PMHA PRIVATE MENTAL HEALTH ALLIANCE NEWSLETTER

Eighth Edition May 2011

Australian Medical Association

Australian Private Hospitals Association

Australian Health Insurance Association

Australian Government

Private Mental Health Consumer Carer Network (Australia)

beyondblue – the national depression initiative

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The PMHA is alliance of major stakeholders who fund and provide mental health services in the Australian private sector. Originally established in 1996, the Alliance is committed to the provision of high quality mental health care in a private sector environment. PMHA addresses issues related to funding, classification, quality of care, outcome measurement, consumer and carer participation and related matters as they affect the private mental health sector.

The PMHA Newsletter provides a brief summary of some of the issues being progressed by our Private Mental Health Alliance, and its Centralised Data Management Service (CDMS). As such it is intended to stimulate discussion and debate concerning the delivery of mental health services in the private sector. We welcome any feedback from our readers, which should be sent to: ptaylor@pmha.com.au

The PMHA Newsletter does not necessarily represent the views of participating organisations, unless otherwise stated. Further information on the PMHA and its CDMS can be obtained from the PMHA Website at: www.pmha.com.au

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From the Chair

Philip Plummer

We kicked off 2011 by getting the PMHA's Quality Improvement Project (QIP) underway. Our Senior Research Officer, Ellie Rosenfeld, started working on the Project on 31 January 2011, out of the new PMHA Research Office in Adelaide. QIP contains a suite of four complementary activities to be undertaken within the context of the available funding.

1. *Implementation of Consumer Perceptions of Care (CPoC) Measure.* This first activity involves the implementation of a standardised measure of CPoC in all private hospital–based psychiatric services across Australia.

2. *Outcomes in Private Psychiatry Practice.* Work on this second activity will establish a research network of psychiatrists evaluating outcomes within the context of their private psychiatry practice.

3. *Internet Access to the PMHA's CDMS.* This third activity involves a scoping exercise to determine the requirements for a model Agreement that would enable appropriate and secure internet–based access for participating stakeholders to the data currently held by the PMHA's CDMS.

4. *Borderline Personality Disorder (BPD).* This activity involves preliminary work to scope what models of care are currently being used for people with a diagnosis of BPD.

We have established a Steering Committee to enable proper reporting arrangements for Ellie and to manage and support QIP over the course of 2011 and 2012.

Additional Funding

It gives me great pleasure to announce that the Commonwealth has provided additional funding of $226,081 to strengthen the work programs for *Outcomes in Private Psychiatry Practice* and *Internet Access to the PMHA's CDMS*.

Private Psychiatrist Research Network

The additional funding for the Outcomes in Private Psychiatry Practice will enable Ellie and Dr Bill Pring to visit WA, SA, QLD, NSW, VIC and facilitate the establishment of the Private Psychiatrist Research Network (PPRN) through participating private psychiatric hospitals and their Medical Advisory Committees.

In relation to *Internet Access to the PMHA's CDMS*, the tasks specified under QIP are just one part of the work that needs to be done to give private hospitals and health insurers secure access to CDMS Training Resources, Standard Quarterly Reports, and ultimately, to a web–based system for ad–hoc analysis that works within the constraints of the National Model's Guidelines for access to aggregate statistical information. That full work program involves the following steps.

First, in order to enable web–based access to Standard Quarterly Reports, the requirements and protocols for secure access to that data by authenticated users must be developed. The tasks originally included under the QIP Work Program will enable the completion of that work. At the same time, the PMHA's website must be redeveloped so that it can provide a secure and more robust platform for the future development of the secure web–based access systems.

Redevelopment of the PMHA website

The additional funding provided by the Commonwealth will enable the existing PMHA web–site to be replaced with a portal based on a widely used and mature MS Windows based Content Management System. This will provide the PMHA with an enhanced website to which a secure front end to the data warehouse may subsequently be added. The additional funding will enable re–development of the PMHA's website to be completed before the end of next month.

Our new carer representative

The PMHA has extended a warm welcome to Mr Patrick Hardwick to replace Mrs Ruth Carson as our Carer representative. Patrick is interested in enhancing promotion of services available for carers and advocating for their rights and needs. He wants to see a cultural change where mental health services take a more family centred approach to treatment and support and automatically involve carers in their planning and decision making processes. Patrick has been the President of ARAFMI (WA) for a period totalling 5 years and is a past Board Member of the Mental Health Council of Australia.

Philip is the Independent Chair of the PMHA, based in Adelaide.

AMA AND MENTAL HEALTH REFORM

Dr Choong–Siew Yong

The Australian Medical Association (AMA) Federal Budget Submission 2011–12 called on the Federal Government to provide $5 billion over four years to expand health and social support services to ensure that all people with mental illness are properly supported.

This was followed by the release of our Mental Health Position Statement outlining what is required to assist the Government to meet its commitment to making mental health a successful second–term priority. The Position Statement has been widely commended as comprehensive and called for support in the following areas.

Prevention, destigmatisation and community understanding, through sustained national community awareness campaigns to increase mental health literacy and reduce stigma, public education campaigns for prevention and a reduction in substance abuse, and promotion of good health and resilience in young people at school and in the community.

Early identification and intervention, including support for more online and phone counselling and support services, comprehensive information about local referral pathways to ensure that patients get linked to the right service at the right time, more child–, adolescent– and youth–friendly services, and mental health screening for infants, children, and adolescents to identify symptoms as early as possible.

Expansion of Community–based care, by improving the Medicare Benefits Schedule (MBS) rebates and streamlining MBS arrangements to improve access to psychiatrists and GPs for patients treated in community–based settings. We also want to see improved access to:

- mental health assessment facilities and mobile outreach;
- specialised community–based programs to treat specific clinical conditions including eating disorders, perinatal depression, personality disorders, suicide and self–harm;
- specialised mental health assessment and care and dementia care services for the elderly in residential aged care; and
- community–based mental health care services in rural and urban communities to meet local needs.

Subacute care, including more capital and recurrent funding for subacute beds for long–stay patients and for residential rehabilitation; step–up and step–down residential care as an alternative to inpatient admission, or for a period of transition after hospital discharge; and more respite care for people with mental illness and their families.

Acute care needs funding to open and continue to operate additional acute care beds in public hospitals; increase access to public patient mental health outpatient services. We need specialised mental health and dual diagnosis spaces in public hospital emergency departments and additional capacity to provide patients with the option of being treated in single sex mental health wards in public hospitals.

Crisis and outreach care needs further investment, particularly for those with severe mental illness and/or those at risk of suicide, and the establishment of a rapid–response outreach team for every acute mental health service.

Support and services for special needs groups must be improved to provide access to specialised mental health services, including for people in Indigenous communities, people with disabilities, those with significant drug and alcohol issues, older people, the homeless, and those people from culturally and linguistically diverse backgrounds, prisoners, and people in detention centres.

Measures to address the social, environmental and economic determinants of mental health require improved access to education, supported community–based housing, public housing, social support including services to prevent neglect and sexual abuse of children, vocational rehabilitation, employment support and post–placement employment support, and a social service system that links to community mental health services to enable appropriate clinical support, especially for those with severe and/or chronic mental illness.

Expanding the mental health workforce calls for increasing the number of funded psychiatrist trainee places, increasing the number of training opportunities for other mental health workers, providing further continuing professional development and competency training opportunities for the primary health care workforce who want it, and more debriefing services for mental workers and doctors.

Improved coordination and access including additional funding for mental health coordinators to assist with transition in and out of acute and subacute care, increased online support and access to telemedicine and e–health technology; improved coordination, information and communication flows; and reducing access gaps and improving referral pathways at the local level between acute care and community–based services and between the public and private sector providers working in them.

Research needs to be funded to enable more mental health research in the areas of neuroscience, clinical treatment and translational research, to ensure that mental health services are evidence–based and continuously improve.

Copies of the AMA Position Statement are available from the AMA website at: http://ama.com.au/node/6524

Choong–Siew Yong is a psychiatrist and represents the AMA on the PMHA.

A snapshot of the Gillard Government's recent mental health reform budget announcements are briefly summarised in Budget Round–up section of this Newsletter.

MENTAL HEALTH REFORM UPDATE

The Hon. Mark Butler MP

I'd like to take this opportunity to update you on what the Gillard Government is doing to advance vital reforms in mental health. We know that mental health is an issue that is firmly on the minds of many Australians.

As I am sure you would be aware, the Prime Minister identified mental health reform as a major priority for this term of government. That is why she appointed me as the first ever Commonwealth Minister for Mental Health. In my first few months as Minister, I had many experts and service providers come to Canberra to give me their views on mental health reform. Very early on the Mental Health Council of Australia told me to get out there and hear from consumers and carers firsthand. It was good advice.

Since then, I've participated in more than 18 forums in cities and towns around the country with consumers and carers, including an online forum with young people. I've had forums with culturally and linguistically diverse communities, with different sections of the mental health workforce, with community mental health providers, with state and territory governments, and many more.

What was clear from these consultations is that the community expects us as a nation to do better by people with a mental illness. To do better as a nation, it was clear to me that Australians expect their national Government to do more. We need to do more in terms of reforming the way the mental health system works and of course more by way of investment.

The Gillard Government has nearly tripled our investment in specific mental health programs (beyond the PBS and Medicare) over the next four years to $1.4 billion, in comparison to the previous Liberal Government who spent just $516.3 million in their last four years of government.

This includes the $175 million investment made in last year's budget to expand headspace services, to build Early Psychosis Prevention and Intervention Centres (EPPIC), to expand the Mental Health Nurse Incentive program and to deliver flexible care packages to better support up to 25,000 people with severe mental illness.

The Government's record investment in mental health services also includes the $275 million Taking Action to Tackle Suicide package announced as part of the federal election campaign last year, with more information available at: www.health.gov.au/mentalhealth

Despite these investments, the Gillard Government recognises that we need to do more. This is why the Prime Minister has asked me to chair a group of mental health experts to very quickly develop options for further reform.

This group includes former Australian of the Year Professor Patrick McGorry, Professor Ian Hickie of the Brain and Mind Research Institute, former Chair of the Health and Hospitals Reform Commission Dr Christine Bennet, South Australian Social Inclusion Commissioner Monsignor David Cappo, representatives of consumers and carers and a number of others.

This expert group has already started to provide ideas for real improvements to the mental health system that are achievable and make the best possible use of funding that is already available. The experts have been very clear about two things; first, that the mental health system needs a long term plan for sustainable reform; and second, that mental health reform is about more than just health services – it's about employment, education, family, and housing services as well. The expert working group is currently finalising their work.

You might also be aware that at the recent Council of Australian Government's meeting (COAG) a major agreement was struck on health reform. This will deliver a better deal for all health patients and secure the long–term sustainability of Australia's health system. This will deliver lasting benefits to mental health consumers. To find out more I encourage you to visit: www.yourhealth.gov.au

The Prime Minister has also agreed that mental health reform will be listed as an important topic of discussion at a next meeting of the Council of Australian Governments (COAG) later in the year.

This is a significant and welcome step towards developing a cohesive mental health strategy incorporating the states and territories.

My consultations, the efforts of the expert group and the work taking place in the lead up to the next COAG meeting will all lead to further significant reforms in mental health.

This reform effort will seek to build on the work done in our first term to make lasting improvements to mental health care. While I will continue to work closely with mental health stakeholders, including consumers and carers, we have decided to focus future mental health reform on the following areas.

- Strengthening the focus on the mental health needs of children and youth.
- Improving outcomes for people with severe mental illness through better coordination of services.
- Strengthening primary mental health care services.
- Increasing economic and social participation for people with mental illness.
- Ensuring quality, accountability and innovation in mental health services.

Mark is the Australian Government Minister for Mental Health and Ageing.

A snapshot of the Gillard Government's recent mental health reform budget announcements are briefly summarised in Budget Round–up section of this Newsletter.

PRIVATE MENTAL HEALTH CONSUMER AND CARER NETWORK

Ms Janne McMahon OAM

Private Mental Health Consumer Carer Network (Australia) [Network] is of critical importance to the private mental health sector. I first conceived of the Network in 2002 in an attempt to improve the participation and to capture the informed voice of consumers and their carers using private sector mental health services.

Role

The Network seeks to provide the private sector with the honest feedback it needs on service provision and funding. While the feedback is not always what stakeholders want to hear, without it they run the risk of service provision and funding being out of alignment with what is actually needed. The Network provides a valuable service to the whole sector and is able to advise on issues of national significance.

Structure

I chair the Network, which is comprised of representatives from all Australian States and the Australian Capital Territory who are either consumers or carers. The Network has developed a framework of state committees to support those representatives in their work. The Network meets for two days twice a year in Melbourne and at other times via teleconference.

Since its inception, we have been advocating on behalf of private mental health consumers and their carers on a range of issues and in a number of national forums, including the PMHA.

Mental Health Reform

We know that mental health is a sophisticated, comprehensive and resource intensive area of service provision within the Australian health care system.

We want to see it fully funded across the entire service continuum to enable the delivery of comprehensive, integrated and coordinated mental health services for all Australians who may develop an acute or chronic mental illness at any stage of their life.

Access should be equal and supported by consumer and carer participation with a focus on recovery. It should be evidence–based and underpinned by sound research.

We believe the system must be accountable and seek to continuously improve itself through transparent reporting and independent evaluation.

Reforming the system to meet the needs of consumers and their carers is not any easy task, but we are showing that consumers and carers can make a real difference.

BPD Campaign

In 2010–11, for example, we initiated a substantive lobbying campaign to address the issue of Borderline Personality Disorder (BPD) that resulted in the following positive outcomes.

- A *Borderline Personality Disorder Expert Reference Group (BPDERG)* has been established and Ms McMahon has been appointed to represent the Network on the BPDERG. The first meeting of the BPDERG was held on 9 December 2010 and the next meeting is scheduled for 9 March 2011.
- DoHA has supported an undertaking for the National Institute of Clinical Studies (NICS) and the National Health and Medical Research Council (NHMRC) to develop a Clinical Practice Guideline for the management of BPD. The Network Chair was recently appointed to the NHMRC BPD Clinical Guideline Development Committee.
- An anonymous survey will be undertaken by the Network of consumers who have the diagnosis of BPD and their carers to determine issues around access, gaps, barriers and strengths of the Australian mental health system both public and private, together with the role that GPs play. DoHA has provided funding to enable the Network to prepare a brief report and advice for the BPDERG, based on the responses received, and through them, the new Commonwealth Minister for Mental Health, The Hon. Mark Butler MP.

The Network is currently establishing an informal consumer and carer group of interested consumers and carers who suffer from BPD.

Further information on our activities and details on how to join the Network are on our website at:

www.pmhccn.com.au

Janne is the Independent Chair of the Network.

PSYCHOGENOMICS

Dr Bill Pring

Recent advances in neuroscience, particularly in the areas of genetics and molecular biology have led to significant progress in understanding psychiatric illness.

In 2010, I attended a course on psychogenomics at the Mayo Clinic in the United States. The course provided an insight into the direction of molecular biology in relation to mental health and for the whole of medicine.

Psychogenomics and mental health

At this stage, one of the most useful aspects of psychogenomics, which is not being used very widely in Australia or the rest of the world, is the capacity to determine the genetics of the liver enzymes that metabolise psychiatric medications.

Essentially, by defining the genetic processes that determine the enzymes in the liver, an approximation of the genetics of the individual can be made that provides some idea of what level a particular medication is likely to achieve in the bloodstream.

In Australia, there is one laboratory doing this work in Victoria, where they are testing for four enzymes in the liver. Once those four are known then the doctor can take this into account when prescribing medication, particularly in relation to how quickly a patient can metabolise certain medications.

There are also pharmacokinetic factors and pharmacodynamic factors that influence how quickly a medication is metabolised.

For each enzyme there are arbitrary categories that can predict whether someone is going to be one of the following types of metabolisers.

1. Poor

Poor metabolisers have serious difficulty in clearing medications and are, therefore, prone to side effects.

2. Intermediate

Intermediate Metabolisers fall between 1 and 3. They can become Poor Metabolisers for other drugs if they are on a medication that inhibits the metabolising enzyme.

3. Extensive

Extensive metabolisers are considered to be the normal state. These individuals can also have difficulties, however, in the presence of a strong enzyme inhibitor.

4. Ultra Rapid

Ultra rapid metabolisers, metabolise certain medication extremely quickly.

Case Study

The implications of this new form of testing and one particular but dramatic case, highlights the importance of this new technology.

The baby of a woman who was breast feeding failed to thrive. The mother had a chronic pain condition and was taking a prescription medication containing codeine.

The 2D6 gene converts codeine into a morphine metabolite, which is part of the main activity of codeine.

Even though a paediatrician felt the mother was doing everything correctly, the baby died and the coroner was investigating the mother for infanticide.

At the suggestion of her lawyers, the mother underwent genetic testing as was found to be an *Ultra Rapid Metaboliser*.

The mother's breast milk was then tested and found to be toxic with morphine metabolites in it.

The Future

Psychogenomics is an emerging technology that will help us to improve our capacity in the area of diagnosis, treatment and ultimately, prevention.

Bill represents the AMA on the PMHA.

BUDGET ROUND–UP

We have suspended our usual *Stakeholder Round–up* for this Edition to provide our readers with a brief snapshot of the key budget measures related to National Mental Health Reform (NMHR) that were recently announced by the Australian Government. The information detailed below has been compiled from the *2010-11 Australian Government Budget — Budget Paper No. 2.* The Commonwealth Budget Papers and Budget related information are available on the central Budget website at: www.budget.gov.au

Leadership in mental health reform

$64.1m over five years to continue national evaluation, accountability and reporting mechanisms in mental health. This continues the 2009–10 Budget measure *Leadership in mental health reform — continuation and further efficiency***.** This measure will continue 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. The Government will provide $56.8m over five years for the continuation of these activities with the remaining $7.3m redirected to the establishment of a National Mental Health Commission**.** The provision of the $64.1m over five years is already included in the forward estimates.

Better Access Initiative – rationalisation of allied health treatment sessions

The Government will revise the number of allied health treatment services available to patients under the Better Access initiative. Under the new arrangements, patients will be able to access up to six subsidised mental health services through the Medicare Benefits Schedule (MBS). An additional four MBS subsidised mental health services will be available to patients who require additional assistance. The 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.

Better Access Initiative — rationalisation of GP mental health services

The Government will introduce a two tiered rebate for Mental Health Treatment Plans delivered by General Practitioners (GPs) through the *Better Access to Psychiatrists, Psychologists and General Practitioners initiative* (Better Access) to adjust the level of rebate to better reflect the time taken to deliver the service. The revised rebates are modelled 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 rebates for GP Mental Health Treatment Plans will remain higher for those GPs who have completed Mental Health Skills Training. 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.

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

$549.8m over five years to develop a single assessment framework and provide better coordinated care for people with severe and persistent mental illness who have complex care needs. Care services will be coordinated through Medicare Locals and Non–Government Organisations. Under this measure, services for people who meet the assessment criteria will be provided, in consultation with the individual and their family, through a tailored multidisciplinary care plan. The 2010–11 Budget measure *National Health and Hospitals Network — Mental health — flexible care packages for patients with severe mental illnesses* will be expanded to provide additional services.

Early Psychosis Prevention and Intervention Centre (EPPIC) model — further expansion

$222.4m over five years to establish up to 12 additional EPPICs in partnership with states and territories, bringing the total number of centres to up to 16. EPPICs provide an integrated and comprehensive psychiatric service to help address the needs of people aged 15–24 with emerging psychotic disorders. Services provided include early intervention and clinical treatment.

National Mental Health Commission

$32.0m over five years to establish the Commission 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 the Commonwealth Department of Health and Ageing (DoHA), including the administering of the Annual National Report Card on Mental Health and Suicide Prevention, will be transferred to the Commission.

Mental health online portal

$14.4m over five years to help establish a single mental health online portal, to enable consumers to more easily identify and access services. The portal will also provide online training and support to GPs, Indigenous health workers and other clinicians delivering mental health services. The e–mental health portal will provide consumers with access to a suite of online assistance at a range of treatment levels. Health professionals will have access to information, training and resources that will assist them in delivering treatment and mental health services.

Expansion of Access to Allied Psychological Services

$205.9m over five years to expand funding for the Access to Allied Psychological Services program. The expansion, through Medicare Locals, will provide services to children and their families, Aboriginal and Torres Strait Islander people, and people from hard to reach locations with a particular focus on lower socioeconomic areas. Medicare Locals will coordinate services at a local level by integrating primary care services with other community based support for people with mental illness.

Medicare Locals will also receive funding 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.

Expansion of Support for Day–to–Day Living

$19.3m additional funding over five years to the existing *Support for Day to Day Living in the Community* program to support an estimated 3,650 additional people with severe and persistent mental illness per year. The *Support for Day to Day Living in the Community* program provides structured activities such as cooking, shopping and social outings where the individual can participate in social rehabilitation and gain independent living skills.

Expansion of youth mental health

$197.3m over five 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.

Health and wellbeing checks for three year olds

$11.0m over five 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. The program 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.

National Partnership Agreement on Mental Health

$201.3m over five years to provide incentives to states and territories to address major service gaps in their mental health services including accommodation, emergency departments and community–based crisis support. A National Partnership agreement will be negotiated with states and territories to improve access and quality of services for people with mental illnesses. The specific funding profile will be settled following these negotiations. States and territories will be able to access this funding pool through participation in a competitive process. The Government will also seek co–investments from states and territories to leverage greater investment in mental health.

Research funding

$26.2m over five years through the National Health and Medical Research Council (NHMRC) for mental health research priorities. A consultation process managed by the DoHA will establish priorities for mental health research funding. The research will be coordinated by the NHMRC, which will meet the costs from within its existing resourcing.

Additional Family Mental Health Support services

$61.0m over five 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.

Additional personal helpers and mentors and respite

$208.3m over five years to expand and integrate Personal Helpers and Mentors and respite services. This will 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. As part of this expansion, $50.0m 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.

Australian Early Development Index

$29.7m over five years to improve the Australian Early Development Index (AEDI) and ensure the ongoing collection of data every three years. The AEDI collects information on all children in the first year of school across five domains: physical health and wellbeing; social competence, emotional maturity; language and cognitive skills; and communication skills and general knowledge. This provides population level information on how children are faring before they start school. The dataset includes nationally comparable information on young children's mental health and social and emotional development for the benefit of families, communities and the Government.

Employment participation

$2.4m over five years to support increased economic and social participation by people with mental illness. This measure will provide assistance to employers to employ people with a mental illness and increase the capacity of employment services providers and the Department of Human Services by:

- providing training to employment services providers and Department of Human Services staff to enable them to better identify and assist people with mental illness to gain employment, and better connect them with the appropriate services, including community mental health services and Medicare Locals;
- expanding the Job Access telephone service to include mental health professionals; and
- reviewing the Supported Wage System (SWS) to analyse the effectiveness and appropriateness of applying the SWS to people with mental illness.

Social Engagement and Emotional Development survey for Children aged 8 to14 years

$1.5m over five years to develop a national *Social Engagement and Emotional Development* survey for children aged 8 to 14 years. The survey will focus on the social and emotional development of young people and the impact this has on their resilience and wellbeing. Up to 100 children in at least three states and territories would participate in the developmental stage of the survey. The survey will then be trialled with a representative sample of 5,500 school–going children across Australia in 2012.

Fact Sheet

We often hear it said that over 70% of people with a mental illness are now receiving their clinical treatment in the Australian private sector from private hospitals with psychiatric beds, private psychiatrists, clinical psychologists, general practitioners and other allied health professionals. This is a very important statistic for the private sector, but how is it derived?

In an attempt to answer that question, we approached several sources and it soon became apparent that a single agreed percentage is difficult to determine as they can vary depending on how they are derived. What can be determined is that the percentages derived using recent different data sources all fall somewhere between 65% to 75%.

The number of people with a mental illness receiving mental health treatment in Australia has most recently been addressed in the report titled, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative, Summative Evaluation, Final Report.* This evaluation was undertaken by the Centre for Health Policy Programs and Economics at Melbourne University.[1] Appendix 2 of the report, has a fairly detailed assessment of the Australian Government Department of Health and Ageing's estimate of the proportion of Australians with a mental disorder who received mental health care each year between 2006–07 and 2009–10. Some of the key statistics that appear in Appendix 2 are set out below in our usual Fact Sheet Table format.

Table 1: Estimated prevalence and number of persons with a mental disorder

Age Group	Prevalence	2006–07	2007–08	2008–09	2009–10
0–15	15.4%	674,141	681,546	690,366	697,657
16–64	22.2%	3,089,046	3,158,081	3,230,351	3,282,449
65–74	13.6%	197,087	202,750	210,740	219,523
75+	16.1%	210,359	214,342	218,280	223,092
Total	20.1%	4,170,634	4,256,720	4,349,738	4,422,721

Table 2: Estimated numbers of persons treated for a mental health problem

SERVICES	2006–07	2007–08	2008–09	2009–10
State and Territory MHS	300,108	299,530	308,722	312,689
MBS funded MHS - GP only	235,285	386,885	485,056	533,261
MBS funded services -other providers +/- GP	413,990	620,519	740,455	833,519
DVA mental health care	63,415	60,815	58,151	55,628
MBS funded GP services not billed as mental health items	373,518	222,816	188,100	123,240
Other health services	170,996	174,526	178,339	181,332
Total	1,557,313	1,765,091	1,958,824	2,039,668

Table 3: Estimated percentages of Australians with a mental disorder in the past year who received mental health treatment in that year.

SERVICES	2006–07	2007–08	2008–09	2009–10
State and Territory MHS	7.2%	7.0%	7.1%	7.1%
MBS funded MHS - GP only	5.6%	9.1%	11.2%	12.1%
MBS funded services -other providers +/- GP	9.9%	14.6%	17.0%	18.8%
DVA mental health care	1.5%	1.4%	1.3%	1.3%
MBS funded GP services not billed as mental health items	9.0%	5.2%	4.3%	2.8%
Other health services	4.1%	4.1%	4.1%	4.1%
Total	37.3%	41.5%	45.0%	46.1%

Appendix 2 of the Evaluation Report makes it clear that: *People treated in psychiatric units of private hospitals number (around 24,000 pa) were not included because it was assumed that almost all would already be included in the MBS data among people seen by Consultant Psychiatrists.*[2]

Summing the MBS rows of Table 2 and dividing that by the Total row from the same Table, gives a figure just above 70%.

There is also the data emerging from the Council of Australian Governments (COAG) Reform Council report, *National Healthcare Agreement (NHA): Baseline performance report for 2008–09*, Performance Indicator 21 – *Treatment rate for mental illness* (NHA PI#21),[3] and the *COAG National Action Plan on Mental Health 2006–11*.[4]

A rough calculation suggests that the NHA PI#21 data would give a figure of 75% whilst the COAG data would give a figure of 68%.

So the statement that 70% of people with a mental illness now receive their clinical treatment in the Australian private sector is very reasonable.

1 Pirkis J, et.al. 2010, *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative, Summative Evaluation, Final Report*, Centre for Health Policy Programs and Economics, University of Melbourne, pp 51–60.

2 Ibid., p.54.

3 COAG Reform Council 2010, *National Healthcare Agreement: Baseline performance report for 2008–09*, COAG Reform Council, Sydney. pp. 109–113.

4 COAG National Action Plan on Mental Health 2006–11 Second Progress Report covering implementation to 2007–08, p.25.

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