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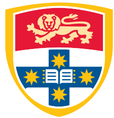

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Mental health provisions in the 2011-12 budget

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Overview

After much prodding and shaming, the Government finally delivered on its commitment to mental health reform in the 2011-12 budget. However given the magnitude of the burden of mental illness and the scope and extent of the needs in mental health , even this significant down payment on new services cannot be considered the endpoint of work in mental health but only the beginning. Going forward there are a number of key issues to be addressed, including: the implementation and ongoing sustainability of current initiatives; ensuring better integration of mental health, substance abuse and physical health services; and developing a whole-of-government approach to tackling the unmet needs of people with mental health problems, their families and carers.

The Gillard Government has 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 the year 2014-15, this will provide just **$407 million** more for funding in the allocated areas, and so these limited dollars will be severely stretched. About a quarter of the whole mental health package (**$580.4 million**) is funded by savings from the Better Access Program. The cost blow-out of this program has been so substantial that it cannot be ignored – it is expected to cost **$3 billion** over the next budget period. This amounts to $10 million per week, which does put the totality of this budget announcement into some perspective.

There is some strange accounting in this funding package, and it seems there is a **$52.6 million** hole in the mental health budget. Some of the funds applied to flexible care packages are redirected from a provision in last year's budget funded by changes in the Better Access program that are reversed in this budget. And **$200 million** of the $549.8 million provided for flexible care packages is unallocated.

Still, this is a substantial new funding commitment – of the same order as the $1.9 billion commitment made by the Howard Government in 2006. However it is salutary to note that, six years later, the returns on this investment are hard to see in many areas. Mental health's share of the total health budget has in fact continued to decline over recent years as total health spending has increased. We should hope that the policy commitments to this package are more lasting than those made to the suicide funding package announced during the 2010 election campaign, which has now been dismantled.

The best thing about the new mental health package is that it invests **$419.7 million / 5 years** in mental health services for teenagers and young adults such as the Early Psychosis Prevention and Intervention Centres (EPPIC) and headspace - initiatives that have been clearly demonstrated to deliver improvements in mental health outcomes. However experts have expressed real concerns that this funding is insufficient to deliver both new services and maintain current services.

A strength of this package is that it recognises that people with serious and continuing mental illness and their carers need a range of services such as flexible community care and care coordination services. Many of the services are not medical, so their delivery through the auspices of Medicare Locals will need to be carefully monitored. However this mechanism does potentially allow for the better integration of mental health into the health care system.

There are other positive steps towards a more holistic approach to the delivery of mental health services. The establishment of a National Mental Health Commission in the Department of Prime Minister and Cabinet should help drive this forward, and ensure that mental health is a high priority for the Commonwealth Government across all portfolios. One obvious and serious omission which must be remedied is that there is no current effort to link in substance abuse services, despite the strong links between mental illness and substance abuse. Failure to do this will inevitably mean a failure to achieve the best, most cost-effective outcomes in behavioural and physical health.

The biggest disappointment in this package is the failure to make evidence-based reforms to the Better Access program. No amount of gloss on the evaluation report, released in March, can hide the fact that evidence about the effectiveness of the Better Access program is weak, and many key population groups do not have better access to the services they need. It is hard to see how the changes made in this budget will improve the program; it appears they are more about achieving savings than improve access or outcomes.

Apparently the plan for the delivery of mental health care in the primary care sector is to confine Better Access services to those with mild to moderate mental health conditions and to expand ATAPS to cover the care of those with more complex conditions, Indigenous patients and those in rural and remote areas. But there are no mechanisms of incentives to deliver this plan or to prioritise access for those most in need, and the likelihood is that those patients best equipped to manipulate the system will get services ahead of those who need them.

For health policy analysts who have attempted to follow the way that federal funds are spent on mental health services over the years and the success or otherwise of these investments, this task has become increasingly difficult. The names of programs change along with departmental responsibilities for their delivery and continuing programs are often presented de novo, with the pretence that these represent new funding investments. A classic example this year is the way funding is provided for the flexible care packages. Most egregiously in all these pea and shell games, there is little focus on the evaluation of quality and effectiveness, with measures of activity presented program outcomes.

Analysis of 2011-12 Budget Provisions

Expansion of youth mental health services – *headspace*

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA (this budget)	-	$13.5m	$22.5m	$34.9m	$61.9m	$65.0m
DoHA (previous budget)	$10.8m	$19.9m	$23.8m	$24.3m	-	-

$197.3 million / 5 years to establish 30 new *headspace* sites, and provide additional funding to existing sites and the *headspace* national office.

The *headspace* program provides community based support and assistance to Australians aged 12 to 25 with, or at risk of, mental illness. This will bring the total number of *headspace* sites to 90; when all sites are fully operational, they will provide services to an estimated 72,000 young people per year.

This funding is on top of the **$78.8 million / 4 years** provided in the 2010-11 budget for 30 new headspace sites, additional funding for the existing sites, and expanded telephone and web-based mental health services to young people.

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 roll-out of these sites has been slow. The *headspace* 2010 report states that there were 30 centres which in 2009-10 serviced 23,000 young people. Chris Tanti, the chief executive of *headspace* has been quoted as saying the 2010 funding is sufficient to build only 23 of the 30 promised centres, so a key issue will be if there is now enough funding over the forward estimates to ensure the national roll-out can be achieved and the operations of current centres maintained without compromising the integrity of this model of care. The expectation that 90 centres will provide services to 72,000 youth seems optimistic.

Expansion of youth mental health services – Early Psychosis Prevention and Intervention Centres (EPPIC)

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA + Treasury (this budget)	*-*	*$2.9m*	*$23.0m*	*$44.9m*	*$70.8m*	*$80.8m*
DoHA + Treasury (previous budget)	*$6.5m*	*$6.3m*	*$6.4m*	*$6.4m*	*-*	*-*

$222.4 million / 5 years for 12 new Early Psychosis Prevention and Intervention Centres to be delivered in partnership with the states and territories. To the extent this funding is subject to matching funds from the states and territories, full implementation is not guaranteed. It is not clear if this initiative will be included in the National Partnership Agreements.

EPPIC provides an integrated and comprehensive psychiatric service aimed at addressing the needs of people aged 15-24 with emerging psychotic disorders. Services include early intervention and clinical treatment. These new centres will be modeled on the existing EPPIC centre in Melbourne's west operated by Orygen.

The 2010-11 budget provided funding of **$25.6 million / 4 years** for four EPPICs. It appears that none of these are yet underway, probably because this funding is inadequate. Total funding now would amount to $7.75 million / year for each of the 16 centres.

Experts have pointed out that the success of these new psychosis services will be dependent on the extent of the fidelity to the EPPIC model. This will require specific governance arrangements to safeguard this investment.

Coordinated care and flexible funding for people with severe and persistent mental illness

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA (this budget)	-	-$25.4m	$35.5m	$69.1m	$117.7m	$146.9m
DoHA (previous budget)						

The budget papers state that **$549.8 million / 5 years** is provided to develop a single assessment framework and provide better coordinated care for people with severe and persistent mental illness who have complex care needs. These care services will be coordinated through Medicare Locals and NGOs. Under this measure, services for people who meet the assessment criteria will be provided through a tailored multidisciplinary care plan developed in consultation with the individual and their family.

The net cost of this measure is **$343.8 million / 5 years**, with the remaining costs of **$206.1 million** to be met from savings (described in media releases as "consolidation of existing elements") from the suicide prevention program announced in December 2010 and the flexible care packages provision in the 2010-11 budget. The savings of $25.4 million in 2011-12 presumably comes from previous (2010) commitments that will not be implemented.

The budget papers do not outline where / how the additional **$200 million** will be spent. While it seems that some of the total $549.8 million committed will go to the development of a "single assessment framework", it's unlikely that would amount to $200 million.

Access to this funding will be up for tender, between NGOs and Medicare Locals. This is a smart way to bring the Medicare Locals and physical health services into the community mental health service realm. The risk here is that the focus will be more on medical approaches that community approaches. It is assumed that there is some role for ATAPS in the provision of these services, although this is not spelt out in the budget papers.

Some budget commentators have highlighted that this provision will be overwhelmed by the need for these services. If only $343.8 million is available to provide services to assist 24,000 people over five years, then it is unlikely that $2,865 / person / year is adequate. While it seems that some of the total $549.8 million committed will go to the development of a "single assessment framework", it's unlikely that would amount to $200 million. Still it's clear that this program as proposed will be insufficient to meet current needs and there will be limits on how much coordination and service purchasing can be done.

"Consolidation" of related mental health programs to fund this initiative

The $276.9 million 'Taking Action to Tackle Suicide' package was announced in September 2010, to be delivered from 2011 - 2012, so presumably little of this money has been spent or allocated to date.

The measures in this package included:

- Greater access to mental health services for those at the greatest risk of suicide, including psychology and psychiatry services and non-clinical support to assist people with severe mental illness and their carers with their day-to-day needs ($113.9 million);
- Increased funding for direct suicide prevention and crisis intervention services such as Lifeline and funding to improve safety at suicide 'hotspots' ($74.3 million);
- Provision of more services and support to men, who are at greatest risk of suicide but least likely to seek help ($22.8 million); and
- Promotion of good mental health and resilience in young people, to prevent suicide later in life ($65.9 million).

It seems that more than just the $114 million allocated to frontline services will now go to this new proposal.

The funding sources get even more convoluted when considering the reallocation of funds in the 2010-11 budget for flexible care packages. This package, costed at **$58.5 million / 5 years**, was to provide personal multidisciplinary care packages for patients with severe mental illness by expanding the ATAPS program. However there was only $5.9 million in new funds for this; the remainder ($52.4 million) was from a requirement (to be effective July 1, 2010) that occupational therapists and social workers could no longer bill Medicare for mental health services provided under the Better Access program – a requirement since rescinded. So it seems there is a funding hole here of $52.4 million.

It is not clear where this initiative sits with respect to the current COAG Community Mental Health program.

Better Access – rationalisation of GP mental health services

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	-$50.1m	-$80.5m	-$85.4m	-$90.9m	-$98.9m

Savings of **$405.9 million / 5 years**, to be redirected to other mental health programs, achieved by introducing a two-tiered rebate for mental health treatment plans delivered by GPs through the Better Access program.

The revised rebates are modeled on the current structure for GP consultations, with a standard rebate for services taking between 20 and 39 minutes, and a higher rebate for those services taking 40 minutes or more. The Medicare payment will drop from $160 to between $85 and $126, depending on the length of consultation. The new fee Medicare payments still represented a 27 per cent premium over amounts GPs are paid for consultations dealing with physical ailments, and the rebates for GP mental health treatment plans remain higher for those GPs who have completed Mental Health Skills Training.

The budget papers state that “Rebates for other mental health services provided by GPs will also be amended to reflect the changes in the rebates for Mental Health Treatment Plans.” It is assumed that this is a reference to the services provided under MBS item 2713 and the MBS items for focused psychological strategies.

The impact of this measure on the mental health services that GPs deliver is unclear as there is no information available about the quality and usefulness of the management plans they produce and the outcomes these deliver for their patients.

Better Access – rationalisation of allied health treatment services

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	-$12.6m	-$26.5m	-$34.9m	-$44.6m	-$55.9m

Savings of **$174.6 million / 5 years** to be redirected to other mental health programs, achieved by reducing the number of allied health treatment services available to patients under the Better Access program. Patients will now be able to access up to six subsidised mental health services with an additional four services available, based on need.

The budget papers explain that “these new arrangements will ensure that the Better Access initiative is more efficient and better targeted by limiting the number of services that patients with mild or moderate mental illness can receive, while patients with advanced mental illness are provided more appropriate treatment through programs such as the Government’s Access to Allied Psychological Services program.” It’s not clear how that division of services based on diagnosis will be achieved: for most patients the main differences between ATAPS and this program will be the ability to access 12 services (18 in exceptional circumstances) as opposed to 10.

When the Better Access program was introduced in 2006 patients with a mental disorder were able to receive up to 12 individual and up to 12 group allied mental health services per calendar year. ATAPS consultations and GP focused psychological strategies services were included in the 12-service limit. It is assumed this is still the case.

Better Access - reinstatement of services for occupational therapists and social workers

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	-	-	-		

$52.6 million / 4 years (from 201011) to allow social workers and occupational therapists to continue to provide Medicare-funded mental health services under the Better Access program.

The 2010-11 budget cut the access of these allied health professionals to Medicare and used to resultant savings ($52.4 million) to fund flexible care packages for patients with severe mental illness (see above). This decision was reversed in November 2010.

Funding for this measure was included as a ‘decision taken but not yet announced’ in the MidYear Economic and Fiscal Outlook 201011.

Expansion of Access to Allied Psychological Services (ATAPS)

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	$16.1m	$31.1m	$43.7m	$53.1m	$61.9m

$205.9 million / 5 years to expand the ATAPS program to provide services to children and their families, Indigenous people, and people from hard to reach locations with a particular focus on lower socioeconomic areas. Medicare Locals will coordinate these services at a local level by integrating primary care services with other community-based support for people with mental illness. Medicare Locals will also be funded to employ part time child liaison officers, who will liaise with specialised child allied mental health professionals, schools and children's services to improve the quality of care.

This initiative addresses the need, emphasised in the 2010 ATAPS review, to increase the program's focus on the needs of Indigenous people and children. However it does nothing to address other areas emphasised in the report such as the need to address the challenges involved in recruiting, training and retaining the ATAPS workforce, and to drive improvements in efficiency, effectiveness and quality.

The ATAPS initiative, under which GPs can refer patients with mental disorders for mental health services delivered by allied health professionals (up to 12 and 18 in exceptional circumstances), was established in 2003. The need for ATAPS has grown, not diminished since the introduction of the Better Access program, which delivers the majority of its services in metropolitan areas and has substantial co-payments. Up until June 2010, the program was receiving about $27 million per year from the federal budget.

Following the review of the ATAPS program released in 2010, the Health Minister wrote a letter to the Divisions of General Practice outlining new funding arrangements. Tier 1 (base) funding for the program was to be based on the current distribution of ATAPS funding and preserved at or close to current levels. Tier 2 (special purpose) funding was to consist of current funds for services for women with perinatal depression, suicide prevention, bushfire victims and people at risk of homelessness. There was also a commitment to a new planning process to prioritise the allocation of Tier 2 funding. The extent to which the current proposals for ATAPS represent a new planning process is unclear.

As previously noted, funds provided in the 2010-11 budget for ATAPS services for people with serious mental illness and some of the funds announced in September 2010 for suicide prevention have been reshuffled, without any clear signal that these services will still be provided through ATAPS. Some additional funding is provided to ATAPS through the National Perinatal Depression Initiative. This ATAPS contribution was initially announced in 2008 as $20 million, but the total funding for the Initiative provided through a National Partnership Agreement is only $36.9 million / 5 years, so ATAPS funding may be less that $20 million.

It does appear that the ATAPS program will now be required to juggle the disparate needs of several different patient groups, with only a minimal budget increase. If all of the funds provided under this initiative were to go to the provision of ATAPS services, in 2014-15 this would deliver just 310,000 services (assuming the current average cost of $171 / service continues to apply). At 6 services / patient, this would mean just 51,700 patients could receive mental health services.

Health and wellbeing checks for three year olds

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	1.0	6.7	0.9	1.3	1.1

$11.0 million / 5 years to expand the existing four-year old health check to include consideration of emotional wellbeing and development, and to bring forward the check to three years of age. This will also fund the establishment of a time limited National Expert Group on childhood mental health to develop and provide advice relating to the three-year old health check and training requirements for health providers.

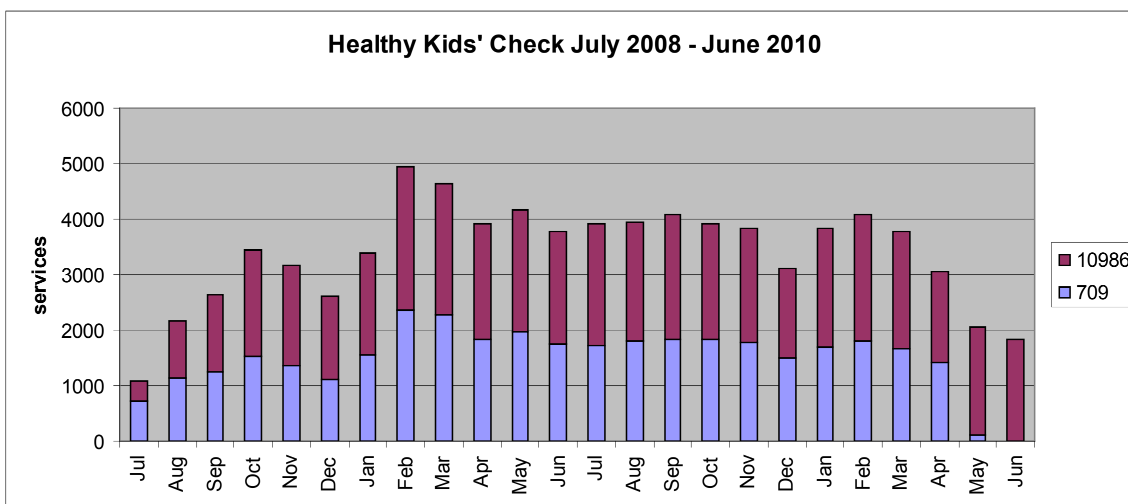
This provision is linked to the election commitment, delivered in the FHCSIA budget at a cost of $12.1 million / 5 years to introduce a requirement that children of parents on income support receive a health assessment before starting school. From 1 July 2011, the payment of the end-of-year Family Tax Benefit Part A supplement (currently valued at $726.35) to parents on income support with a child turning four will be conditional on the child undergoing a preschool health assessment. Families will have up to two years after the end of the year their child turns four to meet the health check requirement and notify Centrelink before losing eligibility for the Family Tax Benefit Part A Supplement.

A National Partnership Agreement set up in 2010 provides $9.4 million / 5 years to the states and territories to strengthen linkage between the healthy kids check and state-funded child health assessment services, and to promote the provision of health assessment services who are about to enter school.

But there's a problem – Healthy Kids' Checks are not working. Only a fraction of four-year olds get this health check, and there is no evidence that those children who do get one benefit from it.

Medicare data show that in the two years to June 2010 since its introduction in July 2008, only 81,463 Healthy Kids' Checks have been done, at a cost of $3.79 million. That's well below what was anticipated for a nation with some 260,000 four-year olds, and a program that was budgeted to cost $25.6 million over 4 years

As the graph shows, the majority of the Healthy Kids' Checks are done by Practice Nurses, and there is only a slight indication, more obvious in 2009 than 2010, that the rate at which these checks are done is linked to the start of the school year.



In contrast, it is possible to see a boost in the number of immunisations delivered by Practice Nurses around February / March each year, which presumably reflects school requirements.

After May 2010 it is no longer possible to track the number of Healthy Kids' Checks delivered by GPs because these are now done under a generic MBS item. Data through the March 2011 for health checks done by practice nurses (item 10986) show that these consistently average 2000 / month, so it could be assumed that overall the uptake continues as shown in the graph and well below expected figures.

The key issue is what happens as a consequence of these checks – are they sufficient to detect problems and what do doctors (and parents) do when they find problems?

The only mandatory requirements are that children's eyesight, hearing, oral health, toilet habits and allergies are checked, although doctors or nurses may ask about eating habits, physical activity, speech and language development, motor skills, and behavioural problems. However there is nothing to require that children get the follow-up medical care, eyeglasses, hearing assistance or speech therapy they might need.

A recent paper published in the Medical Journal of Australia found that most of the components of the Healthy Kids' Check are not supported by evidence-based guidelines.[1]

Establishment of a single mental health online portal

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	$1.9m	$2.9m	$3.0m	$3.3m	$3.3m

$14.4 million / 5 years to help establish a single mental health online portal, which will both enable consumers to more easily identify and access services and provide online training and support to GPs, Aboriginal health Workers, and other clinicians delivering mental health services.

The COAG mental health package contained $60.9 million / 5 years (from 2006-07) for telephone counseling, self help and web-based support programs. It is not clear what the current funding is for these programs, for which an evaluation report is overdue.

Establishment of a National Mental Health Commission

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	-$1.9m	-$4.3m	-$4.3m	-$4.3m	
DPM&C	-	$3.3m	$6.8m	$6.7m	$6.7m	
Total	-	$1.4m	$2.6m	$2.4m	$2.6m	$2.5m
Related capital		$0.6m				

$32.0 million / 5 years to establish a National Mental Health Commission which will be established as an Executive Agency within the Prime Minister's portfolio. The Commission will independently monitor, assess and report on how the system is performing as well as provide advice on mental health policy and programs. Some functions currently performed by DoHA, including the administering of the Annual National Report Card on Mental Health and Suicide Prevention, will be transferred to the Commission.

1 http://www.mja.com.au/public/issues/192_04_150210/ale10184_fm.html

A substantial part of the funding for this measure ($19.8 million) is taken from other initiatives; $7.3 million from the 'Leadership in mental health reform — continuation and further efficiency' measure and $12.5 million from MYEFO 201011 measure 'Taking Action to Tackle Suicide — Providing more frontline services and support for those at greater risk of suicide'.

It is somewhat shocking to realise that the rather perfunctionary reports prepared by DoHA on mental health cost $4.3 million annually.

Nevertheless, the establishment of a new National Mental Health Commission offers the possibility of a whole-of-government approach to tackling mental health and a new level of federal scrutiny and accountability. The fact that the Commission is placed within the Prime Minister's portfolio, rather than DoHA demonstrates an elevated commitment to mental health.

Continuation of 'Leadership in mental health reform' initiative

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA (2009-10) budget)	$11.5m	$11.5m	$11.5m	-	-	-
DoHA (current budget)	-	$10.0m	$11.6m	$11.6m	$11.6m	$11.9m

$56.8 million / 5 years for the continuation of activities to build the national mental health evidence base, strengthen accountability and transparency, lead improvements in service quality and outcomes, and support national peak bodies and stakeholders. When first introduced in 2008-09, this measure was funded at $66.6 million / 4 years, but the 2009-10 budget cut this by $20 million.

Now this year's budget papers state that the measure is funded at $64.1 million / 5 years, although in fact $7.3 million of this ($1.5 million annually) is redirected to the National Mental Health Commission.

Expansion of Support for Day to Day Living in the Community program

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	$2.4m	$4.1m	$4.2m	$4.4m	$4.2m

$19.3 million / 5 years to support services for an estimated 3,650 additional people with severe and persistent mental illness per year. It is assumed that this is on top of continuing funding of around $10 million / year.

The 'Support for Day to Day Living in the Community' program provides structured and socially based activity programs where individuals can participate in social rehabilitation activities and gain independent living skills. The program has strong links to the 'Personal Helpers and Mentors' (PHaMS) program. The program was launched in July 2007. Since then 60 grants have been awarded totalling more than $40 million to NGOs to provide the Day to Day Living Program through to June 2011.

The evaluation report for this program was released in September 2010.[2] It estimated that 7,000 places

2 http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/7665C87AA15ADD17CA2577B5007B77E2/$File/D2DL%20evaluation.pdf

have been added each year since 2007. However this figure does not align with the February 2011 report on the COAG National Mental Health Plan which states that at 30 June 2010, approximately 11,000 people with severe and persistent mental illness had benefited from this initiative.

The report made a number of recommendations, including: revised reporting structures to focus on the quality or structure of services provided, rather than the hours of activity generated; the provision of data systems to allow services to efficiently collect, collate and use data required for monitoring and management of the program; facilitating payment of invoices under funding agreements on submission of progress reports, rather than following review, editing and acceptance; and increased training for providers.

Research funding

$26.2 million / 5 years will be provided through the National Health and Medical Research Council for mental health research priorities. A consultation process to be managed by DoHA will establish priorities for mental health research funding.

This is not new money but will be provided from within the current NHMRC budget.

National Partnership Agreement on Mental Health

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
DoHA	-	$0.5m	-	-	$0.1m	
FHCSIA	-	$0.5m	-	-	$0.1m	
Treasury	-	$21.4m	$43.5m	$44.3m	$45.0m	
Total	-	$22.3m	$43.6m	$44.4m	$45.1m	$46.0m

$201.3 million / 5 years to states and territories through a National Partnership Agreement to address major service gaps in their mental health services including accommodation, emergency departments and community based crisis support. Co-funding is to be sought from the states and territories, which will access the funding pool through participation in a competitive process.

With the expiry of the COAG mental health commitments established on 2006-07, this funding is the only new commitment to COAG initiatives in mental health.

FaHCSIA Initiatives

Family Mental Health Support services

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
FaHCSIA	-	$2.3m	$8.8m	$13.3m	$18.0m	$18.5m

$61.0 million / 5 years to provide an additional 40 Family Mental Health Support services.

These services provide prevention and early intervention support and assistance for families and children to address mental health issues early in life and early in the onset of mental illness. They have a particular focus on young carers and vulnerable children, including those who have been identified as being at risk of mental illness.

This program was originally funded at $45.2 million / 4 years. Funding in 2009-10 was $11 million. It is assumed that this level of funding is provided in the forward estimates to continue current services.

As at 30 June 2010, this program had provided assistance to approximately 63,200 people (with 23.5% identifying as CALD and 10.5% as Indigenous). Services are delivered through 44 non-government organisations.

Personal Helpers and Mentors Services (PHaMS) and respite services

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
FaHCSIA	-	$7.3m	$29.6m	$51.9m	$59.4m	$60.2

$208.3 million / 5 years to expand and integrate Personal Helpers and Mentors and respite services. $50.0 million of this will be allocated to provide personal helpers and mentors to specifically help people with mental illness on, or in the process of claiming, income support including, the Disability Support Pension, and who are participating in employment services. The stated aim is to provide greater access to intensive, one-on-one support for people with persistent and/or episodic mental illness to aid recovery and reduce social isolation, with a focus on employment and educational outcomes. It will also provide improved access to respite for their families and carers.

This measure now combines what were previously two separate programs – PHaMS and respite services. These were originally funded in the 2006-07 budget at $284.8m / 5 years and $224.7 / 5 years respectively. Assuming such sums are included in the forward estimates for both these programs, the new funding provided (minus the funds linked to employment services) represent about a 25% increase.

Reports on the FaCHSIA website state that as at 31 December 2010, a total 14,082 participants have been assisted by PHaMS since April 2007. Of the participants who have or are receiving services, 14% identify as CALD and 9% as Indigenous. There are 175 PHaMs sites operating (97 metro, 67 non metro sites and 11 remote sites across Australia.

The Mental Health Respite initiative has provided assistance to over 60,900 carers and family of people with severe mental illness and intellectual disability from April 2007 to 30 June 2010. In 2009-10 15,592 carers were assisted with brokered services and 5,300 carers and families were assisted by 134 services providers. On this basis the new funds will assist around 5,000 more carers/ families a year.

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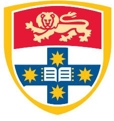

Mental health provisions in the 2011-12 budget

The Menzies Centre for Health Policy is a collaborative Centre between The Australian National University and the University of Sydney. It aims to provide the Australian people with a better understanding of their health system and what it provides for them. The Centre encourages informed debate about how Australians can influence health policy to ensure that it is consistent with their values and priorities and is able to deliver safe, high quality health care that is sustainable in the long term.

The Menzies Centre:

- produces and publishes high-quality analyses of current health policy issues;
- delivers public seminars and education programs on a wide variety of health policy topics;
- undertakes comprehensive research projects on health policy issues.

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