

The Senate

---

Community Affairs  
References Committee

---

Inquiry into Commonwealth Funding and  
Administration of Mental Health Services

November 2011

© Commonwealth of Australia 2011

ISBN 978-1-74229-540-4

Senate Committee Office Secretariat:

Dr Ian Holland (Secretary)

Ms Christine McDonald (Committee Secretary)

Ms Toni Matulick (Committee Secretary)

Mr Gerry McInally (Principal Research Officer)

Ms Janice Webster (Senior Research Officer)

Ms Kyriaki Mechanicos (Senior Research Officer)

Ms Aleshia Bailey (Research Officer)

Ms Victoria Robinson-Conlon (Research Officer)

Ms Amy Welham (Research Officer)

Ms Penny Bear (Administrative Officer)

Ms Hanna Dibley (Administrative Officer)

Mr Tim Hillman (Administrative Officer)

Ms Jo-Anne Holmes (Administrative Officer)

Ms Hanako Jones (Administrative Officer)

Mr Michael Griffiths (Committee Resources Officer)

The Senate

Parliament House

Canberra ACT 2600

Phone: 02 6277 3515

Fax: 02 6277 5829

E-mail: [community.affairs.sen@aph.gov.au](mailto:community.affairs.sen@aph.gov.au)

Internet: [http://www.aph.gov.au/senate\\_ca](http://www.aph.gov.au/senate_ca)

This document was produced by the Senate Community Affairs Committee Secretariat and printed by the Senate Printing Unit, Parliament House, Canberra

# MEMBERSHIP OF THE COMMITTEE

## 43<sup>rd</sup> Parliament

### Members

Senator Rachel Siewert, Chair	AG, Western Australia
Senator Claire Moore, Deputy Chair	ALP, Queensland
Senator Judith Adams	LP, Western Australia
Senator Sue Boyce	LP, Queensland
Senator Carol Brown	ALP, Tasmania
Senator Bridget McKenzie	NATS, Victoria

### Participating Members for the inquiry

Senator Concetta Fierravanti-Wells	LP, New South Wales
Senator Penny Wright	AG, South Australia



# Table of Contents

<b>Chapter 1.....</b>	<b>1</b>
<b>Introduction .....</b>	<b>1</b>
Referral of inquiry .....	1
Conduct of inquiry.....	2
Privilege matters .....	2
Scope of inquiry .....	5
General views on the budget announcements .....	7
Consultation on mental health spending .....	8
<b>Chapter 2.....</b>	<b>11</b>
<b>Better Access Initiative.....</b>	<b>11</b>
Background to Better Access .....	11
Evaluation of Better Access .....	12
Changes to Better Access in the 2011–12 Federal Budget .....	14
<b>Chapter 3.....</b>	<b>29</b>
<b>Access to Allied Psychological Services program.....</b>	<b>29</b>
Introduction .....	29
<b>Chapter 4.....</b>	<b>45</b>
<b>Youth mental health .....</b>	<b>45</b>
Introduction .....	45
<i>headspace</i> .....	45
Early Psychosis Prevention and Intervention Centre (EPPIC).....	52
<b>Chapter 5.....</b>	<b>61</b>

<b>National Mental Health Commission .....</b>	<b>61</b>
Introduction .....	61
Membership and representation .....	62
Accountability and operation .....	64
<b>Chapter 6.....</b>	<b>69</b>
<b>Two-tiered Medicare rebate system for psychologists.....</b>	<b>69</b>
Introduction .....	69
Training to be undertaken by psychologists providing rebatable services under the Better Access initiative.....	70
Two-tiered Medicare rebate system for psychologists—debate .....	73
<b>Chair's Additional Comments .....</b>	<b>79</b>
Introduction .....	79
Better Access .....	79
Access to Allied Psychological Services.....	80
Youth Mental Health .....	82
National Mental Health Commission .....	83
Two-tier rebate for psychologists.....	83
<b>Minority Report .....</b>	<b>85</b>
<b>Australian Labor Party.....</b>	<b>85</b>
<b>Dissenting Report by Coalition Senators.....</b>	<b>87</b>
Chair's Report .....	87
Better Access Initiative.....	87
Evaluation of Better Access .....	89
Changes to the Better Access Initiative.....	91
General views on the budget announcements .....	92
Consultation on mental health spending .....	93
Access to Allied Psychological Services (ATAPS) .....	101

Youth mental health .....	106
<i>headspace</i> .....	106
Early Psychosis Prevention and Intervention Centre (EPPIC).....	108
National Mental Health Commission .....	109
Two-tiered Medicare rebate system for psychologists.....	112
Conclusion .....	113
<b>APPENDIX 1 .....</b>	<b>115</b>
<b>Submissions Received.....</b>	<b>115</b>
<b>Additional Information .....</b>	<b>148</b>
<b>Answers to Questions on Notice .....</b>	<b>149</b>
<b>APPENDIX 2 .....</b>	<b>151</b>
<b>WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC     HEARINGS.....</b>	<b>151</b>



# Chapter 1

## Introduction

### Referral of inquiry

1.1 On 22 June 2011, the Senate referred the following matter to the Community Affairs References Committees for inquiry and report:

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

- a) the Government's 2011–12 Budget changes relating to mental health;
- b) changes to the Better Access Initiative, including:
  - i. the rationalisation of general practitioner (GP) mental health services;
  - ii. the rationalisation of allied health treatment sessions;
  - iii. the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs; and
  - iv. the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;
- c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
- d) services available for people with severe mental illness and the coordination of those services;
- e) mental health workforce issues, including:
  - i. the two-tiered Medicare rebate system for psychologists,
  - ii. workforce qualifications and training of psychologists, and
  - iii. workforce shortages;
- f) the adequacy of mental health funding and services for disadvantaged groups, including:
  - i. culturally and linguistically diverse communities,
  - ii. Indigenous communities, and
  - iii. people with disabilities;
- g) the delivery of a national mental health commission; and

- h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and
- i) any other related matter.

1.2 The reporting date for the inquiry was originally set as 16 August 2011; this date was subsequently extended to 20 September 2011, and again until 20 October 2011. The committee tabled an interim report on 20 October, indicating that the final report would be tabled by 28 October. A second interim report was presented on 28 October 2011 to give the committee time to fully consider the evidence to the inquiry.

### **Conduct of inquiry**

1.3 The inquiry was advertised in *The Australian* and on the internet. The committee also wrote directly to a number of organisations and individuals inviting submissions to the inquiry. The committee received over 1500 submissions as well as form letters, other correspondence and additional information. The committee held two public hearings, the first in Melbourne on 19 August 2011 and the second in Canberra on 5 September 2011.

1.4 The large volume of evidence provided to the committee has delayed completion of the processing of submissions. In a later sitting week there will be a supplementary tabling of evidence received.

### **Privilege matters**

1.5 In mid-July 2011 the committee was considering the submissions that it had received. The committee noted that over ten submissions incorrectly stated that the committee had reached a conclusion:

The Senate Community Affairs Committee has concluded that there are no grounds for the two-tiered Medicare rebate system for psychologists and recommends the single lower rate for all psychologists including clinical psychologists.<sup>1</sup>

1.6 The committee established that these submissions had been prepared in response to a newsletter circulated via email by Mr Cichello from the Australian Psychological Society's College of Clinical Psychologists (CCP). This newsletter had presented a hypothetical scenario, intended to encourage CCP members to make submissions to the inquiry, but was widely misconstrued as implying that the committee had prejudged the issue.

1.7 Once the committee became aware of the source of this problem, it made contact with the Australian Psychological Society (APS) and was advised that there

---

1 For example, Natalie McCall, *Submission 24*, p. 1.

---

had already been clarification within the organisation to address the misconception. As the newsletter was by this time some days old, the committee took the view that there was no merit in trying to correct the record to the original email distribution list. While it meant that the committee received submissions that inaccurately described the committee's work, this did not actually interfere with that work. The committee decided to place on its submissions webpage a notice stating: 'The committee advises that, contrary to some submissions, it has made NO recommendation regarding the two-tiered rebates system'.<sup>2</sup>

1.8 On 24 July, the Australian Association of Psychologists Incorporated (AAPI) sent a newsletter by email to a distribution list that comprised a large number of psychologists (not only its own members), and placed the newsletter on its website. The email / newsletter included the following:

Reading the submissions already received by the Senate Inquiry, one can quickly and easily ascertain how many of our 'clinical colleagues' view the 86% of their non 'clinical' colleagues.

We will be presenting to our readers some of the more interesting comments over the next few weeks, along with the names of the people who have made such arbitrary and derogatory statements. Their comments and names are already publicly available on [the committee website]...

Treat yourself to their collective wisdom by reading their submissions on the above webpage. If you feel inspired to lodge complaints to the PBA about their unethical conduct, you may like to familiarise yourself with Sections C.1.2, C.2.1, C.2.3.a.b.d & f; as well as the expectations that psychologists conduct themselves in ways which respect the rights and dignity of all others, with propriety and integrity. You will get plenty of material from reading their submissions for ethics complaints. All such complaints need to be assessed by the PBA.

As most, if not all of these people are members of the APS; you might consider sending the same ethics complaints on to their professional body that developed the Code of Ethics...

...

AAPi will be naming the 'clinical' psychologists who denigrate most of Australia's psychologists in their submissions to the Senate Inquiry, to assist you in deciding who you want your training funds to go to.

1.9 Within 48 hours of the emailed newsletter being distributed, the committee had received complaints about the newsletter from representatives of two different professional associations, including Mr Cichello. It also received complaints from

---

2 Senate Community Affairs References Committee, Commonwealth Funding and Administration of Mental Health Services: Submissions received by the Committee, [http://www.aph.gov.au/senate/committee/clac\\_ctte/comm\\_fund\\_men\\_hlth/submissions.htm](http://www.aph.gov.au/senate/committee/clac_ctte/comm_fund_men_hlth/submissions.htm) (accessed 16 October 2011)

individuals who believed the message was threatening them or their professional practice.

1.10 The issue was further complicated by the fact that the Mr Cichello had emailed members of the CCP on or around 25 July, drawing their attention to the AAPI newsletter and advising them that he had complained about it to the committee. Some of his organisation's members, concerned about the AAPI newsletter, then wrote to the committee asking that their names be withheld from their submissions, or that their submissions be made confidential.

1.11 On 26 July, the committee held a private meeting, at which it agreed to write immediately to the AAPI, asking them to email a message to their distribution list:

- Indicating that they have withdrawn their most recent newsletter as it may have led some psychologists to believe they were being threatened or attacked over evidence they had given to the Senate inquiry;
- Stating that it was not the AAPI's intention to make any such threat;
- Explaining the requirements of privilege resolution 6(10) and section 12 of the Parliamentary Privileges Act 1987; and
- Encouraging their members to make submissions to the inquiry should they so wish.

1.12 The committee also wrote to Mr Cichello, asking him to email his members:

- Indicating that the Community Affairs Committee had reminded all parties participating in its inquiries, including the Australian Association of Psychologists Inc, of the requirements of privilege resolution 6(10) and section 12 of the Parliamentary Privileges Act 1987; and
- Encouraging their members to make submissions to the inquiry should they so wish.

1.13 On the evening of 26 July, the AAPI complied with the committee's request both by issuing a corrective email and removing the 24 July newsletter from their website. Mr Cichello likewise immediately sent out an email in response to the committee's request.

1.14 Also on 26 July, the committee wrote a general letter to all four psychology associations it had been dealing with to that point: the AAPI, the CCP, the CCP's parent organisation the Australian Psychological Society (APS), and the Australian Clinical Psychology Association (ACPA). The letter stated in part:

The committee is taking this opportunity to draw to the attention of stakeholders the Senate Privilege Resolutions... Of most relevance are resolutions one and six, which concern procedural protection of witnesses, and matters constituting contempt.

If, at any stage, you have any concerns about the conduct of any party in relation to the committee's inquiry, you should bring these concerns directly to the attention of the committee, and let the committee deal with them.

1.15 Unfortunately, this did not represent the end of the matter. Over subsequent weeks the committee received a number of communications from psychologists, complaining about the conduct of members of their own and other organisations. Subjects of the complaints included representatives of the AAPI, the CCP, the APS, and some individuals. Some of this correspondence reflected professional disagreements and debates about submitters' evidence. These were generally accepted as supplementary submissions and answers to questions on notice, which have been published by the committee.

1.16 However, there were also complaints that individuals were being threatened with penalties as a result of their evidence to the committee. The threats included the possibility of loss of office within organisations. As a result of some of these complaints, the committee provided oral advice to a range of parties and on 12 August 2011 wrote to the Australian Psychological Society and to the chairs of its individual colleges, reiterating the importance of parliamentary privilege and the protection of witnesses. It wrote to the APS on a third occasion on 23 August 2011 for a similar purpose.

1.17 Despite the committee's swift response to several complaints, it continued to receive emails and phone calls, right up to the time of tabling the report, from submitters wanting their names withheld or removed from the committee's website, or for their submissions to be made confidential. A significant proportion of these emails and calls appeared to stem from disquiet over the actions of professional associations, particularly the AAPI.

1.18 The committee wishes to place on record that the actions of numerous parties within the psychology profession caused considerable frustration for the committee, anxiety for submitters, and reflected poorly on most of the professional bodies involved. The events above caused significant additional work for the committee without any benefit to its consideration of the terms of reference.

1.19 On balance the committee decided not to seek a referral of any of the above matters to the Senate Committee of Privileges because, while many of the actions involved may constitute potential contempts, the committee's main concern—the obtaining of evidence—as not significantly impeded. While large numbers of submitters sought a change in the status of their submissions (to name withheld or confidential) very few sought to withdraw from the process. On the contrary, several submitters appeared to have been provoked into making submissions because they were angry about the conduct of individuals or organisations.

1.20 The committee advises the professional associations that it remains vigilant regarding any penalties imposed on a witness as a result of evidence given to this inquiry.

### **Scope of inquiry**

1.21 The Government's 2011–12 Federal Budget includes a commitment to *National Mental Health Reform*. Most of the Terms of Reference for the inquiry are

related to, or affected by, funding changes made in the budget.<sup>3</sup> The Government explains in the budget papers that the major goal of the *National Mental Health Reform* is to address service gaps in the mental health care system, with a particular focus on early intervention and addressing the needs of priority groups.<sup>4</sup>

1.22 Priority groups identified in the budget papers include:

- People with a severe and persistent mental illness;
- Young people (under 25);
- Men;
- Indigenous people;
- People from Culturally and Linguistically Diverse (CALD) backgrounds;
- Carers of people with a mental illness;
- Residents of rural and remote areas;
- People living in low income areas; and
- People with a disability.<sup>5</sup>

1.23 As well as stating its immediate goals for mental health reform, the Government also plans to develop a ten year reform roadmap for mental health. This will be informed by the results of the current reform agenda, data analysis, research, and the advice of a National Mental Health Commission also established through funding provided in the 2011–12 budget.

1.24 The first of the two major programs affected by the budget changes is the Better Access Initiative. This is a program designed to encourage patient referrals between GPs, psychologists, clinical psychologists, social workers and occupational therapists, and to promote mental health education and training for health professionals.<sup>6</sup> The program expands services that attract a rebate under the Medicare Benefits Schedule (MBS), and like other MBS items often involves a co-contribution by the consumer. The program is not capped by government.

1.25 The second program is the Access to Allied Psychological Services (ATAPS) program. This has been in existence since 2002 and was designed to fund 'short term

---

3 All Terms of Reference have some link to the 2011–12 budget changes except for items (i) and (ii) of 'mental health workforce issues'. These issues are addressed in Chapter 4.

4 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 3.

5 Several of these priority groups were identified as traditionally underserved by Medicare. *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, pp 10–14.

6 Department of Health and Ageing, *Better Access to Psychiatrists, Psychologists & General Practitioners through the Medical Benefits Schedule Initiative*, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1> (accessed 5 August 2011).

---

psychology services for people with mental health disorders through a capped fundholding arrangement delivered through Divisions of General Practice'.<sup>7</sup> The ATAPS projects enable GPs to refer patients with high prevalence disorders such as depression and anxiety to allied health professionals (predominantly psychologists).<sup>8</sup> The program is not funded through the MBS and does not generally attract a co-contribution from consumers.

## **General views on the budget announcements**

1.26 There was a mixed reaction for the budget announcements with broad support for the overall increase in the mental health budget, qualified by some stakeholders who objected to aspects of the detailed proposals. Consumer organisations in particular welcomed the focus in improving mental health in Australia. The Mental Health Council of Australia expressed the view that the announcements were:

...an important step towards improving the mental health system and the mental health of all Australians. They reflect a commitment by the Government to improving mental health and increasing the availability of mental health services in Australia.<sup>9</sup>

1.27 The Consumer Health Forum agreed with the view that changes will have benefits for mental health consumers:

The Federal Government's 2011-12 Budget promised a range of new initiatives for mental health services that will result in improved outcomes for many Australians.<sup>10</sup>

1.28 The Public Health Association of Australia also concurred that the changes demonstrate a commitment to improving mental health:

The overall changes to the Federal Mental Health Budget are justified and the focus on mental health is welcomed by PHAA.<sup>11</sup>

1.29 The Australian College of Mental Health Nurses stated:

When the Government's mental health reform package was announced as part of the Budget in May 2011, the ACMHN welcomed and supported this investment in improving services and support for people with mental health issues.<sup>12</sup>

---

7 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*—February 2010, p. 3.

8 Department of Health and Ageing, *Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Sixteenth Interim Evaluation Report, July 2010, p 3.

9 Mental Health Council of Australia, *Submission 198*, p. 2.

10 Consumers Health Forum of Australia, *Submission 179*, p. 1.

11 Public Health Association of Australia, *Submission 195*, p. 4.

12 Australian College of Mental Health Nurses, *Submission 447*, p. 2.

1.30 Similarly, the Australian Nursing Federation strongly endorsed the package:

The Australian Nursing Federation (ANF) has welcomed the Australian Government's additional \$1.5 billion budgetary commitment to Australia's mental health services. The raft of new initiatives announced in the 2011/12 Budget will help provide much-needed social and clinical support for mental health across the country.<sup>13</sup>

1.31 The Australian Medical Association, the Royal Australian College of General Practitioners, as well as the Australian Psychologists Society all expressed concerns about the impact of the changes to the Better Access initiative. The AMA requested that the committee:

...recommend that the Government reverse its 2011/12 Federal Budget decision to cut Medicare funding for mental health services delivered by GPs and psychologists under the Better Access Program.<sup>14</sup>

1.32 The Australian Psychological Society urged the committee to:

...focus its attention on the Federal Budget cuts to the Better Access initiative as these are due to come into effect on 1 November 2011 and will deny effective psychological treatment to an estimated 87,000 people per annum from this date.<sup>15</sup>

1.33 While the Royal Australian College of General Practitioners said that:

The College is gravely concerned regarding the proposed cuts to the Better Access program and the subsequent impact on mental health delivery for every patient age group, demographic, and geography throughout Australia.<sup>16</sup>

### **Consultation on mental health spending**

1.34 In 2008, the Government established the National Advisory Council on Mental Health (NACMH). Granted \$2.4 million over three years as part of a 2007 Federal Election commitment, the Council:

...provide[s] a formal mechanism for the Australian Government to gain independent advice from a wide range of experts to inform national mental health reform.<sup>17</sup>

---

13 Australian Nursing Federation, *Submission 542*, p. 1.

14 Australian Medical Association, *Submission 185*, p. 1.

15 Australian Psychological Society, *Submission 159*, p. 3.

16 Royal Australian College of General Practitioners, *Submission 172*, p. 3.

17 Department of Health and Ageing, *National Advisory Council on Mental Health*, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/National+Advisory+Council+on+Mental+Health> (accessed 7 October 2011).

1.35 The NACMH is chaired by the Hon Mark Butler MP, Minister for Mental Health and Ageing. Appointed members were:

Mr Michael Burge; Monsignor David Cappo AO, Deputy Chair; Associate Professor Neil Cole; Ms Adele Cox; Mr David Crosbie; Professor Allan Fels AO; Professor Ian Hickie AM; Professor Lyn Littlefield OAM; Adjunct Professor John Mendoza, former Chair;<sup>18</sup> Professor Helen Milroy; Ms Dawn O'Neil AM; Dr Rob Walters.<sup>19</sup>

1.36 In December 2010, the Mental Health Expert Working Group was established specifically to provide advice on mental health reform in the lead-up to the 2011–12 Federal Budget. Membership of this group comprised:

Dr Christine Bennett; Monsignor David Cappo AO; Dr Pat Dudgeon; Mr Anthony Falker; Mr Toby Hall; Professor Ian Hickie AM; Professor Lyn Littlefield OAM; Ms Janet Maher; Dr Christine McAuliffe; Professor Patrick McGorry; Professor Frank Oberklaid; Ms Sally Sinclair.<sup>20</sup>

1.37 The Terms of Reference for the expert group were determined as follows:

The Mental Health Expert Working Group (MHEWG) is being established as a time-limited working group to provide confidential, strategic and practical advice to the Australian Government to inform mental health reform directions and decisions.

The MHEWG will provide significant input to the Australian Government about how to achieve well coordinated, cost-effective and lasting reforms to mental health care across a broad range of clinical and non clinical service systems with the aim of developing a strong, sustainable system now and into the future.<sup>21</sup>

1.38 Questions were asked by some submitters during the inquiry as to why it was necessary to establish a new group to provide advice on the above matters rather than consult the NACMH. In response to a question about how the membership of the expert group was determined, the Department of Health and Ageing responded:

Twelve members were appointed by the Minister for Health and Ageing, as individual experts on broader social care and participation issues affecting

---

18 Adjunct Professor John Mendoza tendered his resignation from the Council on 18 June 2010.

19 Department of Health and Ageing, *National Advisory Council on Mental Health*, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/National+Advisory+Council+on+Mental+Health> (accessed 7 October 2011).

20 Ms Jane Halton, Secretary, Department of Health and Ageing, *Estimates Hansard*, 30 May 2011, p. 71.

21 Department of Health and Ageing, *Answer to a question on notice*, 30 May 2011, received 26 July 2011. The answer to question E11- 219 has not been quoted in full; see Senate webpage [http://www.aph.gov.au/Senate/committee/clac\\_ctte/estimates/bud\\_1112/DoHA/index.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/estimates/bud_1112/DoHA/index.htm) for the answers to eight written questions on notice in relation to the Mental Health Expert Working Group.

people with mental illness. Membership was settled in consultation with other relevant Commonwealth Portfolios.<sup>22</sup>

1.39 However, other submitters were dissatisfied with its composition:

This submission refutes the defence that this group are independent and impartial including proffered explanation that the group are picked from a small academic mental health sector. There are nearly forty Australian Universities who could make solid contribution to a mental health policy expert panel...

This issue is considerably more significant than concerns about conflict of interest. The mental health reform agenda is intrinsically based in closed, non-consultative and exclusive process which is part of the larger imposed shift of health reform....<sup>23</sup>

1.40 The Department rejected the suggestion that such a group could comprise members without any perceived conflict of interest:

Everyone here declared their conflict of interest. Let us be very clear. Mental health is not a large community. Everyone, in some way, is conflicted because everyone is involved in the delivery of service. All of these people are passionate advocates, and good on them, because they care about the delivery of service. What we did and what the minister did with this process was actually try to get a balanced view about how you deliver a balanced package to meet mental health needs, and the important thing that came out of this was an acknowledgement that mental health is not just a health issue. Mental health is an employment issue, a housing issue, an issue of income, an issue of social justice and I could go on.<sup>24</sup>

---

22 Department of Health and Ageing, *Answer to a question on notice*, 30 May 2011, received 25 July 2011.

23 Name Withheld, *Submission 483*, pp 24–25.

24 Ms Jane Halton, Secretary, Department of Health and Ageing, *Estimates Hansard*, 30 May 2011, p. 72.

# Chapter 2

## Better Access Initiative

### Background to Better Access

2.1 The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme initiative (Better Access) is a central part of the Australian Government's contribution to COAG's National Action Plan on Mental Health (2006–11).

2.2 The purpose of Better Access is to integrate allied health and GP services to improve the treatment and management of mental health, by expanding the services that attract a rebate under the Medicare Benefits Schedule (MBS). The expansion of such services was designed to encourage patient referrals between GPs, psychologists, clinical psychologists, social workers and occupational therapists, and to promote mental health education and training for health professionals.<sup>1</sup> The initiative commenced on 1 November 2006. Changes were made in 2009 that enabled GPs with specific mental health training to claim higher rebates.

2.3 Under Better Access, new (rebatable) Medicare items were introduced that enable:

- GPs to provide mental health assessments and to develop and implement treatment plans;
- Clinical psychologists to provide therapy;
- Psychologists, social workers, GPs and occupational therapists to provide focussed psychological strategies services; and
- Psychiatrists to see new patients for an initial consultation.<sup>2</sup>

2.4 Such items may be provided to eligible patients for up to 12 individual and 12 group sessions per year (plus an additional 6 sessions in exceptional circumstances).<sup>3</sup>

---

1 Department of Health and Ageing, *Better Access to Psychiatrists, Psychologists & General Practitioners through the Medical Benefits Schedule Initiative*, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1> (accessed 5 August 2011).

2 Department of Health and Ageing, *Better Access to Psychiatrists, Psychologists & General Practitioners through the Medical Benefits Schedule Initiative*, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1> (accessed 5 August 2011).

---

## Evaluation of Better Access

2.5 In 2009, the Department of Health and Ageing tendered for consultants to evaluate seven components of the Better Access program. The evaluation was undertaken by researchers from the University of Melbourne (components A, A.2, B and E), Flinders University (component C), KPMG (component D), and the Department (component F). A summative evaluation, undertaken by a consortium of researchers from the University of Melbourne and the University of Queensland, was released in mid-February 2011.<sup>4</sup> The evaluation was overseen by a Project Steering Committee convened by the Department, comprising nine members with 'specific experience, expertise and knowledge in relation to program evaluation and the delivery of mental health services'.<sup>5</sup>

2.6 The evaluation synthesised data from twenty sources to provide responses to three key questions:

- Has Better Access improved access to mental health care?
- Is Better Access an effective (and cost-effective) model of service delivery?
- Has Better Access had an impact on the profile and operation of Australia's mental health workforce?<sup>6</sup>

2.7 The evaluation concluded that the initiative has improved access to mental health care, and the Better Access model has had a generally positive impact on service delivery and the mental health workforce.<sup>7</sup> More detailed findings relevant to the inquiry included:

- Since the introduction of Better Access, more people have accessed mental health services. The uptake of the rebatable sessions has been high and

---

3 Department of Health and Ageing, *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) Initiative—Overview*, <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-over> (accessed 5 August 2011).

4 Department of Health and Ageing, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: questions and answers*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-ques#15> (accessed 5 August 2011).

5 Department of Health and Ageing, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: questions and answers*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval-ques#15> (accessed 5 August 2011).

6 Dr Jane Pirkis, Dr Meredith Harris, Dr Wayne Hall and Dr Maria Ftanou, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, 22 February 2011, p. 2.

7 Dr Jane Pirkis et al, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, 22 February 2011, p. 44.

increasing: 2.7 million, 3.8 million and 4.6 million Better Access services were delivered in 2007, 2008 and 2009 respectively.

- Many Better Access consumers are suffering from anxiety or depression, and are experiencing significant psychological distress, that is, moderate to severe rather than mild symptoms.
- Better Access has gone some way to providing services to people on low incomes, living in regional areas or for other reasons not previously accessing Medicare services.
- Of the consumers who accessed services, most accessed between one and six consultations (72.7 per cent).
- According to the evaluation, Better Access services appear to deliver better health outcomes in a cost-effective manner.<sup>8</sup>

2.8 These findings were qualified by the suggestion, repeated several times throughout the summative evaluation, that limitations in available data prevented the authors from drawing comprehensive conclusions about the effectiveness of any aspect of the program.<sup>9</sup>

2.9 A list of the strengths and weaknesses of each data source was presented in Table 1 in the report. The strengths listed in relation to many of the data sources include: large and representative sampling; use of MBS to provide useful data; and the unique nature of the data collected. Common weaknesses were identified as: selection bias or reliance on self-reporting; a lack of potential to track any change or improvement over time; and difficulties in inferring conclusive information about Better Access from the data.<sup>10</sup>

2.10 Several submitters commented on what they considered weak aspects of the methodology or limitations of the data.<sup>11</sup> The methodology of the study was the target of particular criticism:

---

8 Department of Health and Ageing, *Key findings from the program evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Fact Sheet*, <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-eval-fact#key> (accessed 5 August 2011).

9 Dr Jane Pirkis et al, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, 22 February 2011, for example, p. 6.

10 Dr Jane Pirkis et al, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, 22 February 2011, pp 14,16–20.

11 For example, see Mrs Katrina Frost, *Submission 60*, p. 2.; Mental Health Council of Australia, *Submission 198*, p. 6.

The recent evaluation of BA did not proceed according to scientifically accepted methods, the latter crucial for establishing the most accurate results. We believe the conclusions drawn are readily disputed based on the very poor methodology of the evaluation and therefore of limited value as a basis for decision-making going forward.<sup>12</sup>

2.11 As well as the methodology, the findings of the study are also open to interpretation. For example, some commentators welcomed the evidence that Better Access increased mental health services in rural areas, as well as its significant uptake rate overall. Other commentators were concerned that mental health services in rural areas remain less accessible than in metropolitan areas, and that the significant uptake of Better Access overall has been very expensive. The Government made significant changes to its mental health spending in the 2011–12 Federal Budget, and used findings of the evaluation demonstrating the significant expense of Better Access to support its rationalisation of the initiative.<sup>13</sup>

### **Changes to Better Access in the 2011–12 Federal Budget**

2.12 In its 2011–12 Budget statement, the Government stated that Better Access is an increasingly costly program, and that it has not been fully effective in addressing the mental health needs of all target groups.<sup>14</sup> To address this cost issue, and increase access to mental health care to groups such as Indigenous people, people in regional Australia and people on low incomes, the Government redirected funding from Better Access towards other programs.<sup>15</sup> Savings from Better Access will fund a quarter of the mental health package over the forward estimates period.<sup>16</sup> Programs awarded significant funding increases include Access to Allied Psychological Services (ATAPS), *headspace*, and Early Psychosis Prevention and Intervention Centres (EPPIC), which are discussed in chapters 3–4.

2.13 The savings are gained from two major changes to Better Access:

- The rationalisation of services provided by GPs by introducing time-dependent rebates (allocating separate Medicare items to consultations taking between 20 and 39 minutes, and those taking 40 minutes or more); and

---

12 Nicholas Allen, Henry Jackson, Eoin Killackey and Raymond Rudd, *Submission 657*, p. 2.

13 While acknowledging the limitations of the available data in their evaluation, two of its authors subsequently reflected favourably on the government's budgetary reform to Better Access. Dr Jane Pirkis and Dr Meredith Harris, *Were the budgetary reforms to the Better Access to Mental Health Care initiative appropriate? YES*, Medical Journal of Australia, 12 May 2011, [http://www.mja.com.au/public/issues/194\\_12\\_200611/pir10582\\_fm.html](http://www.mja.com.au/public/issues/194_12_200611/pir10582_fm.html) (accessed 11 October 2011).

14 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 20.

15 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 21.

16 Dr Lesley Russell, *Mental health provisions in the 2011–12 budget*, Menzies Centre for Health Policy, May 2011, p. 1.

- The rationalisation of MBS rebatable allied health services sessions—from 12 individual and 12 group sessions, plus an additional 6 sessions in exceptional circumstances—to a maximum of 10 with no provision for exceptional circumstances.<sup>17</sup>

2.14 The following section discusses each of these changes, and the arguments in support of and against the changes that were made in the course of the inquiry.

### ***Rationalisation of GP mental health services—new time dependent rebates***

2.15 The budget measures lower the fees charged and rebates applicable to all mental health items provided by GPs, introducing a timed rebate system. In making these amendments, the Government has sought to align mental health consultation rebates more closely with standard consultation rebates; GPs will receive the same rebate for a mental health consultation as they would for a standard Level C or D consultation of the same length.<sup>18</sup> However, a relatively higher rebate will be available to GPs who have undertaken specific mental health training.<sup>19</sup> The two-tier rebate system refers to the standard rebate available to GPs who have completed the mental health skills training—tier one—in comparison with that available to those who have not—tier two.

2.16 A comparison between the current charges for mental health consultations and the new timed charges is presented below. It should be noted that these figures represent the total fees charged by GPs, not the total amount charged to the patient; the Medicare rebate is 75 per cent of the total cost for items 2702, 2710 and 2712 and 100 per cent of the cost of item 2913.<sup>20</sup>

---

17 Department of Health and Ageing, *Fact Sheet: Rationalisation of Allied Mental Health Services Under Better Access: 2011–12 Budget Measure*, May 2011.

18 MBS Online, *Medicare Benefits Schedule—Note A5: Attendances by General Practitioners* <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=A5&qt=noteID&criteria=standard%20consultation> (accessed 7 September 2011).

19 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 22; Department of Health and Ageing, *Changes to Rebates For GP Plans*, <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2011-factsheet02.htm> (accessed 2 September 2011).

20 Department of Health and Ageing, *Medicare Benefits Schedule Book*, Operating from 1 July 2011, <http://www.health.gov.au/mbsonline> (accessed 7 September 2011).

Item	Current untimed total fee charged by GPs who <b>have not</b> completed mental health skills training	Current untimed total fee charged by GPs who <b>have</b> completed mental health skills training	New timed total fee charged by GPs who <b>have not</b> completed mental health skills training	New timed total fee charged by GPs who <b>have</b> completed mental health skills training
<b>2702:</b> GP Mental Health Treatment Plan taking 20 to 39 minutes <sup>21</sup>	\$128.20	\$163.35	\$67.65 (-\$60.55)	\$85.92 (-\$77.43)
<b>2710:</b> GP Mental Health Treatment Plan taking 40 minutes or longer <sup>22</sup>	\$128.20	\$163.35	\$99.55 (-\$28.65)	\$126.43 (-\$36.92)
<b>2712:</b> GP Mental Health Review <sup>23</sup>	\$108.90	\$108.90	\$67.65 (-\$41.25)	\$67.65 (-\$41.25)
<b>2913:</b> GP Mental Health Consultation <sup>24</sup>	\$71.85	\$71.85	\$67.65 (-\$4.20)	\$67.65 (-\$4.20)

### *Use of BEACH data*

2.17 The Government has made these changes noting the *Bettering the Evaluation and Care of Health* (BEACH) report, which was one of the twenty data sources used to compile the summative evaluation of Better Access (detailed earlier). The BEACH report indicated that over 80 per cent of GP mental health treatment plans were being completed in less than 40 minutes, with an average time of 28 minutes.<sup>25</sup>

21 Department of Health and Ageing, *Submission 199*, p. 6; Department of Health and Ageing, *Changes to Rebates For GP Plans*, <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2011-factsheet02.htm> (accessed 1 September 2011).

22 Department of Health and Ageing, *Submission 199*, p. 6; Department of Health and Ageing, *Changes to Rebates For GP Plans*, <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2011-factsheet02.htm> (accessed 1 September 2011).

23 Department of Health and Ageing, *Changes to Rebates For GP Plans*, <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2011-factsheet02.htm> (accessed 1 September 2011).

24 Department of Health and Ageing, *Changes to Rebates For GP Plans*, <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2011-factsheet02.htm> (accessed 1 September 2011).

25 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 22.

2.18 The Australian Medical Association (AMA) was concerned that the BEACH data referred to above does not accurately reflect the total time spent by GPs on mental health treatment plans, just the face-to-face time spent with a patient.<sup>26</sup> The AMA, and other GP representative groups such as the Royal Australian College of General Practitioners claim that the Government has misinterpreted the BEACH data and that the changes devalue mental health care.<sup>27</sup> Further, a survey undertaken by the AMA itself indicates that the average time spent by GPs developing mental health plans is closer to 35 minutes with the patient as well as an additional 17 minutes spent developing the plan, co-ordinating patient care and other related work.<sup>28</sup>

2.19 The Department of Health and Ageing (DoHA) responded to the suggestion that the data had been misinterpreted. Mr Bartlett from DoHA said:

All BEACH data is face-to-face time. None of it includes non-face-to-face time. All consultations include a non-face-to-face element. There is debate about how much that is. The AMA over a period of time has suggested that you can split it up 75 face-to-face, 25 non-face-to-face. As I said earlier, when you work through that there is a difference between a level C consultation as an example and a mental health treatment plan in terms of non-face-to-face if you accept the AMA's 18-minute response from the survey, but the difference is considerably smaller than something or nothing. So I think that the use of BEACH data in that way is not invalid.<sup>29</sup>

### *Workforce implications*

2.20 *headspace*, amongst other submitters, objected to the changes on the basis that they might exacerbate workforce difficulties. *headspace*'s submission explained that it is very difficult to attract GPs into youth mental health care, and that reducing the rebate rate, by up to 47 per cent, would act as a further disincentive for GPs to work within the *headspace* mental health care model.<sup>30</sup>

2.21 Similarly, the Rural Doctors Association of Australia (RDAA) was concerned about the rationalisation of GP services under Better Access because of the lack of specialist services in rural and remote areas, and the reliance on GPs with advanced

---

26 The AMA quote the head of the BEACH program, Associate Professor Helena Britt, in an interview in the *Medical Observer*, where she suggests that the '28 minute' average refers only to face-to-face time. Australian Medical Association, *Submission 185*, p. 11.

27 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 19 August 2011, pp 2–5; Dr Steve Hambleton, Federal President, AMA, *Committee Hansard*, 5 September 2011, p. 76.

28 Essential research (2011) *MBS changes—GP Survey: An Assessment of the Impact of 2011-12 Budget Cuts to Medicare Funding for GP Mental Health Services*, Australian Medical Association, 2011; Australian Medical Association, *Submission 185*, p. 11.

29 Department of Health and Ageing, *Proof Committee Hansard*, 5 September 2011, p. 7.

30 *headspace*, *Submission 169*, p. 3.

skills.<sup>31</sup> The RDAA considered that a rural pathway for GPs is more likely to be favoured where there is scope to perform higher level clinical work, and that reducing MBS rebates will act as a disincentive, exacerbating the health services in rural areas.<sup>32</sup>

2.22 However, the committee did receive submissions supportive of the budget changes to Better Access. Beyondblue supported the introduction of timed rebates for GP mental health items, as well as the continued higher rebate for GPs who have completed mental health training.<sup>33</sup> Other submitters expressed general support for the rationalisation of Better Access on the basis that funds would be better diverted to improving services to target groups identified in the Budget.<sup>34</sup>

### *Mental health consultations compared to standard consultations*

2.23 Standard MBS rebates for GPs are based on the amount of time spent with the patient, the complexity of assessment and treatment and other matters such the location where the consultation takes place. GP consultations at the GP's consulting rooms are divided into Levels A, B, C and D. Level A is intended for short, straightforward appointments. Progressively higher rebates are claimable when GPs treat more complex issues that require more time: less than twenty minutes (Level B); at least twenty minutes (Level C); and at least forty minutes (Level D).<sup>35</sup> A Level D consultation is described as a:

Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant:

- (a) Taking a detailed patient history;
  - (b) Performing a clinical examination;
  - (c) Arranging any necessary investigation;
  - (d) Implementing a management plan;
  - (e) Providing appropriate preventative health care;
- in relation to one or more health-related issues, with appropriate documentation.<sup>36</sup>

---

31 Rural Doctors Association of Australia, *Submission 182*, pp 4–5.

32 Rural Doctors Association of Australia, *Submission 182*, p. 6.

33 Beyond Blue, *Submission 171*, p. 4.

34 See for example, Mental Health Community Coalition ACT, *Submission 204*, p. 4; Office of the Commissioner for Social Inclusion SA, *Submission 153*, p. 2.

35 Department of Health and Ageing, *Medicare Benefits Schedule Book*, Operating from 1 July 2011, <http://www.health.gov.au/mbsonline> (accessed 7 September 2011).

36 Department of Health and Ageing, *Medicare Benefits Schedule Book*, Operating from 1 July 2011, <http://www.health.gov.au/mbsonline> (accessed 7 September 2011).

2.24 The process for preparing a Mental Health Treatment Plan includes an assessment of the patient and the preparation of a plan. According to the MBS both steps must include the following:

#### Assessment

- recording the patient's agreement for the GP Mental Health Treatment Plan service;
- taking relevant history (biological, psychological, social) including the presenting complaint;
- conducting a mental state examination;
- assessing associated risk and any co-morbidity;
- making a diagnosis and/or formulation; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

#### Plan

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;
- identifying and discussing referral and treatment options with the patient, including appropriate support services;
- agreeing goals with the patient – what should be achieved by the treatment - and any actions the patient will take;
- provision of psycho-education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.<sup>37</sup>

2.25 The committee explored the issue of comparing a mental health treatment plan with a standard Level C or D consultation which incorporates preparation of a management plan. DoHA responded that:

...there is not a stark distinction between what is done with a mental health treatment plan and what can be and is done under a level C consultation. There is a comparability there...If you go back and accept what the [AMA] said—that the relative value study reflects what you would expect for a level C consultation—you are looking at something like eight to 10 minutes non-face-to-face time for a standard level C consultation. There is a difference, but again there is also a difference in rebate.<sup>38</sup>

2.26 The committee heard that GPs providing mental health consultations are concerned that such consultations require a time commitment beyond face-to-face

---

37 Department of Health and Ageing, *Medicare Benefits Schedule Book*, Operating from 1 July 2011, <http://www.health.gov.au/mbsonline> (accessed 7 September 2011).

38 Department of Health and Ageing, *Proof Committee Hansard*, 5 September 2011, p. 11.

time and as such should be recognised with a higher rebate. However, the committee also notes that it did not seek evidence in relation to GPs who receive standard Level C or D rebates and who may also provide additional services outside the appointment time for patients with other severe or persistent illnesses.

2.27 While the inquiry has not received evidence about preparatory or follow-up work undertaken by GPs treating a range of severe illnesses, the above guidelines for Level B, C and D consultations recognise that additional time beyond that spent face-to-face with the patient is necessary for many health issues, not just mental health care.

2.28 In addition, as mentioned above, the committee notes that the premium will be retained for GPs who have completed mental health training. It is hoped that this incentive for GPs to undertake training will encourage continued quality care.<sup>39</sup> DoHA explained to the committee that 72 per cent of GPs have completed the mental health training, and therefore will be eligible for the higher rebate.<sup>40</sup> As such, most GPs will continue to receive higher rebates for mental health consultations than they do for standard consultations.

### ***Rationalisation of allied health treatment sessions—10 session entitlement***

2.29 The number of rebatable allied health treatment sessions will be capped at 10 individual and 10 group sessions—a course of six sessions plus four additional sessions following a review. The previous maximum for both individual and group sessions was 18—two courses of six sessions plus an additional six sessions in exceptional circumstances.<sup>41</sup>

2.30 This change is made in the context of data indicating that 87 per cent of consumers access between one and ten sessions, and the argument that individuals requiring more than 10 sessions may be better suited to other specialist services such as psychiatrist consultations.<sup>42</sup> However, as mentioned earlier in this chapter, the limitations of the available data about the Better Access program have been acknowledged.

### ***Feedback about the sufficiency of 10 sessions from psychologists***

2.31 Much of the concern expressed about the rationalisation of rebatable sessions under Better Access from a maximum of 18 to 10 was from psychologists. A

---

39 Ms Georgie Harman, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 5 September 2011, p. 12.

40 Ms Rosemary Huxtable, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 September 2011, p. 8.

41 Department of Health and Ageing, *Fact Sheet: Rationalisation of Allied Mental Health Services Under Better Access: 2011–12 Budget Measure*, May 2011.

42 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 22.

significant number of submissions received from psychologists expressed strong views on this issue suggesting broad agreement across the discipline that severe and persistent mental illness requires longer-term treatment than 10 sessions.<sup>43</sup> Others submissions discussed a delineation of severity of mental illness, such as via the multi-axial system, noting that people with some Axis 1 disorders also require more than 10 sessions of treatment.<sup>44</sup>

2.32 The Australian Association of Psychologists inc (AAPi) suggested that 18 sessions is 'sufficient and not oversufficient...[to]...allow a person to overcome a substantial life difficulty':

I would suggest that almost all people who come to a psychologist with a substantial emotional difficulty, a depressive situation, an anxiety situation, a traumatic occurrence, would require 18 sessions. Brief psychological therapy exceeds 10 and goes up to 20. That is considered brief psychological therapy for a person who is undergoing a severe life difficulty. They are not the chronic people. The chronic people come after that and require weekly or fortnightly monitoring lifelong. I would say psychology desperately requires the 18 sessions to do its job.<sup>45</sup>

2.33 Carers NSW cited data indicating that many people with a mental illness are from low-income backgrounds.<sup>46</sup> Carers NSW was concerned that some of these people may not be eligible for ATAPS and rely on Better Access for mental health care. It argued that after the 10 MBS rebatable sessions are exhausted, people with limited means will not be able to afford the full cost of extra sessions.<sup>47</sup> Carers NSW also asserted that many carers rely on GPs for the provision of mental health care, for reasons such as the perceived stigma associated with visiting other specialists, or the additional costs of such appointments.<sup>48</sup>

2.34 The Federation of Ethnic Communities Councils of Australia (FECCA) stated in its submission that capping Better Access sessions to 10 may disadvantage people from a non-English speaking backgrounds, who may require additional sessions in order to build trust, explain the problem or find and build rapport with an interpreter.<sup>49</sup>

---

43 For example, the APS provided figures which states that 13% or 87 000 of Better Access consumers have moderate to severe, or severe mental health disorders. APS, *Proof Committee Hansard*, 19 August 2011, p. 9.

44 Amanda Burlock, Clinical Psychologist, Submission 432, p. 1 and Submission 519, p. 1.

45 Mr Paul Stevenson, President, Australian Association of Psychologists inc, *Committee Hansard*, p. 51.

46 Mental Health Council of Australia, *Mental Health Carers Report 2010*, Canberra, 2010, cited in: Carers NSW, *Submission 176*, p. 4.

47 Carers NSW, *Submission 176*, p. 3.

48 Carers NSW, *Submission 176*, p. 3.

49 Federation of Ethnic Communities Councils of Australia (FECCA), *Submission 187*, pp 9–10.

2.35 ACON (formerly known as the AIDS Council of NSW) was concerned that recovery from mental health illness may be delayed if limited sessions are available, and that there should be exemptions for people with co-morbidities or complex needs.<sup>50</sup> This suggestion that discretion will be required if sessions are rationalised was echoed by the Australian Counselling Association.<sup>51</sup>

2.36 Many people who have first-hand consumer experience of psychiatrist sessions under Better Access provided the committee with submissions asserting that the 18 session maximum should be retained. Several individual submitters explained that management of and recovery from their mental illness would not have been possible without access to the full 18 sessions.<sup>52</sup>

2.37 The arguments above in favour of retaining the 18 session maximum rely on the assumption that Medicare rebatable sessions under Better Access are appropriate to treat people with a severe mental illness. This was debated amongst submitters; some considered that Better Access was not designed to treat people with a severe mental illness, while others contended that it was. The opinion was also expressed that whether or not Better Access was originally intended to treat people with a severe mental illness, viable alternatives do not presently exist and therefore Better Access should be funded to fill the gap.

#### *Targeting hard to reach groups*

2.38 The Better Access evaluation and the various ATAPS evaluations discussed in Chapter 3 of this report indicate that Better Access either does not meet the needs of hard to reach groups, or that the ATAPS model is more suited to the task. However some witnesses questioned these conclusions. The Royal Australian College of General Practitioners (RACGP) for example disputed DoHA's assertion that Better Access is not reaching rural and remote areas. The RACGP suggested that it is workforce shortages, that contribute to fewer services being delivered outside metropolitan areas, and that Better Access has actually had the opposite effect:

The Better Access Evaluation Report actually concludes that while some groups have had greater levels of uptake of Better Access than others, Better Access has reached all groups and increased most dramatically for those who have been the most disadvantaged in the past, including people aged 0–14, rural areas, and the most socio-economically disadvantaged areas.<sup>53</sup>

2.39 The AMA also emphasised the increase of Better Access service delivery to hard to reach groups:

---

50 ACON, *Submission 175*, p. 5.

51 Australian Counselling Association, *Submission 173*, p. 8.

52 Name withheld, *Submission 166*, pp 1–2.

53 Royal Australian College of General Practitioners, *Answer to a question on notice from public hearing 19 August 2011*, received 29 August 2011, p. 2.

The criticisms of it are that it is not reaching the target groups. The greatest growth in this program is actually in those target groups, so, if you like, it is coming to maturity just now. The greatest growth was actually in the young people getting access to this program. The next greatest growth was in the lowest sociodemographic, where over 150,000 people were being treated, but the growth rate in that area was the greatest.<sup>54</sup>

2.40 DoHA accepted RCAGP's point that there was some improvement in the Better Access performance in terms of reaching disadvantaged groups, however it maintained that ATAPS is the more appropriate service delivery for these groups:

The [Better Access] evaluation showed that access for hard-to-reach populations has, to some extent, improved. But, as Ms Huxtable has just said, those groups traditionally less well served by Medicare continue to miss out on mental health services that they need and that is a feature of any universal fee-for-service rebate type scheme. In particular, we know that Better Access continues to struggle to adequately service hard-to-reach and vulnerable groups such as young people, men, people living in rural and remote regions, Indigenous Australians and people living in areas of high socio-economic disadvantage. The evaluation also confirmed that the usage and distribution of services across the community is relatively poor. In rural and remote Australia service levels drop off dramatically. So, for example, the use of services is approximately 12 per cent lower for people in rural areas and approximately 60 per cent lower for people in remote areas compared to that for people living in capital cities. The evaluation data also showed a clear difference in access according to socioeconomic status, with use of Better Access services approximately 10 per cent lower for the people living in the most socioeconomically disadvantaged areas.<sup>55</sup>

2.41 The department also noted a significant disparity in uptake of Better Access services between socio-economic groups:

The use of Better Access services was approximately 10 per cent lower for people living in the most socio-economically disadvantaged areas. In 2009, the richest quintile of Australians accessed 2½ times the number of services and received three times the Medicare rebates, compared to the poorest quintile.<sup>56</sup>

*Better Access as a means of treating people with a severe mental illness*

2.42 The summary of Better Access on the Department of Health and Ageing's Mental Health website explains that the initiative is designed to assist:

Individuals with a clinically diagnosed mental disorder who would benefit from a structured approach to the management of their mental care needs,

---

54 Australian Medical Association, *Proof Committee Hansard*, 5 September 2011, p. 73.

55 Department of Health and Ageing, *Proof Committee Hansard*, 5 September 2011, p. 9.

56 Department of Health and Ageing, *Committee Hansard*, 5 September 2011, p. 8.

using the short to medium term treatment available under the Better Access initiative.<sup>57</sup>

2.43 This suggests that the program might be targeted towards people with less severe mental illnesses who would benefit from 'short to medium term treatment'. It is also clear from a number of sources that the Better Access initiative was envisaged to treat high prevalence mental illnesses, for example, the Summative Evaluation of the Better Access scheme states:

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative was introduced in November 2006 in response to low treatment rates for common mental disorders (e.g., anxiety, depression and substance use disorders). Its ultimate aim is to improve outcomes for people with these disorders by encouraging a multi-disciplinary approach to their care.<sup>58</sup>

2.44 The Department of Health and Ageing's budget publication dating from the inception of Better Access in 2006 indicated that the program would include treatment by psychiatrists of an 'estimated 35,000 additional individuals with a severe mental illness' by 2010–11, suggesting that some people with severe high-prevalence disorders were expected to access the initiative. This is consistent with the COAG National Action Plan on Mental Health 2006 – 2011, introduced around the same time that Better Access was introduced. It stated that the treatment of severe mental health disorders would occur at least in part through the primary health care system through practitioners who are included in the scope of Better Access including:

...psychiatrists in the community and a primary health care sector of GPs, psychologists, mental health nurses, and other allied health workers that provide clinical services to people with mild, moderate and severe mental illness including early identification, assessment, continuous care and case management.<sup>59</sup>

2.45 Better Access was designed to encourage mental health professionals to work together to ensure people's care needs were met in the most appropriate way:

---

57 Department of Health and Ageing, *What is the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule Initiative?* <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1> (accessed 9 September 2011).

58 Dr Jane Pirkis et al, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, 22 February 2011, p. 2.

59 Council of Australian Governments, *National Action Plan on Mental Health 2006 – 2011*, July 2006, p. 9.

---

Reforms will be made to...allow private psychiatrists to see more new patients and refer on those patients who could be more effectively treated by appropriately trained psychologists and GPs.<sup>60</sup>

2.46 However, it is likely that policy makers in 2006 did not anticipate the extent to which Better Access sessions would be utilised in the following years, nor the extent to which people accessing the program would be experiencing severe or very severe symptoms. It is also the case that state and territory governments provide most services for people experiencing severe mental illness, a role Better Access was never intended to supplant.

2.47 Professor Hickie of the Brain and Mind Research Institute, University of Sydney, considered that Better Access is not the appropriate program to be providing long-term assistance to people with a severe mental illness. He explained to the committee that rationalising Better Access sessions could actually assist more people to receive care:

There will be no reduction in psychological services. With a reduction in number of sessions, more people will get into Better Access and, with an increased investment in ATAPS, more people will receive the various levels of ATAPS services.<sup>61</sup>

2.48 The Department of Health and Ageing agreed that primary care programs like Better Access or Tier 1 of the ATAPS program are not the most appropriate programs for people with severe mental illness:

While some people with more complex or intensive care needs may benefit from interventions under Better Access, it was never intended to provide intensive, ongoing therapy for people with severe ongoing illness.

People in this group are generally clients of state and territory government specialist mental health services.

It is important that people get the right care for their needs. As indicated on the Medicare Australia web site, people who currently receive more than ten allied mental health services per calendar year under Better Access are likely to be patients with more complex needs and would be better suited for referral to more appropriate mental health services. This may include the following:

- People with severe and persistent mental disorders who require over ten allied mental health services are still eligible for up to 50 Medicare subsidised consultant psychiatrist services; and
- The specialised mental health system in each state or territory.<sup>62</sup>

---

60 2006–07 Federal Budget, Budget Paper 2, [http://www.budget.gov.au/2006-07/bp2/html/bp2\\_expense-11.htm](http://www.budget.gov.au/2006-07/bp2/html/bp2_expense-11.htm) (accessed 27 October 2011).

61 Professor Ian Hickie, *Committee Hansard*, 5 September 2011, p. 71.

62 DoHA, Answer to question on notice, received 27 October 2011.

2.49 The Department stated that, in the long term, the current approach was able to deliver appropriate levels of mental health care for those suffering severe mental illness. They also noted that some gaps in service delivery do exist:

...as I say, we are looking at the package as a whole: a balanced package of services to start to reform the mental health system and close some of the gaps that we know exist. We are working very closely with the states and territories and will be seeking investment from the states and territories, in respect of the national partnership agreement, for example. And as the government has clearly said through this budget package, they know it is just the start.<sup>63</sup>

2.50 The committee received some submissions that concurred with Professor Hickie and the Department's view. The Mental Health Council of Tasmania as well as the Consumers Health Forum of Australia supported the savings generated by the rationalisation of Better Access sessions and considered that ATAPS is targeted towards assisting people with a severe and persistent mental illness.<sup>64</sup> The Consumers Health Forum, however, qualifies its support for the rationalisation by suggesting that a review and further evaluation of Better Access take place to measure any impact that the changes may have on consumer outcomes.<sup>65</sup>

2.51 Conversely, other submitters considered that Better Access is an appropriate measure, or the best available measure, to treat people with severe mental illness, and that it is working effectively. For example, some witnesses to the inquiry considered that Better Access is needed to support people with eating disorders, for which the committee heard at least 18–20 sessions are required.<sup>66</sup>

2.52 The Private Mental Health Consumer Carer Network was also concerned that a reduction in GP mental health sessions would disadvantage people with severe mental illness for whom psychiatrists may be less accessible.<sup>67</sup> The Network considered that GPs play an integral role in the provision of mental health care and that a reduction in rebatable sessions would have a negative effect on the long-term health of people with mental illness.<sup>68</sup>

2.53 Regardless of the original intent of the initiative, evidence from the Australian Psychological Society suggested that the majority of people accessing mental health treatment under Better Access are experiencing severe symptoms. A 2010 APS survey

---

63 DoHA, *Proof Committee Hansard*, 5 September 2011, p. 18.

64 Mental Health Council of Tasmania, *Submission 377*, p. 3; Consumers Health Forum of Australia, *Submission 179*, pp 3–4.

65 Consumers Health Forum of Australia, *Submission 179*, p. 4.

66 Mrs Christine Morgan, Chief Executive Officer, Butterfly Foundation, *Committee Hansard*, 5 September 2011, p. 1.

67 Private Mental Health Consumer Carer Network, *Submission 189*, p. 4.

68 Private Mental Health Consumer Carer Network, *Submission 189*, pp 4–5.

---

indicated that 81 per cent of Better Access clients requiring more than 10 sessions had depression and/or anxiety disorders; that is, high prevalence, severe disorders.<sup>69</sup>

***Committee view***

2.54 The rationalisation of rebatable Medicare items for mental health consultations should align more closely with standard timed consultations. In addition, the relatively higher rebates should continue to be made available to GPs who have undertaken mental health skills training.

2.55 Aligning rebates for mental health consultations with standard Level C and D consultations would be appropriate, as a range of presentations of severe or complex illnesses require follow-up work by GPs. In order to justify a continued higher rebate for GPs providing mental health consultations without specific training, the case would have to be made very strongly that mental health plans take significantly more time to develop than do the follow-up tasks required to treat all other severe and persistent illnesses.

---

69 Australian Psychological Society, *Submission X*, p. 4.



# Chapter 3

## Access to Allied Psychological Services program

### Introduction

3.1 The Government's 2011–12 Federal Budget *National Mental Health Reform* package is designed to address service gaps in the mental health system to ensure that early and consistent rather than crisis-driven care is provided to people who need it.<sup>1</sup> In addition, the reform is focused on addressing the needs of people identified as not always receiving adequate mental health services (see Chapter 1).<sup>2</sup> The Access to Allied Psychological Services program is seen as one way of meeting these challenges.

### *Access to Allied Psychological Services (ATAPS)*

3.2 The ATAPS program has been in existence since 2002 and was designed to fund 'short term psychology services for people with mental health disorders through fundholding arrangements delivered through Divisions of General Practice'.<sup>3</sup> The ATAPS projects enable GPs to refer patients with high prevalence disorders such as depression and anxiety to allied health professionals (predominantly psychologists).<sup>4</sup>

3.3 Since 2003 there have been a number of policy developments which have impacted on the original design of the program. The most significant of these was the introduction of the Better Access program in 2006 which serves a similar client group, but through the Medicare Benefits Schedule rather than a fundholding arrangement.

3.4 The ATAPS program has been evaluated regularly since its inception with the University of Melbourne's Centre for Health Policy, Programs and Economics producing 16 interim evaluations since 2003. A review of the program was also ordered by the Minister for Health and Ageing in April 2008, and this was completed in February 2010. The purpose of the review was to refocus the program to "better complement Better Access and to target service gaps for people who cannot easily access Medicare based programs."<sup>5</sup> The review was overseen by an Expert Advisory

---

1 Ministerial Statement— *National Mental Health Reform 2010–12*, 10 May 2011, p. 1.

2 Ministerial Statement— *National Mental Health Reform 2010–12*, 10 May 2011, p. 1.

3 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*— February 2010, p. 3.

4 Department of Health and Ageing, *Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Sixteenth Interim Evaluation Report, July 2010, p 3.

5 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*— February 2010, p. 2.

Committee comprising representatives of many of the key stakeholders in the mental health field.<sup>6</sup>

3.5 Figures produced by the review of the program show that since 2003 it has provided over 600,000 mental health sessions of care, achieving improved consumer outcomes in 86 percent of cases.<sup>7</sup> The last evaluation report, which looked at data from January 2006 to June 2010, found that there had been 150,954 referrals made in that period, with 113,107 patients receiving at least one episode of care.<sup>8</sup> The figures are small compared to the 11.1 million Better Access services that were delivered from 2007 to 2009. However a number of recent government health publications have foreshadowed the expansion of the program announced in the budget.

### ***Broader Policy Context***

3.6 In 2009 the National Health and Hospital Reform Commission (NHHRC) published a report called *A Healthier Future for All Australians*. This report included a number of recommendations intent on improving access and equity to better care for people with serious mental illness. Many of these recommendations focus on providing a more holistic approach to mental health care outside of the hospital sector, as well as specifically proposing a national mental and sexual health service aimed at young people and the expansion of early intervention programs for this group. In the broader context the report also recommends the establishment of Primary Health Care Organisations (Medicare Locals) that will evolve from or replace existing Divisions of General Practice.<sup>9</sup>

3.7 The Department of Health and Ageing's *Building a 21<sup>st</sup> Century Primary Care System*–National Primary Health Care Strategy (2010) report has a number of key priorities for the delivery of mental health services. Some of the policies outlined include:

- Access to core services supported by universal access to a Medicare rebate will be retained but will be supplemented by targeted local programs and collaborations across the service system;

---

6 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, Appendix A.

7 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p.3.

8 Department of Health and Ageing, *Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Sixteenth Interim Evaluation Report, July 2010, p. 5.

9 National Health and Hospital Reform Commission Report, *A Healthier Future for All Australians*, June 2009, p. 19.

- 
- Address current variability in access and outcomes, including for after-hours access, traditionally under-serviced groups, and for patients in transition across the service system;
  - Service delivery will proactively respond to the needs of those Australians who find it difficult to access mainstream services, or who have specific health care needs whether because of their location or demographic characteristics or health status or because of the circumstances under which they need to access care. At the same time, mainstream services will be more responsive to the needs of different groups; and
  - Service delivery and funding arrangements will support flexible service delivery models, promote effective and cost-effective use of technology and drive innovation by supporting information flows and workforce education and training.<sup>10</sup>

3.8 The *Fourth National Mental Health Plan* was endorsed by the Australian Health Ministers Conference in 2008. The Plan commits to supporting better access to primary mental health services, particularly to those consumers unable to access Medicare Services. It also cites ATAPS as an example of a flexible delivery model at a local level that can provide targeted services that address service gaps.<sup>11</sup>

3.9 The ATAPS review report summarised the common themes across all of the these reports as—

- The Australian Government has an important role in primary health care including primary mental health care;
- There is a continuing need to ensure Medicare based universal services are provided in addition to blended funding models which utilise fundholding arrangements to target services to particular local and population needs, including episodic care;
- Service gaps need to be better identified and targeted through planned and coordinated approaches;
- Key groups within the community such as children and youth and Aboriginal and Torres Strait Islander people, remain a significant priority and require care sensitive to their needs and which they are more likely to access;
- Collaborative partnerships engaging non-government organisations can play an important local and regional role in providing integrated treatment; and

---

10 Department of Health and Ageing, *Building a 21<sup>st</sup> Century Primary Care System*—National Primary Health Care Strategy, 2010, p. 18.

11 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p.7.

- There is potential to better utilise new technology including web based modes of care in the provision of health services.<sup>12</sup>

### ***ATAPS – performance to date***

3.10 As mentioned above, ATAPS has provided over 600,000 mental health services from 2003 to 2009 with a total spend in that period of \$80.7m. These services were provided by 10,296 GPs (5,914 urban; 4,382 rural) who referred consumers to 3,527 allied health professionals (2,548 urban; 979 rural). The numbers steadily rose between 2003 and 2006 until Better Access was introduced in 2006. To put these figures in context there are currently 24,000 GPs, 16,450 allied health professionals and 1,700 psychiatrists using Medicare items under Better Access.<sup>13</sup> Over 90 percent of the allied health professionals under both programs are psychologists. Following the introduction of the Better Access program the number of people referred by GPs to allied health professionals declined for around a year before rising steadily again. Figures show that the impact of Better Access on ATAPS participation has been much less pronounced in rural areas.<sup>14</sup>

3.11 Over 70 percent of consumers using the ATAPS program are women with an average age of 39. Around 2 percent are Aboriginal or Torres Strait Islanders. Most people accessing the program present with high prevalence disorders such as anxiety and depression and between 2 percent and 6 percent of referrals include a diagnosis of severe mental illness.<sup>15</sup> The breakdown of figures for ATAPS does appear to support the premise that the program has the potential to be able reach marginal groups with 68 percent of all services delivered through ATAPS being accessed by people on a low income, and 45 percent delivered in rural areas.<sup>16</sup> In contrast, 25 percent of Better Access services are delivered in rural areas.

3.12 The treatment profile of those who received treatment through ATAPS is almost identical to that of Better Access patients with approximately 5 services provided per consumer.<sup>17</sup> Discussion of the relationship between the treatment variables and the clinical outcomes in the sixteenth interim evaluation report of

---

12 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p. 8.

13 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p.7.

14 Department of Health and Ageing, *Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Fourteenth Interim Evaluation Report, June 2009, p 3.

15 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p.10.

16 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p.3.

17 Department of Health and Ageing—*Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p.10.

---

ATAPS suggests that six sessions of care 'are not only sufficient, but perhaps optimal in many cases', and that 'greater numbers of sessions are associated with poorer outcomes'.<sup>18</sup>

3.13 Around 75 percent of ATAPS services did not include a co-payment, and where it did it was more common in urban areas than rural. The costs of each service ranged hugely from \$57 to \$631. The review suggests that care be taken with interpreting these costs as they are affected by other factors such as the delivery of services to remote areas, or targeting hard to reach groups.

### ***Australian National Audit Office Report***

3.14 The Australian National Audit Office (ANAO) undertook an independent audit of the ATAPS program in 2010-11, reporting to Parliament on 21 June 2011. The comprehensive report considered the design of the program; delivery aspects; the use of ATAPS in the response to recent natural disasters; and the monitoring and evaluation program for the program.<sup>19</sup>

3.15 The ANAO report highlighted positive features of the ATAPS program, as well as drawing attention to the challenging aspects of administering the scheme. The positive aspects of the program discussed in the report included its capacity to respond quickly and with agility as illustrated during the Victorian bushfires and Queensland floods, and its ability to be used as a platform for new and innovative service delivery, targeting particularly hard to reach groups such as rural and remote consumers and young people.<sup>20</sup>

3.16 The administration of the scheme requires attention if the program is to meet the aims of the recent budget changes. The ANAO report cites problems with the design and subsequent administration of the program to date:

...the administrative arrangements established by DoHA have not consistently supported the achievement of program objectives. In particular, there has been variable administrative performance, over the relatively long life of the program, in relation to a number of important program elements including: the allocation of program funding on the basis of identified need;

---

18 Department of Health and Ageing—*Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Sixteenth Interim Evaluation Report, June 2009, p 12.

19 Australian National Audit Office (ANAO), *Administration of the Access to Allied Psychological Services Program*, ANAO Audit Report No. 51, June 2011, pp. 5-6.

20 Australian National Audit Office (ANAO), *Administration of the Access to Allied Psychological Services Program*, ANAO Audit Report No. 51, June 2011, pp. 15-16.

monitoring compliance with program requirements; and the administration of new ATAPS initiatives.<sup>21</sup>

3.17 Aspects of the funding system in particular drew comment in the report. The funding model of the program was initially population based, but has not correlated consistently with the gradual policy transition to a more needs-based targeted approach. This aspect, tied with the lack of regular assessment of health care needs within GP Divisions, has resulted in 'some communities not receiving an equitable share'.<sup>22</sup>

3.18 The report found that the risk management of the program was also not designed to ensure that the limited resources available had the greatest chance of reaching those most in need. The report suggested:

A risk-based approach to monitoring compliance would enable the department to more effectively deploy its limited resources and to better identify, and if necessary treat, the risk of ATAPS not being used as specified in the program guidelines.<sup>23</sup>

3.19 The report had five recommendations, all of which were agreed to by the Department of Health and Ageing. These were:

- To support the effective targeting of program funding, the ANAO recommends that DoHA provide options, for Ministerial consideration, that would allow the ATAPS program to transition to an appropriate needs based funding model.
- To strengthen management of the ATAPS program, the ANAO recommends that DoHA enhance support for program administrators through the provision of:
  - (a) induction and training tailored to the administration of the ATAPS program;
  - (b) fit-for-purpose policy and procedural materials to guide administrators, support consistent administrative practice and retain corporate knowledge; and
  - (c) a central repository to provide administrators with ready access to key program decisions that they require to efficiently discharge their responsibilities.

---

21 Australian National Audit Office (ANAO), *Administration of the Access to Allied Psychological Services Program*, ANAO Audit Report No. 51, June 2011, p. 15.

22 Australian National Audit Office (ANAO), *Administration of the Access to Allied Psychological Services Program*, ANAO Audit Report No. 51, June 2011, p. 15.

23 Australian National Audit Office (ANAO), *Administration of the Access to Allied Psychological Services Program*, ANAO Audit Report No. 51, June 2011, pp. 15-16.

- To support equitable access to treatment for eligible consumers experiencing a mental health disorder, the ANAO recommends that DoHA periodically review the demand management strategies employed by Divisions funded under the ATAPS program and provide additional assistance and guidance where necessary.
- In order for DoHA to effectively monitor progress and assess the success or otherwise of any future ATAPS initiatives, the ANAO recommends that the department:
  - (a) establish success indicators at the commencement of each initiative and use these indicators to inform ongoing monitoring and evaluation activities; and
  - (b) record key implementation and evaluation decisions to support accountable program delivery.
- In order to plan and coordinate its compliance activities, the ANAO recommends that DoHA establishes a risk-based compliance strategy, promulgates the strategy to internal and external stakeholders, and periodically reviews the strategy.<sup>24</sup>

### *ATAPS—next steps*

3.20 The Government signalled its commitment to expand access to mental health interventions for marginalised and disadvantaged groups through ATAPS with the commissioning of the review of ATAPS in 2008. The review identified four areas for ATAPS to focus on:

#### *Better Addressing Service Gaps*

- The review recommends that there needs to be increased service provision in areas where Medicare services are limited through geography or locality.
- ATAPS should also be utilised to provide services for hard to reach groups including Aboriginal and Torres Strait Islander people, children and young people, services for parents of children with mental health problems, people at high risk of suicide, homeless people, and any other group that could benefit from a more flexible model of care.

#### *Increasing Efficiency*

- The review recommends a change to the funding structure of ATAPS through the introduction of a two tier funding model. The first tier would continue to provide services to supplement Better Access in areas, or for groups with limited access to Better Access. The second

---

24 Australian National Audit Office (ANAO), *Administration of the Access to Allied Psychological Services Program*, ANAO Audit Report No. 51, June 2011, pp. 21-22.

tier would be able to target funding to areas or groups with particular needs.

- An option for services to be delivered by NGOs where GP Divisions cannot or do not want to administer ATAPS services was also proposed.

#### *Encouraging Innovation*

- The Tier 2 funding would be able to be used by Divisions with a track record of providing innovative services for hard to reach groups.
- This tier of funding would also be used for special purposes which in the past have included perinatal depression, bushfire support and telephone based cognitive behaviour therapy.

#### *Improving Quality*

- The review proposes the introduction of a requirement for continual professional development for all those health practitioners involved in the delivery of ATAPS services.
- Information exchange, best practice and benchmarking initiatives should be incorporated into all ATAPS projects and programs.<sup>25</sup>

3.21 The Government has committed to the expansion of the ATAPS program to incorporate the recommendations of the review in the recent budget changes. The funding for ATAPS will increase from \$36.1m in 2010-11 to \$108.7m in 2015-16. This represents a total spend over the next five years of \$432.7m. The aim is to provide services for an additional 185,000 people over five years, specifically targeting hard to reach groups.<sup>26</sup>

#### *The ATAPS service delivery model*

3.22 As discussed at paragraph 3.2 the service delivery model of ATAPS is to fund short term psychology services for people with mental health disorders through fundholding arrangements delivered through Divisions of General Practice, or Medicare Locals as they come on stream. The delivery of these services is more likely to involve the input and collaboration of a number of health practitioners rather than a GP and a psychologist as is typical under Better Access. It is this flexibility in service delivery which the various reports and evaluations have identified as being the strength of the program, but it also presents challenges around areas such as workforce management.

---

25 Department of Health and Ageing—*Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, pp.4-5.

26 Delivering National Mental Health Reform—Media Release—May 2011, pp. 2-3.

3.23 The Australian General Practice Network (AGPN) have been instrumental in designing how ATAPS will function following the budget changes, but also in the context of the introduction of Medicare Locals. They have been funded to develop a 'clinical governance framework for ATAPS that can be implemented in the Medicare Local environment and also to do a systematic workforce mapping exercise to better understand the status, skills and qualifications of the ATAPS workforce.'<sup>27</sup>

3.24 AGPN gave evidence that suggests the potential for ATAPS is significant but there are barriers to its realisation:

ATAPS and related programs make for an opportunity to really embed a robust primary mental health care system. But this also means investment in those functions over and above what you could describe as straight program administration. I am talking about functions such as service planning; service development; partnership and linkage development with other providers<sup>28</sup>

3.25 They also refer to challenges presented by ATAPS being a capped program, rather than being funded through the MBS:

...while these service models have injected much-needed new services that are complementary to MBS funded services, these are capped programs and it has not been uncommon to see demand outstrip supply.<sup>29</sup>

3.26 AGPN's concerns about the type of infrastructure required for ATAPS to be successful are supported by the Australian Association of Psychologists inc. (AAPi) who said:

Our opinion is that the ATAPS funding is targeted towards a client group which requires case management as its primary service. Multidisciplinary teams operate to help people who are homeless and need housing and who are alcohol intoxicated and need detox. A whole range of services can be only provided by case managers and not psychologists. Psychologists are not the right people to be doing that. That money will go into services within offices that last 50 minutes. What is needed is for ATAPS to be directed more to community services like community health centres, community mental health centres, social workers, nurses and welfare officers.<sup>30</sup>

3.27 The Public Health Association of Australia also recognised that the ATAPS program requires the involvement of many health practitioners:

---

27 AGPN, *Proof Committee Hansard*, Monday 5 September 2011, p.32.

28 AGPN, *Proof Committee Hansard*, Monday 5 September 2011, p.32.

29 AGPN, *Proof Committee Hansard*, Monday 5 September 2011, p.32.

30 Australian Association of Psychologists inc., *Proof Committee Hansard*, Friday 19 August 2011, pp. 47-48.

The Budget's extension of access to the ATAPS program will help to promote collaborative care.<sup>31</sup>

3.28 An example of the diversity of an ATAPS program was provided in evidence by North East Health Wangaratta who told the committee:

We are mental health nurses, with a psychologist and a social worker. Given the work we are doing, I think we are doing it admirably.<sup>32</sup>

3.29 This is in contrast to evidence received from the Australian College of Mental Health Nurses who submitted:

Mental Health Nurses have informed the ACMHN that they have difficulty obtaining work under ATAPS. At least one former Division of General Practice which is now a Medicare Local has made a decision only to engage psychologists under ATAPS.<sup>33</sup>

3.30 The AGPN confirmed this diversity in ATAPS teams, and the challenges involved in data collection around the issue:

In some cases some general practice networks employ a single discipline, in some other cases there are multidisciplinary staff... That is one of the things that we are about to try to look at to get some more substantial and significant information on exactly what the ATAPS workforce looks like because we have some of the workforce that is subcontracted and some that is employed. Many general practice networks find it extremely difficult to actually recruit an allied health workforce, particularly in the rural and remote areas.<sup>34</sup>

3.31 The Australian Counselling Association contributed to the debate on the diversity of the ATAPS workforce by describing mental illness as a continuum which could be treated by a variety of different health professionals depending on the stage of the illness:

[We] believe that we certainly meet the criteria for ATAPS. However, that sort of detracts a little bit from the perspective we are coming from in that we believe that mental health is in a continuum...the problem is the siloing of professions. Every profession wants the dollar for their profession and every peak body wants the money for their members—which is fine... Shouldn't it be based on consumer need? The consumer need is best looked

---

31 Public Health Association of Australia (PHAA), *Submission 195*, p. 6.

32 Northeast Health Wangaratta, *Proof Committee Hansard*, Friday 19 August 2011, p. 33.

33 Australian College of Mental Health Nurses, *Submission 447*, p. 4.

34 AGPN, *Proof Committee Hansard*, Monday 5 September 2011, p.33.

---

after by ensuring that the person whom they are seeing is at the appropriate level—not over qualified or underqualified.<sup>35</sup>

3.32 The Australian Psychological Society (APS) also commented on the potential negative impacts. They said in evidence that one of their great worries was that under a capped ATAPS program funded through Medicare Locals or GP Divisions, consumers would be treated by inexperienced psychologists:

They try to find the psychologists they can get for the lowest possible salary...Because the money is much lower for the psychologists [than through Better Access] you do not tend to get the very experienced ones and because now it has become such a niche program to these hard-to-deal-with groups you want the most experienced psychologists there. You actually want people that have really good training in those niche areas. That is a worry.<sup>36</sup>

3.33 One of the consequences of the variety of delivery models with ATAPS is the proportion of the budget that goes into the administration of the program. The AMA submission cites the ANAO report that says:

Originally about 85 percent of ATAPS funding was utilised by Divisions for service delivery and the remaining component was set aside for administration (15 percent). Over recent years, the proportion of funding quarantined by Divisions for administering the initiative has substantially increased. Now many Divisions use a ratio of 75 percent service delivery to 25 percent administration.<sup>37</sup>

3.34 The AMA contrasted these ratios to those of the Better Access initiative in which they say 'every dollar allocated...goes directly to the delivery of clinical care.'<sup>38</sup>

3.35 The committee put these figures to the AGPN at its public hearing in Melbourne on 19 August. The AGPN provided an expansive answer on what additional administration costs may cover:

We have made it clear in our submission that we think the 85:15 ratio is inadequate. Our key point in making that statement, though, is that we would draw a distinction in relation to the sorts of activities that that 15 per cent would cover by way of administering a program, managing a contract with government, entering data into a minimum dataset, which are some of the program administration types of activities that divisions do as a routine undertaking in managing ATAPS. Where we think there needs to be additional capacity is for something that you would not necessarily

---

35 Australian Counselling Association, *Proof Committee Hansard*, Friday 19 August 2011, p. 37.

36 Australian Psychological Society, *Proof Committee Hansard*, Friday 19 August 2011, p. 18.

37 AMA, *Submission 195*, p. 12.

38 AMA, *Submission 195*, p. 12.

categorise as administration but it is a legitimate function of service delivery and service design, and that is to have capacity to do the local consultation and work with local hospital networks and state funded services about how this new expansionary funding into ATAPS can be best mobilised on the ground. It is meant to be a targeted program, so you would not want a division to just replicate a state funded service in the region; you would want it to integrate and to target elsewhere. They are quite sophisticated service development and planning functions that you cannot buy with a 15 per cent admin vote.<sup>39</sup>

3.36 The APS also commented on the additional administration expenses associated with ATAPS:

I think ATAPS is quite expensive, in part for good reason. It is targeting niche groups which are quite difficult, such as homeless people, Indigenous people, people that are suicidal, et cetera. You do need to spend money sometimes on outreach. It is not all in the office and so forth. ATAPS is run through the divisions at the moment and Medicare Locals in the future that take a cut for administration. I personally do not see the need for that happen. I think it can be direct referral through the GPs like Better Access is.<sup>40</sup>

3.37 The ANAO report surveyed GP Divisions on the issue of administration cost for the ATAPS program, and the potential costs following the government's reforms:

All Divisions interviewed by the ANAO commented on the adequacy of administration funding and the implications of the recent increased emphasis on targeting 'hard to reach' consumers through more flexible and innovative models of service delivery. Divisions considered that these developments, coupled with a heavy reporting and data collection workload, warranted a review of the current level of administration funding.<sup>41</sup>

#### *Administration costs*

3.38 The committee notes the expansion of ATAPS to hard to reach groups, and to better meet the mental health needs of consumers in an ongoing and holistic manner. It notes the expectation that this will entail higher administrative costs. It also notes that the ATAPS program is not intended as an alternative to the Better Access initiative. It may be able to provide a different type of care, and one of the ATAPS program's strengths is its flexibility to provide a broad care package to consumers.

---

39 AGPN, *Proof Committee Hansard*, 5 September 2011, p. 34.

40 APS, *Proof Committee Hansard*, 19 August 2011, p. 17.

41 Australian National Audit Office (ANAO), *Administration of the Access to Allied Psychological Services Program*, ANAO Audit Report No. 51, June 2011, p. 54.

---

However, it is expensive in comparison to Better Access,<sup>42</sup> and the substantial funding increases are not due to come on stream until after Better Access has been reduced.

3.39 The ATAPS service delivery model is also complex in nature and requires long-term planning and design, particularly around workforce issues, before it can begin to meet the anticipated needs of consumers. The committee notes that there has been 16.1 million allocated in the 2011–12 financial year, which has begun to be provided to GP divisions.<sup>43</sup> The committee hopes that the various reports, reviews and evaluations provide DoHA with a template to work from in the design and planning necessary for the implementation of an expanded ATAPS program.

### *Can ATAPS fill the gaps?*

3.40 The key question that came up in the evidence before the committee was whether the newly designed program could meet the demands placed on it given the reduction in some aspects of the Better Access program.

### *Funding barriers*

3.41 The ability of ATAPS to improve access for hard to reach groups more effectively than Better Access has been recognised in DoHA's 2010 review, as well as the ANAO report, as one of its potential strengths. However while the emphasis on meeting the needs of key groups within the community such as Aboriginal and Torres Strait Islander people, or people in rural and remote areas is welcomed, the question remains of what happens to those consumers who require an extended level of care that will in future not be provided through the Better Access program.

3.42 The APS were quite forthright in their view that ATAPS is not ready to fill the gap:

The government has stated that people affected by the cuts can be seen under the Access to Allied Psychological Services, or ATAPS, program run through the divisions of general practice, but this is not a viable referral option under current arrangements. There is simply not enough funding in ATAPS to provide services for anything like the 87,000 people per annum.<sup>44</sup>

3.43 The issue of funding levels and administration requirements as barriers to using ATAPS came up frequently during the committee's public hearings. The Royal

---

42 The APS gave evidence that said ATAPS costs from two to 10 times more per session than Better Access. APS, *Proof Committee Hansard*, 19 August 2011, p. 9.

43 Australian Government, *2011–12 Federal Budget, Part 2: Expense measures*, [http://www.budget.gov.au/2011-12/content/bp2/html/bp2\\_expense-12.htm](http://www.budget.gov.au/2011-12/content/bp2/html/bp2_expense-12.htm) (accessed 31 October 2011).

44 APS, *Proof Committee Hansard*, 19 August 2011, p. 9.

Australian College of General Practitioners (RACGP) highlighted the difficulties faced by many GP Divisions in administering ATAPS:

If I refer a patient to ATAPS, as I did last week—and I work in an Aboriginal medical service—I am trying to access services where they are not going to be out of pocket, which is what ATAPS does. I have to be registered with the division myself. That takes time. It requires a meeting with someone from the division. I then have to get a reference number for my patient and I have to determine whether the psychologist I want to send them to also has a reference number. I have to conduct a specific tool that they want—the DASS21 tool—to assess their patient. We then have to complete all the ATAPS forms alongside our mental health plan form, which we do for Better Access anyway. It is an enormous amount of paperwork and the rebate is not there; it is basically the same.<sup>45</sup>

3.44 The RACGP also commented on the budgeting requirements for a capped program such as ATAPS:

...ATAPS has different rules and regulations across Australia. A lot of divisions spend their ATAPS funding six months into the 12 months and then there is nothing left. Also...often there are bureaucratic issues that have to be gone through to finally access the service. Often in mental health emergencies timing is everything. If you have someone who is suicidal or in acute personal crisis, you want to link them with services quickly. So, from my perspective, nationally those are the three issues that most concern our members about ATAPS.<sup>46</sup>

3.45 On this specific issue the committee also heard from Northeast Health Wangaratta who provided information on how they budget within the ATAPS framework:

We budget ours and because it is an employment model we employ the EFT that we can with that funding. I have heard of other divisions where their money has run out three months into the year. Because we have an employment model it is balanced across the year. It means that there is less during the year but it is spread.<sup>47</sup>

3.46 However, Northeast Health Wangaratta added the following points regarding their funding arrangements:

For the last five years, base funding to the ATAPS program for tier 1 services has remained constant, with no consideration of increases in clinician wages or increased travel costs relating to fuel price increases. This has been highlighted to the department repeatedly as an issue for this

---

45 RACGP, *Proof Committee Hansard*, 19 August 2011, p. 3.

46 RACGP, *Proof Committee Hansard*, 19 August 2011, p. 7.

47 Northeast Health Wangaratta, *Proof Committee Hansard*, 19 August 2011, p. 34.

service in annual plans and reports. The increase in wages for clinicians and associated service provision costs has meant a 15 per cent reduction in clinician hours for this coming financial year. This is in stark contrast with the state funding for the area mental health services, which is recurrent and indexed.<sup>48</sup>

### *Clinical need*

3.47 Despite the high participation rate of Better Access, there remains a significant number of people in need of more expert care than Better Access, in its current form, can provide. In evidence to the committee Professor McGorry described the types of disorders this group may be experiencing:

They suffer from a variable mix of persistent mood and anxiety disorders, eating disorders, post-traumatic stress, complex personality problems, substance abuse and psychotic disorders. This group of people need access to more specialised forms of care than the basic primary care approach can provide. This means we need a secondary model involving many different types of expertise running from clinical psychology, psychotherapy, psychiatry and addiction medicine through to social programs for housing, family support, further education and employment.<sup>49</sup>

3.48 The question is whether ATAPS can fulfil the role of that 'secondary model'. The Flexible Care Packages (FCPs) and the 'Tier 2' ATAPS funding initiatives have the potential to better meet the needs of consumers with persistent long-term disorders. In its discussion paper on the Flexible Care Package aspect of ATAPS the Government had originally pledged \$60 million of funding for the three years from 2011-12. This funding was revised in the budget when the Government announced that the money earmarked for FCPs for the two years from 2012-13 would now be rolled into the Coordinated Care and flexible funding for people with severe, persistent mental illness and complex care needs.<sup>50</sup>

3.49 The purpose of the funding has presumably not changed. The January 2011 Discussion paper provided a description of how the FCPs funding would deliver care to consumers:

The total number of ATAPS flexible care services provided to an individual (both clinical and case coordination) will depend on the individual's particular needs. It is estimated that an average of 20 clinical services in a calendar year will be provided to each individual, although it is recognised

---

48 Northeast Health Wangaratta, *Proof Committee Hansard*, 19 August 2011, p. 30.

49 Professor McGorry, *Proof Committee Hansard*, 5 September 2011, p. 65.

50 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 18; Department of Health and Ageing, *Improving outcomes for people with severe and debilitating mental illness*, <http://www.health.gov.au/internet/publications/publishing.nsf/Content/nmhr11-12~nmhr11-12-priorities~outcomes> (accessed 13 October 2011).

that some clients may need more clinical services in a calendar year depending on the level of severity of their illness and associated disability. In addition nonclinical support will be available to the individual, subject to their needs and care plan.<sup>51</sup>

3.50 The Tier 2 ATAPS funding initiative is also an attempt to utilise the agile and flexible capacity of the ATAPS program. The Tier 2 funding is described earlier in this chapter as funding that would be available to GP Divisions, or Medicare Locals for special purposes such as disaster relief or innovative projects to meet the needs of hard to reach groups. Again this is an important initiative with the potential to enhance flexibility and reward innovation. However the question as always remains whether the funding levels will be sufficient to meet the needs of consumers.

3.51 The committee agreed in principle with Professor Hickie's statement that the movement of consumers with complex needs from Better Access is not necessarily a bad thing as it will guide them towards a more appropriate care model provided through ATAPS.<sup>52</sup>

---

51 Department of Health and Ageing, *Flexible Care Packages For People with Severe Mental Illness, Discussion Paper*, January 2011, p. 4.

52 Chapter 2, para 2.49.

# Chapter 4

## Youth mental health

### Introduction

4.1 The Government's 2011–12 Federal Budget mental health reforms focus in part on addressing the needs of people identified as not always receiving adequate mental health services (see Chapter 1).<sup>1</sup> Young people were identified as one of these groups not receiving adequate mental health care.<sup>2</sup> To address their needs, the Budget included expansion of:

- *headspace*; and
- Early Psychosis Prevention and Intervention Centres (EPPIC).<sup>3</sup>

4.2 While much of the commentary about *headspace* and EPPIC links the two programs, there are fundamental differences between them. EPPIC is an early intervention program specifically targeting young people with a psychotic illness, whereas *headspace* is a holistic model of providing mental health care to young people. This chapter provides background information about each program, its funding in the 2011–12 Federal Budget, and commentary from submitters about such funding. It then addresses more general concerns raised about the provision of youth mental health funding in the 2011–12 Federal Budget.

### *headspace*

4.3 *headspace* is a model of delivering integrated mental health services to young people by co-locating specialist and primary health services at *headspace* centres.<sup>4</sup> *headspace*'s vision is:

To improve the mental and social wellbeing of young Australians through the provision of high quality early intervention services, that are welcoming, friendly and supportive.<sup>5</sup>

---

1 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 1.

2 The mental health treatment rate for young people is 25 per cent. *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 1.

3 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, pp 24-27.

4 *headspace* centres are also known as Communities of Youth Services (CYS). *headspace, Submission 169*, p. 3.

5 *headspace, Strategic Plan 2010–2012*, p. 3., [http://www.headspace.org.au/media/55063/headspace\\_strategicplan.pdf](http://www.headspace.org.au/media/55063/headspace_strategicplan.pdf) (accessed 1 October 2011).

4.4 Health professionals at the centres—including GPs, psychologists, social workers, mental health nurses and occupational therapists—are either directly employed through *headspace* core funding, or self-funded through MBS items or private billing.<sup>6</sup>

4.5 *headspace* targets 12–25 year olds with a mild to moderate mental disorder, and seeks to assist them across four key areas:

- General health;
- Mental health and counselling;
- Alcohol and other drug services; and
- Education, employment and other services.<sup>7</sup>

4.6 *headspace* was established in 2006 with Commonwealth funding and currently delivers services at 30 centres across all states and territories. Its original Foundation Executive Committee was formed with the assistance of Orygen Research Centre, the Australian Psychological Society, the Australian General Practice Network, the Brain and Mind Research Institute at the University of Sydney and the University of Melbourne, all of which are now represented on the *headspace* board.<sup>8</sup> The board assumed governance of *headspace* in 2009 when it became a company limited by guarantee, with charitable (not for profit) status.<sup>9</sup> Core funding continues to be provided via the Department of Health and Ageing Youth Mental Health Initiative Program.<sup>10</sup> Funding for individual *headspace* centres is awarded by the *headspace*

---

6 *headspace*, *Submission 169*, p. 3.

7 *headspace*, *What we do*, <http://www.headspace.org.au/about-headspace/about-us/what-we-do>, (accessed 1 October 2011).

8 *headspace's* board membership comprises: Wendy McCarthy AO (Chair), Professor Ian Hickie AM, Barbara Hingston, Professor Lyn Littlefield OAM, Ian Marshman, Peter Mason AM, Professor Patrick McGorry AO, John McGrath AM, Professor Helen Milroy, Sheree Vertigan, Dr Rob Walters and Chris Tanti (CEO). *headspace*, web prospectus, [http://www.headspace.org.au/media/75806/prospectus\\_web.pdf](http://www.headspace.org.au/media/75806/prospectus_web.pdf) (accessed 1 October 2011).

9 Kristy Muir et al, *Headspace Evaluation Report*, Independent Evaluation of *headspace*: the National Youth Mental Health Foundation, Social Policy Research Centre, University of New South Wales, November 2009, p. 2., [http://www.sprc.unsw.edu.au/.../Report19\\_09\\_headspace\\_EvalReport.pdf](http://www.sprc.unsw.edu.au/.../Report19_09_headspace_EvalReport.pdf) (accessed 1 October 2011).

10 *headspace*, *Strategic Plan 2010–2012*, p. 3., [http://www.headspace.org.au/media/55063/headspace\\_strategicplan.pdf](http://www.headspace.org.au/media/55063/headspace_strategicplan.pdf) (accessed 1 October 2011).

Grants Committee via a competitive process. Tenders are made by lead agencies on behalf of a consortia of government and non-government organisations.<sup>11</sup>

4.7 In 2008–2009, the Social Policy Research Centre at the University of New South Wales (UNSW) conducted an Independent Evaluation of *headspace*. The *Headspace Final Evaluation Report*, released in June 2009, commented on the extent to which *headspace* centres assist young people with mental health issues with respect to the four key areas (above).

4.8 The Report notes that *headspace* has improved mental health services for young people, especially early-intervention services for people aged 12–17. The Report attributes these positive outcomes to

effective engagement of young people via good CA [Community Awareness] and high quality, youth-friendly services.<sup>12</sup>

4.9 The Report also provided a number of 'lessons and recommendations' suggesting ways in which *headspace* could improve its service delivery. Some of these are particularly relevant to the present inquiry because they relate to issues that also arose in relation to wider budget changes. These include timeframes for service delivery, the need to engage target groups and funding issues:

- CYSSs [*headspace* centres] require 9–12 months to become fully operational, including 6–7 months for set-up and establishment and 3–6 months to recruit a full complement of staff and refine policies and procedures.
- As CYSSs have now established themselves as service providers within their communities, it is important that they ensure their services are engaging 'hard to reach groups', for example, young people in the lowest socio-economic status groups, those with limited family support, refugee communities and Indigenous young people.
- The sustainability of CYSSs, which will only be achieved with strong clinical governance, cost-effective models that draw on a diverse range of funding sources, some core [Commonwealth] funding, engagement with the community and demand for the service from young people.

---

11 Kristy Muir et al, *Headspace Evaluation Report*, Independent Evaluation of *headspace*: the National Youth Mental Health Foundation, Social Policy Research Centre, University of New South Wales, November 2009, p. 3., [http://www.sprc.unsw.edu.au/.../Report19\\_09\\_headspace\\_EvalReport.pdf](http://www.sprc.unsw.edu.au/.../Report19_09_headspace_EvalReport.pdf) (accessed 1 October 2011).

12 Kristy Muir et al, *Headspace Evaluation Report*, Independent Evaluation of *headspace*: the National Youth Mental Health Foundation, Social Policy Research Centre, University of New South Wales, November 2009, p. xx., [http://www.sprc.unsw.edu.au/.../Report19\\_09\\_headspace\\_EvalReport.pdf](http://www.sprc.unsw.edu.au/.../Report19_09_headspace_EvalReport.pdf) (accessed 1 October 2011).

- CYSSs in remote areas will require a very high proportion of core funding.<sup>13</sup>

### ***Budget increases to headspace funding***

4.10 In the 2010–11 Federal Budget, the Government funded 30 new *headspace* centres. The locations of ten of these centres have been determined and these centres are expected to be operational by December 2011.<sup>14</sup> In the 2011–12 Federal Budget, the Government substantially increased *headspace* funding. The new measures (\$197.3 million over the next five years) provide for the establishment of 30 new *headspace* centres, and will increase funding across all *headspace* centres. The Government intends for a total of 90 sustainable *headspace* centres to be operational by the end of the forward estimates period.<sup>15</sup>

4.11 *headspace's* submission to the inquiry welcomed the additional funding but noted that the rationalisation of Better Access, particularly the changes to MBS mental health treatment items, is likely to add to existing workforce issues with respect to attracting GPs to *headspace* centres.

Attracting GPs is already a considerable challenge, particularly in areas of GP shortage. *headspace*, across its 30 centres, has a full time equivalent of only eight GPs. *headspace* centres are finding it increasingly difficult to recruit GPs as there are not sufficient incentives for GPs to work in youth mental health. We believe that with the current systems and initiatives in place, it is not financially viable for GPs to work with young people. Many GPs are not comfortable working with this client group in general, and financial disincentives exacerbate this reluctance.<sup>16</sup>

4.12 *headspace* CEO Mr Chris Tanti expressed concern that GPs may reduce their availability to practice at *headspace* centres once the proposed cuts are implemented:

Mental health treatment plans are a core activity for GPs working in a *headspace* centre. For example, analysis of 28 out of our 30 centres showed that in the last financial year item No. 2710, for a 40-minute preparation of a mental health treatment plan, equated to over one quarter of the total GP revenue billed at *headspace* centres...

---

13 Kristy Muir et al, *Headspace Evaluation Report*, Independent Evaluation of *headspace*: the National Youth Mental Health Foundation, Social Policy Research Centre, University of New South Wales, November 2009, pp. xvi–xix., [http://www.sprc.unsw.edu.au/.../Report19\\_09\\_headspace\\_EvalReport.pdf](http://www.sprc.unsw.edu.au/.../Report19_09_headspace_EvalReport.pdf) (accessed 1 October 2011).

14 Department of Health and Ageing, *answer to question on notice E11–239*, Budget Estimates 2011–12, Community Affairs Legislation Committee, 30–31 May 2011.

15 Department of Health and Ageing, *answer to question on notice E11–239*, Budget Estimates 2011–12, Community Affairs Legislation Committee, 30–31 May 2011.

16 *headspace*, *Submission 193*, p. 4.

The majority of GPs who are working in our centres are very passionate about working with young people...So I suspect they will not leave entirely but they will reduce the amount of time they have available at *headspace*.<sup>17</sup>

4.13 Rather than a reduction to MBS rebates, *headspace* suggested that a specific MBS item be introduced for the provision of youth mental health services in order to encourage GPs to work with young people with mental health needs.<sup>18</sup> This would provide an incentive for practitioners to train in *headspace* models.<sup>19</sup> As Mr Tanti explained:

What they are saying to me is that they are already not remunerated appropriately given that they are often doing well in excess of 60 minutes... An obvious solution would be to have a particular item number in this space—a youth mental health or a youth health item number. I know that in New South Wales they have been arguing for this for some time, and it makes perfect sense to me.<sup>20</sup>

4.14 Prominent mental health policy advocate, academic and *headspace* board member Professor Ian Hickie also expressed concern about mental health workforce issues in relation to *headspace*. Professor Hickie supported the budget changes to Better Access—although considered that they do not go far enough—and suggested that a reformed ATAPS might better address workforce issues than the 'old Better Access model [which] is poor spending and poor planning'.<sup>21</sup> Professor Hickie considered that better underlying incentive structures alongside genuine commitment from professionals would address issues that arise in the delivery of *headspace* services as well as more systemically in the mental health system:

Many of the problems with ATAPS and seemingly with *headspace*—and I am sure this will happen with the new services—stem from having models that reward GPs, clinical psychologists and mental health nurses for working in those new frameworks instead of working in isolated single practices in the better resourced suburbs in our major cities. At the moment, we do not have the investments of people power under preferential schemes in those areas such as *headspace* and what will be the new early psychosis programs. That has been the problem with ATAPS. A lot of the criticism of ATAPS, particularly by the professions, is highly self-serving. We need those professions to actually align themselves with the transformational projects and we need a government that is serious about putting the

---

17 Mr Chris Tanti, *Committee Hansard*, 19 August 2011, pp 53–54.

18 *headspace*, *Submission 193*, p. 7.

19 *headspace*, *Submission 169*, p. 8.

20 *headspace*, *Proof Committee Hansard*, 19 August 2011, p. 55.

21 This issue of whether Better Access or ATAPS is a more effective program was discussed further in Chapters 2 and 3. See also Professor Ian Hickie, *Committee Hansard*, 5 September 2011, p. 72.

incentives, the allocations of workforces, particularly training workforces in medicine, general medicine, psychiatry and psychology and nursing in those transformational centres.

4.15 Conversely, the Australian Medical Association (AMA) suggested that increased funding to *headspace* should not come at the expense of Better Access. AMA anticipated that the time likely to elapse before new *headspace* centres are operational would suggest continued support to other initiatives in the interim is justified.<sup>22</sup>

4.16 Some submitters were opposed to the substantial additional funding for *headspace* on the basis that a wider range of youth services should have been considered for additional funding. The Australian Clinical Psychology Association (ACPA) submission states:

While additional investment in child and youth mental health is vital, we are concerned that 85% of the \$491.7 million funding to boost services for children and young people has been allocated to two models of care—EPPIC and *headspace*—to the exclusion of other treatment programs which may also be of significant value to the broader community, and which may have a more substantial evidence-base.<sup>23</sup>

4.17 However, the ACPA submission did not mention the alternative programs it considers of significant value. Similarly, the Psychologists Association (South Australian Branch) expressed concern about *headspace* funding but did not present a specific alternative for youth mental health care.<sup>24</sup> The Australian Association of Psychologists inc. (AAPi) suggested that *headspace* and EPPIC received increased funding because they are high profile initiatives, but that Better Access has been more effective:

[W]e agree that EPPIC and *headspace* are very good programs and that they deserve to be funded. But there is plenty of evidence for Better Access as well...

[G]enerally speaking, there is strong evidence for Better Access to take that; better evidence, I think, than there has been for the other programs.<sup>25</sup>

4.18 This concern about the rationalisation of Better Access was also expressed by witnesses who supported *headspace*. These submitters drew parallels between the effectiveness of *headspace* and the availability of MBS items for GPs. The Royal Australian College of General Practitioners (RACGP) and the Australian General

---

22 Australian Medical Association, *Submission 185*, p. 12.

23 Australian Clinical Psychology Association, *Submission 327*, p. 8.

24 Mr Quentin Black, Secretary, Psychologists Association (South Australian Branch), *Committee Hansard*, 5 September 2011, p. 40–41.

25 Mr Paul Stevenson, President, Australian Association of Psychologists inc. *Committee Hansard*, 19 August 2011, p. 49.

Practice Network explained to the committee that cuts to Better Access would reduce the provision of mental health care to young people at *headspace* centres.<sup>26</sup> These organisations considered that higher MBS items make it viable for GPs to provide care to people who would be unable to make significant gap payments themselves. RACGP considers that Better Access MBS items directly enable GPs to provide mental health services to lower-income target groups via models such as *headspace*:

*headspace*...is largely staffed by GPs using the very items that are going to be reduced.<sup>27</sup>

4.19 Several organisations representing health professionals—apart from GPs—and consumers also welcomed *headspace* funding. These included the Mental Health Council of Tasmania and the Federation of Ethnic Communities' Councils of Australia (FECCA) which further suggested that such funding should in part be directed towards assisting young people from Culturally and Linguistically Diverse backgrounds.<sup>28</sup> The National and NSW Councils for Intellectual Disability and Australian Association of Developmental Disability Medicine suggested that *headspace* should be better equipped to cater for people with co-occurring intellectual disability and mental health needs.<sup>29</sup>

4.20 Many organisations with direct experience of the *headspace* model supported the funding increase. The Australian Counselling Association has members who work at *headspace* centres and EPPIC and welcomed the expansion of the program.<sup>30</sup> The Consumers Health Forum considered that the initiative provides effective early-intervention services to young people, but sought reassurance that ongoing evaluation will take place to ensure services continue to be well-targeted.<sup>31</sup> Other groups supportive of *headspace* included Mission Australia, the Royal Australian and New Zealand College of Psychiatrists and the Australian Nursing Federation (Victoria Branch).<sup>32</sup>

---

26 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 19 August 2011, p. 2, Ms Leanne Wells, Chief Executive Officer, Australian General Practice Network, *Committee Hansard*, 5 September 2011, p. 35.

27 Professor Claire Jackson, *Committee Hansard*, 19 August 2011, p. 4.

28 FECCA, *Submission 187*, p. 5, Mental Health Council of Tasmania, *Submission 377*, p. 8.

29 National and NSW Councils for Intellectual Disability and Australian Association of Developmental Disability Medicine, *Submission 196*, p. 8.

30 Australian Counselling Association, *Submission 173*, p. 9.

31 Consumers Health Forum, *Submission 179*, p. 2.

32 Mission Australia, *Submission 209*, p. 4., Royal Australian and New Zealand College of Psychiatrists, *Submission 389*, p. 6., Australian Nursing Federation (Victoria Branch), *Submission 466*, p. 7.

## Early Psychosis Prevention and Intervention Centre (EPPIC)

4.21 The origins of EPPIC date from the 1988 establishment of a ward in the Aubrey-Lewis Unit at Royal Park Hospital dedicated to the treatment of young people hospitalised after their first episode of psychosis. The provision of targeted, early intervention care to young people developed into the EPPIC model which was officially founded in 1992 under the Directorship of Professor Patrick McGorry.<sup>33</sup>

4.22 EPPIC facilitates care to young people (aged 15–24) living in West and North West Melbourne at risk of or exhibiting psychotic illness, and their families and carers. Referrals to the service may be made by any person, and referred young people are subsequently invited to an assessment to determine if EPPIC can most effectively address their needs. If so, an Outpatient Case Manager (OCM) will be assigned to the person, a care plan developed and care services facilitated for a period of two years. The EPPIC model aims to prevent young people from needing to be hospitalised, but if it does become necessary, the Inpatient Psychiatric Unit (IPU) in Footscray can accommodate 16 people.<sup>34</sup> Specialist intervention services provided by EPPIC are modelled on collaborative and continuing care and with a focus on the early 'critical period' considered to be crucial in the management of and recovery from psychosis.<sup>35</sup>

4.23 Over the past 19 years the EPPIC model has grown and expanded in Melbourne and internationally. Orygen Youth Health (OYH) was established in 2001, building on the EPPIC model to provide care to young people experiencing other major (non-psychotic) mental illnesses. EPPIC is now a sub-clinic of OYH.<sup>36</sup> In 1996, the first International Conference on Early Psychosis was held and the International Early Psychosis Association was formed in 1997. Early intervention care based on the EPPIC model is now provided by clinics in North America and Europe.<sup>37</sup>

### *EPPIC funding in the 2011–12 Federal Budget*

4.24 In the 2010–11 Budget, the Federal Government committed to funding four additional EPPIC sites in partnership with interested states and territories. The 2011–12 budget changes commit the Government to engage the states and territories to share the cost of funding and supporting an additional 12 centres, bringing the total

---

33 EPPIC, *About Us*, <http://www.eppic.org.au/about-us> (accessed 25 August 2011);

34 EPPIC, *About Us*, <http://www.eppic.org.au/about-us> (accessed 25 August 2011); EPPIC, *Acute Care*, <http://www.eppic.org.au/acute-care-1> (accessed 26 August 2011).

35 EPPIC, *About Us*, <http://www.eppic.org.au/about-us> (accessed 25 August 2011); EPPIC, *Acute Care*, <http://www.eppic.org.au/acute-care-1> (accessed 26 August 2011).

36 EPPIC, *Our History*, <http://www.eppic.org.au/our-history> (accessed 25 August 2011).

37 International Early Psychosis Association, *About Us*, <http://www.iepa.org.au/ContentPage.aspx?pageID=40> (accessed 6 October 2011).

number of centres to 16.<sup>38</sup> The Federal Government commitment amounts to \$222.4 million over the next five years.<sup>39</sup>

4.25 While no formal partnership with the states or territories has been announced, the Department of Health and Ageing informed the Community Affairs Legislation Committee during the 2011–12 Budget Estimates hearing that there has been 'strong interest...on the EPPIC rollout' from the states and territories.<sup>40</sup> The Department also indicated that the states and territories had committed to early intervention psychosis services in the National Mental Health Plan 2009–2014.<sup>41</sup>

4.26 The submission from Orygen Youth Health itself welcomed the measure and provided the following specific recommendations that it considers will 'ensure national governance and implementation of the EPPIC measure comprehensively addresses issues of quality, accountability, model fidelity, project selection and workforce and system development':

- Providing capable, committed and accountable national leadership to drive quality and strong model fidelity across all new EPPIC services;
- Ensuring new EPPIC services are selected on the basis of being the candidates best equipped for success in terms of impact potential, quality of local leadership and local availability of expertise and resources;
- Supporting new EPPIC services to develop the skills and culture to provide high quality care consistent with Australian Clinical Guidelines for Early Psychosis; and
- Ensuring the availability of clear and reliable outcome measures through ongoing evaluation and monitoring.<sup>42</sup>

---

38 The Hon Julia Gillard MP, Prime Minister, the Hon Nicola Roxon MP, Minister for Health and Ageing, and the Hon Mark Butler MP, Minister for Mental Health and Ageing, *2011–12 Budget offers greater support for mental health patients*, Media Release, 13 May 2011 <http://www.pm.gov.au/press-office/2011-12-budget-offers-greater-support-fo-mental-health-patients> (accessed 26 August 2011).

39 The Hon. Julia Gillard MP, Prime Minister, the Hon Nicola Roxon MP, Minister for Health and Ageing, and the Hon Mark Butler MP, Minister for Mental Health and Ageing, *2011–12 Budget offers greater support for mental health patients*, Media Release, 13 May 2011 <http://www.pm.gov.au/press-office/2011-12-budget-offers-greater-support-fo-mental-health-patients> (accessed 26 August 2011).

40 Ms Georgie Harman, First Assistant Secretary, Mental Health and Chronic Disease Division, Department of Health and Ageing, *Committee Hansard*, Community Affairs Legislation Committee 2011–12 Budget Estimates, 30 May 2011, p. 55.

41 Ms Georgie Harman, Department of Health and Ageing, *Committee Hansard*, Community Affairs Legislation Committee 2011–12 Budget Estimates, 30 May 2011, p. 79.

42 Orygen Youth Health, *Submission 507*, p. 7.

4.27 In agreement with OYH, Consumers Health Forum supported the expansion of EPPIC on the condition that it—as well as *headspace*—is subject to regular evaluation:

CHF welcomes the commitment to these services, particularly the significant expansion of the number of EPPIC sites, in recognition of the current poor management of youth psychosis...

Thorough evaluation will ensure that the ongoing administration of these services will be appropriate.<sup>43</sup>

4.28 Submitters supportive of the expansion of EPPIC included South Australia's Office of the Commissioner for Social Inclusion,<sup>44</sup> Mission Australia,<sup>45</sup> and the Royal Australian and New Zealand College of Psychiatrists.<sup>46</sup>

4.29 Other submitters raised concerns about the extent to which EPPIC addresses the needs of people with mental illnesses across the population. As noted above, the Australian Clinical Psychology Association was concerned about the large amount of funds being allocated to just the two programs (*headspace* and EPPIC).<sup>47</sup> Catholic Social Services Australia considered that early intervention for young people is important, but was concerned about the reach of EPPIC and *headspace* beyond major cities:

At least some of the proposed new services should be placed in rural and remote locations. In addition, the model needs to be flexible enough to be responsive to local needs and priorities, rather than being developed and imposed in accordance with what has worked in a metropolitan area.<sup>48</sup>

4.30 The Melbourne Children's Psychology Clinic expressed concern that the target group for EPPIC, young people experiencing or at risk of experiencing their first psychotic episode, is a relatively small part of the total youth population with mental health needs:

[I]t is estimated that only 2 per cent of people will experience a psychotic episode at some stage in their life...

This is a significantly small proportion of children and adolescents compared with estimates of anxiety, depression and other common childhood disorders that cause significant distress and significantly impact on daily level of functioning. For example, Dadds et al., (2000) noted twelve month prevalence rates ranging from 17 per cent to 21 per cent in

---

43 Consumers Health Forum of Australia, *Submission 179*, p. 2.

44 *Submission 135*.

45 *Submission 209*.

46 *Submission 389*.

47 *Submission 165*, p. 9.

48 Catholic Social Services Australia, *Submission 206*, p. 3.

childhood anxiety and furthermore, that around 8 per cent will be significant enough to require treatment...<sup>49</sup>

4.31 The AMA expressed concern about the time it would take to create the new *headspace* centres, but also queried what will become of the initiative if the states and territories do not enter into a partnership with the Commonwealth as envisaged.

### ***Research on early intervention***

4.32 Early intervention for young people at risk of or exhibiting a first psychotic illness is not a settled field of medicine. There is debate within the psychiatry profession, as well as the broader community, about how to approach early intervention for psychosis.

4.33 An Access Economics analysis undertaken on behalf of Orygen Youth Health found that early intervention is effective in the 'critical [early] period':

Access Economics estimated there will be some 5,320 FEP new incidences per year in Australia...

For this cohort, if EI was universally available...the net present value of savings over the critical period would be \$212.5 million (\$82.5 million in financial savings and \$130 million in reduced burden of disease).<sup>50</sup>

4.34 The committee is also aware that there are some in the medical community who have suggested that advocates of early intervention are 'undoubtedly overstating the evidence'.<sup>51</sup> Louise Newman, past president of the Royal Australian and New Zealand College of Psychiatrists, was recently reported saying the 'focus on early intervention was too narrow and could lead to young people being overmedicated, prematurely diagnosed and stigmatised'.<sup>52</sup>

4.35 The current debate over the evidence base supporting early intervention in psychosis is reflected in current discussion about revising the Diagnostic and Statistical Manual of Mental Disorders (DSM). There is currently a proposal to

49 Melbourne Children's Psychology Clinic, *Submission 543*, p. 3.

50 Access Economics, *The economic impact of youth mental illness and the cost effectiveness of early intervention*, December 2009, Cited on the OYH website: <http://www.eppic.org.au/epnews/cost-effectiveness-early-intervention-psychosis-report-access-economics> (accessed 27 October 2011).

51 David Castle, head of psychiatry at Melbourne's St Vincent's Hospital, quoted in Jill Stark, 'McGorry accused of conflict of interest', *The Age*, 7 August 2011, <http://www.theage.com.au/national/mcgorry-accused-of-conflict-of-interest-20110806-1igxd.html> (accessed 16 October 2011)

52 Jill Stark, 'McGorry accused of conflict of interest', *The Age*, 7 August 2011, <http://www.theage.com.au/national/mcgorry-accused-of-conflict-of-interest-20110806-1igxd.html> (accessed 16 October 2011)

include in the DSM a 'psychosis risk syndrome'.<sup>53</sup> This proposal is fiercely contested. The former chair of the task force that presided over the last revision of the DSM in the 1990s, Professor Emeritus Allen Frances, has said of the proposed revisions that: 'DSM5 would create tens of millions of newly misidentified false positive "patients", thus greatly exacerbating the problems caused already by an overly inclusive DSM4'. Professor Frances is most critical of the proposal for psychosis risk syndrome:

The Psychosis Risk Syndrome is certainly the most worrisome of all the suggestions made for DSM5. The false positive rate would be alarming—70% to 75% in the most careful studies and likely to be much higher once the diagnosis is official, in general use, and becomes a target for drug companies. Hundreds of thousands of teenagers and young adults (especially, it turns out, those on Medicaid) would receive the unnecessary prescription of atypical antipsychotic drugs. There is no proof that the atypical antipsychotics prevent psychotic episodes, but they do most certainly cause large and rapid weight gains (see the recent FDA warning) and are associated with reduced life expectancy—to say nothing about their high cost, other side effects, and stigma.

This suggestion could lead to a public health catastrophe and no field trial could possibly justify its inclusion as an official diagnosis. The attempt at early identification and treatment of at risk individuals is well meaning, but dangerously premature. We must wait until there is a specific diagnostic test and a safe treatment.<sup>54</sup>

4.36 James Phillips, associate clinical professor of psychiatry at the Yale School of Medicine, recently expressed similar concerns regarding:

the controversies surrounding these diagnostic categories, involving the question of creating populations of false-positive patients who would be subjected both to diagnostic mislabeling and unwarranted, potent medications.<sup>55</sup>

4.37 While there may be concerns about the description of disorders and the consequences, there has been for some years now research on early intervention to address psychosis, with some positive results. Nevertheless, a review of the literature in 2010 observed:

---

53 Allen Frances, 'Opening Pandora's Box: The 19 Worst Suggestions For DSM5', *Psychiatric Times*, 11 February 2010, <http://www.psychiatristimes.com/dsm/content/article/10168/1522341> (accessed 16 October 2011). Also referred to as "attenuated psychotic symptoms syndrome": see, for example, SW Woods, BC Walsh, JR Saksa and TH McGlashan, 'The case for including Attenuated Psychotic Symptoms Syndrome in DSM-5 as a psychosis risk syndrome', *Schizophrenia Research*, vol. 123, 2010, pp 199–207.

54 Allen Frances, 'Opening Pandora's Box: The 19 Worst Suggestions For DSM5', *Psychiatric Times*, 11 February 2010, <http://www.psychiatristimes.com/dsm/content/article/10168/1522341> (accessed 16 October 2011)

55 James Phillips, 'The Leaders' Report on DSM-5', *Psychiatric Times*, 23 August 2011, <http://www.psychiatristimes.com/blog/dsm-5/content/article/10168/1934043> (accessed 16 October 2011)

Despite initially encouraging results concerning the predictive validity of [psychosis risk syndrome] criteria, recent findings of declining conversion rates demonstrate the need for further investigations. Results from intervention studies, mostly involving second-generation antipsychotics and cognitive behavioral therapy, are encouraging, but are currently still insufficient to make treatment recommendations for this early, relatively non-specific illness phase.<sup>56</sup>

4.38 Underpinning this policy debate are fundamental questions about whether there are identifiable underlying biological processes associated with psychosis or not; and a debate about whether identifying people at high risk of developing psychosis actually helps ensure appropriate intervention.<sup>57</sup> Some suggest, of psychosis, that 'there has never been an underlying disease process to be identified',<sup>58</sup> while others think this to be an open question, worthy of continued research.<sup>59</sup>

4.39 Despite the debate, there are significant points of agreement,<sup>60</sup> and the committee notes that the focus of the EPPIC model is not exclusively on prevention, but represents a broader model. The EPPIC model recognises that:

Preventative intervention can occur in the three key phases of early psychosis:

1. The "at-risk" phase, when symptoms are subtle and can be confused with adolescent development issues
2. The period of frank symptoms of psychosis that remains untreated, which may compound the issues of risk and the development of prolonged disability
3. The critical period after the onset of the first psychotic episode, which can be up to five years in duration, when treatment needs to be comprehensive and phase-specific.<sup>61</sup>

---

56 C. Correll, M. Hauser, A. Auther and B. Cornblatt, 'Research in people with psychosis risk syndrome: a review of the current evidence and future directions', *Journal of Child Psychology and Psychiatry*, 51(4):390–431, April 2010, p. 1.

57 Anthony Jorm, "'Prodromal diagnosis' of psychosis: an impartial commentary', *Australian and New Zealand Journal of Psychiatry*, vol. 45, pp 520–523.

58 Stephen Rosenman, Peter Anderson, 'Does prodromal diagnosis delay early intervention?', *Australian and New Zealand Journal of Psychiatry*, vol. 45, pp 509–514.

59 Patrick McGorry, 'Pre-emptive intervention in psychosis: agnostic rather than diagnostic', *Australian and New Zealand Journal of Psychiatry*, vol. 45, pp 515–519.

60 See, for example, Anthony Jorm, "'Prodromal diagnosis' of psychosis: an impartial commentary', *Australian and New Zealand Journal of Psychiatry*, vol. 45, pp 520–523.

61 Early Psychosis Prevention and Intervention Centre, Early Intervention: a Rationale, <http://www.eppic.org.au/node/169> (accessed 19 October 2011).

4.40 Early Psychosis Prevention and Intervention Centres address the needs of young people with, or at risk of developing, a psychotic illness. As discussed earlier, service gaps do exist in the care of people with severe mental illness and the Government's commitment to EPPIC is welcome in this context.

4.41 Psychosis can be debilitating and contributes to a heavy disease burden, disproportionately borne by the young. Early intervention is a worthwhile objective, provided it:

- Is carefully based on published research and evidence;
- Engages with the full range of views in the research and clinical community;
- Involves multi-disciplinary teams;
- Includes a substantial role for psycho-social interventions; and
- Actively engages patients and families.

4.42 There is some disquiet around the funding of EPPIC, however the committee believes the above conditions are being met. The committee did not receive evidence to suggest that the EPPIC model involved inappropriate prophylactic use of anti-psychotic drugs, which is a particular point of concern in some quarters.

4.43 It will be important for EPPIC to publish regular reports that outline its operations and that there should be an external clinical review after an appropriate period, to help ensure that the EPPIC program reflects the range of results in the research literature of what is a fast-evolving field.

4.44 It is also essential that the significant funding directed to EPPIC demonstrably delivers cost-effective, good health outcomes. In this respect the committee holds some reservations:

- An independent evaluation of the cost-effectiveness of EPPIC has not been carried out.
- There is no guarantee that the Government's commitment to EPPIC will be matched by state and territory funding, and therefore no guarantee that the Government will be able to fully deliver its planned expansion to EPPIC.
- It is likely that EPPIC will be unable, at least in the short term, to deliver services to people outside metropolitan areas. In this respect the committee continues to urge the Government to identify or develop strategies to meet the needs of young people in rural and remote areas.

### **Recommendation 1**

**4.45 The committee supports the increased funding to EPPIC and headspace in the 2011–12 Federal Budget on the proviso that this significant policy transformation be evaluated after two years. However, the committee urges the**

**Government to identify or develop strategies that will address the need for early psychosis prevention and intervention in rural and remote areas.**



# Chapter 5

## National Mental Health Commission

### Introduction

5.1 In the 2011–12 Federal Budget the Government allocated \$32 million over five years for the establishment and operation of the National Mental Health Commission (the Commission).<sup>1</sup> The Commission will comprise nine commissioners, raising the profile of mental health issues, and the provision of independent advice to improve transparency and accountability in mental health policy.<sup>2</sup>

5.2 The Commission's advice and feedback on mental health policy and spending measures is envisaged to help inform and shape future reform and spending:

The core function of the Commission will be to monitor, assess and report on how the system is performing and its impact on consumer and carer outcomes.<sup>3</sup>

5.3 In the first instance, the Commission will produce an Annual National Report Card on Mental Health and Suicide Prevention. The Report Card will assess the relative effectiveness of a range of mental health programs and services, highlighting which services are actually delivering outcomes for people experiencing mental illness.<sup>4</sup>

5.4 The Government intends to establish the Commission as an executive agency within the Department of Prime Minister and Cabinet and governed by a Chief Executive Officer. Under this model, the Commission will report to an agency minister within the Prime Minister's portfolio, who will also be responsible for appointing the nine commissioners.<sup>5</sup>

---

1 Of the \$32 million, \$12 million is new funding while the remainder has been redirected from the 2009–10 budget measure, *Leadership in mental health reform—continuation and further efficiency*. Department of Treasury, *Part 2: Expense Measures—Health and Ageing*, Budget 2011–12, [http://www.budget.gov.au/2011-12/content/glossy/health/html/health\\_overview\\_11.htm](http://www.budget.gov.au/2011-12/content/glossy/health/html/health_overview_11.htm) (accessed 9 October 2011).

2 National Mental Health Commission Interim Office, *Submission 527*, p.1.

3 Department of Treasury, *A new National Mental Health Commission*, Budget Overview 2011–12, [http://www.budget.gov.au/2011-12/content/glossy/health/html/health\\_overview\\_11.htm](http://www.budget.gov.au/2011-12/content/glossy/health/html/health_overview_11.htm) (accessed 9 October 2011).

4 *National Mental Health Reform 2010–12—Ministerial Statement*, 10 May 2011, p. 33.

5 Department of Prime Minister and Cabinet, *Answer to a question on notice*, Estimates 2011–12, Outcome 1.1.1., 8 July 2011.

5.5 While most submitters who commented on the Commission supported the concept of an independent voice on mental health,<sup>6</sup> several suggested changing the format of the Commission, mostly with respect to ensuring its independence from or links to government, but also its membership and representation, accountability and operation.

### **Membership and representation**

5.6 Under the Government's plan for the National Mental Health Commission, the commissioners will be appointed by the relevant agency minister, presently the Minister for Mental Health and Ageing. The Interim Office of the Commission notes that consultation is underway to inform the selection of the commissioners and that an announcement is expected in the coming months. The first meeting of the Commission is planned for early 2012.<sup>7</sup>

5.7 Some submitters expressed views about which groups should be represented on the Commission. The Aboriginal and Torres Strait Islander Healing Foundation, for example, welcomed the Commission but considered that an Indigenous Commissioner would be integral to its success in meeting the needs of Indigenous people:

However, it is important...that any strategies to address the mental health issues for Aboriginal and Torres Strait Islander people are undertaken within a cultural framework and meet the diverse needs of the Aboriginal and Torres Strait Islander community. The appointment of an Indigenous Mental Health Commissioner will ensure that cultural responses are given appropriate weight and the community will feel that the Federal government is sincere in their efforts to Close the Gap at all levels.<sup>8</sup>

5.8 The Australian Clinical Psychology Association held the view that the Commission may be able to facilitate better coordination of mental health service delivery, but that it 'need[s] experts':

We may need some representation from professional bodies like our own and others, but it needs to have experts working in the field and we need representation from our psychology board.<sup>9</sup>

5.9 The Private Mental Health Consumer Carer Network considered that consumers, carers and the private sector should be represented on the Commission:

---

6 See for example, Mr Frank Quinlan, Chief Executive Officer, Mental Health Council of Australia, *Committee Hansard*, 5 September 2011, p. 82.; NSW Nurses Association, *Submission 178*, p. 6.; SANE Australia, *Submission 654*, p. 1.

7 National Mental Health Commission Interim Office, *Submission 527*, p. 2.

8 Aboriginal and Torres Strait Islander Healing Foundation, *Submission 208*, p. 14.

9 Dr Judy Hyde, President, Australian Clinical Psychology Association, *Committee Hansard*, 19 August 2011, p. 23.

We are of the very firm belief that there must be a consumer commissioner and a carer commissioner in order to bring the consumer and carer perspectives to the very entity that is going to be looking at the transparency of services and also looking towards policies and looking towards advising government on perhaps where...mental health funding [is] best allocated.

I also think that the private sector is an area that too often gets forgotten in our health system, certainly in mental health. We have approximately 20 per cent of inpatient beds and around the same for the mental health workforce, so it is a significant area...

We believe that the commission must have a consumer commissioner, a carer commissioner and a commissioner from the private sector.<sup>10</sup>

5.10 Similarly, the National Mental Health Consumer and Carer Forum believed that people with first-hand experience of the mental health system should be represented on the Commission:

We believe that the development of a national mental health commission will be an outstanding and exciting opportunity to involve mental health consumers and carers. We are advocating for the establishment of a consumer and carer specific advisory body to inform the commission...

It is seen as essential that there must be commissioners who have a lived experience as a consumer and/or a carer.<sup>11</sup>

5.11 With respect to consumer representation on the Commission, the committee notes that the budget overview indicates that the Government wishes to engage consumers:

[The Commission] will also provide a strong and consolidated consumer voice, which will contribute to more responsive and accountable policy and program directions within the sector.<sup>12</sup>

5.12 The committee notes that consumer representation can be delivered in different ways. In New Zealand consumers are members of its Mental Health Commission Advisory Group.<sup>13</sup> In Western Australia there is an association of consumers funded by the Western Australia Mental Health Commission, as well as a

---

10 Ms Janne McMahon, Independent Chair, Private Mental Health Consumer Carer Network, *Committee Hansard*, 5 September 2011, pp. 53–54.

11 Mr Keiran Booth, Carer Co-Chair, National Mental Health Consumer and Carer Forum, *Committee Hansard*, 5 September 2011, p. 46.

12 Department of Treasury, *A new National Mental Health Commission*, Budget Overview 2011–12, [http://www.budget.gov.au/2011-12/content/glossy/health/html/health\\_overview\\_11.htm](http://www.budget.gov.au/2011-12/content/glossy/health/html/health_overview_11.htm) (accessed 9 October 2011).

13 New Zealand Mental Health Commission, *Our Advisory Group*, <http://www.mhc.govt.nz/our-advisory-group> (accessed 27 October 2011).

Consumer Advisor appointed to the Commission.<sup>14</sup> There is consumer and carer representation on the Board of the Mental Welfare Commission for Scotland,<sup>15</sup> while there are also members with lived experience of mental illness amongst the directors of the Mental Health Commission of Canada.<sup>16</sup> New South Wales, which is currently in the process of establishing a commission, has recognised that it will need 'designated and ongoing consumer, carer and family engagement and representation'.<sup>17</sup>

## Accountability and operation

5.13 Some submitters queried whether or not the Commission, as an executive agency of the Department of Prime Minister and Cabinet, would be able to provide fully independent advice. However, it was clear from the evidence that the Commission's wider accountability and effective operation was also important.

5.14 As the body promoting accountability and transparency in mental health services, some submitters asserted that the Commission's own operation must be accountable and transparent. The Australian Council on Healthcare Standards expressed concern that the parameters governing how the Commission will report on mental health services have not yet been determined:

It is encouraging to note that the Commission will 'report on Australian Government and state system performance against service expectations'. It is unclear however, what system performance will be measured against, and no reference is made to the recently updated National Standards for Mental Health Services 2010, nor an accreditation framework to drive implementation of, or monitor assessment against, these standards.<sup>18</sup>

5.15 The Australian College of Mental Health Nurses held a similar view, but extended it to the authority of the Commission:

The ACMHN believes that the national Mental Health Commission must operate with clear guidelines around its roles and responsibilities, independence, and authority to implement changes.<sup>19</sup>

---

14 Western Australia Mental Health Commission, *Consumer and carer involvement*, [http://www.mentalhealth.wa.gov.au/mentalhealth\\_changes/Consumer\\_carer.aspx](http://www.mentalhealth.wa.gov.au/mentalhealth_changes/Consumer_carer.aspx) (accessed 13 October 2011)

15 The Mental Welfare Commission for Scotland, *Our Board*, <http://www.mwscot.org.uk/web/FILES/Commissioners/BoardDetails2011.pdf> (accessed 13 October 2011)

16 Mental Health Commission of Canada, *Non-Government Directors*, [http://www.mentalhealthcommission.ca/English/Pages/MHCC\\_Non\\_Gov\\_Directors.aspx#Peter](http://www.mentalhealthcommission.ca/English/Pages/MHCC_Non_Gov_Directors.aspx#Peter) (accessed 13 October 2011)

17 New South Wales Health, *Establishment of the NSW Mental Health Commission*, <http://www.health.nsw.gov.au/mhdao/mhcommission.asp> (accessed 13 October 2011)

18 Australian Council on Healthcare Standards, *Submission 110*, p. 1.

19 Australian College of Mental Health Nurses, *Submission 447*, p. 8.

5.16 Rather than implementing changes, the Public Health Association of Australia considered that the Commission should exert pressure on governments to consider mental health issues in implementation across a broad range of initiatives. It recommended that the Federal Government should:

Use the new National Mental Health Commission to advocate for the inclusion and measurement of mental health in all government initiatives and programs. This will allow the effect of the multiple influences on mental health to be visible and for broad, appropriate action to be taken.<sup>20</sup>

5.17 The committee notes that the Commission's stated function is advisory rather than authoritative. This advisory role is a function that some submitters consider will only be possible in partnership with other organisations and governments. The Mental Health Council of Australia considered that the Commission will need to engage effectively with the states and territories, as well as the broader health and community sectors, in order to link the many levels of mental health services and inform 'effective planning':

Ensuring that various plans are linked to clearly defined and reportable targets is one way of ensuring greater scrutiny of progress. Feeding all of these processes into the 10 Year Roadmap will also be important.<sup>21</sup>

5.18 Similarly, Catholic Social Services Australia (CSSA) believed that the Commission's success will 'depend on active participation by community managed services and NGOs'.<sup>22</sup> In addition, CSSA expressed concern about whether the Commission as currently envisaged will be able to generate practical, coordinated improvements to mental health services:

In the absence of clear terms of reference, it is hard to comment on the Commission's potential as an effective 'watchdog' and advisory body.

The Commission will need to represent a broad spectrum of consumer, carer, service provider and community interests in order to guide realistic long term planning and coordination. A very real challenge for the Commission will be to demonstrate leadership for systemic and policy change that transcends jurisdictional and portfolio silos.<sup>23</sup>

5.19 While CSSA expressed doubts about whether or not the Commission could transcend portfolio and jurisdictional boundaries, several other submitters suggested that the Commission must be completely independent from government in order to deliver impartial advice.

---

20 Public Health Association of Australia, *Submission 195*, p. 7.

21 Mental Health Council of Australia, *Submission 198*, pp 3–4.

22 Catholic Social Services Australia, *Submission 206*, p. 3.

23 Catholic Social Services Australia, *Submission 206*, p. 3.

5.20 The Department of Health and Ageing explained that the rationale for the Commission's positioning in the Prime Minister's Department is to ensure cross-portfolio coordination:

...really importantly, the fact that the mental health response is not just a health response. The thinking behind having the agency housed within the Department of the Prime Minister and Cabinet is really recognising the need for many portfolios to be engaged in improving mental health outcomes.<sup>24</sup>

5.21 Some witnesses to the inquiry considered that this arrangement will be effective, while others suggested that the Commission should be independent from government. Those satisfied with the placement of the Commission as an executive agency under the Prime Minister's portfolio included the National Mental Health Consumer and Carer Forum.<sup>25</sup>

5.22 The Mental Health Council of Australia explained that there could be both advantages and disadvantages to independence from government:

We certainly have a view that the principle of independence is an important one to the commission, but so too is the power and capacity of the commission to get access to a range of data sources. We think that positioning the commission within the Department of Prime Minister and Cabinet will allow the commission to gain access to and have the authority across portfolios within the federal government, and that is welcomed...

We will adopt a supportive but a wait-and-see approach.<sup>26</sup>

5.23 Beyondblue expressed a similar view, as did Professor Hickie, who considered that the Commission needed to operate at a high level order to be equipped to make decisions about overarching policy and funding issues:

...I think at this stage we have become more generally concerned that we get a national commission that does operate at a higher level; and, within the bureaucracy, Prime Minister and Cabinet is obviously the highest level. We would expect it, however, to have the characteristics of independence that you are talking about...<sup>27</sup>

5.24 Professor McGorry agreed, although noted that eventually, independence could be better achieved outside of government:

---

24 Ms Rosemary Huxtable, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 September 2011, p. 21.

25 Mr Keiran Booth, Carer Co-Chair, National Mental Health Consumer and Carer Forum, *Committee Hansard*, 5 September 2011, p. 48.

26 Mr Frank Quinlan, Chief Executive Officer, Mental Health Council of Australia, *Committee Hansard*, 5 September 2011, pp 82–83.

27 Professor Ian Hickie, *Committee Hansard*, 5 September 2011, p. 69. See also, Ms Dawn O'Neil, (then) Chief Executive Officer, Beyondblue, *Committee Hansard*, 19 August 2011, p. 61.

---

I think the ideal is actually an independent commission—I think that is what we should aim for in due course; that is really the only way to guarantee independence—similar to the Human Rights Commission and those sorts of structures.<sup>28</sup>

5.25 Several other witnesses were more sceptical of the level of independence that the Commission could have if it were an executive agency within the Department of Prime Minister and Cabinet. Professor Lyn Littlefield, Australian Psychological Society, considered that the Commission should be independent from government because one of its key roles is to evaluate government spending:

It should be an independent body. I think it should be a body that looks at transparency, accountability and evaluation of the money that is spent in mental health. In those respects I do think it is a very important body. It should give advice as to the best services possible for what we want to do. It needs real experts on it.<sup>29</sup>

5.26 The Royal Australian and New Zealand College of Psychiatrists expressed a similar view:

The Royal Australian and New Zealand College of Psychiatrists supports the development of a mental health commission but that this needs to be independent of government to objectively report on the state and progress of mental health services.<sup>30</sup>

---

28 Professor Patrick McGorry, *Committee Hansard*, 5 September 2011, p. 69.

29 Professor Lyn Littlefield, Executive Director, Australian Psychological Society, *Committee Hansard*, 19 August 2011, p. 17.

30 Dr Maria Tomasic, President, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 5 September 2011, p. 25.



## Chapter 6

### Two-tiered Medicare rebate system for psychologists

#### Introduction

6.1 As discussed in Chapter 2, the Better Access initiative provides Medicare rebates for mental health services provided by GPs, psychologists, occupational therapists and social workers. The rebatable amount for psychological services varies according to:

- the time spent providing services to the client;
- where such services are provided (in consulting rooms or otherwise); and
- whether such services are provided by a clinical or non-clinical psychologist.

6.2 The inquiry's term of reference (e) addresses the 'two-tiered Medicare rebate system for psychologists'. The 'two-tiered system' refers to the situation whereby services provided by clinical psychologists (tier one) attract a higher rebate than those provided by registered psychologists (tier two). The Department of Health and Ageing notes that this has been the case since the implementation of the Better Access initiative, and 'based on advice from the psychology profession'.<sup>1</sup> The Medicare items relevant to psychologists are:

- Items 80000, 80005, 80010 and 80015—Individual Psychological Therapy services provided by a clinical psychologist;
- Item 80020—Group Psychological Therapy services provided by a clinical psychologist;
- Items 80100, 80105, 80110 and 80115—Individual Focussed Psychological Strategies services provided by a psychologist;
- Item 80120—Group Focussed Psychological Strategies services provided by a psychologist.<sup>2</sup>

6.3 As seen above, Medicare differentiates the services provided by psychologists from those provide by clinical psychologists. The items that clinical psychologists may use attract a higher rebate than those provided by (general) psychologists. For example, the recommended fee and benefit rate for item 80000—a 30 to 50 minute consultation for psychological therapy provided by a clinical psychologist at

---

1 Department of Health and Ageing, *Submission 199*, p. 11.

2 Department of Health and Ageing, *MBS Items – Psychologists and other allied mental health professionals*, <http://www.health.gov.au/internet/main/publishing.nsf/content/health-pcd-programs-amhpm-pdf-factsheet> (accessed 16 August 2011).

consulting rooms—are \$92.20 and \$78.40 respectively. However, the recommended fee and benefit rate for item 80100—a 20 to 50 minute consultation for focussed psychological strategies services provided by a psychologist at consulting rooms—are \$65.30 and \$55.55 respectively.<sup>3</sup>

6.4 This chapter examines the differing requirements for registration as a general psychologist, a clinical psychologist and an endorsed psychologist (in any of the nine practice areas). It then provides a summary of the arguments presented both for and against the two-tiered system. The committee notes that no proposal to adjust the two-tiered system was made by the government in the 2011–12 Federal Budget.

### **Training to be undertaken by psychologists providing rebatable services under the Better Access initiative**

6.5 Psychologists eligible to provide rebatable focussed psychological strategies services under the Better Access initiative are required to hold and maintain General registration with the Psychology Board of Australia (the Board), and be registered with Medicare.<sup>4</sup> In most cases, General registration for a psychologist is granted to applicants who have completed a total of six years of training approved by the Board; for example, six years of university training, or five or four years of university training plus an approved internship for one or two years respectively.<sup>5</sup> Many submitters to the inquiry cited four years' study and a two-year internship (the '4+2' pathway) as the most common pathway to General registration. However, the Board is currently liaising with the Australian Psychology Accreditation Council (APAC) and universities to transition away from the 4+2 system and towards a new 5+1 system.<sup>6</sup>

6.6 This registration system is part of the National Registration and Accreditation Scheme for psychologists which replaced previous state- and territory- based registration arrangements on 1 July 2010.<sup>7</sup> On the day of the commencement of the scheme, registration was transferred at equivalent level from state and territory boards to the Australian Psychology Board. Subsequent renewal applications (required on an

---

3 Department of Health and Ageing, *Group M6—Psychological Therapy Services and Group M7—Focussed Psychological Strategies*, Medicare Benefits Schedule Online, <http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-201107> (accessed 16 August 2011).

4 Department of Health and Ageing, *Allied Mental Health Professional Eligibility*, <http://www.health.gov.au/internet/main/publishing.nsf/content/health-pcd-programs-amhpm-pdf-explan> (accessed 16 August 2011).

5 Psychology Board of Australia, *General Registration*, <http://www.psychologyboard.gov.au/Registration/General.aspx> (accessed 16 August 2011).

6 Psychology Board of Australia, *5+1 Internship Program*, <http://www.psychologyboard.gov.au/Registration/Provisional/5-1-Internship-Program.aspx> (accessed 17 August 2011).

7 The scheme commenced on 18 October 2010 in WA. Psychology Board of Australia, *General Registration*, <http://www.psychologyboard.gov.au/Registration/General.aspx> (accessed 17 August 2011).

---

annual basis) are made to the Board. The transition will be complete by 30 November 2011 at which time psychologists in all states and territories will be uniformly registered with the Board until 30 November 2012.<sup>8</sup>

6.7 As part of the transition arrangements, registrants were initially transferred to the equivalent registration level in the national scheme for a period of less than one year and are subsequently obliged to register under the national scheme. All psychologists in all states must have applied for General registration under the current national scheme by 30 November 2011.<sup>9</sup>

6.8 To maintain General registration, the Board requires psychologists to complete 30 hours of Continuing Professional Development (CPD) each year. Board guidelines stipulate details of acceptable training, record keeping, auditing and related matters.<sup>10</sup> This training requirement came into effect on 1 July 2010 as part of the National Registration and Accreditation Scheme.

6.9 In the 2009–10 Federal Budget, and to apply from 1 July 2011, the Government introduced further training requirements for allied health professionals, including (non-clinical) psychologists providing focussed psychological strategies services. Eligible psychologists must have completed 10 hours of focussed psychological strategies Continuing Professional Development (FPS CPD) in the period 1 July 2009–1 July 2011, and then an additional 10 hours of approved training annually to remain eligible for Medicare registration.<sup>11</sup>

6.10 Rebateable psychological therapy services under the Better Access initiative may only be provided by clinical psychiatrists registered as such with Medicare. In order to be eligible for registration with Medicare, clinical psychiatrists must:

- Hold and maintain General registration with the Psychology Board of Australia, and either:
  - Hold and maintain membership of the Australian Psychological Society's (APS) College of Clinical Psychologists; or

---

8 Psychology Board of Australia, *Psychology Registration Renewal Fact Sheet*, <http://www.psychologyboard.gov.au/Registration/General.aspx> (accessed 17 August 2011).

9 Psychology Board of Australia, *Transition*, <http://www.psychologyboard.gov.au/Registration/Transition.aspx> (accessed 17 August 2011).

10 Psychology Board of Australia, *Continuing professional development registration standard*, <http://www.psychologyboard.gov.au/Registration/General.aspx> (accessed 17 August 2011).

11 Department of Health and Ageing, *Fact Sheet: Focussed Psychological Strategies Continuing Professional Development*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-focus#wan> (accessed 16 August 2011).

- Meet the requirements of such membership as judged by the Australian Psychological Society; or
- Hold and maintain endorsement as a clinical psychologist by the Psychology Board of Australia.

6.11 In order to gain eligibility for membership of the Australian Psychological Society's (APS) College of Clinical Psychologists:

...a minimum of six years university training, including approved postgraduate clinical studies and placements in mental health settings, plus a further two years approved supervision in the clinical field is required. Members are also required to maintain a program of ongoing professional development.<sup>12</sup>

6.12 The Psychology Board of Australia may grant endorsement to eligible psychologists in nine areas of practice: clinical psychology, counselling psychology, forensic psychology, clinical neuropsychology, organisational psychology, sport and exercise psychology, educational and developmental psychology, health psychology and community psychology.<sup>13</sup> Of these nine areas, only clinical psychologists can access the higher rebate tier of the Medicare rebate.

6.13 In order to gain endorsement in any of the nine practice areas, candidates must satisfy an area-specific list of competencies and have completed further specialised study (usually an approved doctorate or master degree and one or two years' approved supervised practice respectively).<sup>14</sup>

6.14 As discussed above, a national registration scheme was introduced relatively recently. As part of the transition from the state- and territory- based accreditation systems to endorsement by the Board, transition arrangements and grandparent clauses apply. In the case of WA, psychologists holding *specialist* registration in seven practice areas (including clinical psychology), were eligible for automatic endorsement. Titles such as 'Specialist Clinical Psychologist' may not be used by any psychologist except those registered as specialist psychologists in WA on 17 October 2010, for a period of three years from 18 November 2010.<sup>15</sup>

---

12 Australian Psychological Society, *APS College of Clinical Psychologists—About Us*, [http://www.groups.psychology.org.au/cclin/about\\_us/](http://www.groups.psychology.org.au/cclin/about_us/) (accessed 16 August 2011).

13 Psychology Board of Australia, *Codes Guidelines Policies*, <http://www.psychologyboard.gov.au/Endorsement/Codes-Guidelines-Policies.aspx> (accessed 17 August 2011).

14 Psychology Board of Australia, *Codes Guidelines Policies*, <http://www.psychologyboard.gov.au/Endorsement/Codes-Guidelines-Policies.aspx> (accessed 17 August 2011).

15 Psychology Board of Australia, *Frequently Asked Questions*, <http://www.psychologyboard.gov.au/Endorsement/FAQ.aspx> (accessed 17 August 2011).

---

## Two-tiered Medicare rebate system for psychologists—debate

6.15 Submitters were divided as to whether the current scheme should remain unchanged (the argument primarily made by clinical psychologists) or should be changed to a single- or multi- tiered system (the argument primarily made by non-clinical psychologists). Aspects of this debate—alongside the rationalisation of rebatable sessions from a maximum of 18 to a maximum of 10 as discussed earlier—provided the impetus for more than a thousand psychologists to submit to the inquiry.

### *In favour of the two-tiered system*

6.16 Most witnesses who considered that the higher rebate should be retained for clinical psychologists justified this position by referring to the higher education and training requirements for registration as a clinical psychologist as opposed to general registration as a psychologist.

6.17 As discussed above, candidates are required to have completed six years of formal education and two years of supervised practice in order to be eligible for Medicare registration as a clinical psychologist. Several submitters considered that this combination of education and experience better equips clinical psychologists to make holistic diagnoses and implement treatment plans.<sup>16</sup>

6.18 Some clients who had experienced positive mental health outcomes as a result of treatment by a clinical psychologist made submissions in support of the two-tiered rebate. For example, submitters 58 and 213 (both name withheld), considered that clinical psychologists provide better treatment, especially to clients with complex mental health needs:

Originally, and for nearly 20 years, [my son's] schizophrenia was controlled almost entirely with medication. Counseling from a clinical psychologist from 2006 onwards worked a miraculous improvement in the quality of his life.<sup>17</sup>

6.19 Given that study leading to endorsement as a clinical psychologist requires significant time and financial commitments, some submitters held the view that abolishing the higher rebate for clinical psychologists may act as a disincentive to professional development in that field:

The loss of the two tiered system will lead to the loss of the clinical skills...to the community of Australia. Simply, the loss of the two tiered system will turn back the advancements that have been achieved over 30 years. In a short period of time the skills of the clinical psychologist will be

---

16 See for example, Name Withheld, *Submission 71*, p. 2.

17 Name Withheld, *Submission 58*, p. 1.

lost because there will be no incentive and no career path for psychologists to train and move to specialisation.<sup>18</sup>

6.20 Several submitters emphasised the considerable expense of post-graduate education in clinical psychology:

A professional clinical doctorate costs in excess of \$100,000 when course fees and loss of income to attend lectures and clinical placements is taken into account. This is a significant disincentive to those early in their careers.<sup>19</sup>

6.21 Other clinical psychologists cited international training standards and asserted that Australia has comparatively low requirements for registered psychologists. These submitters consider that clinical psychologists should be recognised with the higher rebate because the number of years they spend training is similar to that required of registered psychologists overseas.<sup>20</sup>

6.22 The Australian Psychological Society (APS) College of Clinical Psychologists stated that the higher rebate for clinical psychologists is vital to the public interest—that the general population needs to be able to compare clinical and non-clinical psychologists in order to make informed choices when accessing psychological services:

In the best interests of the public, who cannot be reasonably expected en-masse to have the required knowledge-set to easily differentiate who has received accredited specialist training in the provision of evidence-based and scientifically-informed psychological interventions with psychiatric disorder across the entire lifespan and all levels of complexity and severity...<sup>21</sup>

6.23 While those who supported the continuation of the current two-tier rebate cited the educational qualifications of clinical psychologists, other submitters held that their own qualifications justify the opposite argument.

### ***In favour of change to the two-tiered system***

6.24 Many submitters who advocated for change to the present two-tier rebate arrangement did so on the basis that clinical psychology is only one of nine practice areas eligible for endorsement by the Psychology Board of Australia. As discussed earlier, endorsement in any given practice area has approximately equivalent requirements with respect to post-graduate study and experience. Several submissions were received from psychologists endorsed in one of the practice areas apart from

---

18 Dr Darryl Monaglio, *Submission 57*, p. 8.

19 Mr Chris Wilcox, *Submission 549*, p. 3.

20 See for example, Australian Clinical Psychology Association, *Submission 165*, pp 4–5.

21 Australian Psychological Society (APS) College of Clinical Psychologists, *Submission 161*, p. 6.

clinical psychology who consider it inequitable that they are ineligible for the higher rebate. The sentiment of the following submitter, a forensic psychologist, is echoed in many other submissions from psychologists endorsed in non-clinical practice areas:

I am an experienced forensic psychologist with a Doctoral Degree and eight years experience in the field.

At present, my clients are within the criminal justice system and have drug addictions, homelessness and mental illness.

Although, I am a recognised specialist in working with these clients, the two tiered Medicare system does not recognise me. Instead, if I was a clinical psychologist with no experience working with individuals in the criminal justice system, I would receive a higher rate of pay for working with these clients.

I do not charge my clients a fee and rely solely on the Medicare rebate. This is because my clients are often homeless and suffering significant financial hardships. Equality in the rate of pay for the Medicare system would allow me to broaden my work with disadvantaged clients and provide additional services.<sup>22</sup>

6.25 The above example illustrates the primary arguments made in favour of change to the two-tiered system: that other endorsed psychologists are also highly trained; that the current system favours one particular qualification over experience; and that other endorsed psychologists and their clients deserve more assistance from Medicare.

6.26 Other submitters suggested that an independent assessment process should take place to recognise highly-skilled psychologists.<sup>23</sup> This process is envisaged to be completely separate both from the present recognition of clinical psychologists through the top tier rebate, or current PBA endorsement requirements:

Rather than maintaining a ‘two-class’ rebate system based on which degree someone completed at university, I propose to implement a national registration and accreditation body (perhaps as part of the Australian Health Practitioner Registration Agency) which assesses the knowledge and skills of all health professionals at the time they apply for their Medicare provider status. In this way if a non-clinical psychologist or allied health professional could demonstrate that they possess equal skills to those of a Clinical Psychologist they should be able to provide psychological therapy services and charge accordingly.<sup>24</sup>

---

22 Name Withheld, *Submission 569*, p. 1. See also, for example, Australian Psychological Society (APS) College of Counselling Psychologists, *Submission 125*, p. 3.

23 See for example, Name Withheld, *Submission 225*, p. 3.

24 Dr Carsten Schley, *Submission 77*, p. 2.

6.27 The proposal was also made that the two-tiered system be abolished completely. Under the model proposed by some submitters, every registered psychologist would be eligible for the same Medicare rebate, regardless of any further qualification:

The solution to the dichotomy created in the profession by the two-tier Medicare rebate system is to immediately abolish this discriminatory and divisive system and replace it with a single rebate covering consultations with registered psychologist under a mental health care plan.<sup>25</sup>

6.28 While the committee received a very high volume of submissions from psychologists regarding the two-tiered rebate, the vast majority cited anecdotal evidence in support of their positions. There was almost no systematic, independent evidence demonstrating any difference or similarity in health outcomes achieved by clients of clinical compared with other psychologists.

### *Health outcomes for clients*

6.29 Some submitters claimed a comparison of results achieved by clinical and non-clinical psychologists shows no difference in health outcomes. The committee is not aware of any reputable study supporting this, nor the opposing claim. In early 2009, an AAP article cited University of Canberra academic Associate Professor Tim Carey's claim that comparable treatment outcomes can be achieved by clinical and non-clinical psychologists.<sup>26</sup> The Australian Psychological Society responded to this assertion, stating:

[N]o study has been done comparing the two, therefore there is no evidence...

Given their differences in training, it is reasonable to expect that general and clinical psychologists will often be treating cases of different complexity. It is this and their more extensive, specialised training that justifies the higher Medicare rebates for their patients, just as similar factors justify higher rebates for medical specialists.<sup>27</sup>

6.30 Pirkis' evaluation of Better Access included an analysis of the outcomes achieved by clinical psychologists, general psychologists and GPs.<sup>28</sup> Three linear regression analyses were undertaken to demonstrate factors contributing to clients'

25 Australian Association of Psychologists inc., *Submission 197*, p. 3.

26 AAP, 'Money spent on psychologist rebate wasted: academic', 3 February 2009, <http://www.medicalsearch.com.au/News/Money-spent-on-psychologist-rebate-wastedacademic-36680> (accessed 11 October 2011).

27 Mr Bob Montgomery, then Australian Psychological Society President, *Attack on Medicare rebates for clinical psychology unfounded*, [http://www.psychology.org.au/news/media\\_releases/5feb09/](http://www.psychology.org.au/news/media_releases/5feb09/) (accessed 17 August 2011).

28 Dr Jane Pirkis et al, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, 22 February 2011, pp 28–32.

improvements as measured by the Kessler Psychological Distress Scale (K-10). However, the purpose of the analysis was to examine factors contributing to improvements *within* the cohort of clients receiving treatment by each group of professionals—clinical psychologists, general psychologists and GPs—rather than comparing them. Nevertheless, the analysis demonstrated similar trends in treatment outcomes across professional groups:

...for all three groups of consumers, those with worse baseline manifestations of psychological distress demonstrated greater levels of improvement than those with lower pre-treatment scores.<sup>29</sup>

6.31 This trend is reflected in the mean improvement in K-10 scores of the sample groups who consulted clinical psychologists, registered psychologists and GPs: 9.53, 10.58 and 8.01 respectively.<sup>30</sup> While the raw data may appear to suggest slightly better results are achieved by registered psychologists, it is actually reflective of the higher distress level recorded pre-treatment by clients in the sample group who consulted registered psychologists. As quoted above, the greater the initial distress experienced by the client, the greater the improvement, regardless of which professional was engaged to provide treatment.

**Senator Rachel Siewert**

**Chair**

---

29 Dr Jane Pirkis et al, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, 22 February 2011, p. 28.

30 Dr Jane Pirkis et al, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation Final Report*, 22 February 2011, p. 27.



# **Chair's Additional Comments**

## **Introduction**

1.1 The Community Affairs References Committee strives to reach consensus in inquiry reports. In this case, the committee has tabled a majority report that it agrees outlines the evidence received during the course of the inquiry. However, committee members were unable to agree on specific recommendations to address the concerns raised by those who contributed to the inquiry. Therefore, Senators from each party have tabled additional comments or dissenting reports. The Chair has carefully considered all the material presented to the committee and identified recommendations that she feels best reflect the breadth of the evidence received. This report needs to be read in conjunction with the majority report as it specifically addresses issues raised in the majority report.

## **Better Access**

1.2 Given the conclusions reached in both the Better Access and ATAPS evaluations, the Chair accepts the Government's conclusions that Better Access has not reached lower socio-economic groups or rural or remote areas as well as it has people in metropolitan areas. There is greater scope for ATAPS to meet the needs of hard to reach groups than Better Access, in particular, ATAPS is structured more appropriately to reach those groups.

1.3 Better Access began as an initiative aimed at high-prevalence disorders. However, the initiative has been increasingly used by people experiencing severe symptoms. The Government has not been sufficiently clear in communicating whether its objective is to target particular mental illnesses, particular levels of severity of condition, or conditions of a particular duration (chronic versus short-term episodic). The Government needs to communicate better to both professions and the public about what Better Access is for, and what it is not for. It also needs to make clear, to those for whom Better Access is not the right program, what existing service they should be accessing.

1.4 In the case of severe conditions, such as eating disorders, the committee heard that people have difficulty securing treatment. This echoes evidence received over six years ago by the Select Committee on Mental Health. The extended 18 sessions of Better Access have provided a way for professionals to deliver a recognised treatment program for these disorders. The Government's view may be that this was not the intention of Better Access, but at this point there is no alternative. This situation will become worse under the Government's proposed changes.

1.5 The rationalisation of MBS rebatable sessions under the Better Access initiative is likely to, in the immediate term, exacerbate existing service gaps for people with severe and persistent mental illness. The committee has not received evidence that ATAPS will meet the needs of these people in the short term. In theory

the Better Access initiative was designed to address high prevalence disorders that could be treated by 6–12 sessions. However, in the absence of viable alternatives, this initiative has been utilised to provide treatment to people with a severe mental illness who need the maximum 18 sessions. Until the Government provides an alternative, effective means to address the needs of people with a severe mental illness, it cannot justify excluding these people from accessing services under Better Access.

### **Recommendation 1**

**1.6 The Chair of the committee recommends that the rationalisation of the number of rebatable allied health sessions under Better Access be delayed until it can be demonstrated that other programs (such as ATAPS) are adequately equipped to provide services to people with a severe or persistent mental illness.**

### **Recommendation 2**

**1.7 The Chair of the committee recommends that the Government consider putting in place an interim program through the MBS that would allow access to six additional sessions under Better Access for consumers who meet tightened criteria based on the severity of their condition.**

### **Recommendation 3**

**1.8 The Chair of the committee recommends that the Government continue to evaluate Better Access and keep a watching brief on how the program is being accessed nationwide with a particular focus on the take up of Better Access services by hard to reach groups.**

### **Access to Allied Psychological Services**

1.9 The mental health workforce is key to the delivery of any mental health policy initiative. The expansion of ATAPS, in conjunction with the introduction of Medicare Locals, presents significant opportunities to embed mental health services in primary care. However, the program faces significant challenges. The composition of the workforce should be expanded more consistently, beyond GPs and psychologists, to incorporate more mental health nurses, social workers and counsellors. In addition, the design and planning of care initiatives through interaction with hospital and NGO networks should be central to what the program can deliver. The Northeast Health Wangaratta model is an excellent example of this.

1.10 The Chair supports the Government's initiatives to broaden the ATAPS program and provide the type of holistic care that is required by some consumers. The effort to reward innovation through Tier 2 funding is also encouraging.

1.11 ATAPS will not and is not designed to meet the needs of consumers in crisis. For this reason it is not going to meet the needs of those experiencing severe mental illness who are currently receiving treatment under the 'exceptional circumstances' provision of the Better Access program.

1.12 In addition, ATAPS places a greater administrative burden on GPs than the Better Access program does. The APS suggestion that referrals could be carried out in a similar administrative manner to Better Access should be explored.

1.13 Further, ATAPS is a capped funding model while Better Access is not. In the context of specific funding arrangements, financial management will become an important consideration for GP Divisions, Medicare Locals or NGOs. The employment model used by Northeast Health Wangaratta is a useful model, although in some cases this may not be appropriate.

1.14 While flexibility and the ability to design the program according to local need is one of the positive elements of ATAPS, there is a danger that this could result in patchy or inconsistent service delivery across the country. The Government needs to develop guidance to assist in the rollout of Medicare Locals and the expansion of ATAPS and advise practitioners on how to achieve the full potential of ATAPS. This guidance should include advice on financial management and the development of innovative programs targeting hard to reach groups. Given that the timescale for the expansion of ATAPS is relatively long, there is also scope to establish a comprehensive performance assessment framework that could highlight examples of best practice in service delivery that could be disseminated and adopted across the country.

#### **Recommendation 4**

**1.15 The Chair of the committee recommends that the Government develop guidance materials as quickly as possible to assist Medicare Locals and GP Divisions in meeting the full potential of the expanded ATAPS program. This material should include examples of nationwide best practice in areas such as financial management and the development of innovative projects targeting hard to reach groups.**

#### **Recommendation 5**

**1.16 The Chair of the committee recommends that a comprehensive performance assessment framework be established as part of the ATAPS expansion. The data gathered should be used to develop benchmarking tools to compare ATAPS service delivery across Medicare Locals and GP Divisions with similar geographic and demographic indicators.**

1.17 The expansion of ATAPS is an appropriate recognition of the complex challenges which face mental health delivery nationwide. The diversity possible within the program, ranging across the traditional Tier 1 funding, through Tier 2, to the Funding Care Packages and Coordinated care model, is an encouraging first step in what needs to be a long term policy commitment by Government to bring mental health to the same stage as physical health care. However while the committee did not hear any evidence that opposed the expansion of the ATAPS program, it has also not heard any evidence that supported a view that the program will be substantially operational in its new form by November 2011. Under the current proposals there will

almost certainly be a substantial period where Medicare Locals and GP Divisions will not be fully engaged with the ATAPS program, and consequently will not be able to deliver appropriate mental health care for consumers. The Chair is greatly troubled by this scenario.

### **Recommendation 6**

**1.18 The Chair of the committee urges the Government to revise its scheduling for the 2011–12 Federal Budget changes to ensure continuity of care.**

### **Youth Mental Health**

1.19 There is widespread support for *headspace*, but also widespread concern about whether all the policy settings are right to ensure the initiative succeeds. The external evaluation identified a range of issues, and submitters have added to those. The greatest concern appeared to be whether the funding model would be effective in ensuring the ongoing participation of GPs.

1.20 Adequate remuneration for GPs will be needed if they are going to agree to participate in *headspace* centres rather than working elsewhere. However, as *headspace* pointed out, health professionals including GPs working in the centres do not have to be self-funded through the MBS. They can also be paid as employees of the centres.

1.21 The Government is increasing the level of funding for each centre, not only expanding the number of centres. Accordingly, one of the options available is for the *headspace* consortia to seek to make use of this money to employ GPs directly, ensuring a guaranteed funding base that provides a buffer against the time pressures and other issues that submitters identified as discouraging some GPs from working in this field.

1.22 The Chair is concerned about the transitional issues. Fundamentally, an approach that cuts funding for one program now, with the expansion of funding of other programs only coming later, cannot be supported. Funding shifts should be closely matched. Changes to Better Access should take place, for example, only as expansion measures such as additional *headspace* centres come online. As the evaluation report noted, this will be 9–12 months after there is agreement to fund them, to which must be added the lead times involved in the competitive bid process.

### **Recommendation 7**

**1.23 The Chair of the committee recommends that any tightening of eligibility for Better Access be delayed until the youth mental health initiatives funded in the 2011–12 Federal Budget are fully expanded and operational.**

---

## **National Mental Health Commission**

### **Recommendation 8**

**1.24 The Chair of the committee considers that consumers must have a central role in any mental health advisory body, and that Aboriginal and Torres Strait Islander people should be represented. The National Mental Health Commission, which will have nine Commissioners and a Chair, should include at least one commissioner who is a consumer, one who is a carer and one who has Aboriginal or Torres Strait Islander heritage.**

### **Recommendation 9**

**1.25 The Chair of the committee recommends that the Government review the operation and structure of the National Mental Health Commission after two years with a view to placing it on a statutory basis.**

### **Two-tier rebate for psychologists**

1.26 The evidence does not provide adequately compelling arguments to change the current arrangements. Out of nine areas of practice endorsement that generally require higher levels of study, only one attracts a higher Medicare rebate. The Chair recognises, however, the value of the services provided across the range of practice areas. In these circumstances, the Government should undertake ongoing monitoring of any effects of the two-tier Medicare rebate for psychologists on workforce composition.

### **Recommendation 10**

**1.27 The Chair of the committee believes that the new Mental Health Commission should undertake ongoing monitoring of the two-tier Medicare rebate for psychologists to ensure that patients have access to the most appropriate practitioners and that workforce balance across the mental health sector is maintained.**

**Senator Rachel Siewert  
Chair  
Australian Greens, Western Australia**

**Senator Penny Wright  
Australian Greens, South Australia**



# **Minority Report**

## **Australian Labor Party**

It is the view of Labor Senators that while Better Access is a good program for those it is reaching, it is still not servicing hard to reach groups like young people, men, people living in rural and remote regions, Indigenous Australians and people living in areas of high socio economic disadvantage.

The Better Access evaluation showed that people on lower incomes received both significantly less services and funding under Better Access than those on higher incomes. The evaluation also showed that almost three-quarters of people who access services used between one and six sessions a year meaning that the vast majority (87 per cent) of people will therefore be unaffected by this change.

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

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

It is important that people get the right care for their needs. People who currently receive more than ten allied mental health services under Better Access are likely to be patients with more complex needs and would be better suited for referral to more appropriate mental health services. GPs can continue to refer those people with more severe ongoing mental disorders to Medicare subsidised consultant psychiatrist services, where 50 sessions can be provided per year, or state/territory specialised mental health services.

It is also important to note that Better Access will continue to be a growth program with more than \$4 billion projected to be spent over the next five years.

The changes being implemented by the Government will achieve a better balance between the Medicare fee based model provided through Better Access and the low to no cost services directly targeted to hard to reach groups through ATAPS.

This measure will see funding shifted from Better Access to ensure a doubling of the services currently provided through ATAPS and to a range of other mental health services including those provided online, for young people and for people with severe and debilitating mental illness.

Every dollar redirected from Better Access, as part of these measures, will be re-invested into other and new mental health services targeting some of the most disadvantaged people in our community.

**Senator Claire Moore**

**Queensland**

**Senator Carol Brown**

**Tasmania**

**Senator Mark Furner**

**Queensland**

## **Dissenting Report by Coalition Senators**

### **Chair's Report**

1.1 Coalition Senators note that the Chair's report was to only have reported the evidence given at the hearing or extracts from submissions. This was the agreement reached at the meeting of the Community Affairs Committee on 28 October. Instead, the Chair's report includes commentary about the evidence.

1.2 The Coalition's comments herein are intended to comment solely on the evidence received and our conclusions drawn from the same.

### **Better Access Initiative**

1.3 The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme initiative (Better Access) was a central part of the Howard Government's contribution to COAG's National Action Plan on Mental Health (2006–11). The agreement by COAG in July 2006 was:

based on a recognition that, after a decade of national reform, renewed government effort was needed to give greater impetus to the reform process. The Action Plan represented a landmark in the history of mental health services in Australia. For the first time, leaders of all governments focused on the issue of mental health and agreed to a plan to reform mental health services that addressed not only health needs, but made commitments to activities in other key areas of housing, employment, education and correctional services, all of which have an essential part to play in improving the mental health of Australians.<sup>1</sup>

1.4 The intention of the Coalition's historic 2006 investment of \$1.9 billion in mental health and its centrepiece Better Access was to integrate allied health and GP services to improve the treatment and management of mental health, by expanding the services that attract a rebate under the Medicare Benefits Schedule (MBS). The expansion of such services was designed to encourage patient referrals between GPs, psychologists, clinical psychologists, social workers and occupational therapists, and to promote mental health education and training for health professionals. The initiative commenced on 1 November 2006.

1.5 The joint media release by then Minister Abbott and Pyne of 9 May 2006, outlines the objective of the COAG mental health announcement:

The 2006-07 Budget delivers on the Government's commitment of \$1.9 billion to improve services for people with a mental illness, their families

---

1 Council of Australian Government, *National Action Plan for Mental Health 2006-2011, Second Progress Report covering implementation 20 2007-08*, September 2009, Foreword, p. 1. Available at: [http://www.coag.gov.au/coag\\_meeting.../2006.../nap\\_mental\\_health.pdf](http://www.coag.gov.au/coag_meeting.../2006.../nap_mental_health.pdf) Similar (accessed 31 October 2011).

and carers. These measures are the Commonwealth Government's contribution to the COAG Mental Health package, as announced by the Prime Minister on 5 April 2006.

These practical measures will provide families, schools and health professionals with more support in recognising and addressing mental illness and new assistance to people who are living with mental illness and their families.

A national information campaign will raise awareness of the links between illicit drug use and mental illness.<sup>2</sup>

1.6 Under Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Scheme new rebatable Medicare items were introduced:

New Medicare rebates will be introduced for people with mental illnesses to access improved services from appropriately trained GPs and psychiatrists and, on referral, from clinical psychologists.

It is expected that, in the fifth year of the initiative, an additional 35,000 people with severe mental illness will be able to obtain access to a psychiatrist. Also in the fifth year, approximately 400,000 Medicare-funded services will be provided by clinical psychologists.

It will encourage team-based mental health care in the community with psychologists working alongside GPs, psychiatrists, mental health nurses and other allied mental health professionals. GPs will be provided with training to improve their detection of mental illness and quality of services.<sup>3</sup>

1.7 It is clear from the Ministers' press release and comments such as the following from then Prime Minister Howard, that the focus was on mental illness, with no differentiation between mild to moderate or severe:

The package I am announcing today comprehensively addresses the key shortcomings in mental health services in those areas for which the Australian Government has responsibility.

...

We are providing:

- A major increase in clinical and health services available in the community and new team work arrangements for psychiatrists, GPs, psychologists and mental health nurses;
- New non-clinical and respite services for people with mental illness and their families and carers;
- An increase in the mental health workforce; and

---

<sup>2</sup> <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2006-hmedia2.htm>

<sup>3</sup> <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2006-hmedia2.htm>

- 
- New programmes for community awareness.<sup>4</sup>

1.8 Eligible patients were able to receive up to 12 individual and 12 group sessions per year (plus an additional 6 sessions in exceptional circumstances).<sup>5</sup> Changes were made in 2009 that enabled GPs with specific mental health training to claim higher rebates.

### **Evaluation of Better Access**

1.9 In 2009, the Department of Health and Ageing tendered for consultants to evaluate seven components of the Better Access program. The evaluation was not released until mid-February 2011.

1.10 Criticism of the evaluation included the lack of measurement of key objectives of the Better Access program and how performance over the time of the program had been measured. For example, one of the initial objects was better co-ordination of services between mental health professionals. The evaluation did not measure this and other objectives.

1.11 The evaluation showed positive results including that since the introduction of Better Access, more people have accessed mental health services and the uptake of the rebatable sessions has been high and increasing with 2.7 million, 3.8 million and 4.6 million Better Access services being delivered in 2007, 2008 and 2009 respectively.

1.12 These findings were qualified by the suggestion, repeated several times throughout the summative evaluation, that limitations in available data prevented the authors from drawing comprehensive conclusions about the effectiveness of any aspect of the program. Indeed, there were real criticisms levelled at the evaluation, including from the Mental Health Council of Australia.

1.13 The Government is spending about \$10 million a week on this program but only about \$1 million on this evaluation. Since 2007 over 2 million people had received more than 11.1 mental services, yet only about 1,350 consumers were assessed despite the 2 year long evaluation. Uptake rates of treatment were 10% lower for people in the most disadvantaged areas and there was no evaluation at all of those traditionally disadvantaged, those from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander people. This evaluation raised more questions than it answered.

---

<sup>4</sup> [http://pandora.nla.gov.au/pan/10052/20060621-0000/www.pm.gov.au/news/media\\_releases/media\\_Release1858.html](http://pandora.nla.gov.au/pan/10052/20060621-0000/www.pm.gov.au/news/media_releases/media_Release1858.html)

<sup>5</sup> Department of Health and Ageing, *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) Initiative—Overview*, <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-over> (accessed 5 August 2011).

1.14 The Coalition raised questions at past Estimates about the evaluation including about the tender process. As indicated, Better Access has assisted about two million people but the evaluation only surveyed about 1,350 consumers; or about 0.07%. It is questionable whether the sample used was an effective one, in order to achieve statistically and clinically significant results and whether the Government adequately consulted on what such an effective sample might have been to achieve statistically and clinically significant results.

1.15 The Coalition also raised questions about who determined the consumers to be surveyed in that it appeared that the very providers who were providing the services chose the consumers to be surveyed.

1.16 As indicated above in the Abbott/Pyne media release of 9 May 2006, one of the explicit founding objectives of this program is to encourage collaborative care, the Coalition is concerned that this was not properly assessed. The evaluation reports that there have been some 16 million mental health sessions under the program and it was unclear from the evaluation what therapies were being provided and whether they were evidence based care like cognitive behavioural therapy or just non-specific counselling.

1.17 At previous Estimates, evidence was provided about the overall proportion of new customers to repeat customers. Answers provided on notice indicate that in 2008, 68% of better Access clients were new customers. In 2009, this percentage had dropped to 57%. This would indicate that the program was designed for short sharp (cognitive behavioural therapy) CBT-based interventions were being used to provide ongoing or continual mental health services to the same clients.

1.18 Table 1 in the evaluation report purports to list the strengths and weaknesses of each data source. The strengths listed in relation to many of the data sources includes supposedly large and representative sampling which is questionable given that only 1,350 consumers were assessed. The common weaknesses identified were selection bias or reliance on self-reporting; a lack of potential to track any change or improvement over time; and difficulties in inferring conclusive information about Better Access from the data.

1.19 Several submitters commented on what they considered weak aspects of the methodology or limitations of the data set. The methodology of the study was the target of particular criticism in that it did not proceed according to scientifically accepted methods, the latter crucial for establishing the most accurate results. For example, the Australian Psychological Society College of Clinical Psychologists drew the committee's attention to:

...significant research methodological flaws within the Better Access study, which cautions us as to the credibility of the study and to any unintended simplistic equating of its findings to “proof” or “fact” to a level of evidence that would inform thinking around service planning and workforce issues.

---

The level of evidence attributable to a single study with such a research design is not sufficient for such purposes.<sup>6</sup>

1.20 The Coalition shares the concerns of various submitters and believes the conclusions drawn are readily disputed based on the very poor methodology of the evaluation and therefore of limited value as a basis for decision-making going forward.

1.21 As well as the methodology, the findings of the study are also open to interpretation. For example, some commentators welcomed the evidence that Better Access increased mental health services in rural areas, as well as its significant uptake rate overall. Other commentators were concerned that mental health services in rural areas remain less comparative to metropolitan areas, and that the significant uptake of Better Access overall has been very expensive. The Government asserts it has made significant changes to its mental health spending in the 2011–12 Federal Budget and has used findings of the evaluation demonstrating the significant expense of Better Access to support its rationalisation of the initiative.

1.22 In short, it is arguable that the Better Access evaluation, with all its methodology and data set faults was set up to fail in order to enable the Government to take the money out of the program in order to recycle money back into the sector to give the appearance of "mental health reform" at a time when the Government has no real money available to spend on mental health.

1.23 There appears to be little evidence in the evaluation that justifies changing the GP rebate or the number of psychology sessions.

### **Changes to the Better Access Initiative**

1.24 In its 2011–12 Budget statement, the Government stated that Better Access is an increasingly costly program, and that it has not been fully effective in addressing the mental health needs of all target groups. To address this cost issue, and increase access to mental health care to groups such as Indigenous people, people in regional Australia and people on low incomes, the Government wants to redirect funding from Better Access towards other programs such as Access to Allied Psychological Services (ATAPS), *headspace*, and Early Psychosis Prevention and Intervention Centres (EPPIC).

1.25 Rather than reforming mental health, it appears that the Government here is robbing Peter to pay Paul! By rationalising services, the Government is redirecting funds from one program to another.

1.26 In so doing, it is unclear whether the Government has any plan to monitor any impact on the quality of care available to people as a result of the changes.

---

6 *Submission 161*, p. 9.

1.27 Criticism has also been levelled at the Government at the lack of transparency leading up to the decision to cut the Better Access program. In 2008

### **General views on the budget announcements**

1.28 There was a mixed reaction for the budget announcements with some initial support for what appeared to be overall increase in the mental health budget, qualified by some stakeholders who objected to aspects of the detailed proposals.

1.29 The Mental Health Council of Australia expressed the view that the announcements were:

...an important step towards improving the mental health system and the mental health of all Australians. They reflect a commitment by the Government to improving mental health and increasing the availability of mental health services in Australia.<sup>7</sup>

1.30 The Consumer Health Forum commented:

The Federal Government's 2011-12 Budget promised a range of new initiatives for mental health services that will result in improved outcomes for many Australians.<sup>8</sup>

1.31 However, the Australian Medical Association, the Royal Australian College of General Practitioners, as well as the Australian Psychologists Society all expressed concerns about the impact of the changes to the Better Access initiative. The AMA requested that the committee:

...recommend that the Government reverse its 2011/12 Federal Budget decision to cut Medicare funding for mental health services delivered by GPs and psychologists under the Better Access Program.<sup>9</sup>

1.32 The Australian Psychological Society urged the committee to:

...focus its attention on the Federal Budget cuts to the Better Access initiative as these are due to come into effect on 1 November 2011 and will deny effective psychological treatment to an estimated 87,000 people per annum from this date.<sup>10</sup>

1.33 While the Royal Australian College of General Practitioners said that:

The College is gravely concerned regarding the proposed cuts to the Better Access program and the subsequent impact on mental health delivery for

---

7 Mental Health Council of Australia, *Submission 198*, p. 2.

8 Consumers Health Forum of Australia, *Submission 179*, p. 1.

9 Australian Medical Association, *Submission 185*, p. 1.

10 Australian Psychological Society, *Submission 159*, p. 3.

---

every patient age group, demographic, and geography throughout Australia.<sup>11</sup>

### **Consultation on mental health spending**

1.34 In 2008, the Government established the National Advisory Council on Mental Health (NACMH) with the objective to:

...provide[s] a formal mechanism for the Australian Government to gain independent advice from a wide range of experts to inform national mental health reform.<sup>12</sup>

1.35 Professor John Mendoza was appointed the Chairman but in June 2010, he resigned criticising the Rudd government for its lack of action on mental health. In an interview on PM on 21 June 2010 gave his reasons for his resignation:

Well it's a frustration rather than anger. When I took this role on I genuinely believed that the Government was going to take a different approach to mental health reform. They'd certainly made clear in opposition that they were determined to address the long standing problems in this area.

They had commented on many aspects of the Howard government's response in this area as being inadequate and wanting to do a lot better and, in fact, the formation of the council was specifically in response to, I guess, the lack of progress from the reform policy agenda that had been in place for some time.

So after two years, however, it was pretty clear we were getting nowhere.<sup>13</sup>

1.36 The chairmanship remained vacant until December 2010 when the Minister for Ageing and Mental, the Hon. Mark Butler appointed himself as the chairman of the NACMH. Either Mr Butler could not find anyone to replace Professor John Mendoza who quit the council in disgust in June or he wants to take a 'hands-on' approach and steer the council on the government's path which appears to be to do very little. South Australia's Social Inclusion Commissioner, Monsignor David Cappo, was appointed as deputy chair. At the time there was criticism about lack of transparency and objectivity – how can you have an advisory council to the minister chaired by the minister himself?

1.37 Despite the existence of the NACMH, in December 2010, the Mental Health Expert Working Group was established by Minister Butler specifically to provide advice on mental health reform in the lead-up to the 2011–12 Federal Budget. Membership of this group comprised:

---

11 Royal Australian College of General Practitioners, *Submission 172*, p. 3.

12 Department of Health and Ageing, *National Advisory Council on Mental Health*, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/National+Advisory+Council+on+Mental+Health> (accessed 7 October 2011).

13 <http://www.abc.net.au/pm/content/2010/s2932959.htm>

Dr Christine Bennett; Monsignor David Cappo AO; Dr Pat Dudgeon; Mr Anthony Falker; Mr Toby Hall; Professor Ian Hickie AM; Professor Lyn Littlefield OAM; Ms Janet Maher; Dr Christine McAuliffe; Professor Patrick McGorry; Professor Frank Oberklaid; Ms Sally Sinclair.<sup>14</sup>

1.38 The Terms of Reference for the expert group were determined as follows:

The Mental Health Expert Working Group (MHEWG) is being established as a time-limited working group to provide confidential, strategic and practical advice to the Australian Government to inform mental health reform directions and decisions.

The MHEWG will provide significant input to the Australian Government about how to achieve well coordinated, cost-effective and lasting reforms to mental health care across a broad range of clinical and non clinical service systems with the aim of developing a strong, sustainable system now and into the future.<sup>15</sup>

1.39 Questions were asked by some submitters during the inquiry as to why it was necessary to establish a new group to provide advice on the above matters rather than consult the NACMH. However, other submitters were dissatisfied with its composition:

This submission refutes the defence that this group are independent and impartial including proffered explanation that the group are picked from a small academic mental health sector. There are nearly forty Australian Universities who could make solid contribution to a mental health policy expert panel...

This issue is considerably more significant than concerns about conflict of interest. The mental health reform agenda is intrinsically based in closed, non-consultative and exclusive process which is part of the larger imposed shift of health reform....<sup>16</sup>

1.40 The Australian Clinical Psychology Association (ACPA) commented:

While this group includes eminent mental health professionals whose knowledge and direction may be generally useful in determining policy, the group was dominated by public sector interests, and under-represented by those working within the Better Access Initiative, which was the program most affected by the changes made. The recent resignation of Dr Christine

---

14 Ms Jane Halton, Secretary, Department of Health and Ageing, *Estimates Hansard*, 30 May 2011, p. 71.

15 Department of Health and Ageing, *Answer to a question on notice*, 30 May 2011, received 26 July 2011. The answer to question E11- 219 has not been quoted in full; see Senate webpage [http://www.aph.gov.au/Senate/committee/clac\\_ctte/estimates/bud\\_1112/DoHA/index.htm](http://www.aph.gov.au/Senate/committee/clac_ctte/estimates/bud_1112/DoHA/index.htm) for the answers to eight written questions on notice in relation to the Mental Health Expert Working Group.

16 Name Withheld, *Submission 483*, pp 24–25.

---

McAuliffe, who represented GPs within this group, is of considerable concern.<sup>17</sup>

1.41 The Association of Counselling Psychologists (ACP) also expressed disquiet about the group:

The ACP questions the independence of the Mental Health Expert Working Group, on the basis that a significant number of the members of that group have a longstanding bias against Better Access and a conflict of interest towards funding their own projects.<sup>18</sup>

1.42 The Coalition is concerned that there was confusion about the consultation processes that this expert group undertook. In Estimates evidence was given that this group did consider the Better Access evaluation. Indeed, there is a real issue as to precisely why this expert group was established, and having been established, why it failed to contain within its ranks key representatives of the affected groups, including consumers.

1.43 The process was not handled as well as it could have been, and appears to have raised doubts amongst some stakeholders about the effectiveness of the National Advisory Council on Mental Health. It not only reinforces the earlier point about the credibility of an advisory body set up to give advice to the minister but chaired by the minister himself, but raises real questions about transparency and objectivity of its deliberations. .

### ***Rationalisation of GP mental health services—new time dependent rebates***

1.44 The budget measures lower the fees charged and rebates applicable to all mental health items provided by GPs, introducing a timed rebate system. In making these amendments, the Government argues it has sought to align mental health consultation rebates more closely with standard consultation rebates and that GPs will receive the same rebate for a mental health consultation as they would for a standard Level C or D consultation of the same length. However, a relatively higher rebate will be available to GPs who have undertaken specific mental health training. The two-tier rebate system refers to the standard rebate available to GPs who have completed the mental health skills training—tier one—in comparison with that available to those who have not—tier two.

1.45 The Royal Australian College of General Practitioners (RACGP) have 27,000 GPs on their vocational register.<sup>19</sup> Figures from 2006/07 show that 31% of these GPs

---

17 Australian Clinical Psychology Association, *Submission 165*, p. 9.

18 Association of Counselling Psychologists, *Submission 214*, p. 3.

19 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 19 August 2011, p. 8

worked in areas outside major cities.<sup>20</sup> In the first full year of the Better Access program in 2007, GPs provided services to 618,867 people through the Better Access Initiative, rising to 971,836 in 2009.<sup>21</sup> In 2010 an estimated 72% of GPs using Better Access have completed mental health skills training and are eligible to claim the higher rebates for consultations.<sup>22</sup>

1.46 The Government asserts it has made these changes noting the *Bettering the Evaluation and Care of Health* (BEACH) report, which was one of the data sources used to compile the evaluation. The BEACH report indicated that over 80% of GP mental health treatment plans were being completed in less than 40 minutes, with an average time of 28 minutes. Criticism was levelled at the use of BEACH data because it does not take into account the total time spent by GPs in preparing plans.

1.47 The Australian Medical Association (AMA) was concerned that the BEACH data only refers to face-to-face time between GPs and patients and as such does not accurately reflect the total time spent by GPs on mental health treatment plans. In evidence at the hearing the AMA and other GP representative groups such as the Royal Australian College of General Practitioners claim that the Government has misinterpreted the BEACH data and that the changes devalue mental health care.<sup>23</sup>

1.48 Further, a survey undertaken by the AMA itself indicates that the average time spent by GPs developing mental health plans is closer to 35 minutes with the patient as well as an additional 17 minutes spent developing the plan, co-ordinating patient care and other related work.<sup>24</sup> Professor Claire Jackson, President, Royal Australian College of General Practitioners (RACGP) summarised these concerns for the committee:

The cuts to the Better Access program announced in the recent federal budget will jeopardise the mental health care of an estimated one million

- 
- 20 Australian Government Department of Health and Ageing (DoHA), 2008. *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008. Commonwealth of Australia, Canberra, p. 8. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/4F3A981914316A11CA257434008189EC/\\$File/rur2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/4F3A981914316A11CA257434008189EC/$File/rur2.pdf) (Accessed on 1 November 2011).
- 21 Evaluation of Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative, *Component F: Analysis of the Second National Survey of Mental Health and Wellbeing*, December 2010, p. 17. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/Content/8D0647CB60F3EBCACA25784C00767E20/\\$File/F.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/8D0647CB60F3EBCACA25784C00767E20/$File/F.pdf) (accessed 31 October 2011).
- 22 Department of Health, *Submission 199*, p. 6.
- 23 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 19 August 2011, pp 2–5; Dr Steve Hambleton, Federal President, AMA, *Committee Hansard*, 5 September 2011, p. 76.
- 24 Essential research (2011) *MBS changes—GP Survey: An Assessment of the Impact of 2011-12 Budget Cuts to Medicare Funding for GP Mental Health Services*, Australian Medical Association, 2011; Australian Medical Association, *Submission 185*, p. 11.

---

patients per annum, risking the current high patient access levels, quality of patient care, excellent clinical outcomes and our mental health workforce capacity.<sup>25</sup>

1.49 Moreover, the changes fail to take into account that they might exacerbate workforce difficulties. *headspace's* submission explained that it is very difficult to attract GPs into youth mental health care, and that reducing the rebate rate, by up to 47%, would act as a further disincentive for GPs to work within the *headspace* mental health care model.<sup>26</sup>

1.50 Similarly, the Rural Doctors Association of Australia (RDAA) was concerned about the rationalisation of GP services under Better Access because of the lack of specialist services in rural and remote areas, and the reliance on GPs with advanced skills and that a rural pathway for GPs is more likely to be favoured where there is scope to perform higher level clinical work, and that reducing MBS rebates will act as a disincentive, exacerbating the health services in rural areas.<sup>27</sup> It is clear that the major provider submitters were very concerned about these changes.

1.51 GPs providing mental health consultations are concerned that those consultations require a time commitment beyond face-to-face time and as such advocate they be recognised with a higher rebate. However, in acknowledging this view, the Coalition notes that there was no specific evidence in relation to GPs who receive standard Level C or D rebates and who may also provide additional services outside the appointment time for patients with other severe or persistent illnesses. In this sense, it would have been preferable for consultations to occur with key providers and stakeholders to canvass the effect of these changes and other options available. This was not done. Accordingly, in the absence of clear evidence about this, the Government cannot draw this conclusion as the Department sought to do in evidence.

1.52 In addition, the Coalition notes that the higher rebate will be retained for GPs who have completed mental health training but it is unclear whether this incentive for GPs to undertake training will encourage continued quality care. At the hearing, the Department of Health and Ageing (DoHA) explained to the committee that 72% of GPs have completed the mental health training, and therefore will be eligible for the higher rebate. It can be inferred (although there is no evidence of this) that most GPs will continue to receive higher rebates for mental health consultations than they do for standard consultations.

1.53 The Coalition believes that any rationalisation of rebatable Medicare items for mental health consultations to align more closely with standard timed consultations ought to have been discussed and fully canvassed with key provider groups and

---

25 *Committee Hansard*, 19 August 2011, p. 1.

26 *headspace, Submission 169*, p. 3.

27 Rural Doctors Association of Australia, *Submission 182*, pp 4–6.

stakeholders before being arbitrarily inserted into the budget purely as a cost saving measure.

### ***Rationalisation of allied health treatment sessions—10 session entitlement***

1.54 The number of rebatable allied health treatment sessions will be capped at 10 individual and 10 group sessions—a course of six sessions plus four additional sessions following a review. The previous maximum for both individual and group sessions was 18—two courses of six sessions plus an additional six sessions in exceptional circumstances. This change has been made as a savings measure based on an evaluation which at the very least has limitations of the available data about the Better Access program and at worst, asks more questions than it provides answers. It is clear from the evidence at the hearing that the impact on patients was not fully canvassed.

1.55 Concerns have been expressed about the rationalisation of rebatable sessions under Better Access from a maximum of 18 to 10 mostly by psychologists. Understandably, many of their patients would feel reticent about providing submissions about this change, although the committee is grateful to those patients who have made such submissions.

1.56 The arguments above in favour of retaining the 18 session maximum relies on the assumption those Medicare rebatable sessions under Better Access should be used to treat people with a severe mental illness. This was debated amongst submitters; some considered that Better Access was not designed to treat people with a severe mental illness, while others contended that it was. The opinion was also expressed that whether or not Better Access was originally intended to treat people with a severe mental illness, viable alternatives do not presently exist and therefore Better Access should be funded to fill the gap.

1.57 This goes back to the objectives of the original program. It is the basis of the Coalition's criticism of the Better Access evaluation in that it did not measure whether the program actually achieved what it set out to do.

### ***Targeting hard to reach groups***

1.58 The Better Access evaluation and the various ATAPS evaluations discussed in the Chair's report appear to suggest that Better Access either does not meet the needs of hard to reach groups or that the ATAPS model is more suited to the task. However some witnesses questioned these conclusions. RACGP for example disputed DoHA's assertion that Better Access is not reaching rural and remote areas.

1.59 The RACGP suggested that it is workforce shortages, that contribute to fewer services being delivered outside metropolitan areas, and that Better Access has actually had the opposite effect:

The Better Access evaluation actually concludes that while some groups have had greater levels of uptake of Better Access than others, Better Access has reached all groups and increased most dramatically for those

---

who have been the most disadvantaged in the past, including people aged 0–14, rural areas, and the most socio-economically disadvantaged areas.<sup>28</sup>

1.60 The AMA also emphasised the increase of Better Access service delivery to hard to reach groups:

The criticisms of it are that it is not reaching the target groups. The greatest growth in this program is actually in those target groups, so, if you like, it is coming to maturity just now. The greatest growth was actually in the young people getting access to this program. The next greatest growth was in the lowest socio demographic, where over 150,000 people were being treated, but the growth rate in that area was the greatest.<sup>29</sup>

1.61 The Coalition recognises the conclusions reached in both the Better Access and ATAPS evaluations but also notes that these, most particularly the Better Access evaluation, have been criticised. Despite the increased access to services afforded by Better Access, there remain issues about access by lower socio-economic groups, those living in rural or remote areas as well as people in metropolitan areas.

1.62 Whilst there may be greater scope for ATAPS to meet the needs of hard to reach groups than Better Access, there is a real issue as to whether ATAPS is structurally able to do so. In the absence of this assessment, the Coalition is concerned that denying access under Better Access, in the absence of a clear, viable and properly structured alternative, is not in the best interests of patients.

1.63 However, it is likely that policy makers in 2006 did not anticipate the extent to which Better Access sessions would be utilised in the following years, the extent of the dormant demand in the community, nor the extent to which people accessing the program would be experiencing severe or very severe symptoms. It is also the case that state and territory governments provide most services for people experiencing severe mental illness, a role Better Access was never intended to supplant.

*Better Access as a means of treating people with a severe mental illness*

1.64 DoHA maintains that primary care programs like Better Access or Tier 1 of the ATAPS program are not the most appropriate programs for people with severe mental illness. DoHA also maintained that in the long term the current approach was able to deliver appropriate levels of mental health care for those suffering severe mental illness. However they did concede that some gaps in service delivery do exist:

...these are people who should not necessarily be treated in the kind of primary care program like Better Access or, indeed, ATAPS. We would be encouraging states and territories, through their specialist mental health

---

28 Royal Australian College of General Practitioners, *Answer to a question on notice from public hearing 19 August 2011*, received 29 August 2011, p. 2.

29 Australian Medical Association, *Committee Hansard*, 5 September 2011, p. 73.

systems, to be lifting their game and closing service gaps that we all know exist in those kinds of areas—the pointy end of service delivery.<sup>30</sup>

1.65 Coalition notes that some submissions support the savings generated by the rationalisation of Better Access sessions and consider that ATAPS is targeted towards assisting people with a severe and persistent mental illness.

1.66 The Consumers Health Forum, however, qualifies its support for the rationalisation by suggesting that a review and further evaluation of Better Access take place to measure any impact that the changes may have on consumer outcomes.

1.67 Conversely, other submitters considered that Better Access is an appropriate measure, or the best available measure, to treat people with severe mental illness, and that it is working effectively.

1.68 The RACGP commented:

The budget cuts have been formulated despite the proven benefit of the Better Access program, including improved overall treatment rates for patients...<sup>31</sup>

1.69 The Australian Psychology Association (APS) conducted research on the types of conditions that were treated through Better Access:

The research conducted on a large sample of 9,900 people who received between 11 and 18 sessions of treatment from psychologists under the Better Access initiative last year shows that these people are overwhelmingly those with severe depression or anxiety disorders...These people would be denied the additional sessions of psychological care required for effective treatment through the Better Access initiative under the 2011 budget funding cuts.<sup>32</sup>

1.70 It is very clear that there is a real difference of opinion as to whether Better Access or ATAPS is the more appropriate service delivery for these groups. The existence of this disparity of views is further testimony that the Government has failed to undertake proper consultation on the most appropriate way forward.

1.71 The Coalition is concerned that the rationalisation of MBS rebatable sessions under the Better Access initiative is likely to, in the immediate term, exacerbate existing service gaps for people with severe and persistent mental illness. We are further concerned that the committee has not received evidence that ATAPS will meet the needs of these people in the short term.

---

30 Department of Health, *Committee Hansard*, 5 September 2011, p. 17.

31 Royal Australian College of General Practitioners, *Proof Committee Hansard*, 19 August 2011, p. 1.

32 Australian Psychological Society, *Proof Committee Hansard*, 19 August 2011, p. 9.

1.72 In theory the Better Access initiative was designed to address high prevalence disorders that could be treated by 6–12 sessions. However, in the absence of viable alternatives, this initiative has been utilised to provide treatment to people with a severe mental illness who need the maximum 18 sessions.

1.73 Until the government provides an alternative, effective means to address the needs of people with a severe mental illness, it cannot justify excluding these people from accessing services under Better Access.

### **Access to Allied Psychological Services (ATAPS)**

1.74 The Government's asserts that its 2011–12 Federal Budget *National Mental Health Reform* package is designed to address service gaps in the mental health system to ensure that early and consistent rather than crisis-driven care is provided to people who need it and that its reform is supposedly focused on addressing the needs of people identified as not always receiving adequate mental health services. The Government believes that the Access to Allied Psychological Services (ATAPS) program is seen as one way of meeting these challenges.

1.75 The ATAPS program was established by the Coalition in 2002 with the objective of funding 'short term psychology services for people with mental health disorders through fund-holding arrangements delivered through Divisions of General Practice'. The ATAPS projects enable GPs to refer patients with high prevalence disorders such as depression and anxiety to allied health professionals (predominantly psychologists).

1.76 Since 2003 there have been a number of policy developments which have impacted on the original design of the program. The most significant of these was the introduction of the Better Access program in 2006 which serves a similar client group, but through the Medicare Benefits Schedule rather than a fund-holding arrangement.

1.77 The ATAPS program has been evaluated regularly since its inception. Since 2003 it has provided over 600,000 mental health sessions of care, achieving improved consumer outcomes in 86%. The last evaluation report, which looked at data from January 2006 to June 2010, found that there had been 150,954 referrals made in that period, with 113,107 patients receiving at least one episode of care.<sup>33</sup> Certainly, the 150,954 referrals made from January 2006 to June 2010 are relatively small compared to the 11.1 million Better Access services that were delivered from 2007 to 2009.

1.78 As mentioned above, ATAPS has provided over 600,000 mental health services from 2003 to 2009 with a total spend in that period of \$80.7m. These services were provided by 10,296 GPs (5,914 urban; 4,382 rural) who referred consumers to 3,527 allied health professionals (2,548 urban; 979 rural). The numbers

---

33 Department of Health and Ageing, *Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Sixteenth Interim Evaluation Report, July 2010, p. 5.

steadily rose between 2003 and 2006 until Better Access was introduced in 2006. To put these figures in context there are currently 24,000 GPs, 16,450 allied health professionals and 1,700 psychiatrists using Medicare items under Better Access.<sup>34</sup> Over 90% of the allied health professionals under both programs are psychologists. Following the introduction of the Better Access program the numbers for referring both GPs and allied health professionals declined for around a year before rising steadily again. Figures show that the impact of Better Access on ATAPS participation has been much less pronounced in rural areas.<sup>35</sup>

1.79 Over 70% of consumers using the ATAPS program are women with an average age of 39. Around 2% are Aboriginal or Torres Strait Islanders. Most people accessing the program present with high prevalence disorders such as anxiety and depression and between 2% and 6% of referrals include a diagnosis of severe mental illness.<sup>36</sup>

1.80 The breakdown of figures for ATAPS does appear to support the premise that the program has the potential to be able reach marginal groups with 68% of all services delivered through ATAPS being accessed by people on a low income, and 45% delivered in rural areas. In contrast, 25% of Better Access services are delivered in rural areas.

1.81 The Australian National Audit Office (ANAO) undertook an independent audit of the ATAPS program in 2010-11, reporting to Parliament on 21 June 2011. Whilst the ANAO report highlighted positive features of the ATAPS program, it did draw attention to the challenging aspects of administering the scheme. The positive aspects of the program discussed in the report included its capacity to respond quickly and with agility as illustrated during the Victorian bushfires and Queensland floods, and its ability to be used as a platform for new and innovative service delivery, targeting particularly hard to reach groups such as rural and remote consumers and young people.

1.82 However, the ANAO report cited problems with the design and subsequent administration of the program to date:

...the administrative arrangements established by DoHA have not consistently supported the achievement of program objectives. In particular, there has been variable administrative performance, over the relatively long life of the program, in relation to a number of important program elements including: the allocation of program

---

34 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p.7.

35 Department of Health and Ageing, *Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Fourteenth Interim Evaluation Report, June 2009, p 3.

36 Department of Health and Ageing, *Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, February 2010, p.10.

---

funding on the basis of identified need; monitoring compliance with program requirements; and the administration of new ATAPS initiatives.<sup>37</sup>

1.83 Aspects of the funding system in particular drew comment in the ANAO report. The funding model of the program was initially population based, but has not correlated consistently with the gradual policy transition to a more needs-based targeted approach. This aspect, tied with the lack of regular assessment of health care needs within GP Divisions, has resulted in 'some communities not receiving an equitable share'.

1.84 The ANAO report also considers that the risk management of the program was also not designed to ensure that the limited resources available had the greatest chance of reaching those most in need. The ANAO report made certain recommendations noted in the Chair's report and the areas identified for ATAPS to focus on namely: better addressing service gaps, increasing efficiency, encouraging innovation and improving quality.

1.85 The Government asserts that it has committed to the expansion of the ATAPS program to incorporate the recommendations of the review in the recent budget changes with funding for ATAPS to increase from \$36.1 million in 2010-11 to \$108.7 million in 2015-16 (\$432.7 million over 5 years) with the aim being to provide services for an additional 185,000 people over five years, specifically targeting hard to reach groups.

1.86 As indicated earlier, the service delivery model of ATAPS is to fund short term psychology services for people with mental health disorders through fund-holding arrangements delivered through Divisions of General Practice, or Medicare Locals as they come on stream. The Coalition has been critical of Medicare Locals and has stated its objective of abolishing them.

1.87 The Coalition notes evidence that the Australian General Practice Network (AGPN) have been funded to develop a 'clinical governance framework for ATAPS that can be implemented in the Medicare Local environment and also to do a systematic workforce mapping exercise to better understand the status, skills and qualifications of the ATAPS workforce.' However, that evidence suggests that whilst the potential for ATAPS is significant, there are barriers to its realisation:

ATAPS and related programs make for an opportunity to really embed a robust primary mental health care system. But this also means investment in those functions over and above what you could describe as straight program administration. I am talking about functions such as service

---

37 Australian National Audit Office (ANAO), *Administration of the Access to Allied Psychological Services Program*, ANAO Audit Report No. 51, June 2011, p. 15.

planning; service development; partnership and linkage development with other providers.<sup>38</sup>

1.88 The Coalition points to evidence in the hearing about the challenges presented by ATAPS being a capped program rather than being funded through the MBS including:

- a. reports by Divisions that demand far outstrips supply and funds are running out well and truly before the end of the year;
- b. the funding is targeted towards a client group which requires case management as its primary service with multidisciplinary teams and the involvement of many health practitioners;
- c. concerns that only psychologists are providing services and other allied mental health professionals are being excluded;
- d. the capped funding means that in some cases, Divisions may be forced to employ less experienced psychologists to make funding go further; and
- e. the proportion of the budget that goes into the administration of the program (with the ANAO report stating that originally 85:15 ratio of service delivery to administration has now become 75:25).

1.89 The Coalition notes that the AMA's submission contrasted these ratios to those of the Better Access initiative where 'every dollar allocated...goes directly to the delivery of clinical care.'<sup>39</sup>

1.90 At the hearing, the AGPN stated the 85:15 ratio is inadequate and advocated for an additional capacity for service development and planning functions that you cannot buy with the current 15% administration vote.

1.91 The Coalition is concerned that there has been lack of consultation about the impact on the mental health workforce of the shift from Better Access to ATAPS. Given our criticism of Medical Locals, the proposed expansion of ATAPS does present challenges that have not been properly considered. The Government has failed to consult key stakeholder providers.

1.92 It is also unclear whether the Government proposes ATAPS as an alternative to the Better Access initiative. Whilst it is arguable that ATAPS may be able to provide a different type of care, and one of the ATAPS program's strengths is its flexibility to provide a broad care package to consumers, it is expensive in comparison to Better Access, and the substantial funding increases are not due to come on stream until after Better Access has been reduced.

---

38 AGPN, *Proof Committee Hansard*, Monday 5 September 2011, p.32.

39 *Submission 185*, p. 12.

1.93 The ATAPS service delivery model is also complex in nature and requires long-term planning and design, particularly around workforce issues, before it can begin to meet the anticipated needs of consumers. The Coalition cannot see how the necessary foundations will be in place by November 2011.

1.94 The key question that came up in the evidence before the committee was whether the newly designed program could meet the demands placed on it given the reduction in some aspects of the Better Access program.

1.95 Whilst it has been argued that ATAPS can improve access for hard to reach groups more effectively than Better Access, the Coalition is concerned as to what happens to those consumers who require an extended level of care that will in future not be provided through the Better Access program.

1.96 The Australian Psychological Society (APS) were quite forthright in their view that ATAPS is not ready to fill the gap:

The government has stated that people affected by the cuts can be seen under the Access to Allied Psychological Services, or ATAPS, program run through the divisions of general practice, but this is not a viable referral option under current arrangements. There is simply not enough funding in ATAPS to provide services for anything like the 87,000 people per annum.<sup>40</sup>

1.97 The issue of funding levels and administration requirements as barriers to using ATAPS came up frequently during the committee's public hearings. RACGP highlighted the difficulties faced by many GP Divisions in administering ATAPS paperwork in the absence of any rebate, including:

- (a) accessing services where the patient will not be out of pocket;
- (b) ensuring the GP and any psychologist referred to also has requisite reference number;
- (c) ensure the appropriate assessment tools are adopted;
- (d) complete ATAPS forms and any mental health plans;
- (e) other general administrative requirements.<sup>41</sup>

1.98 The RACGP also commented on the budgeting requirements for a capped program such as ATAPS and pointed to the following three issues of concern:

- (a) ATAPS has different rules and regulations across Australia;
- (b) a lot of divisions spend their ATAPS funding six months into the 12 months and then there is nothing left; and

---

40 APS, *Committee Hansard*, 19 August 2011, p. 9.

41 Dr Elizabeth Marles, *Committee Hansard*, 19 August 2011, p. 3.

- (c) often there are bureaucratic issues that have to be negotiated to access the service and these are especially challenging in cases of mental health emergencies where timing and the need to access services quickly is critical (for example where patients are suicidal or facing an acute personal crisis and therefore need to be linked with services quickly).<sup>42</sup>

1.99 Whilst the Coalition appreciates the flexibility of ATAPS, there are concerns that this could result in patchy or inconsistent service delivery across the country. We are concerned that the shift from Better Access to the ATAPS structure is not adequate to meet the challenges of the added requirements placed on the ATAPS program. As a consequence, we share the concerns of those submitters in relation to adequate service delivery.

1.100 The Coalition is concerned that the impact of the shift from Better Access to ATAPS has not been fully considered, especially given the complex challenges which face mental health delivery nationwide. The Government's assertions of the diversity possible within the program, ranging across the traditional Tier 1 funding, through Tier 2, to the Funding Care Packages and Coordinated care model have not been properly assessed with key stakeholders.

1.101 Clearly, there is no evidence that the program will be substantially operational in its new form by November 2011. The Coalition is concerned that under the current proposals there will almost certainly be a substantial period where Medicare Locals and GP Divisions will not be fully engaged with the ATAPS program, and consequently will not be able to access appropriate mental health care for consumers.

### **Youth mental health**

1.102 The Coalition supports *headspace* and Early Psychosis Prevention and Intervention Centres (EPPIC). The Coalition's Real Action Plan for Better Mental Health will provide a nationwide network of staged care to assist young Australians to access quality mental health services and pursue productive and fulfilling lives. The Coalition's announcement at the 2010 election includes:

- (a) 20 Early Psychosis Intervention Centres;
- (b) 800 mental health beds; and
- (c) 60 additional youth *headspace* sites.

### ***headspace***

1.103 The Coalition established *headspace* in 2006 with Commonwealth funding. *headspace* currently delivers services at 30 centres across all states and territories. *headspace* is a model of delivering integrated mental health services to young people by co-locating specialist and primary health services at *headspace* centres and its

---

42 Professor Jackson, *Committee Hansard*, 19 August 2011, p. 7.

---

vision is: “To improve the mental and social wellbeing of young Australians through the provision of high quality early intervention services, that are welcoming, friendly and supportive.”

1.104 The Coalition shares the concerns of *headspace* that these changes will affect *headspace* services given that health professionals at the centres, including GPs, psychologists, social workers, mental health nurses and occupational therapists, are either directly employed through *headspace* core funding, or self-funded through MBS items or private billing.

1.105 *headspace* targets 12–25 year olds with a mild to moderate mental disorder, and seeks to assist them across four key areas: general health; mental health and counselling; alcohol and other drug services; and education, employment and other services. The Chair’s report outlines the history of *headspace* and various evaluations of its work which indicate that *headspace* has improved mental health services for young people, especially early-intervention services for people aged 12–17.

1.106 The report also suggests ways in which *headspace* could improve its timeframes for service delivery, the need to engage target groups and funding issues, all of which will be impacted by the Government’s proposed changes.

1.107 The Coalition notes that in advocating an expansion of the *headspace* centres, the Government is adopting the Coalition’s policy. Whilst the *headspace*’s submission to the inquiry welcomed additional funding, it highlighted that the rationalisation of Better Access, particularly the changes to MBS mental health treatment items, is likely to add to existing workforce issues with respect to attracting GPs to *headspace* centres:

Attracting GPs is already a considerable challenge, particularly in areas of GP shortage. *headspace*, across its 30 centres, has a full time equivalent of only eight GPs. *headspace* centres are finding it increasingly difficult to recruit GPs as there are not sufficient incentives for GPs to work in youth mental health. We believe that with the current systems and initiatives in place, it is not financially viable for GPs to work with young people. Many GPs are not comfortable working with this client group in general, and financial disincentives exacerbate this reluctance.<sup>43</sup>

1.108 *headspace* CEO Chris Tanti expressed concern that GPs may reduce their availability to practice at *headspace* centres once the proposed cuts are implemented:

Mental health treatment plans are a core activity for GPs working in a *headspace* centre. For example, analysis of 28 out of our 30 centres showed that in the last financial year item No. 2710, for a 40-minute preparation of a mental health treatment plan, equated to over one quarter of the total GP revenue billed at *headspace* centres...

---

43 *headspace*, Submission 193, p. 4.

The majority of GPs who are working in our centres are very passionate about working with young people...So I suspect they will not leave entirely but they will reduce the amount of time they have available at *headspace*.<sup>44</sup>

1.109 Conversely, the Australian Medical Association (AMA) suggested that increased funding to *headspace* should not come at the expense of Better Access. AMA anticipated that the time likely to elapse before new *headspace* centres are operational would suggest continued support to other initiatives in the interim is justified.<sup>45</sup>

1.110 The Coalition is aware that there is widespread support for *headspace*, but also widespread concerns about whether all the policy settings are right to ensure the initiative succeeds. The external evaluation identified a range of issues, and submitters have added to those. The greatest concern appeared to be whether the funding model would be effective in ensuring the ongoing participation of GPs.

1.111 The Coalition is critical of the Government for not having undertaken the necessary consultations with key stakeholders about these changes to fully assess their impacts. Whilst the Government is increasing the level of funding for *headspace*, the Better Access changes may result in *headspace* centres being forced to use such additional funding to employ GPs directly, thereby countering the disincentives caused by changes to the Better Access Initiative.

### **Early Psychosis Prevention and Intervention Centre (EPPIC)**

1.112 The Chair's report traces the origins of EPPIC from the 1988 establishment of a ward in the Aubrey-Lewis Unit at Royal Park Hospital dedicated to the treatment of young people hospitalised after their first episode of psychosis.

1.113 Whilst the Coalition recognises some disquiet about EPPICs, the Coalition supports early psychosis intervention centres as an important frontline service in addressing mental health issues. Indeed, such disquiet is compounded by the fact that the Government is cutting Better Access to provide funding for *headspace* and EPPICs, a criticism levelled at it by various submitters.

1.114 As indicated above, the Coalition is committed to Commonwealth funding for 20 centres. This is in contrast with the Government's less promising commitment to fund four additional EPPIC sites in partnership with interested states and territories. The 2011-12 budget changes commit the Government to engage the states and territories to share the cost of funding and supporting an additional 12 centres, bringing the total number of centres to 16.

1.115 The Coalition is concerned that if the States and Territories do not make a contribution, then it is questionable whether the Commonwealth will maintain its

---

44 Mr Chris Tanti, *Committee Hansard*, 19 August 2011, pp 53–54.

45 Australian Medical Association, *Submission 185*, p. 12.

commitment. Despite repeated requests, the Commonwealth and its department have not been prepared to commit to full Commonwealth funding if the deal falls through with the States and Territories. Hence, there is no guarantee that the Government's commitment to EPPIC will be matched by state and territory funding, and therefore no guarantee that the government will be able to fully deliver its planned expansion to EPPIC.

1.116 The Coalition is also concerned about the transitional issues in that the Government is cutting funding for Better Access now, with the expansion of funding of other programs only coming later. Accordingly, the Coalition believes that any changes to Better Access need to be considered in the context of new *headspace* centres and EPPICs coming online.

### **National Mental Health Commission**

1.117 In the 2011–12 Federal Budget the Government allocated \$32 million over five years for the establishment and operation of the National Mental Health Commission (the Commission) which it asserts will comprise nine commissioners, raise the profile of mental health issues, and provide independent advice to improve transparency and accountability in mental health policy.<sup>46</sup>

1.118 The Coalition supports the establishment of an independent National Mental Health Commission.

1.119 The Coalition has expressed grave reservations about the lack of transparency in appointments to the new National Mental Health Commission and most especially, about the appointment of Monsignor David Cappo as the first National Mental Health Commissioner.

1.120 Rather than being an independent body, the Government established a version of a NMHC as a unit in the Department of Prime Minister and Cabinet. Despite repeated questions, the Government has failed to outline what the selection process was for three appointments to the National Mental Health Commission.

1.121 In a Media Release on 1 June 2011, Minister for Ageing and Mental Health, the Hon Mark Butler promised greater accountability in mental health. He stated that:

More transparency and accountability in the mental health system will drive continuous improvement and innovation and help inform future investment in mental health...<sup>47</sup>

1.122 However, in a recent Estimates hearing, Mr Richard Eccles from the Department of Prime Minister and Cabinet, was not able to explain the selection

---

46 National Mental Health Commission Interim Office, *Submission 527*, p.1.

47 The Hon. Mark Butler, Minister for Ageing and Mental Health, 'Greater Accountability in Mental Health' Media Release, 1 June 2011.

process for the new CEO, Robyn Kruk, announced on 1 June 2011 or for the choice of Monsignor David Cappo as chair of the commission or of his replacement, Professor Allan Fels.

1.123 Monsignor Cappo had to step down barely a week after accepting this important role. In light of the media reports surrounding his appointment and various matters raised in the senate by Senator Xenophon, it was not surprising that Monsignor Cappo decided to step down for the position of Chair of the National Mental Health Commission.

1.124 The appointment of Monsignor Cappo had caused quiet concern in the sector as the role is seen as needing experience and the ability to deliver at the highest levels of government and the public sector. Mental Health is too important to be compromised in any way. His appointment lacked transparency and any semblance of a proper selection process. Indeed, the Coalition questioned the assertion by Minister Butler that Monsignor Cappo was the 'obvious choice', a position he maintained in the media release announcing Monsignor Cappo's resignation.

1.125 There has been no consultation on any of the appointments and now no official explanation as to who made the choices or on what basis they were made. The Coalition has been critical of Minister Butler for failing to clarify how the appointments were made, how the nine new commissioners will be chosen and what the role and remuneration for all appointments will be.

1.126 Despite this criticism, Minister Butler persists in making assertions, such as the following in a Media Release of 7 September 2011:

This will drive greater transparency and accountability in our mental health system and deliver better outcomes for consumers and carers...<sup>48</sup>

1.127 The Chair's report sets out the core function of the Commission namely to monitor, assess and report on how the system is performing and its impact on consumer and carer outcomes. The Commission will produce an Annual National Report Card on Mental Health and Suicide Prevention which will assess the relative effectiveness of a range of mental health programs and services, highlighting which services are actually delivering outcomes for people experiencing mental illness. The Chair's report also indicates that the Government intends to establish the Commission as an executive agency, within the Department of Prime Minister and Cabinet, governed by a Chief Executive Officer. Under this model, the Commission will report to an agency minister within the Prime Minister's portfolio, who will also be responsible for appointing the nine commissioners.

1.128 Criticism has been levelled at the Government on two fronts about the Commission – about its limited scope and its lack of independence.

---

48 The Hon. Mark Butler, Minister for Ageing and Mental Health, Media Release, 7 September 2011.

1.129 The Coalition shares the views of most submitters who commented on the Commission and supported the concept of an independent voice on mental health.<sup>49</sup> Several submitters suggested changing the format of the Commission, mostly to ensure its independence from to government, but also to improve its membership and representation, accountability and operation.

1.130 Under the Government's plan for the National Mental Health Commission, the commissioners will be appointed by the relevant agency minister, presently the Minister for Mental Health and Ageing. Given the lack of transparency of the process thus far, the Coalition shares the concerns of submitters about the selection of the commissioners and the need to ensure key stakeholders views are represented.

1.131 Some submitters queried whether or not the Commission, as an executive agency of the Department of Prime Minister and Cabinet, would be able to provide fully independent advice. However, it was clear from the evidence that the Commission's wider accountability and effective operation was also important.

1.132 As the body promoting accountability and transparency in mental health services, some submitters stressed that the Commission's own operation must be accountable and transparent. Submitters expressed concern that the parameters governing how the Commission will report on mental health services have not yet been determined and indeed, that the Commission should operate with clear guidelines around its roles and responsibilities, independence, and authority to implement changes.

1.133 Beyondblue commented that at this stage we really don't know what the Commission will look like:

it is a bit hard to respond...because no-one really knows just yet what it is going to look like... Our vision would be an entity that would be able to gather information and monitor the performance of mental health service delivery in Australia.<sup>50</sup>

1.134 Professor McGorry emphasised the importance of the Commission being independent:

I think the ideal is actually an independent commission—I think that is what we should aim for in due course; that is really the only way to guarantee independence...<sup>51</sup>

1.135 While the Mental Health Council of Australia also underlined the issue of independence and transparency:

---

49 See for example, Mr Frank Quinlan, Chief Executive Officer, Mental Health Council of Australia, *Committee Hansard*, 5 September 2011, p. 82.; NSW Nurses Association, *Submission 178*, p. 6.; SANE Australia, *Submission 654*, p. 1.

50 Beyondblue, *Proof Committee Hansard*, 19 August 2011, p. 59.

51 Professor McGorry, *Proof Committee Hansard*, 5 September 2011, p. 69.

We think there remain a number of questions to be answered, really, about how a national mental health commission will relate to similar or related bodies in the state jurisdictions and whether a mental health commission will in fact carry the independence and authority that are required.<sup>52</sup>

1.136 Whilst the Government explained that the rationale for positioning the Commission in the Department of Prime Minister and Cabinet was to ensure cross-portfolio coordination, this was not a rationale accepted by submitters who expressed doubts about whether the Commission could transcend portfolio and jurisdictional boundaries. Indeed, several submitters suggested that the Commission must be completely independent from government in order to deliver impartial advice and evaluate government spending.

### **Two-tiered Medicare rebate system for psychologists**

1.137 The Chair's report outlines the applicability and amounts of Medicare rebates for mental health services provided by GPs, psychologists, occupational therapists and social workers. The rebatable amount under Better Access for psychological services varies according to:

- (a) the time spent providing services to the client;
- (b) where such services are provided (in consulting rooms or otherwise); and
- (c) whether such services are provided by a clinical or non-clinical psychologist.

1.138 The 'two-tiered system' refers to the situation whereby services provided by clinical psychologists (tier one) attract a higher rebate than those provided by registered psychologists (tier two). The Chair's report indicates that this has been the case since the implementation of the Better Access Initiative, and according to the Department of Health and Ageing, is based on advice from the psychology profession.

1.139 Medicare differentiates the services provided by psychologists from those provide by clinical psychologists. The Chair's report examines the differing requirements for registration as a general psychologist, a clinical psychologist and an endorsed psychologist (in any of the nine practice areas) and then provides a summary of the arguments presented both for and against the two-tiered system.

1.140 The registration system is part of the National Registration and Accreditation Scheme for psychologists which replaced previous state and territory based registration arrangements on 1 July 2010. On the day of the commencement of the scheme, registration was transferred at equivalent level from state and territory boards to the Australian Psychology Board. Subsequent renewal applications (required on an

---

52 Mental Health Council of Australia, *Proof Committee Hansard*, 5 September 2011, p. 82.

---

annual basis) are made to the Board. The transition will be complete by 30 November 2011 at which time psychologists in all states and territories will be uniformly registered with the Board until 30 November 2012.

1.141 Submitters were divided as to whether the current scheme should remain unchanged (the argument primarily made by clinical psychologists) or should be changed to a single- or multi- tiered system (the argument primarily made by non-clinical psychologists). Aspects of this debate—alongside the rationalisation of rebatable sessions from a maximum of 18 to a maximum of 10 as discussed earlier—provided the impetus for more than a thousand psychologists to submit to the inquiry.

1.142 The Chair's report traverses the arguments for and against the two-tiered system. The proposal was also made that the two-tiered system be abolished completely. Under the model proposed by some submitters, every registered psychologist would be eligible for the same Medicare rebate, regardless of any further qualification.

1.143 Whilst the committee received a very high volume of submissions from psychologists regarding the two-tiered rebate, the vast majority cited anecdotal evidence in support of their positions. However, it is clear that at a time when one in five Australians have some form of mental illness and the demand for mental health services is increasing, such a major difference of view amongst psychologist should be resolved, especially given the impact on workforce availability and on health outcomes for patients.

1.144 The Coalition suggests that consideration be given to referring the issue of the two-tiered system to the Australian Health Practitioner Regulation Agency (AHPRA) for further consideration as to whether current arrangements should be altered, including consideration of all the evidence provided to the inquiry. AHPRA was established on 1 July 2010 as part of the National Registration and Accreditation Scheme to regulate 10 health professions. The ten health professions regulated by AHPRA are: chiropractors; dental practitioners (including dentists, dental specialists, dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; and psychologists. The AHPRA annual report for 2009–10 indicated that from July 2012, a further four health professions are planned to join the scheme: Aboriginal and Torres Strait Islander health practitioners; Chinese medicine practitioners; medical radiation practitioners; and occupational therapists.

1.145 In any case, the Coalition suggests that that the Government should undertake ongoing monitoring of any effects of the two tier Medicare rebate for psychologists on workforce composition.

## **Conclusion**

1.146 In summary, the Coalition is critical of the Government for the way it has undertaken changes to Better Access. There has been scant consultation with key stakeholders to assess the impact of the changes, most especially on patients. Instead,

the Government has relied heavily on the Better Access evaluation, which has been criticised on deficiencies in methodology and data sets.

1.147 The Coalition believes that until the EPPICs and additional *headspace* centres have been established and are operational, it will be difficult to fully assess the impact of these changes.

1.148 Furthermore, we are concerned that the consequences of the shift from Better Access to ATAPS have not been fully considered. This is particularly worrying given the challenges facing ATAPS which are highlighted in the ANAO report. Fundamentally, there is a real question as to whether the ATAPS structure is sufficient to meet this new demand. This is especially concerning given the estimates given at the hearing that there are potentially 87,000 people who are going to move from better Access to ATAPS. This is also complicated by the uncertainty of the move from the current system of Divisions of General Practice to Medicare Locals and how these changes will exacerbate already strained financial and structural issues.

1.149 In short, the Government has, like many other issues in Health and Ageing, taken action but failed to adequately assess the impact of its actions on key stakeholders and most importantly, on patients.

**Senator Concetta Fierravanti-Wells**  
LP, New South Wales

**Senator Judith Adams**  
LP, Western Australia

**Senator Sue Boyce**  
LP, Queensland

**Senator Bridget McKenzie**  
NATS, Victoria

# APPENDIX 1

## Submissions Received

- 1 Confidential
- 2 Name Withheld
- 3 Name Withheld
- 4 Confidential
- 5 Name Withheld
- 6 Dr Christopher Basten
- 7 Name Withheld
- 8 Dr Georgina O'Donnell
- 9 Name Withheld
- 10 Dr Jennifer Fitzgerald
- 11 Dr Clare Rosoman
- 12 Ms Tracey Jarvis
- 13 Ms Anne Etchells
- 14 Mr Gareth M Dawes
- 15 Dr Terry Simpson
- 16 Dr Melanie O'Shea
- 17 Dr Paul Whetham
- 18 Dr Shanel Few
- 19 Confidential
- 20 Name Withheld
- 21 Mr Jeff Munday
- 22 Ms Cynthia Mifsud
- 23 Dr Jennifer Pearce
- 24 Ms Natalie McCall
- 25 Dr John Jakupi
- 26 Dr Frances M Moran
- 27 Ms Sarah Purvey
- 28 Dr Rene Grypma
- 29 Dr Claudia Ovenden
- 30 Dr David Cockram
- 31 Name Withheld

- 32 Dr Jessica Brands
- 33 Dr Rita Lapidus
- 34 Dr Vanessa Spiller
- 35 Dr Michael Groome
- 36 Dr Margaret Musico
- 37 Dr Brendan Evans
- 38 Dr Carl Zabel
- 39 Name Withheld
- 40 Dr Samantha Ward
- 41 Dr Arend Tibben
- 42 Dr Lisa Shanahan
- 43 Mr Anthony Warren
- 44 Name Withheld
- 45 Ms Nadia Del Col
- 46 Dr Jeffrey Edmonds
- 47 Dr Friederike Gerull
- 48 Dr Helen Harrison
- 49 Dr Chris Day
- 50 Mrs Lyn Benson
- 51 Dr Melanie Newton
- 52 Name Withheld
- 54 Name Withheld
- 55 Mr Neil Ballardie
- 56 Dr Henry Briffa
- 57 Dr Darryl Menaglio
- 58 Name Withheld
- 59 Dr Bruce Murray
- 60 Mrs Katrina Frost
- 61 Mr Simon Vincenzi
- 62 Name Withheld
- 63 Miss Maria Chorney
- 64 Dr Georgie Paulik-White
- 65 Ms Suzanne Plotzza
- 66 Ms Tamara Plotzza

---

67	Mr Colin Barling
68	Mr. Adolph Hanich
69	Dr Sandra Pertot
70	Professor Anthony Jorm and Ms Betty Kitchener AOM
71	Name Withheld
72	Name Withheld
73	Dr Claudia Michels
74	Name Withheld
75	Name Withheld
76	Name Withheld
77	Dr Carsten Schley
78	Dr Lisa Storchheim
79	Dr Cheryl Quinn
80	Dr Ian McCombie
81	Name Withheld
82	Name Withheld
83	Ms Kirsty Sloan
84	Mr Peter Walker
85	Dr John Jacmon
86	Name Withheld
87	Name Withheld
88	Dr Reg Davis
89	Name Withheld
90	Name Withheld
91	Name Withheld
92	Dr Patrick Fleming
93	Dr Marcus Hunter
94	Dr Patrick Rahilly
95	Ms Annette Ross
96	Ms Anna De La Rae
97	Confidential
98	Name Withheld
99	Name Withheld
100	Name Withheld

- 101** Name Withheld
- 102** Name Withheld
- 103** Ms Louise Trimble
- 104** Ms Kerry Cavanagh
- 105** Name Withheld
- 106** Name Withheld
- 107** Ms Michele Colman
- 108** Mr Jeffrey Kelly
- 109** Ms Anne-Marie Loney
- 110** Australian Council on Healthcare Standards (ACHS)
- 111** Mr Ben Hansen  
Supplementary Submission
- 112** Name Withheld
- 113** Northeast Health Wangaratta
- 114** Name Withheld
- 115** Dr Aaron Frost
- 116** Name Withheld
- 117** Ms Jeanne Abelson
- 118** Dr Robyn Weir
- 119** Mr Gavan Bennett  
Supplementary Submission
- 120** Dr Marion Oke
- 121** Dr Cal Paterson
- 122** Name Withheld
- 123** Dr Mimi Wellisch
- 124** Mr Christopher Trewavas
- 125** Australian Psychological Society (APS) College of Counselling Psychologists
- 126** Name Withheld
- 127** Dr Elizabeth Vaskin
- 128** Confidential
- 129** Dr Melissa J Taylor
- 130** Mr Robert Oldani
- 131** White Wreath Assoc Ltd
- 132** Dr Noeline Wilding
- 133** Dr Jennifer Flatt

- 
- 134 Dr Sophia Parnas
- 135 Office of the Commissioner for Social Inclusion, Government of South Australia
- 136 Ms Catherine Soukoulis
- 137 Name Withheld
- 138 Mr Vic Val
- 139 Name Withheld
- 140 Name Withheld
- 141 Name Withheld
- 142 Name Withheld
- 143 Name Withheld
- 144 Name Withheld
- 145 Name Withheld
- 146 Name Withheld
- 147 Name Withheld
- 148 Name Withheld
- 149 Name Withheld
- 150 Name Withheld
- 151 Mr Darren Stones
- 152 Name Withheld
- 153 Name Withheld
- 154 Confidential
- 155 Mr Michael Quinn
- 156 Name Withheld
- 157 Confidential
- 158 Name Withheld
- 159 The Australian Psychological Society Ltd  
Supplementary Submission
- 160 Name Withheld
- 161 Australian Psychological Society (APS) College of Clinical Psychologists  
Supplementary Submission
- 162 Name Withheld
- 163 Name Withheld
- 164 Name Withheld
- 165 Australian Clinical Psychology Association (ACPA)  
Supplementary Submission

- 166** Name Withheld
- 167** Confidential
- 168** Name Withheld
- 169** headspace
- 170** Professor Alan Rosen, Vivienne Miller, Roger Gurr
- 171** beyondblue: the national depression initiative  
Supplementary Submission
- 172** Royal Australian College of General Practitioners  
Supplementary Submission
- 173** Australian Counselling Association Inc
- 174** Dr Clive Jones and Mr Philip Armstrong
- 175** ACON
- 176** Carers NSW
- 177** Northern Territory Legal Aid Commission
- 178** New South Wales Nurses' Association
- 179** Consumers Health Forum of Australia
- 180** Confidential
- 181** Multicultural Mental Health Association of Australia
- 182** Rural Doctors Association of Australia
- 183** New Day Psychological Services Pty Ltd
- 184** Ethnic Disability Advocacy Centre
- 185** Australian Medical Association
- 186** Australian Indigenous Psychologists Association (AIPA)
- 187** Federation of Ethnic Communities' Councils of Australia (FECCA)
- 188** Psychology Private Australia Inc.
- 189** Private Mental Health Consumer Carer Network (Australia)
- 190** The Butterfly Foundation
- 191** Australian General Practice Network
- 192** Confidential
- 193** Psychotherapy and Counselling Federation of Australia
- 194** Australian College of Specialist Psychologists
- 195** Public Health Association of Australia
- 196** National and NSW Councils for Intellectual Disability and Australian  
Association of Developmental Disability Medicine
- 197** Australian Association of Psychologists Incorporated (AAPI)  
Supplementary Submission

- 
- 198 Mental Health Council of Australia
- 199 Department of Health and Ageing
- 200 Australasian Confederation of Psychoanalytic Psychotherapies
- 201 Empower Psychology & Counselling
- 202 National Mental Health Consumer and Carer Forum
- 203 Sydney Clinical Psychology
- 204 Mental Health Community Coalition ACT
- 205 University of New South Wales Department of Developmental Disability  
Neuropsychiatry
- 206 Catholic Social Services Australia
- 207 Inspire Foundation and Australian Youth Affairs Coalition
- 208 Aboriginal and Torres Strait Islander Healing Foundation
- 209 Mission Australia
- 211 Dr Ann Huntress
- 212 Mr James McCloy
- 213 Name Withheld
- 214 Association of Counselling Psychologists
- 215 Psychologists Association SA Branch  
Supplementary Submission
- 216 Ms Sarah Sutton
- 217 Mr Michael Farr
- 218 Mr. Michael Di Mattia
- 219 Ms. Catherine Sanders
- 220 Ms Catherine Steele
- 221 ms renee napier
- 222 Ms Antonia Harold
- 223 Dr Ben Harris
- 224 Dr Karola Belton
- 225 Name Withheld
- 226 Confidential
- 227 Confidential
- 228 Confidential
- 229 Confidential
- 230 Confidential
- 231 Confidential

232 Confidential  
233 Confidential  
234 Confidential  
235 Confidential  
236 Name Withheld  
237 Name Withheld  
240 Name Withheld  
241 Name Withheld  
242 Name Withheld  
243 Name Withheld  
244 Name Withheld  
246 Name Withheld  
248 Name Withheld  
249 Name Withheld  
250 Name Withheld  
251 Name Withheld  
252 Name Withheld  
253 Name Withheld  
254 Name Withheld  
255 Name Withheld  
256 Name Withheld  
257 Name Withheld  
258 Name Withheld  
259 Name Withheld  
260 Name Withheld  
261 Name Withheld  
262 Name Withheld  
263 Name Withheld  
264 Name Withheld  
265 Name Withheld  
266 Mr. Philip Garner  
267 Name Withheld  
268 Name Withheld  
269 Name Withheld

---

<b>270</b>	Name Withheld
<b>271</b>	Name Withheld
<b>272</b>	Name Withheld
<b>273</b>	Name Withheld
<b>274</b>	Name Withheld
<b>275</b>	Name Withheld
<b>276</b>	Name Withheld
<b>277</b>	Name Withheld
<b>278</b>	Name Withheld
<b>279</b>	Ms. Samantha Ferreri
<b>280</b>	Mr. Korey Pagura
<b>281</b>	Ms. Larissa Taylor
<b>282</b>	Dr. Cate Arciuli
<b>283</b>	Ms. Mary Ticinovic
<b>285</b>	Mr. Damien Tuffano
<b>286</b>	Mr. Derek Ruse
<b>287</b>	Mr. Gregory Currie
<b>288</b>	Ms. Dianne Summers
<b>289</b>	Ms. Donna Eshuys
<b>290</b>	Dr. Annette Ostermeyer
<b>291</b>	Mr. Rudd de Bakker
<b>292</b>	NewPsych Psychologists
<b>293</b>	Ms. Caroline Storti
<b>294</b>	Dr. Roger Peters
<b>295</b>	Mr. Gary Croton
<b>296</b>	Name Withheld
<b>297</b>	Ms. Sally McDougall
<b>298</b>	Dr Kerrie Clarke
<b>299</b>	Mrs Rebecca McMillan
<b>300</b>	Ms. Dianne O'Malley
<b>301</b>	Ms. Christine Carter
<b>302</b>	Ms. Judi Pears
<b>303</b>	Name Withheld
<b>304</b>	Ms. Serena Cauchi

- 305** Dr Ashley Craig  
**306** Ms. Anne Woodward  
**307** Dr. Kevin Pyle  
**308** Mr. Bob Duncan  
**309** Ms. Sue Whelan  
**310** Dr. Alan Headey  
**311** Ms Carole Mclean  
**312** Ms. Ella Duckworth  
**313** Mr. Matt Strickland  
**314** Dr. Rebecca Coleman  
**315** Ms. Val Sutton  
**316** Ms. Courtney Smith  
**317** Ms. Josephine Cannon  
**318** Ms. Sophia Farrington  
**319** Name Withheld  
**320** Ms. Julie Wouters  
**321** Ms. Heather Marriott  
**322** Ms. Elizabeth Richardson  
**323** Ms Geraldine Lum  
**324** Ms Rosemary Grahame  
**325** Ms Anne Williams  
**326** Mr Kaye Barr  
**327** Mr Alex Corcoran  
**328** Ms Deborah Turner  
**329** Ms Sarah Calleja  
**330** Name Withheld  
**331** Ms Maria Polymeneas  
**332** Dr Michael Proeve  
**333** Ms Yvonne Town  
**334** Ms Arzu Oytam  
**335** Dr Lisa Chantler  
**336** Dr Mitchell Byrne  
**337** Dr Marlies Alvarenga  
**338** Mr Marcus Squirrell

---

<b>339</b>	Ms Vicky Booth
<b>340</b>	Ms Alison Mynard
<b>341</b>	Ms Fiona Michel
<b>342</b>	Dr Stuart Edser
<b>343</b>	Dr Paul Bowden
<b>344</b>	Ms Janet Freestun
<b>345</b>	Name Withheld
<b>346</b>	Ms Vera Auerbach
<b>347</b>	Mr Paul Thiering
<b>348</b>	Dr Josephine Hurley
<b>349</b>	Mr Tim Loughnan
<b>350</b>	Dr Karen Johnson
<b>351</b>	Mr Greg Hodgson
<b>352</b>	Ms Robyn Habner
<b>353</b>	Mr Paul Phelps
<b>354</b>	Mr Dale Amir
<b>355</b>	Ms Jeni Martin
<b>356</b>	Ms Beth Stone
<b>357</b>	Mr Peter Perisce
<b>358</b>	Ms Carolyn Sullivan
<b>359</b>	Dr Sarah Russo
<b>360</b>	Ms Susan Paxton
<b>361</b>	Ms Voula Antoniadis
<b>362</b>	Confidential
<b>363</b>	Confidential
<b>364</b>	Confidential
<b>365</b>	Confidential
<b>366</b>	Name Withheld
<b>367</b>	Name Withheld
<b>368</b>	Name Withheld
<b>369</b>	Name Withheld
<b>370</b>	Name Withheld
<b>371</b>	Name Withheld
<b>372</b>	Name Withheld

- 373** Name Withheld
- 374** Name Withheld
- 375** Ms Anne Silbereisen
- 376** Mr Tom Sutton  
Supplementary Submission
- 377** Mental Health Council of Tasmania (MHCT)
- 378** Dr Marie-Ange Nambiar
- 379** Ms Donna Kite
- 380** Ms Silvia Benovic
- 381** Name Withheld
- 382** Dr Susie Allanson
- 383** Dr James Campbell
- 384** Ms Amanda White
- 385** Mrs Erika Dyer
- 386** Dr Robert Dawson
- 387** Name Withheld
- 388** Name Withheld
- 389** Name Withheld
- 390** Confidential
- 391** Confidential
- 392** Dr Rebecca Sng
- 393** Mind Zone Psychology
- 394** Confidential
- 395** North Australian Aboriginal Justice Agency
- 396** Dr Christine Hill
- 397** Ms Karen Abbott
- 398** Ms Michele Arthur
- 399** Name Withheld
- 400** mr william doudle
- 401** Name Withheld
- 402** Name Withheld
- 403** Name Withheld
- 404** Ms Frances O'Connor
- 405** Ms Laura Gardner

---

406	Dr Donald Rose
407	Mrs Linda Pullen Supplementary Submission
408	Ms Su Upton
409	Ms Anne Sacco
410	Ms Tracey Maher
411	Mr Lyn Thomson
412	Carlton Brunswick APS Peer Consultation Group
413	Name Withheld
414	Dr Timothy Doyle
415	Ms Paula Beasty
416	OGI Potential
417	Dr Dawn Riisik
418	Ms Anne Symons
419	Dr Amber Keast
420	Dr Carryn Padoa
421	Ms Monika Sherwood
422	Dr Michelle Mulvihill
423	Confidential
424	Ms Linda Werbeloff
425	Confidential
426	Ms Penny Lewis
427	Name Withheld
428	APS College of Educational and Developmental Psychologists
429	Mr Ian Kilpatrick
430	Dr Patricia O'Rourke
431	Mr Simon Jacobs
432	Ms Amanda Burlock
433	Name Withheld
434	Mr Grant Dewar
435	Name Withheld
436	Mr Kim Dunn
437	Ms Kylie McCardle
438	Dr Clare Smith

- 439** Mr Warren Harrison
- 440** Ms Nicola Carter
- 441** Name Withheld  
Supplementary Submission
- 442** Name Withheld
- 443** Mr Frank Breuer
- 444** Name Withheld  
Supplementary Submission
- 445** Ms Hoa Pham
- 446** Minds and Hearts
- 447** Australian College of Mental Health Nurses (ACMHN)
- 448** National Psychology Group
- 449** National Sorry Day Committee
- 450** PACFA
- 451** Ms Aliya Akarsu-Atakan and Ms Serpil Ozturk
- 452** Queensland Advocacy Incorporated
- 453** School of Psychology, The University of Sydney
- 454** Medibank
- 455** Flinders University, School of Psychology
- 456** endorsed NT clinical psychologists
- 457** Embracing the Other Half Psychology Clinic
- 458** Clinical Psychologists CAMHS WA
- 459** Clinical Psychology reference Group, WA Dept of Health
- 460** Mental Illness Fellowship of Australia
- 461** Adults Surviving Child Abuse
- 462** Institute of Private Practising Psychologists (IPPP)
- 463** Clinical Counsellors Association  
Supplementary Submission
- 464** Australian College of Psychologists in Clinical Private Practice (ACPCPP)
- 465** Dr Mick Hunter
- 466** Australian Nursing Federation (Victorian Branch)
- 467** A.N.U. Centre for Mental Health Research
- 468** Name Withheld
- 469** Ms Linda Hansen
- 470** Mr Brett Jones

---

471	Ms Margaret Cole
472	Ms Lesley Akora
473	Dr Joseph Magliaro
474	Dr Jo Rouston
475	Ms Helen Gibbs
476	Mr David Castle
477	Mr Simon Baxter
478	Ms Krystle Borg
479	Dr Sallee McLaren
480	Name Withheld
481	Name Withheld
482	Name Withheld
483	Name Withheld
484	Name Withheld
485	Name Withheld
486	Name Withheld
487	Name Withheld
488	Name Withheld
489	Name Withheld
490	Name Withheld
491	Name Withheld
492	Name Withheld
493	Name Withheld
494	Name Withheld
495	Ms Nerida Saunders
496	Ms Robynne Moore
497	Mr Richard Taylor Supplementary Submission
498	Ms Dianna Hanley
499	Name Withheld
500	Ms Carin Swaddling
501	Dr Sue Stefanovic
502	Confidential
503	Ms Rebecca Lachovitzki

- 504** Queensland Program of Assistance for Survivors of Torture and Trauma (QPASTT)
- 505** The Psychology Foundation of Australia
- 506** Black Dog Institute
- 507** Orygen Youth Health Research Centre  
Supplementary Submission
- 508** Forensicare
- 509** Name Withheld
- 510** Name Withheld
- 511** Mr Jonathon Walker
- 512** Life Promotion Clinic
- 513** Confidential
- 514** Ms Jill Brewin
- 515** Ms Robyn Young
- 516** Central Australian Aboriginal Legal Aid Service Inc. (CAALAS)
- 517** Mercy Health
- 518** Name Withheld
- 519** Name Withheld
- 520** Name Withheld
- 521** Name Withheld
- 522** Name Withheld
- 523** Name Withheld
- 524** Name Withheld
- 525** Name Withheld
- 526** Name Withheld
- 527** Interim Office of the National Mental Health Commission
- 528** Ms Eve Dyer
- 529** Dr Janice Allen
- 530** Professor Mark Creamer
- 531** Ms Lee James
- 532** Dr Esben Strodl
- 533** Australian Association of Group Psychotherapy (AAGP)
- 534** Melbourne Children's Psychology Clinic
- 535** Mrs Nandi Herholdt
- 536** Confidential

- 
- 537 Dr Don Tustin
- 538 Dr Alexandra Osborn, Nina Cook, Kathy Fogarty
- 539 Ms Annie Barkl
- 540 Mrs Astrid von Lojewski-Wilson
- 541 Ms Jill Wright
- 542 Australian Nursing Federation (ANF)
- 543 Deaf Children Australia
- 544 Ms Kathryn Allison
- 545 Ms Vicki Palmer
- 546 Ms Tamara Wolpert
- 547 Ms Jan Gregory
- 548 Ms Mai Doa
- 549 Mr Chris Willcox
- 550 Mr Peter Delany
- 551 Mr Gordon Smith
- 552 Ms Mary Cooke
- 553 Name Withheld
- 554 Dr Shu-Huei Lin
- 555 Mr Raymond Dorling
- 556 Ms Kellie Gordon
- 557 Dr Lee Hearn
- 558 Ms Danielle Goodridge
- 559 Ms Janice Wood
- 560 Dr Loris Alexander
- 561 Name Withheld
- 562 Dr Simone Baker
- 563 Ms Ling Caslick
- 564 Confidential
- 565 Dr Olga Szymanska
- 566 Dr Veronica Harris
- 567 Dr Ronnie Zuessman
- 568 Dr Christine McAuliffe
- 569 Name Withheld
- 570 Mr Peter Pacey

<b>571</b>	Mr Nesh Nikolic
<b>572</b>	Confidential
<b>573</b>	Mr Adrian Donoghue
<b>574</b>	Name Withheld
<b>575</b>	Mr Arthur Cooke
<b>576</b>	Mrs Kristie Clarke
<b>577</b>	Name Withheld
<b>578</b>	Dr Laura Hedayati
<b>579</b>	Mr Neil Gilbert
<b>580</b>	Name Withheld
<b>581</b>	Name Withheld
<b>582</b>	Ms Edwina Birch
<b>583</b>	Confidential
<b>584</b>	Name Withheld
<b>585</b>	Mr Adam Becker
<b>586</b>	Ms Sarah Galea-Pace
<b>587</b>	Ms Zoe Leavitt
<b>588</b>	Ms Anne Marie Havlat
<b>589</b>	Dr Christopher Mogan
<b>590</b>	Name Withheld
<b>591</b>	Dr Laurel Morris
<b>592</b>	Ms Angela Barry
<b>593</b>	Ms Lee-Anne Dawson
<b>594</b>	Ms Julia Reynolds
<b>595</b>	Mr Peter Czislawski
<b>596</b>	Ms Stephanie Allen
<b>597</b>	Confidential
<b>598</b>	Confidential
<b>599</b>	Mr John Reddington
<b>600</b>	Mr Angelo Contarino
<b>601</b>	Confidential
<b>602</b>	Australia New Zealand Society of Jungian Analysts
<b>603</b>	Dr Amelia Scholes
<b>604</b>	Dr Kerry Hill

---

<b>605</b>	Ms Elisabeth Roeder
<b>606</b>	Ms Janet Benson
<b>607</b>	Ms Christine Ffrench
<b>608</b>	Ms Christina Petz
<b>609</b>	Ms Mary Karlson
<b>610</b>	Dr Sarah Pollock
<b>611</b>	Ms Sylvana Mizzi
<b>612</b>	Ms Lee-Ann Prideaux
<b>613</b>	Name Withheld
<b>614</b>	Ms Doreen Westley
<b>615</b>	Ms Rosanne Divenuto
<b>616</b>	Mr Michael Geary
<b>617</b>	Ms Kia Pfaeffli
<b>618</b>	Ms Virginia Woods
<b>619</b>	Ms Ruane Lipkie Supplementary Submission
<b>620</b>	Mr Matthew Evans
<b>621</b>	Mr Graeme King
<b>622</b>	Mr Mil McCormack
<b>623</b>	Ms Tamara Treichel
<b>624</b>	Ms Dianne Perrett-Abrahams
<b>625</b>	Ms Jenny Ingleton
<b>626</b>	Dr Michelle Pain
<b>627</b>	Dr Elise Julien
<b>628</b>	Dr Betty Kotler
<b>629</b>	Dr Karla Johnston
<b>630</b>	Mr Brendan Partridge
<b>631</b>	Dr Jane Direen
<b>632</b>	Ms Fiona Meredith
<b>633</b>	Name Withheld
<b>634</b>	Name Withheld
<b>635</b>	Dr Nikola Tomic
<b>636</b>	Ms Margaret Wilkes
<b>637</b>	Ms Sharon Marcus

- 638** Ms Erika Leonard
- 639** Mr Paul Gertler
- 640** Mr Noah Ariel
- 641** Mr Robert Maxwell
- 642** Dr Kerry Jones
- 643** Mr Ean James
- 644** Dr Bernadette Bywater
- 645** Ms Julie Piercy and Ms Judy Hyde
- 646** Confidential
- 647** Ms Jan Lavoipierre
- 648** Ms Khai Wong
- 649** Dr Marija Radojevic
- 650** Australia and New Zealand Academy for Eating Disorders
- 651** Aboriginal Medical Services Alliance NT (AMSANT)
- 652** Carers WA
- 654** SANE Australia
- 655** Bravehearts  
Supplementary Submission
- 657** Dr Henry Jackson et al.
- 658** Mr Mike Collins
- 659** Name Withheld
- 660** Ms Lindee Smith
- 661** Mental Health Action Reform Group (MHARG)
- 662** Name Withheld
- 663** Name Withheld
- 664** Name Withheld
- 665** Name Withheld
- 666** Name Withheld
- 667** Name Withheld
- 668** Name Withheld
- 669** Name Withheld
- 670** Name Withheld
- 671** Name Withheld
- 672** Name Withheld

---

<b>673</b>	Name Withheld
<b>674</b>	Name Withheld
<b>675</b>	Dr Angelo Pagano
<b>676</b>	Ms Amanda Hall
<b>677</b>	Ms Bianca Denny
<b>678</b>	Mr Brad Johnston
<b>679</b>	Ms Brigid Goldberg
<b>680</b>	Professors Pachana, Sofranoff, Halford, Helmes, Murray, Kyrios, Baillie, O' Donovan
<b>681</b>	Name Withheld
<b>682</b>	Name Withheld
<b>683</b>	Name Withheld
<b>684</b>	Name Withheld
<b>685</b>	Southside Health and Wellbeing
<b>686</b>	Name Withheld
<b>687</b>	Name Withheld
<b>688</b>	Name Withheld
<b>689</b>	Name Withheld
<b>691</b>	Ms Gabrielle Wynne
<b>692</b>	Australian Federation of Deaf Societies (AFDS)
<b>693</b>	Dr John Roodenburg
<b>694</b>	Ms Lydia Senediak
<b>695</b>	Ms Celia Dickson
<b>696</b>	Mr Chris Probets
<b>697</b>	Ms Emma Sanders
<b>698</b>	MsCarolynn Hodges
<b>699</b>	Ms Cassandra Shields
<b>700</b>	Dr Claire Hitchings
<b>701</b>	Ms Cinzia Gagliardi
<b>702</b>	Mr Daren Wilson
<b>703</b>	Mr Dino Cipriani
<b>704</b>	Ms Deirdre Tozer
<b>705</b>	Name Withheld
<b>706</b>	Mr Christopher Semmens

<b>707</b>	Mr Daniel Hobbs
<b>708</b>	Dr Danielle Einstein
<b>709</b>	Mr Dave Misso
<b>710</b>	Dr David Collins
<b>711</b>	Mr Craig Gonsalvez
<b>712</b>	Dr Craig San Roque Supplementary Submission
<b>713</b>	Mr Colby Pearce
<b>714</b>	Ms Erin Bullen
<b>715</b>	Dr Felicity Cockshott
<b>716</b>	Ms Kathryn Collins
<b>717</b>	Ms Coral Warren
<b>718</b>	Dr Crystal McMullen
<b>719</b>	Mr Chris Ludlow
<b>721</b>	Ms Gail Powell
<b>722</b>	Ms Gail Jones
<b>723</b>	Ms Lucy Wise
<b>724</b>	Mr Greg Sorrell
<b>725</b>	Dr Mariana Macphail
<b>726</b>	The Psychologists Richmond (TPR)
<b>727</b>	Dr Frank Walsh
<b>728</b>	Professor David De L Horne
<b>729</b>	Ms Lucy O'Neill
<b>730</b>	Dr Denise Wallis
<b>731</b>	Name Withheld
<b>732</b>	Name Withheld
<b>733</b>	Name Withheld
<b>734</b>	Name Withheld
<b>735</b>	Name Withheld
<b>736</b>	Confidential
<b>737</b>	Confidential
<b>738</b>	Confidential
<b>739</b>	Confidential
<b>740</b>	Ms Desi Achilleos

---

<b>741</b>	Dr Lynn Priddis
<b>742</b>	Ms Eva Ferra
<b>743</b>	Ms Louise Olivier
<b>744</b>	Ms Elizabeth Marks
<b>745</b>	Dr Louisa Hoey
<b>746</b>	Ms Louise Kelso
<b>747</b>	Name Withheld
<b>748</b>	Name Withheld
<b>749</b>	Confidential
<b>750</b>	Confidential
<b>751</b>	Confidential
<b>752</b>	Confidential
<b>753</b>	Name Withheld
<b>754</b>	Queensland Alliance for Mental Health Inc.
<b>755</b>	Amaranth Foundation
<b>756</b>	Mr Julian McNally
<b>757</b>	Ms Duane Smith
<b>758</b>	Ms Julie Dunsmore
<b>759</b>	Ms Judy Bokor
<b>760</b>	Dr Judy Buchholz
<b>761</b>	Dr Judith Ellis
<b>762</b>	Dr Michael Free
<b>763</b>	Dr Marchiene van der Veen
<b>764</b>	Dr Heather McCormack
<b>765</b>	Dr Jennifer Rice
<b>766</b>	Dr Clair Lawson
<b>767</b>	Dr Don Pritchard et al
<b>768</b>	Mr Geoffrey Jones
<b>769</b>	Mr Grant Brecht
<b>770</b>	Dr Gavan Palk
<b>771</b>	Ms Gail Robertson
<b>772</b>	Mr Frances D'Arcy-Tehan
<b>773</b>	Dr Fiona Barenhagen
<b>774</b>	Mr Joseph Gagliano

<b>775</b>	Ms Jocelyn Wake
<b>776</b>	Confidential
<b>777</b>	Dr James Jupp
<b>778</b>	Ms Jillian Harrington
<b>779</b>	Ms Jessamine Chen
<b>780</b>	Ms Jennifer Wilson
<b>781</b>	Confidential
<b>782</b>	Confidential
<b>783</b>	Ms Jennifer Rooney
<b>784</b>	Ms Bernardine McDonald
<b>785</b>	Name Withheld
<b>786</b>	Ms Bernadette Hughes
<b>787</b>	Mr Bruce Falconer
<b>788</b>	Ms Carol Streatfield
<b>790</b>	Dr Brendan Lloyd
<b>791</b>	Name Withheld
<b>792</b>	Mr John Dallimore
<b>793</b>	Ms Julie King
<b>794</b>	Ms Flavia Bises
<b>795</b>	Mr Ivan Raymond
<b>796</b>	Confidential
<b>797</b>	Name Withheld Supplementary Submission
<b>798</b>	Name Withheld
<b>799</b>	Dr M E Henderson
<b>800</b>	Mr Philip Worthen
<b>801</b>	Name Withheld
<b>802</b>	Mr Matthew Ryan
<b>803</b>	Name Withheld
<b>804</b>	Ms Marianne Dyer
<b>805</b>	Dr Maria Scoda
<b>806</b>	Dr James Courtney
<b>807</b>	Dr Marjorie Collins
<b>808</b>	Dr Oleh Kay

---

<b>809</b>	Ms Jane Whitmore
<b>810</b>	Dr Tania Pietrzak
<b>811</b>	Confidential
<b>812</b>	Confidential
<b>813</b>	Confidential
<b>814</b>	Name Withheld
<b>815</b>	Mr Michael Costa
<b>816</b>	Ms Jane McGregor
<b>817</b>	Name Withheld
<b>818</b>	Ms Mary Dewberry
<b>819</b>	Mr Michael Simon
<b>820</b>	Confidential
<b>821</b>	Confidential
<b>822</b>	Ms Helen Gavriel
<b>823</b>	Confidential
<b>824</b>	Name Withheld
<b>825</b>	Name Withheld
<b>826</b>	Ms Merrilly Watson
<b>827</b>	Confidential
<b>828</b>	Name Withheld
<b>829</b>	Confidential
<b>831</b>	Name Withheld
<b>832</b>	Mr Hugh Woolford and nine other clinical psychologists
<b>833</b>	Ms Heather Irvine-Rundle
<b>834</b>	Name Withheld
<b>835</b>	Ms Gillian Marcoolyn
<b>836</b>	Confidential
<b>837</b>	Name Withheld
<b>838</b>	Confidential
<b>839</b>	Name Withheld
<b>840</b>	Dr Jane McGillivray
<b>841</b>	Name Withheld
<b>842</b>	Name Withheld
<b>843</b>	Ms Mariela Occelli

<b>844</b>	Name Withheld
<b>845</b>	Name Withheld
<b>846</b>	Name Withheld
<b>847</b>	Dr Heather Ward
<b>848</b>	Name Withheld
<b>849</b>	Mr Malcolm Desland
<b>850</b>	Name Withheld
<b>851</b>	Australian Association for Cognitive and Behaviour Therapy Ltd
<b>852</b>	Mr Michael Schauer
<b>853</b>	Name Withheld
<b>854</b>	Name Withheld
<b>855</b>	Ms Heidi Germann, Dr Michael John, Ms Phillipa Stunzer and Ms Mary Agar-Wilson
<b>856</b>	Ms Mandy Juniper
<b>857</b>	The Australian Council on Healthcare Standards
<b>858</b>	Mr Michael Dent
<b>859</b>	Mr Kevin Bulbeck
<b>860</b>	Ms Helen Nistico
<b>861</b>	Ms Alexandra Hof
<b>862</b>	Ms Kylee Forrest
<b>863</b>	Ms Leigh Buckley
<b>864</b>	Mr Nick Cocco
<b>865</b>	Name Withheld Supplementary Submission
<b>866</b>	Ms Carole Carter
<b>867</b>	Dr Caroline Croft
<b>868</b>	Ms Emma Campbell
<b>869</b>	Name Withheld
<b>870</b>	Ms Charity Parrish
<b>871</b>	Name Withheld
<b>872</b>	Name Withheld
<b>873</b>	Name Withheld
<b>874</b>	Name Withheld
<b>875</b>	Name Withheld
<b>876</b>	Confidential

---

<b>877</b>	Confidential
<b>878</b>	Ms Belinda Barnes
<b>879</b>	Ms Barbara Wood
<b>880</b>	Ms Barbara Dickson
<b>881</b>	Confidential
<b>882</b>	Name Withheld
<b>883</b>	Name Withheld
<b>884</b>	Ms Anne Moorhouse
<b>885</b>	Ms Ania Kryzstofiak
<b>886</b>	Dr Angela Green Supplementary Submission
<b>887</b>	Mr Andrew Lindsay
<b>888</b>	Ms Alison Newton
<b>889</b>	Dr Alison Christensen
<b>890</b>	Ms Alexandra Harry
<b>891</b>	Mr Alex Knopman
<b>892</b>	Dr Aleksander Chojnacki
<b>893</b>	Suicide Prevention Australia
<b>894</b>	Miss Ailsa Lord
<b>895</b>	Mr Abdul H. Saad
<b>896</b>	Confidential
<b>897</b>	Mr Christopher Wigg
<b>898</b>	Confidential
<b>899</b>	Confidential
<b>900</b>	Confidential
<b>901</b>	Dr Geoff Hatten
<b>902</b>	Ms Gaby Hill
<b>903</b>	Mr Eric Belling
<b>904</b>	Ms Emma Gallagher
<b>905</b>	Dr Elizabeth Westrupp
<b>906</b>	Ms Elizabeth Matjacic
<b>907</b>	Ms Dianne Veitch
<b>908</b>	Confidential
<b>909</b>	Ms Elizabeth Clarkson

<b>910</b>	Mr David Kavanagh
<b>911</b>	Mr David Baldwin
<b>912</b>	Dr Jennifer Torr
<b>913</b>	Mrs Jennifer Morris
<b>914</b>	Ms Janelle Louise (NeLi) Martin
<b>915</b>	Associate Professor Jan Grant and colleagues
<b>916</b>	Ms. Helen Bindoff
<b>917</b>	Confidential
<b>918</b>	Confidential
<b>919</b>	Name Withheld
<b>920</b>	Name Withheld
<b>921</b>	Name Withheld
<b>922</b>	Name Withheld
<b>923</b>	Dr Daniel Riddle
<b>924</b>	Mr Daniel Hayes
<b>925</b>	Mrs Coral Palmer
<b>926</b>	Dr Christopher Duffy
<b>927</b>	Ms Christine Hayes
<b>928</b>	Dr Charmaine Daly
<b>929</b>	Ms Bronwen Bailey
<b>930</b>	Name Withheld
<b>931</b>	Name Withheld
<b>932</b>	Name Withheld
<b>933</b>	Mr John Blythe
<b>934</b>	Name Withheld
<b>935</b>	Name Withheld
<b>936</b>	Confidential
<b>937</b>	Name Withheld
<b>938</b>	Confidential
<b>939</b>	Confidential
<b>940</b>	Confidential
<b>941</b>	Confidential
<b>942</b>	Confidential
<b>943</b>	Confidential

---

<b>944</b>	Confidential
<b>945</b>	Name Withheld
<b>946</b>	Confidential
<b>947</b>	Confidential
<b>948</b>	Confidential
<b>949</b>	Name Withheld
<b>950</b>	Confidential
<b>951</b>	Name Withheld
<b>952</b>	Ms Lisa Elizabeth Irvine
<b>953</b>	Dr Lisa Kettler
<b>954</b>	Ms Lisa McCombe
<b>955</b>	Name Withheld
<b>956</b>	Psychology Works
<b>957</b>	Ms Lisa Miller
<b>958</b>	Dr Lisa Negri and Dr Adrian Schembri
<b>959</b>	Ms Justine Collins
<b>960</b>	Ms Karen Haydon
<b>961</b>	Name Withheld
<b>962</b>	Ms Karen Weiss
<b>963</b>	Dr Kaye Horley
<b>964</b>	Ms Kathryn Nicholson Perry
<b>965</b>	Ms Kathleen Mansfield
<b>966</b>	Ms Robyn Lingard
<b>967</b>	Ms Ann Huntress
<b>968</b>	Mr Matt Strickland
<b>969</b>	Dr Kevin Pyle
<b>970</b>	Name Withheld
<b>971</b>	Dr Melissa Taylor
<b>972</b>	Name Withheld
<b>973</b>	Name Withheld
<b>974</b>	Name Withheld
<b>975</b>	Name Withheld
<b>976</b>	Name Withheld
<b>977</b>	Name Withheld

- 978** Name Withheld
- 979** Name Withheld
- 980** Name Withheld
- 981** Australian Association of Social Workers
- 982** The Queensland GP Alliance  
Supplementary Submission
- 983** Dr Sue Waite
- 984** Mr Walter Kiris
- 985** Ms Wendy Northey
- 986** Occupational Therapy Australia
- 987** Mr Wilfred Lax
- 988** Mr William Pitty
- 989** BoysTown  
Supplementary Submission
- 990** Ms Leanne Shaw, Dr Ian William and Dr Katie Wyman
- 991** Name Withheld
- 992** Mr Ben Jackson
- 993** Ms Zaharah Braybrooke
- 994** Vanessa Hamilton and Monika Castleman
- 995** Dr Ruth Bouma
- 996** Name Withheld
- 997** Ms Rubina Khan
- 998** Dr Richa Gupta
- 999** Name Withheld
- 1000** Mr Andy Prodromidis
- 1001** Name Withheld
- 1002** Name Withheld
- 1003** Name Withheld
- 1004** Ms Rose Cumberland
- 1005** National Disability Services
- 1006** Name Withheld
- 1007** Mr Joseph Riordan
- 1008** Name Withheld
- 1009** Name Withheld
- 1010** Dr Phil Kavanagh

---

<b>1011</b>	Name Withheld
<b>1012</b>	Name Withheld
<b>1013</b>	Name Withheld
<b>1014</b>	Name Withheld
<b>1015</b>	Name Withheld
<b>1016</b>	Name Withheld
<b>1017</b>	Name Withheld
<b>1018</b>	Name Withheld
<b>1019</b>	Name Withheld
<b>1020</b>	Name Withheld
<b>1021</b>	Name Withheld
<b>1022</b>	Name Withheld
<b>1023</b>	Name Withheld
<b>1024</b>	Name Withheld
<b>1025</b>	Name Withheld
<b>1026</b>	Name Withheld
<b>1027</b>	Mr Phil van der Klift
<b>1028</b>	Mr Phil Manning
<b>1029</b>	Dr Peggy Kardaras
<b>1030</b>	Confidential
<b>1031</b>	Confidential
<b>1032</b>	Name Withheld
<b>1033</b>	Name Withheld
<b>1034</b>	Name Withheld
<b>1035</b>	Name Withheld
<b>1036</b>	Name Withheld
<b>1037</b>	Name Withheld
<b>1038</b>	Name Withheld
<b>1039</b>	Name Withheld
<b>1040</b>	Name Withheld
<b>1041</b>	Name Withheld
<b>1042</b>	Mr Peter Fox
<b>1043</b>	Name Withheld
<b>1044</b>	Name Withheld

- 1045** Dr Lindsay Duncan  
**1046** Ms Linda Tilgner  
**1047** Dr Lester Cowell  
**1048** Name Withheld  
**1049** Ms Lepa Arsenieva  
**1050** Name Withheld  
**1051** Ms Kerriane Abbott  
**1052** Dr Katie Thomas  
**1053** Ms Greta Goldberg  
**1054** Ms Karen Huggett  
**1055** Dr John Burnett  
**1056** Ms Karen Behrens  
**1057** Mr Jude Robb  
**1058** Dr Jonathan Andrews and Dr John Warlow  
**1059** Ms Renate Hoffman  
**1060** Name Withheld  
**1061** Name Withheld  
**1062** Name Withheld  
**1063** Name Withheld  
**1064** Name Withheld  
**1065** Name Withheld  
**1066** Name Withheld  
**1067** Name Withheld  
**1068** Name Withheld  
**1069** Name Withheld  
**1070** Name Withheld  
**1071** Name Withheld  
**1072** Ms Maxine Blackburn  
**1073** Name Withheld  
**1074** Name Withheld  
**1075** Name Withheld  
**1076** Name Withheld  
**1077** Name Withheld  
**1078** Name Withheld

---

<b>1079</b>	Mr Michael Costello
<b>1080</b>	Mr Michael Philp
<b>1081</b>	Name Withheld
<b>1082</b>	Name Withheld
<b>1083</b>	Name Withheld
<b>1084</b>	Name Withheld
<b>1085</b>	Dr. Nigar Khawaja
<b>1086</b>	Mr Nigel Alexander
<b>1087</b>	Mr Nigel Denning
<b>1088</b>	Name Withheld
<b>1089</b>	Confidential
<b>1090</b>	Name Withheld
<b>1091</b>	Confidential
<b>1092</b>	Name Withheld
<b>1093</b>	Mrs Penny Fox
<b>1094</b>	Confidential
<b>1095</b>	Name Withheld
<b>1096</b>	Name Withheld
<b>1097</b>	Dr Rachel Costa
<b>1098</b>	Name Withheld
<b>1099</b>	Name Withheld
<b>1100</b>	Name Withheld
<b>1101</b>	Name Withheld

## **Additional Information**

- 1** Dr Anthony Jorm - Additional information: Better Access Scheme
- 2** Additional information received from Australian Healthcare and Hospitals Association, received 29 July 2011: Mental Health Funding Methodologies
- 3** Australian Psychology Board's Guidelines on area of practice endorsements
- 4** I. Hickie, S. Rosenberg, How to Tackle a Giant: Creating a Genuine Evaluation of the Better Access Program, Australian Psychiatry, Vol. 18, No. 6, December 2010
- 5** J. Perkis, M. Harris, Were the Budgetary Reforms to the Better Access to Mental Health Care Initiative Appropriate?-Yes, MJA, 12 May 2011
- 6** I. Hickie, S. Rosenberg, Were the Budgetary Reforms to the Better Access to Mental Health Care Initiative Appropriate?-No, MJA, Volume 194, No. 11, 6 June 2011
- 7** A. Rosen, R. Gurr, P. Fanning, The Future of Community-Centred Health Services in Australia: Lessons from the Mental Health Sector, AHA, 2010, received 5 August 2011
- 8** A. Rosen, D. Goldbloom, P. McGeorge, Mental Health Commissions: Making the Critical Difference to the Development and Reform of Mental Health Services, received 5 August 2010
- 9** V. Miller, A. Rosen, P. Gianfrancesco, P.Hanlon, Australian National Standards for Mental Health Services: a Blueprint for Improvement, The International Journal of Leadership in Public Services, Vol.5, No. 3, October 2009, received 5 August

## **Answers to Questions on Notice**

- 1** The Royal Australian College of General Practitioners, received 29 August 2011
- 2** The Australian Clinical Psychology Association, received 30 August 2011
- 3** The Australian Medical Association, received 12 September 2011
- 4** Attachment to answers to Questions on Notice from the Australian Medical Association, received 12 September 2011
- 5** The Royal Australian and New Zealand College of Psychiatrists, received 13 September 2011
- 6** The Private Mental Health Consumer Carer Network, received 14 September 2011
- 7** The Butterfly Foundation, received 19 September 2011
- 8** The Department of Health and Ageing, received 19 September 2011
- 9** The Department of Health and Ageing, received 20 September 2011
- 10** The Department of Health and Ageing, received 5 October 2011
- 11** The Association of Counselling Psychologists, received 13 September 2011
- 12** The Association of Counselling Psychologists, received 13 September 2011
- 13** The Department of Health and Ageing, received 27 October 2011



## **APPENDIX 2**

### **WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS**

*Friday, 19 August 2011*

*St James Court Conference Centre, 12 Batman St, West Melbourne*

#### **Witnesses**

#### **Royal Australian College of General Practitioners**

JACKSON, Professor Claire, President

MARLES, Dr Elizabeth, Vice President

RAWLIN, Associate Professor Morton, Chair, Victoria Faculty

#### **Australian Psychological Society**

GIESE, Ms Jill, Executive Officer

LITTLEFIELD, Professor Lyn, Executive Director

#### **Australian Psychological Society College of Counselling Psychologists**

HOSIE, Ms Elaine, National Chairperson

#### **Australian Psychological Society College of Clinical Psychologists**

CICHELO, Mr Anthony Michael, National Chair

LEONARD, Ms Erika, Chair, Board of Assessors

#### **Australian Clinical Psychology Association**

BRETHERTON, Dr Lesley Faye, Founding Member and Chair, Victorian Section

HYDE, Dr Judy, President

#### **Northeast Health Wangaratta**

AHRENS, Ms Jennifer Gaye, Manager Integrated Primary Mental Health Service

#### **North-East Victorian Division of General Practice**

ORGIAS, Ms Natalie Kim, Program Manager

**Australian Counselling Association**

ARMSTRONG, Mr Philip Richard, Chief Executive Officer  
JONES, Dr Clive, Board Member

**Australian Association of Psychologists inc.**

POINTER, Ms Michael Alexander, Executive Director  
STEVENSON, Mr Paul Joseph, President  
NORTHEY, Ms Wendy Lillian, Director

**headspace**

LLOYD, Miss Sian, Senior Policy Adviser  
TANTI, Mr Christopher John, Chief Executive Officer

**BeyondBlue**

O'NEIL, Ms Dawn Marie, AM, Chief Executive Officer

*Monday, 5 September 2011*  
*Parliament House, Canberra*

**Witnesses**

**Butterfly Foundation**

MORGAN, Mrs Christine, Chief Executive Officer

**Department of Health and Ageing**

HUXTABLE, Ms Rosemary, Deputy Secretary

BARTLETT, Mr Richard, First Assistant Secretary, Medical Benefits Division

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

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

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

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

**Department of Human Services**

GOLIGHTLY, Ms Malisa, Deputy Secretary, Health and Older Australians

**Royal Australian and New Zealand College of Psychiatrists**

TOMASIC, Dr Maria, President

**Australian General Practice Network**

WELLS, Ms Leanne, Chief Executive Officer

PARHAM, Ms Jennie, Principal Network Adviser, Mental Health

**Psychologists Association (South Australian Branch)**

NIPPRESS, Mr Adrian, Industrial Officer

BLACK, Mr Quentin, Secretary

TUSTIN, Mr Don, Coordinator of Private Practitioners

**National Mental Health Consumer and Carer Forum**

BOOTH, Mr Keiran, Carer Co-Chair

LOVEGROVE, Mr David, Deputy Consumer Co-Chair

**Private Mental Health Consumer Carer Network (Australia)**

McMAHON, Ms Janne Christine, Independent Chair

**Federation of Ethnic Communities Councils of Australia**

MIGLIORINO, Mr Pino, Chair

**Private capacity**

McGORRY, Professor Patrick Dennistoun

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

**Australian Medical Association**

HAMBLETON, Dr Steve, Federal President

SULLIVAN, Mr Francis, Secretary General

**Mental Health Council of Australia**

QUINLAN, Mr Frank, Chief Executive Officer

**Association of Counselling Psychologists**

MULLINGS, Mr Benjamin Luke, Chair