

# **AN ASSESSMENT OF COMMONWEALTH MENTAL HEALTH PROGRAMS**

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## **I. INTRODUCTION**

### **The increasing burden of mental illness**

Mental illness is a major social and economic burden for individuals, the health care system and the nation.

One out of every five Australians will experience some form of mental illness each year, and three out of every ten people will be seriously affected. At least one third of young people have had an episode of mental illness by the age of 25 years. Depression and anxiety are the most prevalent mental disorders experienced by Australians and depression is predicted to be one of the world's largest health problems by 2020.

The majority of mental illnesses begin between the ages of 15 and 25 years, and the 2001 National Health Survey estimated that 1.8 million Australians (9.6% of the population) had a long-term mental or behavioural problem. There are strong links to drug and alcohol problems, incarceration, unemployment and homelessness.

This growing mental health burden poses a significant threat to our nation's future workforce capacity and economic prosperity and there are strong links to drug and alcohol problems, incarceration, unemployment and homelessness. It is estimated that the total annual cost of mental illness is approximately \$20 billion, which includes the cost of lost productivity and participation in the workforce and \$6.5 billion in government spending on health services.

However while the recent focus has been on the need for health reforms that focus on prevention and early intervention, facilitate better management of chronic illnesses in the community so that people do not end up inappropriately in acute care, and provide transitional care or step-down care for patients discharged from acute care, mental health seems to be increasingly off the agenda.

### **Expenditure and funding for mental health services**

According to the National Mental Health Report 2007, in 2005 the total spending on mental health services in Australia was \$3.9 billion or 6.8% of total recurrent expenditure. The Commonwealth Government contributed \$1.38 billion, the states and territories contributed \$2.38 billion and the private health insurance funds contributed \$163 million.

Of the total mental health expenditure, 29% was spent on state and territory hospital services, 23% on state and territory ambulatory services, 17 % on PBS/RPBS medicines and 11.3% on Medicare fees for GPs and psychiatrists.

Mental health has not increased its share of the health dollar since the introduction of the National Mental Health Strategy in 1993.

The majority of Commonwealth expenditure in mental health in 2005 was on the PBS/RPBS (\$626 million or 45.3%). Medicare spending for GP services was \$201 million, and for psychiatric service it was \$214 million. Other major spending was for mental health services to veterans (\$124 million) and the PHI rebate (\$59 million).

AIHW data show that:

- Expenditure on Medicare-subsidised psychiatrist services decreased at an average of 2.1% annually between 2000-01 and 2005-06;
- Expenditure on PBS/RPBS-subsidised mental health-related medications increased at an average of 7.5% per year between 2000-01 and 2005-06; and
- In 2005-06, 10.6% (or \$639 million) was spent on PBS/RPBS-subsidised mental health-related medicines.

The states and territories have all increased funding in mental health, but in the absence of national leadership, many needed critical areas outlined in the COAG National Action Plan on Mental Health 2006-2011, which was delivered to the COAG in July 2006, remain unaddressed and/or underfunded.

Research on mental disorders receives much less allocation of National Health and Medical Research Council (NHMRC) funding (8.9%) than should be the case given their contribution to national burden of disease (19.1%).

### **Inequity and inequality in the provision of services to the mentally ill**

There is a fundamental inequity in the way we fund and treat mental illness compared to physical health, despite the clear links between mental health and physical health. Approximately two-thirds of people with a mental illness do not receive any treatment in any 12 month period and expenditure on mental health care services does not meet the needs of the recurrent or chronically-disabling disorders that most people with a mental illness suffer. Rather the services cater to short-term and limited care.

People with mental illness are a marginalised and stigmatised group with extremely poor health outcomes and a mortality rate that is 2.5 times higher than the general population. .

Lifestyle and behavioural factors such as smoking and poor diet associated with mental illness impact on physical health, but there are very few public health programs aimed at this target population. The excess mortality rates for cancer, stroke and other circulatory disorders, respiratory disorders, communicable diseases, and injuries are not matched by a corresponding increase in hospitalisation and procedure rates.

Access to needed physical health services is hindered by affordability, stigma, lack of appropriate services and communication difficulties. Mental health services are often provided by separate groups of practitioners to physical health services which can mean that mental health professionals may miss physical illnesses as they focus on psychiatric symptoms and people under psychiatric care may not be seen concurrently by general practitioners.

The mentally ill deserve a higher level of care of their physical health than the general community, in proportion to their greater health needs, but they may actually be receiving less.

### **A raft of reports and strategies**

Since 1992, Australia has had a series national mental health strategies and plans which have been endorsed by the Australian Health Ministers' Conference (AHMC).

Mental illness was made a National Health Priority Area (NHPA) in 1997. Since then there has been one report on this NHPA which was issued in 1999 and focussed on depression.

In 1993, the Human Rights and Equal Opportunity Commission's (HREOC's) *National Inquiry into the Human Rights of People with Mental Illness* ('Burdekin Report') exposed the devastating personal consequences of grossly inadequate mental health and welfare services.

In 2003 the *Out of Hospital, Out of Mind!* Report from the Mental Health Council of Australia (MHCA) and the Brain and Mind Research Institute judged the results of reforms over the previous decade harshly, finding that the needs of the mentally ill continue to be ignored. The report stated that: 'After two five-year National Mental Health Plans this does not represent a failure of policy, but rather a failure of implementation. This includes poor government administration and accountability, lack of ongoing government commitment to genuine reform and failure to support the degree of community development required to achieve high quality mental health care outside institutions.'

Twelve years after the Burdekin report, the *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia* report conducted by the MHCA and HREOC, was released in October 2005. It highlighted how little progress had been made, and consequences of inadequate mental health and community care and concluded that 'after 12 years of mental health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected'

In March 2006, a Senate Select Committee on Mental Health released its report, *A national approach to mental health – from crisis to community*. This report found that more money, more effort and more care needed to be given to mental health. It argued for a significant investment in mental health in the short to medium term, with evidence suggesting that by 2012 the mental health budget should reach 9-12% of the total health budget.

### **The need for a national approach to mental health care**

In his forward to the *Not For Service* report, Keith Wilson, the MHCA Chair, called on senior members of government at state and federal levels to reflect on the 'forlorn truth' of the accounts voiced in the report, to accept their validity and in response to show real leadership, so that all Australians will have their rightful access to quality mental health care. In response, Prime Minister John Howard announced that mental health would be on the COAG agenda.

The communiqué from the 10 February 2006 meeting of the Council of Australian Governments (COAG) outlined recognition from Australia's governments that mental health is a major problem for the Australian community that would require more resources from all governments. COAG commissioned senior officials to prepare a mental health action plan for consideration by June 2006, and the National Action Plan on Mental Health 2006-2011 was delivered to COAG in July 2006.

However any possibility of a coordinated national approach to addressing the full range of mental health issues was derailed by the unilateral announcement from the Prime Minister, John Howard, on 5 April 2006 of a package of mental health programs costing at \$1.9 billion / 5 years.

This announcement represented a breakthrough in terms of national leadership and significant new funding for mental health services, but could also be seen as the Howard Government picking and choosing which areas of mental health it would invest in, and then challenging the states and territories to pick up the remainder.

The need to end the cost and blame shifting between governments, to better coordinate complex care needs, to tackle inequities in access to needed services, and to have evidence-based policies which are regularly evaluated is as critical for mental health as for the health care system as a whole. Reforms must be based on a holistic approach that does not exclude mental health.

### **Mental health workforce**

Five professions make up the bulk of the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work.

Data from AIHA and ABS show 3,152 employed psychiatrists in Australia in 2004, with 2,758 (88%) of these in the major cities. MBS claims by psychiatrists have been falling since the mid-1990s, although more providers are making claims.

ABS data give an estimate of 13,900 employed psychologists in 2005, 70% of whom are female. There are also quite disproportionate numbers of psychologists practising in metropolitan areas.

AIHW data show that in 2004 an estimated 14,123 nurses (5.7% of employed nurses) worked principally in mental health. Of these, 29% reported that they had completed a post-registration or post-enrolment course of more than 6 month's duration in mental health. Nurses working in mental health are less likely to be a registered nurse, slightly older than average, and much more likely to be male than nurses in the general workforce. Two-thirds of mental health nurses work in major cities.

Information about workforce shortages is hard to find and there is no publicly available information about national mental health workforce planning. One outer Sydney area health service reported that between November 2004 and April 2005 it had 59 vacancies (7.5% of the total mental health workforce), and that planning for service enhancements over the next 18 months indicated that a further 212 positions were required, an increase of 25% in the workforce. The management reported

“Recruitment to the existing vacancies is an ongoing challenge, filling the service enhancement positions seems insurmountable.”

Public mental health services compete for suitably qualified staff with both private mental health services and a wide range of other health and community services. Only a small percentage of medical, nursing and allied health graduates join the public mental health workforce.

### **The legacy of the Howard Government**

Under the Howard Government mental health was not seen as a central health issues and became the responsibility of the Parliamentary Secretary for Health.

The main focus of the Howard Government was in extending Medicare reimbursements and incentives for the delivery of mental health services through GPs and allied health professionals.

Over this period the focus shifted from training GPs to help them work effectively and collaboratively in multidisciplinary teams with other mental health professionals to provide services to their patients to a more ‘old-fashioned’ fee-for-service program which for the first time allowed psychologists, social workers and occupational therapists direct access to Medicare.

An examination of the implementation of the Commonwealth’s policies highlights that initial concerns that new Medicare mental health services were poorly targeted are valid, and that a number of other programs have been slow to be implemented.

The Howard Government’s unilateral response to the COAG February 2006 commitment to a partnership approach to mental health meant that the States and Territories were left to address a major problem – the shortfall in rehabilitation and accommodation for people with schizophrenia.

The Tolkein II report highlights the huge shortage of step-down, supervised accommodation for the 40,000 Australians with psychosis and how this places an intolerable burden on the mentally ill and the hospitals and staff that treat them. It means that these patients are too often left alone, a danger to themselves and others, to confront homelessness, lack of medication and the problems of alcohol and drugs.

There is a seven fold increase in time to readmission to acute care for those people with chronic psychosis who are in programs that provide proactive care that ensures adherence to medication in an alcohol and drug free environment.

Shifting the emphasis from dependence on acute care units to rehabilitation and good community care and accommodation means that hospital services are more available to those who need them and patients’ quality of life is improved.

While capital is required to provide additional rehabilitation places this should produce serious cost offsets in respect to current expenditure for people with schizophrenia.

## **The promises of the Rudd Government**

During the election campaign, in a speech to the Mental Health Foundation of Australia, Health Minister Nicola Roxon made a number of commitments about the central place of mental health within the health care system. These included: ensuring mental health is on the COAG agenda; an integrated approach to service delivery with States and Territories; a focus on prevention and early intervention; and the establishment of an Australian National Council on Mental Health to provide the government with independent advice from experts on mental health reform.

.There was a commitment of \$85 million / 5 years for the treatment of postnatal depression. This included \$20 million to Access to Allied Psychological Services (ATAPS )and \$5 million to beyondblue, with an expectation of an additional contribution of \$30m / 5 years from the States and Territories.

The Health Minister also committed to an evaluation and accountability of existing mental health services. Data about the utilisation of mental health Medicare items was released in April, at which time the Government announced it would use the data to determine which services are working and which need to be improved. The Government also announced a trial of telephone-based support through rural and remote services, more support for GPs engaging in suicide prevention activities and an increased focus on areas and populations in need.

In April the Minister also announced a \$15 million measure to fund 1200 workshops to train mental health professionals to work with other disciplines to treat the mentally ill.

The 2008-09 Budget cut a number of mental health programs, largely on the basis that uptake was less than expected. However no commitment was to assess the reasons for the slow and low uptakes and to address these. (See Section IV of this paper)

In June the Health Minister announced the membership of the National Advisory Council on Mental Health, to provide the Government with independent expert advice on national mental health reform.

At that time \$50 million was announced for a range of mental health initiatives, although not all of this was for new commitments. The funding includes:

- \$20.6 million in 2008-09 for the National Suicide Prevention Strategy;
- \$5.72 million in grants of up to \$40,000 to 209 community-based mental health organizations;
- \$1.8 million for a mobile tracker system to help people manage their mental health through mobile phones and the internet;
- \$1.55 million for Anxiety Online, an online program to help manage anxiety;
- \$4.8 million to support the KidsMatter suite of activities, to encourage mental health promotion, prevention and early intervention activities in primary schools and early childhood settings; and
- \$12.3 million for MindMatters, to promote mental health in secondary schools.

## **II. AN EVALUATION OF THE IMPACT OF CURRENT COMMONWEALTH MENTAL HEALTH INITIATIVES**

### **1. Access to mental health care and services through general practitioners**

Of the 40% of patients with a mental health problem who access treatment, the majority seek this from a general practitioner. About 11% of all general practice encounters involve the management of mental health problems. About a quarter of these patients are aged 65 years and older and 60% are women, Depression is the most frequently managed mental health-related problem, accounting for 34% of all mental health-related problems managed, followed by anxiety (16%) and sleep disturbance (15%).

BEACH data for the period 1998-99 to 2006-07 show the impact of a range of new initiatives through Medicare and practice incentive payments to help GPs better manage mental illness. In that timeframe there were no significant changes in the rate at which new cases were diagnosed, the management rate across all age groups and both sexes, medication rates and the average length of a consultation where depression was managed.

However there were significant changes in the rate at which clinical treatments such as counseling and advice and referrals to other mental health professionals were used by GPs.

- The rate of psychological counseling increased from 34/100 depression contacts in 1998-99 to 41/100 in 2000-01 and remained at this level through 2005-06, presumably sustained by the introduction in 2001 of the BoMH program.
- It then decreased significantly in 2006-07, coincident with the advent of the Better Access program.
- The rate at which GPs provided advice and education for depression was relatively constant between 1998-99 but then decreased by 50%. This may reflect that trend to have practice nurses provide this advice outside the confines of the GP-patient encounter.
- Referrals for depression to psychiatrists have almost halved over the time frame considered.
- Referrals to psychologists, which had increased slowly since 2001-02, presumably due to the introduction of the ATAPS component of BoMH, doubled between 2004-05 and 2006-07. This later increase is probably due to the Better Access initiative, and is all the more remarkable because it reflects only the first six months of operation of this program.

#### **Who misses out on GP provided mental health services**

Recent initiatives to extend the uptake of treatment for mental health problems have centred around GPs as the initial point of help-seeking.

However few young people see GPs as a preferred source of help, and anecdotal evidence is that people in rural areas, especially men, are reluctant to consult their Gp about mental health problems.

## 2. More Allied Health Services (MAHS)

The MAHS program aims to improve the health of people living in rural areas through allied health care and local linkages between allied health care and general practice. There are 66 MAHS-eligible Divisions of General Practice.

The program is currently funded at \$62.9m over the 4 years from 2004-05, with funding due to lapse at the end of June 2008. Under MAHS, up to 6 short term mental health interventions can be covered.

In 2005-06 about 40% of MAHS services were around mental health. The MAHS program funded 45.8 FTE psychologists, 6.2 FTE mental health nurses, 10.9 FTE social workers, 18.8 FTE counsellors, and 6.1 FTE Aboriginal mental health workers.

There is apparently no national evaluation of the MAHS program, its effectiveness in delivering mental health services, and the impact of the better Access program on this initiative.

## 3. Chronic Disease Management (CDM)

Patients with a chronic condition and complex care needs who are managed by their GP under team care arrangements are eligible for referral for up to 5 allied health services a year. Patients with a mental illness could for example, be referred to a mental health worker, an occupational therapist and/or a psychologist.

An examination of Medicare Australia data highlights the limited number of mental health services provided under the CDM program, and the impact of the introduction of the Better Access program in January 2007.

MBS item / AHS service	2005-06			2006-07		2007- 08 (ytd)	
	services	cost	OOP	services	cost	services	cost
10956 m.h.worker	2,730	\$0.13m	\$30.37	3,903	\$0.19m	1,842	\$0.09m
10958 occ ther	4,928	\$0.247m	\$19.84	9,137	\$0.45m	10,340	\$0.53m
10968 psychologist	45,541	\$2.26m	\$37.55	49,190	\$2.46m	6,254	\$0.33m
<b>Total AHS</b>	<b>530,195</b>	<b>\$24.40m</b>		<b>930,599</b>	<b>\$43.43m</b>	<b>915,503</b>	<b>\$43.50m</b>

Clearly GPs prefer to use the Better Access program for their patients.

#### 4. Better Outcomes in Mental Health (BoMH)

The initiative was begun in 2001 with funding of **\$120.4 million / 4 years**. In 2005-06 further funding of **\$102.2 million / 4 years** was provided. This funding will cease June 2009.

There were five key components to this initiative as first established, and these have been modified with the introduction of the Better Access initiative:

- Education and training for GPs to increase their mental health skills. *This is no longer required for access to GP mental health items and referrals through ATAPS.*
- A Service Incentive Payment (SIP) to encourage effective management of mental health problems by GPs through a 3 Step Mental Health Process that included an assessment, a mental health plan and a review. *This component of the program ceased on 30 April 2007.*
- Focussed Psychological Strategies - to encourage appropriately trained GPs to provide evidence based focused psychological strategies (FPS) through the provision of Medicare Benefits Schedule (MBS) rebates. *Rebates for FPS are still available to appropriately credentialled GPs under the Better Access program.*
- Access to Allied Psychological Services (ATAPS) - to enable GPs to access psychological and other allied health services to support their patients with mental health disorders. *These programs, coordinated by Divisions of General Practice, continue to operate in parallel with the new Medicare rebated psychological services available under the Better Access initiative.*
- Access to Psychiatrist Support - to enable psychiatrists and GPs to participate in case conferencing and for psychiatrists to provide emergency advice to support GPs. *These measures are unchanged.*

By the end of 2005 more than 4400 GPs had registered for BoMH, double the number estimated when the program was announced in 2001. This led to a greater than predicted demand for allied health services, a demand which divisions struggled to meet.

While there were always problems with BoMH in terms of paperwork and a \$10,000 annual cap on the services an individual GP could claim, this was essentially a successful program which allowed patients to have timely and affordable, although limited, access to mental health services.

The only part of the BoMH program which has been evaluated is the ATAPS component. The latest evaluation data demonstrates that the ATAPS projects collectively they have attracted over 6,000 GPs, over 2,000 allied health professionals (mainly psychologists), and over 63,000 consumers. The profile of consumers has remained consistent over time: they are typically female, are aged around 40, are on low incomes, have no previous history of mental health care, and have been diagnosed with depression or anxiety disorders.

The total number of sessions provided to these consumers is 306,419 (188,179 urban; 118,240 rural), with a current average of five sessions per consumer. The profile of these sessions has not changed over time in either urban or rural areas, with the majority being individually-based, an hour in length, and consisting of cognitive and behavioural therapies.

## **5. 2004 election commitments**

There were three major components to the Howard Government's 2004 election commitments in mental health:

### Expansion of Better Outcomes in Mental Health (\$30 m / 4 years)

In their 2004 election policy the Howard Government committed to continuing BoMH through to 2008 and providing a funding increase of \$30 million / 4 years to enable an expansion of this initiative to address the need for better integration of mental health, drug and alcohol and suicide prevention activities and support for rural and remote communities. Priority was to be given to expanding the Access to Allied Health Services component.

However by the time of the 2005-06 budget, decisions had been made to transfer a \$86 million of the BoMH funding to the Chronic Disease Management program, even though the DoHA acknowledged at Senate Estimates that it would not be possible to know that all the money transferred was used for mental health services.

It is not clear if the additional \$30 million election commitment was ever provided to the BoMH program, or even to the CDM program.

### Youth Mental Health (\$50 million / 4 years)

This funding was described as being to support early intervention in the primary care system, including enabling GPs to access advice and services for their young patients from mental health professionals under arrangements to be based on the BoMH initiative.

*Headspace*, the Youth Mental Health Foundation, was finally launched in July 2006, with funding of \$54 million / 3 years.

The *headspace* consortium was charged with:

- establishing up to 30 youth service platforms over two years;
- providing training and professional support to GPs, school counsellors and other health professionals working with young people;
- improving community awareness about youth mental health; and
- establishing a Centre of Excellence to collate, analyse and disseminate research.

Currently there are 14 established *headspace* sites, with 22 more proposed for 2008.

Tackling depression (\$30 million / 4 years)

This funding was for on-going support of the work that *beyondblue* does with depression. It continued, at an increased level, funding of \$17.5 m / 5 years previously provided for the establishment of *beyondblue*, funding which was due to expire in 2005.

### **III. ANALYSIS OF THE IMPLEMENTATION OF 2006 COAG COMMITMENTS IN MENTAL HEALTH**

While most of the spending in the mental health package was in Health, there were also initiatives in Education, Science and Training, Employment and Workplace Relations and Families, Community Services and Indigenous Affairs.

Total health spending on the mental health package was **\$1.357 billion /5 years**. Over the Budget forward estimates 2006-07 to 2009-10 the actual health spending was **\$1.05 billion**.

#### **Measures in Health Portfolio**

In March 2008 the Minister said she was considering changes to the Howard Government's \$1.8 billion mental health plan, including its funding and how to ensure that the money was spent more effectively.

Information released as a result of questions asked at February Senate Estimates show that the cost of the Better Access program, originally set at \$538 million / 4 years in 2006, is now predicted to rise to \$773.5 million / 4 years.

However spending in other mental health programs implemented at the same time is lagging, with only \$25.3 million spent from a total budget allocation of \$637.8 million.

#### 1. Better access to psychiatrists, psychologists and GPs through MBS

**Total cost: \$538 m / 5 years**

	<b>2006-07</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-2011</b>
Est Costs	\$50.7m	\$92.0m	\$108.6m	\$130.2m	\$156.1m

The stated aims of this initiative were to reform the MBS to:

- .Encourage more GPs to participate in early intervention, assessment and management of people with mental illness.
- Increase access to appropriately trained psychologists and allied health professionals on referral from a GP.
- Encourage private psychiatrists to see more new patients and refer patients on to psychologists and GPs
- Provide training to the primary care workforce to help improve recognition and treatment of mental illness.

At the time this program was introduced, concerns were expressed that it represented a move away from collaborative care back to fee-for-service in private practice, making it more likely that there would be increased out-of-pocket costs for patients. In addition there were no incentives to ensure that those most in need, and those living in rural areas, would be able to access services. Such forebodings have proven largely correct.

Data from Medicare Australia shows that in 2007, the cost of the Better Access program was **\$246.3 million**. In this 12-month period, 580,430 GP plans were written or reviewed, indicating that up to 580,430 people were eligible to receive further services from trained GPs, psychologists, occupational therapists and social workers. On this basis, patients received an average of 2.6 such services each, well below the entitlement of 12, in some cases 18, services a year.

Around 79% of services were provided in metropolitan areas, and primarily to women in the 35-40 age group. While GPs bulk billed over 90% of the mental health services provided, psychiatrists and psychologists bulk billed only 30% of services. Out-of-pocket costs for services not bulk billed were high, as much as \$23.54 for a GP consultation, \$65.10 for a psychiatric consultation, and \$33.41 for a psychology consultation.

The provision of increased financial incentives to psychiatrists did not increase the ability of patients to access psychiatric services. The number of MBS services provided by specialist psychiatrists has been declining since 1995-96. In 2007, psychiatrists provided 8% fewer out-patient consultations than in 2006.

Anecdotal evidence is that there has been an increasing exodus of psychologists from public employment into the private sector, making access to psychological services increasingly difficult for some segments of the population.

In July the DoHA advertised for submissions for the evaluation of the Better Access program. No timeframe was provided.

## 2. New funding for mental health nurses

**Total cost: \$191.6 m / 5yrs. Funding for this program was cut by \$188.0 m / 4 yrs.**

	2006-07	2007-08	2008-09	2009-10	2010-11
Initial Costs	\$1.8m	\$23.9m	\$37.7m	\$54.6m	\$72.7m

These funds are provided for mental health nurses in private psychiatry practice, general practice and Indigenous health services to provide services such as home visits, medication monitoring and management and improving links to other health professionals. Participating organisations are able to claim an establishment payment of up to \$10,000, and incentive payments based on the number of sessions that the mental health nurse is engaged for (minimum 2 individual patients per 3.5hr session per week and a maximum ten sessions per week) are paid at the rate of \$240 per session.

This program was implemented 1 July 2007. Uptake has been slow, due in large part to the shortage of mental health nurses and restrictions on eligible practices.

The May 2008 progress report from the DoHA states that a total of **\$1,133,940** in incentive payments has been made to 88 organisations currently participating in the program to date. It is not clear if this figure includes establishment payments.

A pilot program to include private hospitals in the program commenced early in 2008.

### 3 Improved services for people with drug and alcohol problems and mental illness

**Total cost: \$73.9 / 5 yrs**

	<b>2006-07</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>
Costs	\$3.6m	\$19.4m	\$23.7m	\$24.4m	\$2.8m

These funds were for NGOs to provide training for the alcohol and drug workforce to enable them to better assist clients who also have mental health problems. Funding will also be used to identify best practice models for intervention with patients with substance use and mental health co-morbidities.

It was not until September 2007 that the first 87 grants, at a cost of **\$29.9 million**, were announced. Funding was to commence 1 January, 2008.

The first grants (\$29.9 million to 87 NGOs) were not made until April 2008, and it appears from the May 2008 Progress Report from the DoHA that many applicants did not submit proposals that met the objectives of the program.

The report states that as part of the Cross Sectoral Support and Strategic Partnership (CSSSP) project, funding agreements have been put in place for 12 months from January 2008, to enable a peak NGO in alcohol and other drugs treatment services in each state and territory to assist services to build partnerships with other health sectors, identify workforce development and training opportunities, and undertake service improvement activities.

### 4. Expanding suicide prevention programs

**Total cost: \$62.4 m / 5 yrs. An additional \$20.9 million was announced for suicide prevention in 2008-09 in June.**

	<b>2006-07</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-211</b>
Est Costs	\$10.3m	\$10.9m	\$12.3m	\$13.7m	\$15.2m

These funds were to be provided under the National Suicide Prevention Strategy for national and community-based projects and for national research and development to increase the understanding of suicide and its prevention.

However it seems that this was not new funding for suicide prevention, but a continuation of funding to the National Suicide Prevention Strategy which has been funded at about \$10 million /year since 1999 (DoHA website).

To date **\$32.7 million** of these funds have been committed to 50 projects. This includes \$19.7 million to 18 national projects (with \$4.8 million to MindMatters and \$2.25 million to KidsMatter) through 2008-09; \$12.33 million to 17 large community-based projects through June 2009; and \$611,000 to 15 small community-based projects through June 2008.

It appears than these include 10 projects targeted at Indigenous communities (total funding \$6.3 million); 8 projects targeted at children and youth (total funding \$4.5

million); and 4 projects targeted at people in rural and remote areas (total funding \$4.96 million).

The March 2008 progress report from the DoHA does not list any funded initiatives but indicates that the current emphasis is on building the evidence base and development of measures around high-risk groups, consideration of options for more effective targeting of future suicide prevention activities, and ways of addressing the interface between suicide prevention and primary care.

This initiative is not mentioned in the May 2008 progress report.

5. Funding for telephone counselling, self-help and web-based support programs

**Total cost: \$56.9 m / 5 yrs**

	2006-07	2007-08	2008-09	2009-10	2010-11
Est Costs	\$7.0m	\$11.9m	\$12.3m	\$12.8m	\$12.9m

It was stated that these funds, which were in addition to the mental health services that will be part of the National Health Call Centre Network, would be provided to NGOs such as Kids help Line and Lifeline Australia to provide services targeted to individuals with common mental illnesses.

The estimate was that this funding would enable counselling services to help up to 260,000 individuals who do not currently receive treatment.

In October 2006, Lifeline received **\$18 million** in federal funds and in March 2007, the Kids Help Line received **\$5.035 million**. It's not clear if the funding provided to Lifeline includes the \$720,000 grant to Lifeline (Newcastle and Hunter), the \$710,000 grant to Lifeline Australia (ACT), the \$425,000 made to Lifeline Community Care (Qld), and the \$50,000 made to Lifeline (Canberra) made under the National Suicide Prevention Strategy.

During the election campaign, PM John Howard committed an additional **\$8.2 million** to Lifeline.

The March 2008 progress report from the DoHA states that **\$26.2 million / 5 years** has been provided to Lifeline. It does not list funding for the Kids Help Line. It states that proposals are currently being considered in relation to the self-help and web-based support programs component of this initiative.

The May 2008 progress report states that, as part of a joint initiative with the BoMH program, DoHA will conduct a trial of telephone based cognitive behaviour therapy interventions in rural and remote areas within the guidelines of the current ATAPS program. The trial is to run for 12 months in about 15 rural and remote DGPs.

6. Mental health services in rural and remote areas

**Total cost: \$51.7 m / 5 yrs**

	2006-07	2007-08	2008-09	2009-10	2010-11
Est Costs	\$5.3m	\$9.4m	\$10.7m	\$12.4m	\$13.9m

Funds are provided to increase access to treatment services provided by workers such as psychologists, social workers and mental health nurses in rural and remote areas. At the time the policy was released the mechanism for the provision of these services was not stated.

The 2007-08 Budget contained an additional **\$20.6 million / 4 years** to provide up to 114 allied health and/or mental health nursing professionals to drought-affected communities. There was also **\$10.1 million / 2 years** to provide Mental Health Support for Drought Affected Communities through funding to up to 39 DGPs in these areas. This makes of total of **\$82.4 million** for the provision of mental health services in rural and remote areas.

In July and August 2007, the Government announced that 15 organisations (including Divisions of General Practice, Aboriginal Medical Services and the Royal Flying Doctor Service) were funded to provide mental health services at a total cost of **\$21 million**. There is no current measure of how many services have been provided or the type of health care professionals who delivered these services.

In September 2007, the government announced funding of **\$7.4 million** to 39 DGPs in NSW, Queensland, South Australia and Victoria to employ community support workers to provide crisis counselling and outreach services for people psychologically affected by the drought.

The March 2008 progress report from the DoHA says that consultations have taken place with State and Territory Mental Health Directors seeking recommendations for stage 2 funding. It appears from the May 2008 progress report that no further progress has been made, and that stage 2 will include \$20.6 million in drought funding.

#### 7. Support for day-to-day living in the community

**Total cost: \$46.0 m / 5 yrs**

	2006-07	2007-08	2008-09	2009-10	2010-11
Est Costs	\$5.4m	\$9.6m	\$10.0m	\$10.3m	\$10.6m

Funding provided is for 7000 additional places in programs run by NGOs which provide structured social activity programs which can improve health outcomes and quality of life for people with severe and persistent illnesses.

The Day to Day Living program was launched on 17 July 2007. To date 60 grants have been made, with funding of **\$21 million** until June 2009. These grants are at 49 sites which were determined in consultation with the states and territories, taking into account demand for services, availability of clinical care and community support, and NGO capacity.

The March 2008 progress report from the DoHA states that an evaluation of the services funded through phase 1 will inform the roll-out of the program in 2009-2011. The May 2008 progress report notes only that the successful tenderer will be engaged in June 2008.

8. New early intervention services for parents, children and young people

**Total cost: \$28.1 m / 5 yrs**

	2006-07	2007-08	2008-09	2009-10	2010-11
Est Costs	\$1.9m	\$2.5m	\$5.7m	\$7.0m	\$11.0m

This funding is to provide resources, information and training for parents and schools to promote the availability of new mental health services for children and young people with complex mental health conditions, including those due to substance abuse. One part of this new initiative is the provision of information for Children of Parents with a Mental Illness.

The March 2008 progress report from the DoHA says that the Australian Infant, Child, Adolescent and Family mental Health Association has been funded to provide support and information to stakeholders regarding Children of Parents with a Mental Illness. This organisation has received federal funding for work in this area since 2001, so it's not clear whether new funding has been provided.

The progress report says that the Australian National University has been funded to establish a web-based Australian Child and Adolescent Trauma, Loss and Grief Network and an Early Childhood Working Group has been established.

The May 2008 progress report gives the only further progress in this area as discussion with the *Kidsmatter* partner organisations on an adaption of this program for the preschool sector.

9. Alerting the community to links between illicit drugs and mental illness

**Total cost: \$21.6m / 4 yrs. This program was discontinued as part of the savings taken in the 2008-09 Budget.**

	2006-07	2007-08	2008-09	2009-10	2010-11
Est Costs	\$3.0m	\$8.9m	\$9.0m	\$0.7m	-

Funding was for a national information campaign to alert the community to the links between illicit drug use and mental health, and encouraging those affected to seek help or treatment.

The March 2008 progress report from the DoHA states only that 'research and consultative work has been undertaken to inform strategic development'.

10. Improving the capacity of health workers in Indigenous communities

**Total cost \$20.8m / 5 yrs**

	2006-07	2007-08	2008-09	2009-10	2010-11
Est Costs	\$2.1m	\$5.8m	\$4.5m	\$4.4m	\$3.9m

Funding will provide:

- 5 new scholarships /yr under the Puggy Hunter Memorial Scholarship Scheme
- 10 additional mental health worker positions
- a range of training programs and resources to existing Indigenous health workforce

It is expected that training will be provided to 840 Aboriginal mental health workers, counsellors and clinical staff and 350 transport and administration staff in Aboriginal health services who manage clients who present for services.

The Puggy Hunter Scholarship Scheme provides financial assistance to Aboriginal and Torres Strait Islander people who undertake or intend to enrol in the study of Nursing, Medicine, Allied Health, Certificate III and IV or Diploma and Advanced Diploma Aboriginal Health Worker Course, Health Management, Postgraduate and Alternative Medicine Courses at an educational institution/University/Registered Training Organisation.

The Scheme offers students scholarships worth up to \$15,000 per annum for full-time study and up to \$7,500 per annum for part-time study for the usual term of the course.

The Scheme was rolled out in 2002 to provide 44 scholarships over 5 years. So in fact this Budget initiative is a continuation of a program due to lapse next year at a lower level than it has previously been provided.

The May 2008 progress report from the DoHA highlights that initiatives in this area are only just underway.

- ORYGEN Research group has delivered 10 Mental Health First Aid instructor training programs, with a total of 65 instructors trained to date and 120 instructors to be trained by December 2008.
- The Community Services and Health Industry Skills Council has been contracted to develop a training package which was due to be finalised by June 2008.
- 10 additional mental health workers positions have been finalised.
- A contract has been issued for the development of a n ATSI mental health textbook.
- Wodonga TAFE has been contracted to develop a mental health multi-media resource package to help health practitioners in the engagement and treatment of ATSI clients with mental health issues.

#### 11. Mental health in tertiary curricula

**Total cost: \$5.6m / 5 yrs**

	<b>2006-07</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>
Est Costs	\$1.3m	\$1.2m	\$1.1m	\$1.1m	\$1.0m

Funding is for the development of mental health training modules for registered nurses and provision of students with clinical training in multi-disciplinary teams that include allied health, medical and nursing students.

The March 2008 progress report from the DoHA states that applications from Australian university nursing schools for grants to develop and implement mental health curricula in pre-registration nursing degrees closed on 7 March 2008 and the selection process is currently being finalised.

The May 2008 progress report notes that the selection process has been finalised and funding arrangements are currently being negotiated with universities.

#### 12. Increased funding for the Mental Health Council of Australia

**Total cost: \$1.0m / 5yrs**

	<b>2006-07</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>
Costs	\$0.2m	\$0.2m	\$0.2m	\$0.2m	\$0.2m

Funding is provided to the secretariat of the MHCA to assist the Council in responding to an increased focus on mental health issues.

#### Joint portfolio measures

#### 13. Additional education places, scholarships and clinical training in mental health

**Total cost: \$103.5m / 5 yrs**

**Total health cost: \$35.0m / 5 yrs**

	<b>2006-07</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>
Costs (health)	\$3.2m	\$6.3m	\$8.3m	\$8.6m	\$8.6m
Costs (education)	\$6.5m	\$12.0m	\$15.2m	\$17.7m	\$17.7m

Funding is to provide:

- 420 new places for mental health nurses each year to a maximum of 1,148 by 2010 (there is presumably allowance for drop-out)
- 200 new places each year for clinical psychologists (but only in 2007 and 2008)
- 25 full-time and 50 part-time post-graduate scholarships each year for nurses and psychologists.

The May 2008 report from the DoHA states that:

- 210 clinical psychology places and 431 mental health nursing places have been included in the universities' 2007 funding agreements.
- 150 FTE post-graduate scholarships for clinical psychologists and mental health nurses have been offered.
- In 2008 50 new psychiatry training positions will be funded, including 15 in settings other than major public teaching hospitals.
- The RANZCP has been funded to accredit at least 15 new psychiatry training settings other than major public teaching hospitals.

### **Measures in other Portfolios**

#### **FAHCSIA:**

##### 1. New personal helpers and mentors

**\$284.4 m /5years**

To provide a total of 900 personal helpers and mentors (140 in 2006-07 and 260 in 2007-08).

Service providers to deliver the Personal Helpers and Mentors Program in 28 Demonstration Sites across Australia were announced on 5 April 2007. Service providers to deliver the Personal Helpers and Mentors Program in 48 Round 2 Sites across Australia were announced on 13 September 2007.

##### 2. More respite places to help families and carers

**\$224.7m / 5 years**

The Mental Health Respite Program (MHRP) provides a range of flexible respite options for carers of people with severe mental illness/psychiatric disability and carers of people with intellectual disability.

There are two components to the Program:

- Part A - a brokerage service model provided across Australia in all Home and Community Care (HACC) regions using the existing network of Commonwealth Respite and Carelink Centres (Centres). This component of the Program was implemented in April 2007 using a brokerage model enabling carers, the care recipient and their families to have the maximum choice and flexibility tailored to their specific respite needs.
- Part B - a direct funding model using the National Respite Development Fund (NRDF) to increase the availability (supply) of appropriate respite services through the MHRP where limited service supply needs to be addressed.

Service providers to deliver round one, stage one, of the Mental Health National Respite Development Fund, in a number of Home and Community Care (HACC) regions across Australia, were announced on 8 October 2007. Service providers to deliver round one, stage two, of the Mental Health National Respite Development

Fund, in a number of Home and Community Care (HACC) regions across Australia, were announced on 21 April 2008.

3. Community based programs to help families coping with mental illness

**\$42.5 m / 5 yrs**

The Mental Health Community Based Program aims to support families, carers, children and young people (16-24years) affected by mental illness through a diverse range of community programs. The program will seek to build on family strengths and improve resilience and family functioning, particularly for Indigenous families and those from culturally and linguistically diverse backgrounds.

Phase 1 of the Mental Health Community Based Program has funded family mental health support services and carers workshops. Phase 2 service providers to deliver the Mental Health Community Based Program targeted to 32 communities have been announced.

<u>DEST:</u>	Helping young people stay in education	\$59.5 m / 5 yrs
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<u>DEWR:</u>	Helping people with a mental illness enter and remain in employment	\$39.8 m / 5 yrs
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#### **IV. 2008-09 BUDGET INITIATIVES IN MENTAL HEALTH**

*There is very little spending on mental health in this Budget, reflecting the lack of focus on mental health during the election campaign.*

*The new spending is more than offset by the cuts in mental health programs. The rationale provided for these cuts is that the programs have historically been under-spent, and that if demand does increase in the future, then more funds will become available.*

*Most of the affected programs are part of the Howard Government's COAG mental health package funded in the 2006-07 Budget, so there is no long history to support the argument about the reduction in funds reflecting the historical spending pattern. Lack of leadership and strategic policy from the previous government meant that these programs never really got up and running.*

*There is no commitment from the Rudd Government to examine the value of these programs, to understand why uptake rates have been less than predicted, and to invest the budget savings in innovative approaches to the delivery of mental health services. All new programs are currently constrained by severe workforce shortages, and access to services is particularly limited for people who live outside metropolitan areas.*

##### **New spending on mental health initiatives**

The major commitment is **\$41.3 million / 4 years** for a National Plan for Perinatal Depression. However in the media releases accompanying the budget papers, this is described as an **\$85 million** initiative comprising \$55 million from the Commonwealth over the 5 years to 2012-13 and a contribution of \$30 million to be sought from the states and territories. Funding of **\$5 million / 5 years** is to be provided to *beyondblue* to support the implementation of the National Perinatal Depression Plan.

This allocation of funds is somewhat different that that outlined at Senate Estimates in February: *"The actual million commitment itself, Senator, involved a total of \$85 million, of which \$5 million was to go to beyondblue for overseeing the implementation of the plan; \$20 million was to go to the expansion of the Better Outcomes ATAPS program, access to allied psychological services; \$30 million was to go to states and territories to roll out aspects of implementation of the plan and a further \$30 million was to be sought from the states and territories through an invitation to them to invest in the plan as well."*

This measure is described as providing for the routine screening of mothers before and after pregnancy by midwives, child and maternal health workers and GPs. Training will be provided for health professionals to improve support and follow-up for 'at risk' women and to establish research and data collection processes. It is not clear where or if the promised **\$20 million** funding for increased ATAPS services has been delivered.

An additional **\$35 million / 4 years** is provided for post-graduate and masters degree scholarships for mental health nurses (see Workforce section).

**\$2.4 million / 3 years** will be provided from 2008-09 from within existing Departmental resources to establish a National Advisory Council on Mental Health.

The Council will provide independent expert advice to the Government and assist with the coordination of Commonwealth, state and territory mental health services. It is not clear why this measure is not funded over the full forward estimates.

### **Mental health workforce**

\$35.0 million / 4 years is provided to expand the current provision that provides post-graduate funding for mental health nurses and psychologists.

This original measure was in the Howard Government's COAG mental health package in 2006 with funding of **\$103.5 million / 5 years**. This was to provide training support for a total of 1,400 additional mental health nurses and 700 additional clinical psychologists by the end of 2011.

The current Budget states that the additional \$35.0 million will provide scholarships for 1070 mental health nurses (of which over 100 will be for nurses in rural and remote areas) and 222 scholarships for psychologists in rural and remote areas. When compared to 2006, this package seems to be underfunded.

### **Savings**

A number of mental health programs took budget cuts and the fate of some others is unclear. The previous Government ended the Practice Incentive Payment (PIP) available under Better Outcomes in Mental Health in May 2007, and this Government has claimed savings of **\$7.3 million / 4 years** from this.

A further **\$9.7 million** was saved by not delivering on the final two years of funding for the media and educational campaigns to alert the community to the links between illicit drugs and mental illness. The March 2008 report from DoHA on progress on the Commonwealth's component of the COAG National Action Plan on Mental Health indicates that to date only research and consultative work has been undertaken on this initiative, funded initially at \$21.6 million.

Savings totalling **\$503.7 million / 4 years** were made from a range of health programs on the basis that they had a lower than anticipated uptake. Mental health programs were severely hit, with cuts of **\$272.6 million / 4 years**.

It is particularly problematic to see significant cuts in mental health workforce and training programs with no apparent effort to address the reasons for low and slow uptake. The scholarship programs to train more mental health nurses and psychologists will not deliver more mental health workers for three to five years, and action to deliver more and better services cannot wait that long.

**\$188 million** of the \$503.7 million is due to a cutback of the Mental Health Nurses Incentive Program. This program was introduced in July 2007 with funding of \$191.6 million over five years to provide non-MBS incentive payment to general practices, private psychiatrist services and other appropriate community providers (including Divisions of General Practice) to engage or retain mental health nurses to assist in the provision of coordinated clinical care for people, in the community, with severe mental health disorders. However uptake has been slow because of a shortage of mental health nurses.

Training programs for GPs, psychiatrists and other mental health workers have also been cut, with total savings of **\$31.7 million**. This seems particularly opportunistic and **short-sighted**.

**\$15.5 million** of savings comes from reduced funding for mental health services in rural and remote areas, where the need for services is high. The COAG mental health package originally contained \$51.7 million / 5 years to increase access to treatment services provided psychologists, social workers and mental health nurses in rural and remote areas. At the time the policy was released the mechanism for the provision of these services was not stated.

It is not clear which of several recent provisions to fund rural and remote mental health services are being cut. The 2007-08 Budget contained an additional \$20.6 million / 4 years to provide up to 114 allied health and/or mental health nursing professionals to drought-affected communities. There was also \$10.1 million / 2 years to provide Mental Health Support for Drought Affected Communities through funding to up to 39 Divisions of General Practice (DGPs) in these areas. This makes of total of \$82.4 million for the provision of mental health services in rural and remote areas.

In July and August 2007, the Government announced that 15 organisations (including DGPs, Aboriginal Medical Services and the Royal Flying Doctor Service) were funded to provide mental health services at a total cost of \$21 million. There is no current measure of how many services have been provided or the type of health care professionals who delivered these services.

In September 2007, the Government announced funding of \$7.4 million to 39 DGPs in NSW, Queensland, South Australia and Victoria to employ community support workers to provide crisis counselling and outreach services for people psychologically affected by the drought.

**\$28.4 million** is saved from a program referred to as 'COAG risk modification'. It is not clear what this is, but it may be the initiative for improved services for people with drug and alcohol problems and mental illness, originally funded at **\$73.9 million / 5 years**.

It is important to note that these mental health programs are part of the Howard Government's COAG mental health package, and many of the delays in their implementation can be laid to that Government's lack of commitment to mental health. Historical under-spending patterns cannot emerge if programs are yet to be developed.

### Savings in mental health programs

<b>PROGRAMS</b>	<b>Savings over forward estimates</b>
Reduced funding for the Telephone Counselling, Self-Help and Web-based Support Program (COAG mental health package)	\$2.5m
Reduced funding for the Mental Health Nurse Incentive Program (COAG mental health package)	\$188.0m
Reduced funding for NGOs under the National Mental Health Program	\$6.0m
Reduced Funding for the Support for Day to Day Living in the Community Program (COAG mental health package)	\$0.5m
Reduced Funding for Mental Health Services in Rural and Remote Areas Program (COAG mental health package)	\$15.5m
Reduced Funding for - Better Access to Psychiatrists, Psychologists and GPs through the MBS (Better Access) initiative - Education and Training component (COAG mental health package)	\$29.7m
Reduced Funding for psychiatry training outside hospitals (COAG mental health package)	\$2.0m
COAG Risk Modification	\$28.4m
Abolition of PIP for Better Outcomes in Mental health	\$7.3m
Cancel media and educational campaigns to alert the community to the links between illicit drugs and mental illness	\$9.7m
<b>TOTAL</b>	<b>\$289.6m</b>