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 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