

MENTAL HEALTH AND RELATED PROVISIONS IN THE 2014-15 FEDERAL BUDGET

Dr Lesley Russell
Adj Associate Professor, Menzies centre for Health Policy
University of Sydney

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Note

This paper presents the author's analysis of the mental health and related provisions in the Australian Government's 2014-15 Budget in the context of current and past strategies, policies, programs and funding support.

This work has been done using only materials and data that are publicly available.

Similar analyses from previous budgets are available on the University of Sydney e-scholarship website.¹

The opinions expressed are solely those of the author who takes responsibility for them and for any inadvertent errors. This work does not represent the official views of the Menzies Centre for Health Policy.

¹ <http://ses.library.usyd.edu.au/browse?type=author&value=Russell%2C+Lesley>

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Introduction

Despite the Abbott Government's rhetoric of burden-sharing associated with the 2014-15 Budget, it is increasingly apparent that the most disadvantaged in the community will bear most of the burden. For people with a mental illness - who are already among the most disadvantaged in Australian society, and who currently confront many barriers to access the services they need - this budget raises those barriers and imposes additional cost burdens on them and those caring for them. There is a raft of provisions in this budget that will make healthcare services harder to access and will undermine the ability of people with mental illness to lead 'contributing lives' (as outlined by the National Mental Health Commission²) in their communities.

People with mental illness and mental health problems will clearly be affected by the new \$7 co-payment to see their general practitioner, though only up to the \$70 cap if they hold a pension or concession card. Co-payments will not apply if GP visits are billed under "chronic disease management" or "mental health management" items.³ It will be interesting to see if rates of these types of consultations now spike. The impact could be more than \$7 for those patients seeing doctors who do not bulk bill as Medicare rebates to GPs will be reduced by \$5. Many people will have to rely on the altruism of their doctor or go without needed care.

The financial costs of mental illness are further increased by the new \$6 co-payment for prescription medicines. This is a new disincentive for people with mental illness to go and see the doctor and to comply with their medication regimes. Adherence to anti-depressant and anti-psychotic medication is already poor and requires regular monitoring by GPs or specialists.

Those who work in the health sector see this as some kind of perverse cost-shifting: as federally funded primary healthcare services are withdrawn, emergency services and state-funded hospital services are left as the only option. That not only represents poor quality care but a poor use of scarce healthcare resources. It seems the only aim is to reduce the overall spending obligations of the federal government, regardless of the personal, social and economic consequences elsewhere.

This budget contains just **\$56.3 million / 4 years** in new spending on mental health programs, **\$32.9 million** of which is to meet election commitments. This is offset by **\$53.8 million / 2 years** in cuts. In addition it is concerning that **\$230.6 million** previously included in the National Partnership Agreements on Mental Health for Early Psychosis Youth Centres is no longer in the NPs as listed in Budget Paper No 3. We must take it on faith that this funding continues as outlined in previous budgets.

Mental health policy is currently on hold pending the current on-going review of mental health programs. Health Minister Peter Dutton announced in February that the National Mental Health Commission would review "all existing programmes across the government, non-government and private sectors". The aim of the review is to "identify gaps in service delivery, inefficiency, duplication and excessive red tape."⁴ The report is due to be delivered to the Government by the end of November. While a thoughtful, evidence-based review of mental health services is not something

² <http://www.mentalhealthcommission.gov.au/our-2013-report-card.aspx>

³ <https://ama.com.au/gpnn/7-co-payment-proposal-how-it-will-work>

⁴ <http://www.mentalhealthcommission.gov.au/media-centre/news/review-of-existing-mental-health-services-and-programmes-terms-of-reference.aspx>

that should be feared, in this case there are concerns that it simply represents a delay in difficult decision making. Given the host of recent reports and recommendations, especially those from the National Mental Health Commission itself, it is hard to argue that we don't already know what needs to be done, where funding and reform should be a priority, and what isn't working.

Given the pointed focus in the Review's Terms of Reference on efficiency, the paucity of the Coalition's election policies on mental health⁵ and this Government's ideological opposition to the universality of Medicare and "free" healthcare series, we should all be very nervous about what is to come. While all the evidence points to a huge need for more spending in mental health care, the opposite looms as much more likely.

National data on mental health spending that is current and accurate is impossible to come by. By the government's own reckoning,⁶ mental disorders account for 13.1% of Australia's total burden of disease and injury and are estimated to cost the Australian economy up to \$20 billion annually, including lost productivity and labour participation. The AIHW determined that national recurrent expenditure on all mental health-related services in 2011–12 (the most recent data available) was around **\$7.2 billion**.⁷

However the costs are likely much higher. A review of mental health expenditure and system design conducted in 2013 by Nous Group and Medibank Private⁸ estimated direct health expenditure of at least **\$13.8 billion**, and non-direct expenditure of at least \$14.8 billion. The total expenditure of \$28.6 billion is equivalent to 2.2% of Australia's Gross Domestic Product (GDP). This calculation excludes indirect costs, such as lost productivity. The Sax Institute's Evidence Check Review, conducted for the Mental Health Commission of NSW, shows that the conservative cost of mental illness to the community is more than **\$10 billion** a year.⁹

On this basis somewhere between 5-10% of total health spending goes to mental health, a percentage that does not reflect the disease burden or the high economic cost. Moreover, mental health's share of the total health budget has declined over recent years as total health spending has increased.

The consequence is a huge level of unmet need. Less than half of Australians with a mental health disorder receive appropriate support and treatment. For this reason the National Mental Health Commission has called for a doubling in the proportion of the Australian population who receive "timely and appropriate mental health services and support."

Even a relatively modest increase in the proportion of people seeking help for mental health problems, combined with projected Australian population growth, will produce a cumulative increase in the use of mental health services and existing services will not be able to meet this demand. It has been estimated that, under business as usual, the current mental health system will require at least

⁵ <http://www.nationals.org.au/Portals/0/2013/policy/Mental%20Health%20-%20policy%20document.pdf>

⁶ [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2013-2014_Health_PBS_sup2/\\$File/2013-14_DoHA_PBS_2.11_Outcome_11.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2013-2014_Health_PBS_sup2/$File/2013-14_DoHA_PBS_2.11_Outcome_11.pdf)

⁷ <https://mhsa.aihw.gov.au/resources/expenditure/>

⁸ http://www.medibank.com.au/Client/Documents/Pdfs/The_Case_for_Mental_Health_Reform_in_Australia.pdf

⁹ <http://nswmentalhealthcommission.com.au/news/media-centre/media-releases/mental-health-spending-takes-place-in-an-%E2%80%98information-vacuum%E2%80%99>

8,800 additional mental health professionals over the next fifteen years in order to be able to deliver on this objective.¹⁰

We must hope that the mental health review will consider these issues. It will be hampered by the fact that, as revealed by the Sax Institute review, there little Australian research available on where taxpayer dollars would be most effectively spent.¹¹ Most research on what might work to reduce the burden of mental illness has focused on medication and therapy rather than prevention and early intervention programs. Despite two decades of investment in improving mental health services, the mental health of Australians has not improved, and this is likely because adequate resources and emphasis have not been devoted to prevention.

¹⁰ http://inspire.org.au/wp-content/uploads/2014/03/Crossroads_ReachOut_10Mar2014.pdf

¹¹ <http://nswmentalhealthcommission.com.au/news/media-centre/media-releases/mental-health-spending-takes-place-in-an-%E2%80%98information-vacuum%E2%80%99>

Budget Provisions

In an April media release Health Minister Peter Dutton announced **\$170 million** for the continuation of 150 mental health programs in 2014-15.¹² The Department of Health was unable to provide information at Senate Estimates in what these 150 programs were, but it is assumed that this includes grants to individual organisations under programs like Partners in Recovery. This funding does not include that for services provided under Medicare; it's not clear if the figure announced in April reflects the cuts and additional spending announced in the Budget.

Headspace Program – additional funding

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
DoH (this budget)	-	4.5	1.4	1.9	7.2
Previously allocated	59.2	61.9	65.0		

\$14.9 million / 4 years is provided to establish 10 new *headspace* sites and to conduct a 2-year evaluation of the *headspace* program. This measure delivers on an election commitment.

The Howard government kicked off Commonwealth funding for *headspace* with **\$54 million / years** for 30 sites, announced in July 2006. Additional funding of **\$35.6 million / 3 years** for these sites was announced in December 2008. The 2010-11 Budget provided **\$78.8 million / 4 years** for 30 new *headspace* sites, additional funding for the existing sites, and expanded telephone and web-based mental health services to young people. The 2011-12 budget added **\$197.3 million / 5 years** to establish 30 new *headspace* sites, and provide additional funding to existing sites and the *headspace* national office.

On past history, this now appears to be an underfunded program. The first 30 *headspace* sites were funded at **\$1.8 million each**, and all the sites need ongoing operational funding. It appears that there is no further funding for *headspace* provided beyond 2015-16 – and future funding is contingent on the evaluation.

In the past the roll-out of these sites has been slow. Earlier this year Professor Ian Hickie called for an "urgent, systematic national evaluation" of the organisation he helped build, claiming only half its centres are functional.¹³ *Headspace* CEO, Chris Tanti has conceded that one in five centres are experiencing performance management issues related to workforce shortages, difficulties with external agencies, or low client numbers.

¹²

[http://www.health.gov.au/internet/ministers/publishing.nsf/Content/5A47FE45B86AB6DCCA257CB00019392E/\\$File/PD029.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/5A47FE45B86AB6DCCA257CB00019392E/$File/PD029.pdf)

¹³ <http://www.smh.com.au/national/bitter-rift-on-youth-mental-health-provider-headspace-20140412-36k60.html#ixzz346QdxmX1>

Mental Health Nurse Incentive Program - continuation

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
DoH	-	22.4	-	-	-
DHS	-	1.0	-	-	-
Total	-	23.4	-	-	-

\$23.4 million is provided in 204-15 to maintain existing service levels for the Mental Health Nurse Incentive Program.

The 2013-14 Budget previously provided **\$23.8 million** for 2013-14 to maintain existing service levels for this program. Since its inception this program has been endlessly tinkered with and presumably now its future will be decided by the review of mental health services.

The Mental Health Nurse Incentive Program was first introduced in 2007 with funding of **\$191.6 million / 5 years**. This funding was cut by **\$188.0 million / 4 years** in the 2008-09 Budget due to low uptake of the program. The 2010-11 Budget saw **\$13.0 million / 2 years** provided for an additional 136 mental health nurses. In the 2012-13 Budget additional funding of **\$17.6 million / 2 years** was provided for 2011-12 and 2012-13, but the program was capped at existing service levels.

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 3.5 hr session per week and a maximum ten sessions per week) are paid at the rate of \$240 per session.

This program has now been capped at exiting service levels for 3 years, with no knowledge or recognition of what this means for service provision.

National Centre of Excellence in Youth Mental Health – establishment

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
DoH	-	4.2	4.3	4.6	5.0

\$18.0 million / 4 years is provided to the Orygen Youth Health Research Centre to establish and operate a National Centre for Excellence in Youth Mental Health.

This measure delivers on the Government's election commitment.

Partners in Recovery – reduced funding

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
DoH	-25.3	-28.5	-	-	-
Funding remaining (ref 2011-12 Budget)	43.8	89.2			

Savings of **\$53.8 million** are taken by deferring the establishment of the remaining 13 Partners in Recovery organisations for two years.

The Budget Papers state that the existing 48 organisations will continue to operate. The deferral is to enable to effectiveness of existing sites and their interaction with the NDIS to be assessed. It is not clear what will then happen to funds provided for 2015-16 – or whether these have already been taken, un-noticed, as savings.

The savings from this measure go to the Medical Research Future Fund.

This program helps people with severe and persistent mental illness and complex support needs. People in this group are over-represented among the ranks of the unemployed, the long-term unemployed and as recipients of the disability support pension.

Previous funding for Partners in Recovery (from 2011-12 Budget)

	2010-11 \$m	2011-12 \$m	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m
DoH	-	-\$25.4m	\$35.5m	\$69.1m	\$117.7m	\$146.9m

Mental health-specific payments to States and Territories

Up until 2008–09, specific payments were made by the Commonwealth to the States and Territories for mental health under the Medicare Agreements 1993–98, and the Australian Health Care Agreements 1998–2003 and 2008–09. From July 2009 the Australian Government provides Specific Purpose Payments (SPP) to State and Territory governments under the National Healthcare Agreement (NHA) that do not specify the amount to be spent on mental health or any other health area. As a consequence, specific mental health funding for acute care services cannot be identified under the NHA.

Specific funds for mental health services are provided under the National Partnership Agreements on Mental Health, first implemented in 2011-12, and through the National Partnership on the National Perinatal Depression Initiative. In addition, over the period 2010–11 to 2013–14, \$175 million was provided under Schedule E of the National Partnership Agreement - Improving Public Hospital Services for the development of sub-acute beds, including mental health sub-acute beds. However it is not possible to determine how much of these funds actual went to mental health.¹⁴

National Partnership Agreements on Mental Health

In the 2011-12 Budget the Gillard Government put **\$2.2 billion (\$1.5 billion** in new money) on the table over the next five years (\$918 million over the forward estimates) in a major mental health package. About a quarter of the package (**\$580.4 million**) was funded by savings from the Better Access Program.¹⁵ The National Partnership Agreement set up at that time provided **\$201.3 million / 5 years** to the States and Territories (\$45.1 million in 2014-15 and \$46.0 million in 2015-16). These funds, augmented by the State and Territories, are for projects focussed on improving outcomes for people with severe and persistent mental illness through better access to supported housing, support to limit Emergency Department presentations and the need for inpatient admission, and services to enhance recovery. However determining State and Territory contributions to this NP has proved to be impossible.

¹⁴ <https://www.mja.com.au/journal/2012/196/3/well-meant-or-well-spent-accountability-8-billion-mental-health-reform>

¹⁵ My analysis of the mental health provisions in the 2011-12 budget is available at <http://sydney.edu.au/medicine/public-health/menzies-health-policy/publications/11-12budgetmentalhealth230511.pdf>

National Partnership Agreement on Mental Health (2011-12 Budget)

	2011-12 \$m	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m
DoHA	0.5	-	-	0.1	
FHCSIA	0.5	-	-	0.1	
Treasury	21.4	43.5	44.3	45.0	
Total	22.3	43.6	44.4	45.1	46.0

From 2011-12 Budget Papers

In the 2013-14 Budget this National Partnership Agreement was expanded to include the establishment of up to 16 new early psychosis services across Australia. The new services will be based on the model established by the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne. EPPIC provides an integrated and comprehensive mental health service aimed at addressing the needs of people aged 15-24 with a first episode of psychosis.

The 2013-14 Budget provided additional funding for the Early Psychosis Centres (initially **\$222 million / 5 years**) of **\$80.2 million** in 2016-17 which was presumably to cover operational expenses. It was reported at that time that very little of this funding, first committed in the 2011-12 Budget, had been spent.

National Partnership on Mental Health (2013-14 Budget)

	2012-13 \$m	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m
Early Psychosis Youth Centres	28.2	50.2	70.2	80.2	80.2
Supporting National Mental Health Reform	43.3	50.6	51.6	45.3	-
Total	71.5	100.8	121.8	125.5	80.2

From 2013-14 Budget Paper No 3

In this year's Budget Papers funding for National Mental Health Reform is kept at 2013-14 levels, but the funding for Early Psychosis Youth Centres is not included. No explanation is provided; it is assumed that this funding (a total of **\$230.6 million / 3 years**) remains in the forward estimates.

National Partnership on supporting National Mental Health Reform (2014-15 Budget)

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
NP National Mental Health Reform	50.6	51.6	45.3	-	-

From 2014-15 Budget Paper No 3

National Partnership on the National Perinatal Depression Initiative

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
NP National Perinatal Depression Initiative	10.6	8.2	8.2	8.2	-

This funding (**\$37.4 million / 4 years**) was provided in the 2013-14 Budget. Of this, **\$35.4 million** will go to the States and Territories to enable mothers to be screened for depression, provide training to health professionals, improve care and support for women at risk, and continue research and data collection. **\$2 million** is provided to *beyondblue* to support the implementation of this initiative. Contributions of **\$35 million** will be sought from the State and Territory Governments for this work.

At Senate Estimates the breakdown for funding in 2013-14 was given as **\$8.2 million** to the States and Territories, **\$500,000** to *beyondblue* and **\$5 million** to ATAPS. It's not clear how this reflects the budget figures, and raises the issue of whether funding from 2014-115 on includes *beyondblue* and ATAPS. Perhaps this was included in the \$170 million announced in April.

Other Budget Provisions that Impact on People with Mental Illness

The hit to those with mental illness comes not just in the health portfolio, but in a number of other key areas.

Disability Support Pension

The budget describes new arrangements in relation to younger people receiving the disability support pension (DSP). People under 35 years of age will be reviewed (with a few exceptions) and placed on a "program of support" or risk losing their DSP benefit.

Reassessment alone is not the answer to the growth in the DSP. Two decades of evidence from around the world have shown that to get people with a mental illness back into sustained employment, post-placement support is the model of service. Unfortunately, Australian governments have never embraced this evidence and hence we have both a low rate of employment and a high rate of social security among people with a mental illness.

Changes made over recent years have favoured generalist employment support agencies over psychiatric specialist employment support services. There has been a genuine loss of skills and understanding. This has been driven by inappropriate government payment models, creating incentives for employment support agencies to deal with some cases over others. This, combined with minimal effort to raise awareness among employers, means finding employment for people with a mental illness is extremely challenging. Issues are compounded if the person has an undiagnosed mental illness. The budget fails to address these matters.

Homeless

There are currently an estimated 105,000 Australians who are homeless on any given night, and perhaps as many as 75 per cent of these people have a mental illness. Prime Minister Tony Abbott agreed prior to the budget to continue a national partnership agreement with the states but only for one year.

State Mental Health Budgets

The most recent complete set of figures for all the States and Territories that could be found are AIHW data from 2011-12.¹⁶ On this website spending is further broken down by category for the States and Territories.

Mental health spending by State and Territory

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Mental health spend \$m	1,392	1,013	891	581	342	107	79	48	4,456
Per capita \$	191.8	181.6	197.2	243.3	208.0	210.0	213.5	209.1	197.9

It is notoriously difficult to extract mental health spending information from state and territory budgets. At the time of writing a number of the states have not yet handed down their 2014-15 budgets. Most of the State and Territory mental health spending is in acute care and this is rarely broken out in hospital budgets.

New South Wales

The NSW Government has committed **\$1.45 billion** to mental health services in 2014-14.¹⁷ That equates to \$198 per head of population.

Victoria

The Victorian Government currently invests more than **\$1.2 billion** in mental health services each year; equating to \$214 per head of population.

Queensland

The 2014-15 Budget includes **\$1.152 billion** for integrated mental health services.¹⁸ This equates to \$246 per head of population.

¹⁶ <https://mhsa.aihw.gov.au/resources/expenditure/specialised-mh-services/>

¹⁷ http://www.health.nsw.gov.au/news/Documents/20130618_03.pdf

¹⁸ <http://www.budget.qld.gov.au/budget-papers/2014-15/bp5-qh-2014-15.pdf>

Northern Territory

In the 2014-15 Budget \$11.6 million is provided for mental health – community treatment and extended care.¹⁹ Presumably this does not include hospital / acute care. This is about \$48 per person. It represents an increase on 2013-14 when \$10.4 million was allocated but only \$9.1 million was spent.

Budget information for Western Australia, South Australia, Tasmania and the Australian Capital Territory for 2013-14 or 2014-15 was not able to be determined.

¹⁹ <http://www.treasury.nt.gov.au/PMS/Publications/BudgetFinance/BudgetPapers/I-BP03-1415.pdf>

Background information

Around 7.3 million or 45% of Australians aged 16–85 will experience a common mental health-related condition such as depression, anxiety or a substance use disorder in their lifetime according to the 2007 National Survey of Mental Health and Wellbeing. Estimates from the second National Survey of Psychosis conducted in March 2010 suggest almost 64,000 people have a psychotic illness and are in contact with public specialised mental health services each year.

Finding comprehensive, up-to-date mental health services data is difficult and the most recent AIHW data is from 2011–12.²⁰

General Practice

- An estimated 12.1% of GP encounters were mental health-related in 2011–12. This translates to nearly 15.0 million mental health-related GP encounters.
- Depression was the most commonly managed problem by a GP in a mental health-related encounter (over one-third of encounters were for this problem).
- The most common management of mental health-related problems was for the GP to prescribe, supply or recommend medication.
- Nearly 2.2 million Medicare-subsidised mental health-related services (primarily GP management plans under Better Access) were provided by GPs in 2011–12. Females and those aged 35–44 were the highest consumers of these services. Medicare-subsidised mental health-related GP services.
- Over 7.9 million Medicare-subsidised mental health-related services were provided by psychiatrists, GPs, psychologists and other allied health professionals to over 1.6 million patients in 2011–12.

Emergency Departments

- There were an estimated 243,444 ED occasions of service with a mental health-related principal diagnosis in 2010–11.

Community Health Services

- Over 5.5 million community mental health care service contacts were reported for approximately 300,000 patients in 2011–12 (but this is an under-report as it does not include data from Victoria).
- The most frequently recorded type of community mental health care service contact was with an individual patient (as opposed to in a group session) with a duration of 16–30 minutes. The most common principal diagnosis reported for patients receiving these services was schizophrenia, followed by depressive episode and bipolar affective disorders.

²⁰ <http://mhsa.aihw.gov.au/services/general-practice/>

Specialist Homelessness Services

- More than 2 in 5 SHS clients (44.7%) with a current mental health issue reported an episode of homelessness in the 12 months before presenting compared with around 1 in 4 of those clients (26.6%) without a current mental health issue.

Mental Health Expenditure

- Over \$7.2 billion, or \$322 per person, was spent on mental health-related services in Australia during 2011-12, an increase from \$282 per person in 2007-08.
- Of this \$7.2 billion, \$4.5 billion was spent by state and territory mental health services, an average annual increase of 4.3% between 2007-08 and 2011-12. Of this, the most was spent on public hospital services for admitted patients (\$1.9 billion), followed by community mental health care services (\$1.8 billion).
- Private health insurance accounted for \$299 million. However expenditure on specialised mental health services in private hospitals was \$333 million during 2011-12. Presumably most of the difference came from patient's pockets.
- The Australian Government paid \$851 million in benefits for Medicare-subsidised mental health related services in 2011-12, equating to 4.8% of all Medicare subsidies. Expenditure on psychologist services (clinical and other) (\$351 million) made up the largest component of mental health related Medicare subsidies in 2011-12.
- The Australian Government spent \$854 million, or \$38 per person, on subsidised prescriptions under the PBS/RPBS during 2011-12, equating to 8.8% of all PBS/RPBS subsidies. Over 70% of this expenditure was for prescriptions issued by general practitioners (GPs).

Recent Reports

Council of Australian Governments National Action Plan for Mental Health 2006-2011 Final Progress Report covering implementation to 2010-11. June 2013²¹

This report is dated June 2013 but was not released until September 2013. The real impacts of the National Action Plan are not well highlighted in the report, which suffers from a lack of timely data.

Key points are summarised here:

- Total spending on COAG-related initiatives in the five years of the Plan (\$6,884 million) substantially exceeded the original five-year commitment of \$4.1 billion.
 - 8% went to promotion, prevention and early intervention.
 - 74% went to initiatives to integrate and improve the care system.
 - 14% went to 'participation in the community' initiatives, including employment and accommodation
 - 4% went to workforce.
 - The main contribution to care coordination was \$549.8 million / 5 years for the Partners in Recovery Program – all of which came from the Commonwealth Government.
- Average annual suicide rates for the Northern Territory (19.3 per 100,000) are a major concern, nearly double the national rate of 10.6 per 100,000. Tasmania, Western Australia Queensland and South Australia all had rates above the national average. This is attributed to higher proportions of rural areas and Indigenous peoples.
- Assuming minimal overlap between state/territory and Medicare-funded person counts, the data suggest that approximately 1.9 million people, or 8.5% of the population, received clinical mental health care in 2010-11, compared with 970,000 in the first year of the Action Plan. Growth in the proportion of the population people seen by Medicare-funded mental health services is the sole driver of the change over the three years.
- Hospital sector mental health data from both public and private sectors are not simple to interpret but suggest that consumers have a range of clinical outcomes. They also raise questions about what 'best practice' outcomes should be.
- Australia's investment in routine outcome measurement represents 'work in progress' that is both imperfect and incomplete. The main outcome measurement tools being used describe the condition of the consumer from the clinician's perspective and do not address the 'lived experience' from the consumer's viewpoint. There is also concern that the approach used to report outcomes separates a consumer's care into segments (hospital vs community) rather than tracking the person's overall outcomes across treatment settings.
- The transition from hospital to home is often not well managed. In 2010-11 one-week follow-up rates for patients discharged from public hospitals ranged from 19% to 79%. The current national rate of 54% is well below what would be expected from best practice services. Hospital 28-day readmission rates ranged from 5% to 16% in 2010-11.
- Based on the June 2011 data, for every 1,000 adults of working age, 17 are on a disability pension due to mental illness. An implication of these overall findings is that approximately 800,000 working age Australians who have a mental disorder are not in the workforce, and account for about one third of the working age population not in employment or looking for work.
- One in five young people aged 16 to 30 who have a mental disorder are neither in employment nor formal education, compared with one in ten for those who do not have a mental illness.

²¹ <http://www.coag.gov.au/node/512>

- In 2010, one in three (31%) prison entrants reported having ever been told by a health professional that they had a mental disorder (including drug and alcohol abuse); 16% reported that they were currently taking mental health related medication; 21% reported a history of self-harm. On entry to prison, almost one-fifth (19%) of prison entrants were referred to the prison mental health services for observation and further assessment following the reception assessment.
- 34% Of people receiving homeless services in 2010-11 identified as having mental health issues. Of these, about half (56%) had a known diagnosis of a mental illness and about a third (31%) were identified as current users of specialised mental health services.

Productivity Commission Report on Government Services 2014.²²

Chapter 12 of this report deals with Mental Health Management. This looks to the better management and coordination of mental health services and as such reflects on the current recognition of what constitutes best practice in this area. Unfortunately this report is based on data from 2010-11 and earlier so it adds little to the knowledge base, serving only to confirm findings in earlier reports. There is however detailed reporting against the national key indicators, with discussion about the validity of the results.

Priorities for future reporting on mental health management include the following:

- improving the reporting of effectiveness and efficiency indicators for Indigenous Australians, rural/remote and other selected community groups
- developing an estimate of the number of people who need mental health services so that access to services can be measured in terms of need
- improving reporting on government funded non-government entities to include information on their activity and the outcomes of the consumers of these services identifying indicators that relate to the performance framework dimension of sustainability
- improving reporting on outcomes to include indicators that relate to the participation of people with a mental illness in meaningful social and recreational activities
- further developing the measurement and reporting on the clinical mental health outcomes of consumers of specialised public mental health services.

A Contributing Life the 2013 National Report Card on Mental Health and Suicide Prevention. National Mental Health Commission²³

In what can surely be construed as a statement that there was little change since their 2012 report, the NMHC restated the ten recommendations made in that report, finding that since it was released 3.2 million Australians have experienced a mental health problem and at least another 2,200 people have died by suicide. A further eight were added, together with the commitment to “re-visit all recommendations every year until we have evidence of change that can be seen in the lives of people living with mental health problems and their supporters.”

²² <http://www.pc.gov.au/gsp/rogs>

²³ <http://www.mentalhealthcommission.gov.au/>

The 10 original recommendations are:

- Nothing about us, without us – there must be a regular independent survey of people's experiences of and access to all mental health services to drive real improvement.
- Increase access to timely and appropriate mental health services and support from 6-8 per cent to 12 per cent of the Australian population.
- Reduce the use of involuntary practices and work to eliminate seclusion and restraint.
- All governments must set targets and work together to reduce early death and improve the physical health of people with mental illness.
- Include the mental health of Aboriginal and Torres Strait Islander peoples in 'Closing the Gap' targets to reduce early deaths and improve wellbeing.
- There must be the same national commitment to safety and quality of care for mental health services as there is for general health services.
- Invest in healthy families and communities to increase resilience and reduce the longer-term need for crisis services.
- Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels.
- No-one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness. Access to stable and safe places to live must increase.
- Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting.

The additional recommendations are:

- People with co-existing mental health difficulties and substance use problems must be offered appropriate and closely co-ordinated assessment, response and follow-up for their problems.
- National, systematic and adequately funded early intervention approaches must remain. This must be accompanied by robust evaluation to support investment decisions, with a focus on implementation, outcomes and accountability.
- A practical guide for the inclusion of families and support people in services must be developed and implemented, and this must include consideration of the services and supports that they need to be sustained in their role.
- The Commission calls for the implementation and ongoing evaluation of a sustained, multi-faceted national strategy for reducing discrimination.
- All Australians need access to alternative (and innovative) pathways through school, tertiary and vocational education and training.
- Where people with mental health difficulties, their families and supporters come into contact with the justice system and forensic services, practices which promote a rights and recovery focus and which will reduce recidivism must be supported and expanded.
- Governments must sign up to national targets to reduce suicide and suicide attempts and make a plan to reach them. These targets must be based on detailed modelling.

At Senate Estimates it was revealed that the NMHC will not be producing a Report Card in 2014 as it is engaged in the mental health review.