Submission II
Senate Community Affairs Committee
Inquiry into Mental Health Services in Australia
May 2008

Contact:
Corinne Henderson
Senior Policy Officer
Mental Health Coordinating Council
Email: corinne@mhcc.org.au Tel: (02) 9555 8388 ext 101

Table of Contents

MHCC thank the Senate Community Affairs Committee for inviting us to present a second submission to the Inquiry into Mental Health Services in Australia, following our presentation to the committee in the NSW Parliament on 27 March, 2008.

1. NGO Tendering Process

1.1. The committee focused on one of the issues raised by Ms Bateman in her presentation, which surrounded the open tender process for NGOs under COAG. This process frequently favours large organisations that have a capacity to provide professional tender applications, as opposed to recognising that some smaller organisations may have important local connections and knowledge but less impressive tender writing skills. Consultations identified that tender processes for Personal Helpers and Mentors Program (PHaMs) and Housing & Accommodation Support Initiative (HASI) favour larger organisations and exclude smaller NGOs that may be better placed to provide appropriate services within specific regions.

The committee requested that MHCC provide recommendations on a tendering process, and we propose to present a paper to the Senate Committee under the umbrella of Community Mental Health Australia (CMHA), a partnership between the State Mental Health NGO Peak Bodies. To inform this paper, the State Peaks will need to undertake consultations with members and other stakeholders. MHCC will keep the committee informed as to progress regarding this matter.

Recommendation 1

That CMHA explore the issues around NGO tendering processes and research models internationally and report back to the Senate Community Affairs Committee.

2. Co-morbidity

2.1. COAG initiatives included some programs such as *Alerting the Community to Links between Illicit Drugs and Mental Illness* (Commonwealth) and *Improved Services for People with Drug and Alcohol Problems and Mental Illness* (NSW). MHCC are unaware of any reports or evaluations undertaken in terms of service delivery or consumer outcomes. We urge that processes be established in order that the sector can assess the impact of all such initiatives.

2.2. Over recent times there has been an increase in funding for workforce development in mental health directed at drug and alcohol agencies. The suggestion has been made that this emphasis is in response to a politically motivated 'tough on drugs' imperative. Certainly, support for workforce development in drug and alcohol directed at mental health agencies has been far less evident. Research has proved evidence of strong links between mental health and drug and alcohol[i] and MHCC advocate that workforce development on drug and alcohol issues for mental health workers is critical to cross collaboration and capacity building.

2.3. Points raised in NGO Tendering Process above (1.1), are particularly pertinent to the delivery of best practice models for intervention for people with drug and alcohol problems and co-morbid mental illness delivered by NGOs. Whilst there is evidence of improved service delivery as a result of increased workforce development, there remains a lack of coordination between drug and alcohol and mental health services, consumers frequently fall through service delivery gaps.

The absence of consultation between COAG and the sector thus far, has resulted in the process failing to meaningfully engage with those delivering services, who found that tendering process required organisations to compete for resources.

An example of this is the Commonwealth initiative, *Improved Services for People with Drug and Alcohol Problems and Mental Illness,* funded by DOHA. A great idea based on the principle of promoting capacity building between organisations. However, a model of capacity building and collaborative relationships between NGOs that requires them to tender competitively is an oxymoron.

Recommendation 2

That NGO peak bodies are best placed to construct a framework and strategy for service delivery for community recovery; rehabilitation and counselling programs that would enhance capacity and workforce development.

Recommendation 3

That COAG review tendering processes for delivery of best practice models for intervention for people with drug and alcohol problems and mental illness delivered by the NGO sector and that in reviewing tender processes, an option for consortium tenders be investigated**.**

2.4. Some progress has been made in the area of research with an allocation of $3 million across the drug and alcohol and mental health sectors through a Research Grants Program, coordinated and managed by MHCC and the Network of Alcohol and Drug Agencies (NADA). Round three of the initiative is in progress.

The program aims to engage NGOs and non government drug and alcohol organisations in research that will contribute to the field of mental health and drug and alcohol (co-morbid) service delivery. Funding is available for mental health organisations to conduct mental health and drug and alcohol research for up to 2 years. Eligibility is based on sole agency applications or in consortia with other NGOs, to partner with research bodies such as universities, Area Health Services or other research groups.

Outcomes expected from research are as follows:-

- Increased capacity of non government mental health organisations to engage in research and dissemination of research findings
- Increased capacity of non government drug and alcohol organisations to engage in research and dissemination of research findings
- Research findings that have capacity to improve service and related outcomes regarding mental health and drug and alcohol
- That Research experience and findings disseminated through reports, conferences, forums and publications where appropriate.

Recommendation 4

That a mental health research body to undertake high quality research and related activities; to build capacity, improve outcomes for the NGO sector and commission research activity within the NGO sector, on an ongoing basis.

2.5. Another initiative at the planning stage between the two peaks MHCC and NADA is a 12 month project for organisational "Change Management" training. During the 12 month time frame, the aim is to target training for 5 or 6 member organisations to meet front line manager, worker and board member needs.

A training needs analysis will review status responsiveness and focus on individual organisational needs, acknowledging that 'one size may not fit all'. The objective is to provide organisational as well as worker change through service re-orientation, training into practice and working with change processes. Training will include policy and procedure development; assessment; care plans and referral processes.

MHCC expect the package to be available in November 2008, with a pilot undertaken in September which can then be 'tweaked' and rolled out in a further 4 or 5 organisations. Even though targets will be somewhat specialised, we expect that this training will result in a unit of competence. The skill set will enable workers to better identify and respond to people with co-morbidity and enable them to appropriately refer to drug and alcohol agencies.

Despite this positive beginning, this 'pilot' program is a 'scratch on the surface' of sector service delivery and MHCC emphasise the need for ongoing support from the Commonwealth to enable the NGO peaks to lead the direction in model development, capacity building and workforce development, working towards 'best practice'.

Recommendation 5

That to maximise effectiveness, the Commonwealth support ongoing funding of the organisational 'change management' pilot project across NGO services.

3. Ensuring NGO Autonomy

3.1. MHCC draws the Committee's attention to terminology which may be misunderstood. Some presentations and submissions to the committee by other parties have promoted the concept of "integration" between public and NGO services. The NGO sector is adamant that NGO services must maintain their autonomy and that their favoured model is collaborative capacity building, cooperation and "coordination" and ***not*** "integration".

Integration between public and community services has unfortunately resulted in referral through clinical services and created barriers to direct access for consumers to community based interventions. Such a loss in autonomy is likely to impact on flexibility, creativity and an ability to respond to local needs appropriately.

In her presentation, Ms Bateman, MHCC's Chief Executive Officer, highlighted the example of PHaMs and Day to Day Living as extremely important programs providing for some gaps across the spectrum of community care. Nevertheless, in NSW some inconsistencies have become apparent between the States, who have different levels of engagement. In NSW, the PHaMs program is interpreting 'Care Coordination' as 'referral process via clinical services'. We perceive this arrangement as 'integration' rather than 'collaboration', with clients processed through Area Health Services (who often lack capacity to handle the necessary referral processes), rather than referral directly via a GP or other partnerships including self referral.

Community Mental Health Australia (CMHA) which is comprised of the State peak bodies that have formed a National Alliance, representing the Mental Health Community Service Sector, all agree that 'co-ordination' rather than 'integration' to be the preferred model.

> *"If NGOs are conceived of as service delivery arms of public services closely 'integrated' with the directions and approaches as defined by mental health services, they will over time loose their independence, ability to be flexible and responsive and with this their innovative and unique approaches to meeting need within specific or local communities. It is unrealistic to think 'integrated' can mean anything other than 'extension' of the directions as defined by the MH Services. The concept of coordination brings with it the intention of equality and respect of difference and recognition of the fact that there are different yet equally valuable approaches to assisting people with mental health problems"* (CMHA. Memorandum of Understanding: 2008).

Recommendation 6

That in all documentation concerning the relationship between mental health NGOs and public mental health services that policy writers are mindful of the misinterpretation that may arise through the use of the term ' integration' rather 'coordination' between services.

4. Co-ordination

4.1. Responsibility for the PHaMs program rests with the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). It aims to provide increased opportunities for recovery for people whose lives are affected by severe mental illness by increasing their connections to the community taking a strengths-based, recovery approach to supporting them.

Given that FaHCSIA have not undertaken the roll out of mental health services before, it would have been appropriate for extensive consultation to have been initiated between the Department and the mental health sector that were to provide services. Similarly, MHCC emphasise the importance of establishing feedback processes to FaHCSIA as to how programs are running, in terms of support in the community provided by NGOs.

Recommendation 7

That Governments work in a consultative forum together with the State Peaks (CMHA) in order to establish feedback processes, monitor and measure outcomes and brainstorm improvement strategies.

5. The COAG Process

5.1. MHCC reiterate a point made in their first submission to the Committee, that NGOs were not invited to participate in consultations informing the *National Mental Health Plan* 2003-2008*,* and *NSW: A New Direction for Mental Health.* We understand that these plans and strategies were intended to underpin development of the COAG plans, a process in which NGOs were also excluded.

The absence of NGO involvement in consultations on strategy, planning and COAG implementation is unfortunate. The social inclusion agenda promoted by the Federal Government should be followed through into COAG process, and it is timely to note that mental health and disability were excluded in the topics under discussion in the stream that proposed *"making social inclusion a national priority"* entitled Strengthening Communities, Supporting Families and Social Inclusion during the 2020 Summit held in April 2008.

Recommendation 8

That the Senate Committee support NGO peaks' involvement at all stages of consultation informing strategy and planning development of COAG initiatives in the future.

6. The ACHS process

6.1. MHCC support Dr Alan Rosen's comments to the committee regarding the National Mental Health Standards (NMHS) review process. Although technically 'involved', MHCC were marginalised, found the process quite disheartening and despite having expressed objection to the proposed structure of the new standards were not informed at every stage of the process. This will result in a limited 'buy in' from the community sector.

In several areas, our understanding is that no expert input has been requested, i.e. from Aboriginal mental health. We have be told that these concerns were formally conveyed to project management by the Mental Health Council Australia (MHCA), including that the ACHS project writing team have no mental health expertise, that key stakeholders feel less than adequately involved and consulted throughout the process and are therefore unlikely to feel ownership of the final product. Some work is being done by the CMHA to follow up on the issues.

Recommendation 9

That the Senate Committee to support meaningful inclusion of the NGO sector in the NMHS review process.

7. Workforce Development

7.1. It has long been recognised that in order to meet the needs of consumers in the community and circumvent the risk of hospitalisation, the NGO sector must increase its workforce capacity. In the COAG Communiqué (March 2008) as a boost to the health workforce, COAG agreed that Skills Australia would be asked to advise at its July 2008 meeting on the possible allocation of up to 50,000 additional vocational education and training places over three years from 2008-09. This is directed at areas of national skill shortage in health occupations (including vocationally trained nursing, emergency care and allied health occupations).

Recommendation 10

That COAG recognise the importance of inclusion of the community based workforce in the initiative to address the national skill shortage.

7.2. Since 2004 MHCC has been developing its NGO Development Strategy funded by, and in partnership with the NSW Health Mental Health and Drug and Alcohol Office (MHDAO), to provide training for the sector through its Learning and Development Unit (LDU) which is now an accredited RTO (Registered Training Organisation). This venture, the first in the NGO sector, means that finally we have a dedicated resource specifically focused on workforce development and training.

MHCC undertook a Training Needs Analysis as part of the NGO Development Strategy, and is acutely aware of the necessity for increased levels of uptake for workforce training particularly in areas of need such as: rural and remote; Indigenous and CALD communities, and in isolated locations servicing culturally diverse communities. Training offered through the MHCC LDU targets these regions as well as centralised locations and responds to organisations requests to bring training directly to their agency/ region.

7.3. Recruitment and retention have been identified by the sector as important areas of concern in workforce development. The MHCC LDU has been specifically set up to assist in this regard, delivering both accredited and non accredited mental health sector specific training, providing training needs analysis to organisations and recognition of prior learning (RPL) services to experienced workers.
The LDU is also able to offer consultancy services to help integrate learning into the organisational culture. This can maximise the benefit of training and skills transfer and deliver better services to consumers.

7.4. By establishing Cert IV Mental Health (Non Clinical) accredited training as the minimum training qualification, the sector is being provided with the skills necessary to provide psychosocial rehabilitation and disability support to consumers in the community. MHCC's first twenty graduates of the "Rehabilitation for Recovery" course were awarded their Certificate IV Mental Health Work (non-clinical) at a special graduation ceremony during an official launch on 21 April 2008.

Despite the positive outlook for workforce development, there are two critical factors that remain unaddressed. MHCC and the CMHA urge the committee to propose that certain measures are supported under COAG that lead to improved services through training, recruitment and retention of staff in the sector. Whilst the sector is substantially professionalising its workforce and is working towards establishing a minimum standard qualification for the mental health workforce, this necessitates a reality check on the part of Government to acknowledge the inadequacy of the sector's Award structure SACS.

There is concern that the sector will not be able to retain some of its highly skilled workforce with university and postgraduate qualifications, because the disparity between the government and NGO salaries is ever widening. Similarly, a growing well qualified mental health workforce will not unnaturally seek to obtain salaries commensurate with their training and experience.

The sector has always attracted a workforce for whom salary is not the primary motivator, but levels of pay under the SACS Award are unrealistic in terms of reasonable expectations, in comparison to salaries offered in other sectors that require similar levels of education and experience. The NGO workforce often regards the nature of their work as being devalued by Government and the community at large.

Recommendation 11

That COAG review the SACS Award in order to meet the needs and aspirations of an ever increasingly skilled workforce, and to address national staff shortages in the sector.

7.5. The second issue is that whilst the availability of training is now well established, the necessity for backfill has been ignored. Funding streams to provide backup for workers whilst they participate in training and study are necessary. This is particularly important in smaller community services where only one worker is fulfilling a role. The NGO sector is well placed to undertake capacity building, but without meaningful funding streams to support best practice, service delivery in the community sector will have a limited ability to reach and maintain best practice goals.

Recommendation 12

That COAG ensure funding is available in order to support workforce development with the necessary backfill, so that services may continue to run efficiently whilst workers undertake training.

8. Mental Health Nurses

8.1. The mental health NGO sector is very supportive of the initiative for mental health nurses to assist people with serious mental illnesses to receive better coordinated care, under the COAG Commonwealth initiative 'New Funding for Mental Health Nurses' to which $191.6 million was allocated. This was to provide for new mental health nurses in private psychiatry practice, general practice and other appropriate organisations. The concept was for them to work closely with a psychiatrist or GP to provide services such as home visiting, medication management, and improving links to other health professionals.

The roll out of these funds was July 2007, however, MHCC has been unable to establish what take up of funds has eventuated or what evaluation process have been undertaken to measure impact.

Recommendation 13

That a report be undertaken to provide documentation on the implementation of coordinated treatment and care by mental health nurses including how consumer outcomes are to be measured.

8.2. MHCC propose that the initiative might be better established if developed and managed by the Division of GPs in that they could manage nurses to operate in the community in a model not unlike that of palliative care nurses in the community. In other words, nurses could be connected to consumers via GPs and NGO service providers. NGOs have a long history in providing outreach care coordination, and are well placed to offer a suitable location and connect with GPs and nurses.

Nurses tend to work with a narrower focus than NGOs, who take a social inclusion approach. MHCC suggest that this might prove to be a very attractive partnership model, with NGO services providing connections between themselves and consumers, GP's and mental health nurses. Since GPs are frequently the gatekeepers for clinical care, partnership relationships between GPs and NGOs are vitally important in order to meet the needs of consumers living in the community.

Recommendation 14

That the initiative the new funding for Mental Health Nurses be reviewed and that a model be developed that enables GPs and NGOs to access the services of mental health nurses in a location most appropriate to the consumers needs.

Recommendation 15

That COAG support a project to be undertaken to research and develop a model of partnership between the Divisions of GPs, CMHA and the Australian & New Zealand College of Mental Health Nurses, to be steered by a consultative group comprised of all three plus the state departments of health.

9. Medical Benefits Schedule

9.1. MHCC attach a soft copy to the submission paper addressing some sector concerns regarding the MBS scheme presented to the Committee on 27 March, 2008. The paper refers to aspects of access; assessment; suitability; systemic problems; accountability and cost effectiveness.

9.2. In addition to those points, MHCC comment that most decisions are generally made in hospital rather than at a community level, and we support a case management / triage model with mechanisms that promote consumer autonomy and social inclusion. One of the problems is how to engage GPs in up-skilling when they will only undertake training if paid to participate (i.e. Better Service Delivery). The NGO sector does not have the resources to pay for GP's to undertake training.

We suggest that in order to make connections between GPs and NGOs truly meaningful, it is necessary for COAG to support the development of a program that links GPs, NGOs and mental health nurses in a face to face context, perhaps auspiced by the Division of GPs. In a local network/forum/ information sharing environment in which NGOs could shopfront their services, meet with and present to GPs and mental health nurses, they could provide information as to what is available in any location once or twice a year. An interagency group could be established to provide a coordinated partnership between the Divisions and local NGOs, to discuss for example: gaps in service delivery, training and information dissemination.

Recommendation 16

That COAG establish a research grant program to enable the community peaks (CMHA) to work together to develop a model of capacity building between GPs, NGOs and mental health nurses to later be rolled out nationally.

9.3. The NSW Mental Health Association (MHA) who are funded by NSW Health to maintain an online directory of mental health and community services across the State. Currently, organisations are required to pay an annual fee for access online.

Recommendation 17

That the MHA Directory be made freely available to all consumers and carers, community services and sole providers in NSW for referral purposes.

10. Outcome Measurement and Evaluation

10.1. MHCC expressed in their first submission to the Committee, and reiterate now, that it is of the utmost importance that the success or failure of COAG funded programs is measured and that a mechanism for data collection be established. This was made particularly evident by the COAG Progress Report released 23 April 2008, which whilst giving data as to take-up of and dollar expenditure gave little insight into the effectiveness of programs and initiatives.

Recommendation 18

That COAG appoint a person to head up the development and implementation of a model for collecting data and evaluating outcomes on all COAG programs.

11. Accountability

11.1. MHCC conclude with the observation that accountability in all areas of service delivery are critical to best practice, and that whilst NGOs provided with State and/or Commonwealth funding are required to reapply for their resources and provide extensive detail as to all aspects of service delivery on an ongoing basis at extremely regular intervals, GPs as sole providers are highly supported, rarely receive supervision, and are not in any way accountable except through health complaints and legal mechanisms. As mentioned in the attached Appendix 1, the same now applies to psychologists under the new MBS scheme.

Recommendation 19

That COAG appoint a person to head up the development and implementation of a model for collecting data and evaluating outcomes of the MBS scheme supporting delivery of primary mental health services through the range of registered medical and allied mental health professionals .

MHCC thank the Senate Committee for their interest in these matters and have endeavoured to clarify the issues raised by the Committee on 27 March, 2008. Other than recommendations with regard to the Tender Processes (Item 1.) we hope we have fulfilled the task. In the event that the Committee would like further information or to discuss other matters, we are happy to provide any additional material. For further information please contact Corinne Henderson, Senior Policy Officer at corinne@mhcc.org.au or telephone: 02 9555 8388 ext 101.

Appendix 1

Recommendations

Recommendation 1

That CMHA explore the issues around NGO tendering processes and research models internationally and report back to the Senate Community Affairs Committee.

Recommendation 2

That NGO peak bodies are best placed to construct a framework and strategy for service delivery for community recovery; rehabilitation and counselling programs that would enhance capacity and workforce development.

Recommendation 3

That COAG review tendering processes for delivery of best practice models for intervention for people with drug and alcohol problems and mental illness delivered by the NGO sector and that in reviewing tender processes, an option for consortium tenders be investigated**.**

Recommendation 4

That a mental health research body to undertake high quality research and related activities; to build capacity, improve outcomes for the NGO sector and commission research activity within the NGO sector, on an ongoing basis.

Recommendation 5

That to maximise effectiveness, the Commonwealth support ongoing funding of the organisational 'change management' pilot project across NGO services.

Recommendation 6

That in all documentation concerning the relationship between mental health NGOs and public mental health services that policy writers are mindful of the misinterpretation that may arise through the use of the term ' integration' rather 'coordination' between services.

Recommendation 7

That Governments work in a consultative forum together with the State Peaks (CMHA) in order to establish feedback processes, monitor and measure outcomes and brainstorm improvement strategies.

Recommendation 8

That the Senate Committee support NGO peaks' involvement at all stages of consultation informing strategy and planning development of COAG initiatives in the future.

Recommendation 9

That the Senate Committee to support meaningful inclusion of the NGO sector in the NMHS review process.

Recommendation 10

That COAG recognise the importance of inclusion of the community based workforce in the initiative to address the national skill shortage.

Recommendation 11

That COAG review the SACS Award in order to meet the needs and aspirations of an ever increasingly skilled workforce, and to address national staff shortages in the sector.

Recommendation 12

That COAG ensure funding is available in order to support workforce development with the necessary backfill, so that services may continue to run efficiently whilst workers undertake training.

Recommendation 13

That a report be undertaken to provide documentation on the implementation of coordinated treatment and care by mental health nurses including how consumer outcomes are to be measured.

Recommendation 14

That the initiative the new funding for Mental Health Nurses be reviewed and that a model be developed that enables GPs and NGOs to access the services of mental health nurses in a location most appropriate to the consumers needs.

Recommendation 15

That COAG support a project to be undertaken to research and develop a model of partnership between the Divisions of GPs, CMHA and the Australian & New Zealand College of Mental Health Nurses, to be steered by a consultative group comprised of all three plus the state departments of health.

Recommendation 16

That COAG establish a research grant program to enable the community peaks (CMHA) to work together to develop a model of capacity building between GPs, NGOs and mental health nurses to later be rolled out nationally.

Recommendation 17

That the MHA Directory be made freely available to all consumers and carers, community services and sole providers in NSW for referral purposes.

Recommendation 18

That COAG appoint a person to head up the development and implementation of a model for collecting data and evaluating outcomes on all COAG programs.

Recommendation 19

That COAG appoint a person to head up the development and implementation of a model for collecting data and evaluating outcomes of the MBS scheme supporting delivery of primary mental health services through the range of registered medical and allied mental health professionals .

Appendix 2

Senate Community Affairs Committee
MHCC presentation 27 March, 2008

Improved access through Medical Benefits Schedule (MBS)

MHCC and its members would like to thank the Senate Community Affairs Committee for inviting us to present and giving us the opportunity to provide input. One of the issues we wish to highlight today is that of better access to Psychiatrists, Psychologists, Social Workers and General Practitioners through the Medical Benefits Schedule (MBS).

This issue has received widespread support in the community. Nevertheless, numerous concerns have been raised during the course of consultation across all states with consumers, clinicians, non-government and mainstream service providers.

Announced in July 2006, the Commonwealth COAG mental health reform package, allocated $538m (over five years) to enable better access through the MBS[ii]. A report published by the Mental Health Council of Australia (MHCA) [iii] presenting an analysis of the first six months of the new program identified that there has been a large uptake of the new MBS items. Over 170,000 services provided in May 2007 alone, were mostly for psychological services. Of the $78 million committed during the 6 months, $52 million was been spent on services for women, $26 million on men. Despite these figures the concern is that to a large degree access for those to whom the scheme was directed has not be equitable. According to MHCA, even with no increase to the level of services funded, the likely minimum 12 month cost will exceed $220 million.

In addressing the problems under a number of headings[iv], MHCC suggest that:

Access

In terms of access, distribution of services across Australia is not uniform, with some States making much higher levels of claims for the new services on a per capita basis. The distribution of claims appears to broadly match the distribution of health professionals.

Many accredited psychologists do not bulk bill or charge fees that match the MBS fee. The out-of-pocket expense frequently represents a barrier to access for many consumers. From feedback received from some GPs, they report that many clients now using the MBS scheme represent those already accessing services privately. We are concerned that this may be causing a shift from services for the seriously mentally unwell to those better able to access referrals and able to pay the gap.

Whilst we support the availability of psychological services to the community in general, since the absence of early intervention may ultimately result in deeper psychological distress if not addressed, we suggest that the aim of the scheme was to provide care for people with a mental illness or a severe psychological disorder. The process of referral requiring a mental health assessment has given rise to concerns as to how the program has been established.

Significantly, while 75% of all mental disorders appear before 25 years of age, current data indicates this group has yet to access these new MBS items. A key at-risk group requiring early intervention primary care appears to be missing out on the benefits of the new MBS arrangements. [v]

Assessment

MHCC support the concept of the GP as the most stable provider for clinical care but the MBS scheme fails to include a mechanism through which GPs can be up-skilled to manage assessment and care plans, monitor a consumer's symptoms or work closely with the NGO sector to ensure a client's social, employment and other needs are met. The sector is concerned that there is difficulty in locating GPs that can provide assessments and care plans particularly in rural and remote locations.

We feel it important to highlight the need to ensure that the MBS scheme is coordinated into existing service delivery and develop models of practice whereby GPs can work collaboratively with community services so that consumers can access services in the most useful way, and make choices as to the manner in which they receive care and treatment.

Suitability

In the first instance, GPs are required to issue a mental health assessment for referral. Whilst the Australian Psychological Society (APS) list key areas of expertise and identify the therapeutic approach of accredited clinical and registered psychologists, many GPs may be inadequately trained to understand the appropriateness of a modality, and match it to client needs. GPs may also be disposed to refer according to location or to those personally known to them rather than by modality.

The implementation of MBS access excludes practitioners other than psychologists and social workers as service providers. By excluding trained professionals who may be appropriately qualified to deal with a multitude of complex presentations, offering a broad range of therapeutic modalities, the process is underutilising a resource of skilled mental health practitioners. MHCC suggest that the scheme be expanded in order to utilise other qualified practitioners such as professionally registered counsellors and psychotherapists, accredited clinical members of State and National professional bodies.

The focus on Cognitive Behaviour Therapy (CBT) as the evidence based practice (shown to be very effective for depression, anxiety disorders and obsessive compulsive disorders) may not necessarily be suitable for all consumers.

A treatment plan may refer a client for 6 - 12 sessions per annum (in exceptional circumstances 18), may present a duty of care dilemma. Some clients may require ongoing therapy over long periods, for example survivors of childhood abuse, or trauma and torture victims frequently require long-term psychotherapy and short term treatment may result in negative outcomes.

Systemic problems
Anecdotally, MHCC have been given to understand that the scheme represents an opportunity which may be encouraging psychologists and social workers into private practice, away from mainstream and community services already experiencing shortages of suitably trained professionals. Meanwhile, counselling and psychotherapist associations all report a reduction in private practice utilisation.

Of particular concern is the availability of suitably qualified professionals in rural, regional and remote locations that meet MBS requirements. MHCC suggest that a review is undertaken of proposals from national and state-wide professional bodies to provide accreditation for suitably qualified counsellors, psychotherapists and mental health professionals as a further resource to be included within the MBS scheme.

MHCC note that under the expanded options for access to mental health care under Medicare such as group therapies, symptom management and psycho-education, services outside of specialist consulting rooms and remote (phone) counselling is negligible**.** We suggest this is due to the fact that these options would be more appropriately placed within community services utilising a broad spectrum of mental health practitioners. This would seem to represent a lost opportunity to provide equity to a broad spectrum of consumers.

Accountability
MHCC highlight the issue of accountability in terms of independent reporting of outcomes of mental health services, treatment and care. Whilst annual reporting occurs through state and territory health departments, it does not include comprehensive information from consumers, carers and communities. A mechanism has not been established to obtain information from GPs as to whether mental health plans and initiatives are having an impact on mental health or providing effective early intervention. Such outcomes need to be evaluated and funded under the scheme.

Consultations raised concern that the absence of transparent, comprehensive, nationally agreed outcome measurement strategies for reporting on service delivery of new initiatives will limit the ability to develop national plans and strategies for improved best practice into the future.

Cost effectiveness
In view of the degree to which the MBS has been taken up it would seem prudent to be able to measure its effectiveness. Similarly, were funding allocated to a broader spectrum of community services and allied professionals working independently, this might not only prove to be more cost effective but could provide improved access to services and offer a level of service options and affordability to the consumer.

MHCC thank the committee for their time and look forward to the outcome of their findings.

[i] Cappo, D. (2006). *Alcohol, Drugs and Mental Health – A Heady Mix.* Commissioner for Social Inclusion. A joint forum of the Mental Health Coalition of SA and the SA Network of Drug and Alcohol Services.

[ii] *Council of Australian Governments National Action Plan on Mental Health,* 2006-11. http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.pdf

[iii] Mental Health Council Australia. (2007). *Mental Health and the new Medicare Services: An Analysis of the First Six Months.* Prepared by Crosbie, David. & Rosenberg, S.

[iv] Access; Assessment; Suitability; Systemic problems; Accountability; Cost effectiveness.

[v] Mental Health Council Australia. (2007). *Mental Health and the new Medicare Services: An Analysis of the First Six Months.* Prepared by Crosbie, David. & Rosenberg, S.