get off. So therapy would be provided before long-term disability support, and that is not really consistent with the movement of money away from the therapy program into the ATAPS program.

Senator FIERRAVANTI-WELLS: In other words you have to go through possibly up to 18 under Better Access and then, if that is not working, you refer on to ATAPS.

Mr Tustin: Yes. I would probably phrase it: one program of therapy of about one year. And this is very clear that a person is highly disabled and that the borderline cases—the ones that I am concerned about, with moderate severity—those moderately complex people, if in doubt, are allocated therapy first. The experience from my clinic is that 80 per cent of those people recover and within two years can be discharged. They require intensive therapy for one year. In the second year they are being supported within the standard allocation, and in third the year we discharge them. It really can be done for 80 per cent. There are a small number where we are not successful, and I see those people as then moving onto a long-term disability support program that could be provided through ATAPS.

Senator McKENZIE: My question relates to rural and remote areas. You made some comments in the submission that we have seen today, on page 6, about the opportunities afforded under telemedicine and the Medical Specialist Outreach Assistance Program. I wonder if you could expand, in two minutes or less, on your thoughts around that.

Mr Black: Basically we believe that the government has good initiatives in place in terms of supporting psychiatric outreach services. At one stage I was acting chief of staff for a newly-established minister for health in South Australia, some few years ago, and there were about 34 part-time psychiatrists visiting rural and remote South Australia, but there were only two clinical psychologists who were outside of the urban area. Part of that is because the state government does not offer the same level of support programs, but also now that there has been an exodus of clinical psychologists out into the private sector there is not the level of support that would assist them to be able to provide those specialist services in rural and remote communities, and it is just not there at the moment. They are not supported by the existing divisions of general practice in any consistent way. There are some levels of support offered, but often it is highly variable from region to region. I think that sort of consistent national program, which has been shown to be effective for psychiatric services, would be equally effective for the services offered by specialist psychologists.

Senator McKENZIE: Specifically I think I was going to the online opportunities.

Mr Black: Absolutely.

Senator McKENZIE: Today we heard that relationships are the basis of good treatment around this sort of issue, and I was wondering whether it is the same for psychology. It seems complementary rather than—

Mr Black: Certainly I would support those comments, but I would also make the point that there are opportunities to establish relationships via, say, an MSOP program—a psychologist to go out and visit a remote Indigenous community, for example, and then being able to follow up with regular contacts via telemedicine. I think that is the same sort of model that we would encourage in medicine as well.

Senator BOYCE: I was looking at the same section in your submission, Mr Black. You talk about specific incentives for targeted groups. We have had a few submissions around the topic of people with intellectual disability and mental health problems that you have not mentioned. Could you explain why or tell me what you think should happen with regard to that group?

Mr Black: This is an area where Dr Tustin has extensive experience.

Mr Tustin: It is true we have not talked about that. I think we have been struggling to make sure that the mainstream population continues to get a reasonable psychological service. I have worked for 17 years in that field. I would probably identify that as a specific subpopulation that does warrant attention, and it is a complex area and would warrant reimbursement at the specialist level. Again I think it would be hard to be highly effective all the time with 10 sessions. Once again, it is a worthy area and it would fall, in my view, in the specialist area, requiring access to a specialist psychologist and more than 10 sessions in a year.

Mr Black: That would actually be an appropriate area to extend the item number for carers and family members for enabling specialists to be able to talk to carers—

Senator BOYCE: To use Better Access or ATAPS?

Mr Tustin: The Better Access system is very medically oriented. It takes the view that the client is a client and you do not talk to anyone else. In psychological work, and especially with the intellectually disabled, it is very cost-effective to work with carers and parents of a younger person and to spend perhaps more time educating the parents on what to do, the good things they are doing, and there might be mistakes in a managing behavioural disorder. So it really would be a great advance if there were an item for psychologists to work with carers for the benefit of the client. That item is valuable for psychiatrists but at this point is not available for psychologists. That would be a great advance, particularly with that client group. Having said that, the same applies to parents who have got a child with a behavioural disorder or, say, autism. A lot of the people I see are parents who are depressed and anxious themselves, and a significant part of the reason is that they have got children who persist in misbehaving. It is sensible to have some time allocated to the parent. Just now our system is not family friendly.

Senator BOYCE: Thank you.

Evidence was then taken in camera but later resumed in public—

BOOTH, Mr Keiran, Carer Co-Chair, National Mental Health Consumer and Carer Forum**LOVEGROVE, Mr David, Deputy Consumer Co-Chair, National Mental Health Consumer and Carer Forum**

[14:09]

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you, although I know you have done this before. We have your submission. It is No. 202. I know you know the pack drill here. I invite you to make an opening statement, and then we will ask you some questions.

Mr Booth: The National Mental Health Consumer and Carer Forum welcomes the opportunity to appear before the committee to provide a national mental health consumer and carer perspective as to the hearing and the issues relating to the funding and administration of mental health services in Australia. The forum is the combined national voice for consumers and carers participating in the development of mental health policy in Australia and through our membership the forum gives mental health consumers and carers the opportunity to meet, to form partnerships and to be involved in the development and implementation of mental health reform. Our aims are to utilise our lived experience and unique expertise in mental health to identify what does and does not work in the mental health sector; to identify important and innovative ways to bring about positive change within the mental health system; and to be a powerful, respected, combined national voice for mental health consumers and carers.

We support the budget initiatives to fund the re-establishment of a national consumer peak organisation. We believe that this will go some way to ensure that consumers are better represented and have greater capacity to be involved in the development of national mental health policy. The National Mental Health Consumer and Carer Forum wishes to see, however, a greater degree of consultation with those consumers in the establishment of such a network and we certainly look forward to including this new organisation in our membership, as we were able to do with the former Australian Mental Health Consumer Network. We believe that the development of a national mental health commission will be an outstanding and exciting opportunity to involve mental health consumers and carers. We are advocating for the establishment of a consumer and carer specific advisory body to inform the commission. We believe that we are ideally placed, as experts by lived experience, to provide such advice and information. It is seen as essential that there must be commissioners who have a lived experience as a consumer and/or a carer. This, along with the consumer and carer participation in advisory support to the commission, will go a long way to demonstrate a very real commitment to consumer and carer participation at all levels.

We welcome the budget's focus on services for people with severe and persistent mental illness. The overwhelming need for a coordinated approach to the often complex support needs of these people is of great concern to consumers and carers alike. There has been a long period of failure to recognise the ongoing impact of the psychosocial disability relating to people with mental illness, which has been highlighted in our submission to this inquiry and also to the recent Productivity Commission inquiry into disability care and support. We welcome the budget initiatives as a strategic first step in rebuilding our national mental health system. We recognise that this system has been underfunded over a long period of time and as such there is much to do and this will not be easy or quick. We believe that a key component of such reform and rebuilding is the development and formation of partnerships with mental health consumers and carers to help drive these initiatives, to ensure that the proposed reforms are meaningful and strategic, consumer focused and developed using the lived experience of mental health consumers and carers. The inclusion of mental health consumers and carers has in the past been patchy, at the worst tokenistic. There must be a more comprehensive and meaningful inclusion of these experts with lived experience. The forum believes that consumers and carers need to be included in the key policy advisory positions that will stem from the budget initiatives. They should not just be consulted but must be involved at the centre of that change. Consumers and carers will need to be genuinely and openly recognised and supported in their role to address the imbalance of the past and must be supported to build their individual and organisational capacity to provide such input.

We encourage the new Mental Health Commission, the national partnership agreement and the ten-year roadmap to access and utilise the lived experience and expertise of our members. This will also apply to the implementation of the proposed changes to the ATAPS. In the past this program has heavily relied on the clinical expertise of divisions of general practice and there has been little or no involvement or practical partnerships with

consumers and carers, who must be regarded in this program as experts with lived experience and so are fundamental in the reshaping of the program.

In relation to e-mental health, we believe that there are potential issues around access, affordability and privacy in the home and we should also see structures made available for information kiosks. Whilst reduced service access to GP mental health plans is of concern, we do recognise that the savings will be able to be used in the delivery of more specific psychological services for people with severe and persistent mental illness. We would also like to see a more comprehensive system change in relation to the management of physical and psychological health matters. We believe that psychiatrists, who also happen to be medical practitioners, need to be more engaged with and accountable to the physical health needs of their patients. We thank you, Senators, for the opportunity to put these specific needs of consumers, their family and carers before this inquiry.

CHAIR: Thank you. Mr Lovegrove, do you wish to make any additional comment?

Mr Lovegrove: Not at this stage, thanks.

Senator FIERRAVANTI-WELLS: Just a general comment at the beginning, if I may, Mr Booth. You talk about these budget initiatives as the first step. Does that mean you are totally discounting mental health spending that started in 2006-2011, which I understand was a rather large \$1.9 billion investment.

Mr Booth: I thought you might suggest that, Senator. We believe it is the first step in the rebuilding of a system that has been run down for a long time. We do not discount the input that other governments or former governments have had to mental health, but what we are seeing now we believe is strategic rebuilding of a system that has been run down over a period of time.

Senator FIERRAVANTI-WELLS: That contradicts the tenor of previous evidence that what this package is doing is ticking over or rolling over previous programs. What you are saying is that those programs have not been of any benefit?

Mr Booth: I did not say that, Senator.

Senator FIERRAVANTI-WELLS: Just in reading your submission, it does not seem to be giving any credit to past activity.

Mr Booth: That might be your reading of it. That is not what we imply. What we say is that we recognise that these initiatives are a first step for us in rebuilding of the whole system.

Senator FIERRAVANTI-WELLS: From your consumer perspective?

Mr Booth: I am a carer.

Senator FIERRAVANTI-WELLS: I mean from the perspective of the consumer and carer forum.

Mr Booth: Correct.

Senator FIERRAVANTI-WELLS: You started out back in 2002. I think therefore there have been some hiccups along the way. You have always been funded, though, through DoHA, haven't you?

Mr Booth: No. I understand we are funded through the states and territories and the jurisdictions provide funding through their budgets to the Mental Health Standing Committee.

Senator FIERRAVANTI-WELLS: So you do not get any funding now from DoHA?

Mr Booth: I would have to take advice on that. I do not know about the specific funding. All I know is that states and territories fund representatives for consumers and carers from their jurisdictions.

Senator FIERRAVANTI-WELLS: My understanding was that there was some funding through the Commonwealth in a previous iteration.

Mr Booth: As I said, I would have to take advice, but I will certainly find out and get back to you.

Senator FIERRAVANTI-WELLS: Were you consulted at all before these changes were made by the government? Had you had any discussions at all prior to the budget announcements of the cuts?

Mr Booth: There had certainly been opportunities for us to meet with members of government to put our concerns forward, yes.

Senator FIERRAVANTI-WELLS: Were you aware of the budget cuts before the budget announcements?

Mr Booth: Personally, no.

Senator FIERRAVANTI-WELLS: Was the forum aware or did it have any input?

Mr Booth: Not to my knowledge.

Senator FIERRAVANTI-WELLS: Tell me about your views on the Mental Health Commission. You set out some issues there about accountability. How do you see it operating? Do you believe it should be a separate statutory authority, or what are your views on that?

Mr Booth: We are happy with the idea of the commission reporting through the Prime Minister and cabinet, but our issues are not so much around the accountability of it. What we are concerned about mainly is the ability within the commission to represent and understand the needs of consumers and carers.

Senator FIERRAVANTI-WELLS: Have you had any input? Had you been consulted at all before it was established?

Mr Lovegrove: Yes, a number of consumers and carers have made representations to the minister and through other bodies such as the Mental Health Council, especially around the importance of having consumer and carer representatives as members of the commission. More recently, we have had discussions with the minister at our forum meetings and then highlighting the importance of more general consumer and carer input in an advisory status as well—

Senator FIERRAVANTI-WELLS: Have you been given any indications that any of the commissioners will be focused on consumer and carer specific—

Mr Lovegrove: I think we have been pleasantly encouraged in terms of the expectations around that, yes.

Senator FIERRAVANTI-WELLS: But there has been no commitment given in relation to that?

Mr Lovegrove: I think there have been in principle commitments of having strong carer and consumer involvement in the commission. The details of that, of course, we are not yet privy to, but I am hoping that it will.

Senator FIERRAVANTI-WELLS: In relation to some of the Better Access cuts, do you have a handle on how many consumers and carers will now have unmet needs, or do you think it is all sunshine and roses?

Mr Booth: We do not have any specific numbers around the people who will no longer be able to access those additional services. As we point out in our submission, we are disappointed to see a loss of any type of program, but we certainly do recognise, with the funding cuts that have been made, that that money is going to be moved across to supply greater psychological services for people with a severe and persistent mental illness, so in that regard we are very happy. We recognise that for up to 85 per cent of people who used the service previously it only delivered eight services, I think it was. We would rather see a growth and no cut, but we are happy that the money is staying within the sector and will improve services, as I say, for those people with severe and persistent mental illness.

Senator FIERRAVANTI-WELLS: As far as advocacy for those people is concerned, we have had plenty of evidence from right across the spectrum. You have probably seen the evidence. There are major concerns about the many people who will now miss out. What do you propose to do in relation to that?

Are you going to continue your advocacy for those people or just simply accept that this is going to happen? I am just a bit surprised at your attitude, Mr Booth. You seem to have just accepted this. Everybody else is jumping up and down and saying that this is not very good and patients are going to be disadvantaged et cetera.

Senator MOORE: Concetta, I think 'everybody' is a wide statement.

Senator FIERRAVANTI-WELLS: There has been a general view by certainly most of the people who have appeared before us who have given evidence in relation to what they perceive will be—

Mr Booth: Senator, may I ask: would most of those people be service providers, the providers who provide those psychological services, or are you talking about consumers and carers?

CHAIR: Psychologists.

Mr Booth: Thank you, Senator.

Senator FIERRAVANTI-WELLS: We have had a range of people who have given it. We have had a thousand submissions, Mr Booth. You do not normally get Senate inquiries that have a thousand submissions.

Mr Booth: I am pleased. I think it is wonderful that the community is right behind this, and I congratulate the Senate on holding this inquiry. We recognise that there will be other people with opinions differing from ours, but as recently as Friday, in Adelaide, the 24 members of the forum who were present were able to meet with Minister Butler and we held a conversation with him for approximately an hour and a half where we were able to put our concerns to him. As you say, we will continue to advocate for services for people with mental illness, but at the moment we recognise that we are in a system of rebuilding.

Senator FIERRAVANTI-WELLS: Tell me: who does the forum represent? What are your organisations that are part of the forum?

Mr Booth: We have 26 members, 13 carers and 13 consumers, from each state and territory. They are nominated by their various jurisdictions, which gives us 14 of the 26, and then we have Mental Health Carers Arafmi Australia, blueVoices, Carers Australia, the Consumers Health Forum of Australia, Grow Australia and the Private Mental Health Consumer Carer Network (Australia). They are the national and state representatives that make up our forum.

Senator FIERRAVANTI-WELLS: And they are nominated by the respective governments?

Mr Booth: By the state health departments if they are a state representative, yes, and the federal ones are nominated by the organisations themselves.

Mr Lovegrove: Some states and territories have peak consumer and carer bodies that have been given charge and responsibility to nominate or carry out a selection process to nominate people independently to that forum as well.

Senator FIERRAVANTI-WELLS: Will you have input into the COAG process as part of that?

Mr Booth: We have not had the opportunity to address COAG, but certainly through its affiliation with the Mental Health Council of Australia the forum is able to provide its views to that body, and then those views are taken up in consideration.

Senator FIERRAVANTI-WELLS: We keep hearing about the one in five Australians who have mental health issues, and I think those statistics are quite well known. Do you think that a 10-year road map for those people who need help now is an adequate response? We keep hearing the statistic. One in five is a lot of Australians, Mr Booth. You have all these experts saying all these things. For those, I am just thinking that 10 years is a long time to wait for a road map in mental health.

Mr Booth: I guess it depends on where the journey starts. As I understand it, it is a 10-year road map to where we are going to get to, but we are not privy to what is happening today or tomorrow. But we would certainly welcome the opportunity—as we will have tomorrow at Old Parliament House—to contribute to that 10-year road map and to the planning. We have had the opportunity to meet with the Mental Health Council of Australia, with Minister Butler and with DoHA to look at providing our input to that, and the voices of many others.

Mr Lovegrove: I also do not think it is an either/or situation, of having to choose between a road map that is more strategic in its perspective and having a very holistic and systemic reform and cultural reform agenda at a national and a state and territory level, as well as having programs that attempt to meet needs more immediately. There is certainly more than enough need out there, as I am sure you are indicating. But I think it needs to be more strategic and more collaborative, and also it needs to build national infrastructure that has long been missing, like the Mental Health Commission, like a new national consumer peak body, like infrastructure to enable consumers and carers to participate in these processes in monitoring and in service planning and delivery. There is certainly plenty of work there, and capacity building required that can only be done incrementally. But I think it is important that it is done in a strategic way.

Senator MOORE: Gentlemen, in terms of this submission, the major focus is on ensuring that the voices of consumers and carers are heard; is that right?

Mr Booth: Correct.

Senator MOORE: And you have raised some concerns about tokenistic processes in the past, particularly for the ATAPS, the Medical Locals and the new structures coming forward in the plan, including those programs that have gone before and those moving forward. How do you think that can happen? This is a question I consistently ask consumers' and carers' groups. Everybody has a policy that says people should be involved, but how do you actually do it? You have said numerous times in your submission that you think it has to happen, and you have been concerned about the past. Do you want to share with us today how it should happen, or do you want to think about that and give the answer to us on notice? It is a tenet of the program that consumers and carers must be engaged. How should that happen?

Mr Booth: We certainly would like to come back to the inquiry with a more detailed proposal as to how that should happen. But essentially that is exactly what we are saying: that for too long it has been an afterthought and this is a great opportunity now to build in that consultation from the very start. We will certainly be happy to come back to you with more detail.

Senator MOORE: And on the question about whose voices, too, because every consumer and carer is different. So no matter what form of representative body you have, is that the best model? That again is something that your submission refers to, in terms of future process.

My next question is on the ATAPS program. You have raised concerns that it could well have been clinically focused as opposed to community focused. Do you have any particular issue about how that could go forward? As you know, the proposal as to government policy is that there will be more funding put into ATAPS to pick up the longer care needs of people, particularly in regional and vulnerable areas. So what is your balance to your concern about the clinical nature of how it may have operated up until now?

Mr Lovegrove: I think it is more about how that functions and how it works with other service providers that are available. There are the community and non-government services, social services, not just the clinical. So that has got to be more a collaborative effort with whatever services there are in particular regions, or remote or urban areas. I think it is really important that the way people work together in a clinical setting is not just in a clinical setting but has stronger partnerships and links with the wider community in terms of meeting the psychosocial needs of the people that they are treating.

Senator MOORE: A lot of your submission is about those psychosocial needs.

Mr Lovegrove: That is right. The whole sector, as well as the whole community, is only starting to really become conscious of and to realise and understand the significance of the dimension of disability resulting from mental health conditions and illness. So we are really pleased that that has been included in the new plans for the National Disability Insurance Scheme as a reality that many consumers and carers experience across a whole range of day-to-day life situations and experiences.

Senator MOORE: I could go on for days on that, but I will not. My last question—Chair, I promise—is to do with the comment you have made about GPs in your submission. In particular, the area of concern is about the operation of Better Access and, to an extent, ATAPS—about the link between the GP intervention and what comes next. You make a fairly strong statement about, 'A lot of GPs do not know about the programs and do not pass it on.' I am interested to get a bit of information about that. Also, a question I have asked a number of representative groups is: how do you have that information? Was it a survey arrangement? Was it through people coming to you?

You have made the statement in your submission. Where do those concerns come from? Given the importance in the process of the whole area of increased GP knowledge and training, it is a fairly serious allegation that in that process it is not being passed on. I would like to get something on record about that.

Mr Booth: Again, with the consumer and carer participation issue and the clinical nature of ATAPS, we will bring something back to you on that. A lot of it to date is anecdotal but I am sure we will be able to pull together the different feedback mechanisms.

Senator MOORE: That would be very useful.

Mr Booth: I can certainly say that as late as Friday one of the discussions that came up around this very issue was GPs having extensive networks within their local area, just as everyone else would, but not necessarily knowing perhaps what the strengths were of those individuals within the network. Many of our members spoke quite passionately on Friday about being referred to a psychologist only to find that they took three or four different psychologists before they actually found one who had the skills and qualifications to deal with their specific illness. So that is certainly part of the issue that we speak of, but we will come back to you with the rest in detail.

Senator MOORE: We would appreciate that. It would be very useful.

Senator WRIGHT: Thank you, Mr Lovegrove and Mr Booth, for giving us your time today. I acknowledge that the key message from your submission is the importance of taking into account the experience of consumers and carers both for designing programs and also for effectively evaluating them. I would like to take you to that point because it is crucial, isn't it? We can have the finest intentions in the world, but if it is a waste of money or it is not getting anywhere then there are a lot of disappointed aspirants and things are not getting any better. I noticed you were particularly critical of the day-to-day living program, as opposed to the PHaMs program, so I am interested in what lessons can be taken from PHaMs and what the particular issues are that you are concerned about with the support for day-to-day living. I wish we had longer to talk to you but it might be something you would like to take notice and get back to us in more detail on those issues. I think you were concerned about the lack of effective evaluation of how useful that program is.

Mr Lovegrove: Yes, and evaluation of the impact on the consumers and carers themselves, not just from a service provider perspective. That is a principle that across the whole system could be a big factor in improving and reforming the whole mental health system.

Senator WRIGHT: In a sense that is what it is all about, isn't it? If it is not working for the people who are receiving the service, there is not a whole lot of point really, even if it makes everyone else feel good about what they are doing.

Mr Lovegrove: Indeed.

Senator WRIGHT: The second thing I would like to ask you about, and this might also be something you need to explore a bit more and take into account what we have heard today in evidence from the Australian General Practice Network, is your concern about how the co-ordinated care and flexible funding packages are going to be administered or who is going to coordinate them. Your concern, quite clearly stated, was that that may be dominated or coordinated by the Medicare Locals. I am reading into that a concern that it may then just have a clinical focus as opposed to a holistic one including all the other aspects that help to keep people well and participating in the community.

We heard earlier today from the Australian GP Network about their concern that there is going to be some kind of contest or adversarial process, with bidding between potentially the GPs and the NGOs, who obviously have a lot of experience and understanding about the provision of the other services and so on. In their submission their proposal is that they would prefer to have a partnership model as the best option for implementing FCPs 'through planned and coordinated arrangements between primary, acute and social care service providers'. I would like to get a bit more of a sense of how that might work. To me it sounded quite promising in the sense that it is using the skills and knowledge base of the various people who have an interest in this area but making sure that the holistic needs of consumers and carers are taken into account, from the people who know exactly what needs to happen there. I do not know if that is something you have encountered as an idea and what your views are about that. Would you like to get back to us with a bit more information about that?

Mr Lovegrove: We can certainly do that. It depends a lot on the different jurisdictions and the respective strengths of the various organisations within jurisdictions, whether it is the Medicare Local or the non-government service providers or others. My understanding was that it is still being advocated that it should be a collaboration in any case. The details of that still, of course, need to be worked out. It would be great to see a more equal partnership model taking shape rather than one sector dominating the other, because we do need to use the strengths and resources that are there in the optimal way. It would be a pity to do otherwise.

Mr Booth: The other thing we are most concerned about is the dumbing-down of the mental health sector through an open tender process whereby the organisation that can write the best tender but perhaps has the least amount of knowledge in mental health is brought into it. We would agree that partnerships are a very strong way to process, but what we would like to see is that the many good organisations that are out there delivering effective and realistic mental health services and treatments are seen as the experts and that we do not start to bring in some very large bank organisation that can write a great tender.

Mr Lovegrove: But again the success of any partnership model would be very limited and not very sustainable if it is not including consumer and carer organisations at that local level and having capacity built to be able to fill that role in a collective, representative way on behalf of their people who are most directly affected. That requires an investment as well from the community, which I do not think is as yet fully appreciated in terms of the need for that and development of the consumer and carer sector right from the top of the national level down to the local and regional level and having that not fragmented or splintered in more ways than it already is.

CHAIR: I am going to have to move on. We are running out of time. Senator McKenzie.

Senator McKENZIE: Thank you. It is great to have this perspective at the table. I was hoping you could expand on page 9 of your submission—the anecdotally patchy quality of services provided through many GPs mental care plans. Then, further, I am wanting a bit more information around your support for the introduction of a two-tiered rebate structure.

Mr Booth: With the latter, if we could come back to you on that—it is not something that we have something here on.

Senator McKENZIE: Yes, absolutely.

Mr Booth: The anecdotal stuff is perhaps what I was referring to earlier about. We have GPs who are referring people to psychologists. One consumer who spoke very passionately on Friday suffers from post-traumatic stress disorder as a result of his defence service for this country. It took him five psychologists before he could find one that he was referred to who had the specific skills to deal with that. That is the type of patchiness that we are referring to.

Senator McKENZIE: Given that the average uptake of Better Access is around that five sessions, and here we have a person who has gone once five times before he has found someone, have we got any data around

finding your home, finding the right specialist to deal with your particular issue, as opposed to people who are determined and keep going back to try and find somebody who can help them and the third group of people who do once and drop-out, because it is not helpful at all?

Mr Booth: We do not have any specific data, to be short, no. But we have certainly engaged in this very discussion with the minister and let him know of our concerns around exactly that issue. We will certainly put that further in our feedback back to the inquiry.

Senator McKENZIE: Thank you. Great.

Mr Lovegrove: I think the situation with the GPs is also related to the wider funding issue in terms of relating to mental health care plans and their effectiveness. The fee-for-service system does have its limitations in that regard, because one of the most important things for mental health consumers and their carers is taking the time that is involved in a holistic approach that does look at some of the psychosocial and social determinants of their illness and problems. So any incentives that can be built into the system to reward that taking of the time and working with other practitioners, other social agencies, to get that plan that is certainly coordinated and holistic and helps people get back and prevent them falling back into the acute service system would be good. The whole is funding system needs to look at how that works and how that can be improved.

CHAIR: Thank you very much. We have run out of time. You have taken lots of homework on board. That is very much appreciated as is your time today and your submission. Thank you very much.

Senator MOORE: Mr Booth, we need it with quite a short turnaround, as well. We are sorry to do this to you, because I know you are a community organisation, but we would need responses back—

CHAIR: By the beginning of next week at the very latest.

Senator MOORE: Next week?

Mr Booth: Yes.

CHAIR: That would be good. Thank you.

Mr Lovegrove: Thank you.

**McMAHON, Ms Janne Christine, Independent Chair, Private Mental Health Consumer Carer Network
(Australia)**

[14:45]

CHAIR: Welcome. I know you know the drill. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you—if you do not know it already! We have your submission; it is No. 189. I would like to invite you to make an opening statement and then we will ask you some questions.

Ms McMahon: I would like to thank the Senate Community Affairs References Committee for the opportunity to appear before you today, and I would certainly like to acknowledge the very significant funding that has been made available in the 2011-12 budget. If we look at the Better Access initiative, which formed a good part of the terms of reference for this inquiry, for us it is very hard to find an argument against the 87 per cent of two million people who have accessed the Better Access initiative who have received between one and six sessions, averaging about five sessions. But our major concern is the other 13 per cent, and, in particular, the 10 per cent who went from the six to the 12. In particular, of great importance is that three per cent who were accessing the 12 to 18 sessions, following on, in terms of the Better Access program, and I would like to come back to that at a later date.

Looking at the rationalisation of the GP payments under Medicare—which was also part of the terms of reference—for consumers and carers, GPs are really the first port of call for all of our health problems, but particularly so for mental health problems. We require the GPs to refer us to appropriate mental health care, and we very often find that GPs are picking up those consumers who fall through the gaps. So it is our view as consumers that GPs are an absolutely essential element of our mental health system, and I would have thought that the provision of incentives rather than disincentives would have been most appropriate. The public sector is really focused on schizophrenia and psychosis and is certainly driven by those, whereas folk who suffer from depression and anxiety disorders find it really hard to access services from the public sector, and that is where the Better Access initiative came into play, to look after those.

Turning to the ATAPS model, we welcome the significant additional funding for that program, and we are looking at an additional \$184,000 being available over the five-year period. We look at the ATAPS program in terms of the coordination of care, and the suggestion is that those folk who can no longer access more than the 10 Better Access sessions per year can perhaps be referred to either public sector services or private psychiatrists, or indeed even the ATAPS program. We have some really grave concerns around picking up those small numbers—and when I say 'small numbers' I mean 'small percentages'; they are actually large numbers of people. We are asking for two things. One is a delay in implementation of the rollback to the 10 sessions per year of the Better Access initiative to allow that large number of people, who are very vulnerable consumers, particularly at the severe end, to find other appropriate services. If that is a psychiatrist, if we take Hobart, for example, I think there are 62 practising psychiatrists down there and I understand there is a six-month waiting period. They are the sorts of issues that we have major concerns about.

If we look at the care coordination model, it is a wonderful initiative with a care coordination facilitator. We understand that this will be run through Medicare locals, but we have some concerns around that, given that the divisions of general practice have previously looked after ATAPS, for example, and I think there have been something like 167 current divisions which have been condensed down into fewer than 40 Medicare locals. So what that means in our minds is that there will be larger geographic areas. Will they therefore have the ability to expand in time to accept the additional people?

In terms of the online therapy, that is something that our network has been calling for a long period of time. It makes sense to us if you can use a computer and talk to someone in Budapest and can see the clothes they are wearing and the expressions on their face. Particularly for people in those hard-to-reach areas—the rural, the remote, the Indigenous and even those folk who have a mental illness that contains them within their house: agoraphobia, social phobia and those sorts of things—who could really benefit, we gratefully support the psychiatrist NBN item number to provide those online consultations.

Finally, the terms of reference refer to the Mental Health Commission, which we certainly welcome. Our concerns with that are the make-up of that commission and the representation of those commissioners. I understand there will be nine, including the chair. We are of the very firm belief that there must be a consumer commissioner and a carer commissioner in order to bring the consumer and carer perspectives to the very entity

that is going to be looking at the transparency of services and also looking towards policies and looking towards advising government on perhaps where those mental health fundings are best allocated.

I also think that the private sector is an area that too often gets forgotten in our health system, certainly in mental health. We have approximately 20 per cent of inpatient beds and around the same for the mental health workforce, so it is a significant area. If you look at the Medicare rebates for private practitioners, you are then looking at roughly 70 per cent of mental health being delivered by the private sector. We believe that the commission must have a consumer commissioner, a carer commissioner and a commissioner from the private sector.

Thank you, Senator Siewert. I think that probably concludes my opening address. I am very happy to take any questions and try to answer them if I can.

CHAIR: Thank you. Senator Fierravanti-Wells?

Senator FIERRAVANTI-WELLS: I will start from your last point. You say in your submission that you represent Australians who have private health insurance—that is about 11 million Australians—and/or who receive their treatment and care from the private sector setting for their mental illness or disorders. Did you just correct me? Is 70 per cent of mental health being delivered by the private sector?

Ms McMahon: Yes, if you take into consideration the Medicare—

Senator FIERRAVANTI-WELLS: [inaudible]

Ms McMahon: Yes. In other words your private psychiatrist, your private psychologist and the private hospital sector.

Senator FIERRAVANTI-WELLS: What is your organisation and your network comprised of?

Ms McMahon: We are comprised solely of consumers and carers. As a consumer I chair the network and I am responsible for the running of the network.

Senator FIERRAVANTI-WELLS: When you consider the number of services being delivered, and the number of people, we really are talking about millions of Australians?

Ms McMahon: Yes.

Senator FIERRAVANTI-WELLS: You probably heard Mr Booth's evidence before. He obviously gave evidence from the public mental health perspective. From your evidence most of that is delivered by the state systems. The rest of it is basically delivered by the private sector, which is really your consumers.

Ms McMahon: Yes.

Senator FIERRAVANTI-WELLS: I wanted to put that into context, because there are two types of consumers and carers. There are the smaller group, which is in the public sector, through public services, and then the far greater group, which is in the private sector.

Ms McMahon: Yes, if you consider those who receive services from private practitioners but do not actually access hospital or community based support.

CHAIR: But a large number of the ones in the private sector will be funded by Commonwealth or state money?

Ms McMahon: Commonwealth monies under Medicare. The funding of the private sector is basically from Commonwealth funding, under Medicare funding and through health insurers for inpatient and hospital care through private health insurance.

CHAIR: So, it is not as black and white an issue as the biggest groups being provided privately, because it is funded by public money?

Ms McMahon: Yes. But if you look at the public sector services, certainly inpatient community care is currently being funded by the states and territories. If you look at the number who access the public sector—and as I mentioned earlier it is roughly 20 per cent or a little bit less—and who receive inpatient care, only 20 per cent is private and 80 per cent is public. Does that clarify it?

CHAIR: Yes.

Senator FIERRAVANTI-WELLS: But we are talking in terms of numbers and this is what I was trying to get to. If I understood your earlier evidence, Ms McMahon, those people who access services in the public sector are much smaller in number than those who access services through the private sector?

Ms McMahon: Yes.

Senator FIERRAVANTI-WELLS: That was the point I was trying to make.

CHAIR: It is still not—

Ms McMahan: Well, only that I put the proviso on it that there is a very clear differentiation between the private psychiatrists or private practitioners who take up the major part of the private sector. I need to be very clear about that. So, in the overall view of mental health, the overall view of the workforce and the overall view of inpatient beds and community settings you will find that we are a little under the 20 per cent, but the majority—

Senator FIERRAVANTI-WELLS: I have understood what you were trying to say.

Senator MOORE: I need one bit of clarification. I know that you, Ms McMahan, worked very closely with the previous organisation, the consumers and carers. I just need to ensure that those people do not only access public services.

Ms McMahan: No, you are absolutely right.

Senator MOORE: So it is not quite such a clear public user/private user issue.

Ms McMahan: You are absolutely right.

Senator MOORE: The special need that you provide, and you have done for many years, is the particular use of private health insurance.

Ms McMahan: Predominantly, yes.

Senator MOORE: And that has been your area of expertise for many more years than we would like to mention!

Ms McMahan: Yes.

Senator FIERRAVANTI-WELLS: In terms of the rationalisation of mental health services, have you had the opportunity to estimate the number of people you think might ultimately miss out on services as a consequence of these cuts?

We have heard from a whole range of people. The evidence seems to be overwhelming that there will be a resulting number of people who will miss out on services. From your perspective, do you have a handle on the numbers and those sorts of things?

Ms McMahan: I may wrong; I am not a health economist, so please take it as an uninformed view.

Senator FIERRAVANTI-WELLS: Sure.

Ms McMahan: But if you look at the two million people who have accessed the Better Access initiative since its implementation, 10 per cent of those were receiving between the six and the 12, so whatever that equates to, and three per cent of the two million were accessing between 12 and 18. I am sorry; I do not have a calculator, but that would be the percentage. I could certainly work that out.

Senator FIERRAVANTI-WELLS: No, I accept that.

Ms McMahan: It would represent a significant number. Our major focus is on the three per cent. In saying that, a number of the senators sitting around the table know that I have a particular passion for those with borderline personality disorder, for example. They are people who are actively excluded from the public sector and, whilst the Better Access initiative was developed to focus on the high prevalence disorders of depression and anxiety, a number of folk who could not receive services anywhere else were actually accessing the Better Access initiative, certainly for the 12 and then the 18 sessions.

Senator FIERRAVANTI-WELLS: The Better Access initiative was non-discriminatory. It basically said, 'mental illness'. When you go back to the initial literature as to how it was set up, it was set up for mental illness. There was not discrimination. It was to help people with mental health issues and mental illness.

Ms McMahan: Yes.

Senator FIERRAVANTI-WELLS: You made a comment that mild to moderate mental illness cannot go unacknowledged, and that really seems to be the major gap which we are now going to see.

Ms McMahan: No, I would say the mild to moderate would probably be picked up. Certainly the mild would be picked up in the six sessions, and perhaps even the moderate would be. It is more the high-end moderate and the high-end severe.

CHAIR: Is this the three per cent you were talking about?

Ms McMahan: Yes, and even part of the 10 per cent who would be significantly unwell and would be significantly affected by their mental illness. They are the areas that I have major concerns about.

Senator FIERRAVANTI-WELLS: You say that you do not believe the ATAPS program will be able to expand in a short time to deal with the needs of people at the more severe end of the spectrum, thereby leaving a large number of vulnerable people without appropriate options for treatment.

Ms McMahan: Yes. My concern is that this will take time to implement and, as I understand it, the ATAPS will be administered through Medicare locals. This means that with the rollover from the divisions of general practice into the new Medicare locals it will take some time to establish and there will be a flowover effect. The reduction in the numbers of divisions of general practice, which are about 167, down to fewer than 40 Medicare locals with a much bigger geographic area is, I think, going to cause some concerns until that has bedded down. Our view is that we would certainly like and would request a moratorium for 12 months allowing those people to access either a private psychiatrist or some other form of assistance rather than just the cut-off point coming. That being the case, in my mind it will take some time for the transition between the divisions and the Medicare locals. In my mind it will take some time for the transition between the divisions and the Medicare locals.

Senator FIERRAVANTI-WELLS: You might bed them down, but you are still left with the problem. For example, 90 per cent of South Australia is in one Medicare local.

Ms McMahan: You are quite right. It is a huge geographic area.

Senator FIERRAVANTI-WELLS: That is the point. From a consumer and carer perspective are you confident that the whole experiment with Medicare locals is not really going to leave not just some vulnerable people, possibly, without appropriate treatment but the whole concept? How do you deal with 90 per cent of South Australians being in one Medicare local and still achieve some modicum of proper service?

Ms McMahan: In saying that, a good part of that area is in the remote area of South Australia.

Senator FIERRAVANTI-WELLS: I have spent quite a bit of time travelling around there recently.

Ms McMahan: I agree. It is a huge geographic area, and that is one of our concerns. Also, the ATAPS is more around coordination of care. It is not only providing clinical care but it is also tapping people in with the other needs as required. I am not sure that folk who currently are receiving between the six and the 12 really need that amount of coordinated care rather than access to a good clinical professional who can look after their mental health issues. But, yes, I do have concerns and that is one of our major concerns.

Senator MOORE: One of the issues you raised here is that of getting access to services. I note that you recommend there be a delay in the change to the Better Access processes whilst people are able to access alternative services. Is that on the basis of the proposals in terms of ATAPS; particularly for your members—who for a whole range of reasons have maintained private health insurance, mainly because of their health needs—trying to find a practitioner they could go to?

Ms McMahan: Yes, I mentioned Hobart for example.

Senator MOORE: I made a note of that here.

Ms McMahan: I think there are roughly around 60 or so private psychiatrists, but I have not checked the figure recently. Many of them have long waiting lists and it may take six or more months to access them.

There is one other thing I would like to mention before I forget it. In terms of that 10 per cent or the three per cent, we would really like to see some sort of specific criteria or guidelines that would still allow people who have met particular criteria to access those 18 sessions.

Senator MOORE: Which is what should occur now—between the 12 and the 18.

Ms McMahan: Yes.

Senator MOORE: When you read the parameters of the program those periods of extra care should go only when you meet a lot of quite specific parameters.

Ms McMahan: And it means tightening up the criteria. If that means making specific criteria for perhaps specific diagnostic groups—for example, borderline personality disorder—I would have thought that that would be something that was a reasonable request and a reasonable way forward.

Senator MOORE: So, a tightening of that next step?

Ms McMahan: Yes. The development of specific criteria to allow people to access those additional consultations that they currently do now.

Senator MOORE: What is your organisation's awareness of any questions around the varying quality of GP referrals in the mental health plans being developed? Anecdotally, statements have been made that there is a wide variance from GP to GP in terms of the quality, detail and extensiveness of the mental health plans that are created. Is that something your organisation has heard of?

Ms McMahan: The responses back are that most consumers feel relatively well serviced by the current mental health treatment plans. And I, too, have heard the anecdotal evidence. I also checked the website not that long ago and some of the divisions in South Australia have a template which they were using as a mental health treatment plan. I understand that many of the GPs do that. One would think that, if you have a template and it just requires the relevant fields to be filled in, you would have a high-quality mental health treatment plan, which I understand a lot are using.

Senator MOORE: My understanding from some of the divisions is that they are moving forward in terms of making that a more standard model. At the moment people use it or not but by having a template people, with their knowledge and training, would be able to do that more simply.

Ms McMahan: Yes. That would standardise the treatment plan and the requirements and so forth.

Senator WRIGHT: Following up on that particular point, I suppose having a template is one thing but it is actually the quality of the information that goes into filling in the fields and the degree to which a particular general practitioner is prepared to do the extra legwork in terms of contacting relatives and schools or workplaces, whatever they need to do to fill it in, where you get the variability in quality. That is just a comment. Would you like to comment on that?

Ms McMahan: I think there is quite a lot of additional time and work involved once we as the patient leave the surgery. So I guess it goes back to my original statement that we as consumers rely heavily on the GP to provide mental health care and treatment for many Australians who do not actually access mental health services, public or private. This is a concern for us because in my mind anything that provides a disincentive to GPs, rather than an incentive, is not something that is welcome. We rely heavily on GPs. They are the first port of call. They very often take patients or consumers when others have given up. That is certainly so for a lot of people from the public sector. So we are very reliant on the GPs. If we look at the rationalisation of the timing, that is something that I cannot really comment on with any evidence. As I said, anything that is done that disadvantages or is a disincentive is not necessarily a good thing in my mind.

Senator WRIGHT: Thank you, Ms McMahan. I have lots of other questions but it is a very thorough submission, so I will pass.

Senator MOORE: Ms McMahan, you said that GPs often take people that other people have give up on. That is a comment I have not heard before. What does that mean?

Ms McMahan: If you talk to some of the GPs, they will tell you that they pick up the people who cannot access public sector services, or private for that matter, because of cost and co-occurring gap payments. If you talk to some GPs who are really interested—and you have one in Brisbane in particular—they will tell you what often happens when the public sector gives up. What happens to someone? Where do they go when they fall through the gaps? Very often they go back to the GP.

Senator MOORE: Strangely enough, when you talk to the public sector, they say they are the ones who get the people that they cannot find a GP for. It varies for individuals, but I do know the case you are talking about and I totally accept your point in that case.

CHAIR: I think we have given you a little bit of homework, haven't we?

Ms McMahan: No.

CHAIR: Didn't we? That is remiss of us! We are not working hard enough.

Ms McMahan: Can I just make one comment. It really relates to the previous witnesses, the consumer and carer forum. It is something that I feel a bit passionate about. In terms of the design of services and consumer and carer input into that, I think it is reasonable to say that there is very little, in fact no, input into service planning and provision from the budget initiatives. Having said that, I also need to point out that the Department of Health and Ageing, the minister and a number of senators have been very responsive and very proactive in assisting a consumer driven passion, particularly around borderline personality disorder. That is really the first initiative, in my mind and understanding, that has ever been a consumer driven thing that has actually been listened to, accepted and taken forward. By that, the department has certainly funded the borderline personality expert reference group and also the development under the National Health and Medical Research Council of clinical practice guidelines. That is the first initiative that I understand has been a consumer driven thing. When it comes to the other major issues and major funding, I am not sure that consumers and carers from the grassroots are actually involved. That is why I would particularly like to see a consumer commissioner and a carer commissioner on the new commission. Thank you.

CHAIR: Thank you very much.

MIGLIORINO, Mr Pino, Chair, Federation of Ethnic Communities Councils of Australia

Evidence was taken via teleconference—

[15:16]

CHAIR: Welcome. I understand you have been given information on parliamentary privilege and the protection of witnesses and evidence?

Mr Migliorino: I have.

CHAIR: Thank you. Your submission is No. 187. I invite you to make an opening statement. Then we will ask you some questions.

Mr Migliorino: Thank you very much. I apologise for not being there in person. I am a volunteer with the organisation and had work commitments precluding me from flying down this morning, so this is not as optimal as being there face to face but I hope it works in terms of representing the issues that we feel are important.

There is a strong belief in FECCA that there is a need to address the particular mental health needs of Australians from culturally and linguistically diverse backgrounds generally and in particular the needs of refugees and humanitarian entrants, as they present a major issue for us, at least in the short-to-medium term. Overall there is a strong sense that we would like to lobby and advocate for an increase in funding in accordance with a number of particular considerations. The first one is an increasing number of CALD Australians generally and a commensurate increase in mental health issues as a proportion of the population. Just on straight equity terms, looking at mental health issues as they occur throughout the population, if the non-English population is increasing then proportionately we should also be looking at a relative level of consideration of their needs as that would happen. This is certainly the case in many health areas where there is an attempt to measure the level of need by reference to demography and numbers in the first instance. That is a starting point in terms of a claim for resources.

The second is one where there is a claim that there are increasing numbers of older people from this category. It is true to say that 30 per cent of all people 65-plus will be from non-English-speaking backgrounds by the year 2021. What we are suggesting through that is that there will be a far greater need for mental health resources targeting this group, particularly in the psychogeriatric domain. A number of state jurisdictions have started looking at the particular issues of ageing Australians but not necessarily the same level of attention is being paid to those who are ageing from non-English-speaking backgrounds. We feel this will become a major issue in terms of an impact on the aged-care environment, where there will be increasing numbers of people from non-English-speaking backgrounds presenting with mental health and geriatric complaints or conditions.

The third area is that there are ongoing mental health issues pertinent to recent migration. That is certainly being picked up right through the communities. FECCA undertakes a range of access and equity consultations on an ongoing basis as part of our funding by the Department of Immigration and Citizenship. There are particular issues which are cropping up more and more in the experiences of new and emerging communities, especially those coming from a refugee background.

What is tending to happen if I put these three together is that there is increasing complexity in the mental health environment as it pertains to CALD communities. In response to that, we are keen and supportive for the increase in funding for mental health programs out of the 2011-12 budget, but there was no new funding to CALD-specific mental health services, and we see this as a major concern in terms of how we move into the future.

The federal government does fund a Multicultural Mental Health Australia program to the level of \$2.7 million. That has just been reallocated to new providers across Australia. Overall, our concern is a very low level of funding for specific CALD services. What makes these figures more important in this domain is the impact of inaccessibility to services and the relevance of these services. While it is commendable and certainly welcome that more resources go into mental health, from our perspective the accessibility of these services to people from diverse linguistic and cultural backgrounds is extremely important, and we certainly feel that unless some things are put in place we could lose out.

There is a need for a two-pronged approach in this. The first one is increasing resources in ethnic-specific contexts similar to those developed in the aged-care sector which have proved to be extremely effective in increasing levels of participation and service access in those groups. We have been able to identify documents and evaluate models which do increase access. Secondly, a far greater attention should be paid to increasing the competence and resources necessary for mainstream services to administer culturally and linguistically competent mental health services and cases. I think this is also where we need to look quite critically. The reality is we will

never be able to fund parallel services across all groups. Therefore, the bulk of the responsibility of servicing a diverse Australia will fall to the mainstream services. I think that is where we also need to place a fair bit of consideration and specific requests in terms of what type of contractual responsibility those larger bodies who will get the bulk of the resources for mental health service provision will be compelled to do in keeping with maximising the accessibility of their services for people from linguistically and culturally diverse backgrounds.

There are a series of recommendations we have made in our submission. I will go to some of those which I think are really important. There should be increased funding allocated for ethnic-specific services with a particular requirement for the funding of a transcultural mental health centre in states and territories where one does not exist. At the moment no such service exists in South Australia, the ACT, Tasmania or the Northern Territory. From our experiences, these centres have been an extremely important focus of dealing with issues to do with mental health in different cultural domains, and the level of expertise and the professional and clinical practice that comes out of these centres are extremely important. We believe it is unacceptable that you would be able to get better access to services in Sydney than you might in Adelaide because of the lack of these critical infrastructure resources.

We also would really like to see increased funding to build an evidence base to better inform this area. At the moment we are looking at data which is implied—data which is assumed from other data sets—and I honestly believe there is a far greater need for a stronger evidence base in terms of new research in this area. We also need stronger organisational and contracted requirements to compel mainstream services to develop culturally competent practice. This does mean increasing levels of resourcing for interpreters and bilingual commissions across all areas of mental health.

Equally, ethnic communities need to evolve this issue as well. I think that goes hand in hand with having mainstream service providers be able to better deal with cultural diversity in terms of its client groups. We also need to make sure that ethnic communities themselves do not abrogate their responsibilities on this issue. In a recent speech I made for the International Year of disabled persons, I talked about how ethnic communities need to evolve this issue from one which is taboo in their own communities to one which is a legitimate community need. Too many community organisations and structures see mental health as a topic that they are not taking responsibility for in their own communities. In that, we would really like to see a far greater emphasis on public education targeting these groups. We would also like to see a specific focus on suicide and suicide prevention in these groups and ensure that the government funded services such as beyondblue and headspace are resourced and required to address CALD issues as core issues rather than what we believe is currently marginal to their operations.

Finally, I think what we are also looking at is ATAPS—Access to Allied Psychological Services. There are a range of access issues around this service. There needs to be a structural recognition that many people who already see that this issue is taboo in their own community setting and who might not have familiarity with service access might take more time to be able to benefit from the services that exist. What we would like to see is a higher number of initial sessions allocated for people from a non-English-speaking background to establish familiarity and comfort with the counselling process.

The paper we have presented is far more detailed and far better argued than this initial presentation, but I did want the opportunity to raise some of the key issues as we saw them. I am happy to take questions now.

CHAIR: Thank you.

Senator FIERRAVANTI-WELLS: Thank you. I have known Mr Migliorino for many years, and many of the issues that Mr Migliorino has highlighted today are ones that we have discussed, given my 25 years involvement in the ethnic communities before becoming a senator. I first of all say that you would have noticed the various submissions and the paucity of comment that most submissions made in relation to CALD issues and CALD feedback, which troubled me a lot and no doubt troubled you as well.

Mr Migliorino: Can I respond to that? I think that is a really telling point. It is not just an issue in this domain or this jurisdiction; it is equally in other areas, and for a number of reasons. I feel there is a lack of infrastructure funding which allows these voices to be better organised. I know that a lot of the advocacy work that I undertake for FECCA is done on a voluntary basis because the organisation does not have the resources to actually develop the network of information, experiences and input that it requires. I also think that what becomes really telling is that many of the community organisations that we have tend to organise themselves almost in a hero or success approach, where things that migration brings are absolutely lauded and celebrated by the community but issues which are marginal in those communities receive very little attention.

This applies to many areas with which I professionally work. Mental health is clearly one of them. Dementia is another. Sexual orientation is another. It can go on and on. It becomes really difficult to express a level of need, and I think it is for that reason that I was quite keen to suggest that there is a need for a far better evidence base. If we have a model that only depends on the level of advocacy that is received, given that mental health is an area which is already marginal, it will not be able to get the attention it deserves. I think that, the more we have an evidence base of research and experiences which are documented and brought forward, the more it will compel services providers, government policymakers and systems to respond accordingly.

Senator FIERRAVANTI-WELLS: I agree with that. One of the other issues which you have referred to is the ageing CALD population. As we know from direct experience in many communities, as our Australians of non-English-speaking background get older, not only do they lose what for some are very limited English skills, on many occasions they revert back to the dialects of their childhood, which makes it even more difficult to deal with their needs, mental and otherwise. Finding people that can actually understand them is very difficult.

For the record I want to share this. Recently I was in Western Australia, where an aged-care facility that is specifically dementia focused had to wait a month to try to find a person who spoke a dialect of a 99-year-old Chinese fellow because they could not understand him. He had been there for a month. It took that aged-care facility a month to locate somebody who could communicate with this gentleman, because he spoke an obscure dialect. Mr Migliorino would no doubt know we have many instances of that happening on a daily basis in the community, and we certainly do not have the proper research to back that up.

Mr Migliorino: I would agree with that.

Senator FIERRAVANTI-WELLS: I have a couple of things I want to focus on. You mentioned the Multicultural Mental Health Australia project, which had been operated from March 2003 till June 2011 under the auspices of the Sydney West Area Health Service, which are no doubt familiar to you. You are aware of some of the controversy that has existed over the funding to that organisation ceasing and a new provider now being announced. Did FECCA have any input at all into the criteria for both the valuation of past services or the delivery of that project by the new provider?

Mr Migliorino: We did take action, and I am more than happy to share that with the committee. The issue of the ongoing nature of the funding to the service in what is the western health area of Sydney was of course of concern to us. The information that was passed to us as an organisation was that the organisation had been placed on notice and given preliminary information that they were not successful in the tender bid. In response to that I wrote to the Minister for Mental Health and Ageing, the Honourable Mark Butler, indicating that, while it was not our domain to question or doubt the basis of decision making by government in terms of these grant programs, I was very keen to be reassured that the capacities of any new service providers were, if not better, at least at the level of the current ones, because the reality is that that centre in Western Sydney had a very good history. Its understanding of issues and promotion of mental health issues has been extremely strong, and its commitment to public education around this issue is also well documented. When the final decision was made and the final decision was a consortium which had the Queensland Transcultural Mental Health Centre in association with that of Victoria and a person by the name of Nicholas Procter from the University of Adelaide, we really had no basis to suggest that those groups were any less able to deliver or did not have the capacity to deliver against the criteria for funding, given that we were not party to funding.

From my point of view—and this is an issue that we are expressing again in both formal and informal situations—the expertise that was developed in New South Wales should not be lost in the process. I am not clear what efforts or attempts will be made to ensure that that experience is somehow brought into the fold, but it was a fairly complicated and difficult process for FECCA to comment on, given the fact that we were not party to the selection process nor, indeed, informed of the criteria. So it is very much a watch-and-see brief, hoping that the new funded services will be able to develop or at least manifest the experience and the capacity that the previous provider had.

Senator FIERRAVANTI-WELLS: In fact, those were the concerns that I had in relation to the fact that this project had been operated for such a long period of time in one place and had built up an expertise. My efforts to date to elicit further information in relation to that have not been very successful. I place on the record that to date I have not been able to get the assessment. I have specifically asked whether the Multicultural Mental Health Australia project had delivered on all activities. I have been advised that the final outcomes of the project are yet to be received and evaluated. I place that on the record because this is an issue, given the statistics and the points that Mr Migliorino has made, that the department has not given us a very clear picture about. It is only a small portion of the funding—leaving aside what Mr Migliorino has said about added funding in this area, which is important—but we still do not even have an evaluation of those services.

I pick up a couple of other points that you made. With regard to the stigma, it is even more so in CALD communities because you are not only dealing with the person; you are actually often dealing with the family and the issues in relation to mental health, and current services just do not cover those aspects of it.

Mr Migliorino: I absolutely concur. It strengthens the argument for resources which are specific to these groups. The reality is that once mental health problems start to surface, even if they are diagnosed the response is not an immediate one of going to seek services, because many of the service structures, be they primary, secondary or tertiary health that ethnic communities actually access, are language-specific. The big issue is that, if it is identified and diagnosed, is one of the potential responses that it gets taken more in-house rather than used as a basis to access services? Families are very much part of that, especially in the geriatric area, where it occurs in family structures where the children might have already left home and the role of the carer then becomes extremely difficult in that regard. So the notion that needs to be considered here is that, if that is potentially one of the community responses, what does that then mean for the service sets and the capacities which no longer can—I know this has been a big issue for mental health—just wait and receive who comes to the door. There is almost an absolute onus on service providers to reach out, because they need to be able to bridge what is a cultural gap as well as a service access gap.

I undertook some work on a strategy in New South Wales for mental health for older people. The acronym escapes me, but popularly it was called SMHOP. It was looking at the mental health needs of older people. Already older people are marginal in the mental health debate. When you then start considering people of a non-English-speaking background, they were a margin within a margin, so you get very low levels of resource allocation. These issues and these needs need to be brought far higher up on the mental health agenda.

Senator FIERRAVANTI-WELLS: You make the point about cultural competency not just being about token access to interpreters. It is far deeper than that. I understand through my informal networks that there has been some work that FECCA may have done in relation to looking more at bicultural work issues and some other work that you may have done. If there has been some work that FECCA has done in this area, I am sure the committee would be very happy to receive that.

Mr Migliorino: Absolutely. We will certainly look to our existing policy set and make those available. I think the issue for us is increasingly that the argument about access and equity is a minority argument and one which is not given a lot of attention in government service provision. It almost is relegated to previous times when multiculturalism was a preferred policy construct. And what this actually means is that it is increasingly difficult to argue for a resource allocation which is commensurate with need. I think it is really important we understand that. The mental health services, to reiterate, are under a lot of stress, whether it be crises, community based or any other manifestations of it. We know and have a view of the fact that the ability to deal with diversity is such that if you are under such numeric stress you will tend to service those who are easier to service. That is because many of our service providers are not from the linguistic or cultural background of the clients they are assessing or working with; or, if they are, do they actually have the time to do so?

So I think it becomes critical in our understanding of this to ask what the structural mechanisms are that we can put in place to create far greater capacity. Yes, there is obviously a need for interpreters, but there is probably a more important need for communication paradigms which allow three-way conversations to exist over satellite or video connection. We need to really look at the recruitment processes and the skill sets of existing services to increase the volume of people with bicultural, bilingual skills so we enable and adapt the service structure to be able to deal with greater diversity. We need to consider, if dealing with someone through an interpreter takes more time, especially in a mental health assessment, what that means for number flow, resource orientation and resource organisation. I think all of these become absolutely critical to how services are able to then deal with a reality, especially in certain areas of Sydney, where it is not just one in 10, one in five, or a random person, but the bulk of people coming through the doors who are of non-English-speaking backgrounds, because that is the area in which they are living and drawn from.

Senator MOORE: Thank you for your submission and the ongoing process in your submission about the need for greater consideration of multicultural needs in all health but particularly in mental health. You particularly mentioned better access. Do you have any knowledge of the number of people from multicultural backgrounds accessing better access?

Mr Migliorino: No, I do not.

Senator MOORE: It is a question I am seeking. The data we have is based on Medicare, and no data set we have indicates socioeconomic background, so I was wondering whether your organisation had anything special in that area.

Mr Migliorino: No. In fact, that is part of why I am suggesting a far greater set—

Senator MOORE: I understand the research issue totally. I just wanted to clarify that point. So your process is across-the-board better understanding, acknowledgement and engagement in multicultural issues. Is that right?

Mr Migliorino: I think that is a very important start because it allows the overall service delivery structure to identify it as a priority. What needs to be added to that is any specialist requirement or particular need of a subgroup. The whole area of refugee mental health becomes critical—geriatric mental health as well. To me it is the composition of what is an extension of capacity to broaden the reach of services generally as well as the articulation of specific need, which allows the development of targeted services.

Senator MOORE: And, most clearly, language services.

Mr Migliorino: It is language services but it is also an understanding. A lot of what happens in mental health is an interpretation of behaviour in a context. To a committee as informed as this one I do not need to argue that, but it becomes really important. Unless you understand that cultural background, that social setting and that context, there is a risk of misdiagnosis.

Senator MOORE: And certainly my understanding is that within the refugee post-trauma area there is that acknowledgement but it does not go wider than that.

Mr Migliorino: True. It is also interesting, and again it is crossing over those two, that there is increasing attention being paid to refugee experiences as they manifest as people age rather than as an immediate post immigration or refugee movement. There is certainly increasing attention in that area but, again, no comment through resources to see what you actually do about it.

Senator MOORE: Thank you.

Senator FIERRAVANTI-WELLS: Mr Migliorino, are we now not seeing two facets of the issue? We are now seeing people from the post-war migration with their ageing and mental health issues, and a lot of older Australians from different backgrounds dealing with, for example, post-war issues and those sorts of things, parallel to a lot more people who have bilingual ability as part of their day-to-day living but who, as we have encouraged more and more people to speak their own language, we are now starting to see have issues in relation to English language and English language proficiency. So we have an intersection of two, more complex issues all coming to a head at one point.

Mr Migliorino: I agree with that, and if there were an area to be targeted certainly you would look at how you target it. The new arrival refugees are clearly one group that the psychogeriatric—and it is not just those who may have experienced refugee trauma in their past life; there is also the major impact of depression, especially in men who outlive their wives, and a range of other manifestations that can take place.

Language is an important issue because many people develop a level of language ability that allows them to shop, to deal with their profession and to do a whole range of things, but we are actually talking about the level of literacy to be able to form the words to be expressed, the emotions and feelings, to the point that they can be interpreted in the mental health context. I think the bar is actually far higher, and I think we can address it by increasing the capacity to work more at the level of the individual older person than at the level of the needs of the clinician.

Senator FIERRAVANTI-WELLS: Thank you.

Senator WRIGHT: Mr Migliorino, I would like to follow on from that conversation. You have a very thoughtful submission and it raised some interesting points for me. Some of what you have just spoken about resonated with me because I conducted a mental health review tribunal in South Australia for about eight years. One of the issues that confronted us quite often was the need for accurate interpreters to enable people at the hearings to have a voice and the cultural literacy issues that you raised. So much of working with people with mental health issues is the ability to understand someone's subjective experience and their behaviour and thoughts, which is so reliant on words and the ability to express those words. So if it is not done accurately or within context there is a capacity to misunderstand or misdiagnose, so they are really important issues.

Mr Migliorino: I think they are very important. There is a lot of debate not just on the linguistic issues but also on the tools we use for assessment. There is still a great resistance to using adaptive tools such as the RUDAS scale, which is used in the dementia area but which can be adapted to the mental health area. There are many major issues around that. There really is a need to say, 'Okay, if we're going to deliver these services to people from a variety of backgrounds, we actually need the tools which are robust and flexible enough to accommodate difference.' Even the very notion of the normalisation process for someone with mental health can be different: what is normal in one cultural context might be absolutely different for someone else. The one I have

looked at and understood, as an observer, is the expression of grief, especially after the loss of a loved one, which can be interpreted as a depressive state but indeed might not be clinical depression but the expression culturally of grief. So it is those types of issues that I think need to be part and parcel of the vernacular of the clinicians who are making these assessments.

Senator WRIGHT: Yes. I often thought it was as much an art as a science.

Mr Migliorino: Yes—even being human in terms of understanding that people are not just products of a number of questions.

Senator WRIGHT: I would like to clarify a comment in your submission. You say:

There are currently significant problems within Better Access and ATAPS, as people who do not speak English are not able to access psychological services because private practitioners cannot use free interpreter services ...

Would you just expand on that, because that is of great concern? It is a common problem in courts and tribunals as well.

Mr Migliorino: It is an issue of both supply and demand. I think the reality is that in communities where there are psychologists and psychiatrists in private practice who speak the language of their community then access to them is enhanced. That is my experience with the Italian community and some of the fine clinicians coming out that community are there. But if that is not the case, and if your whole access to primary care is through a language-specific professional, then moving on to a specialist or a psychologist or psychiatrist who does not speak the language is a major blockage. In the private domain, the inability to access interpreting services as a Medicare item become a blockage. So, yes, we feel that is the case. That might indeed be relieved by greater numbers of private clinicians coming forward who actually speak languages or have training in those areas, but there will never be the supply requirement to meet the needs of what are fairly significant and large groups.

Senator WRIGHT: Could I clarify that a bit further. Someone attending a private psychologist or psychiatrist would not be able to have access to the telephone interpreting service, for instance.

Mr Migliorino: To my knowledge that is the case.

Senator WRIGHT: What about GPs?

Mr Migliorino: I think GPs can, but again I would have to take that on notice. There is a technicality around whether there is a Medicare item to actually allow a consultation using an interpreter and whether the interpreter would be paid for. It is an area of ignorance on my part and I do apologise for not having the answer.

Senator WRIGHT: I would appreciate it if you could take that on notice and just clarify that for us. Thank you.

Senator FIERRAVANTI-WELLS: Could I add on that point: the submission from the Australian General Practice Network, at page 14, says, 'Currently there is no specific provision for funding interpreter services under ATAPS.'

Mr Migliorino: That was my assumption but I have not seen that. If that is the case then I would certainly be happy with that, but I will also undertake to review that.

CHAIR: Senator Moore, did you want to add something there?

Senator MOORE: No, I am just making some notes. That is fine. I will ask the department directly about that last one.

Mr Migliorino: That saves me a task; I will take it off the 'to do' list!

Senator MOORE: You should not have to do the homework. We can ask the department.

CHAIR: It is actually really helpful, though, to have your understanding of the situation, because your understanding may be different from what is happening, but it is a bit of an issue if you do not know, as a peak organisation. If you do not know what it is there is obviously a lack of information somewhere.

Mr Migliorino: And it is not just my view. The paper was based on some fantastic input from a number of people working in our sector and from supporting sectors as well. So if it is not just my lack of knowledge, if indeed it is not a piece of information which is generally known, then there is an issue.

CHAIR: And that is the point I was coming to.

Mr Migliorino: I appreciate that.

Senator FIERRAVANTI-WELLS: I have one question, and you touched on it in terms of the ethnic communities needing to be involved. One of the things that perhaps we have not tapped into is the extent to which providers could utilise the services of various organisations in terms of sourcing perhaps not high-level assistance

or workforce but certainly at a community level. Those sorts of things have been talked about but not much work has been done in those areas.

Mr Migliorino: There is one comment I would make on that. We talk about two-speed economies or patchwork economies. In ethnic communities there are two speeds of organisations—the Italian, Greek, some of the Jewish communities and even with the Dutch community we have quite a specific focus around issues to do with mental health and ageing. They are in the perfect position to do so, but the reality for many other communities is that they lack any form of structured infrastructure, which is funded or not funded. So if you want to speak to the Croatian, the Serbian or the Vietnamese communities in Sydney—which are all sizeable communities—you would struggle to find people from 9 to 5 whom you could actually contact and who could provide you with interpretive information. I think one of the real issues we have come to realise is that, given the development of function specific funding of ethnic communities to provide aged care or, in this case, mental health care and a number of other types of services, what is missing is anything which provides a base for communities to have a voice. What I am suggesting is that, yes, that works for communities where those resources are on tap, but for many other communities you would have to fight very hard to find exactly who could speak with any authority around what the community issues are.

Senator FIERRAVANTI-WELLS: Thank you.

CHAIR: That puts us bang on time.

Mr Migliorino: Thank you for the opportunity. I really do appreciate you allowing me to give evidence by phone.

CHAIR: Thank you very much for providing your submission and for giving evidence. You also have a little bit of homework, so that is also very much appreciated.

Proceedings suspended from 15:56 to 16:19

HICKIE, Professor Ian Bernard, Executive Director, Brain and Mind Research Institute, University of Sydney

McGORRY, Professor Patrick Dennistoun, Private capacity

Evidence was taken via teleconference—

CHAIR: Welcome. I know that you are both fully aware of the issues around parliamentary privilege and the protection of witnesses and evidence. I invite either of you or both of you to make an opening statement and then we will ask you some questions.

Prof. McGorry: I really appreciate the opportunity to make this statement and to be part of this inquiry. I would like to start by drawing your attention to the fact that what we are focusing on here, in my view, is building a national mental health system. I think this is the 21st century engineering challenge and I am reminded of one of our greatest symbols of nation building, the Sydney Harbour Bridge. Construction lasted nearly a decade through a series of carefully planned and executed stages. We all remember the photograph of the incomplete arch being built simultaneously from opposite shores. Planning, precision and cooperation were essential if the two ends were to meet in alignment. Mental health reform is a 21st-century opportunity for nation building that requires cooperation between state and territory governments building mental health services from one shore and the federal government building from the other. Up to now we have had eight sets of engineers, eight sets of plans and nowhere near enough money for the task. The chances of the two sides of the system aligning or indeed ever meeting will be slim indeed unless these issues are addressed.

The state governments have financed their construction from the proceeds of deinstitutionalisation in the 1980s and they began building the first section of the arch. These included general hospital in-patient units, community treatment teams and generic case management. It was poorly designed, not built to scale and could not withstand the strain of unmet community need. Much of it has buckled or actually been dismantled with ongoing cuts to state funded community mental health services. The federal government has been building multidisciplinary models of primary care such as Better Access and headspace to respond to mental ill health in its early stages and of mild to moderate severity and briefer duration.

The gap between federal and state funded systems has been sharply revealed by community concerns about the May budget's reduction in the maximum number of sessions of allied health care under Better Access. The federal side of the community arch has been scaled back with the government arguing it was veering offcourse and that finite funding could be better targeted to other mental health investments. The state side has been eroding for years and is not up to bearing additional strain. People are genuinely suffering as a result.

So who are these people stranded in the middle of this construction zone? They are a spectrum of Australians from all walks of life and all age groups. The disadvantaged, the young and those in rural and regional Australia are especially excluded. At one end, they are people who despite the primary care experience of Better Access have a need for more specialised and sustained multidisciplinary care. They are people who genuinely need more expert help. They suffer from a variable mix of persistent mood and anxiety disorders, eating disorders, post-traumatic stress, complex personality problems, substance abuse and psychotic disorders. This group of people need access to more specialised forms of care than the basic primary care approach can provide. This means we need a secondary model involving many different types of expertise running from clinical psychology, psychotherapy, psychiatry and addiction medicine through to social programs for housing, family support, further education and employment.

Even further along this spectrum are people with more severe forms of illnesses, usually in combination, and who are or may become socially excluded and homeless—people with severe and enduring mental illness, the people that deinstitutionalisation failed. These people lost in the middle require a substantial and systemic solution, one that not only restores access to those whose ongoing care has been restricted but goes much further and provides better access to care of a more specialised nature to a much greater number of Australians with more complex and persistent mental ill health needs who never had such access in the first place.

However, efforts to find a comprehensive solution are frustrated by the inevitable fighting over scraps that will probably continue so long as mental health remains so desperately underfunded. The \$1.5 billion of new investment over five years pledged by the Australian government in May, though a welcome and important step in the right direction, was just under half of the amount that a number of mental health leaders, including me,

identified as part of an independent blueprint as being immediately required. As a result, current discussion of the needs of the people lost in the middle is seen as a zero-sum game. As framed by some commentators, the zero-sum policy choice is either restoring funding for an unchanged Better Access program or building the new supports in the mental health reform package such as the \$105 million boost to the ATAPS program, the \$571 million to improve care for people with severe and persistent mental illness or the \$419 million expansions to the primary and specialist youth mental healthcare programs. Either way, there are losers as well as winners.

In physical health, we rarely see positive new initiatives such as the ones I have just mentioned criticised on the basis that there are other areas that also need urgent attention or funded by restricting access to other popular programs. Unfortunately, in mental health care the investment case on behalf of one group of people is often made at the expense of the care needs of another group. To liberate mental health policy from such zero-sum thinking, all Australian governments must respond to the scale of the unmet need and commit to steadily increasing the share of the health budget allocated to mental health over the lifetime of a 10-year reform process. Ultimately, mental health spending needs to double so that the resources allocated to mental health care can match the burden of mental ill health on Australian society. Mental health reform therefore needs a sequential plan, like the Sydney Harbour Bridge blueprint, tied to an investment schedule in which every budget makes further progress towards completing this major nation-building project. We must pursue transformational change and not be seduced into patching up a system that has been failing for years.

Because unmet need abounds, notwithstanding the National Health and Hospitals Reform Commission's recommendations, debate continues about where to start. While there is no doubt that all these needs must ultimately be met, the sequence for investment must follow principles of capacity to benefit, cost-effectiveness and social inclusion. This is why the early intervention and youth mental health reforms are the most precious in that transformational sense. We need a much more unified and professional approach to this, which transcends vested interests. Our whole sector needs to behave in a much more mature manner, eschew public conflict and partner better with the community, including the business community.

The 19 August meeting of the Council of Australian Governments in Canberra at least committed all Australian governments to developing a 10-year road map for mental health reform. However, this road map will only be meaningful if it is developed with a clear, unifying purpose and creates an engineering blueprint supported by sufficient collective will, expertise and funding. The National Disability Insurance Scheme initiative, which has tripartisan support, contains some important lessons that may be applied to developing aspects of this road map. When David Cappelletti, Frank Quinlan and I presented to first ministers at the COAG meeting this month, our central recommendation was that the 10-year road map endorsed what the mental health sector last year identified as its core goal—that all Australians should have the same access to quality care for mental ill health as for physical ill health. Making substantial progress towards achieving this goal should be the unifying purpose of the 10-year road map and the measure of its success. Like the Sydney Harbour Bridge, the construction process to transform mental health care into a system fit for the modern era depends on a unifying vision and the skill and resources to achieve it. The people currently lost in the middle are relying on the mental health sector to represent them in a mature and effective way and all of our governments to step up and make it happen. Thank you for the opportunity to make this statement.

CHAIR: Thank you. Dr Hickie, do you want to make an opening statement?

Prof. Hickie: First of all, I would like to commend the committee for continuing this tripartisan commitment to evaluating mental health and continuing to have it as a focus of national attention. It is very important to outline some of my own interests, because I think a number of the submissions and some of the evidence to the committee have reflected the interests of many other groups, particularly the professional groups, and I am concerned about the extent to which the genuine community interest is prioritised. As I am likely to go on to criticise others, it is very important that I outline my own specific interests.

The Brain and Mind Research Institute manages two Headspace sites in Sydney—in central Sydney and in Camperdown. I am a director of the Headspace company. I have worked for a number of governments and gave advice about the implementation of the Better Outcomes program, which preceded the Better Access program, during the period of the Howard government. During the period of the Rudd and subsequent Gillard governments I worked for the National Advisory Council on Mental Health, previously chaired by John Mendoza, and the more recent Mental Health Working Group.

I am the scientific chair of the new cooperative research centre, led by the Inspire Foundation, for youth, technology and wellbeing which deals with e-health technologies and I was part of a previous tender by the Australian Institute of Health and Welfare and the Mental Health Council of Australia which bid for the department of health tender for the evaluation of the Better Access program.

Importantly, historically, when I was the CEO of beyondblue, I was intimately involved in the first major national government initiative to fund psychological care in general practice, known as Better Outcomes. That was a very important transformation in the Australian healthcare system to fund for the first time psychological services in addition to medical services and pharmaceutical benefits for people with mental health problems. That particular program, which is a credit to Michael Wooldridge, who at the time was the minister in the Howard government, only had \$120 million to spend over a four-year period. It was announced in the 2001 budget and the implementation was led by me and Dr Julie Thompson, who at that stage was the chair of the Australian Divisions of General Practice. It put a very high emphasis on collaborative care, funding outcomes rather than activity and providing services to rural and regional Australia and those who were more limited financially in terms of access to psychological care.

It is important to say that before 2001 Australians did access psychological care but paid for it out of their own pockets. Needless to say, most services were located in the city areas and were mostly accessed by those of higher socioeconomic means. So the Better Outcomes program was the first attempt to more equitably distribute and to provide a financial structure for access to psychological care to match access to medical care and pharmaceuticals for the treatment of the types of psychological problems that frequently occur in general practice, namely, anxiety and depression.

As chair of the committee that recommended the original evaluation of that program it is important to say that the department of health did not accept the full extent of our recommendations and only conducted a limited evaluation of the psychological aspects of that program. Subsequently, through a lot of your own particular work and the lobbying in the Senate in 2005 and 2006—and I point out my own evidence to the Senate in 2005 strongly supporting expansion of that program to particularly fund clinical psychologists to deliver skilled psychological services—we were then very fortunate when the Howard government and the Iemma government came together to lead the first major COAG process in 2006 which led to a major expansion of mental health financing and, from the Commonwealth point of view, the introduction of Better Access.

It is very important to say that at that period of time, however, the major associations in medicine and allied health recommended moves away from the outcome focus, the collaborative focus and the equity focus of Better Outcomes to the standard Medicare fee-for-service systems much more easily run by providers where they live and easier for them to administer. We warned the government at the time that not only would that result in higher costs because of the number of people in Australia who did not access care, but it was highly likely that the distribution would be inequitable, as is commonly the case under our Medicare services for specialised access to care.

With the arrival of the Rudd government I was involved with the Mental Health Council in a subsequent series of evaluations of data that the minister, Minister Roxon, kindly made available from 2008 onwards which demonstrated a consistent pattern of inequitable distribution of access to those services. It is important to say that I do believe most of the people who receive those services are in need of care. But the distribution by income range and by location is not acceptable, I think, to the wider Australian public. So the equity issues have been very much championed by the Mental Health Council and by aspects of the academic sector that I have been associated with, and these issues were brought to the attention of Minister Roxon through her own National Advisory Council on Mental Health, chaired by John Mendoza, where the majority view at that time was that the scheme required revision, as it continued to grow, to address these equity issues. Also, from a consumer and carer point of view issues were raised with us continuously about the quality of the program, the training of personnel to deal with more complex issues and the relative exclusion of care for those with more complex and ongoing needs.

In 2011 the evaluation of this program was released. It is important to say the previous advisory council and many others have been critical of the very limited scope of that evaluation. I think very sadly a lot of the hot air that now surrounds this particular debate could have been cleared and avoided if there had been adequate scope to that evaluation. One of the strongest statements I would make is the need for ongoing serious health service research and evaluation around such an expensive program, rather than the style of very limited and self-serving evaluation that has currently surrounded many aspects of this review. This is an issue that is now being debated in the academic journals and I would suggest the senators see the debate in the Royal Australian and New Zealand College of Psychiatrists' journal in recent months around these issues.

In association with Professor McGorry I have worked with the mental health working group and David Cappo in making recommendations into the 2011 budget. Contrary to what many people believe, the government did not simply accept our recommendations; it made its own finance decisions and its own choices. I would commend the Prime Minister and Minister Butler for basically saying what we need is a transformational set of investments. I

do believe that those that are basically set out in this year's budget potentially take us down that path if, as Professor McGorry has highlighted, it results in continuing investment and continuing serious evaluation of the success or otherwise of these programs. I think the role of the Senate and your committee is the first step in that. I hope we see in the future the style of national commission that really takes responsibility for that serious ongoing evaluation.

There are other aspects of the investments in the 2011 budget, particularly the youth investments, the new approach to the coordinated care of those with serious and persisting illness, the potential investments in e-health and the reinvestment in mental health research, that are a marked change from previous investments by our national and state governments. They really highlight the need to have systems that result in social and economic participation. As part of that, what I would see as trying to correct the balance in the Better Access program by potentially limiting GP payments and some aspects of the psychological services so that particularly the psychological services can grow under the more appropriate ATAPS program is extremely welcome. I think there has been a great deal of misinformation about a reduction in services, as distinct from a potential expansion in services to those who have previously been excluded by economic means, by geography or by the more complex nature of their care, which is welcome.

I think the problem that has been highlighted in the public debate is that there are so many gaps in the national mental health system, particularly surrounding those who would be served by long-term psychological care outside of hospital systems. We have never funded such a system in Australia. To use Pat's Sydney Harbour Bridge analogy, it is one of the yawning gaps with a constant game of tennis as to who will take care of that group being batted backwards and forwards between states and territories and the Commonwealth. There is no commitment to providing the style of care that those people need, which needs to be specialised and in my view delivered by clinical psychologists or psychiatrists who have real skill to deal with complex cases. It needs to be delivered in a collaborative model and it needs to have an appropriate number of Medicare style accesses over the course of the year.

Michael Wooldridge started to deal with this issue for psychiatrists back at the end of the last decade, setting a number of somewhere between 30 and 50 sessions per year for those particular groups. That group needs to be very tightly defined in terms of its need. Typically people with eating disorders, often people with borderline personality disorders, those with complicated substance abuse and mental health problems and those who are accessing the disability support pension would be best serviced by that style of system. If we go down that path, we need to ensure we do not end up with the same inequity by socioeconomic status that has characterised much of the care currently provided under Better Access.

There are also much better alternatives now available. I would particularly highlight the e-health area and the work of Professor Helen Christensen showing that much standard psychological care could probably be provided for \$10 a head through appropriate internet services versus \$900 a head through general psychological counselling services. As we move into the more complex areas I would really like to continue to make public my continuing commitment to specially trained clinical psychologists joining with psychiatrists to provide much of that specialised assessment and care for complex cases. As we move forward I think it is important for this committee to support the 2011 budget reforms and make sure that we continue to focus on issues of equity and quality as we try to expand the out-of-hospital services where Better Access has picked up part of the load that was never designed and never intended to deal with the yawning gap of ongoing care for those in high need outside of hospitals. I thank you for the opportunity to make this statement.

Senator FIERRAVANTI-WELLS: Professors, I will limit my comments to three areas. I want to start with your comments, Professor Hickie, about so many gaps. Is that part of the reason why we are seeing some of this commentary? We have effectively had a situation, a perception, of robbing Peter to pay Paul? Professor McGorry, I think you mentioned double the spending, and I think the papers that the group put out talked about \$3 billion or \$3½ billion as the price. Is the reason why some of this is happening that we have picked and chosen what we will support as opposed to filling the gaps right across the system?

Prof. Hickie: I think that is absolutely true. One of the important issues here is that Better Access was never designed, in the original Better Outcomes or subsequently, to deal with all psychological care outside of hospitals, particularly those with ongoing care needs. What has happened is that providers have attempted to assess the patients who come for care through the existing system and, of course, it is oversubscribed and there is a great deal of demand. Now there seems to be competition between different age groups, between men and women, between those accessing early intervention programs and those who are having ongoing care and between city and country in terms of the provision of services. While we have a grossly inadequate system this problem will continue.

Prof. McGorry: I would like to add to that. I totally agree with you that a lot of this problem could have been avoided in the short term if more money had been made available. To get to the right level of funding, it is really going to be double what we are currently spending. We cannot get to that point in one step. We do need to have sequential transformational stepwise investments. The principles underlying that have to be based on to what extent there are new systems that can transform what is currently happening. We really have got a very dysfunctional system. There was consensus all around Australia last year and across all sides of politics that the system needed radical change, so that means new, evidence based transformational programs. I think we really need to stick with those directions. If there are choices to be made in the short term we have to make them with building better, new systems in mind.

What I am trying to say about Better Access is that it is a good primary care first step, but the people who come to the end of the 10 sessions need something more, of higher quality. They do not just need more of the same. There certainly needs to be an evaluation of their needs, which are quite likely going to involve more specialised and expensive care at that point, not more of the same.

Senator FIERRAVANTI-WELLS: Professor Hickie, I want to pick up the point that you made that, had there been a better evaluation of the scheme—and I certainly was critical of the evaluation and have pursued that aspect of it. It is very clear that the parameters of the evaluation were to achieve a particular objective. As I understand, it was a tender process and various suggestions were made as to how the project should be evaluated. I think the government then chose its own criteria and we now have this result, which has been criticised in terms of its evaluation.

CHAIR: Is there a question there, Senator Fierravanti-Wells?

Senator FIERRAVANTI-WELLS: I was just making the point to Professor Hickie. I have one question I do want to ask both of you. There have been discussions about a national mental health commission. The model suggested by the government, which is a unit in Prime Minister and Cabinet, does not seem to accord with what I have seen in the literature or discussions that have been had with various people in terms of the commission. Are you satisfied that a unit within the parameters of Prime Minister and Cabinet is actually going to provide the sort of national leadership that a commission should; should it not be a more independent statutory authority?

Prof. Hickie: I think it is a very contentious question. At this stage, we would like to see any national commission that—

Senator FIERRAVANTI-WELLS: It has been 10 years in the making!

Prof. Hickie: does actually work at a higher level. We have struggled. And your point about the evaluation is so important: the evaluation was grossly inadequate, and now we are having a public debate, trying to interpret numbers, many of which are essentially meaningless. In fact, the authors themselves say that the comparison of clinical psychology and general psychology is meaningless, yet people are drawing interpretations from that. There are issues about who gets access, the style of care and what should happen in the future. When we introduce programs like Better Access and we look at the actual equity issues—the fact that 2½ times more services go to those in the highest income group than to those in the lowest income group—we obviously need to make serious decisions. So I think at this stage we have become more generally concerned that we get a national commission that does operate at a higher level; and, within the bureaucracy, Prime Minister and Cabinet is obviously the highest level. We would expect it, however, to have the characteristics of independence that you are talking about—one of the welcome characteristics, for example, of this Senate committee.

Prof. McGorry: My view is similar but a little bit different. I think the ideal is actually an independent commission—I think that is what we should aim for in due course; that is really the only way to guarantee independence—similar to the Human Rights Commission and those sorts of structures. But I agree with Professor Hickie in the sense that, if it is going to be linked to government, being linked at the prime ministerial level is the best position to put it, because prime ministerial support, from whichever side of politics, is vital for mental health reform to be continued over the long haul. We have never seen mental health reform progress when the poor old health minister is the only one leading the charge.

Senator FIERRAVANTI-WELLS: I am conscious of the time, Chair, so I will end there.

CHAIR: Senator Moore.

Senator MOORE: Gentlemen, I only have one question. It is clear that the best possible outcome would be to have more money across the whole of the mental health sector—and I am not even going to ask if you agree with that, because of course you do. Under the Better Access initiative, we are looking in particular at the 10 to a maximum of 18 sessions. But my understanding of Better Access was that, at each stage, there was supposed to be a critical evaluation of the patient's needs before they moved on to the next step—so six sessions, 12 and then

the maximum of 18. That last bit is the area that people are talking about at the moment. If I understood what you were saying, you both think that there needed to be an evaluation at that stage about whether there was a need for a different type of service or whether more of the Better Access type service was appropriate. Basically, the 10-session level is the maximum under Better Access, but there is fully an expectation that people would move on if necessary to another form of service, be it ATAPS, public health or community services. Is that how you see it?

Prof. Hickie: I am one of the people who have very much supported the changes that have come out in the budget, and I think there are some really fundamental misunderstandings. There are some people with certain kinds of conditions who never really should have been treated under the Better Access framework. It is very clear in the Medicare schedule that it is designed for focused psychological strategies for those sets of disorders that would respond. Most people in fact have had five sessions. Eighteen was meant to be exceptional. But, if people go in with an eating disorder, a borderline personality disorder or a complex disorder, no-one believes they are going to get better in five or 10 sessions. From the start, the providers of care need to be upfront about what sort of care is going to be provided. What is needed is for the ATAPS program to develop and become more sophisticated—as it started, but it has been grossly underfunded—to provide the style of ongoing collaborative care that is required for many of those serious disorders. I would certainly say that, for those who come in under Better Access and a single provider, going beyond 10 sessions should have been and should remain exceptional. What has clearly happened though is that many people with high needs have linked with a provider and continued that psychological care.

I think this is one of the issues that seriously needs to be sorted out. Going back to the system as it was simply means that we have people who should not be in that care system receiving long-term care while many other people are excluded. In fact, if you do the maths, the 80,000 who were said to lose services by going for a long series of sessions essentially keep a quarter of a million people out of service who would have received shorter numbers of services. So I think we have to design a care system that is actually correct and separate out the two issues and not use the wrong system to meet the needs of people who have ongoing and serious care needs and are better dealt with by sophisticated teams of professionals outside of hospitals. I do not have any doubt that at the end of the day that will be a Commonwealth responsibility. That will never be done by the states. It is better done in association with these other outpatient, general practice and specialist programs the Commonwealth funds under the MBS network, but it needs the appropriate ATAPS framework to distribute it regionally, overcome the economic equity issues and work to collaborative and outcome models, not provider activity models.

Prof. McGorry: Did you want me to make a comment as well?

Senator MOORE: Yes, go for it.

Prof. McGorry: I will just make a brief statement. There was not the \$3.5 billion in the budget, and choices were made by the government, I hasten to say. I would also put on the record that the mental health expert working group discussed all these issues. As you have already seen in your previous hearings, the decisions were somewhat of a surprise to the members of the expert working group on budget night. We were not expecting that. We were still hoping that we would get a much larger investment, which would allow all of these things to be taken forward more positively. Now that that has happened, the next step is for the government to consider exactly what Professor Hickie has just been saying: how do we build a much more effective, specialised second-tier?

I notice you have had a lot of debate and argument amongst different psychology groups about the one- and two-tier systems, which is sort of relevant to the point here. We believe that if someone needs more than the initial 10 sessions now of primary care mental health care with a GP and a basic allied health person, if they are not in good shape by the end of that, they need a serious re-evaluation and they probably need more skilled psychological care going forward and probably—not always—in many cases, on a team basis. I do not know if ATAPS is the solution to that, but I think we need to go back and design something that is appropriate to those people's needs. I agree with Professor Hickie that that is only going to happen from the federal end of the bridge. The state system, as I said earlier, is actually going backwards if anything, not forwards. Somehow that has to be tackled as the next step in reform.

If we think that what was announced in May is all that we are going to be doing for the next five years, that is a very big problem. We need to go back to government next year and say, 'We need more investment. That is not enough to deal with the community need.' We cannot sit by and watch this level of unmet need—and that is I think what has come through the submissions to your inquiry and through the media and the community. There are a lot of people out there that need a response. It is not fair for us to just be shuffling the deckchairs. We have to move forward with a blueprint, as I said in my opening remarks.

Senator MOORE: I have one other question and I think both of you have touched on it—particularly you, Professor Hickie, in one of your previous answers. There has been some discussion that the changes in the budget will actually mean a reduction in the numbers of people across Australia who will be receiving care and that the changes will mean that fewer people will be serviced. My understanding is that, in a previous answer, Professor Hickie, you felt that that was not true—that in fact the changes would mean that there would be an expansion of services. I would like to have something more on record about changes—

Prof. Hickie: I would like to make a statement about that because I think it is one of those big lies that becomes a media statement. There will be no reduction in psychological services. With a reduction in number of sessions, more people will get into Better Access and, with an increased investment in ATAPS, more people will receive the various levels of ATAPS services. In total numbers more people will be receiving psychological services and there will be no less activity by a psychologist or by anyone else using those systems.

The problem arises for those who have been in longer term treatment programs that have been partially underfunded by the so-called exceptional circumstances. I think most of those people have very high-end needs. They are often people with eating disorders, or borderline personalities, comorbid substance abuse or severe mental illnesses like bipolar disorder and receiving psychological care. They are the people with real care needs. The longer they are in those care systems and using many of those systems up to 18, then three people who would have used five or six sessions are actually not receiving services. It is all the same to the psychologists and everybody else; they will be equally active and using the system and billing in exactly the same way.

The issue is that group has never been designed and dealt with specifically. I do think, contrary to what Pat was saying, that ATAPS can be modified and run in a more equitable way, as it was under Better Outcomes, through a regional distribution of services and a collaborative team care model. It will be expensive but it needs to be done. The statement that 80,000 people less are going to receive care is a nonsense. People would have got to the end of ATAPS programs at 12 or 18. In fact more people will come in. By having more people in chronic care or long-term care you keep more people out, and most of those people are poorer, they are unable to co-pay, they are younger and they are in rural and regional Australia. I am really fussed that the media reporting of these issues never includes those who have no voice in this debate.

Senator WRIGHT: I just want to thank you for your time, and congratulate you Professor McGorry on your evocative metaphors as usual. It does help us to visualise the situation that we are facing. I will not take any more time with questions, thank you.

Senator McKENZIE: My question goes to e-initiatives. I have a particular interest in the rural and regional Australia. We have heard today from a variety of providers about the use of e-technologies in treating mental illness. Some say it is possible to treat it as a front-line treatment communication method. Others see it as a more of a complementary method once that face-to-face relationship has been established with potential clients. I would really appreciate your expertise on this.

Prof. Hickie: I am of the group that has a very strong view that many of the straightforward basic psychological services can be provided online. Many young people would prefer to use them online, and actually many older people, who are disabled, and many people who have to travel distances to health care love 24/7 availability of e-health services. They love the privacy. Many people are familiar with using those technologies and find this a better way of interacting with the system. From a cost-effective point of view, Professor Christensen's modelling of \$10 a head versus \$900 a head to me suggests to any government that many services that could be replaced.

The history of medicine is replacing people based services with technologies that are often more efficient to the great distress of those people who have been trained in the same types of treatments. I am afraid to say that has happened in medicine on many occasions. I think what we are seeing is a rearguard action by clinicians, who have been trained in particular strategies, who can see the writing on the wall. There is a very important role of conditions in the initial assessment in certain situations and in review. If you actually look at the e-health technologies it is well delivered by Professor Christensen and Professor Andrews and many others. They actually encourage those who are not responding to come to the more specialised care that Pat and I were talking about. I have no doubt in the future that many of the things, which were actually included in the original Better Outcomes, to be provided by people in the very short future will be provided by technologies that do at least as good a job as those basic clinicians.

Prof. McGorry: Just very briefly I will add that Ian, Helen Christensen and I, and I think about another 60 partners, are involved in a federal government funded cooperative research centre in new technologies in youth mental health, which is an incredible nation-building venture, which will really complement in a 21st century way the investments in headspace and the early psychosis programs that will roll out. These are the sorts of

transformational changes which are going to bring mental health care in Australia into the 21st century. I think that a lot of the vested interest that Professor Hickie has been describing, defending a dysfunctional status quo, has to be seen in that light to some degree. We have to move forward. We really appreciate the opportunity of speaking to you today. We hope that the tripartisan support for mental health reform that has been so impressive in the last couple of years continues.

CHAIR: I have one last question following on from what you, Professor Hickie, were saying earlier about the number of people who are now going to be treated through the new system and your comment that the 80,000 is a misnomer. I take your point about the need for better systems that treat those who are chronically ill. A lot of the concern that has been expressed to us is about the transformation that we are talking about, that the current ATAPS system is not ready to deal with that group of people who will move out of Better Access into ATAPS. That is the sort of concern that we are hearing. We have heard comment around the ANAO report. We have heard comment about the services running out of money and the fact that we are in transition between divisions and Medicare Locals and that the system is not going to be up and running and ready to take that cohort of people. Do you have any suggestions or comments on those points?

Prof. Hickie: Again, I think this matter is very important. As currently designed, with no change to the budget, those people would have got to the end of 18 sessions in the pre-existing situation or 10 sessions in the situation going forward. It is a system failure. What we need to do is focus on how ATAPS—and I might say a number of other specialist systems come up to speed quickly and much of that is through manpower—

CHAIR: Or women power!

Prof. Hickie: People power; let us say profession power. Many of the problems with ATAPS and seemingly with headspace—and I am sure this will happen with the new services—stem from having models that reward GPs, clinical psychologists and mental health nurses for working in those new frameworks instead of working in isolated single practices in the better resourced suburbs in our major cities. At the moment, we do not have the investments of people power under preferential schemes in those areas such as headspace and what will be the new early psychosis programs. That has been the problem with ATAPS. A lot of the criticism of ATAPS, particularly by the professions, is highly self-serving. We need those professions to actually align themselves with the transformational projects and we need a government that is serious about putting the incentives, the allocations of workforces, particularly training workforces in medicine, general medicine, psychiatry and psychology and nursing in those transformational centres. We will then be picking up from the start many of those people who have ongoing care needs. So, in a sense, it is not a lack of concern for those people but a recognition that we need a system that will meet not just their needs but the needs of many other hundreds and thousands of Australians who will find themselves in that situation in the future. Trying to stick it together with the old Better Access model is poor spending and poor planning.

CHAIR: Thank you. I have run us over time because we started late. Thank you very much for giving up some time in Paris to come and talk to us.

Prof. McGorry: Thank you. We really appreciate it.

Prof. Hickie: Thank you.

HAMBLETON, Dr Steve, Federal President, Australian Medical Association**SULLIVAN, Mr Francis, Secretary General, Australian Medical Association**

[17:03]

CHAIR: Welcome. I understand that you know the issues around parliamentary privilege and the protection of witnesses and evidence. We have received your submission as No. 185. I invite you to make an opening statement and then we will go through the usual pack drill of asking you some questions.

Dr Hambleton: Thank you very much and good afternoon, senators. The AMA appreciate the opportunity to appear at the inquiry, which has attracted enormous interest and, we understand, a large number of submissions. For too many years people with mental illness have struggled to navigate the health system as well as access the support and treatment they need. The community has also struggled to acknowledge the prevalence and impact of mental illness, while state and federal governments are only just coming to fully appreciate the need to invest more resources in this area. Not surprisingly, funding for mental healthcare services is woefully inadequate. Thankfully, it seems attitudes are changing.

The cost of mental illnesses is significant. It is estimated that depression in the workforce costs the community \$12.6 billion every year, largely through lost productivity and job turnover. Really, that is just the tip of the iceberg. Organisations like the AMA have campaigned strongly to raise community awareness of the impact of mental illness and for much greater government support for accessible and high-quality mental health services. We know this can make a real difference to the lives of patients, their carers and the community. When patients are able to seek help at an early stage of the illness, we can keep them in the workforce, alleviate the burdens on their carers, reduce costs to the health system and save the community money in the long term. Clearly, this is an investment rather than a cost.

I am a GP from Brisbane and I deal with patients suffering from mental illness on a daily basis. Patients trust their GP, and we are often the only place they can turn to for advice and help. GPs are at the front line in tackling this illness, which can be so debilitating. The introduction of Medicare rebates for GP mental health services under the Better Access program was a big leap forward for mental healthcare delivery. Through increased funding it made services more accessible. It supported GPs to devote more time to these patients not only in the consulting room but also outside, in developing a structured treatment plan and coordinating access to other services. Importantly, by utilising mainstream GP services, Better Access has also reduced some of the stigma associated with seeking treatment for a mental health problem.

Better Access has been very popular, and this reflects the reality that there has been an enormous unmet need in the community and over a million people treated every year, including 150,000 services for people in the most disadvantaged area. The government's own independent evaluation of the Better Access program found that it was cost-effective and stated that it is a crucial piece of the web of Australian primary mental healthcare reforms and is helpful to previously unmet need.

On budget night, the AMA was looking to government to build on the success of programs like Better Access and substantially boost funding for mental health care. We needed to see a big investment across a range of worthy programs. We were profoundly disappointed. While the government claimed a \$2.2 billion health package on budget night, we know that the government's package does not match the rhetoric. In a normal four-year budgetary cycle, the net new mental health spend is only \$390 million. In a cruel blow for patients, the government chose to slash \$400 million in Medicare funding for GP mental health services to pay for other programs. Indeed, funding for mental health services in the first year of the government's package falls by \$26 million. Shifting money from one needy group to another in an underfunded area of health care is unfair and unwarranted. We asked for an investment program, not a savings program.

Ninety-three per cent of patients with mental illness currently face no out-of-pocket costs when they see a GP for mental health services. These patients will now see their Medicare rebate cut by up to half. Clearly the government's decision will affect vulnerable patients and make access to vital GP services less affordable. There was no consultation with the profession regarding these cuts, and it appears that the government bypassed its own expert advisory group on mental health. This looks like a policy based on advice from Treasury and Finance, not health professionals working at the coalface.

These cuts also send the wrong signal to people with a mental illness. Medicare will now treat them less favourably than people with a physical illness. Despite involving more work and responsibility, rebates for GP

mental health plans will be between 10 and 50 per cent lower than a GP management plan for a chronic illness. This devalues the importance of tackling mental illness.

Since the budget I have been travelling around the country talking to GPs. Last week I visited general practices in rural South Australia and metropolitan Adelaide. I can assure you that GPs are very angry about these cuts, which they believe devalue the role of general practice in mental health care and will make it harder for patients to access services that they need.

We need to support patients with mental illness and ensure they have every opportunity to live a normal and productive life. I recognise that the government made some welcome new investments in mental health in the budget, particularly in relation to targeting hard-to-reach groups. However, these should not have come at the expense of Better Access funding, which is supporting delivery of evidence based therapies, delivering good outcomes in a cost-effective way. This inquiry will shine a spotlight on the impact of the cuts, and it is our hope that the evidence provided will force the government to rethink its decision, which, in terms of this year's federal budget expenditure of \$350 billion, would represent only a very modest cost but would make such an enormous difference to the lives of those who will otherwise be adversely affected. Thank you.

CHAIR: Thank you.

Senator FIERRAVANTI-WELLS: Thank you, Dr Hambleton. You must have been talking to the same GPs that I was talking to in regional and rural South Australia last week, who told me exactly the same thing. Obviously Professor Hickie and, to a lesser extent, Professor McGorry were being quite critical in their presentation. I wonder if you would like the opportunity to respond. He was clearly having a go at the clinicians and the professionals. I afford you the opportunity if you want to respond to what Professor Hickie and Professor McGorry have said.

Dr Hambleton: Thank you very much. The independent evaluation said that this program was cost-effective and it was treating people with real needs—even Professor Hickie and Patrick McGorry were saying the same thing. It is not as though the people being treated do not have serious needs that are being met. The program evaluation has shown that. The criticisms of it are that it is not reaching the target groups. The greatest growth in this program is actually in those target groups, so, if you like, it is coming to maturity just now. The greatest growth was actually in the young people getting access to this program. The next greatest growth was in the lowest sociodemographic, where over 150,000 people were being treated, but the growth rate in that area was the greatest. So we are now getting to the very people that he is showing some concern about, with real mental illnesses that need real treatments, and this program is offering that. It is doing it in a very special way, though. It is doing it in conjunction with the family doctor. In 85 per cent of the cases in that evaluation, it was the family doctor, the regular doctor, someone who knew that patient on an ongoing basis, who was linked into this service. I think that is a very powerful thing because it was building that team environment that he was talking about.

Senator FIERRAVANTI-WELLS: That is particularly the case in regional and rural areas, because the doctor is such a vital part of that network.

Dr Hambleton: I was in rural South Australia last week—and we talked about people working alone. I saw some flagship practices where the doctors are the health service. In fact, they have got funding for infrastructure grants. They have a mental health nurse working in the practice. There are six or eight doctors collected together. They provide all of the services and they bring the people into the surgeries. I saw some really good team approaches. They are treating the whole patient, 24/7. They are the emergency doctors. They are the mental health doctors. They are the obstetric doctors. It is part of a package, and I think this is part of the package that, with these cuts, they will have difficulty delivering.

Senator FIERRAVANTI-WELLS: One graphic example was given to me where a person had an episode and the GP basically had to keep the person in their surgery for three hours, medicated, to wait for an ambulance to take them to a bed that was at least 90 kilometres away. But he said that he is the only one in that town who could look after that particular patient. It is that sort of thing. One of the questions I asked earlier, which seemed to have been fobbed off by the department, is about the issue of the lack of—

Senator MOORE: I am sorry, but the verb 'to fob off' in that sense I think—

Senator FIERRAVANTI-WELLS: I withdraw that. Some evidence was given earlier in relation to the number of practitioners and the correlation between fewer services in particular areas and the lack of practitioners, and that is why we are not seeing figures. We are not seeing people from disadvantaged areas accessing Better Access because they just do not have the services there and the practitioners are not there.

Dr Hambleton: That is true. If your base service is based on the family doctor you have got a longitudinal ongoing relationship, which we need to build on. The fact that the funding was there to allow doctors to spend

longer with their patients was so important. We do talk about mental health and we do talk about physical health, but the reality is there are comorbidities and you are dealing with multiple problems at once and they are interrelated. It is often the lower socioeconomic demographic that needs that access and needs that time spent. I do have a fear as to the changes in the fees and the rebates that are available. We have surveyed our doctors and found that with some of them there will be reduced access. I think that is even worse.

Senator FIERRAVANTI-WELLS: This is about the essential research that was conducted, with your 763 GPs across the spectrum.

Dr Hambleton: We tried to get a good sample. Essential Research are an outside company and they tell us that the number that they saw, 763 GPs, gave them the 95 per cent confidence intervals to say that the answers they found were appropriate and could be interpreted across the board. They are very disturbing figures: 50 per cent of GPs are telling us that they are going to maintain the current fees, and that is certainly going to impact on access; 28 per cent of GPs are saying they are not going to use these at all, and remember that this is the front door to the psychological services that are there; 58 per cent of GPs are going to spend less time. Every time we look at time spent with patients we find that you get a better outcome the longer you can spend. There are comorbidities here that all need to be treated simultaneously, but for mental health it is the most difficult area. I remember a case of my own. With young people—and this was to do with a young person—you do not want to jump into a mental health diagnosis straightaway. These are undifferentiated illnesses. In fact, we formed the view over a few visits that this young lady needed to see a clinical psychologist. She did not get a large number of visits. The return information that came back to me led us to believe that this was a very serious matter and she did get referred on to other services. I did hear earlier that perhaps reviews and reevaluation are not taking place. I dispute that. They are taking place. In this case these were family doctors. I knew this little kid when she broke her arm at 10, and at 16 she was suicidal. It was an awful thing.

Senator MOORE: My brain must have been switched off then. Could you repeat the point you were making about reviews?

Dr Hambleton: Yes. I heard earlier that people end up having 10-plus or up to 18 visits and perhaps GPs are not thinking about sending people on to higher level services or to admission or to psychiatrists. In fact, it was after two visits with the psychologist, where the psychologist actually called me. The psychologist did not wait for the six visits but actually called me after two and said, 'I am worried about this young lady as well. I think we need to call in some other help.' That is the great value of this program. I had some anxieties. The psychologist had the same ones.

Senator MOORE: On the issue of the review I didn't get it as there are so many definitions of 'review'.

Dr Hambleton: It was an informal rather than a formal review.

Senator MOORE: Thank you.

Senator FIERRAVANTI-WELLS: You make the point on pages 2 to 3 of your submission about the figures and about the net new spend and about how they are on the record, and I certainly take that point.

CHAIR: We did put on record that there was some dispute from the department this morning, so you might want to look at the department's evidence.

Dr Hambleton: I have read the department's submission. I think they are taking a longer time frame rather than a shorter time frame and they are looking outside of the health system spend. Now that is needed but if we are talking about the health system and the fact that there is a reduction in the next year, then I think that is terrible.

CHAIR: You may want to look at their evidence from this morning and see whether you want to put in any further comment.

Dr Hambleton: All right; I will do that.

Senator MOORE: They are going to do some more work and come back to us as well.

Senator FIERRAVANTI-WELLS: Can I come to one aspect which troubles me. It is about not only the cuts but also the cuts in the context of the Medicare Locals. You made the point, and we traversed this in evidence this morning, about your criticisms of the ATAPS and the administrative costs and you picked up the points of the ANAO audit report and how in contrast every dollar allocated to Better Access goes directly to delivery of clinical care. I share your concerns about the administrative costs. We are likely to see ATAPS get more money but how much of that is going to go into administration costs because of the complexity of what they now need to deal with, which is more than what they have at the moment?

Dr Hambleton: There are great difficulties in that area. I think we need investment in a large number of areas. I think that the two previous speakers identified that we need to double the spend in mental health. In fact the AMA put a paper together that said we need a \$5 billion investment in mental health. There are niches that do need to be looked after. I think we need to evaluate that as we go. I agree with the previous speakers that evaluation is so important to make sure we are actually delivering good care in each area.

Medicare Locals are in their infancy. They are actually going to be commissioning or doing some of the services that the divisions are doing. We have got a great problem there. Having visited South Australia—again, it was my first visit to some of these rural divisions—they are losing staff. So existing divisions with the prospect of no future funding are losing quality staff. For the Medicare Local to pick up that work in the near future is going to be difficult. Even commissioning it through what is left of the existing divisions is going to be very difficult because there is a huge lack of confidence, yet the GPs are there on the front line doing it right now. So in the next year in particular there is going to be a huge issue with access to services if in fact the access is cut in the way that is proposed.

Senator FIERRAVANTI-WELLS: When you take a Medicare Local that is going to be 90 per cent of South Australia, where is the local in that concept? There is absolutely none whatsoever. That is going to be an amalgam of about five divisions of general practice. How you can argue that you are going to have better delivery of service under those circumstances is really beyond me. My views on Medicare Locals are well known.

CHAIR: Yes, and we are trying to get questions rather than opinions at the moment. We are going to run out of time.

Senator FIERRAVANTI-WELLS: He did nod. I take that as agreement with my point.

CHAIR: The *Hansard* does not record nods, so you may want to say something.

Dr Hambleton: I do agree.

Senator FIERRAVANTI-WELLS: Thank you. I put to DoHA this morning a series of questions that picked up points in your submission. Could you please have a look at that evidence and, if you wish to rebut any of it, could you please respond accordingly. I think that is best way.

Dr Hambleton: We would be happy to provide a supplementary paper.

Senator FIERRAVANTI-WELLS: That is the best way of dealing with it. Thank you.

Senator MOORE: Gentlemen, I have not got many questions. Your submission is very detailed. I have a particular question about a figure in here that says that GP access will be cut by up to 49 per cent. I have read your submission and I cannot find it. Maybe I am not looking at all the right Medicare numbers, but from my understanding of the ones I was looking at I could not see a cut of 49 per cent. Naturally, now that I am turning the pages, I cannot find it.

Dr Hambleton: It may well come out of the Essential Research information.

Senator MOORE: I had a look at that. I could not find 49 per cent in there either.

Dr Hambleton: It might be the percentage rebate cut to GPs. There are two issues there. There is the rebate cut, which is between 10 and 49 per cent—

Senator MOORE: I just could not find the 49 per cent in the rebate cuts and I worked it out.

Dr Hambleton: We will come back to you on that. We will put something in our supplementary submission.

Senator MOORE: That would be really useful. It is just a big number. I look at the proposed cuts and I do not see 49 per cent. I definitely see a cut in the two levels of rebate that GPs can get. I understand the concerns; there is no doubt about that. But I could not see it.

Dr Hambleton: We will try to clarify that.

Senator MOORE: That would be very useful. Have concerns in the community about the variable nature of mental health plans and servicing come out in any discussions that the AMA has had? We have heard great evidence from GPs who are very knowledgeable and very caring about the time they spend. There is stuff that comes out in every community meeting I have attended. I do not know whether I have trawled through the same areas of South Australia as you and Senator Fierravanti-Wells, but I have been around. There are concerns about the amount of time they have with their GPs, the amount of knowledge the GPs have and also the time they put into doing the plans. Have you heard any of that in general discussion? I am not asking you to make a comment on it, but have you heard those issues raised?

Dr Hambleton: The broad number of people that I have spoken to actually are spending quite a long time with their patients in trying to provide a comprehensive framework for people to operate on. In fact, the more

people I speak to, the more people say, 'I couldn't possibly do it in less than 30 minutes and I have actually got to do a lot more work on the phone and try to organise things outside of that.' I certainly do not think we should be designing a system for a few who perhaps do not do the right thing; I think our focus should be on the great majority who are trying to spend appropriate amounts of time with their patients.

Senator MOORE: I understand that point, definitely; I am just trying to find out whether the AMA has heard the same anecdotal comments that other areas have heard about some concern with some GPs about the quality of the plans that come out.

Dr Hambleton: We certainly heard some concerns about isolated cases where there are problems. I think those need to be sorted, but I am heartened by the majority, I must say.

CHAIR: Senator McKenzie has a supplementary question.

Senator McKENZIE: I was going to ask the same question, but my subsequent question would be about the AMA or its members' opinion on the adequacy of training around their capacity to construct mental health plans. Is the training adequate for the task?

Dr Hambleton: There are a couple of issues around that. To just start work independently as a GP in this country, the training is enormously lengthy and comprehensive. When better access came out and said, 'You need extra training to be able to deliver mental health services,' a lot of my colleagues were very unhappy about that given that they are providing mental health support in the community and have done for years. The very fact that there is some additional training requirement over and above what a GP with a minimum of 10 years training plus up to 10 to 20 years in practice needed to be able to access the Medicare rebate was seen as a bit unusual in that you have a comprehensively trained primary care workforce delivering services right across the board in physical and mental health.

Over and above the background training, that additional training is one weekend's extra training on the basis of a lifetime of reading and education. We are in a specialty that tries to keep itself up to date and learn new material, and I would support all of my colleagues, whether they have had specific mental health care training or not, in their ability to treat patients.

Senator MOORE: Regarding the evidence we have had at this committee over many years, it was the GPs themselves who came to the committee and said they wanted the training. They came to us and said that they were uncomfortable dealing with mental health. It was a difficult process and, considering their standard medical training, complex and overwhelming as it is, with the amount of variation that GPs cope with on a daily basis, it was they who said they wanted the extra training. We are probably in deep agreement, but it was a slightly different approach.

Dr Hambleton: I think we are in a specialty that is always thirsting for information. If there is opportunity for more training, people put their hand up. We live in an environment where we are expected to have triennium training, so we should be plugging it in.

Senator MOORE: The other issue is the formatting of plans. We had some evidence that in some parts of the country people are getting together a bit of a template. I know the AMA has been deeply involved in templates in other areas, such as informed choice and things like that. Is a template for mental health plans something that the AMA supports?

Dr Hambleton: I think it does. A certain minimum number of elements are required to put together a comprehensive plan. If you follow that through and individualise that to the patient, you are not going to leave something out. Having an outcome measurement tool as part of that suite of arrangements is very useful. If you want to do a proper mental state analysis, looking at how the patient presents—their mood and their memory—and you lay it out in an appropriate way and have those headings available, I think you get a more powerful review of the patient at the time. To some degree I absolutely support a framework being there to build upon, but it has to be individualised to the patient in front of you.

Senator MOORE: Absolutely.

Mr Sullivan: I think it is important just to put on record—if we have not already made the point—that what Dr Hambleton is saying is that of course there is anecdotal conversation around this area. So when we asked Essential Research to do research we asked the doctors to say on average how much time it would take to complete the mental health plan, and it came to 52 minutes on average.

Senator MOORE: I will not get into a discussion about how, if you ask someone how much time they have spent, not many people are going to say, 'Ten minutes.'

Mr Sullivan: I just wanted to let you know that that was one of the results of our research.

Senator MOORE: I read the survey in detail and I acknowledge the wonderful work that many GPs do. I think we are all in major agreement on that. One of the expectations of Better Access was that it would pull together a more collaborative arrangement for treatment so that, by having the GP plans linked to the referrals and so on, it would mean that there would be the beginning of what we always talked about, which is a multidisciplinary community focused effect for mental health. I noticed in the survey that that was not asked. From your understanding in the AMA, has there been, in the process of Better Access, that kind of interrelationship, so that it is not just when you write the plan and refer but there is something greater? We were hoping, as people who cared, in 2000 and whenever it was that that would be the focus into the future. We had evidence last week from parts of Victoria where there was co-location within the one centre, where the GPs and the psychologists and the social workers were co-located. I think that would be a good model. Has the AMA done any work on the collaborative arrangements with mental health?

Dr Hambleton: I guess we have not done any specific work. I can speak from my own experience.

Senator MOORE: Sure. That is good.

Dr Hambleton: Certainly I have developed a better relationship with the range of psychologists that are around and within my practice. Even in that example I gave earlier, after only two visits I got a personal phone call from the psychologist and I have got her personal mobile phone number as well, in case I need to access her. I have found that very beneficial. In fact, learning about the skills that that person can provide for a range of conditions has been helpful to me and my practice. The other place that I saw some very good cooperation was in rural South Australia—I was there just last week—with mental health nurses actually working in the practice and psychologists working in the practice—

Senator MOORE: In the practice unit, yes.

Dr Hambleton: With doctors in the practice. I specifically said, 'Next week I'm going to the inquiry; tell me how it works.' I was very pleased, and I can report that there is a team approach. They do spend time with their registrars, their students and the psychologists and they do have case conferences at times about patients. So we are developing much, much better a team view of health care, and I think those practices are exemplary. I would be happy to take you on a tour, to be honest.

Senator MOORE: That would be very useful in terms of the ongoing process about that collaborative arrangement. Can you tell me whether those case conferences were Medicare funded?

Dr Hambleton: I did not ask. I presume they were.

Senator WRIGHT: My question follows on from that one. Dr Hambleton and Mr Sullivan, thanks for your time today. Earlier today we had a very strong submission from the National Mental Health Consumer and Carer Forum. The thrust of what they were saying was how vital it is if we are going to have transformational change in the system that the experiences and views of consumers and carers—who in the end this is all designed to assist—are taken into account both in the design of programs and in the evaluation ongoing to see if the programs that we all think are wonderful are actually being effective. It is good to hear about collaboration with the other service providers, but are there any systematic means of collaborating with the consumer and carer forums and hearing their voices, which I think have to really be informing this debate constantly?

Dr Hambleton: I guess I am referencing things from the very front line. I think that you need to take a bird's eye view from the next step back. Certainly I agree with you that there needs to be a bit of a broader view of these things, but hopefully we are desensitising people to the stigma of mental illness. People are actually owning up a bit earlier. Hopefully they are getting some treatment before the time they need medication. Hopefully they are getting some psychological strategies to build on their own self-confidence. Hopefully we are keeping people actually in employment and making it easier for them both to reveal that they have an issue at work and to stay at work. I think that is good for Australia.

Mr Sullivan: Just to add to that, the AMA is a member of the Mental Health Council and the reason it is a member is because it wants to demonstrate that we are all in this together. If you are talking about a transformational time, we all recognise that. And there needs to be, beyond the micro experience, a broader conversation; we get that.

Senator WRIGHT: It just strikes me that there is so much experience residing in the non-government organisations that are dealing with people who are living with mental illness all the time. I certainly hear about the role of GPs, perhaps in terms of earlier intervention and so on, but I am actually thinking about the important role of GPs in terms of ongoing physical health care. We know that people with chronic mental illnesses often have far worse physical health outcomes than people in the ordinary population. So I imagine it would be very useful for

GPs to be, perhaps through their peak organisation, well-informed about the particular challenges and experiences of people living with those more chronic conditions as well. So that is why I am interested.

Being part of the Mental Health Council is obviously very desirable, but I think it is often about really listening—not just being in there, but actually really learning from and listening to those who have things to offer who perhaps we, as a community, are not very good at listening to at the moment. I guess I am putting a personal view there. What you have said so far is interesting, so I suppose I am just throwing that out there.

The other question I have is this. I respect the role of GPs and see how important that will be as a portal for many people coming in, as an unstigmatised way of getting some assistance. They may perhaps have mental health issues they are not even aware of until they see their GP and have a consultation and get some advice about them. But I am thinking also about the issues of equity and access and the fact that there is concern that, under Better Access, it appears that people of lower socioeconomic backgrounds and so on have not been accessing Better Access to the same extent as those from wealthy backgrounds and so on. I think, Dr Hambleton, you said that if you base services on the family doctor then you have ongoing longitudinal relationships, which is clearly important. But isn't that also a problem if, as is my understanding, wealthier suburbs are actually much better serviced by GPs and family doctors? Mightn't that make it more difficult for people in other areas to get access? If we base a service on a relationship with a family doctor and there are not as many GPs available in some suburbs, isn't that actually going to exacerbate the issues of inequity in access?

Dr Hambleton: I think there are two issues that you have raised that should be responded to. One is that we are looking at a program that had not reached its full maturity. We have now looked at the evaluation in 2009, published in 2011, which shows that the biggest area of growth in this program was actually in the very area that we are talking about. So you could argue that the early adopters were those people in the better serviced suburbs, but then in fact it was growing at the greatest rate in the area of greatest focus. But we do not propose that this is the only solution. We do need a range of solutions, and I think we need to make sure that we invest in other areas as well. So we certainly are not saying to the government, 'Take the money from where you're spending it and put it back here;' we are just saying to the government, 'Don't take it from Better Access, because it's doing a good job, and we should be investing in mental health not taking away from it.'

We need a range of services to fill those gaps, because there will be gaps, and we do need specialist services. It is a real struggle, when you have a sick patient in front of you, to get access to private or public psychiatric services, particularly for people who are very ill. One per cent of Australians will develop schizophrenia and that means that they can be quite sick, and getting acute access to services is really difficult. So I think that we need a range of solutions to make sure we cover the range of problems that we are seeing in the range of sociodemographic areas. But this program actually was doing pretty well. There was something like a 96 per cent growth in the use of this area by young people, and the most rapidly growing area was that lowest sociodemographic, at the time of the analysis.

Senator BOYCE: I just want to ask a general question, but could I ask several? Two? One?

CHAIR: One.

Senator BOYCE: Perhaps I will put my other questions on notice. There has been the view put that of course the AMA would say that cutting this back is terrible, it is affecting their hip pockets. Why wouldn't they say that? You have got your survey; if there is any other information you would like to provide that you perceive as countering that argument, would you please do so. My question relates to your position statement talking about priority areas for government action, including special needs. I just wanted to put on record your views regarding the need for specialist help for people with intellectual disability and mental health issues. What if anything has the AMA done on that; and, perhaps on notice, you might like to talk about the long consultation and how successful or otherwise that has been for people with intellectual disability.

Dr Hambleton: I think this is an area of great need as well, and some of this we will put in a supplementary paper so that we can flesh it out a little bit more. In many areas, getting access to medical support has been a real difficulty over a long period of time.

Senator BOYCE: Yes. It is not just in the mental health area; it is the health area almost.

Dr Hambleton: Yes, it is. It is probably better to flesh it out properly with a paper that we would come back with.

Senator BOYCE: Thank you.

CHAIR: Thank you very much. You have agreed to take on some homework. We are not wanting to push you too hard, but if we could have it within about a week, is that possible? That would be appreciated.

Dr Hambleton: I believe so.

CHAIR: Thank you very much.

QUINLAN, Mr Frank, Chief Executive Officer, Mental Health Council of Australia

[17:42]

CHAIR: I know very well that you already know about parliamentary privilege and the protection of witnesses and evidence.

Mr Quinlan: Yes, I do.

CHAIR: We have your submission. It is No. 198. I invite you to make an opening statement and then we will ask you some questions.

Mr Quinlan: Thank you. In just the last month, I have heard accounts from carers that would cause one to doubt whether we have a mental health system at all. I welcome the opportunity today to talk about that situation. In one case a father who is caring for his 35-year-old son, who is experiencing severe mental illness, recounted to me the decision he took, in cooperation with the police who had attended his home, to have his sick son arrested. This was very recently. This was the only pathway they could see to ensure that the son would receive any access to reasonably timely care. What other form of illness requires a father to have his child arrested in order to gain access to health care?

In a second case, just in the past month, a young father described how mental illness had overwhelmed his wife, for the first time in her life, just nine days after the birth of their first child. Notwithstanding the attention of a range of services over the ensuing nine months, his wife eventually took her own life; and he was left wondering why the system had not worked more effectively to assist her.

As the Senate examines the government's funding and administration of mental health services in Australia, we ought not forget that these kinds of stories are not uncommon for those experiencing mental illness. Neither should we forget that something like two-thirds of those experiencing high-prevalence illnesses such as depression and anxiety are unlikely to ever receive any treatment. We do not currently have a functioning mental health system. We do have a disparate set of services of variable effectiveness that often relate to each other in an ad hoc manner that is governed much more by the dedication, creativity and personal relationships of those delivering services than by the organisation of governments. Many more building blocks are required and many more systems need to be developed before we can begin to claim that we are running a mental health system. Many of these building blocks have been identified previously by the Senate and by various inquiries, national plans and research reports. Many of the answers are known to us. The core of the problem is that our services are currently dramatically underfunded. Another way of saying this is that those who need services cannot get access to the services they need. Yet another way of saying this is that those who are currently delivering services cannot provide them to all of the people who need them. It ought to be no surprise, then, that those who currently are delivering fewer services than their communities require would come to the Senate and make their case for more funding, sometimes at each other's expense.

There has been debate amongst the Mental Health Council of Australia membership in recent months, including efforts to convince the council to take one path or another, particularly in relation to the cuts to the Better Access program, and to comment on the number of psychology services available under ATAPS. As understandable as this debate is, this level of debate runs the risk of diverting us from the reality of the challenges that we face in reforming a system that has been underfunded for so long. The current ad hoc arrangements have evolved, literally, over decades, and it could easily take another decade of serious reform to see substantial improvement.

In this context, it will remain a challenge for system reformers that some parts of the system are funded and controlled by different governments and different portfolios within those governments. Some parts of the system receive capped funding, while others receive uncapped funding. We have a system that is more driven by addressing crisis than it is focused on prevention and early intervention. In this context, it would be fair to expect that funding would be systematically increased over time to address a greater and greater proportion of required services. It would be fair to expect that funding would be reallocated within the system from time to time in order to better target identified need or to meet existing need more effectively and more efficiently. It would also be fair to expect, however, that such adjustments ought not to be made in such a way as to disadvantage people who are already vulnerable and ought not to condemn any particular group to a deterioration of their illness while they wait for appropriate services. Funding across the system should be on a growth trajectory for many years to come, as should the funding of effective programs within the system.

The Mental Health Council of Australia have a history of advocating for greater resources across the sector. We supported the coalition's mental health package before the last election and we have supported the government's recent budget initiatives, in particular the establishment of a mental health commission and the commitment to the development of a 10-year road map which will guide future investment and coordination efforts. We support too the Senate's ongoing efforts to examine and re-examine the system and to make recommendations about improving it: more funding, more efficient and effective programs, better coordination across systems.

We also acknowledge the challenge that governments, and the Senate, face in making these decisions, as there is such limited information available on which to base decisions about some parts of the system ahead of others. Policymakers are asked to assess the merits of one particular program in comparison to those of others, yet the information required to do this is frequently not available. How can the cuts to the Better Access program, which remains on a growth trajectory, be assessed without weighing the growth trajectory of this program against that of other mental health programs? How does the growth trajectory of the mental health system compare to other parts of the health system? How does the allocation of overall funding to mental health services compare with the overall funding allocation to other conditions, such as diabetes or cancer? In addition to funding allocations, what provisions are made to ensure that funding is able to grow alongside population increases? Furthermore, are funded programs adequately indexed so that real expenditure keeps pace with increasing costs?

There can be little doubt that, if mental health services are to be brought up to par, the overall proportion of funding spent on mental health services will increase as a relative proportion of the health system for many years to come. There is also little doubt that, in addition to the reduced human suffering, the economic and productivity benefits of providing services to people when and how they need them will be enormous if this reduces subsequent and future hospitalisations. In other parts of the health system, consumers are usually offered choice. For mental health services, consumers must too often settle for whatever service is available to them in their location at any given time, regardless of its suitability.

I know the Senate has a number of specific issues before it in relation to the savings measures within the budget. GPs provide important and valuable mental health services in the community, but the principle of matching funding to time spent delivering services seems to be the right approach to GP services. The impact of such cuts ought to be fully evaluated within the broader context of mental health services. Cuts to the number of psychologist services also warrant close examination—in particular, asking whether those most affected by the cuts will be picked up by other services or left to deteriorate. We do have a fear that some of those affected by cuts to the Better Access program and by cuts to the number of psychology services will not easily gain access to community mental health services because they have severe anxiety and depression and not psychosis, and many will fail to access private psychiatrists and ATAPS. These issues warrant close and ongoing monitoring and attention. It appears likely that at least some of the group accessing these programs will gain access to mental health services based in the community, and community health services often have deep links to other, related clinical and community services and can offer very comprehensive care packages as a result.

As I indicated earlier, the reliable data that would allow decision makers to have confidence is not consistently available. The effects of these decisions must be monitored closely if unexpected consequences are to be avoided. Our current surveillance systems are unlikely to identify these effects reliably. We would hope and anticipate that the important steps towards greater accountability and monitoring taken in the recent budget initiatives—that is, the establishment of a mental health commission and the 10-year road map, which has now been agreed by COAG—will generate improvements in data to underpin these important policy decisions in future. Thank you. I am happy to take any questions.

CHAIR: Thank you.

Senator FIERRAVANTI-WELLS: Yes, thank you. I will start with the National Mental Health Commission. There has been a fair bit of evidence given that it really should be a statutory body with autonomy and independence. Does the Mental Health Council have a view on that?

Mr Quinlan: We certainly have a view that the principle of independence is an important one to the commission, but so too is the power and capacity of the commission to get access to a range of data sources. We think that positioning the commission within the Department of Prime Minister and Cabinet will allow the commission to gain access to and have the authority across portfolios within the federal government, and that is welcomed. We think there remain a number of questions to be answered, really, about how a national mental health commission will relate to similar or related bodies in the state jurisdictions and whether a mental health commission will in fact carry the independence and authority that are required.

We have literally just been conducting some consultations for the Department of Health and Ageing and the Department of Prime Minister and Cabinet—I came from there today—about the establishment of a mental health commission, and I would report, broadly, that there is a high level of confidence in and hope for the commission but also an acknowledgement that some of these questions remain unanswered. I think an independent statutory authority that was starved of resources and not supported across a range of governments might struggle as much as a commission that was positioned within the Department of the Prime Minister and Cabinet but not really given the independence to run. We will adopt a supportive but a wait-and-see approach.

Senator FIERRAVANTI-WELLS: Equally, with a small number of staff and a few commissioners we do not quite know what they are going to do at the moment.

I would like to ask you about this consultation. Can you explain to me what the relationship is between the national mental health advisory body—the Minister Butler/David Cappo body—and your organisation? I notice that you are conducting these consultations as opposed to this body, so can you explain it to me?

Mr Quinlan: Yes, only briefly; I am not sure if I will get to what you are asking for. I am a member of the minister's expert working group on mental health. I have come to this position relatively recently, having been appointed to that role, but I have attended my first meeting, so I have some access through that means to provide input to some of these issues. We are funded out of a broad program called the Commonwealth secretariat support—there is another 's' but I cannot remember what it is, I am sorry, but it is a program out of Health that funds a number of peak organisations.

We are funded to provide two-way communications between the department of health and the government and the sector: to be alerting the government to the sorts of concerns that our members like the AMA, community mental health services, psychologists, consumers and others would have but, similarly, to be alerting our membership to the sorts of directions that government are taking. In that context we are running a number of stakeholder forums: one on the Mental Health Commission, one on the 10-year roadmap and one on the coordinated care initiatives. On the back of the input that we receive from that very diverse membership and representatives beyond our own membership, we will develop an issues paper that will then be again consulted widely across the sector to try and provide input to the government and the relevant offices about the development of these initiatives. I would note, for instance, that today the new CEO of the executive office within Prime Minister and Cabinet, Robyn Kruk, attended today and heard a lot of the input directly from the sector, firsthand.

Senator FIERRAVANTI-WELLS: The last time I saw Ms Kruk she was running the environment department in New South Wales many moons ago, so I think the transition from environment to mental health will be very interesting. On your funding, you do not get any funding from your member organisations?

Mr Quinlan: Yes, we do.

Senator FIERRAVANTI-WELLS: It is a mix of both?

Mr Quinlan: It is a mix of funding. We have a core grant from the department of health. We charge our members a fee to be members. We then also attract funding by conducting particular research projects or activities on particular issues. We host, for instance, the national consumer and carer forum as an auspicing arrangement.

Senator FIERRAVANTI-WELLS: Were the planning sessions at the request of Minister Butler or at the instigation of the Mental Health Council of Australia?

Mr Quinlan: We put a submission to the Department of Health and Ageing and asked if we could conduct these workshops as part of the early engagement around the post-budget initiatives.

Senator FIERRAVANTI-WELLS: For a fee?

Mr Quinlan: Yes.

Senator FIERRAVANTI-WELLS: So, basically, Health is outsourcing this consultation to the National Mental Health Council.

Mr Quinlan: That is right.

Senator FIERRAVANTI-WELLS: I notice you had 14 sessions across Australia. Who chose those sites?

Mr Quinlan: That was a different initiative. That occurred prior to the last budget when the Mental Health Council conducted a number of consultative forums. That was a pre-budget project that precedes my time at the council. I am talking now about the specific post-budget consultations that we are doing.

Senator FIERRAVANTI-WELLS: So there is a different agenda or different issues, or is it the same sort of thing?

Mr Quinlan: There is a completely different agenda. My understanding of the forums that we ran prior to the budget was that there was much broader consultation, if I could describe it that way, asking the question: what needs to happen in mental health? It was that broad. What are the sorts of things that the government should be looking at? A number of the budget initiatives came out of direct input to those forums and a number of things did not. I could provide you with a report of those forums if it is helpful.

Senator FIERRAVANTI-WELLS: I have had a look at the national summary. It did not include cutting Better Access or making major cuts to services, so I am surprised. I am just making the statement. In that capacity, could you take on notice, please, who chose those 14 places?

Mr Quinlan: Sure.

Senator FIERRAVANTI-WELLS: They are interesting—they are mostly in marginal seats. Having had some experience with the department of health, I am interested to know the process of selection and whether it was at the instigation of the minister's office, the department or the Mental Health Council of Australia.

Mr Quinlan: We can get back to you very quickly on that.

Senator FIERRAVANTI-WELLS: Thank you. The Mental Health Council of Australia is a peak body. Did you know about or were you consulted about the cuts and the changes in the budget?

Mr Quinlan: Again, I apologise. That preceded my time at the council.

Senator FIERRAVANTI-WELLS: Are you aware?

Mr Quinlan: I understand that prior to the budget there were a number of initiatives discussed, but I am not aware that there were specific proposals considered—for instance, to cut the Better Access program.

Senator FIERRAVANTI-WELLS: Was your predecessor on the Mental Health Council part of the minister's little expert group?

Mr Quinlan: I do not believe our predecessor did, no.

Senator FIERRAVANTI-WELLS: That is interesting.

Mr Quinlan: We would have had a number of members, including some of our board members—for instance, Dr Lyn Littlefield—

Senator FIERRAVANTI-WELLS: In their individual capacity?

Mr Quinlan: In their individual capacity.

Senator FIERRAVANTI-WELLS: Who instigated your national forums across Australia with Minister Butler?

Mr Quinlan: These forums were at our instigation. There were only a small number of forums and they were quite purposeful. We had one forum on the coordinated care initiative, we had a forum today on the Mental Health Commission and we have one on the 10-year roadmap tomorrow.

Senator FIERRAVANTI-WELLS: You are choosing the areas and you are running the agenda for those?

Mr Quinlan: That is correct. We run the agenda, we run the invitation list, we run the consultations and we write the reports.

Senator FIERRAVANTI-WELLS: On the 10-year roadmap, we know the statistic that one in five Australians needs help now. Are we going to wait 10 years for some effective action? That is the question I am asking.

Mr Quinlan: It is a question that many of us would share. I do not think any of us want to wait around for 10 years. The benefit that I would see from the roadmap, picking up on the notion of bipartisanship that I touched on earlier, is that it seems to me we need to find an environment where—

Senator FIERRAVANTI-WELLS: I am not prepared to wait 10 years. I think I have been very clear in my public statements that 10 years is a long time to wait for some assistance.

Mr Quinlan: I am not suggesting you wait. I would hope that we lock in a plan that will have a life beyond the changes of government. The plan will begin implementation immediately. I think what the sector needs, at both the Commonwealth level and the state level, is some degree of certainty beyond the life cycle of particular governments, which will always come and go. I am not setting aside or minimising the differences, because I know there are real differences between parties on some of these issues, but my own sense is that there is also a great sense of priority around these issues that is shared across political parties and shared across governments. I was lucky enough to be part of the COAG discussions on this. There were strong statements from Liberal governments supporting the Commonwealth's initiative as well. I think for the sector, as I look at a 10-year

roadmap, that is really what we are trying to build; some sense of an ongoing plan that has to start immediately. It has to start yesterday but, nonetheless, it has to provide some sort of sense of certainty that we are not really lurching from one policy to another as we follow the electoral cycle in various jurisdictions.

Senator MOORE: Mr Quinlan, there are lots of questions but the chair is harsh and she has given me one.

Mr Quinlan: I got to ask a few to, which I thought was a nice change.

Senator MOORE: The question is about the evaluation. You made the point very carefully that any changes and any new developments in the system require very careful scrutiny and evaluation. Do you have any suggestions how that should operate? We have had reviews on reviews and no matter which model you have there is a difference about whether it is an effective methodology or not. That will always happen. One of the core things we were looking at this morning was the evaluation of the Better Access program. The only thing you get out of Medicare data is who was serviced by whom and where. That is it. Statements about socioeconomic aspects and those sorts of things are not in the data. I would like to have some idea about devaluation.

Mr Quinlan: Sure, you have heard me give a similar answer in other contexts. I think the challenge is to find ways of ensuring and requiring that our various funding streams have built into them the sorts of resources that we need for evaluation. That is very tough to do in an environment where, if you are a GP there is a waiting room full of people and if you are a community mental health provider or a psychologist there is a backlog of people waiting for services. I think that disciplinary of us actually deciding what proportion of funding ought to be applied to ongoing evaluation is a critical one. Then there also ought to be, and this is again part of my thinking about around the 10-year roadmap and a commission, some outside monitoring and accountability that allows certain indicators to be set and monitored over time, so that at least we get a de facto measure of the effectiveness of our programs. If we can monitor some of these trends over much longer periods than we have been monitoring to date, I think we are more likely to get a long-term approach to evaluation that is actually going to serve our needs.

We also need to find ways of conducting more rigorous macro analysis because, at the moment, we can have quite detailed, and Better Access is a good example, and robust examination of a particular program but then we have to step back and ask the question of whether it is good or bad and how do we actually compare our expenditure and the value of our expenditure in that area to other areas. I think there is very little data in that regard.

Senator MOORE: Would you turn your mind to that issue of evaluation and scrutiny, because certainly it is a big issue about whatever we do? My understanding is that in major programs it is now part of the expectation. When it is put up there is an element of review in it and there are standard review cycles.

Mr Quinlan: It is often part of the expectation. It is easier to find in the expectations and the objectives than it is in the budget for the programs.

Senator MOORE: Absolutely. I am interested in your point about scrutiny and the outside process in what is going to be scrutinised. Is that developed at the start or is there an evolution of that? It is that kind of modelling that I think is critical. Whether all people agree or not, we need to have an agreement around how it is going to be done.

Senator WRIGHT: I noticed you have made a strong call in your submission for a national mental health promotion and antistigma campaign, which interests me greatly. I have heard about a very good campaign in Scotland recently. In terms of where that might come from in the future, is that something that you would envisage as being something that the commission would see as important in commencing?

Mr Quinlan: If we are going to be undertaking those kinds of campaigns, they need to be taken in the context of a broad national approach and a long-term approach. If we look at the effectiveness of some of our drug and alcohol programs, they now have a very long life. I think that is the sort of lifespan that we might expect an effective mental health program to have. In that context it really is going to need a long run-up and a long implementation plan. Again, I think it is difficult to find the investments for these sorts of programs in an environment where the need for immediate services is so challenging. But, of course, you would be aware that the savings, both in terms of reduced human misery but also in terms of long-term savings and productivity benefits, are enormous if we can find a way of making some of those investments early.

Senator McKENZIE: I have just got a quick question. I guess I am trying to reconcile something in my own head, so hopefully you can help me with that. In your submission under service integration, you talk about the equity of the distribution of mental health services. It seems to contradict a section in the AMA's submission, which is the member body of the council, so I am just wondering if you can flesh that out for me a bit.

Mr Quinlan: Sure. Can you point me to the contradiction?

Senator McKENZIE: Sure. 'A one-size-fits-all approach to mental health service delivery has not led to accessible services that are equitably distributed or distributed according to need,' whereas when the AMA says that actually it is probably more a function that the program of Better Access has not come to maturity, and so we were seeing that it was meeting the needs of the targeted groups that it was meant to be meeting.

Mr Quinlan: Sure. I do not think we were trying to say in the context of our submission that we were talking specifically about the Better Access program per se. We were talking about a one-size-fits-all model.

Senator McKENZIE: Or policy—yes, totally agree. No problems. Thank you.

CHAIR: You were not here for the evidence that we had from Professor Hickie and Professor McGorry. Professor Hickie was making the point that those clients who need the 18 sessions under the Better Access program may have been better off in another program or in ATAPS. He was saying therefore that changing the Better Access program would better meet the needs of people that need the shorter number of sessions, which is what the program was originally designed for, but that ATAPS would better meet their needs. We have had quite a lot of evidence to suggest that ATAPS at this stage probably could not meet people's needs because of the capped funding, which means that some divisions have run out of funding halfway through the financial year, that the access to psychologists and other professionals is sometimes limited, that they are transitioning at the moment between the divisions and Medicare Locals—in other words, they are not going to be up to speed. I would like you to comment, if you could, on Professor Hickie's proposition in the first place that ATAPS would be better to meet the needs of those who are more chronically ill and also on whether you think that the ATAPS program at the moment is sufficiently robust enough to absorb people straightaway?

Mr Quinlan: Sure. I actually think there are a number of questions there that go to the concerns that we raised in my opening statement. One of the concerns is about the suitability of the program. I think there are excellent ATAPS programs around that are able to provide very high quality services. The question that needs to be asked and in our view needs to be monitored though is whether there is in fact a permeability between those programs in any case. So there might be some suitability. It may be true—and I would defer to the judgment of people like Professor Hickie ahead of my own—to say that program A is better or worse at servicing a need than program B, but that is not to say that there is an easy transferability between those two programs and it is not to say, for the patient who knocks on door A, if door A disappears, there is a door B available to them. I think that is the broader challenge which goes to the question that I raised in the early part of the submission about the fact that we do not currently, across many parts of the system, have those transfer and referral arrangements in place in order to pick up these sorts of anomalies that can occur as systems come and go and change. I would make the point though that none of that shortage or crisis in programs is necessarily caused by this particular round of cuts. We are a chronically under-resourced sector that is currently not providing services to a large number of people who need them.

CHAIR: Thank you. Did you take anything on notice?

Mr Quinlan: I took a couple of questions on notice.

CHAIR: So we have given you some homework. If possible, could we have that by the beginning of next week?

Mr Quinlan: I would be very happy to do that. If it is helpful for your planning, I do only have a very brief submission to make on the other matters.

CHAIR: Thank you.

Proceedings suspended from 18:16 to 18:26

MULLINGS, Mr Benjamin Luke, Chair, Association of Counselling Psychologists

[18:26]

CHAIR: I welcome Mr Benjamin Mullings from the Association of Counselling Psychologists in that great state of Western Australia—no bias! I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

Mr Mullings: Yes, it has.

CHAIR: Could you please state the capacity in which you appear.

Mr Mullings: I am here to represent the Association of Counselling Psychologists, the ACP, which is a group in WA that represents counselling psychologists nationally. We are based in WA. I am also here to represent a consumer-driven campaign. I am aware that there are 1,000 to 2,000 people who are strongly urging me to present their perspective, so I am here doing that too.

CHAIR: Thank you very much. We have your submission. It is No. 214. I invite you to make an opening statement and then we will ask you some questions.

Mr Mullings: I would like to begin by briefly describing counselling psychologists to you all so you have a better sense of where this distinctive group fits in the system. I am aware that there is a lot of confusion about who we are, even within our own profession, so I want to make sure everyone is really clear. Counselling psychology is the second largest specialisation in psychology. We have approximately 1,000 counselling psychologists across Australia. It is one of the four traditional speciality areas of psychology which were formed about 60 years ago in the US. Each specialist area applied to a setting. For hospitals we had clinical psychologists. For schools, education, workplaces, industry and the general community we had counselling psychology. The name comes from the fact that at the time psychotherapy was considered to be synonymous with psychoanalysis, which was considered to be a medical intervention. If you said you did that then you were accused of claiming to practise medicine, so counselling was used by all psychologists as a way to describe the work we do. These days, it means something slightly different but we are stuck with the name. One of the chief functions at the time that counselling psychology was created was to provide psychotherapy to returning soldiers from World War II who, by today's standards, would be recognised as having post-traumatic stress disorder. Over the decades since then, the mental health stigma has gradually faded, community based care has been increasingly adopted and it has become more acceptable for people to go and see a psychologist for a wide range of issues. That means that nowadays there is very little to distinguish clinical and counselling psychologists from one another once they are in practice. What tends to be the distinction is simply a matter of philosophy. This means that the training of counselling psychologists for mental health care in the general community is second to none. We have the same high standards of six to eight years of postgraduate education, with an additional two years of specialised supervision on top of that, so it is quite extensive training focused on psychotherapy for people in the general community.

I have heard some people say that clinical psychologists are the only ones who are appropriate to deliver mental health services. I have to say that I find that nonsensical, given the training that we are talking about in any case. Some of the problems the committee has heard about in relation to Medicare funded psychology services and the controversies around that go back to 2001, when the better outcomes initiative was launched. I have worked in both the better outcomes and the Better Access programs so I can offer a perspective about how both of those programs work.

In the better outcomes program the term 'focused psychological strategies' was controversial, and it originally applied to a shortlist of psychological techniques that GPs were permitted to use after a two-day workshop. Psychologists at that time were assured that focused psychological strategies did not mean psychotherapy and that it was an abbreviated or watered down version for mild problems. So when the Better Access system came into effect in 2006 we saw that clinical psychologists had their work described as psychological therapy whereas everybody else got classed as a generalist, even though many of them are specialists and their work has been described as being focused psychological strategy. As you can imagine, counselling psychologists, who are specialists in psychological therapy, were quite confused about what had happened and how we managed to end up in a category where we could not really do the work that we are trained to do specifically. In effect, this sidelined all the other mental health specialists in the profession of psychology, quite aside from any other mental health specialists who work in the scheme, which made some problems for identifying skilled practitioners and ultimately ended up discriminating against consumers of services in their preferred choice of therapist.

The government at the time told us that they were advised by the APS to make the system this way, and I think that has been repeated to this committee, whereas the Australian Psychological Society has pointed the finger at government and said it was their decision. I can tell you that I have obtained documents through a freedom of information request that show that the APS advised the government to structure the system this way. In any case, the system does not work.

Senator MOORE: Excuse me, Mr Mullings, would you restate that for me. Did you say that you have documentation?

Mr Mullings: I have documentation from a freedom of information request to the Department of Health and Ageing, every document that the APS submitted to DoHA in 2006, that shows the Australian Psychological Society advised the government to structure the system in the way that it is now, which has caused significant tension in the profession. I think some of the submissions that you will have received would say that. The problem is that I have been unable to show the rest of my colleagues those documents, for a range of reasons. In any case, one of the other absurdities of the system is that because it has required other specialists to show their eligibility to enter the APS College of Clinical Psychologists, it has resulted in situations where mental health specialists have had to do an individual bridging plan. To give you an idea of some of the problems with this, in the ACP we have heard about the goalposts being changed for this. So people may start an independent bridging plan and be told, after they have started, that the criteria have changed. I have heard of people who are experts in child psychology being told that because they did not do a clinical masters degree they need to go back and do child psychology units. I have even heard of a case of a person who was teaching a psychopharmacology course. She was told to go and do a psychopharmacology course, and the one that they advised her to do was the course that she was teaching.

CHAIR: The one that she was teaching!

Mr Mullings: Right. So there are some significant problems. Obviously we would like to see some of those things simplified and resolved.

Ideally, the ACP would like to see policymakers legislating for a fair and inclusive process that identifies all of our skilled mental health professionals. Counselling psychology, in our opinion, would meet that criteria. We would prefer a system that recognises advanced postgraduate education so that we encourage young psychologists to persist with advanced training. We think that this is in the community interests. A two-tiered system would probably work provided that we fixed the two tiers so that the top tier is more inclusive of the full range of specialists.

In any case, since the budget was launched the ACP has collaborated with mental health consumers and other members of the public to hear some perspective on the planned cuts to services in the Better Access program. The first thing I want to say about those consumer perspectives is that offering people just 10 sessions of treatment in many ways sets them up to fail. It is an unrealistic length of time. The message it sends people is that if they do not improve quickly then they have failed and they are a burden on the system. I do not really think that that is very sensible for people who are, for instance, depressed. It is such an obvious case of mental health stigma, to me; nobody that I have spoken to would support it. The evidence from research would show that people need more like 15 to 20 sessions of treatment, particularly for complex mental health issues, but also for mild to moderate problems. That is something that I do not think has been stated plainly. I want to state it plainly here.

People are saying that if they are only offered 10 sessions then many of them will not even bother starting the process. I guess the issue is that people who are most in need of treatment are just not going to get it from the Better Access program any more.

What I want to say in closing is that policymakers need to understand that these people are not simply going to vanish from the system. They have family, jobs, loved ones, who are all going to be impacted. There are obvious knock-on effects here. When people do not get appropriate treatment it impacts on their productivity, family life and marital conflict. It can result in self-medication with drugs and alcohol. People can end up interacting with police and the legal system or they can end up in hospital. At worst, we can see suicides, which in my opinion are quite preventable if we provide people with adequate support. The last thing I would say is that if we are saying that mental healthcare is a priority we cannot just turn our backs on these people.

Senator FIERRAVANTI-WELLS: Can I start with your submission. You start with a comment about the non-discriminatory nature of the Better Access initiative and the fact that it targeted the full spectrum of mental health disorders. You go on to state:

By contrast, the *Access to Allied Psychological Services* (ATAPS) program has always been specifically targeted to 'mild to moderate' mental health disorders.

And you quote the operational guidelines for the ATAPS model, as follows:

ATAPS in its current form is particularly suitable for providing short term psychological services to individuals with mild to moderate common mental illness.

You then make the point that, in your opinion, what the government is basically doing is to 'arbitrarily redefine the client population who utilise both of these schemes'. What happens to those guidelines when people with severe disorders are put into ATAPS?

Mr Mullings: It is a complete reversal of the reality of how these services are used. We have just seen the evaluation of the better access program showing that over 80 per cent of people who utilise the program have severe to extremely severe psychopathology. The people who access the better access program do have severe and complex mental health disorders; they do not have mild to moderate disorders. And that is exactly the same statistic that we saw when the APS did a review several years ago. We are seeing the same proportion: 80 to 85 per cent of people who access the services have moderate to severe symptom levels. So, to say better access is for mild to moderate disorders makes no sense. The operational guidelines have said since 2001 that the better outcomes or ATAPS program is for mild to moderate disorders. If people are now saying it is for moderate to severe disorders, it is a complete reversal of the reality of these programs.

Senator FIERRAVANTI-WELLS: Are you aware of any change to those guidelines for the ATAPS program?

Mr Mullings: I have not seen anything published since the budget was announced. I am only going by what has been published from 2001 until now.

Senator FIERRAVANTI-WELLS: If I could put on the record, because I am sure the Department of Health and Ageing will read the transcript—

CHAIR: I am sure they will.

Senator FIERRAVANTI-WELLS: that there are changed guidelines, and if the department would comment in relation to that point made by Mr Mullings. In your submission, Mr Mullings, your next point is that the two-tiered rebate structure 'will discourage doctors from referring to the better access scheme', and that, in your view, 20 per cent 'will no longer provide mental health care plans'. In effect, that it is defeating the purpose—it is a savings measure rather than a health measure.

Mr Mullings: Yes. From memory, when DoHA presented early today, they actually said as much—that it was about constraining the costs of the program. I think that makes that point.

Senator FIERRAVANTI-WELLS: You then talk about the potential cost blow-outs and the costs of delivering services. This is under (c) in your submission:

Part of this cost is associated with the fact that ATAPS provides a salaried funding arrangement, meaning that tax-payers are funding sessions ...

This is a point made earlier. What you are really saying is that it is not cost-effective because we have a lot of 'do not attends' and the taxpayers are paying for those, whereas in the better access program it is a fee for attendance, so it is better value for money.

Mr Mullings: There are some genuine, bona fide, costs associated with ATAPS. For instance, if you have a program in a difficult to reach area, the practitioner might need to drive out some distance and there might be extra administrative costs. There are some genuine costs built into ATAPS. The problem with a salaried arrangement is that, if a program is poorly built and does not meet the needs of the people in the region it has been designed for, so people do not take it up, you still have to pay somebody to occupy the role of, for instance, therapist, in the hope that someone does take up those services. If no-one turns up, the therapist still has to be paid. You can have costs for sick days and all kinds of other things that are not resulting in services. I am not for one minute saying that therapists should not be paid for things like telephone calls or reports and so on, or these extra things, but if the argument is that we have a limited amount of mental health dollars and that we have to spend what we have got wisely until we build up the system a little more then I would argue that it is better value for money to make sure that the precious few dollars we have are actually spent on service delivery as much as possible.

Senator FIERRAVANTI-WELLS: You make a very valid point about the GP being the focal point of family and we go to our GP. You do pick up the point that even when people do move often they will travel back to see their GP even though they have moved out of that area, which strengthens the argument about accessing directly to the GPs. Can I pick up on a couple of other points. Your submission is very detailed in relation to

psychologists. Do I understand that you are basically saying that we should go back to the pre-2005 situation? Do I read that into your comments?

Mr Mullings: No. I do support the current structure of the system provided that for the practitioners who are recognised as being psychological therapy providers, the ones who are identified as being more skilled practitioners, for instance, that there is a broadening of that criterion and that we actually leave the parts of the system that are working intact. So I am not arguing that we should go back to Better Outcomes or the ATAPS type model but rather that we should keep the Better Access program in its present form with a slight modification to the top tier thing. The reason that I say that is that a lot of the tensions we have seen with people fighting over crumbs are about that top tier issue, about the narrow scope of inclusion there.

Senator FIERRAVANTI-WELLS: I am conscious of time. There are a couple of things I want to cover. One is your quite strident comments in relation to the conflict of interest with the Mental Health Expert Working Group and your concerns that since the budget was announced a small group of individuals 'with well-known links to the advisory group has been defending the cuts across medical journals, in some cases mischaracterising those who utilise Better Access as the worried well'. Are you seeing that as a sustained campaign afterwards and an attempt basically to just—

Mr Mullings: It has gone on for some time. Ever since the budget was announced we have been seeing regular appearances and some of them just a slight change in staff. We have also seen recently on the website that we made for consumers one of the representatives or a senior researcher from one of these programs—I do not wish to mention this person, but it was exposed that the person was actually concealing their identity and arguing vigorously—

Senator MOORE: Mr Mullings, that is an extremely serious allegations and if you going to put it on record I would like to be in camera and you can tell us who it is. I am uncomfortable with such a statement as you have just made hanging there was no name linked to it. In camera it is completely confidential—

Mr Mullings: It is on my website.

Senator MOORE: You got a public website that names the person and you are telling us to go to that rather than naming. I am cool with that.

Mr Mullings: I would rather do it in confidence, if that is what you mean.

Senator MOORE: You can do that in confidence. But if it is on your public website then it is pretty hard—

Mr Mullings: It does not name the person on my website but the information is there. The person essentially outs themselves and there are hyperlinks provided.

Senator MOORE: I think it is a fairly serious allegation, Chair. It is going to be put on record in *Hansard* I would like us as a committee to find out what it is about.

CHAIR: We will go in camera.

Evidence was then taken in camera but later resumed in public—

Proceedings suspended from 18:50 to 19:00

Senator MOORE: I do not have too many questions, Mr Mullings. I am interested in your statement:

There are an enormous amount of controlled studies and research about relapse prevention that shows that 6 to 10 sessions is plainly inadequate for the 80% of people who access the program with moderate to severe presentations.

The indication we have from the review of Better Access, which was widely publicised, is that less than 87 per cent of people actually access the full 18 sessions. The guidelines clearly say 'to moderate'. It does not say that 'severe' should be in this program. I have just looked at the email.

Mr Mullings: I guess what I am saying is that the reality is that it is moderate to severe—over 80 per cent of people accessing the program.

Senator MOORE: And you have that evidence on what basis?

Mr Mullings: There are two. There was a survey conducted of the program a while ago and it showed that in excess of 80 per cent of clients—

Senator MOORE: The survey was after the cuts were proposed.

Mr Mullings: No. This is before the budget cuts. We are talking about the Better Access program before the budget cuts. They were saying that over 80 per cent of people who access the scheme have moderate to severe levels of psychopathology, and the Better Access evaluation says exactly the same thing.

Senator MOORE: Mr Mullings, if you look at the intent of the Better Access program, from when it was started, it was never intended for moderate to severe people. That was not the intent. It has been resourced on the basis that it was mild to moderate. If you listen to the evidence we have had from a number of practitioners, the understanding was that after the 10th to 12th, when you are getting the extra numbers, it was only supposed to be for a very small number of people to go that far. What you are saying is that the whole program has been skewed, that the program that was intended for mild to moderate is now being accessed by 80 per cent of the people who access it for moderate to severe.

Mr Mullings: That is what two separate evaluations have shown. In reality, the way that mental health consumers access the scheme is that when people with anxiety and depression go to see a GP they have moderate to severe levels of psychopathology at the start. They receive treatment and they end up with mild to moderate or nothing in their symptom severity. That is just the reality of what the stats are showing. But what I wanted to say is that this idea that there is a large percentage of people who only utilise a small number of services is greatly skewed by a whole range of factors. The first factor is that people will sometimes begin therapy and then pull out, because they are not ready to make the changes. They might test the water and decide, 'Wow, this is too much.' Sometimes people will access services towards the end of the calendar year. They use, say, six in that calendar year and then they use another six or so in the next calendar year. So you are ending up with some of those 80 per cent just being because they started later in the year. It is about what proportion of people did it in that calendar year. There are all kinds of factors there. I am trying to say that scientific evidence from randomised, controlled studies has shown for decades that it takes at least 12 sessions and often 15 to 20 sessions for even mild to moderate anxiety, depression and so on.

Senator MOORE: Eighteen as a number is not sufficient either?

Mr Mullings: I am only reporting it—

Senator MOORE: I am raising the point that we have had this evidence, the same scientific base, that people have used, so the magic number 18 has no more relevance.

Mr Mullings: It does approach that 20 figure that colleagues mentioned. That is going to take us with some considerable way towards a fair system. The problem is that the Harnett-Lambert and colleagues study has shown that, with the 12 sessions, only about a third of people are likely to show reliable change, which means that when the symptom's severity drops initially it will stay down and continue to improve over time. This Better Access evaluation does not have follow-up, so they did not follow the clients six months, 18 months, or three years down the track, which would allow us to see whether the symptom's severity dropped, remained low or improved. That is part of the issue too.

Senator MOORE: There needs to be better evaluation. May also take up on page 7 of your document that says: 'The position of the government's most widespread mental health problems can be fully treated in just over two months is nonsensical.' Where did you get two months from?

Mr Mullings: Going through 10 sessions or eight sessions in two months once a week.

Senator MOORE: People use that in a widely differing range of ways, as you would understand. Mr Mullings, I have never seen the two-month figure used in any other piece of information.

Mr Mullings: If you have someone come in with an acute presentation it is not unusual in the first week or two weeks to see them twice in those week and then to see them every week thereafter. Then you have consumed all your 10 sessions in two months. That is what that figure reflects. There are eight weeks in a two-month period and, if you saw them multiple times in the first acute period, which often happens with complicated presentations.

Senator MOORE: Do we have any data to say that is how they are used?

Mr Mullings: I am only speaking as a practitioner.

Senator MOORE: You have data from your own practice. Can you tell us from your own practice how many people have the 10 sessions in the two-month period you have just told us about?

Mr Mullings: I could not give you the figures off the top of my head.

Senator MOORE: I would not expect you to.

CHAIR: If you could send us something.

Mr Mullings: I could certainly do an audit of my current caseload.

Senator MOORE: The government has never said that people can be fully treated in two months.

Mr Mullings: They have certainly never made that claim. They have advised that they would like to see the system in 10 sessions. I am suggesting that that will set people up to fail, and some people will not even bother starting. That is something that consumers have attested to.

Senator MOORE: The 80 per cent of people?

Mr Mullings: Yes, the majority of people with moderate to severe presentations who access the program.

Senator MOORE: I have one other question to do with the inference in the phrase, 'Apart from Better Access the only methodology of treatment is medication.' It runs through some of your statements. You say, 'It is not appropriate to medicate every person who has a mental disorder.' Where is the inference in any government policy that it is appropriate to medicate every person?

Mr Mullings: It is not in policy but is in statements that have been made, some of them published in newspapers by the federal minister for mental health, Mark Butler, that Better Access cuts are acceptable because people can still access a psychiatrist for up to 50 sessions in a calendar year. The reality is that only some psychiatrists will actually deliver psychological therapies. What this is going to mean is that many people are really only have the option of Better Access or going to see a psychiatrist or ATAPS, which will mean starting again with another practitioner, which we think is going to cause problems as well. The biggest predictor of therapeutic outcome—and this is a stat that has 60 years of backing and research—is the therapeutic alliance, which is the rapport between a client and therapist. I think an earlier presenter today, a psychiatrist, mentioned the same thing.

Senator MOORE: I totally take the point. Your statement tends to indicate that psychiatrists, as an option, would automatically mean medication. I will check Minister Butler's statement, but I do not think he has ever made a statement that it would mean medication.

Mr Mullings: No, he has not made that statement; this is a statement that consumers have expressed concern about.

Senator WRIGHT: Mr Mullings, thank you for your time. I will take you back to the issue that Senator Moore was exploring. What you are saying is so at odds with the information that we have from DoHA, for instance, after the evaluation of Better Access that I really want to go back to it. I will quote from their submission:

The recent, comprehensive and independent evaluation of the Better Access program—
we have heard queries about how comprehensive and effective that was—

found that almost three-quarters of people who access services only needed between one and six sessions a year and the average number of mental health services received after a GP Mental Health Treatment Plan is five.

I take your point that if it was to go across into the new calendar year or the new financial year, if that is how it is measured, there may be some skewing, but it is still a pretty significant statistic that is quite at odds with the statistic that you gave. That is my first question. I have a supplementary question to that: as Senator Moore has pointed out, this program was established to deal with people in the mild to moderate range. From the information you are giving, disproportionately perhaps, people from the moderate to severe range are actually being treated. So of course it is not going to be adequate for that. Some of the evidence put to the committee is that in fact other programs would need to be designed or would be more appropriate for that kind of condition or disorder.

Mr Mullings: I do not actually buy that argument.

Senator WRIGHT: Okay. Start with the first question and then move to the second.

Mr Mullings: I would actually like to see the data that shows that there is a better treatment option for people with moderate to severe depression and anxiety, for instance.

Senator WRIGHT: Sorry, are you dealing with the second part? I did throw two questions together and that was a bit unfair. I am sorry. I will go back. The first question was just about the number of sessions that are required. The data we have been given is that three-quarters of people only require between one and six, or five after a GP mental health plan.

Mr Mullings: The way it is framed is interesting. What the statistics actually show is that large proportions of people do not utilise the services. That does not mean that they do not require them for their recovery. Many people will start therapy and will stop therapy because it becomes too much or because other problems emerge in their life. There will also be people who have been offered medication at the first point of referral. They will start treatment and four or five weeks later, when the side-effects die down for the antidepressant, for instance, they start to feel a bit better and decide they do not need to come in for any more sessions.

Senator WRIGHT: Can I ask you to clarify whether you are talking about people in the mild to moderate range here or the moderate to severe range?

Mr Mullings: All people who would access the program. Antidepressants would affect people with mild, moderate and severe levels of depression and anxiety. So it will affect all people in the same way. After about three or four weeks you will see people starting to feel a bit better and a proportion of people will stop going to see a psychologist.

Senator WRIGHT: What is the data? You have given us information about people in the moderate to severe range and how many sessions the evidence suggests they need. How many sessions do people in the mild to moderate range generally need on the basis of evidence and international data?

Mr Mullings: It is difficult to get a lot of data from randomised clinical trials on that. What I can tell you is that in general there is critique in the profession about participants in research to the effect that many people who are involved in the research base that we have are actually in the mild to moderate range anyway. The most severe and complex cases often get rejected at the initial point of going into the study because their needs are very complex. Often we are trying to test whether a specific intervention, say cognitive behavioural therapy, will work for a specific disorder like depression. So if they have depression, a personality disorder, anxiety, post-traumatic stress disorder and so on there are too many confounding variables and they need to be screened sometimes from the analysis. What happens is that those complex presentations are often not in there, so the data shows from controlled studies that people with mild to moderate levels of psychopathology need those 15 to 20 sessions of therapy. That has been replicated in Cochrane reviews, National Institute for Clinical Excellence studies and, ironically, a Department of Health and Ageing funded review of psychological interventions performed by the APS. This is gold-standard research that is confirmed in the US, UK and Australia.

Senator McKENZIE: I have two questions. You said earlier about the psychology wars that there is a philosophical difference. Did all you counselling psychologists go to a similar university or do you have—

Mr Mullings: Quite often we are—

Senator McKENZIE: Usually a certain lecturer or professor will have his or her particular way of viewing the world.

Mr Mullings: We have separate programs, often running side-by-side. We have a counselling psychology Masters or PhD course that will run alongside a clinical psychology Masters or PhD course, and quite often there are units shared between them. For instance, I trained in the same class for quite a number of things, including assessment and diagnosis and research methods with clinical psychs. So some of the differences that are being mentioned are, I would argue, overstated. In my case, I have a clinical psychologist supervisor and a counselling psychologist supervisor.

Senator McKENZIE: One thing that I have been particularly interested in is the online service provision, and I note that in your submission you are saying that it:

... should not be seen as a replacement for face-to-face therapy, but rather, another tool to deliver services to hard to reach groups.

You have been here most of the day and heard some people say that it is a substitute for face-to-face treatment—or can be. I would like to get your perspective on that.

Mr Mullings: Two weeks ago I handed in my PhD specifically about this topic. I did a comparative trial of face-to-face therapy and internet therapy using a synchronous chat system with clinical psychologists as the therapists. I can tell you that, for some people, talking to a psychologist over the internet is appropriate and in fact preferable. I think Ian Hickie mentioned that earlier, and it is definitely true. Some of the reasons are comfort—being able to access it at home. Some people are not quite ready and think that therapists are too scary. To put it simply, in the words of one of the clients in my study, 'I can cry and type at the same time.' If she speaks about her problem with someone in person, she cries—she is sobbing—and she cannot speak, so she cannot get the words out. That can be a difference for some people. I believe that we need a full range of approaches for different people with different needs, but my point was really about avoiding trying to set up automated CBT for people in regional and remote Australia and instead giving them access to a therapist on the ground, because there are always going to be people who need a human being in the room with them to talk things through.

CHAIR: Thank you very much for coming all the way from Rottneest. I hope you get to go back to Rottneest!

Mr Mullings: I will!

CHAIR: We are giving you some homework. Given that you are at Rottneest, are you able to get something to us by the beginning of next week?

Mr Mullings: Yes. Will I get an email or something telling me what I need to do?

CHAIR: We will send the *Hansard*—that will probably be easier. Given the timeframe, we are under the pump a bit. Thank you very much. That is the conclusion, at this stage, of the inquiry into mental health funding.

Committee adjourned at 19:20