Submission to Senate Select Committee on Mental Health

Introduction

It is estimated that about 3% of the Australian population suffers from a serious mental illness and that about one in five will suffer from a clinically definable mental illness at some stage in their lives.

While it is easy to say that the mental health system must be able to respond appropriately to the full spectrum of mental illness in the community, the task of dealing with mental illness and promoting good mental health is beyond the capacity of the mental health system and the health system in general.

The target group for the specialist mental health sector should be people who have a mental illness or disorder and who are experiencing disability as a consequence of their disorder. The important point is disability, not the dangerousness criterion we fall back on as the entry or intervention threshold when the system is overloaded and has entered failure mode.

The specialist mental health sector is no different to other tertiary health services. In the same way that we do not expect (and do not want) heart surgeons to take responsibility for preventing heart attacks, the role of the specialist mental health sector is not to be responsible for the mental health of people in Australia.

The corollary of role delineation in mental health is that other parts of the health system should be responsible for prevention, early intervention etc, with specialist services providing training and support if necessary. No doubt the committee will receive numerous submissions arguing that more specialist Mental Health Services are needed. The issue for the committee to judge is whether more specialist services are needed or whether what is needed is more effective intervention by the primary and secondary tiers of the health system and, more broadly, the human services beyond health.

Another critically important role for the mental health sector is support for public policies which promote mental health and recovery from mental illness, and reduce as far as possible the impacts of mental illness on individuals, families and communities.

The level of concern voiced by some mental health professionals and consumer groups about the proportion of the health budget devoted to mental health services in Australia must be placed in the context of how well Australia performs in preventing disabling mental illness, ameliorating the effects of mental illness when it presents and

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promoting recovery. It is difficult to compare health expenditure across countries, and the level of expenditure on any one part of the system does not necessarily reflect success or failure in meeting health care needs. Low expenditure on discrete mental health services *may* reflect relative success in minimising the incidence and impact of mental illness through other strategies that can be expected to reduce demand on mental health services.

Calls for major increases in the mental health budget must be weighed carefully against other options, which may help lower the incidence and severity of mental illness and its impact at the individual and community level.

The National Mental Health Plan 2003–2008 argues that the influences on mental health occur in the events and settings of everyday life and recognises that health and illness result from the complex interplay of biological, psychological, social, environmental and economic factors at all levels – individual, family, community, national and global.

> 'The determinants of mental health status, at the population level, comprise a range of psychosocial and environmental factors, including income, employment, poverty, education and access to community resources, as well as demographic factors. The National Mental Health Plan 2003–2008 recognises that improving the mental health of Australians cannot be achieved within the health sector alone and that a whole-of-government approach is required which brings together a range of sectors that impact on the mental health of individuals, such as housing, education, welfare and justice.'[1]

This submission addresses the nexus between mental illness, poverty and disadvantage and argues for greater investment in the supports and services needed to ensure that people with mental illness do not live in poverty and that poverty does not contribute to the incidence, severity or persistence of mental illness. It also highlights recent proposals to change eligibility for the Disability Support Pension (DSP) that will almost certainly work against the achievement of the goals of the National Mental Health Plan.

The submission then looks at the structure of the health system and analyses the obstacles to better mental health service delivery as a result of deficiencies in the general health system.

The submission concludes with a more detailed discussion of mental health services, including the roles and responsibilities of the various levels of government, non-government and private entities in the planning, funding and delivery of mental health services.

(Note: the relevant terms of reference addressed in the submission are highlighted at the beginning of each sub-section).

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[1] Australian Health Ministers (2003), *National Mental Health Plan 2003-2008*, Commonwealth of Australia, p9

Part 1: Poverty, Disadvantage and Mental Illness - Terms of Reference (b), (e), (f), (m)

Poverty and mental illness

It is accepted that people in poverty suffer increased levels of physical and mental illness. Poverty, and unemployment in particular, impacts on general health and in particular on depression, anxiety and low self esteem.

Persons with mental illness report ongoing discrimination in key areas of employment and insurance, and restricted access to basic welfare services and support.

While there is a clear and strong association between poverty and mental illness, the causal links are more complex. Nevertheless, it is at least as likely that the stresses relating to poverty and disadvantage are as significant in contributing to mental illness as the presence of mental illness is to the likelihood of a person living in poverty. What is indisputable is that poverty and mental illness can combine in a vicious cycle in which the fact of poverty contributes to the manifestation of mental illness, which in turn contributes to the risk of poverty.

The clear conclusion to be drawn here is the critical importance of ensuring that people with a mental illness not be placed at risk of poverty and disadvantage. This requires a range of policies across government which address income support, employment assistance, housing, active anti-discrimination measures and access to health, rehabilitation and community support services.

Over the past thirty years Australian governments have worked to reduce poverty in various ways, including by:

- increasing income support for low income households in the 70s and 80s through benchmarking pensions to 25% of total male average earnings has meant that older people have a much lower risk of poverty now than in the early 70s (down from 7.5% to 4.6%)
- improvements in family assistance to low income families in the1980s and 1990s, including the child poverty package in 1988, estimated to reduce child poverty by one third
- expanding the range of human services (including Medicare, home care, aged care and child care services) thereby reducing the cost of living for many people on low incomes. These 'social wage' outlays were estimated to have increased from 18.7% of average disposable income in 1984 to 21.3% in 1998.

More recently, the government has significantly boosted the incomes of the poorest families with children by improving their family payments.

However, much remains to be done:

- Over two million Australians live in poverty.
- 860,000 children are growing up in jobless families.
- Aboriginal people live for 20 years less, on average, than other Australians. Rates of disease, including influenza and pneumonia, are up to four times higher in Indigenous communities than in the general community. Suicide rates among Indigenous people are around three times higher.

- Although in late 2004 the national unemployment rate was at a 30 year low of 5.4%, the rate in Sunshine (Victoria) was 14%, in Salisbury (SA) it was 9%, in Maryborough (Queensland) it was 11% and in Campbelltown (NSW) it was 10%.
- Many jobless people find casual work then fall back into unemployment because more secure work is not available to them. The official ABS estimate for long term unemployment (over one year) is just under 100,000 (down from over 300,000 after the last recession). But this excludes people with as little as a week's part time work. By contrast, the number on unemployment payments long term (which includes those with a few weeks' part or full time work during the year) remains over 300,000, as it has for the past decade.
- Between 1995 and 2001, the after-tax incomes of the top 20% of households rose by 14% ($111 per week), compared with just 8% ($13 per week) for those relying on government pensions and allowances and 11% ($41 per week) for middle income earners.
- A single adult on the maximum Newstart Allowance lives on a total income of just under $250 per week, while the average full time wage is now almost $1,000 per week.
- While the overall value of wealth in the form of housing rose by 68% from 2000 to 2003, over 300,000 private tenants on income support devote more than 30% of their income to rent and other housing costs.

Income support recipients and mental illness

People whose main source of income is Government benefits are consistently found to be at greater risk of poverty than other groups. This is particularly so for people who remain in this situation for many years, such as long term unemployment beneficiaries, many sole parents, people with disabilities and carers.

All mental disorders are much more prevalent among income support recipients than non-recipients. Almost one in three income support recipients (more than 30%) have a diagnosable mental disorder in any 12-month period. This is 66% more than the prevalence of mental disorders among Australian adults not receiving income support (18.6%). Substance use disorders are more prevalent among people receiving unemployment benefits and students. These groups also experience elevated levels of anxiety and depression. The prevalence of clinical anxiety and depressive disorders among lone mother income support recipients is between three and four times the national average with 45% of lone mothers experiencing a diagnosable mental disorder.[2]

Australia's social security system is a last line of defence against poverty. It provides a regular source of income for those who have none of their own. It is simply not realistic to expect that poverty will be eliminated by getting poor people into jobs. Job creation would need to be much stronger than that of the past thirty years. Moreover, for many people with disabilities and those involved in caring responsibilities or

[2] Butterworth, P. (2003) *Estimating the prevalence of mental disorders among income support recipients: Approach, validity and findings*, Policy Research Paper 21, Centre for Mental Health Research, Australian National University, Canberra, p. viii

experiencing episodes of chronic ill health, full time employment is not appropriate. This underscores the importance of an adequate safety net to protect jobless people and those with low or insecure earnings.

However, social security payments for many households are significantly lower than Australian income poverty benchmarks. The worst affected by these payment anomalies are single unemployed people, young unemployed people and students. In this sense, the Australian social security system is poorly targeted in terms of reducing poverty, as those facing the highest risks of poverty are the very groups who receive the lowest payments.

Other major concerns are that:

- some payments are too low to cover basic costs of living
- gaps in entitlement have been constructed to exclude some groups from support
- people who take unpaid work often receive little reward
- compliance requirements, penalties and debts remain very harsh and directly contribute to the incidence of poverty.

Emergency Relief (ER) agencies consistently report increasing demand from families and individuals in crisis who are seeking material and financial assistance. In the financial year 2003-04, there was a 5.4% increase in the number of client contacts over the 2002-03 year, and an 8.9% increase in the number of people they turned away[3]. Such growth in demand is inevitable given:

- significant growth in casual and part-time employment in lieu of full-time secure employment
- increasing housing stress
- the inadequacy of social security payments to meet basic living costs for some groups such as single unemployed people and sole parents[4].

Mental illness and disability

Sixteen per cent of people with a disability have a mental or behavioural disorder as their main condition and are more likely to have a profound or severe core-activity limitation than those with a physical condition (46% compared to 29%).[5] Over a quarter of Disability Support Pension (DSP) recipients have a mental illness.

Poverty is particularly high amongst people who have a disability. People with disabilities both have a lower participation rate in the workforce and a higher unemployment rate when they are in the workforce. In large part this reflects an unwillingness by society to recognise that different capacity does not necessarily mean

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[3] ACOSS & the State/Territory Councils of Social Service (2005) *Australian Community Sector Survey 2005, ACOSS*: Sydney pp 13-14.

[4] See 'Key Challenges for Emergency Relief' – an ACOSS submission to the Federal Government regarding the Emergency Relief Program, May 2003.

[5] Australian Bureau of Statistics (2003), *Disability, Ageing and Carers: Summary of Findings*, Australia, ABS Cat No 4430.0, Commonwealth of Australia , Canberra, 2003 p 6

reduced capacity, an attitude that frequently leads to the exclusion of people from mainstream employment.

In addition to being excluded from the earning of adequate income, people with disabilities often have higher costs of living associated with their disabilities. This can be the high and continual cost of medication, equipment or aids, appropriate housing, transport, and services related to personal care or maintenance of a person's home.

The combination of higher costs of living, along with income deprivation, leads to a strong connection between disability, illness and poverty. This connection also affects carers of people with disabilities, and adds to the substantial stress experienced through lack of resources and absence of essential services including personal and respite care.

The available data also suggests that people with disabilities experience significantly reduced participation in education. In 1998, 42% of people who had never attended school had a disability. Of those who left school when aged 15 or less, 35.7% had a disability. Of those who did not complete year 12, 19.1% had a disability.[6]

Working age people with a disability have markedly lower incomes than those without a disability. Some 70% of those with profound core activity restrictions and 56% of those with severe restrictions had incomes in the lowest two income quintiles, compared to 31% of people with no disability.

Only 6% of DSP recipients participate in employment programs and only 9% have a part time job, but the reason for this is not simply reluctance to look for work.

Until recently, employment programs were not comprehensively promoted among DSP recipients. Even if they were, there are queues for employment and rehabilitation services for people with disabilities because funding for these programs is capped.

A major reason for the low employment rate among disability pensioners in Australia is that they are less likely to receive help to get a job, or rehabilitation or training. The Australian Government only spends about two thirds of the OECD average expenditure on these services, in proportion to the size of our economy[7]. To contain costs, the number of places available in the main specialist program of employment assistance for people with disabilities – 'open employment services' – is capped, so there are queues for help. As a result, in Australia a relatively low proportion of disability pension recipients receive help with employment or training.

Many people with disabilities already receive social security payments other than DSP. For example, there are 50,000 Newstart Allowance (unemployment benefit) recipients identified as having an illness or disability, and their number grew strongly throughout the 1990s.

The recent changes to eligibility for DSP announced in the 2005 Federal Budget will

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[6] Bradbury B, Norris K, Abello D 2001, *Socio-economic disadvantage and the prevalence of disability*, SPRC Report 1/01, Social Policy Research Centre, University of NSW, p66.

[7] OECD (2003), *Transforming Disability into Ability*, OECD Paris.

make it harder for people with disabilities to get DSP and most future recipients will simply be diverted to the lower paid Newstart Allowance. As a result of these changes, 54,000 people with disabilities – a large proportion of whom will be suffering from a mental illness - face weekly payment cuts between $20-$40 over the three years from 2006, as they will no longer be eligible for pensions so instead will be put on unemployment payments.

Many people with recurring mental illnesses are able to work part time but can't hold down a full time job. Allowing them to keep the pension while they work part time (as the present DSP rules do) is sensible because it encourages DSP recipients to look for work. The Government could change this, without making it harder for people with disabilities to get the pension.

As details of Budget changes come to light, it seems clear the Government has used more cuts than carrots in its welfare-to-work package. Increased and welcomed investment in childcare, wage subsidies and employment assistance for people with disabilities are almost paid for by the estimated value of cuts to payments and employment assistance.

The cut to Job Network employment assistance of $500 million means that the level of help, training and work experience available to people who need to skill up to get back to work will be inadequate. Job Network providers are already under resourced with an allowance of just $900 for training and other assistance for most jobseekers and $1,350 for people classified as highly disadvantaged. ACOSS is concerned that possible limitations on how people are classified as highly disadvantaged will mean that people with many barriers to work will receive the biggest cut to employment assistance. Any cuts to employment services will affect Australians who have low levels of skills or education and are surviving on unemployment payments of as little as $200 a week. [8]

Another problem is that until recently, Governments have made no systematic attempt to enrol DSP recipients in job and rehabilitation programs. Those who want to participate are often confronted with waiting lists due to a shortage of places in employment and training programs that specialise in helping people with disabilities – Disability Employment Assistance and CRS (Rehabilitation). Funding for these programs is capped.

The Job Network is an alternative employment program where places are not capped, presumably because Job Network places are much cheaper. But only 6,500 DSP recipients participated in 'intensive assistance' services provided by the Job Network in 2002 (just 2% of all participants in intensive assistance). The main reason for this very low level of participation is that the Job Network is not properly resourced to meet their needs. The highest level of assistance within the Job Network is now *Customised Assistance*, during which providers can draw on a 'Job Seeker Account' to fund training, job placements and other help to overcome barriers to employment. But the amount available for each highly disadvantaged job seeker is only about $1,300. This won't buy much rehabilitation or training and people will not generally be eligible for this level of assistance until they have been with the Job Network provider for 12 months. Job Network funding is well below that available to the specialist programs of employment assistance for people with disabilities described above.[9] As a result of this

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[8] ACOSS (2005) *Budget offers jobseekers more cuts than carrots*, Media Release, 18 May

[9] The highest level of funding available to assist a job seeker through the Job Network is

under-investment in employment assistance for people with disabilities, only about 6% of the overall number of people on DSP in 2002-03 participated in an employment program. [10]

Mental illness and disability services

People with serious or enduring mental illness rely upon a range of disability services funded under the Commonwealth State/Territory Disability Agreement (CSTDA). The new CSTDA contains welcome funding increases over the previous agreement but the backlog of unmet need is estimated to be at least 30% over current levels,[11] and growth in the number of people in the CSTDA target group is very rapid.[12] For these reasons, further increases in funding will be needed and can not be left until the new Agreement expires in 2007.

Mental illness, housing and homelessness

Access to adequate housing plays a critical role in determining whether or not people live in poverty, the stability of their lives and their physical and mental well being. Housing impacts on people's ability to participate in employment, education and training and the maintenance of health and well being. Although Australia is well housed in general, a growing housing affordability problem has emerged, especially for people on low incomes. At the same time, between 1984 and 1995 per capita levels of spending on social housing via the Commonwealth State Housing Agreement decreased by 25%. Further, house price inflation has decreased access to home ownership and affordable rental options, the latter of which declined by 28% for low income people. An additional problem is that Commonwealth Rent Assistance is relatively ineffective in providing housing affordability for people in the major housing and employment markets.

There has also been a rapid rise in homelessness over the last decade with up to 105,000 homeless people on any given night in 2000, which is in part related to the lack of affordable housing options.

The amount of well located, affordable housing, particularly for low income households, continues to decrease. Current policy settings are distorting both the home

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around $7,600 (only paid if the person achieves sustained employment), compared with funding levels of $5,600 $8,500 $12,300 and $18,000 for open employment services for people with disabilities, depending on the severity of the disability.

[10] ACOSS (2005), *Effects of possible changes to the Disability Support Pension*, ACOSS Info 317, p31

[11] Based on conservative estimates provided in the 2002 AIHW study prepared for Commonwealth and State/Territory Disability Administrators - Unmet need for disability services: effectiveness of funding and remaining shortfalls- which showed additional unmet need for 12,500 accommodation and respite places, 8,200 community access places, and 5,400 employment support places.

[12] Between 2000 and 2006, it has been estimated that the number of people aged between 15 and 64 in the CSDA target group will increase by 12%. See Australian Institute of Health and Welfare Disability Data Briefing Number 22 September 2002 AIHW: Canberra p10

ownership and rental markets and effectively locking out low income earners. There is a chronic mismatch between housing supply and demand, a lack of affordable housing (to buy or rent), entrenched homelessness, and a declining social housing system. This has contributed to persistent unemployment, a lack of labour supply (including for key workers such as nurses and teachers, especially in rural and remote communities) and the long-term polarisation of rich and poor groups in society.[13]

It is clear that access to economic and social opportunities are becoming more and more geographically polarised. Regions where disadvantage is already concentrated tend to be characterised by low investment and low levels of education, which further discriminates against the future well being of community members. Recognising that the incidence of mental illness is higher among lower income groups, this situation has important ramifications for the prospects of prevention of and recovery from mental illness, the management of mental illness in the community, and the type and location of mental health services.

One of the major vehicles for the delivery of housing assistance, the CSHA, was renegotiated and signed by all parties in 2003. The Agreement includes indexation which will make funding more sustainable. However, the CSHA continues to shrink - base grant funding has decreased by 54% over the last 10 years to $1.28 billion. This is in an environment where levels of housing stress continue to increase, especially for households in the bottom 20% of incomes.[14]

The Supported Accommodation Assistance Program (SAAP) is the joint Commonwealth-State funding program targeting people who are homeless or at risk of homelessness through a range of accommodation and support services.

SAAP currently funds 1,286 homeless assistance services across Australia. Each year the homelessness service system provides almost 3,000,000 nights of accommodation to more than 150,000 homeless Australians. However, there remains a high level of unmet demand with only 1 in every 7 people who are homeless finding a bed in the homeless service system. Every day 100,000 homeless Australians are without safe, secure and affordable housing and the homelessness service system is struggling to meet the increasing demand for services.

The most recent evaluation of Australia's homeless service system found that funding levels must be increased significantly if the program is to continue to address homelessness.[15]

Each year the homeless service system accommodates more than 53,000 children who seek assistance in the company of a parent. They are not recognised as clients of the program by the Commonwealth Government, yet they are the single largest group of those seeking assistance from the homeless service system.

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[13] ACOSS (2005), ACOSS Federal Budget Priorities Statement 2005-2006, p45

[14] Ibid. p47

[15] Erebus Consulting Partners (2004) Final Report of the National Evaluation of the Supported Accommodation Assistance Program(SAAP) IV Commonwealth of Australia, Canberra pp 190-213

ACOSS has recommended that government funding for the Supported Accommodation Assistance Program and the Crisis Accommodation Program should be increased by 40% in real terms to alleviate unmet demand. Within this overall increase there should be a particular focus on meeting the needs of children, who are growing as a proportion of service users. All levels of government should work together to improve the links between housing and support services at a program and service level. [16]

ACOSS has also recommended that the SAAP Coordination and Development Committee should draw together, publish and utilise the wealth of information developed at a state and territory level through their homelessness strategies in national planning to address homelessness and housing responses and the allocation of resources. [17]

[16] ACOSS (2005), *Federal Budget Priorities Statement 2005-2006*, p48
[17] Ibid. p48

Part 2: Equity and access in the health care system – Terms of reference (a), (b), (c), (h), (i), (m), (p)

Mental health services form a part of the broader health system. One of the directions of reform under the National Mental Health Strategy has been for greater integration of mental health care within the broader health system. The achievement of the aims and objectives of the National Mental Health Strategy is therefore contingent upon a general health care system which is supportive of these objectives.

There is currently a strong case for reform of the Australian health care system to ensure that all Australians have universal access to a defined set of medical and pharmaceutical benefits.

Medicare has never been a properly universal system (for example many people in rural and remote areas and Indigenous communities have missed out because resources follow the location of medical services rather than health need) and the universality of the system has been eroded by the increasing use of public subsidies to support the health care choices of wealthy consumers at the same time as patient contributions have increased for basic medical services and pharmaceuticals. Other basic services, such as dental care, physiotherapy and psychological counselling services, are highly restricted within the public system but available to those with sufficient private means and/or private health insurance.

This is not a conducive environment in which effective mental health services can be built, considering that a disproportionate number of people with mental illness live on low incomes, cannot afford copayments and do not hold private health insurance.

One particular concern in relation to the management of mental illness has been the increase in patient co-payments for Pharmaceutical Benefits Scheme listed medications which took effect from the beginning of 2005 and the weakening of the safety net provisions announced in the 2005-6 Federal Budget. Policy changes such as these can be expected to have a significant impact on the management of mental illness through the proper use of medicines, as people with a mental illness on low incomes cannot afford to medicate themselves properly or do without other essentials in order to afford medication.

A closely related problem has been the steady decline in the proportion of General Practice services which are bulk billed over the past 5 years. While the national aggregate figures show some improvement, the situation varies markedly across the country and the impact of such a persistent historical decline on the health status of low income groups cannot be discounted. Lack of access to GPs due to financial barriers means that people with a mental illness living on low incomes cannot readily access needed prescriptions, support, counselling or advice. The only option for a person in this situation is to attend a public hospital or community mental health service, assuming these are available locally.

The broad problem is that the health care system (at least on the medical services side and particularly in terms of primary health care) does not direct resources according to health care need nor to the most effective interventions, but rather to where doctors happen to be located. Exacerbating this problem has been the lack of integration between the various parts of the health system, particularly across the different parts of the health system funded and managed by the Commonwealth and the States.

There needs to be a much stronger focus on building a framework for health care which drives investment where it is most needed and effective and ensures that cost is never a barrier to people receiving high quality health care. This must include much greater integration between Commonwealth and State funded programs to avoid, for example, GPs competing with State funded community health services to provide primary health care for people with a mental illness.

ACOSS advocates a health system that provides an appropriate balance between public health and treatment services; quality health services provided according to need; low or no payments by consumers at the time of service; revenue raised according to ability to pay through taxation or a health levy; and methods of resource allocation and cost control that ensure efficient provision of health services.

ACOSS has supported a number of government initiatives: the provision under Medicare of Extended Primary Care items to encourage GPs to work with other health professionals on case management; the inclusion in MedicarePlus of Medicare payments to allied health services for people with chronic conditions; plans to train more GPs and allied health professionals; and the election policy to pay for 2-yearly health checks for Indigenous people.

Both the Prime Minister and Minister for Health have stated the Government's commitment to Medicare principles and the Coalition's election document (*100% Medicare*) stated that 'the Howard Government is committed to protecting and strengthening Medicare and delivering high quality, affordable health care to all Australians'. The Australian Government, through the Australian Health Care Agreements with the State and Territory governments, has established the principle that 'access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period'. ACOSS considers that a number of the Government's key policies are producing outcomes that are in conflict with the Government's objectives of affordable health care for all Australians by contributing to higher cost in the health care system and health care according to need.

Private health insurance policy and the Medicare Safety Net

The Private Health Insurance Subsidy is having serious consequences for lower income patients who are dependent on the public hospital system in accessing important medical and surgical treatments. Given the shortage of medical and nursing specialists, the significant increase in private hospital use by insured people has come about as a result of transferring resources from the public hospitals and patients to private hospitals and patients. Costs of services in private hospitals are higher than in public hospitals, thus contributing to higher inflation in total health expenditure.

The MedicarePlus Safety Net is contributing to price inflation of doctors' fees and distributing benefits inequitably. In the short time it has operated Safety Net payments are already much higher than the Government predicted, and some doctors have restructured so that they are eligible for the subsidy. Based on past experience, it is likely that there will be further increases in doctors' fees over and above the Medicare Schedule of fees and benefits, making access to services even more difficult for low income people. Safety Net payments have gone disproportionately to high income groups who already have better health and better access to health services than do low income groups.

In summary, ACOSS is concerned that:

- the Private Health Insurance Subsidy results in services being allocated to patients on the basis of ability to pay and not according to the principle of need
- the Private Health Insurance Subsidy does not have any mechanism to ensure that the private health service providers provide services in an efficient manner
- the MedicarePlus Safety Net is increasing the capacity of doctors to charge above the schedule fee and this reduces their willingness to provide services in the public sector and adds to escalating health care costs.

ACOSS recognises that the Australian Government is committed to maintaining the role of private health insurance in the health care system. Within this framework it is critical to that serious efforts are made to ensure equity of access to health care for all Australians and to improve efficiency of service delivery.

One way of achieving this would be for the Australian Government, in consultation with State and Territory governments and the community, to develop:

(i) A Charter of Medicare Entitlements which sets out:

- the principles which underpin a universal health insurance system in which the private sector has a major role
- Medicare Entitlements to Services – the services that the Commonwealth will fund for Australians, whether public or privately insured, and the maximum time that individuals should have to wait for service for major services (regardless of whether privately insured)
- the additional benefits, entitlements or privileges that are available to privately insured persons.

(ii) A Charter of Mutual Obligations which requires:

- the public and private sector to work together to ensure that services are allocated according to need and within the times specified in the Medicare Entitlements to Services, regardless of insurance status
- public and private health service providers who receive Commonwealth funding to meet efficiency and other standards set by the Commonwealth
- public and private sector health service providers to keep fees and charges to agreed levels (the Australian Health Care Agreements already define this for public sector providers)
- mechanisms by which the Commonwealth, States and Territories, and private sector providers will ensure that the elements of the Charter of Medicare Entitlements and Charter of Mutual Obligations will be implemented and enforced.

Review of Election and MedicarePlus Policies

The operations of the MedicarePlus Safety Net have already shown to be inappropriate: payments are much higher than predicted by the government; large subsidies go to people in high income electorates and low subsidies to people in low income electorates, despite the fact that people in high income areas already have higher standards of health and better access to health services; groups of doctors have already restructured their fees so that a larger proportion of fees are covered by Medicare; the Safety Net is likely to result in further inflation of doctors' fees in high income areas where doctors have traditionally charged above the scheduled fees.

The increase in the Private Health Insurance Subsidy for Older Australians announced in the election campaign further reduces the principle of access to health care according to need and strengthens the principle of access to care according to ability to pay. The proposal will further reduce the viability of private health insurance by encouraging people with high health care needs to join the funds while providing contributions less than the costs. Continuing instability of the private health insurance sector diverts attention from the need to find more equitable and cost efficient ways of providing health care for all Australians.

The equity and efficiency gains from implementing a Charter of Medicare Entitlements and a Charter of Mutual Obligations and reviewing Election Commitments in the health portfolio would free resources for greater and better investment in parts of the health system which would support better care for people with a mental illness.

Community-based health services, for example, are a critical part of Australia's health care system, providing vital preventative and allied health services in the community and the home. They also provide an alternative setting through which medical services can be delivered, for example, through the employment of salaried doctors or nurses in community health centres. Investment in community-based health care thus offers one avenue for offsetting the patchiness of bulk-billed GP services and would be a cheaper, more multi-disciplinary and more effective alternative to the current piecemeal approach of uncoordinated incentives to individual GPs.

The Australian Government should consider supporting community-based health services by investing substantial funds to drive enhancements in the availability, scope and standard of community based health care services. This should initially be targeted to areas of greatest need and aimed at overcoming the inequities in the distribution of health care resources, created by the combination of Medicare payments following the distribution of doctors, access to Pharmaceutical Benefits Scheme drugs following the distribution of dispensaries and the operation of private health insurance arrangements which favours wealthier areas over poorer areas.

Part 3: Mental health services and the roles of the various levels of government, the non-government sector and the private sector – Terms of reference (a), (b), (c), (d), (g), (h), (i), (m), (n), (o), (p)

[The material in this section of the submission is generalised and may not reflect the situation of mental health services in all States and Territories.]

Perceptions, realities and accountability

The National Mental Health Strategy has been useful because it has drawn attention to the right issues – through its information strategy and evaluation agenda, and through an independent expert review.

However, there appears to be some inconsistency between the data reported in the National Mental Health Reports and community perceptions. Current care systems are perceived to be chaotic, under-resourced and overly focused on providing brief periods of medicalised care, largely within acute care settings.

This suggests that the National Mental Health Reports may not fully capture the reality of stakeholder experience and this lack of broad-based ownership of mental health care and reform has resulted in problems associated with a perceived lack of accountability by States and Territories to the National Mental Health Policy and Plans. This problem is clearly compounded by the federated system of health care which results in the continual shifting of blame for inadequacies in the system to 'other' levels or 'other' areas of government. There are also concerns regarding the lack of visibility of the funding allocation of each State and Territory and the distribution of funding from the Commonwealth to the local level - information which would enable better management of funds and increase accountability.

Models of care: roles and responsibilities

Health services have sought to involve consumers at a number of levels in the health system. This has sometimes led to improvements in services but in general the models of care are not consumer oriented. The model of care is too often focussed on demand management for beds and not on properly resourced care in the community, where consumers take responsibility for their own care within a supportive network of services and supports. Consumer involvement requires investment of resources and a commitment for consumer views to influence vision and policy setting at all levels.

As noted above the specialist mental health sector is at the receiving end of failures in other sectors. There is real danger that a simplistic call for more beds, in a context of little or no extra funding, and an inadequate funding model, will mean resources sucked out of the places we want to grow them in – community rehabilitation, primary mental health care, non-government agencies. The reform agenda is well in place but the hard bit is the culture change and workforce planning that will support new models of care.

The specialist mental health sector is no different to other tertiary health services. In the same way that we do not expect (and do not want) heart surgeons to take responsibility for preventing heart attacks, the role of the specialist mental health sector is not to be responsible for the mental health of people in Australia. Mental

health is everyone's business. This idea is illustrated with (non-exhaustive) examples below.

The mental health continuum					
Intervention:	Prevention	Early identification and intervention	Acute treatment	Rehabilitation	Maintenance and support
Those with a role beyond health	Families Schools Child care Recreation Employment Etc	Families Schools Child care Employers Police NGOs (esp. first point of contact agencies such as Lifeline) Etc	Families Schools Police NGOs (esp. first point of contact agencies such as Lifeline) Etc	Families Schools Employers Housing Etc	Families Schools Employers Housing Etc
Other health sectors with a role	GPs Child health Community health Drug & alcohol Etc	Emergency departments Obstetric services GPs Etc	Emergency departments Obstetric services GPs Etc	Commonwealth Rehabilitation Service Health NGOs	GPs Pharmacists
Role of the specialist mental health sector	None, other than perhaps staff training (but even that is doubtful)	Triage and assessment Rapid and effective response to those experiencing their first episode of serious mental illness[18]	Acute treatment, either in an inpatient unit or in the community, depending on the circumstances	Structured and time limited programs that are designed to improve functioning and reduce disability[19]	Primary responsibility should be with mental health NGOs, but delivered in partnership with community mental health teams

[18] There is good evidence that effective treatment at first episode can reduce subsequent relapses and disability

[19] The international evidence suggests that rehabilitation is best delivered in the community, not in hospital. But effective rehabilitation requires more than just health care (eg. housing and employment)

A large part of the problem relates to the fact that models of care are still too specialised and separatist. Levels of support for non-government organisations are inadequate and uneven between the States and Territories and between areas in some States. Affordable supports are only likely to be available when the problem has become acute or the justice system is involved. There remains a severe shortage of community support services, especially those which are consumer initiated and managed, including housing, home help, recreation, family support, employment and education options for people with a mental illness and their families (see discussion in Part 1).

NGOs are increasingly being expected to take on the broader and more demanding responsibilities of supporting mental health consumers and their carers. However, funding for NGOs has not been commensurate with the increasing demands being placed on them. At the National Mental Health Summit held in May 2003, many consumers and carers expressed concern about consumer and carer organisations/ NGOs being under threat through funding cuts or through receiving inadequate funding in comparison with other areas and projects. Many felt that the survival of consumer and carer networks and NGOs was critical to community empowerment and to the success of the National Mental Health Strategy.

The Australian Community Sector Survey 2005 found a 9.2% increase in the services provided to people in 2003-4 compared with 2002-3 and demand for services has outstripped growth in expenditure (8.9%) and income (6.8%).[20] The corollary of this is that people are being turned away from agencies. Thirty-two per cent of survey respondents said that they had assisted all the people who sought assistance from their service while 68% said that they had not been able to do so.[21]

The majority of respondents to the survey (67%) reported an increase in the complexity of client need in 2003-4 when compared with 2002-3.[22] A lack of mental health services and supports was frequently reported by respondents as a major issue facing their service.

The services that NGOs provide are affected by the policies and programs of government agencies such as housing, education and training, employment, justice, police, community and disability services. These agencies have a role in assisting with the recovery of people with psychiatric disability. An attempt to align the policies and programs of these government departments so that they complement the Mental Health Strategy was made when relevant Ministers endorsed findings of the Mental Health Forum on Intersectoral Linkages. Little evaluation of this component of the Strategy has been undertaken, and the achievements have been limited.

The only realistic strategy to improve mental health services is to clearly delineate roles – government, non-government, specialist mental health, primary care. There also has to be a re-investment in changing the methods of delivery – the way that care

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[20] ACOSS (2005) *Australian Community Sector Survey 2005*, ACOSS Paper 138, pp2-3

[21] Ibid. p3

[22] Ibid. p3

is funded, organised and delivered. Funding models must encourage equity, effectiveness and efficiency, and there need to be coherent plans for mental health service funding - across both the Commonwealth and the States - to move systematically and progressively toward funding based either on population need or service outputs.

The corollary of role delineation in mental health is that other parts of the health system should be responsible for prevention, early intervention etc, with specialist services providing training and support if necessary. No doubt the committee will receive numerous submissions arguing that more specialist Mental Health Services are needed. The issue for the committee to judge is whether more specialist services are needed or whether what is needed is more effective intervention by the primary and secondary tiers of the health system and, more broadly, the human services beyond health.

Beds are important, but what is important about them is how they are managed. And they are only one part of a bigger picture. The best way to manage beds is not to open more beds. It is through providing better community services both before and after an admission and to stop an admission occurring. One goal is clear and fundamental to resolving the 'mental health crisis' in Australia – to reduce readmission rates. Unless this occurs, the system will remain in a perceived crisis. Mental health is poor at bed management – and a clear strategy for better bed management with step-down arrangements with non-government rehabilitation and disability services would improve things.

All of this suggests that mental health services policy must remain focussed on community and primary health care sector support for mental health service delivery. A more integrated health system is striven for but never completely achieved. There is an ongoing need for initiatives and incentives to achieve better integration between the public mental health sector, private psychiatrists, GPs, NGOs and others (eg. community health). The next step should be the gathering and dissemination of systematic evidence on what already works in practice and how it can be rolled out to settings where integration is poor.

For community-based treatment of people with an ongoing illness to be effective however, there needs to be access to a range of different services and supports - specialised mental health services, general medical services, housing, accommodation support, social support, community and domiciliary care, income security, and employment and training services can all have a significant impact on the capacity of a person with a mental illness or psychiatric disability to live in the community, free from discrimination and stigma.

Information and referral systems need to be attuned to this and data captured which enables planning and development of the appropriate mix of service types at a local level. In many instances, the provision of good quality and appropriate mental health services has been hijacked by a poor understanding of community needs which in turn results from poor planning and resource utilisation processes.

Planning and workforce issues

In some cases services are clearly not adequate – they may have contracted under the pressures of staff leaving and recruitment difficulties, or as a result of poor management and badly planned organisational changes. Whatever the cause, the resulting workforce issues are considerable.

Workforce planning and training is paramount. The biggest problem is with the recruitment and retention of nursing staff. One issue is the general shortage of nurses. Another is that, relative to other specialties, mental health nursing has low status and difficult working conditions.

An important complementary or alternative strategy to consider is to change the workforce profile altogether and to introduce other professional classifications (eg. personal care attendants) as seen in the disability and aged care sectors. While the current levels of training and support in these other sectors should not be seen as sufficient for the complexity and difficulty of the tasks, there is no reason to believe that the majority of mental health care needs to be delivered by nurses with 5 years of training.

The community care sector is developing its training agenda to include new competencies in assessment and case management as well as a range of issues like dealing with abuse, challenging behaviour, cultural sensitivity, standards monitoring and reporting. There are generic skills in relation to providing supported accommodation and maintenance and support services for people with disabilities, the homeless and young people at risk. Increasing the role of the NGO sector, and reinforcing the supporting role of the public mental health sector as specialists, would undoubtedly assist in developing a different (and potentially more cost effective) workforce profile.

People with a mental illness and the criminal justice system

The over-representation of people with a mental illness in the criminal justice system and in custody is a sign of broad policy failure. Better screening for mental illness and diversionary programs should be the priority for people who have already come into contact with the criminal justice system. Much greater investment in a range of accommodation options for people at risk, counselling services, drug and alcohol services and employment services, coupled with adequate income support should be the priorities at the prevention/early intervention end of the spectrum.

Detention and seclusion within mental health facilities

Protecting the rights of people in mental health facilities implies a much greater place for systemic advocacy for the rights of people affected by mental illness, within all facilities dealing with people with mental illness and their review bodies.

The proven practice in promoting engagement and minimising treatment refusal and coercion works on the basis that the person gets services and support that will actually help them. The fact is that the resources in the community just aren't there to see that

this happens. The prevailing model of care mitigates against it and there is no formula for the distribution of resources or regional planning to ensure that people get what they need in the community. Resources have to be provided to a level where the appropriate model of care can be implemented.

Stigma and mental illness

Organisations such as SANE Australia, beyondblue and the Brain and Mind Institute have done some excellent work in demonstrating strategies to de-stigmatise mental illness and provide information and support to people affected by mental illness and their families and carers.

However, there is little doubt that fear and prejudice about mental illness is still a significant concern and this reiterates the importance of moving from a model of care centred on mental health services to one which embraces a role for schools, workplaces, services, church and community groups etc in promoting good mental health, providing information about mental illness and ensuring a supportive environment for people with a mental illness.

The proficiency and accountability of agencies such as housing, employment, law enforcement and general health services in dealing appropriately with people affected by mental illness

The prevailing model of care for people affected by mental illness (with its focus on acute episodes of mental illness), the lack of clear role delineation and insufficient support for non-health services dealing with people affected by mental illness mitigates against these agencies being as proficient or as accountable as they should be in dealing appropriately with to people affected by mental illness.

As effective responses to people affected by mental illness require a coordinated response across agencies and sectors, there is a strong case for developing horizontal lines of accountability and perhaps less focus on vertical or programmatic accountability. However, it is essential to ensure that the burden of accountability on front-line workers is kept to a minimum by ensuring only necessary and appropriate information is collected and that service supports are in place to make this is efficient as possible. Support for accountability is assured where the loop is closed and accountability translates into service development and better support for front-line workers.

Data collection and monitoring

Currently the collection of data useful for planning and improving services is uneven across jurisdictions, and the role of the Australian Government can be one of encouraging better use of the utilisation and consumer outcome data that is already being collected. Under the mental health reforms to date we have seen improvements towards the use of more standardised and comparable data. More support should be given to the national repository where data is compiled so that it can be used to make more meaningful comparisons between agencies and across jurisdictions.

Services collecting data are more likely to be motivated by seeing a clear link between the data collected and improved service planning and investment, than by the threat of funding being withdrawn for failure to comply with national standards. Consumers, their families and carers are also likely to support the collection of data where the information gathered demonstrably leads to improvements in services.