



**Evaluation of the Better Access to Psychiatrists,
Psychologists and GPs through the Medicare Benefits
Schedule Initiative**

**Component A:
A study of consumers and their outcomes**

FINAL REPORT

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Executive summary

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative is successfully responding to low treatment rates for common mental disorders and improving outcomes for people with such disorders. Better Access consumers are not presenting with mild complaints. More than 90% have diagnoses of depression and/or anxiety (compared with 13% of the general population). More than 80% are experiencing high or very high levels of psychological distress (compared with 10% of the general population). The initiative is not just bolstering mental health care for those who were already using services. Around half of all Better Access consumers have no previous history of mental health care. Better Access consumers respond well to the care they receive through the initiative. Not only are they extremely satisfied with the skills of the providers they see and the quality of the treatment they are offered, but they also make statistically significant and clinically meaningful gains when assessed by standardised mental health outcome measures. Many report that their symptoms reduce, their psychological distress diminishes, and their overall wellbeing improves. Providers who are delivering services under Better Access are appreciative of the opportunities it affords for themselves and the consumers who seek care from them.

Background

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) was introduced in November 2006 in response to low treatment rates for common mental disorders. Its ultimate aim is to improve outcomes for people with such disorders by encouraging a multi-disciplinary approach to their care. Its key feature is a series of new item numbers which have been added to the Medicare Benefits Schedule (MBS) to provide a rebate for selected services provided by GPs, psychiatrists, psychologists, social workers and occupational therapists.

In 2009, the Commonwealth Department of Health and Ageing commissioned an evaluation of the Better Access initiative, and appointed a Project Steering Committee to provide advice to the evaluation. The Centre for Health Policy, Programs and Economics (CHPPE) at the University of Melbourne was contracted to undertake several components of the evaluation. The first of these, Component A, was designed to profile the consumers who had received Better Access services from clinical psychologists, registered psychologists, GPs and psychiatrists, and examine the outcomes of their care. A secondary aim of Component A was to examine the experiences of providers who delivered Better Access care, and the experiences of consumers who received it.

Method

We approached a stratified random sample of providers who had billed for at least 100 occasions of service under the Better Access item numbers in 2008 (509 clinical psychologists, 640 registered psychologists, 1,280 GPs and 203 psychiatrists) and invited them to participate. Those who agreed were asked to approach their next 20 consecutive English-speaking consumers with a view to recruiting 5-10.

Data collection began on 1 October 2009 and continued for 13 months. Seven types of data were collected from consumers and providers over this period. The first four were collected via a password-protected, secure, web-based minimum dataset, and the next three were collected via telephone interviews or surveys with consumers and providers.

Data collection via the minimum dataset

Four types of data were collected via the minimum dataset:

1. Provider-level data (demographic, professional): These data were collected from providers when they enrolled in the project at the beginning of the 13-month data collection period and included demographic details, professional qualification(s), year of most recent qualification, mental disorders treated etc.
2. Consumer-level data (socio-demographic, clinical): These data were collected from consumers by providers when they began treatment (i.e., at their first session) and included demographic details, socio-economic indicators (e.g., postcode, health care card status) and clinical information (e.g., diagnoses, previous psychiatric service use).
3. Consumer-level (outcomes): These data involved the use of two standardised outcome measures, namely the Depression Anxiety Stress Scales (DASS-21)¹ (used with consumers recruited by clinical and registered psychologists) and the Kessler-10 (K-10)² (used with consumers recruited by all providers). Data from these instruments were collected from consumers by providers when they began treatment (i.e., at their first session) and end treatment (i.e., at their final session, or in the final month of the data collection period, whichever came first).
4. Session-level data: These data were collected at each session and included detail on the duration of the session, the assessment(s) and intervention(s) that were provided during its course, the item number billed, and whether the session attracted a co-payment.

Logistically, data entry into the minimum dataset worked in the following way. The minimum dataset contained linked provider, consumer and session modules, each of which took the form of a screen that showed the relevant questions and provided check boxes which could be automatically ticked as appropriate. Once they were recruited into the study and had consented, providers were given access to the web-based minimum dataset, via a user name and password. They were then able to enter data into it from their own computers. They were asked to enter the above provider-level data into the minimum dataset, and then begin the process of recruiting their 5-10 new English-speaking consumers. Once the consumers were recruited, providers collected the relevant consumer-level data for them at the required points in time. In most cases, this involved asking consumers to complete a paper-based version of the particular instrument. Providers then took the completed paper-based forms from consumers, and entered the relevant data into the minimum dataset. For example, in the case of the consumer-level outcome data, consumers were given paper-based versions of the instruments and asked to complete them before they left. Once they returned these, providers entered the data into the web-based minimum dataset. Providers differed in how they chose to do this – some encouraged consumers to complete the instruments during the session, whereas others asked them to complete them in the waiting room once the session was over. The consumer-based clinical data was not elicited from consumers, but relied on judgements made by providers. Similarly, the session-based data did not require input from consumers, and was generated by providers. These data were entered by providers into the minimum dataset in the same way as data elicited directly from consumers.

Data collection via interviews/surveys with consumers and providers

In addition to the primary data that were collected via the minimum dataset, data were collected via brief (15 minute) telephone interviews or surveys with consumers and providers conducted at the end of their participation in the study. Both were initially asked to complete the interview

but those who were not able to do this were offered the survey option. Both methods elicited data via the same set of questions. The following three types of data were sought through the questions in the interviews/surveys:

1. Consumer-level data (experiences with receiving care through Better Access).
2. Consumer-level data (any change in health and wellbeing attributable to Better Access): This was ascertained by a question which required them to indicate whether their health and wellbeing had changed during the course of their care, and, if so, whether they attributed the change to the care they received.
3. Provider-level data (experiences with providing care under Better Access).

Members of the study team conducted the interviews and sent out the surveys. Consumer interviews/surveys were conducted in a staggered fashion, within one month of the last session being provided to a given consumer or in the last month of data collection, whichever came first; provider interviews/surveys were conducted in a block, towards the end of the 13-month data collection period. All consumers for whom data existed on the minimum dataset and all providers who had recruited consumers were invited to complete the interview/survey.

Key findings

In total, 41 clinical psychologists recruited 289 consumers, 49 registered psychologists recruited 317 consumers, 39 GPs recruited 277 consumers, and three psychiatrists recruited 23 consumers. Because of the low response rates for psychiatrists and the consumers recruited by them, these groups were excluded from the evaluation. Key findings as they relate to the remaining groups are presented below.

Characteristics of Better Access consumers

Medicare data show that two thirds of Better Access consumers are female, and that three quarters are aged below fifty. Location-wise, around three quarters reside in metropolitan areas, and about half live in areas that make up the two quintiles of least disadvantage. Our consumer samples were broadly representative of all Better Access consumers, although our sampling strategy resulted in some over-representation by consumers in rural areas and consumers in areas of relatively greater disadvantage.

Notwithstanding these relatively minor discrepancies, our study provides the first clinical profiles of Better Access consumers that are based on systematically-collected data. Data collected via our minimum dataset suggest that Better Access consumers are not “the worried well”. The vast majority (over 90%) of our participating consumers had diagnoses of depression and/or anxiety (with or without co-morbid conditions), and many (over 80%) had high or very high levels of psychological distress. Our data also refutes the suggestion that many Better Access consumers are people who were already “in the system” – around half of our consumers had no previous history of mental health care.

Outcomes of Better Access care for consumers

Participating consumers who received care from clinical psychologists, registered psychologists and GPs under Better Access shifted from having high or very high levels of psychological distress to having much more moderate levels of psychological distress (as assessed by the K-10). Consumers who received care from clinical psychologists and registered psychologists also showed shifts from moderate or severe levels of depression, anxiety and stress to having normal

or mild levels of these conditions (as assessed by the DASS-21). These consumers clearly achieved positive outcomes, as assessed by these standardised measures. These outcomes were not only statistically significant; they were clinically meaningful too.

In the main, socio-demographic factors did not appear to have a major influence on outcomes; equivalent outcomes were achieved irrespective of whether the consumer was male or female, young or old, or wealthy or struggling financially. Instead, clinical and treatment variables were generally the ones that made a difference. For consumers recruited by all three types of providers, those with worst baseline manifestations of psychological distress (i.e., higher pre-treatment K-10 scores) made the greatest gains. For consumers recruited by clinical psychologists, no other variables were predictive of outcomes. For consumers recruited by registered psychologists, those who had completed treatment or were still in treatment experienced greater gains than those for whom treatment was incomplete, and those in metropolitan areas showed lesser improvement than their rural counterparts. For consumers recruited by GPs, those who had six sessions of care experienced optimal outcomes, and those who had no previous history of mental health care showed greater levels of improvement than those who had received mental health care in the past.

Consumers' experiences with receiving care through Better Access

Participating consumers were extremely positive about Better Access, and their reports were consistent with the above findings with respect to their characteristics and outcomes. They provided corroboration for the suggestion that, as a group, Better Access consumers have significant mental health problems and are experiencing high levels of psychological distress; the most common triggers to their seeking care were a deterioration in their mental health and wellbeing observed by themselves or others, and specific traumatic events. Their subjective reports of improvement provided further evidence that Better Access is achieving positive consumer outcomes; the majority indicated that they had experienced significant changes for the better in terms of their mental health and their ability to cope with stressful situations, and that often this had gone hand-in-hand with rejuvenated outlook and/or improved life circumstances. They commonly spoke of improvements in their mental health, discussing reductions in symptoms and commenting on the strategies they had learnt to modify maladaptive thought patterns and change negative behaviours. The majority attributed these changes, at least in part, to the care they had received through Better Access.

Many consumers had experienced hurdles to accessing mental health care in the past – often related to cost – and they appreciated the fact that Better Access had made mental health care more readily available. They experienced extremely high levels of satisfaction with the care they received from the various providers. They appreciated the professional skills and competencies of these providers, often commenting on their ability to establish rapport, their communication skills, their listening abilities, their kindness, their empathy and their non-judgemental approach. Consumers also expressed satisfaction with the advice, strategies and guidance that they received from these providers. In addition to being positive about the clinical care offered by the Better Access providers, most consumers indicated that they found the process of dealing with Medicare very straightforward.

Relatively speaking, consumers had few complaints about Better Access. Those who did identify negative aspects tended to focus on the restricted number of sessions, or on residual difficulties with out-of-pocket payments. Some also found the process of “opening up” about their mental health issues quite confronting.

Providers' experiences with delivering care through Better Access

Participating clinical psychologists, registered psychologists and GPs were extremely positive about the Better Access initiative. Again, many of their views tallied with the evidence provided above with respect to the profiles of and outcomes for consumers. Many commented that they are now providing mental health care to a greater number of people, and that their caseloads include proportionally more people who have complex needs, are on low incomes, and would not have been able to access mental health care in the past. Many also mentioned that they are now in a better position to meet these consumers' needs because they can provide timely, comprehensive and integrated care. They perceived this to have direct benefits for consumers in terms of improved access and affordability of care, and, consequentially, improvements in their mental health status, understanding of mental health symptoms and how to manage them, and relapse prevention.

Participating providers were also positive about the processes associated with Better Access. In particular, they noted that the Better Access model of service delivery, which relies on psychologists and GPs collaborating with each other, has generally worked well. Each party has developed an increased appreciation of the role of the other in providing mental health care. The reporting requirements of Better Access have improved the two-way communication between these providers. In the main, these providers have had positive experiences with dealing with Medicare.

Participating providers reported few negative impacts of Better Access. Sometimes communication has been sub-optimal; psychologists have not always received adequate referral information from GPs, and GPs have sometimes felt that they do not get sufficient feedback from psychologists about consumers' progress. Some psychologists and GPs have experienced administrative issues, such as difficulties with the interface between their own local systems and the Medicare system. Some GPs sought greater clarity around the "rules" of Better Access, and some psychologists questioned some of its restrictions on the number of sessions and forms of therapy that they could provide. Some psychologists were critical of the fact that GPs acted as the "gatekeeper" to their care. Some psychologists also commented on the level of the rebate, calling for it to be brought in line with the Australian Psychological Society's recommended rate. Some registered psychologists questioned the level of reimbursement for their services, arguing that they should receive the same payments as clinical psychologists.

Conclusion

The findings suggest that Better Access is playing an important part in meeting the community's previously unmet need for mental health care. The initiative has improved access to services for consumers who have clinically-diagnosable disorders and are experiencing considerable psychological distress. These consumers' mental health status improves markedly during the course of their care; their symptoms reduce, their psychological distress diminishes, and their overall wellbeing improves. They are extremely positive about Better Access, appreciating the fact that it enables them to receive free or low-cost services from specialised providers. The providers are also positive, enjoying the role they are playing in facilitating access to quality care.

Chapter 1: Background

The Better Access initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative is one of 18 Australian Government initiatives introduced under the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011.

Better Access was introduced in response to low treatment rates for mental disorders, and its ultimate aim is to improve outcomes for people with such disorders by encouraging a multi-disciplinary approach to their mental health care. Underpinning this aim are the following objectives:

- Encouraging more GPs to participate in early intervention, assessment and management of patients with mental disorders and streamlining access to appropriate psychological interventions in primary care;
- Encouraging private psychiatrists to see more new patients;
- Providing referral pathways for appropriate treatment of patients with mental disorders, including by psychiatrists, GPs, clinical psychologists, registered psychologists and other appropriately trained allied mental health professionals; and
- Supporting GPs and primary care service providers with education and training to better diagnose and treat mental illness.

Better Access takes the form of a series of new item numbers which have been added to the Medicare Benefits Schedule (MBS), supported by a range of education and training activities for relevant providers. The specific MBS items numbers include:

- **GP items numbers:** These reimburse GPs for preparing (2710 and 2702^a) and reviewing mental health treatment plans (2712) and providing mental health care consultations (2713);
- **Psychiatrist items numbers:** These reimburse psychiatrists for conducting an initial consultation with a new patient in their consulting rooms, in a hospital or at the patient's home (296, 297 and 299, respectively), for providing and reviewing a patient assessment and management plan (291 and 293, respectively); and
- **Allied health professional item numbers:** These reimburse clinical psychologists for delivering psychological therapy (80000, 80005, 80010, 80015 and 80020), registered psychologists for providing focused psychological strategies (80100, 80105, 80110, 80115 and 80120), selected occupational therapists for providing focused psychological strategies (80125, 80130, 80135, 80140 and 80145) and selected social workers for providing focused psychological strategies (80150, 80155, 80160, 80165 and 80170).

^a 2702 was introduced later than the other item numbers, in January 2010. It enables GPs who have not completed accredited mental health skills training to prepare a mental health treatment plan. It attracts a lower rebate than 2710, which is only available for use by GPs who have completed accredited mental health skills training.

Evaluation of the Better Access initiative

An evaluation framework was developed at the commencement of the Better Access initiative to guide the evaluation of the initiative. In 2009, the Department of Health and Ageing commissioned an evaluation of the Better Access initiative and appointed a Project Steering Committee to provide advice to the evaluation. The objective of the evaluation was to assess the overall appropriateness, effectiveness and impact of the initiative, specifically addressing the following evaluation questions:

- To what extent has the Better Access initiative achieved its objectives?
- To what extent has the Better Access initiative been an effective response to the need for primary mental health care for people with high prevalence mental disorders?

The evaluation framework included six original components (A-F), and a seventh (A.2) was subsequently added. These components were as follows:

- **Component A:** A study of consumers and their outcomes;
- **Component A.2:** A study of consumers and their outcomes (focusing on the occupational therapy and social work sectors);
- **Component B:** Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) administrative data;
- **Component C:** An analysis of allied mental health workforce supply and distribution;
- **Component D:** Stakeholder consultations;
- **Component E:** Evaluation of main education and training projects; and
- **Component F:** An analysis of the second National Survey of Mental Health and Wellbeing (NSMHWB), completed in 2007

The Centre for Health Policy, Programs and Economics was contracted to undertake Component A, which was designed to profile the consumers who had received Better Access services from clinical psychologists, registered psychologists, GPs and psychiatrists, and examine the outcomes of their care. Our team employed a novel methodology under which participating psychologists, GPs and psychiatrists recruited consumers when they first presented for services provided via the item numbers. We collected socio-demographic, clinical and treatment data relating to these consumers during the course of their care, via a purpose-designed minimum dataset. We also collected outcome data (based on assessments with standardised outcome measures) via the minimum dataset. We also conducted interviews/surveys with consumers and providers to explore their experiences with receiving and delivering care through Better Access, respectively.

The current report

Chapter 2 of the current report provides an overview of the methodological approach we took to the evaluation. Chapter 3 describes the various study samples. Chapter 4 profiles Better Access consumers in terms of their clinical and treatment characteristics. Chapter 5 presents data on the outcomes of Better Access care for consumers. Chapter 6 describes consumers' experiences with receiving care through Better Access, and Chapter 7 describes providers' experiences with delivering this care. Chapter 8 provides a discussion of these findings in the context of what they mean for the Better Access initiative.

Chapter 2: Overview of methodological approach

Recruitment of providers and consumers

Our original aim was to recruit eighty psychologists, 160 GPs and 40 psychiatrists into the study, each of whom would recruit 5-10 English-speaking consumers.

The Medical Benefits Division of the Department of Health and Ageing acted as an intermediary in the recruitment of psychologists, psychiatrists and GPs, identifying the potential pool of providers through their use of the relevant Medicare item numbers. Random samples of clinical psychologists (n=509), registered psychologists (n=640), GPs (n=1,280) and psychiatrists (n=203) were selected from listings of those who billed for at least 100 occasions of service under the Better Access item numbers in 2008. These random samples were stratified by urbanicity/rurality, in order to address a request from the Department of Health and Ageing that we over-sample rural providers. The Medical Benefits Division provided us with contact details for these providers, and we sent them letters of invitation, plain language statements and consent forms. We subsequently conducted a second mail-out, in order to maximise our response rate. Providers who agreed to participate returned signed consent forms to the study team, and were enrolled in the project.

Participating providers acted as intermediaries and were asked to approach their first 20 consecutive new English-speaking consumers when they first presented for services partially or fully funded through the MBS item numbers. Consumers who agreed to be part of the project were asked to sign a consent form which indicated that they agreed to their contact details being made available to us, as well as data on the nature and outcomes of their care. Consumers returned the consent form to providers who then forwarded them to our study team. This method ensured that only the names and contact details of consumers who agreed to participate were made known to us.

Data collection

The data collection period began on 1 October 2009. Originally, the data collection period was to have ended on 30 September 2010, but we revised this to 31 October 2010. This decision was made to maximise the numbers of participating consumers by extending the window for recruitment. Effectively, the decision extended the data collection period from 12 months to 13 months, and recognised that the first month was something of a “settling in” period where recruitment was relatively slow.

Seven main types of data were collected from consumers and providers over the 13-month data collection period, most via a password-protected, secure, web-based minimum dataset and some via telephone interviews or surveys.

Data collection via the minimum dataset

Four types of data were collected via the minimum dataset:

1. Provider-level data (demographic, professional): These data were collected from providers when they enrolled in the project at the beginning of the 13-month data collection period and included demographic details, professional qualification(s), year of most recent qualification, mental disorders treated etc.

2. Consumer-level data (socio-demographic, clinical): These data were collected from consumers when they began treatment (i.e., at their first session) and included demographic details, socio-economic indicators (e.g., postcode, health care card status) and clinical information (e.g., diagnoses, previous psychiatric service use).
3. Consumer-level (outcomes): These data involved the use of two standardised outcome measures, namely the Depression Anxiety Stress Scales (DASS-21)² (used with consumers recruited by clinical and registered psychologists) and the Kessler-10 (K-10)² (used with consumers recruited by all providers). These instruments are described in Table 1, and full versions of each are provided in Appendices 1 and 2. Data from these instruments were collected from consumers when they began treatment (i.e., at their first session) and end treatment (i.e., at their final session, or in the final month of the data collection period, whichever came first).
4. Session-level data: These data were collected at each session and included detail on the duration of the session, the assessment(s) and intervention(s) that were provided during its course, the item number billed, and whether the session attracted a co-payment.

Logistically, data entry into the minimum dataset worked in the following way. The minimum dataset contained linked provider, consumer and session modules, each of which took the form of a screen that showed the relevant questions and provided check boxes which could be automatically ticked as appropriate. Once they were recruited into the study and had consented, providers were given access to the web-based minimum dataset, via a user name and password. They were then able to enter data into it from their own computers. They were asked to enter the above provider-level data into the minimum dataset, and then begin the process of recruiting their 5-10 new English-speaking consumers. Once the consumers were recruited, providers collected the relevant consumer-level data for them at the required points in time. In most cases, this involved asking consumers to complete a paper-based version of the particular instrument. Providers then took the completed paper-based forms from consumers, and entered the relevant data into the minimum dataset. For example, in the case of the consumer-level outcome data, consumers were given paper-based versions of the instruments and asked to complete them before they left. Once they returned these, providers entered the data into the web-based minimum dataset. Providers differed in how they chose to do this – some encouraged consumers to complete the instruments during the session, whereas others ask them to complete them in the waiting room once the session was over. The consumer-based clinical data was not elicited from consumers, but relied on judgements made by providers. Similarly, the session-based data did not require input from consumers, and was generated by providers. These data were entered by providers into the minimum dataset in the same way as data elicited directly from consumers.

Table 1: Summary of outcome measures used in the evaluation

Instrument	Description	Scoring	Use in evaluation
<p>Depression Anxiety Stress Scales (DASS-21)¹</p>	<p>Consumer-rated measure consisting of three sub-scales designed to measure depression, anxiety and stress, respectively. Each sub-scale consists of seven items, each of which consists of a statement relating to a symptom of depression, anxiety or stress. The consumer is asked to consider how much each statement applied to him or her in the past week.</p>	<p>Each item is scored from 0 (“Did not apply to me at all”) to 3 (“Applied to me very much, or most of the time”). The raw sub-scale score on the DASS-21 ranges from 0 to 21 and is then doubled so that it ranges from 0 to 42.</p> <p>Recommended cut-off scores for conventional severity labels (normal, mild, moderate, severe) are as follows:</p> <ul style="list-style-type: none"> • Depression: 0-9 (Normal); 10-13 (Mild); 14-20 (Moderate); 21-27 (Severe); ≥28 (Extremely severe); • Anxiety: 0-7 (Normal); 8-9 (Mild); 10-14 (Moderate); 15-19 (Severe); ≥20 (Extremely severe); and • Stress: 0-14 (Normal); 15-18 (Mild); 19-25 (Moderate); 26-33 (Severe); ≥37 (Extremely severe). <p>A positive difference between pre- and post-treatment scores on the DASS-21 indicates improvement.</p>	<p>Used to assess pre- and post- treatment levels of depression, anxiety and stress for consumers recruited by:</p> <ul style="list-style-type: none"> • Clinical psychologists; and • Registered psychologists.
<p>Kessler-10 (K-10)²</p>	<p>Consumer-rated measure developed to assess non-specific psychological distress. Comprises 10 items which ask the consumer about symptoms of depression and anxiety in the past four weeks.</p>	<p>Each item is rated from 1 (“None of the time”) to 5 (“All of the time”), resulting in a total score that ranges from 10 to 50.</p> <p>Standard cut-off scores for levels of psychological distress are as follows: 10-15 (Low); 16-21 (Moderate); 22-29 (High); ≥30 (Very high).</p> <p>A positive difference between pre- and post-treatment scores indicates improvement.</p>	<p>Used to assess pre- and post- treatment levels of psychological distress for consumers recruited by:</p> <ul style="list-style-type: none"> • Clinical psychologists; • Registered psychologists; and • GPs.

Data collection via interviews/surveys with consumers and providers

In addition to the primary data that were collected via the minimum dataset, data were collected via brief (15 minute) telephone interviews or surveys with consumers and providers conducted at the end of their participation in the study. Both were initially asked to complete the interview but those who were not able to do this were offered the survey option. Both methods elicited data via the same set of questions (see Appendices 3 and 4). The following three types of data were sought through the questions in the interviews/surveys:

1. Consumer-level data (experiences with receiving care through Better Access).
2. Consumer-level data (any change in health and wellbeing attributable to Better Access): This was ascertained by a question which required them to indicate whether their health and wellbeing had changed during the course of their care, and, if so, whether they attributed the change to the care they received.
3. Provider-level data (experiences with providing care under Better Access).

Members of the study team conducted the interviews and sent out the surveys. Consumer interviews/surveys were conducted in a staggered fashion, within one month of the last session being provided to a given consumer or in the last month of data collection, whichever came first; provider interviews/surveys were conducted in a block, towards the end of the 13-month data collection period. All consumers for whom data existed on the minimum dataset and all providers who had recruited consumers were invited to complete the interview/survey.

Data analysis

Quantitative data from outcome measures

We used paired t-tests to examine the difference between mean pre- and post-treatment scores on the K-10 and the DASS-21, excluding consumers who did not have a “matched pair” of pre- and post-treatment scores. We then conducted linear regression analyses using scores on the K-10 as the outcome of interest, and a range of socio-demographic, clinical and treatment variables as covariates. We selected the K-10 for this analysis because it was available for consumers from all providers groups, whereas the DASS-21 was only available for consumers who had been recruited by clinical and registered psychologists. Because outcomes for consumers recruited by the same provider were likely to be correlated, variance was calculated using cluster-robust standard errors. Pre-treatment scores were included as a covariate. The effect of categorical predictors was assessed using the joint Wald test.

Qualitative data from the interviews/surveys

Coding templates or “code books” were developed to summarise and organise salient themes as they emerged from the data. Separate code books were developed to manage the providers’ responses and the consumers’ responses. In each case, the process began with the identification of some broad, apriori themes. Responses to each question were read and re-read with these themes in mind, and segments of text were coded as belonging to these themes. During this process, additional broad themes were identified and portions of text were coded as being relevant to these new themes. Once the final set of broad themes was settled upon, the text relating to each theme was re-examined and narrower themes were identified and coded. The complete set of broad and narrow themes then formed the final code book that was applied

across all relevant responses. This process was iterative, and each set of responses was read a number of times.

Wherever possible, an attempt was made to quantify the qualitative responses once they had been coded into broad and narrow themes. There is debate among qualitative researchers about whether such quantification is appropriate. Those who are opposed to this approach argue that it is contrary to the purpose of qualitative research, which is to elicit a range of views on a given issue rather than to gauge the representativeness of these views. Those who favour this approach argue that, in the right circumstances, quantifying qualitative responses can increase the objectivity and replicability of a given study, and can strengthen the potential for generalising its findings if the sampling strategy permits this. In the current evaluation, quantifying the qualitative responses was considered justified on the grounds that the thematic coding categories were systematically generated using the code books described above, and the sampling strategy did not involve purposive selection.

Chapter 3: Study samples

Providers

Recruitment and retention of providers

In total, 299 providers were recruited into the study. By the end of the data collection period, 69 of these had withdrawn, citing the following reasons: “unforeseen circumstances”, “recruitment difficulties”, “time consuming”, “labour intensive”, “closing down practice”, “moving practice”, “only sees children”, “too busy”, “going overseas”, “family member ill”, “own illness”, “audited by Medicare”, “too complicated”, “can’t provide service under Medicare”, “no Medicare referrals”, “unhappy with Medicare or the Australian Psychological Society”, “does not use the relevant Medicare item numbers”, and “not interested”. A further 98 did not actively withdraw, but did not actually recruit any consumers and did not participate in the interview/survey. The final total of participating providers was therefore 132 (41 clinical psychologists, 49 registered psychologists, 39 GPs and three psychiatrists).

Table 2 shows the approached, recruited, retained, and participating samples of providers. Taking the participating providers as the numerator and the approached providers as the denominator, the overall response rate was 5% (8% for clinical psychologists, 8% for registered psychologists, 3% for GPs and 1% for psychiatrists).

Table 2 also shows our original targets (based on sample size calculations performed using data from our evaluation of the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program) and modified targets based on discussions with the Project Steering Committee and the Department of Health and Ageing. This table shows that our participant numbers met the original and revised targets with respect to clinical and registered psychologists, and almost met the original target (but not the revised target) with respect to GPs. Despite our best efforts, the response from psychiatrists was disappointing. Overall, we met our original target (but not the revised target) in terms of all providers.

Table 2: Actual and target samples of providers

	Approached	Recruited	Retained (i.e., did not actively withdraw)	Participated	Original target	Revised target
Clinical psychologists	509	77	57	41	20	40
Registered psychologists	640	81	73	49	20	40
GPs	1,280	125	90	39	40	160
Psychiatrists	203	16	10	3	40	40
Total	2,632	299	230	132	120	280

Nature of participation in the evaluation by providers

Because of the low response rate for psychiatrists, this group was excluded from the evaluation. The nature of participation of the remaining groups of providers is summarised in Table 3. Almost all participating providers recruited consumers and entered data into the minimum dataset – 40 clinical psychologists, 48 registered psychologists 39 and GPs. The vast majority also participated in the interview/survey about their experiences with delivering care through Better Access – 39 clinical psychologists, 45 registered psychologists and 32 GPs.

Table 3: Nature of participation in the evaluation by providers

	Recruited consumers and entered data into minimum dataset	Provided views on delivering care through Better Access		
		Took part in interview ¹	Completed survey ¹	Total
Clinical psychologists (n=41)	40	39	0	39
Registered psychologists (n=49)	48	44	1	45
GPs (n=39)	39	31	1	32
Total (n=129)	127	114	2	116

1. The questions in the interview and the survey were the same.

Representativeness of provider samples

Tables 4, 5 and 6 profile the participating clinical psychologists, registered psychologists and GPs in terms of their demographic and professional details, and their delivery of care through Better Access. Comparisons are made with the overall random sample of providers from which these providers were recruited (i.e., all clinical psychologists, registered psychologists and GPs who provided services through Better Access between 1 January and 31 December 2008).

Participating providers were broadly similar to the random samples of providers who were invited to take part in terms of their demographic and professional characteristics, with some exceptions. The participating clinical psychologists and registered psychologists were similar to the groups from which they were drawn in terms of gender, with two thirds being female. Nearly two thirds of the participating GPs were also female, but only about one third of the random sample of GPs were. Around 80% of all participating clinical psychologists, registered psychologists and GPs were accounted for by those aged between 35 and 64; the same was true for the random samples from which these groups came. The majority (around 80%) of both groups of participating psychologists had qualified after 1990, and a similar proportion of participating GPs had done so after 1980. These figures corresponded with the overall random samples.

Participating clinical psychologists shared a similar activity profile with the broader group from which they came; on average, they had provided a similar number of Better Access sessions and seen a similar number of consumers in 2008. Participating registered psychologists and participating GPs had typically provided a slightly higher number of sessions and seen a slightly higher number of consumers than the groups from which they came.

Table 4: Profiles of clinical psychologists providing care through Better Access

		Participating clinical psychologists ¹ (n=41) ²		Random sample of all clinical psychologists ¹ (n=509) ²	
		Freq	%	Freq	%
Gender	Male	13	32%	143	28%
	Female	28	68%	366	72%
Age	<25	0	0%	0	0%
	25-34	4	10%	78	15%
	35-44	9	22%	139	27%
	45-54	15	37%	156	31%
	55-64	9	22%	108	21%
	>64	4	10%	28	6%
Year of qualification	Pre-1960	0	0%	0	0%
	1960-1969	0	0%	6	1%
	1970-1979	5	12%	48	9%
	1980-1989	7	17%	95	19%
	1990-1999	15	37%	175	34%
	2000-2009	14	34%	185	36%
		Median	Range	Median	Range
No. of Better Access sessions provided from 1 Jan to 31 Dec 2008		410.0	112-1,886	408.5	101-2,505
No. of consumers seen via Better Access from 1 Jan to 31 Dec 2008		89.0	23-383	81.0	9-482

1. Providing care through Better Access from 1 Jan to 31 Dec 2008.
2. Cells do not always sum to the total n due to some missing data.

Table 5: Profiles of registered psychologists providing care through Better Access

		Participating registered psychologists ¹ (n=49) ²		Random sample of all registered psychologists ¹ (n=640) ²	
		Freq	%	Freq	%
Gender	Male	15	31%	184	29%
	Female	34	69%	455	71%
Age	<25	0	0%	2	0%
	25-34	2	4%	108	17%
	35-44	9	18%	141	22%
	45-54	12	24%	177	28%
	55-64	19	39%	166	26%
	>64	7	14%	46	7%
Year of qualification	Pre-1960	1	2%	1	0%
	1960-1969	3	6%	13	2%
	1970-1979	6	12%	48	8%
	1980-1989	6	12%	97	15%
	1990-1999	25	51%	251	39%
	2000-2009	8	16%	230	36%
		Median	Range	Median	Range
No. of Better Access sessions provided from 1 Jan to 31 Dec 2008		332.0	110-1,910	294.0	100-2,805
No. of consumers seen via Better Access from 1 Jan to 31 Dec 2008		74.0	22-372	64.0	10-552

1. Providing care through Better Access from 1 Jan to 31 Dec 2008.
2. Cells do not always sum to the total n due to some missing data.

Table 6: Profiles of GPs providing care through Better Access

		Participating GPs ¹ (n=39) ²		Random sample of all GPs ¹ (n=1,280) ²	
		Freq	%	Freq	%
Gender	Male	16	41%	776	61%
	Female	23	59%	504	39%
Age	<25	0	0%	0	0%
	25-34	3	8%	121	10%
	35-44	12	31%	392	31%
	45-54	18	46%	524	41%
	55-64	5	13%	214	17%
	>64	1	3%	20	2%
Year of qualification	Pre-1960	0	0%	1	0%
	1960-1969	1	3%	35	3%
	1970-1979	5	13%	252	20%
	1980-1989	18	46%	519	41%
	1990-1999	14	36%	364	28%
	2000-2009	1	3%	109	9%
		Median	Range	Median	Range
No. of Better Access sessions provided from 1 Jan to 31 Dec 2008		184.0	100-891	163.0	100-3,028
No. of consumers seen via Better Access from 1 Jan to 31 Dec 2008		113.0	50-279	102.0	15-692

1. Providing care through Better Access from 1 Jan to 31 Dec 2008.
2. Cells do not always sum to the total n due to some missing data.

Consumers

Recruitment and retention of consumers

By the end of the data collection period, 906 consumers had been recruited into the study (289 by clinical psychologists, 317 by registered psychologists, 277 by GPs and 23 by psychiatrists). Recruitment, retention and participation were more synonymous for consumers than they were for providers, in the sense that all recruited consumers had data entered into the minimum dataset. Table 7 shows the recruited samples of consumers, and compares them with the original and revised target samples. This table shows that we met the original and revised targets with respect to clinical and registered psychologists, and met the original target (but not the revised target) with respect to GPs. Again, we had difficulty with the numbers of consumers recruited by psychiatrists. Overall, we met our original target (but not the revised target) in terms of all consumers.

Table 7: Actual and target samples of consumers

	Recruited, retained and participated	Original target	Revised target
Recruited by clinical psychologists	289	100-200	200-400
Recruited by registered psychologists	317	100-200	200-400
Recruited by GPs	277	200-400	800-1,600
Recruited by psychiatrists	23	200-400	200-400
Total	906	600-1,200	1,400-2,800

Nature of participation in the evaluation by consumers

Because of the low response rates for consumers recruited by psychiatrists, this group was excluded from the evaluation. The nature of participation of the remaining groups of consumers is summarised in Table 8 and described in more detail below.

Table 8: Nature of participation in the evaluation by consumers

	Had relevant socio-demographic, clinical and treatment data entered into minimum dataset	Had pre- and post-treatment outcome data entered into minimum dataset	Provided views on receiving care through Better Access		
			Took part in interview ¹	Completed survey ¹	Total
Recruited by clinical psychologists (n=289)	289	205	112	21	133
Recruited by registered psychologists (n=317)	317	208	136	16	152
Recruited by GPs (n=277)	277	177	104	17	121
Total (n=883)	883	590	352	54	406

1. The questions in the interview and the survey were the same.

All participating consumers who were recruited by clinical psychologists (n=289), registered psychologists (n=317) and GPs (n=277) consented to have relevant socio-demographic, clinical and treatment information entered into the minimum dataset.

Ideally, all participating consumers should have had pre- and post-treatment outcome data, but this was not ultimately the case. As noted in Chapter 2, we asked providers to collect outcome data from consumers when they began treatment (i.e., at their first session) and end treatment (i.e., at their final session, or in the final month of the data collection period, whichever came first). Pre-treatment outcome data were collected to a high level of completion. Post-treatment outcome data were relatively comprehensively collected when the consumer finished treatment, but when treatment was ongoing beyond the study period the collection rate was poorer. In total, we had pre- and post-treatment pairs of outcome data for 590 consumers (205 recruited by clinical psychologists, 208 recruited by registered psychologists, and 177 recruited by GPs).

All participating consumers were invited to participate in the interview/survey about their experiences with receiving care through Better Access, and 406 did so (133 recruited by clinical psychologists, 152 recruited by registered psychologists and 121 recruited by GPs).

Representativeness of consumer samples

Tables 9, 10 and 11 provide a breakdown of the key socio-demographic characteristics of all participating consumers and consumers for whom outcome data were available, and compares them with the overall group of Better Access consumers seen by the relevant groups of providers from 1 January 2009 to 31 December 2009. It should be noted that this time frame differs from the period in which participating consumers received care from Better Access (1 October 2009 to 31 October 2010), but was chosen as the closest full one-year period for which Medicare data were readily available.

Participating consumers who were recruited by clinical psychologists, registered psychologists and GPs, and the sub-samples for whom outcome data were available, were broadly similar to all consumers who received Better Access care from these providers in terms of their age and gender. In each case, about two thirds were female, and three quarters were accounted for by the youngest three age groupings.

Consumers from rural and remote areas were somewhat over-represented among our participating consumers (and the sub-samples for whom outcome data were available) according to the Rural, Remote and Metropolitan Areas (RRMA) system; more than half of our consumers fell into these groups, whereas around one quarter of all consumers did so. Consumers from relatively more socio-economically disadvantaged areas were also somewhat over-represented in our samples and sub-samples; three fifths or more resided in areas deemed to be in the

bottom three Index of Relative Socio-Economic Disadvantage (IRSED) quintiles, whereas less than half of the total consumer populations did so. The over-representation of rural consumers can be explained by our sampling strategy, which deliberately over-sampled rural providers (and, consequently, rural consumers). This is likely to have also had some bearing on our over-representation of consumers from socio-economically disadvantaged areas, although it would not completely explain it.

Table 9: Socio-demographic profiles of consumers seen by clinical psychologists through Better Access

		Participating consumers ¹ (n=289) ³		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=205) ³		All consumers ² (n=100,434) ³	
		Freq	%	Freq	%	Freq	%
Gender	Male	101	35%	74	36%	69,254	37%
	Female	188	65%	131	64%	120,164	63%
Age	<30	68	24%	45	22%	672,36	35%
	30-39	68	24%	52	25%	43,092	23%
	40-49	66	23%	45	22%	37,392	20%
	50-59	51	18%	40	20%	26,095	14%
	60-69	24	8%	15	7%	11,530	6%
	>69	11	4%	7	3%	4,073	2%
Region⁴	Metropolitan	145	50%	108	53%	157,569	83%
	Rural	126	44%	91	44%	30,929	16%
	Remote	18	6%	6	3%	916	0%
Socio-economic disadvantage⁵	Quintile 5 (Least)	70	24%	51	25%	67,343	36%
	Quintile 4	56	19%	44	21%	41,567	22%
	Quintile 3	97	34%	71	35%	35,733	19%
	Quintile 2	38	13%	23	11%	23,903	13%
	Quintile 1 (Most)	27	9%	16	8%	18,346	10%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010
2. Received care through Better Access between 1 Jan 2009 and 31 Dec 2009
3. Cells do not always sum to the total n due to some missing data.
4. Region based on RRMA classification.
5. Socio-economic disadvantage based on IRSED classification.

Table 10: Socio-demographic profiles of consumers seen by registered psychologists through Better Access

		Participating consumers ¹ (n=317) ³		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=208) ³		All consumers ² (n=348,417) ³	
		Freq	%	Freq	%	Freq	%
Gender	Male	90	28%	55	26%	124,498	36%
	Female	226	72%	153	74%	223,919	64%
Age	<30	58	19%	24	12%	117,374	34%
	30-39	67	21%	48	23%	79,070	23%
	40-49	81	26%	54	26%	71,964	21%
	50-59	68	22%	52	25%	49,607	14%
	60-69	32	10%	23	11%	22,470	6%
	>69	7	2%	5	2%	7,932	2%
Region⁴	Metropolitan	127	40%	87	42%	260,651	75%
	Rural	177	56%	110	53%	85,561	25%
	Remote	12	4%	10	5%	2,203	1%
Socio-economic disadvantage⁵	Quintile 5 (Least)	69	22%	53	26%	93,188	27%
	Quintile 4	59	19%	42	20%	80,727	23%
	Quintile 3	106	34%	68	33%	69,447	20%
	Quintile 2	58	18%	32	16%	58,931	17%
	Quintile 1 (Most)	22	7%	11	5%	42,897	12%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010
2. Received care through Better Access between 1 Jan 2009 and 31 Dec 2009
3. Cells do not always sum to the total n due to some missing data.
4. Region based on RRMA classification.
5. Socio-economic disadvantage based on IRSED classification.

Table 11: Socio-demographic profiles of consumers seen by GPs through Better Access

		Participating consumers ¹ (n=277) ³		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=177) ³		All consumers ² (n=971,836) ³	
		Freq	%	Freq	%	Freq	%
Gender	Male	81	30%	53	30%	351,621	36%
	Female	193	70%	123	70%	620,215	64%
Age	<30	53	19%	30	17%	308,421	32%
	30-39	57	21%	29	17%	216,330	22%
	40-49	71	26%	44	25%	195,278	20%
	50-59	55	20%	41	23%	139,853	14%
	60-69	31	11%	25	14%	71,977	7%
	>69	8	3%	6	3%	39,977	4%
Region⁴	Metropolitan	138	50%	88	50%	717,817	74%
	Rural	137	50%	88	50%	243,158	25%
	Remote	0	0%	0	0%	10,853	1%
Socio-economic disadvantage⁵	Quintile 5 (Least)	30	11%	25	14%	247,452	26%
	Quintile 4	80	29%	52	30%	211,256	22%
	Quintile 3	75	27%	42	24%	199,709	21%
	Quintile 2	70	26%	42	24%	172,162	18%
	Quintile 1 (Most)	19	7%	14	8%	130,682	14%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010
2. Received care through Better Access between 1 Jan 2009 and 31 Dec 2009
3. Cells do not always sum to the total n due to some missing data.
4. Region based on RRMA classification.
5. Socio-economic disadvantage based on IRSED classification.

Chapter 4: Clinical and treatment characteristics of Better Access consumers

Until now, it has not been possible to accurately profile consumers who use Better Access services in terms of their clinical characteristics and the nature of treatment they receive. Basic socio-demographic details (namely those described in Chapter 3) are routinely collected by Medicare Australia, as are details of the number of sessions of care provided. However, it is beyond the capacity of Medicare Australia's systems to collect consumer-level data on variables like diagnosis, severity of symptoms, and specific treatment received.

Our minimum dataset was purpose designed to collect key information about the clinical and treatment characteristics of Better Access consumers. The remainder of this chapter presents this information for the full groups of consumers who participated in the evaluation and for the sub-samples for whom outcome data were available. Having established in the previous chapter that our samples were broadly representative of all Better Access users, we would suggest that these profiles can be cautiously generalised.

Clinical characteristics

Tables 12, 13 and 14 outline the clinical characteristics of participating consumers. They consider diagnosis, level of psychological distress (as assessed by the K-10), and previous history of mental health care.

Diagnosis was classified hierarchically,^b with greatest emphasis given to depression and anxiety on the grounds that these are the two disorders that are primarily targeted by Better Access. Around three quarters of the consumers recruited by each type of provider had depression with or without anxiety (and with or without other diagnoses), and about another one fifth had anxiety without depression (with or without other diagnoses). The sub-groups for whom pre- and post-treatment outcome data were available shared these diagnostic profiles. Just over one tenth of the general population meet diagnostic criteria for these disorders in any given year.³

Four fifths of participating consumers recruited by each type of provider were experiencing high or very high levels of psychological distress (as assessed by the K-10) when they presented for care. The sub-groups for whom pre- and post-treatment outcome data were available also demonstrated this pattern. Less than one tenth of the general population experience these levels of psychological distress.⁴

Only two fifths of participating consumers who were recruited by clinical and registered psychologists had previously received mental health care; slightly more (three fifths) of those who were recruited by GPs had done so. These patterns held for the respective sub-groups of consumers for whom outcome data were available.

^b The hierarchy worked in the following way. Consumers with depression and anxiety were classified as having both disorders, irrespective of whether they had additional diagnoses (i.e., alcohol and drug use disorders, psychotic disorders, unexplained somatic disorders, and/or other disorders). Consumers with depression but not anxiety were classified as having depression, irrespective of whether they had any of the previously-mentioned additional diagnoses. Consumers with anxiety but not depression were classified as having anxiety, irrespective of whether they had any of the additional diagnoses. Consumers without depression or anxiety were classified as having other disorders, as were those with unknown or missing diagnoses.

Table 12: Clinical profiles of consumers seen by clinical psychologists through Better Access

		Participating consumers ¹ (n=289) ²		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=205) ²	
		Freq	%	Freq	%
Diagnosis	Depression and anxiety ³	99	34%	69	34%
	Depression without anxiety ³	105	36%	71	35%
	Anxiety without depression ³	66	23%	51	25%
	Other ⁴	19	7%	14	7%
Pre-treatment K-10 score	10-15 (Low psychological distress)	13	5%	9	4%
	16-21 (Moderate psychological distress)	37	13%	28	14%
	22-29 (High psychological distress)	103	36%	78	38%
	≥30 (Very high psychological distress)	133	47%	89	44%
Previous history of mental health care	No previous history of mental health care	169	58%	128	62%
	Previous history of mental health care	109	38%	69	34%
	Unknown	11	4%	8	4%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Cells do not always sum to the total n due to some missing data.
3. With or without alcohol and drug use disorders, psychotic disorders, and/or unexplained somatic disorders.
4. Alcohol and drug use disorders, psychotic disorders, unexplained somatic disorders, and/or unknown or missing diagnoses.

Table 13: Clinical profiles of consumers seen by registered psychologists through Better Access

		Participating consumers ¹ (n=317) ²		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=208) ²	
		Freq	%	Freq	%
Diagnosis	Depression and anxiety ³	121	38%	76	37%
	Depression without anxiety ³	117	37%	77	37%
	Anxiety without depression ³	60	19%	40	19%
	Other ⁴	19	6%	15	7%
Pre-treatment K-10 score	10-15 (Low psychological distress)	8	3%	5	3%
	16-21 (Moderate psychological distress)	43	14%	27	14%
	22-29 (High psychological distress)	93	31%	62	31%
	≥30 (Very high psychological distress)	159	53%	105	53%
Previous history of mental health care	No previous history of mental health care	162	51%	107	51%
	Previous history of mental health care	134	42%	90	43%
	Unknown	21	7%	11	5%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Cells do not always sum to the total n due to some missing data.
3. With or without alcohol and drug use disorders, psychotic disorders, and/or unexplained somatic disorders.
4. Alcohol and drug use disorders, psychotic disorders, unexplained somatic disorders, and/or unknown or missing diagnoses.

Table 14: Clinical profiles of consumers seen by GPs through Better Access

		Participating consumers ¹ (n=277) ²		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=177) ²	
		Freq	%	Freq	%
Diagnosis	Depression and anxiety ³	113	41%	81	46%
	Depression without anxiety ³	102	37%	52	29%
	Anxiety without depression ³	38	14%	28	16%
	Other ⁴	24	9%	16	9%
Pre-treatment K-10 score	10-15 (Low psychological distress)	8	3%	5	3%
	16-21 (Moderate psychological distress)	26	10%	19	11%
	22-29 (High psychological distress)	81	30%	50	28%
	≥30 (Very high psychological distress)	158	58%	103	58%
Previous history of mental health care	No previous history of mental health care	117	42%	72	41%
	Previous history of mental health care	156	56%	101	57%
	Unknown	4	1%	4	2%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Cells do not always sum to the total n due to some missing data.
3. With or without alcohol and drug use disorders, psychotic disorders, and/or unexplained somatic disorders.
4. Alcohol and drug use disorders, psychotic disorders, unexplained somatic disorders, and/or unknown or missing diagnoses.

Treatment characteristics

Tables 15, 16 and 17 describe the treatment profile of participating consumers. They consider the number of sessions of care received, the kind of treatment offered in those sessions, whether treatment was completed, and whether a co-payment was made.

Participating consumers who were recruited by clinical psychologists and registered psychologists received a median of five sessions of care; those who were recruited by GPs received a median of two sessions. Around one fifth of participating consumers recruited by each provider group had not completed treatment (with the remainder either having done so or still receiving care). The sub-samples of consumers for whom outcome data were available had slightly higher median numbers of sessions (six for those recruited by the two groups of psychologists and three for those recruited by GPs), and were more likely to have completed treatment. This was a function of the time frame of the study. Inevitably, some consumers were recruited who did not complete their recommended number of sessions of care. Although we requested that post-treatment outcome data be collected for all consumers at the completion of treatment or the end of the study period, whichever came first, providers were more likely to record post-treatment outcome data for those who had completed treatment. This introduced a bias whereby those for whom outcome data were collected were more likely to have had close to the recommended number of sessions.

The vast majority of participating consumers received cognitive behavioural therapy (CBT) in at least one session, irrespective of the type of provider who recruited them. This was also true for the sub-groups of consumers for whom outcome data were available.

Around two thirds of participating consumers paid a co-payment in at least one session. Again, this pattern held for the sub-groups of consumers for whom outcome data were available.

Table 15: Treatment profiles of consumers seen by clinical psychologists through Better Access

		Participating consumers ¹ (n=289) ²		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=205) ²	
		Freq	%	Freq	%
Number of sessions	1	20	7%	0	0%
	2-3	65	22%	37	18%
	4-5	66	23%	44	21%
	6	65	22%	57	28%
	7-12	57	20%	52	25%
	13-18	13	4%	12	6%
	>18	3	1%	3	1%
	(Median)	(5)		(6)	
Treatment completion	Treatment incomplete	47	16%	10	5%
	Treatment completed or ongoing	242	84%	195	95%
Treatment received	Received CBT in at least one session ⁵	251	87%	190	93%
	Received no CBT in any session ⁶	38	13%	15	7%
Copayment	Paid co-payment in at least one session	198	69%	145	71%
	Did not pay co-payment in any session	91	31%	60	29%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010
2. Cells do not always sum to the total n due to some missing data.
3. Includes behavioural interventions and/or cognitive interventions, with or without diagnostic assessment, psycho-education, relaxation strategies, skills training and/or interpersonal therapy.
4. Excludes behavioural interventions and/or cognitive interventions, and includes diagnostic assessment, psycho-education, relaxation strategies, skills training and/or interpersonal therapy.

Table 16: Treatment profiles of consumers seen by registered psychologists through Better Access

		Participating consumers ¹ (n=317) ²		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=208) ²	
		Freq	%	Freq	%
Number of sessions	1	23	7%	2	1%
	2-3	78	25%	36	17%
	4-5	82	26%	63	30%
	6	63	20%	49	24%
	7-12	55	17%	44	21%
	13-18	14	4%	13	6%
	>18	1	0%	1	0%
	(Median)	(5)		(6)	
Treatment completion	Treatment incomplete	59	19%	23	11%
	Treatment completed or ongoing	258	81%	185	89%
Treatment received	Received CBT in at least one session ³	286	90%	194	93%
	Received no CBT in any session ⁴	31	10%	14	7%
Copayment	Paid co-payment in at least one session	206	65%	138	66%
	Did not pay co-payment in any session	111	35%	70	34%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010
2. Cells do not always sum to the total n due to some missing data.
3. Includes behavioural interventions and/or cognitive interventions, with or without diagnostic assessment, psycho-education, relaxation strategies, skills training and/or interpersonal therapy.
4. Excludes behavioural interventions and/or cognitive interventions, and includes diagnostic assessment, psycho-education, relaxation strategies, skills training and/or interpersonal therapy.

Table 17: Treatment profiles of consumers seen by GPs through Better Access

		Participating consumers ¹ (n=277) ²		Participating consumers for whom pre-and post-treatment outcome data were available ¹ (n=177) ²	
		Freq	%	Freq	%
Number of sessions	1	59	21%	0	0%
	2-3	161	58%	125	71%
	4-5	47	17%	43	24%
	6	6	2%	5	3%
	7-12	4	1%	4	2%
	13-18	0	0%	0	0%
	>18	0	0%	0	0%
	(Median)	(2)		(3)	
Treatment completion	Treatment incomplete	69	25%	38	21%
	Treatment completed or ongoing	208	75%	139	79%
Treatment received	Received CBT in at least one session ³	199	72%	142	80%
	Received no CBT in any session ⁴	78	28%	35	20%
Copayment	Paid co-payment in at least one session	153	55%	113	64%
	Did not pay co-payment in any session	124	45%	64	36%

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010
2. Cells do not always sum to the total n due to some missing data.
3. Includes behavioural interventions and/or cognitive interventions, with or without diagnostic assessment, psycho-education, relaxation strategies, skills training and/or interpersonal therapy.
4. Excludes behavioural interventions and/or cognitive interventions, and includes diagnostic assessment, psycho-education, relaxation strategies, skills training and/or interpersonal therapy.

Chapter 5: Outcomes of Better Access care for consumers

Changes on outcome measures from pre- to post-treatment

Tables 18, 19 and 20 present outcome data for participating consumers who were recruited by clinical psychologists, registered psychologists and GPs, respectively. We used paired t-tests to examine the difference between mean pre- and post-treatment scores on the range of outcome measures, excluding consumers who did not have a “matched pair” of pre- and post-treatment scores.

Table 18: Outcome data for consumers seen by clinical psychologists through Better Access

	Participating consumers for whom pre-and post-treatment outcome data were available ¹			
	Pre-treatment mean (s.d.)	Post-treatment mean (s.d.)	Mean difference (s.d.)	P-value
K-10 (n=193)	28.63 (7.57)	19.09 (6.96)	9.53 (7.84)	0.000
DASS_Depression (n=205)	21.02 (11.00)	9.66 (9.63)	11.37 (10.92)	0.000
DASS_Anxiety (n=205)	14.75 (9.44)	7.58 (7.32)	7.17 (8.73)	0.000
DASS_Stress (n=205)	22.85 (8.58)	12.93 (8.48)	9.93 (9.50)	0.000

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010

Table 19: Outcome data for consumers seen by registered psychologists through Better Access

	Participating consumers for whom pre-and post-treatment outcome data were available ¹			
	Pre-treatment mean (s.d.)	Post-treatment mean (s.d.)	Mean difference (s.d.)	P-value
K-10 (n=192)	29.44 (7.33)	18.86 (7.13)	10.58 (8.83)	0.000
DASS_Depression (n=204)	20.41 (10.58)	8.96 (8.99)	11.46 (11.43)	0.000
DASS_Anxiety (n=204)	15.34 (9.59)	6.55 (7.01)	8.78 (10.09)	0.000
DASS_Stress (n=204)	23.91 (9.41)	12.22(9.28)	11.69 (11.01)	0.000

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010

Table 20: Outcome data for consumers seen by GPs through Better Access

	Participating consumers for whom pre-and post-treatment outcome data were available ¹			
	Pre-treatment mean (s.d.)	Post-treatment mean (s.d.)	Mean difference (s.d.)	P-value
K-10 (n=177)	30.89 (7.94)	22.88 (8.54)	8.01 (8.72)	0.000

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010

Consumers who were recruited by all three types of provider shifted from having high or very high levels of psychological distress to having much more moderate levels of psychological distress (as assessed by the K-10). Consumers who were recruited by clinical psychologists and registered psychologists shifted from having moderate or severe levels of depression, anxiety and stress to having normal or mild levels of these conditions (as assessed by the DASS-21).

These outcomes are of a similar level of magnitude to those experienced by consumers who receive care from psychologists through the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program,⁵ and to those experienced by consumers who receive care through virtual clinic operated by the Clinical Research Unit for Anxiety and Depression (CRUfAD).⁶ They also correspond with the sorts of effects seen by major primary mental health care programs overseas, like the Improving Access to Psychological Therapies initiative in the United Kingdom.⁷

As an aside, it is worth considering differences in scores on the K-10 and the DASS-21, both of which were completed by consumers who saw clinical psychologists and registered psychologists. In each case, pre-treatment scores on the K-10 put these consumers in the “high” range, whereas pre-treatment scores on the DASS-21 put them in the “moderate” range. Similarly, post-treatment scores on the K-10 placed them in the “moderate” range, whereas post-treatment scores on the DASS-21 placed them in the “normal” range. The strong likelihood is that the instruments are measuring different, though related constructs. The K-10 assesses non-specific psychological distress, whereas the DASS-21 assesses symptoms of depression, anxiety and stress. Support for this contention comes from the results of a separate analysis we conducted which combined data from consumers recruited by clinical and registered psychologists, and examined correlations between the K-10 and the sub-scales of the DASS-21 taken at the same point in time. The correlations between the K-10 and each of the DASS-21 subscales were around 0.6-0.8 and statistically significant, both at pre-treatment and at post-treatment. These findings are consistent with a separate analysis we conducted of 805 consumers who received care from psychologists through the ATAPS program.⁸ They are also consistent with pooled analyses from three randomised controlled trials conducted at the Clinical Research Unit for Anxiety and Depression (CRUFAD) which included 283 consumers.⁹

Predictors of improvement on outcome measures

We conducted three linear regression analyses (one for consumers recruited by each of the three provider groups) using scores on the K-10 outcome of interest. The full range of socio-demographic, clinical and treatment variables described in Chapter 4 were used as covariates; pre-treatment scores were also included as a co-variate. Tables 21, 22 and 23 show the results for consumers recruited by clinical psychologists, registered psychologists and GPs, respectively.

Those with comparatively higher pre-treatment K-10 scores (i.e., worse baseline manifestations of psychological distress) demonstrated greater levels of improvement than those with lower pre-treatment scores. For consumers recruited by clinical psychologists, improvements rose at a rate of 0.58 points per each additional one-point increase on the pre-treatment score. For consumers recruited by registered psychologists and GPs, the equivalent figures were 0.81 and 0.53, respectively. In other words, for all three groups of consumers, those with worse baseline manifestations of psychological distress demonstrated greater levels of improvement than those with lower pre-treatment scores. This finding is consistent with a recent study by Prytys et al¹⁰ which found that those who were above clinical cut-offs on given measures of depression benefited more from CBT workshops than those who scored below this threshold at presentation. Our finding is at odds, however, with a review by Hamilton and Dobson¹¹ which found that, on balance, individuals with more extreme symptoms of depression appeared to be less responsive to CBT. One explanation for the pattern we observed may be that those with higher original scores may have greater opportunities to improve before they hit a “floor” score. Another explanation may be that, arguably, they have more “invested” in treatment.

For consumers recruited by clinical psychologists, no other factors were predictive of levels of gain in K-10 scores.

For consumers recruited by registered psychologists, two other variables were significant predictors of outcome. The first of these was treatment completion was also a significant predictor; those who had completed treatment or were still in treatment experienced improvements 5.98 points higher than those for whom treatment was incomplete. This is perhaps not surprising given that, according to the interviews/surveys, those who dropped out of treatment prematurely did so because they felt it was not doing them any good or because they did not have a sufficiently good rapport with the therapist.

The second significant variable for consumers who were recruited by registered psychologists was region. Those who were in metropolitan areas showed lesser improvement than their rural counterparts, on average gaining 2.44 points less. This finding is difficult to interpret and requires further exploration.

For consumers who were recruited by GPs, two additional variables were associated with positive outcomes. The first was the number of sessions of care received. Six sessions were optimal; lesser improvements were achieved when the consumer had fewer sessions, and equivalent sessions were achieved when they had more sessions. This finding is difficult to interpret because these consumers may have seen the GP in isolation, or may have been referred to a psychologist or another allied health professional for additional sessions of psychological care. Therefore, the total number of sessions with the GP may not be representative of the total number of sessions of care they received.

The second important factor for consumers who were recruited by GPs was whether they had previously received mental health care. Those who had not received previous mental health care showed levels of improvement that were 3.77 points higher than those who had done so. One interpretation of this finding might be that a considerable proportion of those who are new to the system may have had difficulties accessing services in the past, and these people may be particularly likely to be compliant with treatment now that they have been given the opportunity to access care. A second interpretation might be that these people have less chronic conditions, and may therefore have less entrenched symptoms. A third and related interpretation might be that intervention is occurring earlier for these people.

Table 21: Coefficients and 95% confidence intervals predicting change in K-10 scores for consumers seen by clinical psychologists

Covariate		Coefficient (95% CI)	P-value
Gender	Male	1.00	0.704
	Female	-0.42 (-2.64-1.80)	
Age	<30	1.00	0.754
	30-49	0.96 (-1.63-3.55)	
	50-69	1.40 (-1.48-4.28)	
	>69	2.40 (-3.81-8.60)	
Region	Metropolitan	0.31 (-2.26-2.87)	0.810
	Rural	1.00	
Socio-economic disadvantage	Quintile 5 (Least)	-2.65 (-7.54-2.23)	0.400
	Quintile 4	0.19 (-4.55-4.92)	
	Quintile 3	-1.10 (-5.41-3.20)	
	Quintile 2	-2.70 (-7.75-2.34)	
	Quintile 1 (Most)	1.00	
Diagnosis	Depression and anxiety	4.37 (-0.18-8.92)	0.227
	Depression without anxiety	4.00 (0.01-7.99)	
	Anxiety without depression	2.90 (-1.70-7.49)	
	Other	1.00	
Previous history of mental health care	No previous history of mental health care	1.70 (-0.92-4.33)	0.360
	Previous history of mental health care	1.00	
	Unknown	-3.08 (-9.81-3.65)	
Number of sessions	1-3	1.20 (-1.98-4.39)	0.099
	4-5	2.35 (-0.64-5.33)	
	6	1.00	
	7-12	0.08 (-2.53-2.70)	
	13 or more	-2.92 (-6.58-0.73)	
Treatment received	Received CBT in at least one session ⁸	0.12 (-2.46-2.70)	0.926
	Received no CBT in any session ⁹	1.00	
Treatment completion	Treatment incomplete	1.00	0.067
	Treatment completed or ongoing	6.62 (-0.48-13.72)	
Copolyment	Paid co-payment in at least one session	0.39 (-2.02-2.79)	0.747
	Did not pay co-payment in any session	1.00	
Pre-treatment K-10 score		.58 (0.40-0.76)	0.000
Intercept		-18.10 (-29.25- -6.96)	0.002

Table 22: Coefficients and 95% confidence intervals predicting change in K-10 scores for consumers seen by registered psychologists

Covariate		Coefficient (95% CI)	P-value
Gender	Male	1.00	0.519
	Female	-0.56 (-2.28-1.17)	
Age	<30	1.00	0.498
	30-49	0.79 (-3.65-5.22)	
	50-69	2.07 (-1.91-6.06)	
	>69	1.04 (-3.82-5.92)	
Region	Metropolitan	-2.44 (-4.88- -0.01)	0.010
	Rural	1.00	
Socio-economic disadvantage	Quintile 5 (Least)	-2.00 (-5.55-1.56)	0.062
	Quintile 4	0.60 (-2.80-4.00)	
	Quintile 3	-1.99 (-5.63-1.64)	
	Quintile 2	-2.43 (-6.70-1.84)	
	Quintile 1 (Most)	1.00	
Diagnosis	Depression and anxiety	-1.70 (-4.42-1.02)	0.609
	Depression without anxiety	-0.99 (-3.79-1.81)	
	Anxiety without depression	-0.15 (-3.49-3.20)	
	Other	1.00	
Previous history of mental health care	No previous history of mental health care	2.64 (0.34-4.93)	0.667
	Previous history of mental health care	1.00	
	Unknown	-1.18 (-6.66-4.31)	
Number of sessions	1-3	1.03 (-2.31-4.38)	0.187
	4-5	-0.36 (-3.23-2.52)	
	6	1.00	
	7-12	1.13 (-2.25-4.50)	
	13 or more	3.86 (-0.02-7.75)	
Treatment received	Received CBT in at least one session	-0.24 (-4.29-3.82)	0.907
	Received no CBT in any session	1.00	
Treatment completion	Treatment incomplete	1.00	0.022
	Treatment completed or ongoing	5.98 (0.93-11.03)	
Copayment	Paid co-payment in at least one session	0.19 (-1.87-2.25)	0.853
	Did not pay co-payment in any session	1.00	
Pre-treatment K-10 score		0.81 (0.64-0.97)	0.000
Intercept		-17.56 (-27.43- -7.68)	0.001

Table 23: Coefficients and 95% confidence intervals predicting change in K-10 scores for consumers seen by GPs

Covariate		Coefficient (95% CI)	P-value
Gender	Male	1.00	0.938
	Female	0.10 (-2.59-2.79)	
Age	<30	1.00	0.520
	30-49	0.84 (-2.81-4.49)	
	50-69	2.27 (-1.23-5.77)	
	>69	2.86 (-2.49-8.22)	
Region ⁴	Metropolitan	0.67 (-2.85-4.19)	0.701
	Rural	1.00	
Socio-economic disadvantage ⁵	Quintile 5 (Least)	2.80 (-4.07-9.66)	0.596
	Quintile 4	3.91 (-2.80-10.61)	
	Quintile 3	0.92 (-6.05-7.89)	
	Quintile 2	2.00 (-5.05-9.05)	
	Quintile 1 (Most)	1.00	
Diagnosis	Depression and anxiety ⁶	1.17 (-2.90-5.25)	0.793
	Depression without anxiety ⁶	2.37 (-2.61-7.35)	
	Anxiety without depression ⁶	1.71 (-3.50-6.91)	
	Other ⁷	1.00	
Previous history of mental health care	No previous history of mental health care	3.77 (1.32-6.21)	0.017
	Previous history of mental health care	1.00	
	Unknown	7.79 (1.47-14.10)	
Number of sessions	1-3	-5.12 (-7.58- -2.65)	0.000
	4-5	-3.89 (-7.50- -0.29)	
	6	1.00	
	7-12	-1.35 (-9.72-7.03)	
	13 or more	-	
Treatment received	Received CBT in at least one session ⁸	-0.44 (-3.34-2.46)	0.762
	Received no CBT in any session ⁹	1.00	
Treatment completion	Treatment incomplete	1.00	0.140
	Treatment completed or ongoing	2.72 (-0.94-6.38)	
Copolyment	Paid co-payment in at least one session	-1.56 (-4.09-0.97)	0.218
	Did not pay co-payment in any session	1.00	
Pre-treatment K-10 score		0.53 (0.36-0.71)	0.000
Intercept		-11.62 (-23.44-0.21)	0.054

Chapter 6: Consumers' experiences with receiving care through Better Access

As noted in Chapter 3, 133 consumers recruited by clinical psychologists contributed their views to the evaluation via interview/survey, as did 152 consumers recruited by registered psychologists and 121 consumers recruited by GPs.

It is worth noting here that although consumers recruited by all three provider groups were asked the same questions, there were some nuances in terms of the way they interpreted them. In particular, consumers who were recruited by clinical and registered psychologists interpreted the questions as being about the care they had received from these individual providers. Sometimes consumers who were recruited by GPs did this too, particularly in circumstances where the GP had been the sole provider of their mental health care. In other cases, however, consumers who were recruited by GPs tended to think more broadly about the package of care they had received, and often this included care from the GP and another Better Access provider (e.g., a clinical or registered psychologist, a social worker or an occupational therapist) to whom he or she had been referred by the GP.

Experiences of consumers who were recruited by clinical psychologists

Previous barriers to seeking mental health care

Consumers who were recruited by clinical psychologists were asked whether cost had acted as a barrier to their seeking mental health care in the past, and whether there had been any other barriers to their seeking care. Their responses are recorded in Table 24.

Table 24: Previous barriers to seeking care experienced by consumers who received Better Access services from clinical psychologists (n=133)*

	Freq	%
Costs	70	53%
Stigma	18	14%
Difficulty accessing services	17	13%
Not perceived as relevant	17	13%
Other/prior contact with mental health services	15	11%
Personal factors	12	9%
Limited knowledge of available services	9	7%
Didn't want medication	1	1%

* Multiple responses permitted

Over half of all consumers (70, or 53%) noted that cost had limited their access to mental health care in the past.

Stigma was the next most common obstacle mentioned by consumers. Eighteen consumers (14%) indicated that this had influenced their previous help-seeking behaviour. Some made general comments about stigma, and others talked of not wanting people they knew finding out about their seeking mental health care and the possible ramifications of this. Examples of these different sorts of comments include:

"Probably the social stigma more than anything else."

“Number one is the stigma attached to having psychological support or some kind of mental health issue.”

“I’m a long standing professional in my area and I didn’t want other professionals to know how I was feeling and that I needed support.”

Difficulties with accessing services were also mentioned relatively frequently (by 17 consumers, or 13%). These difficulties included problems with making a booking with some mental health professionals, and physically getting to services. Below is a sample of some of their responses:

“Transport to access services.”

“I work, full time work so it’s very difficult to get time, I have to make an appointment and not be at work and ask for time off to go and do that - I’m very reluctant to do so.”

“I have had to wait a long time to get an appointment after working hours.”

“Just getting an appointment with my psychologist was really difficult, because she was quite booked out.”

Another barrier mentioned by 17 consumers (13%) related to their own perceptions of their mental health problems. They indicated that they had not considered themselves to have a problem, or that their problem was not significant enough to warrant the intervention of a mental health care professional. They made comments like:

“I did not think that I needed to go.”

“I hadn’t seen anyone for years and years, but I’ve suffered depression.”

“I suppose not admitting that I needed help. Denial.”

“I suppose I just didn’t feel that I really needed it until my health became such an issue, and family members got involved in it.”

“I felt that I was going okay.”

Other less commonly mentioned barriers to prior mental health care utilisation included previous negative experiences with mental health services (mentioned by 15 consumers, or 11%), personal factors such as others discouraging them from seeking help and/or not feeling ready to seek help themselves (mentioned by 12, or 9%), limited knowledge of available services (mentioned by nine, or 7%), and not wanting to be prescribed medication (mentioned by one, or 1%).

Reasons for seeking care

Consumers were asked what prompted them to seek care from the clinical psychologist on this occasion. Their responses fell into the themes listed in Table 25.

Table 25: Reasons for consumers seeking care from a clinical psychologist on this occasion (n=133)*

	Freq	%
Referral by health professional	50	38%
Symptoms worsening	46	35%
Traumatic event	28	21%
Perceived need	25	19%
Encouragement by family/friends	20	15%
General health problems	10	8%
Addiction problems	1	1%

* Multiple responses permitted

Most commonly, consumers indicated that they had seen the clinical psychologist because they were referred by a GP. Fifty consumers (38%) responded in this way, making comments like:

"... I had tried medications, but as soon as I went off it everything came back, so I went to my GP and she suggested that it'd be a good idea to see a psychologist."

"A referral from a GP. He suggested that I see someone. He believed I was suffering depression and on top of that I went from depression to anxiety. I wouldn't have thought of seeing someone otherwise."

Consumers also frequently made reference to realising that that their symptoms were worsening or not remitting. Forty six consumers (35%) made remarks along these lines, including:

"Severely depressed and serious personal issues and I lost my job and stuff like that."

"I got to a stage where I got sick of everything and thought now it's actually time to get help."

"My life wasn't what I wanted it to be. I wasn't fulfilled or happy or thriving, as I wanted to be. I decided to get help and change."

"I'd been depressed for so long I had gotten into a pattern of negative thinking."

Approximately one in five consumers (28, or 21%) indicated that a stressful or traumatic life event (e.g., losing a job, death of someone close, relationship breakdown, adjustment after the birth of a child) had acted as a catalyst to their seeking help on this occasion. Some examples of consumers' responses are:

"...I had a friend die in front of me."

"My mother had a stroke and I had a bypass and I get very depressed."

"I was having some real issues in my marriage and I wasn't coping very well with it, so I just wanted an outsider to kind of mediate what was happening in my marriage at the time."

Another relatively common reason cited by consumers for seeking care was that they perceived a need to seek the advice of a professional or that they began to recognise their symptoms or need for treatment. Twenty five consumers (19%) made responses that fell into this category. For example, some made remarks such as:

"I just suddenly realised that there was so many issues affecting me from my whole life. It just suddenly hit me one day like a bolt from the blue. I suppose I always knew there were a lot of things that weren't great, but it just hit me like a ton of bricks one day from a small incident and from that everything came tumbling down."

"Recognising that I had some issues that I needed professional assistance in dealing with."

"Realising that I've got an anxiety problem I suppose."

"I just know enough to know that I needed some help with what was going on."

Twenty consumers (15%) made reference to the influence or involvement of family members or friends. They made comments like:

"A friend of mine went to see her for herself for another issue and we've spoken quite a lot ... She said 'I think she'd be someone you could approach and talk to and someone you can relate to and talk to about your issues'."

"I'm in a relationship so that was being affected and I was really pushed by my partner and his family."

Other less frequent responses related to health or addiction problems, cited by 10 consumers (8%) and one consumer (1%), respectively.

Sessions of care

Half of the 133 consumers recruited by clinical psychologists (67, or 50%) indicated that they had received treatment for the recommended number of sessions and/or experienced sufficient improvement to discontinue care, or were still receiving sessions of care. These consumers were positive about the quality and quantity of care they had received, as indicated by comments like:

"Because I was just feeling a lot better in myself, our sessions were, had sort of run their course I suppose, and the issue that I had has been dealt with."

"I was doing quite well and managing my depression or how I was feeling and coping with things, so she'd given me a number of tools and I felt quite safe to not have to rely on her to go back to her fortnightly."

"I went to all the sessions."

A minority of consumers had discontinued care before the recommended number of sessions because they did not find the treatment met their needs. Six (5%) commented that they found the costs prohibitive, six (5%) felt that the treatment was not having its desired effect, six (5%) were put off by the therapist's manner or approach, and five (4%) indicated that they had difficulties fitting the sessions in around competing commitments.

Process of seeking care through Medicare

Consumers were asked how they found the process of receiving psychological services that were refundable by Medicare. Table 26 shows that the vast majority of consumers were happy with the process.

Table 26: Experiences of the process of receiving care through Medicare (n=133)*

	Freq	%
Good due to the lowered costs, processes of claiming were good or easy, helpful bulk-billing or automatic system	64	48%
Generally good/easy/helpful	58	44%
Remaining costs, high gap payments, prefer more bulk-billing	5	4%
Processes not good: unclear process, took too long to obtain consultation or cancellation of consultation	4	3%

* Multiple responses permitted

Fifty eight (44%) reported that it was generally “good”, “easy” or “helpful”. Sixty four (48%) offered more direct observations about positive aspects of the system (e.g., lowered costs, ease of processing claims), making statements like:

“Really, it was fantastic. I am retired and don’t have that sort of money. It was fabulous to be able to have the help.”

“It has been very easy. Not having to worry about the financial aspect made it easier.”

“The refund was a huge benefit. I probably wouldn't have gone if there wasn't a refund.”

A small number of consumers contradicted the above view. Five (4%) felt that paying up-front was difficult and that the rebate was insufficient. Four (3%) indicated that there were logistical difficulties with claiming the rebate. Their concerns are summarised in the comments below:

“They were alright, only it was not enough of course. Not enough dollars, with the circumstances of being unemployed and not having any money and not being able to get to the doctor, and then when I did get into the doctor not having food and all the rest of it, just to allow for doctors appointments and that, well everything just compounded, it's purely a financial thing, because there's no bulk-billing doctors in this town.”

“She was fabulous, easy to talk to. My problem was I couldn't come up with \$140 on the day and even though I would get most of that back it was hard to come up with \$140 cash on the day.”

“I work 9am-5pm, so to claim I have to do it in my lunch hour.”

Positive aspects of clinical care

Overwhelmingly, consumers indicated that they were satisfied with the clinical care provided by their clinical psychologist. Table 27 describes particular elements of care that consumers liked.

Table 27: Positive aspects of care received (n=133)*

	Freq	%
Professional skills, qualities and competency of the provider (e.g., established rapport, non judgemental, good to talk to).	99	74%
Good, satisfied, received helpful or constructive advice or care (e.g., useful strategies or resources were provided)	52	39%
Did not impose financial burden	2	2%

* Multiple responses permitted

Most commonly, consumers were positive about the professional skills and competencies of the psychologist. Ninety nine (74%) commented on particular qualities, such as empathy and

kindness, a non-judgemental attitude, the ability to communicate well and establish rapport, and the ability to listen. Their viewpoints are exemplified in the following statements:

“I was able to speak to her clearly. I had a rapport with her.”

“She was easy to talk to, comforting, feeling.”

“She was very professional and experienced. Had good counselling skills.”

“She had very valuable listening skills and allowed me to talk about things that I thought were important, not things that she thought I should be talking about, and then giving me feedback about why I was feeling the way I was and how I could resolve that.”

“She has been amazing. She is very accessible. She cares and she calls me to check up when she sees that I am not particularly well which I haven't found with anyone else.”

Consumers also expressed satisfaction with the advice, strategies and guidance that they received from their clinical psychologist. Fifty two consumers (39%) made comments in this regard, including:

“The aspects that were good were identifying specific issues and working out ways to address them. It was very specific. It was almost like training for a job in some ways, for your personal life, and I found that really, really good.”

“I went to a psychologist and I did cognitive behavioural therapy and it was mainly just good because it's just teaching you really practical things. Really useful things.”

“There was a plan and process that you understand from the beginning and it felt like there was a beginning middle and end to it.”

Negative aspects of clinical care

Nearly half of all consumers (60, or 45%) could not cite any negative aspects of care. They made statements like:

“Nothing - I wish I could keep going.”

“I wouldn't say that anything was bad. My experience was a positive experience.”

A minority of consumers identified some negative aspects of care, and these are summarised in Table 28.

Table 28: Negative aspects of care received (n=133)*

	Freq	%
Uncomfortable talking about personal issues or other personal factors	16	12%
Not comfortable with the provider, no rapport, judgemental	13	10%
Took too long to see someone	12	9%
Uncertain about the value or usefulness of the treatment	7	5%
Difficulties with cost	5	4%
Stigma/privacy concerns	2	2%

* Multiple responses permitted

Most commonly, they talked about being uncomfortable discussing personal issues with the psychologist. Sixteen consumers (12%) mentioned this as a concern. Typically, they made comments like:

“Just emotional rawness.”

“In the beginning it was about talking about the trauma and reliving that was re-traumatizing.”

Thirteen consumers (10%) made reference to the fact that they felt uncomfortable with the psychologist, usually because they experienced a lack of understanding on the psychologist’s part. The following comment exemplifies this:

“I feel that she was trying to provide practical solutions to my problems but not really trying to work out emotionally what was going on for me.”

Twelve consumers (9%) felt disadvantaged by the time it took to see the psychologist, noting that:

“Availability was an issue.”

Other less common responses related to uncertainty about the value of treatment (mentioned by seven consumers, or 5%), difficulties with meeting the cost of care (mentioned by five, or 4%) and concerns about stigma and privacy (mentioned by two, or 2%).

Types of change

Consumers were asked whether their general wellbeing had shifted since seeing their psychologist. Nearly all consumers (124, or 93%) felt that there had been a change in their wellbeing. For most of these, the change was positive. Table 29 summarises the kinds of changes consumers observed.

Table 29: Types of positive change noticed (n=133)*

	Freq	%
Improvements in mental health (e.g., symptoms or feelings improved, have learnt strategies for managing)	59	44%
Generalised improvement	39	29%
Some improvements but underlying causes are still present	14	11%
Reduced unhealthy behaviours	5	4%
Return to work, coping better at work or seeking work	4	3%
Improvements in physical health/lifestyle/sleeping	4	3%

* Multiple responses permitted

Most commonly, consumers spoke of improvements in their mental health. Fifty nine (44%) discussed reductions in their symptoms, and commented on the strategies they had learnt to modify maladaptive thought patterns and change negative behaviours. They made comments like:

“Much better control of anxiety.”

“I saw her for problems with anxiety and she has given me tools to cope with that. I have seen a big difference with my state of mind and daily life.”

“She taught me to work through things. It put things into perspective.”

“She pointed out things that were going on in my thinking. The negative side of my thinking was pointed out to me and I thought, ‘Oh, okay, that is a different way of thinking about it.’ I have come out of it a lot more positive.”

“I dealt with my ability to manage anger.”

Many consumers (39, or 29%) also reflected on more general improvements (e.g., increased confidence, improved outlook on life, better attitudes). Their views are highlighted in the following comments:

“I think I've gotten better overall since going to see them.”

“A lot happier, more content, more appreciative of the little things. Not getting myself caught up in silly ideals.”

Fourteen consumers (11%) noted some improvements but still felt that they had unresolved mental health issues. They made comments like:

“I can be very up and down. However, I have found that it has been very helpful when I have been in the right headspace, and haven't been having a meltdown.”

“Although the anxiety isn't totally gone because my husband's still sick, yeah, it's a lot better, and it's an ongoing thing.”

Less frequently, consumers noted reductions in unhealthy behaviours (cited by five, or 4%), improvements in their physical health and/or sleeping patterns (cited by four, or 3%), and ability to cope in work situations (cited by four, or 3%).

Attribution of change

Consumers were asked the extent to which they would attribute any of the above changes to the care provided by their clinical psychologist. The majority of consumers who provided responses to this question indicated that their clinical psychologist had contributed to the change in their wellbeing. Sixty nine consumers (52%) attributed all or most of their improvements to their consultations with the clinical psychologist. They made comments like:

“Definitely attribute change to the psychologist.”

“A huge percentage. I don't know if I could have gotten myself out of the rut by myself.”

Having said this, a sizeable number of consumers (45, or 34%) indicated that although seeing the psychologist was a contributing factor, there were also other influences on their improved state. They made comments like:

“Work with the psychologist has been significant in conjunction with the other supports I have.”

“Seeing a psych is a tool. It's not 100% of the improvement, but I also don't want to minimise the importance.”

Only six consumers (5%) did not feel that they could attribute change to the psychologist. Typically, these consumers said that they thought they would have improved anyway, or that their life circumstances had changed.

Experiences of consumers who were recruited by registered psychologists

Previous barriers to seeking mental health care

Consumers were asked whether cost or other barriers had prevented them seeking mental health care in the past. Table 30 shows the results.

Table 30: Previous barriers to seeking care experienced by consumers who received Better Access services from registered psychologists (n=152)*

	Freq	%
Costs	72	47%
Personal factors	20	13%
Availability and difficulty accessing services	19	13%
Associated stigma	18	12%
Lack of knowledge regarding services	8	5%
Previous negative experience with mental health services	4	3%
Not recognising mental health issue	4	3%

* Multiple responses permitted

Seventy two consumers (47%) indicated that cost had previously been a barrier to seeking mental health care. They made statements like:

“I put it off (seeking treatment) because of the cost.”

Other barriers to seeking care in the past included personal factors (reported by 20 consumers or 13%), such as overcoming the anxiety involved in seeking care, lack of motivation and feelings of *“not being ready”*. Several consumers reported previously believing that they could cope on their own.

Difficulties accessing services was also reported as a barrier by 19 consumers (13%). This included difficulties with accessing services because of waiting lists, distance, and lack of available services out of work hours. Several consumers reported difficulties finding a *“good”* practitioner or someone they could relate to or *“find that rapport with”*.

Eighteen consumers (12%) reported the stigma associated with seeking mental health care had limited their doing so in the past. These consumers made comments like:

“It might be [seen as] a weakness, to think that you need help.”

“Sometimes there [are] perception[s] that I should be able to sort it out myself.”

“I didn’t like to admit that I had a problem ... [because] oh gee, there must be something wrong with me!”

Other less commonly cited barriers to accessing care in the past included lack of knowledge about available services or how to access services (cited by eight consumers, or 5%), previous negative experience with or contact with mental health services (cited by four, or 3%), and not recognising they had a problem (cited by four, or 3%).

Reasons for seeking care

Consumers were asked to describe what prompted them to seek care from the registered psychologist for this episode of care. Responses fell into the thematic categories listed in Table 31.

Table 31: Reasons for consumers seeking care from a registered psychologist on this occasion (n=152)*

	Freq	%
Symptoms associated with mental health issue	56	37%
Referral suggested by GP or another health professional	48	32%
Perceived need for professional intervention	31	20%
Traumatic life events	31	20%
Encouraged to seek care by friend or family member	10	7%
General health problems	5	3%
Addiction problems	2	1%
Compelled to seek help	2	1%

* Multiple responses permitted

Issues that were associated with mental health symptoms (e.g., symptoms of anxiety, depression, or general distress) were most commonly mentioned as the catalyst for their seeking care. Fifty six consumers (37%) made comments along the lines of the following:

“I just wasn't handling things very well. Things were getting on top of me and I was getting very distressed and very angry. That's about it.”

“Well I was sort of, I don't want to embarrass myself, I was depressed for a long time – a 10 year period – and I desperately wanted to make things better, so yeah ...”

“[I] just got sick of feeling down all the time and wanted to do something about it.”

A considerable number of consumers reported that they were referred for care by their GP or another health professional (48, or 32%), or encouraged by friends or family members (10, or 7%).

Thirty-one consumers (20%) reported seeking help because they themselves recognised a need for assistance. This sentiment is illustrated in the following quotation:

“I suddenly realised that if I didn't do something that this thing was going to be bigger than me really and was going to just swallow me up.”

Consumers also frequently mentioned seeking assistance to cope with difficult, distressing situations. Thirty one consumers (20%) reported traumatic or stressful life events, such as the death of a loved one or relationship issues as the reason for seeking care. Responses included:

“My sister died suddenly and unexpectedly, and I was absolutely crushed.”

“We were going through a family crisis. My mother had Alzheimers, my relationship broke down and my cousin said ‘you need a mental health plan’.”

Other less commonly cited reasons for seeking help from the registered psychologist included issues arising from general health problems (cited by five consumers, or 3%), addiction problems (cited by two, or 1%), and being compelled (for legal reasons) to seek help (cited by two, or 1%).

Sessions of care

The majority of the 152 consumers recruited by registered psychologists (97, or 64%) had received treatment for the recommended number of sessions and/or experienced sufficient improvement to cease care, or were still continuing care. These consumers expressed satisfaction with the amount of care they had received, making comments like:

“I became happy, pretty much that simple.”

“I was feeling better and I was able to put the strategies that she taught me into practice and it helped me get through the situation.”

“I felt as if I was on top of it all and I didn't really need any more help.”

A minority of consumers had discontinued care before the recommended number of sessions because they were unsatisfied with some aspect of treatment. Five (3%) commented on the cost, five (3%) felt that the registered psychologist did not have a sufficiently strong rapport with them, four (2%) indicated that they found it difficult to fit their treatment in around their other responsibilities, and three (2%) expressed concerns that the treatment was not making any difference. These issues are highlighted in the following comments:

“I could not afford to pay the rebate.”

“I didn't feel she was helping me at all. In fact, she made me feel like my problems were worse than they were. She was extremely unsympathetic to my feelings.”

“I can't get there during the hours that they are open. And they don't open after 5pm. I just can't get time off work at the moment to get there. I have to take annual leave to get to the appointment.”

“Because frankly I didn't think it was of any great benefit to me.”

Process of seeking care through Medicare

Consumers were asked how they found the process of receiving psychological services that were refundable by Medicare. Table 32 shows that the vast majority indicated that they were happy with the process, either by reporting that it was generally “good” or “easy” (94, or 62%) or by being more specific about the aspects of the systems that they were happy with, such as lowered costs, or ease of processing claims (26, 17%).

Table 32: Experiences of the process of receiving care through Medicare (n=152)*

	Freq	%
Generally good/easy/helpful	94	62%
Good due to the lowered costs, processes of claiming were good or easy, helpful bulk-billing or automatic system	26	17%
Remaining costs, high gap payments, prefer more bulk-billing	10	7%
Processes not good: unclear process, took too long to obtain consultation or cancellation of consultation	5	3%

* Multiple responses permitted

Those who were less positive indicated that cost was still an issue or that aspects of the processes were poor (e.g., because they had to get a referral from a GP, had to pay up-front and claim back from Medicare). The former issues were cited by 10 consumers (7%) and the latter were cited by five (3%). The following comments illustrate some of these concerns:

“It was good except for the fact that I had to have the money, and instead of paying the gap I had to pay the whole amount and then get the refund. Sometimes I did not have the \$100. If you just had to pay the gap fee it would be a far more accessible system.”

“If I was poor it would be tragic because the refund was only 80% of what I spent.”

“In Victoria it was easy to find a psychologist who bulk-bills, but in Brisbane a lot of them tended to want extra payments on top of that. So it was hard. It was a month before I could see someone who bulk-billed.”

“The referral was a bit, an extra step I had to go through I had to pay and take time out to see a GP when I didn't think I needed to, I knew I needed to see a psychologist.”

Positive aspects of clinical care

The vast majority of consumers (139, or 91%) were generally satisfied with the clinical care that they received, with consumers reporting that they were “very satisfied”, “absolutely satisfied”, and that the care was “good”, or “excellent”. Table 33 indicates the key aspects of their care that contributed to these high levels of satisfaction.

Table 33: Positive aspects of care received (n=152)*

	Freq	%
Professional skills, qualities and competency of the provider (e.g., established rapport, non judgemental, good to talk to).	82	54%
Good, satisfied, received helpful or constructive advice or care (e.g., useful strategies or resources were provided)	67	44%
Other issues	9	6%
Everything	7	5%
Did not impose financial burden	3	2%

* Multiple responses permitted

Most commonly, consumers indicated that the qualities of the registered psychologist (e.g., competency, empathy, and ability to establish rapport) shaped their positive experience with their care. Eighty two (54%) made comments like the following:

“I found her very understanding. I found her not judgemental and I found that she saw me as a person. The communication between her and I was very important.”

“She was insightful, experienced, very good and non-judgemental, compassionate and really objective which is what I was seeking.”

“She was warm and open and I could open up [because] she was so lovely.”

“She was older and experienced and that was important to me.”

Sixty-seven consumers (44%) indicated that the help, advice, strategies and resources they were given were positive aspects. Many consumers reported being taught to challenge their thinking and to look at things from different perspectives. Many also indicated that the care and

resources with which they were provided enabled them to feel more control over their particular situation. Consumers' comments included:

"It just made me realise that I can have different ways of thinking around things, instead of just hitting a brick wall and not being able to progress further, or just slipping backwards into that horrible dark place. Just different ways to attack it."

"I think it is very helpful in giving an insight into my issues and illness and developing strategies to deal with it (identifying triggers, that sort of thing), so you become proactive in your own health so it is not such a fearful thing. It has made a big difference in my life."

"My condition has improved dramatically. I valued my existence at 1/10 when I sought help, now I feel 7/10. The breathing techniques, positive thinking strategies and learning new ways to communicate were good aspects."

A small number of consumers (nine, or 6%) indicated other positive aspects such as ease of access, a safe, comfortable environment and the unhurried pace of treatment. Seven (5%) consumers reported that 'everything' about the care they received was positive. Three (2%) reiterated the point that it did not impose a financial burden.

Negative aspects of clinical care

Almost half of all consumers (72, or 47%) indicated that the care they received had no negative aspects. Where negative aspects were mentioned, they tended to coalesce around the themes indicated in Table 34.

Table 34: Negative aspects of care received (n=152)*

	Freq	%
Uncomfortable talking about personal issues or other personal factors	13	9%
Practical difficulties	11	7%
Uncertain about the value or usefulness of the treatment	9	6%
Not comfortable with the provider, no rapport, judgemental	8	5%
Miscellaneous	16	11%

* Multiple responses permitted

Most commonly, those who mentioned negative aspects of care indicated that they found it difficult to discuss personal or painful issues with a stranger. Thirteen consumers (9%) gave this sort of response:

"It brought up issues that I did not want to think about."

"Just the opening up and telling them what was the problem."

"Going through the emotions and reliving it."

Eleven consumers (7%) reported practical difficulties such as making appointments, needing to travel to appointments, finding time in busy schedules and organising child care. Examples of responses included:

"The wait list annoyed me a bit. Getting the office people to get back to me was shocking."

“Difficult to get to in lunch break and sometimes if it was a difficult session you don’t feel like going back to work. Also by the time you get into an issue the time is up.”

“Because the provider I was seeing only visited [at certain times] and my town here doesn't have a full-time service available locally, it was difficult trying to fit in appointment times around my work commitments.”

Nine consumers (6%) expressed uncertainty about the value of their treatment (9, 6%). They made comments like:

“Not entirely satisfied because I still have symptoms that I first went in there with.”

Eight consumers (5%) talked about a lack of confidence in the registered psychologist, making statements like:

“In some senses I felt like (I've never been to anyone else so I don't know) she didn't give me a lot of techniques to go away with. She gave me a few books to read, but I felt like there wasn't a lot of technique given to help me. We were talking about stuff and it was all good, but there wasn't a lot of technique giving.”

“I feel like sometimes I was just sitting down having a chat with a friend. I was almost wanting her to hurry up and give me something more.”

“I guess I just didn't particularly find what she had to say helpful as I thought it would be.”

A number of isolated negative aspects were each mentioned by one consumer. These included factors like cost, the limited number of sessions available, treatment being time-consuming, and the fact that the registered psychologist could not prescribe medication.

Types of change

Consumers were asked whether they had noticed any change in their wellbeing since seeing their psychologist. One hundred and twenty six consumers (83%) reported that they had noticed a change. Twenty three (15%) reported no change in wellbeing. The remainder were unsure or did not respond.

The vast majority of those who reported change discussed specific, positive changes. These are summarised in Table 35.

Table 35: Types of positive change noticed (n=152)*

	Freq	%
Improvements in mental health (e.g., symptoms or feelings improved, have learnt strategies for managing)	74	49%
Generalised improvement	29	19%
Improvements in physical health/lifestyle/sleeping	10	7%
Some improvements but underlying causes are still present	3	2%
Reduced alcohol consumption	2	1%
Return to work, coping better at work or seeking work	2	1%

* Multiple responses permitted

Most commonly, consumers indicated that they had experienced positive improvements in their mental health, either in terms of a reduction in symptoms or in terms of an increased ability to manage negative thoughts, feelings and situations. Seventy four (49%) made comments in this

regard. Twenty nine consumers (19%) indicated more generalised improvements. Typical responses included:

"I am quite happy these days. I don't worry as much. I had a bit of a crash and now I am optimistic with living."

"I developed a balanced perspective [and] learnt ways to avoid anxiety and develop a level of preparedness regarding incidents and particular people."

"I'm a bit more relaxed and not as uptight about things, less stressed."

"I am a much stronger person. I have got far more confidence in myself."

"The difference in my wellbeing from the very first appointment to my last appointment is incredible. It was great for me to be seeing a psychologist on a regular basis. I went from strength to strength. I used to think that there was nothing that I could do to help myself, but with (my psychologist's) guidance, I know that there is SO MUCH that I can do. I have been consistently stable."

"Absolutely, I am a different person. I am communicating now."

Ten consumers (7%) reported improvements in their physical health (including improvements in lifestyle and sleeping habits). Two (1%) talked about reductions in their alcohol use, and two (1%) discussed improvements in their work situations (including being able to return to work or coping better at work). Examples of consumer responses include:

"Got back on my feet, and was able to survive my job. I fell apart when I first went in and now I'm feeling pretty strong and capable."

"I am not as tired all the time. I am more motivated to do things whereas I wasn't motivated at all before."

"Stopped drinking, felt better about self. More self awareness, realise ... takes time to improve your situation but you can do it."

A small number of consumers (three, or 2%) noted that although they had experienced some improvements, they still had ongoing difficulties. This is illustrated by the following quotation:

"I feel like I am in control now. Before I was trying to change the situation and I can't, so now I have accepted that the situation is the way it is and I am coping a lot better – so much better that I have reduced my anti-depressant."

Attribution of change

Consumers were asked the extent to which they would attribute any change in their wellbeing to the care that they had received from their psychologist. The majority of consumers who provided responses to this question indicated that their psychologist had contributed to the change in their wellbeing. Fifty six consumers (37%) indicated that their psychologist had been largely responsible for the improvements. A further 33 (22%) suggested that their psychologist had played a significant role. Only nine (6%) actively indicated that their psychologist had not helped.

Experiences of consumers who were recruited by GPs

Consumers who were recruited by GPs were asked the same set of questions as those who were recruited by clinical and registered psychologists, but some of them interpreted these questions in a slightly different way. Consumers who were recruited by clinical and registered psychologists interpreted the questions as being about the care they had received from these individual providers. Sometimes consumers who were recruited by GPs did this too, particularly in circumstances where the GP had been the sole provider of their mental health care. In other cases, however, consumers who were recruited by GPs tended to think more broadly about the package of care they had received, and often this included care from the GP and another Better Access provider (e.g., a clinical or registered psychologist, a social worker or an occupational therapist) to whom he or she had been referred by the GP.

Previous barriers to seeking mental health care

Consumers were asked whether cost had acted as a barrier to their seeking mental health care in the past. They were also asked to describe any other barriers that may have previously prevented their seeing a mental health care provider. Their responses fell into the categories listed in Table 36.

Table 36: Previous barriers to seeking care experienced by consumers who received Better Access services from GPs (n=121)*

	Freq	%
Costs	68	56%
Not recognising mental health issue	14	12%
Availability and difficulty accessing services	13	11%
Personal factors	11	9%
Previous experience or contact with mental health services	8	7%
Lack of knowledge regarding services	6	5%
Did not want medication	1	1%

* Multiple responses permitted

Just over half of the consumers recruited by GPs (68, or 56%) indicated that cost had acted as a barrier to their seeking mental health care in the past. These consumers often made brief, summary statements about the previous impact of costs on their help-seeking behaviour such as:

“Only financial.”

The next most commonly-identified barrier to their previously seeking care was a lack of recognition on their part that they had a mental health issue. This barrier was mentioned by 14 consumers (12%) who made comments like:

“I just was not aware that I had mental health issues.”

“Main barrier was not admitting to myself that I needed care and advice.”

The availability of services and difficulties with accessing them were also mentioned relatively frequently (by 13 consumers, or 11%). Specifically, consumers discussed the fact that the distance and associated travel time had limited their access in the past and that sometimes they had experienced long waiting times. The following comments exemplify these responses:

“At one stage it was the distance.”

“The waiting time to get in to see someone.”

Other less commonly mentioned barriers included personal factors (mentioned by 11 consumers, or 9%), previous negative experiences with mental health care (mentioned by eight, or 7%), lack of knowledge about what services were available (mentioned by six, or 5%), and a concern that they might be prescribed medication (mentioned by one, or 1%).

Reasons for seeking care

Consumers were asked what had prompted them to seek mental health care from their GP on this occasion. Their responses were aggregated into the thematic categories listed in Table 37.

Table 37: Reasons for seeking care from a GP on this occasion (n=121)*

	Freq	%
Symptoms worsening	42	35%
Referral suggested by GP or another health professional	33	27%
Traumatic life events	18	15%
Perceived need for professional intervention	18	15%
General health problems	16	13%
Suggestion from family or friend	4	3%
Addiction problems	2	2%
Compelled to seek help	1	1%
Other	2	2%

* Multiple responses permitted

Most commonly, consumers indicated that a deterioration in their mental health had acted as the catalyst for seeing their GP. Forty two consumers (35%) indicated that they had noticed that particular symptoms (e.g., negative feelings) had increased in intensity or were not remitting with the passing of time. Some noted that they felt overwhelmed by this. The following comments are typical:

“I felt that it was not worth being here. I lost my self esteem. Lots of other reasons. My nerves were very bad I worried about having another breakdown.”

“I was very stressed, very angry, very depressed. I wasn't coping with it, and I normally can but I wasn't.”

In addition to mental health problems, some consumers indicated that they were prompted to seek mental health care as a result of general health problems (16, or 13%) and/or addiction problems (2, or 2%).

Over one quarter of consumers (33, or 27%) said that the reason for their seeking care was a recommendation from a health professional. Usually this took the form of a referral from their GP during a regular visit for an unrelated health problem. They made statements like:

“Recommendation from my GP.”

“[I] moved and needed to find a new GP. [I] met her [and] on [a] regular visit [while] talking about my medical history, [I] told her I had a bad burnout some years before. She started to evaluate me in that whole area, so that's how it came about.”

In a similar vein, several of the consumers (4 or 3%) mentioned that other third parties (usually a family member or friend) had suggested that they seek help, and a larger number (18, or 15%)

had come to this conclusion themselves. In all cases, the increased understanding that help might be beneficial had led them to seek mental health care through their GP.

Traumatic or stressful life events were also cited as a reason for seeking care on this occasion. Eighteen consumers (15%) made mention of triggers such as a relationship break-up, the death of a loved one and the loss of employment. Some of these are highlighted in the quotations below:

“What's the best way to describe...? I can't think now, isn't that terrible? It was the death of my mother ... just trying to think of the word 'grief'.”

“Struggling with work relationships and marital relationship.”

Sessions of care

The majority of the 121 consumers recruited by GPs (68, or 56%) had received treatment for the recommended number of sessions and/or experienced sufficient improvement, or were still continuing care. They expressed satisfaction with the amount of care they had received, making comments like:

“I have finished now, I don't need any more at this point. I had six sessions.”

“We'd had 6 sessions I think I was entitled to 12, but the issues were quite thoroughly I think dealt with, it was a very positive outcome.”

A minority had discontinued care, as some of these expanded on their reasons for doing so. Five (4%) had difficulty fitting the sessions in around their other responsibilities, three (3%) experienced a lack of rapport or confidence with the provider, two (2%) felt that the treatment was not making a difference, and two (2%) experienced issues associated with cost.

Process of receiving care through Medicare

Consumers were asked about their experiences of the process of receiving psychological services that were refundable by Medicare. Table 38 summarises the results.

The majority (78, or 64%) described the positive aspects of receiving care through Medicare in very general terms, indicating that they found the process “good”, “easy” and “helpful”. A smaller number (20, or 17%) were more specific, indicating that they appreciated the fact that Medicare had lowered the costs of care and that the process of claiming had been straightforward. This latter group made comments like:

“And obviously with the help of Medicare and all that ... with the reimbursement [and] things like that ... it makes it a lot easier. I probably wouldn't have done it, to be honest, if I didn't have that. Just because of financial tightness.”

Table 38: Experiences of the process of receiving care through Medicare (n=121)*

	Freq	%
Generally good/easy/helpful	78	64%
Good due to the lowered costs, processes of claiming were good or easy, helpful bulk-billing or automatic system	20	17%
Remaining costs (e.g., high gap payments or prefer more bulk-billing)	5	4%
Processes were not good (e.g., unclear process, took too long to obtain consultation or cancellation of consultation)	4	3%

* Multiple responses permitted

A minority of consumers indicated that there was room for improvement in the Medicare process. Five (4%) were negative about the out-of-pocket costs they paid over and above the schedule fee and/or found the process of going to a Medicare office to claim the rebate cumbersome. Four felt that the processes were unsatisfactory in some way (e.g., because they were unclear). These negative perceptions of the process are highlighted in the following quotations:

“It still leaves a fair whack to pay.”

“It would be good if there was a bulk-billing arrangement ... so you wouldn't have to go to Medicare. It is a bit frustrating at times to do that.”

Satisfaction with clinical care received

An overwhelming majority of consumers (116, or 96%) were satisfied with the clinical care they received. Table 39 clarifies particular aspects of this care that consumers viewed positively.

Table 39: Positive aspects of care received (n=121)*

	Freq	%
Good, satisfied, received helpful or constructive advice or care	66	55%
Professional skills, qualities and competency of the provider	43	36%
Did not impose financial burden	3	2%
Other issues	4	3%

* Multiple responses permitted

Over half of all consumers (66, or 55%) expressed satisfaction with the advice, strategies and guidance that they received. They made comments like:

“The GP that I was seeing was very helpful in telling me about what I was feeling and who I could contact.”

“Since I've been going I've only really had one panic attack. It wasn't half as bad as the panic attack that I was having because she helped me learn to breathe properly and relax and everything. I can't explain it to you ... Yes, she has helped me so much.”

Over a third of consumers spoke in glowing terms of the professional skills and competencies of the GP (and/or of the mental health professional they saw as a result of the GP's referral). They commented on the providers' specialised skills, and on the fact that they took the time to develop a rapport with them, listen to them, and provide them with support. Several also commented that the providers were non-judgemental and kind. Typical comments included:

“He is easy to talk to.”

“Both GP and the psychologist are wonderful, really good. I am telling others about them. The listening part [was good]. The GP took ... time to listen and explain things to me. He went through everything with me and he followed up and provided me with feedback.”

Negative aspects of clinical care

Consumers were asked what aspects of care they found unsatisfactory. Two thirds did not identify any such aspects of care. Those who did made comments consistent with the themes identified in Table 40.

Table 40: Negative aspects of care received (n=121)*

	Freq	%
Unfamiliar or uncomfortable to talk about personal issues or other personal factors	15	12%
Uncertain about the value or usefulness of the treatment	10	8%
Took too long to see someone or other practical difficulties	7	6%
Not comfortable with the provider (e.g., no rapport, judgemental)	6	5%
Cost or payment difficulties	2	2%

* Multiple responses permitted

When consumers did identify negative aspects of care, they most commonly spoke about feeling outside of their “comfort zone”. Fifteen consumers (12%) indicated that they felt awkward discussing personal or painful issues, making comments like:

“The strangeness of opening up to a stranger.”

“I felt embarrassed to talk about it.”

Other less common responses related to questioning the value of treatment, practical difficulties (often related to the availability of GPs or other mental health professionals), lack of comfort with the GP or other mental health professional, and cost or payment difficulties. In each case, these comments were made by ten or less consumers. These were mentioned by seven consumers (6%), six consumers (5%) and two consumers (2%), respectively.

Types of change

Consumers were asked the types of change they had experienced since receiving care. Table 41 summarises the results.

Table 41: Types of change noticed (n=121)*

	Freq	%
Generalised improvement	58	48%
Improvements in mental health	18	15%
Improvements in physical health/lifestyle/sleeping	9	7%
Return to work, coping better at work or seeking work	7	6%
Reduced unhealthy behaviours (e.g., smoking, drinking)	3	2%
Some improvements but underlying causes are still present	2	2%

* Multiple responses permitted

Most commonly, consumers reported that they had experienced generalised improvements in their wellbeing. Fifty eight consumers (48%) made comments along these lines, including:

“Just in myself personally I feel better. My partner and my kids have noticed the difference - it is noticeable.”

“More energy, more motivation, more enthusiasm for life - Just enthusiasm for life rather than before where I had none”

Eighteen consumers (15%) indicated that they had made gains in their mental health. Some commented on a reduction in symptoms of depression, anxiety or stress, and others mentioned that they had learnt new coping strategies. These responses are exemplified in the following comments:

“Yes, my suicidal tendencies are far less.”

“My anxiety has improved and my mood has stabilized.”

“I now have strategies to couple with the situations that may arise.”

Less common responses related to improvements in physical health or lifestyle (mentioned by nine consumers, or 7%), improvements in ability to work (mentioned by seven, or 6%), and reductions in unhealthy behaviours (mentioned by three, or 3%). Two consumers (2%) mentioned unspecific, small-scale improvements and indicated that the underlying causes were still present.

Attribution of change

Consumers were asked to consider the extent to which they would attribute any changes they had noticed to the GP. Sixty four consumers (52%) totally attributed their observed changes to the service provider, and 23 (19%) partially did so. Twenty nine consumers (24%) did not answer this question.

Chapter 7: Providers' experiences with delivering care through Better Access

As noted in Chapter 3, 39 clinical psychologists contributed their views to the evaluation via interview/survey, as did 45 registered psychologists and 32 GPs. The experiences of these providers are described below.

Experiences of clinical psychologists

Impact on consultations

Clinical psychologists were asked whether Better Access had had an impact on their consultations. Just over half (20, or 51%) reported that Better Access had increased their caseload. By contrast, one third (12, or 31%) reported that Better Access had had no impact on their caseload because they were already well established as private practitioners prior its introduction. Responses that typify those from these different groups are highlighted below:

"Yes, because if I didn't have the Medicare rebate I think I'd have a lot less clients. I know that for sure. All my referrals are Medicare, apart from the occasional young person that probably goes under their parents' health fund or like migrants who don't have Medicare access."

"It has increased."

"No, it hasn't because I've been in private practice for a long time and I'm well known and therefore I always had a busy practice. So in a way it hasn't. In terms of number of clients it hasn't."

"Personally no because I was really busy before the Medicare items came in and I've only got so many hours in a week."

A number of clinical psychologists (four, or 10%) reported that the make-up of their caseload had changed to include greater numbers of people with fewer financial resources and more complex mental health care needs. They made statements like:

"The demographic has changed in that people who couldn't afford to see me can now afford to."

"It has had an impact - it's not upped the amount of work I do in the community at all in terms of numbers - I have always had a full clinic - but what it has brought in from the doctors is what you'd call dual diagnosis. I have seen lots of kids with major medical problems ... as well as the psychological aspects of it and that was a new thing. Prior to Medicare, the GPs they really didn't refer and so you would only occasionally see a chronic fatigue case or something because they were out of school, but Medicare has certainly brought in the medical cases of kids and it's certainly brought in parents that you might not see, parents with major medical illnesses, cancer or other major things. [They] now feel that this aspect of psychological treatment for their children and families is part of what they can have along with it, so there is more, there has definitely been a shift, there is a bigger medical side. It's really good."

“...I think that there is a much broader range of people that can access services now that couldn't in the past. There is a whole lot of people with socio-economic issues that couldn't access privately before that can now. And I guess they are more likely to bring their kids for help.”

Clinical psychologists were also asked whether Better Access had had an impact on the way in which they conducted sessions. Twenty one (54%) indicated that Better Access had not led to changes in the way they conducted sessions, whereas 15 (38%) indicated that Better Access had assisted them in offering timely, comprehensive and integrated care to consumers. Twelve clinical psychologists (31%) explicitly commented on the impact that the number of sessions had had on their practice. Some felt that it provided them with structure while others were conscious that they had to achieve an outcome within a certain time frame and others found the item numbers restrictive. The variation in views is highlighted in the comments below:

“In terms of the content of therapy that sort of thing, I do the same stuff no matter how they get to me. It's more about the financial side of it really for people.”

“No, I do the same thing as I used to. It hasn't changed the duration of sessions, it hasn't changed the assessments.”

“... It's taken some of the pressure away from us having to consult at a fairly, at a very forced level to get results because the fees have been so high, and people couldn't afford it ... It's meant that we are able to be more effective in the sense of having the luxury of a few more sessions with people to be able to achieve a desired outcome.”

“I am much more likely to offer what I feel is a comprehensive professionally adequate service to them. Before I'd reduce the number of sessions I would have had with them even though I felt it was not adequate for them, just to make it affordable for people, they wouldn't get as many sessions, they wouldn't get them as often perhaps as they were able to now.”

“I'm thinking because of the limited number of sessions sometimes if they're going to need more sessions than the Medicare ones then we try and pick that up really early in the piece and make an appropriate referral because I'm conscious of the 12 session limit and I know sometimes you can get 18, in fact I haven't been able to get 18 but most of them in the long run deal within the 12, but I'm conscious if someone may have an issue that's going to be much more time consuming we have to be clear about that up front.”

“I am more aware of the timeframe and the consultations available to individual clients.”

Communication with other mental health care providers

Clinical psychologists were asked about how they had found communicating with other providers in the course of providing Better Access care. For the most part, they discussed their communication with GPs.

Twenty seven clinical psychologists (69%) reported that the referrals they received from the GP were appropriate. Seven (18%) reported that the appropriateness of referrals varied; where they were inappropriate it tended to be because the consumer had particularly complex needs, did not have a diagnosable mental disorder, or lacked motivation. The following comments exemplify these responses:

“I think the majority of cases, yes. [However] some people do turn up and they initially say they're only there because the doctor's told them it's a good idea, and some of those

people might attend for a few sessions and then not attend, but the majority of the time, yes, they are appropriate, although often the problem identified by the client is not exactly the problem that's written on the mental health treatment plan. I have found that the client will often ... give me info that they may not have given to the GP"

"In general, very appropriate. We get referrals from a number of specific clinics and I think we've had enough communication with them to develop a good understanding of who's going to benefit, the type of clients that will benefit."

"I think they are really good. Some of them are very hard. I get sent people with very complex care needs, but you know I might have a presentation with, like an ex-heroin addict on an opiate replacement programme with some paranoia and depression and anxiety, and they're pretty hard to manage in say 12 sessions, but they usually send people that are motivated to do something ... Sometimes in a private setting when people would just ring up out of the phone book or whatever I'd get some pretty scary people, so I feel a lot safer in the work that I do."

"Nearly always highly appropriate. Occasionally they refer people who are not depressed or anxious; they do not have a diagnosable condition in my opinion. I would only see these people once or twice; they just need to talk. Because I have a long waiting list, I don't want to spend my time with the 'worried well', but I would refer them somewhere else if they needed to talk."

Ten clinical psychologists (26%) felt that the referral information provided by GPs in the mental health treatment plan was adequate or comprehensive. By contrast, 25 (64%) indicated that it was at best variable and at worst inadequate. Their complaints included that the information was too general, lacking in detail, missing processing information (e.g., the GP's provider number), or inaccurate from a clinical perspective. Examples of these divergent responses are provided below:

"GPs could put more information on referrals".

"Variable is the best answer for that. We actually had one client who was a child who came with the mental health care plan but mum had filled it out in pencil. The doctor had printed it off and signed it and the mother had filled out all the information in it. So that's one extreme and the other extreme is very comprehensive where the doctor's done some basic psychometrics, has given a medical and psychological history, knows what we mean by the difference between CBT and interpersonal therapy ... It takes all kinds I suppose."

"They are pretty useless, to be honest. Even though they are apparently doing an extended consultation, I would be surprised if they were all doing this. Most are templated. I pretty much ignore their assessment because it is mostly inaccurate and they do not have the diagnostic skill. I think that it is an unnecessary part of the process. But they are the gate-keepers. I wouldn't be saying it so frankly outside of this setting."

"The only point about the mental health care plan that can come in is that the doctor may have signed it but not have left his provider number or anything about the practice from which he's working, so I might have to ring the secretary and say what's the provider number, because everything links on the provider number. So it's a little secretarial thing. It would be good if that was a part of how they sign their signature or put their stamp on it. That helps a little bit."

A number of clinical psychologists discussed the kinds of additional referral information that would be useful in the mental health treatment plan. They sought more information about the consumer's background, general health status, previous mental health history and current treatment (including medications). They also desired additional detail on risk issues, and favoured the inclusion of a mental state examination and scores on any outcome measure that had been administered. They were also keen on receiving a treatment recommendation. The comments below illustrate some of these points:

"Some of the medications ... It would be helpful to me to know exactly what the client is taking and the dosage, because often that's not up to date. Probably a little bit more background information because you know they may have known the client for a long time, so they may have more information and certainly medical conditions."

"I think the information from the GP that's been most useful is what the goals are for therapy and what way they think, their knowledge of what this person actually needs so a good referral for me is if they can make a diagnosis and then identify what particular therapy they need, so CBT for anxiety."

"Some of them do the K-10 and the DASS. If they ... [gave me those results] ... that would give me a nice start."

"Probably risk, level of risk. If you are in a situation where you've got waiting lists, it's always good to know just in terms of triaging appointments."

Having said this, three clinical psychologists (8%) indicated that although they did not find the mental health treatment plans particularly useful, they did not require further detail because they conducted their own assessments and did so "from scratch". This group made comments like:

"To be honest, it's a bit superfluous. I don't feel that mental health care plans are really necessary. I have to do my own assessment for my own peace of mind. You know, the doctor might make a diagnosis and that's fine, they put in some diagnosis or other and I'm going to do my work whichever way it goes. If they sent no referral or a mental health care plan, I'm still going to work in the same way."

"Really, the plan is not overly helpful for us. What we need really is just the referrals. When a person comes for the first session, we always do our own diagnosis in that session and it's thorough, and we look at the... problem and the expectations of the client and so really the referral note, with just, I mean if the doctor has done some diagnosis, that's excellent."

Clinical psychologists were also asked about how they provided information back to the GP during and after treatment. The vast majority (34, or 87%) indicated that they had fulfilled the Better Access reporting requirements by providing routine reports or letters, usually after the initial consultation and definitely after the 6th, 12th or 18th session. The clinical psychologists' written reports focused on providing GPs with information relating to the consumer's current situation, his or her treatment response and any future treatment recommendations. Some clinical psychologists also reported that they phoned GPs to communicate any pressing risk issues.

"What I do as soon as I see the client for the first session ... [is] ... send back a letter acknowledging the referral and also if I've done the DASS I'll give that information as well. Then if there is something else that's very relevant and ... I don't really know if the GP knows that information, I will provide that information in that letter, and of course if

there is any sort of risk assessment if there is suicide ideation I send that information back initially as well. Then I will write to the GP at the end of six sessions or earlier, and outline the treatment strategies, the results of the DASS if I've used that again or any other psychometric instrument I've used and then if I've really got any concerns about the client I'll actually also write that. Often in the first instance [I] try to ring and pass that information on to the GP, and then [I] also follow it up with a letter if that's fairly important and the GP might want that on the file as well."

"Usually by a letter unless there is some sort of crisis where I think the GP might be able to help, in which case I'll ring them up. Just a letter, just trying to limit to one page because they don't have the time to read more and trying to get things as concise and in a nutshell as possible."

"We write to the GP after the first session, the sixth session and every anniversary at the 6th session and after the final session and we have in-house proformas that we use for that. Our 6th session review is probably quite long. It's about a page and a half, but at that point we do a reasonably detailed one because we've got the best idea at that point of diagnosis and treatment."

Logistics of registering with and billing Medicare

The majority of clinical psychologists (33, or 85%) said that they did not experience difficulties registering with Medicare to provide Better Access services. They described the process as "easy" "straight forward" and "very efficient". A smaller number (4, or 10%) reported some difficulties, mostly relating to the paperwork being time-consuming. The former group noted that their membership with the Clinical College of the Australian Psychological Society made the process easier; the latter group found having to register through the APS was cumbersome. The range of responses from the two groups is illustrated by the quotations below:

"Well, my experience was fairly smooth because I was a member of the Clinical College so it virtually went straight through straight away, right at the start of the program. I didn't have any major hassles that I remember."

"I was one of those who did it within the first 12 months or so and did it through APS, so while it was time consuming to do, I suspect it might be easier than what people have to do now, I am not a 100% sure. The only complication I would say is it did take a lot of time and a lot of paperwork."

"I had to join the APS at the time which I thought I shouldn't have needed to do. I think you don't have to now."

"Well this is nothing to do with Medicare because I was a counselling psychologist before so I had to go through rigmarole with the APS to be registered as a clinical psychologist and that was the only real hassle."

Many clinical psychologists found the process of billing Medicare relatively easy. Twenty seven (69%) reported having no problems or minor issues only. However, nine (23%) experienced some difficulties, mostly to do with late payments, the time-consuming nature of the process, and not being able to charge only the "gap" payment (but rather having to charge the full schedule fee and the "gap" and then asking the consumer to seek a rebate for the schedule fee from Medicare). The following quotations illustrate the range of views:

"It has been fine. I haven't had any problems. There is a little bit of a delay in payment when you bulk-bill people, but the cheque turns up eventually."

"I do bulk-bill a number of my clients, I only work in private practice one day a week and I do bulk bill and that's fine that works well, no dramas there, but what I find the main problem is ... if I don't bulk-bill them they can't just do a gap payment, they have to do the up-front fee and then claim it back and I find that very difficult. I feel for them to have to do that, you know for lower income people sometimes you don't want to bulk-bill everyone, you can't afford to, and to make it easier for them would be if they could just do a gap payment."

"It's been slightly frustrating in that we can't charge a kind of small gap for people when we bulk bill and what we're getting is we get people paying the gap as an upfront payment when they come for the appointment and then the cheque may never arrive".

"I do it manually so I've just got the old fashioned swiping thing and then I'm filling in manually the form for Medicare. It's a little bit time consuming. I have had my practice manager come and assist me with that and I've eventually got her to be doing more of filling in the details. Because I work on my own I've got to make sure I've got a witness to sign off my form and send that off to Medicare and I've got a bit of a system going so it's going quite okay. And it's my choice not to do it online because here in the bush we just haven't got access to the internet, it can drop in and out on a cloudy day or a rainy day so for me it's just easier to do it all manually."

Charging policies

Clinical psychologists reported a range of charging policies. Five clinical psychologists (13%) indicated that they bulk-billed all of their consumers, usually because they worked with socio-economically disadvantaged groups, wanted to improve access for consumers, and/or considered the schedule fee to be sufficiently generous. These psychologists made statements like:

"Yes I just bulk-bill. That's what we should be doing, all of us should be doing. Clinical psychologists get a reasonable rebate so why would we be charging more."

"Bulk-bill. It's easy. People in my area don't have a lot of money and other barriers prevent may prevent them from accessing (e.g., availability of care and stigma)."

Twenty five clinical psychologists (64%) indicated that they bulk-billed some consumers but not others. They said they made the decision on a case-by-case basis, being more likely to bulk-bill people on low incomes. Standard responses from this group included:

"I bulk-bill clients on Centrelink, disability, aged pension, study allowance, if financially difficult. Everyone else gets charged the same fee and they get the rebate."

"I am bulk-billing people that have got financial difficulties. My fee is \$160, however, I don't think I ever get that because if you've got a health care card you pay 20% less, if you're in financial difficulty then you will pay 30% less, if you are a single parent or struggling I will bulk-bill so I actually try and help as much as possible. So there are very few people that actually pay the fee."

"Bulk-billing clients on low income. I bulk bill if they are on a health care card or there is some other specific situation that causes them to be in that low income [bracket], otherwise ... I charge \$140 so that gives a small gap otherwise."

Six clinical psychologists (15%) indicated that they did not bulk-bill and charged a set fee for all consumers unless there were exceptional circumstances. Three (8%) reported that they did not bulk-bill either, but that they charged a reduced fee to consumers with financial difficulties. Examples of these responses are provided below:

“Well I run a non-bulk billing practice, so basically the discount fee that's a small gap, it's basically consistent with my colleagues in private practice. And I do make it very clear to people when they come in for an appointment that it's a non-bulk billing facility.”

“No my fee doesn't change regardless of whether it's a Medicare customer or some other circumstance ... I stay very much with the fee that I've set. I mean occasionally people will ask for a discount. I tend not to give them but I'll always listen to a person's circumstances and if I think it's appropriate I'll take that into consideration.”

“I've always had a policy of lowering my fee for people who struggle to pay. It hasn't been affected by this. I don't bulk bill but I offer patients who I feel would struggle a lower fee than the standard fee.”

Positive impacts for clinical psychologists

Clinical psychologists were asked whether Better Access had had positive impacts for them, and 36 (92%) indicated that they had. Table 42 summarises the kinds of positive impacts that clinical psychologists mentioned.

Table 42: Positive impacts for clinical psychologists (n=39)*

	Freq	%
Improving access	26	67%
Affordable care	16	41%
Integration of care	8	21%
Financial rewards	8	21%
Professional opportunities and development	5	13%
Early Intervention	4	10%
Professional recognition	3	8%

* Multiple responses permitted

In response to this question, clinical psychologists most commonly made mention of benefits that accrued for consumers, sometimes noting that these offered indirect, flow-on benefits for them as providers. The most frequently cited positive impacts were improved access and affordability of care for consumers. Twenty six clinical psychologists (67%) commented on access and 16 (41%) made mention of affordability. Clinical psychologists talked about the fact that broadening the availability of high quality mental health care was very satisfying for them.

Typical comments included:

“I think that it allows ... it frees up the financial thing from the actual treatment room. So when people in the past were paying full fee for themselves there was an urgency about it – ‘You've got to get fixed really quickly because you can't afford more than one or two sessions’, so I think there is a sense that you can actually do therapy properly.”

“I feel that I am able to provide therapy to a wider group and more people because it is affordable.”

Another commonly cited positive impact, mentioned by eight clinical psychologists (21%), was the ability to provide integrated, co-ordinated care. For many, this went hand-in-hand with

improved inter-disciplinary communication and collaboration. Clinical psychologists found it extremely satisfying to operate as part of a network of providers with similar goals. The comments below illustrate these points:

“... I think it's really been good. I think it should overall improve the communication between referrers and psychologists and I think there's an accountability process there that I really like. I like the fact that referrers and therapists have to be accountable, that therapists have to be accountable to the GPs. I think that's an absolute must, and you know there has to be a knowledge on the clients [part] that this is going to occur from Day 1, that there is going to be a communication process and accountability for making sure that the services we provide are effective and timely.”

“I like the idea of it being part of some sort of team, [that] I am not the person who is solely responsible for someone's wellbeing. In terms of the co-ordinated care, I really like that.”

“Probably the most significant positive impact has been the effect of improved information exchange, particularly emanating from the GP ... Generally speaking, the effect of [the mental health treatment plan] has been the basis for me receiving more information about the client. I guess implicitly it's also provided a better feedback loop in terms of me feeding information back to the GP and maybe being more structured in that.”

Financial benefits were also mentioned by eight (21%) clinical psychologists. They noted that the Better Access initiative enhanced the viability of their private practice and gave them a steady flow of referrals. The following responses were typical:

“At a business level it probably does maintain a steady flow of customers. I mean, again, like I said before, who knows if it wasn't there what the marketplace would be like, but my guess would be that perhaps it would be more difficult to keep up a consistent caseload number if the Medicare access wasn't available.”

“More money, more income.”

“Running a business. I haven't had to search for clients.”

Five clinical psychologists (13%) also reported that Better Access had provided them with professional opportunities. Some mentioned that it had extended their skills base by enabling them to work with different consumers with more complex issues, while other said that it gave them the opportunity to work in private practice settings. The variation in responses is highlighted in the comments below:

“So for me I think it's enabled me to have an opportunity to get into more private practice work. It's also allowed me to work within that primary care or sort of GP allied health model and I do enjoy working in that setting, that type of environment where you're working in conjunction with a general practitioner. It's quite a solid meaningful type of work and you expect a higher professional standard obviously.”

“It has enabled me to practice a broad range of psychological therapies across a broad range of areas. It has made me a much more 'rounded' psychologist.”

Four clinical psychologists (10%) noted that Better Access had increased their ability to provide early intervention. They made comments like:

“Look, I think it's a great system, I think it's certainly a step in the right direction and it has had positive impacts. I think our practice is busier as a result, we're getting more referrals and people who otherwise would have been left untreated are getting treatment ... particularly in the early intervention stage when the problems first start arising we're getting more of those referrals which is great because I think it can prevent problems from escalating ...”

“... I'm seeing more younger people early so I'd like to think that there might even be a bit more prevention going on than there would have been before so of course families can afford to bring their children who are anxious or depressed and have an option other than the local Child and Adolescent Mental Health Service [CAMHS] system I think.”

Another less frequently mentioned impact was increased professional recognition. Three clinical psychologists (8%) commented that Better Access had given psychologists greater legitimacy, and had reduced some of the stigma attached to seeking psychological care. They made comments like:

“I guess it's recognition of the profession of psychology. It's given us a significant degree of legitimacy I think with the GP.”

“And I think I like the way it's sort of raised the profile of psychology, psychological treatment. I think it's sort of destigmatised things a bit, not completely but I think it's having that effect.”

Negative impacts for clinical psychologists

Clinical psychologists were also asked whether Better Access had had negative impacts for them. Close to half (17, or 44%) explicitly said that the scheme had had no negative impacts for them. Twenty one (54%) noted that Better Access had had some negative impact for them, but often this was quite minor. Table 43 shows the kinds of negative impacts mentioned by clinical psychologists.

Table 43: Negative impacts for clinical psychologists (n=39)*

	Freq	%
Increased demand	7	18%
Issues with different stakeholders	6	15%
Increased paperwork	6	15%
Fee structure/financial concerns	6	15%
Session limits	2	5%

* Multiple responses permitted

Seven clinical psychologists (18%) were concerned about the increased work demands that were associated with increases in numbers of referrals. Some clinical psychologists did not feel that they had adequate resources to meet these demands. Their comments are summarised in the one below:

“Demand, not all get follow through, more demand than I have capacity. For example, trying to manage [my] waiting list ... Clients expect me to see them on the day or next day. It's hard to manage the waiting list.”

Six clinical psychologists (15%) talked about issues with different stakeholders, and in particular other providers. The fact that the GP acts as a “gatekeeper” was key among their concerns. They suggested that this caused delays and misunderstandings, and sometimes led to

inappropriate referrals and people “falling through the net”. The following comments highlight these concerns:

“If people ring often they will ask, ‘Do I need to have a referral to see you?’ You know, sometimes people that probably want to get in fairly quickly then realise that they have to go through the GP, so I am just wondering whether that extra step sometimes means that you lose clients because you could have seen them fairly quickly if they could have actually come through themselves without going through the GP first.”

“... I think that having GPs as the referral source is a bit of a nonsense and I think that it overly complicates things and I think it provides GPs with a revenue stream. I understand a significant proportion of the Medicare dollars for psychology goes to GPs and I think that's ridiculous because I don't think that they add anything. They're doing a mental health assessment and then saying, ‘Yes, you need to go and see a psychologist.’ Someone could go directly to a psychologist and get the same thing. But they have to, the way the system is, the doctors are the gatekeepers to the health industry but I think that's a real problem because they don't add anything to the patient care. In fact, I think they might sort of stop quite a lot of people from accessing the services ... So I think that's quite a serious issue. But I don't think we'll get the GPs to agree to not being the gatekeeper.”

Another negative impact, mentioned by six clinical psychologists (15%), was the increased paperwork. These psychologists made statements like:

“Well the added paperwork certainly has been a big thing. No, just the added paperwork.”

“... There's the report writing time which isn't acknowledged in the fee. I mean it isn't an onerous amount of time. I mean the other side to that is that it is a way of thinking and crystallizing and formulating cases and that is articulated and documented. I mean not to say that it wouldn't happen in the absence of that feedback to the GP but it is a way that structures that. It's only the time factor that's not acknowledged in the reports.”

An equivalent number of clinical psychologists (six, or 15%) had financial concerns that revolved around their fee structure. Some commented that the rebate was insufficient. Some felt that excessive bulk-billing was devaluing their services, while others felt that their peers were becoming “greedy”. These varying views are indicated in the quotations below:

“I don't think the rebate is high enough compared to the APS recommended fee, and I think that's a negative thing. Because then as a practitioner I have to decide my own fee ... Because it [the schedule fee] is just over half of the APS recommended fee, I need to make a decision about how much to charge people which puts the onus on me. Personally, I'd prefer if it was standard across the board. If it was a reasonable rebate then just charge the rebate and then everyone would know. I think it would take [away] some of that discrepancy, the difference between all the different practitioners.”

“The numbers of people who are bulk-billed and don't pay anything, it devalues our service and profession for some people. We are treated as a governmental department or community service. It is just a select minority, I think.”

“Only in that the other private psychologists tend not to bulk-bill. The negative impact for me is that I'm seeing other private psychologists being money hungry and greedy, that's the only negative thing. I went to a psychologists' breakfast the other morning and I had one of the other psychologists sitting across the table from me saying, ‘Oh well

you know the APS has a recommended fee and we should all charge it. But we're living in the bush and it's just you know in the city I know that people can be more competitive, we don't need to be competitive here.' And that really irks me. So, you know, I think Medicare is a wonderful thing for access because having worked in the health service I saw how hard it was for clients to access a psychologist and they were not accessing quality services. So I'm really pleased that the clients can access a service ... but the only negative impact is those greedy psychologists."

Two clinical psychologists (5%) saw the prescribed limit to the number of sessions as problematic. They felt that this meant they could not always meet the needs of consumers with chronic and severe conditions, and made statements like:

"Most people you do your 12 sessions and that's okay, some people need that exceptional circumstance the extra six sessions and that's okay. There are a small number of people who have chronic, severe conditions ... [and] ... you can only see them 12 times a year. It's just sometimes totally unrealistic and it's sets us up for failure ..."

Perceived positive impacts for consumers

The vast majority of clinical psychologists (38, or 97%) felt that being able to provide psychological services via the Better Access had benefited consumers under their care. Table 44 provides a breakdown of the kinds of benefits that they discussed.

Table 44: Perceived positive impacts for consumers (n=39)*

	Freq	%
Access	31	79%
Generalised benefits	10	26%
Integration/co-ordination	6	15%
Early intervention	2	5%
Reduced reliance on public sector mental health services	2	5%
Long-term care	2	5%

* Multiple responses permitted

The most commonly identified consumer benefit was improved access to care. Thirty one clinical psychologists (79%) commented on this, making statements like:

"It has meant that people who previously could not afford services can now see someone. Previously, there were really long waiting lists for services and people didn't have the option to go privately because they didn't have enough money. I think it has made it much more accessible for that client group."

"Absolutely. ...It's taken away the biggest worry in terms of, you know, financial situations. Because psychological intervention is not a one off thing, if I was to charge people say \$160 and they didn't have Medicare ... it's an incredible financial burden for people. I get this often that people say, 'I am so glad that there is Medicare there so that these problems I've had, I've been depressed most of my life, but I've never been able to afford to come and see somebody.'"

Ten clinical psychologists (26%) commented more broadly on the fact that Better Access had generalised mental health benefits for consumers including, improved mental health status, increased understanding of mental health symptoms and how to manage them, and better relapse prevention. These psychologists made comments like:

"I'd say definitely. The feedback I get from the clients anyway is that usually outcome valuations are quite positive and there's been real shifts in their mental health status."

"Well yes, definitely, definitely. If someone comes and they are in a very sort of depressed, confused state, they can't understand why something has happened or why they're feeling a particular way and when you're able to help them understand what is going on, you know, they can move forward ... Most of the people that come to me are stuck somewhere, they're stuck and then you know when we as professionals are able to help them see or understand the reason why they're stuck, then they can move forward and that's huge I think for people, it's huge."

"I think it certainly has. It's helped them for one thing to understand psychological impacts and to understand why they feel the way they do, most especially those who had trauma as children, and they don't realise the trauma has been with them throughout. I have 60 year old women who were molested at the age of five, and it's really ruined their lives up to that point then they suddenly realise. 'Oh, right, this is why I am like this. I am now going to change.' It's such a revelation to them ... It's so wonderful to see that change."

"The most obvious is that their mental health has improved. Fast access to psychology, and intervening before issues become chronic. Timeliness of treatment - two week turnaround. GP gatekeeper – relapse prevention timely."

Six clinical psychologists (15%) indicated that Better Access had improved the integration and co-ordination of care for consumers. They made comments like:

"Definitely, yes, and it's the same thing, it's about the structure, it's about knowing what sort of therapy they're going to be given and I give them all that information in the first session. They know how many sessions they'll have, [and] they're keeping in regular contact with their GP which is really important. People who are a little bit hesitant to come to therapy and they need it they're getting the referral from the GP and the GP is the person who they really trust and they listen to what the GP says. So it's been very beneficial."

"... It's produced, I think, better coordinated care. I think doctors are more aware of psychological, you know, mental health as well as physical health ..."

Other less commonly cited benefits were a reduced burden on public sector mental health services, early intervention and longer-term engagement with treatment (each mentioned by two clinical psychologists, or 5%).

Perceived negative impacts for consumers

Seventeen clinical psychologists (44%) perceived there to be no negative impacts of Better Access for consumers. Eighteen (46%) articulated some negative impacts, and these are listed in Table 45.

Table 45: Perceived negative impacts for consumers (n=39)*

	Freq	%
GP involvement	7	18%
Limited sessions	6	15%
Motivation for treatment	6	15%
Confidentiality	4	10%
Inappropriate service providers	2	5%

* Multiple responses permitted

The most commonly cited negative impact, mentioned by seven clinical psychologists (18%) was the requirement that consumers be referred to the psychologist by a GP and reviewed by the GP to receive additional sessions beyond the first six (or 12). Responding clinical psychologists felt that this mandatory GP involvement delayed treatment, interrupted the therapeutic process and treatment and, in some cases, prevented access.

"I think sometimes because it's difficult to get in to see GPs, you know, when clients have to go back for review, sometimes that they have to change their appointment because they haven't been able to get into the GP. I have had to send people back because they may have used their 12 sessions, and then they still may need to see you and still want to see you, the exceptional circumstances, the client having to go back and explain that, so I often have to write that in the letter to the GP as well."

"Only in that some GPs aren't always co-operative in doing a mental health care plan. They seem to see themselves as gatekeepers to the Medicare system. They're not always happy to do the review after six [sessions] or ... if in their opinion the patient doesn't need any further therapy, they can stand in the way of the patient getting psychological treatment. It doesn't happen often I must say but I have had that situation a few times."

"... I think for some clients they get annoyed that they have to go back and see their GP for a review. Part of that's about how difficult it is to get into see a GP. You have to book a couple of weeks in advance. In my area, yes, because it's a little area [with] not many GPs. Yes, I think some of them don't see the point initially but I guess once I explain to them what it's all about they go, 'Yes, all right, we'll do it.'"

"As I said before ... sometimes treatment can be disrupted, trying to get into doctors and keeping the whole thing flowing."

Six clinical psychologists (15%) felt that six (or even 12 or 18) sessions was too restrictive. These psychologists felt that some consumers would benefit from more sessions and made comments like:

"... When someone has significant issues and limited resources to cope and we run out of ... sessions ..."

"... Generally no, but ... for some people ... I think the way that Medicare is structured may not be helpful. [For example] people that have been sexually abused or experienced trauma and where there's been some clinical symptom to that and you know one of the worst things that you can do for these people is to build a relationship that then gets severed because there's trust issues and so that can be problematic. I guess that's one area that I would think is really important to monitor very closely and look at scrutinizing in the interest of the patient's needs."

Six clinical psychologists (15%) commented that the Better Access initiative might impact negatively on consumers' motivation. Some mentioned that GPs sometimes referred consumers who were not likely to engage in treatment. Others were of the view that the access to free or low-cost mental health care might mean that consumers had insufficient investment in it to be motivated to follow through with therapy. These responses are exemplified by the comments below:

"Well there has been instances where people have not shown up for appointments. They may have had two or three times when they haven't come and I've said, 'Well, you know ... there's no commitment to treatment so therefore I can't work with you.' In that instance, maybe it was negative."

"The expectation of something for nothing and not valuing it again."

"One or two clients have taken a lot of liberty with the fact that when I bulk-bill them they don't show up sometimes. They don't even phone to tell me they are not coming. They come late, and those clients then I have to tell them the fee involved when you cancel without telling us when you just don't turn up, and they are so annoyed and so surprised that you know I am telling them this, and I tell them Medicare does not pay your cancellation fee you'll have to pay it, and it's a very small one \$25 you know, and I hope that helps them to realise they are getting all this free and have some respect for the fact that this care is given to them free of charge."

Four clinical psychologists (10%) were worried about confidentiality issues as they might relate to consumers. They commented that some consumers were hesitant about seeking mental health care because they did not want their GP or Medicare holding records that indicated they had done so. They felt that consumers might be particularly concerned that their Medicare history might be sighted by third parties. These sentiments are summarised in the comments below:

"... I just have a duty of care to report certain things. There is still other sensitive information that the client wishes to keep confidential, but because it is related to the treatment ... I think that's the most sticky situation. For example, [the] client having an affair. I am not in the duty of care to report that to the GP but if it is impacting on the fact that they can't sleep at night or whatever obviously that's a cause of symptoms you can't communicate, those types of situations it makes it tricky."

"I think that some people are somewhat apprehensive about having Medicare have a record of them accessing psychological services. I've had people that are working in positions you know in the government or various organisations and they've been concerned [that] were this information to be known to their colleagues or superiors that it might adversely affect their career ..."

"The only negative impact that I can think of is ... [the] impact on people accessing or going into police employment or armed forces if they've had mental health care plans up. I am not really sure of that factor. That's my hesitation sometimes when I get children referred under mental health care plans, but I don't think clients themselves have said that that's a negative thing, that's my perception."

Two clinical psychologists (5%) expressed concerns about consumers being referred to less experienced mental health professionals. By way of example, one said the following:

"... The people in our service have all registered and keep their PD points and all those kind of things. I guess there's a risk that there could be dodgy people out there but that could occur in any system."

Additional comments

Clinical psychologists were given the opportunity to share any additional views they held about Better Access. Mostly, those who did so expanded on points they had made previously. Thirty five (90%) reiterated that Better Access was a positive initiative that was filling an important gap in mental health service delivery. They made statements like:

"I am just am really appreciative that the government has realised how ... important psychological services are and that they are prepared to pay a rebate, and so I am just delighted that they do it ... I think it's generally a good system and we are very lucky to have it."

"I just think that it really is a great service. As I said, people who could not ordinarily afford to come are able to come for treatment. If it weren't for Medicare ... I would still be charging very reasonable fees and trying to work as quickly as possible with people so they could be helped. But as I said this is very good. And I think the doctors that I've been working with have been, they're very happy, they can see that with early intervention these people have been able to overcome a depression that perhaps ordinarily they might not have been able to or it would have taken much longer."

Two clinical psychologists (5%) went on to say that they were concerned about the longevity of Better Access. They made the following comments:

"I hope it continues to be supported. It provides communication with other providers not previously available. GPs are more able to refer with minimal costs. It is a good use of taxpayers' money."

"Look, I guess I'm concerned that there is some talk that the government is looking at cost cutting and this is an area that's being looked at. I know that people within psychology are concerned about that and I share that concern. I think that if the government were to take this away, I think that they'd be really putting the Australian public at a serious disadvantage in terms of their overall health care and I can see a political cycle with a three year election cycle that might be quite an expedient thing for them to do if they want to cut costs and they're not looking term at the overall mental health needs of the Australian community. So that's a worry that I have."

A number of clinical psychologists (16, or 41%) suggested that there was scope for further expansion of the initiative. Specifically, they proposed that some of the existing criteria could be relaxed. The following comments illustrate these points:

"... I guess what I am saying is ... if Medicare was going to review the number of sessions ... I would like to see an increase in the availability of number of sessions for chronic mental illnesses for clinical psychologists to treat. If truly Medicare wants us to treat chronic mental health issues such as bipolar disorder and schizophrenia and complex PTSD, then they need to make better provision for that and not lumber them in with everyone else, and maybe it could be restricted to clinical psychologists."

"One very, very important thing is why are we not allowed to have two sessions side by side? I have people who come from the south and they travel four hours sometimes to see me and they can't have a double session for example, and I think double sessions to begin with would be so helpful to so many people because I have to cut them in the middle, you know they are crying, I give them an extra five minutes but that doesn't help too much to wind down. If I had a double session it would be so much better. I could get

a lot accomplished especially for these country people who have to come from so far. They don't understand why - why doesn't Medicare allow a double session, at least with the first sessions. [It] doesn't make sense for my clients who travel all that way. That's the most important one."

"I would like it so that, for instance, if some of our clients during treatment are hospitalised [e.g., in a children's ward or a psychiatric ward], ... if we do a visit to them and go up to the ward we can't actually claim that, and often it's really important that we actually continue our care while they are in that facility ... I think that's just one little glitch. One of my colleagues – a patient [of hers] ... made a massive suicide attempt this week and the ward rang up saying, 'Can you come up?' and she could but she had to do all that for free. The other issue is some, for people with eating disorders, it's really hard to get full treatment ... and the same with complex [cases] where there is co-morbidity like personality problems ... It's really hard sometimes to fit treatment into 12 or 18 sessions ... It's fine if they turn up in the second half of the year because we can space out sessions and they can run on into the next year, but if they turn up at the beginning of the year we just can't manage them, get enough treatment sessions."

Six clinical psychologists (15%) re-stated concerns with the Medicare rebate rates. They mentioned wanting to be paid for administrative tasks, wanting the schedule fee brought in line with the Australian Psychological Society's recommended rates, and wanting reassurance that the rebate would rise in line with the Consumer Price Index:

"No, I mean I find the system pretty straightforward really. I mean, I guess if I was going to have a whinge I might say it would be nice if there was an item number for issuing reports because sometimes they can be substantial and there isn't, you know. In other third party payment arrangements like Workcover and TAC you do get paid for reports, but generally they're to the insurer rather than the doctor but, look, that's the only issue. I find the system very straightforward."

"There is a lot of paper work correspondence. [There's] no fee from Medicare for that time, whereas other professions get Medicare [payments for] them. The scheduled fee is well below what the APS recommends."

"The only thing is if you are charging people the full rate, the "gap" is still quite significant, so as a result I think a lot of people don't charge the full rate – full APS rates anyway, recommended rates ... [This] sometimes impacts on their income. Medicare, it's really useful and helpful having the Medicare rebate."

"One concern is whether the rates will keep increasing with time or whether they'll fall behind. There needs to be a consideration for item numbers for testing, that family therapy needs to be considered ..."

Three clinical psychologists (8%) emphasised that they felt it would be appropriate for consumers to refer themselves directly for psychological care, rather than needing to seek a referral from their GP. They made comments like:

"My preference would be that people could refer themselves. I can see the benefit with the GP because there may be people that may not even think of a psychologist but have come because it's been suggested by the GP, but once they see the value that they will continue but I am sure there is many people that probably if they could ring, know that they could ring a psychologist and go through Medicare they would probably come straight to you, and because in a regional area the GPs are very, very busy. Clients have to wait weeks to get in sometimes and it just, it might be just enough to make it difficult

for people to actually access it because you've got to go through the GP that extra step. I think can make a difference."

Experiences of registered psychologists

Impact on consultations

Registered psychologists were asked whether Better Access had had an impact on their consultations, and prompted to consider changes related to their overall caseload and the way in which they conducted their consultations. About two thirds (29, or 64%) reported that Better Access had had an impact on their consultations. For most, this translated into a change in the mix of consumers they were seeing. In particular, a number commented that they were now providing treatment for proportionally more consumers from low socio-economic backgrounds and young consumers. These psychologists made comments like:

"I know that I've seen more people who would not have accessed psychological services at all before this became available, and I'm talking about people who are in the lower socio-economic group in the community. So people who might have possibly gone to community health centres for counselling or other services. So ... I'm seeing more of a spread within the community ... More young people [too]."

Despite these observed changes in the make-up of their caseloads, the majority of registered psychologists (34, or 76%) indicated that Better Access had made no change to the absolute size of their caseload, usually because they were operating at their maximum capacity prior to the introduction of Better Access. However, eight psychologists (18%) indicated that their caseload had increased in size. Typically, these psychologists said that this was because Better Access had opened up private practice opportunities for them that had not been available to them in the past. They made comments like:

"Absolutely ... I wasn't in private practice before Medicare came in ..."

For many psychologists (21, or 47%), this improved access translated into a different way of providing care. They spoke about being able to provide more sessions of care to people on low incomes, rather than not being able to offer them anything or offering them a limited number of sessions and then referring them on to publicly-funded services. This enabled them to address consumers' issues in a more thorough manner. The following responses were typical of this group:

"It's been extremely beneficial in being able to work with people with low incomes and people who also are having difficulty with depression or anxiety but probably would not have sought help without the Medicare rebate."

"The financial reality is that while in the past I have been able to see them for maybe two or three sessions and say 'Now I am sorry I am going to have to move you to the CASA [Centre Against Sexual Assault], but we've got a good grounding here and I will make sure they're briefed ...', whereas now I am able to complete their counselling with them over a period of somewhere between six and 12 sessions."

"Absolutely ... before Medicare came in ... they [financially disadvantaged consumers] ... could not even afford to pay the basic minimum of \$50 or \$60 that I was willing to charge to provide the service. These are women who are students who are single parents who are immigrants, who are working part time. Since Medicare came in there

has been an absolute 100% of a positive impact on my ability to provide the service to this particular clientele ..."

Quite commonly, registered psychologists observed that Better Access had impacted on the way in which they conducted their consultations. Twelve (27%) noted that Better Access had contributed positive changes in their approach to providing therapy. They commented that Better Access provided a framework which they used to inform their practice, and that the reporting requirements made them more reflective and accountable. Typical responses included:

"I probably work differently. More focused, shorter-term people come with a different expectation."

"It does give you a really neat way of managing your treatment and re-testing, pre-testing and post-testing. So I've found that the Medicare the Better Access program has actually informed my practice if you like as a psychologist as well. "

"I guess you're sort of conscious that you're working to the criteria so you know you can't drift off into something that they might want to do if it's not covered by the item."

"...having to do the mid term report ... for the GPs gets you to sit and reflect on the gaps, the issues that haven't been tackled yet."

"There's probably been more feedback to doctors which I think is really quite beneficial ... having the six week and the 12 week feedback that sheet that goes back to the doctor I think is very useful. I think they appreciate being kept in the loop too."

"I think even though the psychologists are sort of complaining and whinging that we don't get paid for reporting back to the GP, I think that actually helps that you have to do a bit of a treatment summary and clinical formulation every six sessions. Yeah I think you're reflecting on your work a lot more."

Three psychologists (7%) indicated that Better Access had enhanced their capacity to provide care. They expressed this in different ways, sometimes reiterating the point made above that increased access afforded by Better Access meant that they take therapy further, and sometimes discussing the opportunities to intervene with consumers earlier. These different views are expressed in the comments below:

"Yes because there's more in-depth stuff because, you know, you've got a few sessions to play with. We can definitely get into some heavy duty, more in-depth [therapy] ..."

"... It's really helpful, particularly because it allows for the ongoing sessions and that means that we can get to the point where we can actually, in the majority of cases, resolve their presenting issues because we've got a sufficient number of sessions and time in which to do that."

"It's actually enabled people to access [care] that wouldn't have been able to access [it] before, and access [it] earlier. So for some particular issue, such as a recent trauma or a grief or, you know, a recent relationship breakdown or something like that, it's actually enabled a session to happen fairly quickly ... [As a result] I have been able to provide containment and therapeutic work quickly which has potentially prevented issues."

Communication with other mental health care providers

Registered psychologists were asked how they found the process of communicating with other mental health professionals. In particular, they were asked to consider the two-way communication between themselves and GPs.

The vast majority of registered psychologists (39, or 87%) indicated that they found the referrals they received from GPs to be appropriate. Four (9%) reported a contrary view. These different opinions are exemplified by the responses below:

“Appropriate, very appropriate.”

“99% appropriate. Yeah, I can't think of any off the top of my head that haven't been suitable, so yes.”

“Probably about 98% appropriate. Every once in a while ... one gets through where I think to myself, ‘Well, you know, it could be questionable as to whether or not the person fulfils the criteria for referral’, but I'd say about 98% ... somewhere around there.”

“Pretty good. Its' taken a while. It was a case of mutual learning and I've been at this surgery for almost four years now so I'd say over time we've taught each other what's appropriate and what isn't appropriate.”

“I've found them actually really fantastic for a private practice. It screens the people that come in so they're ready for counselling ... It gets people thinking about what the things that are concerning them are and what their goals will be and its kind of screened who is appropriate for counselling and who isn't, so I get people who are ready to start working on things ... Prior to Better Access, I would tend to have people who would have long phone calls before a counselling session. They weren't really ready for counselling, they [were] kind of more shopping.”

“Occasionally they're good. Usually they're absolutely irrelevant and pathetic.”

Psychologists also commented on the adequacy of referral information they received from GPs via the mental health treatment plan. Just over half (24, or 53%) found this information to be inadequate, sometimes because it was too brief, sometimes because it included unnecessary detail, and sometimes because it lacked relevance. Seventeen psychologists (38%) found it adequate, at least in some cases, and some of these mentioned that it had improved over time. The range of views is indicated by the quotations below:

“Unnecessary. There's a lot of information but it's really not necessary. I do my own assessments and so it's not really an issue, there isn't a lot in there that really needs to be provided.”

“Utterly useless.”

“Mostly it's very minimal. I mean some GPs give you a really good referral, but mostly it's sort of just a tick and flick that doesn't have a lot of information.”

“The GP referrals are usually very short, with not much information. Sometimes you don't even have a proper diagnosis done by the doctor. Sometimes they don't inform which medication the client is on.”

“The referral information for the most part is fairly basic, but by having the opportunity to have [the review to facilitate] the ongoing sessions, I can gather the information that’s needed to fill in the gaps.”

“It varies from very good to very bad. You get some doctors who will give you a very comprehensive mental health care plan and other doctors who will just send a letter with two lines on it saying, ‘Please see this person under a mental health care plan’, and so it varies between those two extremes.”

“It’s really quite good now. It’s improved enormously. Are Medicare being more strict with the doctors now about referral information? It’s actually pretty good now. I get ... much fuller information and they’re filling out the forms ... properly now. It used to be a bit scatty in the beginning. I don’t think anybody really knew what they had to do way back when it started.”

Registered psychologists were also asked about how they provided information back to the GP during and after treatment. All but one (44, or 98%) indicated that they had fulfilled the reporting requirements of the Better Access Initiative by providing a report after the sixth or twelfth sessions if a review was required, and at the end of treatment. Many psychologists described additional, far more detailed communication with GPs as well. Some, like the psychologist quoted below, indicated that Better Access had improved their communication with GPs:

“I think I’ve improved in my communication with GPs. I mean in the past before [Better Access], quite a number of my clients [were] also referred by my GP but it didn’t occur to me that I needed to communicate with them [the GP]. But now, because I’m required, [I] give progress reports, and I find it very helpful. And actually, I’ve found myself ringing the referring GP a lot more than before. We have good communication and good relationships.”

Logistics of registering with and billing Medicare

Registered psychologists were asked about their experiences of registering to provide services through Medicare. Forty psychologists (89%) spoke in positive terms. Typically they used phrases like the following:

“No problems.”

“Fine, easy.”

Registered psychologists were also asked to comment on the logistics of billing Medicare for their services. Again, many were positive. Twenty five (56%) indicated that they had experienced no problems, or minor teething problems that they had since resolved. However, nine (20%) commented on a range of issues, including getting information from Medicare, the requirement that referring GPs submit their paperwork before psychologists can claim, and the user-unfriendliness of the forms. The following comments exemplify this range of experiences:

“I use both systems. I did use bulk-billing – you know, sign the slip – and I found that easy as well. We’d just send the forms away and Medicare would deposit money in the account very easily. I have no problems with payment from Medicare at all.”

“After you learn how to do it, it is okay.”

"I find bulk-billing quite difficult from time to time. I find the bulk-billing forms that you have to fill in quite time consuming, and you have to get someone else to witness the other one, the form that goes with the bulk billing voucher. I find it very difficult unless you're using EFTPOS machines. They're a little bit easier."

"It's been very difficult to get information back from Medicare regarding payee advice – whether or not they've paid the client."

"[It's like] a black hole. A lot goes in and nothing comes out. And it's not the staff because I've found the staff have been excellent."

"The only real thing is if the doctor doesn't lodge their item number in a timely manner. I've just had a case in the last month where I was working with a teenage girl who had attempted suicide and her doctor's accountant apparently went on leave so they didn't lodge their paperwork and the family couldn't access their rebates so it was causing a huge showdown."

"A nightmare. There's no other word. The people on the phones I find are magic, they're really nice people. Once in a while you get a difficult person but they seem to know as little as I know at times, and counting the sessions and how many sessions people have [had] and sometimes like for instance a doctor will change a practice and refer the client through a different practice and because that provider number has changed, Medicare will reject your claim but won't tell you that's why they're rejecting your claim."

"Basically what we do now before submitting stuff we ring up and check for each client whether it's authorised."

Charging policies

Registered psychologists were asked about their charging policies and reported a range of different, standard practices. Eleven (24%) indicated that they bulk-billed all consumers, 20 (44%) noted that they bulk-billed particular consumers (e.g., those on low incomes, young people), and 11 (24%) said that they rarely or never bulk-billed. Irrespective of their bulk-billing practices, some (17, or 38%) used a sliding scale which favoured people on low incomes.

Taken together, the reports of registered psychologists' varied charging policies suggest that only a minority of these psychologists were charging low income earners much above the schedule fee. Psychologists' concern that financially disadvantaged consumers should have equal access to psychological care often underpinned their decisions. This notion is illustrated in the following quotations:

"For some clients who are pensioners or have a health care card I only bulk bill and for people who are in employment I charge \$100 and so there's a gap that's probably \$20."

"...my basic principle has been if someone is on Centrelink benefits (e.g., unemployed) or [has] retired, no matter how well off they are, I will do a Medicare rebate. Other than that ... I've got a bit of a sliding schedule from sort of \$100 to \$140 depending on how well off people are."

Positive impacts for registered psychologists

Registered psychologists were asked about whether being able to provide psychological services via Better Access had had any positive impacts for them as practitioners. Forty one registered

psychologists (91%) reported having experienced positive impacts, and these are summarised in Table 46. Many of these impacts overlapped.

Table 46: Positive impacts for registered psychologists (n=45)*

	Freq	%
Enhanced viability of private practice	23	51%
Increased capacity to meet consumer need	18	40%
Opportunities for better co-ordination with other mental health care providers	13	29%
Promotion of understanding of mental health issues	9	20%
Increased sense of satisfaction with work	7	16%
Increased capacity to provide services to people with low income	6	13%

* Multiple responses permitted

The most commonly reported positive impact was the enhanced viability of private practice. This was mentioned by 23 registered psychologists (51%). Sometimes they referred to this in an altruistic way, making comments about it being a means by which they could better serve the community. On other occasions they talked about it in terms of financial benefits. These different responses are exemplified by the comments below:

"I don't like the charging part of the business and that's my own sort of difficulty I suppose. I find it a bit hard ... I know it's a profession, I know we have to charge but I'm not that, that's not the part of the work that I prefer. So to have Medicare fund all or most of the fee I personally find really freeing ... it frees me up. It frees me up to sort of focus more on the provision of psychological services if you like rather than being a business person."

"I suppose a stable income stream..."

Another frequently cited benefit was the increased capacity to meet consumers' needs, mentioned by 18 registered psychologists (40%). Some (6, or 13%) specifically commented on the fact that they were now in a better position to provide services to people on low incomes. These psychologists commented that they found this gratifying in a professional sense. Typical responses included:

"... that sense of ongoing care, availability for ongoing care is just a lifesaver for some people who struggle very hard."

"... people who couldn't afford it before are now able to access it and it's just wonderful."

"I work in lower economic areas and I do that by choice. ... People just couldn't afford to pay and I couldn't afford to make a living being a psychologist without it so that's pretty positive."

Registered psychologists were also positive about the improved linkages between themselves and other mental health care providers. Thirteen, or 28%, explicitly mentioned this. Some discussed the fact that this had led to system improvements that were better for consumers, and others talked about the fact that it made their work easier because consumers had been screened and were ready for therapy. Examples of both sorts of response are provided below:

"One positive impact is ongoing contact with local GPs. That's been a good thing because you can work together for the welfare of their patient and my client."

“A positive impact for me is I think the clients that come through are ready for counselling [and] have been screened appropriately. They also have the back up care of their GP.”

Nine registered psychologists (20%) felt that Better Access had led to improved mental health literacy in the community. They discussed the fact that this was not only a positive development for people with mental health problems, in that it reduced the stigma surrounding mental illness. They also mentioned that this had flow-on benefits for them because it implicitly gave mental health care more prominence. One psychologist, for example, said:

“I think it gives weight to mental health being just as big a concern to others as any physical kind of problem.”

For many registered psychologists, a sense of increased professional satisfaction was implicit in the kind of comments made above. Seven (16%), however, explicitly talked about improvements in their levels of professional satisfaction. They made comments like:

“Mostly I deal with real significant issues and I can make a major difference. And you know, one likes a challenge.”

“For me as a provider it has had great impacts because I feel that I'm getting to be able to service people who are really in need, people in the community who are on health care cards or who would not be serviced by my service. So for me that has been really quite rewarding and what I had hoped the system would do. It has been able to do that.”

“... you're getting the message from the community that you're valued as a mental health care provider so it makes a big difference in your professional self esteem I suppose.”

Negative impacts for registered psychologists

Registered psychologists were invited to reflect upon whether Better Access had had any negative impacts for them. Over half (24, or 53%) said that they could not think of any negative impacts. Those who could cited a range of impacts, often noting that these were outweighed by the advantages described above. The cited negative impacts are summarised in Table 47.

Table 47: Negative impacts for registered psychologists (n=45)*

	Freq	%
Increased demands on providers	10	22%
Challenges of keeping consumers engaged in treatment	9	20%
Increase in paperwork and administrative burdens	8	18%
Difficulties ensuring financial viability of practice	8	18%
Discontent/criticism related to lower rebate amounts registered psychologists as compared to clinical psychologists	5	11%
Issues with different stakeholders	4	9%
Issues relating to confidentiality	2	4%

* Multiple responses permitted

A number of registered psychologists made comments about the increased demands made on them by Better Access. Some (ten, or 22%) talked about this in general terms, and others (eight, or 18%) talked about increases in their administrative load. Examples of these general and specific comments are provided below:

“I've had to close my books for about 3 months because I was just overloaded ...”

"I definitely feel under the pump a lot more with the written work. You know, supposed days off are not days off."

Nine registered psychologists (20%) made reference to the difficulties and challenges of keeping consumers engaged in treatment. In particular, they talked about consumers missing appointment times, consumers' expectations of and investment in treatment, and their ability to provide care within the criteria laid out under Better Access. They made comments like:

"Medicare clients as distinct from other clients have tended to have a higher no show rate."

"Possibly a negative impact I would say because I'm seeing more people who are on health care cards and who lead chaotic lives, and if they're bulk billed then there's possibly not a sense of investment in this process for them and so I'm probably having more no shows or cancellations from that group of clients so that has an impact on my business."

"Sometimes people's expectations are that things should perhaps get better a little bit more quickly than they can."

"...there's always the challenge of trying to fit what the client needs with the requirements of whatever program you're using, the number of sessions and the requirements of it but it's not particularly different."

"... needing to terminate early with a client because the session numbers have run out."

"I particularly like to do relationship work and that's not covered with the Medicare rebate. I think that relationship stress impacts on depression, anxiety, anger, grief, you know, and just general stress. So I think that if relationship and family work was put in there, that it was more recognised and supported, then that would be beneficial for the patients to be able to access it for that."

Eight psychologists (18%) talked about difficulties they were experiencing with ensuring the financial viability of their practices. In this context, some (five, 11%) mentioned the higher rebate for their clinical psychologists colleagues. They made statements like:

"I'd like to get paid twice as much."

"As I said, I'm the best therapist in the area but on the lower rank of Medicare ... I think it's unjust."

"Well one of them is the difference between psychologists, the clinical versus the generalist. That's definitely a negative, a big time negative."

"It's been a negative impact in terms of a sense of a split in the discipline ... You know, an in-group/out-group sort of feel about things."

Four registered psychologists (9%) spoke of negative impacts from a system that involves various stakeholders in organising and delivering care for a given consumer. More specifically, they questioned the value of having referrals come through GPs. They made statements like:

"If a client rings me from the phone book or, you know, word of mouth, I'll have to direct them back to a GP in order for them to be able to get a GP mental health care plan. So

that's probably the only negative, [but] that does happen fairly regularly ... And that sometimes is a negative for them because they may not want to go and talk to their GP."

Finally, two registered psychologists (4%), raised issues about confidentiality. Specifically, they discussed the fact that they did not always think it was appropriate to share confidential information that the consumer may have provided in confidence with his or her GP. One put it this way:

"... under the Medicare scheme it's very important that there is some information that will need to be shared back with your doctor, so just making sure that you cover that confidentiality issue."

Perceived positive impacts for consumers

Forty three registered psychologists (96%) felt that their being able to provide services through Better Access had positive impacts for consumers. Table 48 summarises the nature of these perceived benefits.

Table 48: Perceived positive impacts for consumers (n=45)*

	Freq	%
Generalised benefits for consumers	28	62%
Reduces financial strain in seeking treatment	24	53%
Promotes longer-term engagement with treatment	8	18%
Offers choice to consumers	5	11%
Promotes improved co-ordination/co-operation between service providers	4	8%
Reduces reliance on public sector mental health services	1	2%
Promotes opportunities for early intervention/preventive treatment	1	2%
Provides improved access to mental health services in rural/remote areas	1	2%

* Multiple responses permitted

Most commonly, registered psychologists talked about non-specific benefits for consumers, making global statements about increases in availability and accessibility, improvements in mental health literacy and decreases in stigma. Twenty eight psychologists (62%) used this sort of phrasing:

"It's made counselling available to people who would not have come."

"Availability, access to counselling is the major benefit."

"Most of my clients they wouldn't have this awareness that they need to see a psychologist or they wouldn't have the resources to see a psychologist before so I am encouraged that so many clients now have this awareness to seek psychological support and they really benefit from it."

"It's opened up more discussion between GPs and patients [about psychology as a therapeutic option]."

"It's also made accessing psychology okay whereas before that it had quite a stigma."

"It's almost like being referred through the GP gives it a stamp of approval."

Over half of the registered psychologists (24, or 53%) made a specific reference to the fact that Better Access had reduced financial barriers to seeking mental health care for people on low incomes. The following comment typifies their responses:

“Treatment is now affordable for the large majority of people.”

Eight registered psychologists (18%) held the view that Better Access had resulted in consumers engaging more effectively with treatment which had, in turn, improved therapeutic outcomes. They made comments like:

“In the past when people had to fund counselling themselves they came [for] a minimum [number of sessions] - sometimes one or two times – purely because of the cost ... Therefore treatment was quite, well, it wasn't as effective. Now, because people are funded for at least six sessions, most people are choosing to come four to six times ... and so therefore the treatment program is a lot more effective and you can see the difference in what you are doing, and the difference it makes in someone's life.”

Five registered psychologists (11%) felt that Better Access had offered consumers a choice of different therapeutic approaches, or, more specifically, an alternative or adjunct to pharmacotherapy. These psychologists offered insights like:

“Some of my clients can review their medication or even wean out their medication after seeing me which is great.”

Four registered psychologists (8%) felt that Better Access had made a difference for consumers by increasing co-ordination and co-operation between providers. They made comments like:

“I think clients have felt maybe a degree of reassurance from knowing that there is a health professional working with their GP.”

Less commonly, psychologists commented on reductions in the reliance on public sector mental health services, the creation of opportunities for early intervention, and improvements in access to mental health care in rural and remote areas. One psychologist (2%) commented on each of these as a perceived benefit.

Perceived negative impacts for consumers

Almost two thirds of the registered psychologists (28, or 62%) felt that Better Access had no negative impacts for consumers. Fifteen (33%) cited some negative impacts, sometimes reiterating points they had made about negative impacts for themselves. Table 49 shows the key themes that emerged when these responses were analysed.

Table 49: Perceived negative impacts for consumers (n=45)*

	Freq	%
Difficulties around the referral or review system	9	20%
Issues associated with confidentiality	7	16%
Not enough sessions	7	16%
Clients not understanding aims of the initiative, not motivated or not seeking change	4	9%
Cost barriers, cost for further treatment after allocated sessions have expired	1	2%

* Multiple responses permitted

Most commonly, registered psychologists discussed the fact that, from their point of view, having the GP act as a “gatekeeper” was unnecessarily cumbersome for consumers. Nine (20%) mentioned this, noting that there were situations where the GP did not agree that the consumer required mental health care, and circumstances where it was inconvenient for the consumer to return to the GP for a review. Typical responses are provided below:

“...where clients have been declined by their GP but that's only happened a handful of times.”

“Sometimes the GPs aren't interested.”

“If the client doesn't want to go back to see the GP for some reason. You know, like if they don't get on with their GP particularly, or they find that their GP is a little bit critical or not aware of their mental health condition or thinks perhaps in that amazingly old-fashioned way that they should just get over it, there could be some negativity there.”

“The fact that they have to go back and see a GP to be reviewed its inconvenient for them and a lot of people have busy lives, they work, they have a range of commitments, having to go back and see people all the time is just an added burden for them.”

Seven registered psychologists (16%) suggested that some consumers were concerned about confidentiality. In particular, they mentioned that consumers were sometimes loath to seek care through Better Access because they thought that having a record of having sought mental health care could have negative repercussions for them. In a similar vein, they suggested that some consumers were “put off” by the fact that confidential information about their mental health might be shared with their GP. The following comments were typical:

“[Some consumers] were hesitant about the possible medical records ...”

“Maybe the exchange of confidential information.”

Seven registered psychologists (16%) viewed the restrictions on the number of sessions of care available through Better Access as a disadvantage for consumers. They made comments like:

“I don't think six sessions is enough.”

“I think sometimes there's a sense of needing to terminate too early so that the therapy is based on session numbers, not necessarily on therapy goals.”

Another perceived negative impact for consumers, mentioned by four registered psychologists (9%), was that not all understood what was being offered by Better Access and/or that some were not motivated to change. They made comments like:

“...they will say things to me like, ‘Why I do need to come in and talk when I [just] need more medication?’”

Finally, cost was mentioned as a potential negative impact for consumers by one registered psychologist (2%). This psychologist spoke about the residual costs for consumers over and above the rebate.

Additional comments

Registered psychologists were given the opportunity to offer any additional observations about Better Access. Those who did tended to reiterate issues that they had already raised, rather than introduce new ones.

Most commonly, registered psychologists commented on the “rules” of Better Access service delivery, arguing that they were too restrictive. They mentioned session numbers, session lengths and the range of eligible disorders and therapeutic approaches. Their comments included the following:

“About half of what I do is with kids and the number of consultations and the payments and all that kind of stuff are the same for kids and for adults.”

“Well I'd like to see the item numbers include chronic pain and I'd like to see it opened more to a multi-disciplinary approach.”

“I rarely have a brief appointment because I don't find them very effective.”

Thirteen registered psychologists (29%) referred to the fact that the rebates for their services were lower than those for clinical psychologists. They said things like:

“The two tier Medicare refund, it doesn't work for the community.”

“I think we should all just get paid the same.”

Four registered psychologists (9%) reiterated their concerns about the need for the referral and review roles of the GP. They made comments like:

“GPs are completely unskilled in this field so it doesn't make sense for them to be the gatekeeper.”

“Look, I think there's a big question about the GPs having to be the gatekeepers. I think that could be refined.”

Despite wanting to make the above points, many participating psychologists specifically elected to end on a positive note. Many reinforced the benefits of Better Access for consumers (seven, 16%) and/or made an appeal for its continuation (five, 11%). Their views are summarised in the comment below:

“I think it's been a fantastic thing.”

Experiences of GPs

Impact on consultations

GPs were asked whether Better Access had had an impact on their consultations. One third (ten, or 31%) indicated that their caseload had increased; and another third (11, or 34%) said that it had remained the same. The former group commented that the increase in their caseload was directly accounted for by people with mental health problems, and the latter group noted that they already saw significant numbers of people who presented with these sorts of issues but that Better Access provided additional opportunities for treatment. Examples of both sorts of comments are provided below:

"I'd say it probably would have increased things. It's a little bit difficult for me because I had a break from practice, but compared with how I was before I went off to have my last baby, I'm certainly doing more of them, more of those item numbers in the past year."

"It's increased the number of patients that we look after for mental health reasons. And I think it's raised our awareness. It's led to a greater awareness of mental health problems and how they impact on patients."

"I probably see the same proportion of patients. I've had a very fixed number of patients for the last five years because my books have been closed all of that time. So I've had a steady cohort of patients, but there just seems to be a high incidence of mental health in that. But that keeps recurring, so I don't think it's changed how hard I have to work. It just means they get treatment they wouldn't have got before."

The vast majority of GPs (27, or 84%) indicated that Better Access had led to some kind of change in the way they conducted their consultations. Mostly, they reported that Better Access enabled them to refer consumers to allied health professionals, which made psychological care accessible for those who might previously have been unable to afford it. They made comments like:

"... it's certainly opened up a lot more avenues for people who need psychological help. [It] probably means I have to do less counselling myself, so I suppose it has, yes."

"Well it's meant that I have been able to refer people for appropriate counselling, people have been prepared to come back for follow-up visits, and I have bulk billed everybody through that system, so it's basically opened the doors to make access to mental health care more accessible I guess. ... In the past I have had people desperately needing counselling and the most they could afford was to see a Lifeline counsellor who had done a six week counselling course for a gold coin donation, you know, that sort of stuff, which was really quite discouraging, but that's the best they could do, if that. So it's been great for the people who financially have really needed it – and I guess for other people – but certainly from a financial point of view for people it's been great."

Nine GPs (28%) reported that Better Access had contributed to positive changes in their approach to treatment. They noted that the structure of the item numbers provided them with guidance that was helpful and increased their efficiency, and led to their providing better care and achieving better outcomes. The following responses exemplify these notions:

"... because there are certain requirements for the item number that I have followed ... perhaps it's ensured those things. ... I spent as much time with them before all of that, but perhaps it is good to formally have those guidelines and do those psych tools. I think the psych tools and the management plan are the differences, doing it formally."

"What it has done is it's given more structure to the care of people with mental health problems, which essentially I sort of didn't really appreciate initially, but as I started to use mental health care plans and I found it extremely useful to have worked out a set of goals and a plan with people and I think they appreciate it too because I think with this sort of work it can be very nebulous and directionless sometimes. And I think having a set of clear goals that you're working towards, and then checking you can go through that list with people ... I think it keeps up the direction and the momentum and I think it improves outcomes."

“I think it makes it more okay to deal with mental health issues because the pathway for treatment is more clear. So instead of not necessarily being able to do anything with it – I would do treatment within my practice [but] it was more frustrating because the pathways weren't so clear – this way, it's much easier to make good referrals and good follow-ups and get good outcomes so it's ... been a very good process.”

“With the introduction of the Medicare item numbers, I then adopted the very structured mental health assessment and plan from that, that I go through with each patient and that's been very, very valuable because there are individual questions in that, that sometimes weren't covered in a more informal assessment, as I used to do them. Especially alcohol consumption. I certainly have detected a lot more problems with alcohol abuse, especially in women with depression and anxiety. I don't think it's made a lot of other changes.”

Eight GPs (25%) reported that Better Access increased their consultation time with consumers. In the main, they viewed this in a positive light, noting that the time allocated to mental health-specific consultations by Better Access encouraged them to thoroughly address consumers' concerns and enabled them to refer on more appropriately. Some noted that this meant that they were adequately reimbursed for providing mental health care. However, two GPs (6%) noted that the corollary of this increased consultation time was increased paperwork. These views are summarised in the following comments:

“[It] can allow me a little bit more time to spend purely on psychological matters which in fact constitute quite a large bulk of the consultations that I have.”

“I think the consultations have been lengthened and we've put specific time aside for those consultations for those mental health patients, we've allocated more time.”

“Not really just that I'm better financially paid for what I do and as I say it makes it easier to find a referral point.”

“Doesn't change anything with the management or how we consult with the patient, probably the timing yes. It took a long time doing the paperwork.”

Two GPs (6%) felt that some of the work that they were doing in their consultations overlapped with the work the psychologist was doing, and that the psychologist was better suited to do the work. One of these commented:

“The other thing is that I find it difficult, and very often inappropriate, to administer a K10 ... you know, the fact that it's sort of regarded as my job to do that, rather than the psychologist's. Sometimes I find that quite intrusive in a general consultation.”

Communication with other mental health care providers

GPs were asked about their experiences with communicating with other providers in the course of providing Better Access care. In the main, they discussed their communication with psychologists. Over half (17, or 53%) reported that their communication with psychologists was good, and some of these noted that Better Access had improved this communication. Fourteen (44%) reported that this improved communication had resulted in better collaboration between themselves and psychologists. The following comments exemplify these responses:

“Wonderful, excellent, really good really worthwhile. It's actually opened up the communication channels really well having the referral system in place and the feedback from them ... Previously I'd refer people privately without Medicare

(obviously) and I'd never hear from them again – well, I wouldn't often have any feedback from the psychologists and that. Not like they have to provide now, which is good.”

“Very good. Appropriate, good in this area with most psychologists.”

“Fine, yes, usually done, in fact almost exclusively done via written correspondence and occasionally by phone if – and that goes both ways, so sometimes they ring me and sometimes I'll ring them – if there's specific things I either don't want to put in a referral, or if something comes up during treatment. It's probably more often that they would ring me, but yes, certainly there's been times, you know, it's not infrequent that I would contact one of them part way through treatment and say 'this issue has come up can you assist with this.'”

“It has definitely facilitated collaborative care ... When you do a referral under that, you expect to get stuff back and you nearly always do and so therefore, you know, you're able to include those suggestions into the care plan and modify it and through the use of outcome measures, and it's a much more structured way of providing mental health care. The consent of part of the care plan is also very good to have that documented to know that if you are concerned you can ring the allied health provider and they do the same thing. And you've got the patient's consent to do that so that sort of secures it medico legally.”

Seven GPs (22%) indicated that their communication with the psychologist was variable and/or insufficient. Some (four, or 13%) attributed this to a lack of time on the part of both parties, and indicated that this had always been the case. Others (two, or 6%) felt that there were some specific aspects of Better Access that led to communication difficulties, notably confusion regarding the Medicare item numbers. Typical comments from these GPs included:

“Varied. I think there are a good proportion of psychologists who are excellent and have been fabulous in communicating either [in] written [form] or by phone and in those cases I find it a terrific process. It's been terrific to get really detailed helpful feedback and when it happens it's terrific and there are of course a proportion of people that don't write back as well, and that's frustrating but in the cases where it happens it's excellent, really very, very useful ... most of the time, I would say.”

“Great generally, but I find that sometimes letters [from the psychologist] are overly brief ... and really don't add anything to my understanding of the patient or the treatment plan, and sometimes they're excellent ... The most useful thing for me is when I speak by phone to them and get their assessment. That's hard [and] takes more time of course but I find that the best way to communicate.”

“Not very often, as the other clinicians were very booked as well. Also trying to coordinate appropriate times to discuss patient care was difficult.”

“So I think it's a bit confusing, like some psychologists don't seem to send the patients back for review, but still keep claiming the sessions. There ... seems to be uncertainty about ... whether Medicare [will] pay if your item number doesn't appear. I'm not sure about that, I thought that they don't get the extra six [or] the patient ends up not getting the money back. Well, yeah, I'm not sure about that ... Maybe some just get through, but my impression was [it was] more like an auditing issue where... if the review hasn't been done, then the psychologist could be in trouble. But as to whether they actually pay or not, I got the impression they still paid, but I can't remember a patient that came back, who's ever come back and said 'I couldn't' or anyone's ever

claimed not getting paid, simply because a review hadn't been done after six sessions. So that's an area that could be clarified."

Logistics of registering with and billing Medicare

The majority of GPs (19, or 59%) said that they did not experience any difficulties registering with Medicare. They described the process in positive ways, using phrases like:

"No problem at all."

"Straightforward after completing relevant training and many ... had a practice manager assist them with registering."

A smaller number (six, or 19%) reported some difficulties, mostly related to having to undergo specialist training or that their previous training had occurred too long ago or was not recognised. This group made statements like:

"I had the limited experience in psychiatry. Mental health training came here and [I] did some courses and got myself registered, when this thing came in ... They didn't register my previous ones so I had to go back and do other things for the practice purposes ... They said, 'That's not done, you have to do something new', and then I had to sit and do a different one which I had done already. I found that funny."

Most GPs found the process of billing Medicare relatively easy. Twenty two (69%) reported having no problems with billing Medicare, finding the process straightforward and streamlined. The following comments are typical of their responses:

"Quite straightforward. I don't think I have had any particular hassles. Once you get your head around the item numbers, they are quite straightforward."

"I haven't found a problem with it. It's been pretty easy. Obviously we are only really using three item numbers – 2710, 2712 and 2713 – for the assessments, the plan and the review of the mental health plan."

A smaller number (seven, or 22%) experienced some difficulties, mostly to do with recommending additional sessions following a review, knowing when to use the item numbers (particularly if consumers presented with physical comorbidities as well as the mental health problem), and ensuring that they were adhering to the conditions of use of the item numbers. The following quotations illustrate this range of difficulties:

"...Logistically it has worked. I guess sometimes there are a few quibbles about when you're doing your reviews and whether you have a big enough gap between them and ensuring that people who have had extenuating circumstances [receive extra sessions]. Where they need more than 12 sessions, and you're trying to get them the 18 sessions, sometimes that takes a bit more persistence, but I think as a practice for us, we've kind of worked out how to do that so that we don't get rejected, we've worked around it but it hasn't been completely straightforward."

"Mostly no problems now. Our receptionists do it and it's mainly 2710s 2712s and 2713s ... Sometimes we are getting them [the 2713s] queried and coming back and each different person in Medicare on the hotline would have a different interpretation of them. I think now I understand their criteria better and it's less of a problem but a lot of them were getting rejected early on and I wasn't understanding that you could

put something on them to say could they have an extra six sessions because of x, y or z. [It's] generally okay but a bit of an extra encumbrance."

"Very hard ... Patients hardly ever come here with just a mental health ... often they've got some other thing and it's just at the last minute the [mental health problem is mentioned] ... Often you will find that in the consultation you are dealing not just with a mental health problem but with other issues, so it becomes hard to know now whether to bill it as a mental health thing ... Initially it was a problem [because] I wasn't sure whether to bill it to Medicare as a long consult or to bill it as a mental health thing ..."

"... [The] only issue has been people have turned up who've already had a 2710 done elsewhere and perhaps [I] wasn't completely aware of that. How does that affect you if that's happened? Because I think it's just been a bit confusing if it's already been claimed and they've come in ... It's just when people are not sure how the process, or it hasn't been explained to them how the mental health care plan works. Does that mean you don't get paid? ... In a situation like that I am usually referring them to my choice of ... psychologist who hasn't been who they've been attending so I don't have a copy of the original plan so it's a little bit awkward ... I sort of do my own letter, I claim as 2713 for the consultation but then I need them, well they need to remember how many sessions they've already used up, and it just means it's hard when you are come in as an extra to try and regroup and carry on with someone new, but that's the only issue."

Charging policies

The majority of GPs (22, or 69%) indicated that they bulk-billed all mental health item numbers. Some did this in the context of bulk-billing all consumers, others because they found that many of the consumers who required mental health care were disadvantaged, and others because they thought the schedule fee was sufficiently generous. These GPs made comments like:

"... We're a practice that bulk bills anybody on healthcare cards, or low incomes and privately bills other people generally, and with the mental health item numbers – particularly the mental health care plans – I mostly bulk bill everybody because I think they are reasonably generous, they're rebated and patients [and] I find that quite satisfactory."

"We have just decided that all mental health item numbers are being bulk billed. So basically 2713, 2710 and 2712 in our practice are being bulk billed, even though we are not only a bulk billing practice. Mostly we are feeling that patients are usually ... quite needy financially as well, and I don't want to add to their stress."

"Bulk billing for those patients that are on the programme."

Eight GPs (25%) indicated that they bulk-billed some consumers but not others. They said that the decision was based on whether the given consumer was a low income earner and/or on a pension or held a health care card. Standard responses from this group included:

"The 2713 is negotiated with the practice ... We make a decision about bulk billing on people's health care cards, so people with health care cards get bulk billed for everything or children, anyone who gets the bulk billing incentive, otherwise we can do it privately. But, having said that, where I work, 80% of them are on health care, so we're largely a bulk billing practice."

"I have my personal charging policy that I apply to all of my consultations and that is that anybody who is on a health care card, or any form of government benefit, is bulk-

billed. Others usually will pay the gap. I waive that with individual discretion. Anyone under 16 is automatically bulk-billed.”

“I have quite a sophisticated billing system which I across the board because I have a system of voluntary patient registration, which has a fee associated with it. Then, when people do register with my practice, they will get a discounted billing rate and if they have a concession card, then they do get bulk billed and that's for all services, not just for particular item numbers, so it's fairly complicated.”

Positive impacts for GPs

GPs were asked whether Better Access had positive impacts for them, and 26 (96%) indicated that they had. Table 50 summarises the kinds of impacts that these GPs mentioned.

Table 50: Positive impacts for GPs (n=32)*

	Freq	%
Reducing work demands for GPs	12	38%
Improved access for consumers	11	34%
Financial benefits for GPs	10	31%
Affordable care	5	16%
Improved integration	3	9%
Clear pathways	3	9%

* Multiple responses permitted

The most commonly reported positive impact, mentioned by 12 GPs (38%), was the reduction of demand on them to provide psychological therapies or address the mental health concerns of their patients on their own. They often commented that psychologists had more specialist training in this area, and were therefore better placed to provide this sort of care. These GPs gave responses like:

“For me, it's taken away a lot of that need for just seeing people ... for ... sort of supportive counselling ... to try and help them through some of their concerns. So it freed me up from doing that and I think that gives them a better chance as well.”

“I don't have to counsel all the patients which I've [have] had [to do] before because they couldn't afford to go to a psychologist. At one stage, I was going to take a CBT course just to help the patients through and when this came in then I thought, ‘Why bother because they do their job and I do my job.’ [It's] easy [because] they have it on Medicare so the patient doesn't need to pay out-of-pocket ... and the patient comes back with positive outcomes. Multiple things, it's good.”

“I do less counselling myself so it takes a bit of stress off there and I've been able to see positive results in my patients, which [has] made me happy.”

A number of GPs mentioned positive impacts for consumers, noting that these had flow-on benefits for them as providers. Improved access and increased affordability for consumers were mentioned by eleven (34%) and five (16%), respectively, in the context of their improving professional satisfaction for GPs. These GPs made statements like:

“It's very much easier to access therapy for patients now and I guess that means we do a lot less ringing around, trying to find a suitable therapist or psychiatrist. It makes my life incredibly easy compared with prior to the access to psychologists.”

“It's very satisfying to be able to get someone in for psychological services who previously wouldn't have been able to afford. That's the main one.”

Around one third of GPs (ten, or 31%) commented on the financial benefits of Better Access. They talked about being able to take longer with consumers with mental health problems, and being adequately reimbursed for their time. The following responses were typical:

“I tend to only really use [the] 2713 number myself apart from the 2710 and 2712 on referral, so I don't do a lot of the direct ongoing psychological practice, but using the 2713 number does allow me a little bit more time and [to] be reasonably remunerated for my time.”

“I feel less guilty when I spend more time with a patient that has mental health problems. It's good that I am getting paid for it and reimbursed for my time and energy.”

Other less frequently mentioned positive impacts were improved integration/co-ordination of care (mentioned by three, or 9%) and clear pathways for referrals (also mentioned by three). Both were seen as system-level improvements that made the GP's role in the provision of mental health care more streamlined and collaborative.

Negative impacts for GPs

GPs were also asked whether Better Access had negative impacts for them. Eleven GPs (34%) explicitly said that the scheme had no negative impacts for them. A further 21 (66%) mentioned some negative impacts, but usually indicated that these were quite minor. Often they regarded these impacts as small inconveniences, and noted that the overall benefits far outweighed these. Table 51 summarises the negative impacts that were mentioned by GPs.

Table 51: Negative impacts for GPs (n=32)*

	Freq	%
Increased paperwork	9	28
Increased demands	8	25
Lack of understanding by consumers	6	19
Misuse of the Better Access Item	1	3

* Multiple responses permitted

The most commonly cited negative impact, mentioned by nine GPs (28%) was the increased paperwork associated with the initiative. These GPs made statements like:

“Look, the only negative impact really I can think of would be the administrative burden to ourselves preparing the formal mental health plan, and I understand why that's been instituted – to make sure that referrals are reasonably detailed. I actually don't find the mental health plan a substitute for a decent referral letter, so I find myself duplicating, because I write the mental health plan and then I write a detailed referral letter as well, which has duplicated information in it, and I personally think that the referral letter could probably give more efficient information, instead of just a narrative of the problem.”

“I don't think there have been any negative impacts. Perhaps a little bit more paperwork, that's about all I can say. But being able to refer to psychologists is wonderful.”

Increased work demands were mentioned as a disadvantage by eight GPs (25%). These GPs made comments about time pressures and emotional demands. Some also noted that the increase in their workload had led to an increase in waiting times for consumers to see them and the psychologist.

"It's very time consuming, so it's really hard when a patient's trying to get in so it's time consuming, I find the actual consult, if you give even a double appointment to a triple, like 45 minutes, it's always over, it just takes time, and so when you have 2 or 3 in a session, you've seen 3 people, and not much else, so it's very time consuming, and just emotionally draining, personally, sometimes. And so just doing a lot of work sometimes, I just get, sometimes I go through patches and I'm just getting, from one after the other, I personally find that a bit hard. It's rewarding, I'm happy to do it for the person, the need is there, but personally I find it hard, a heavy load at times."

"At the moment we are in a situation where my waiting times just for normal appointments are 8 weeks so that's the pressure that we are under."

"And the only other disadvantage has been because, well initially when it came out only that there were only a few GPs adopting it, and then more psychologists came onboard, and basically we went through a period where there wasn't very much of a waiting list, but then as more GPs came onboard, using the item numbers, there now is quite a substantial waiting list."

Consumers' lack of understanding was cited as a negative impact by six GPs (19%). Some referred to consumers having a limited comprehension of the way in which Better Access worked, and others talked about consumers' unrealistic expectations of the psychological care they received through Better Access. Typical comments included:

"The only negative side would be the patient going to a psychologist self-referred and then coming back and demanding a 2710 thinking they can get it across the counter ... For us, [for] every 2710 we do we do a full assessment. If you did want a negative you could say that was time consuming, but the end justifies the means ... it's worthwhile overall."

"... Some people think going to a psychologist fixes everything. Sometimes we have to explain ..."

One GP (3%) was concerned about public sector mental health services and/or Federal agencies such as Centrelink referring people for Better Access care inappropriately. This GP said:

"The psychiatric services see this as a way of them removing themselves from providing psychological counselling and support to people with much more serious mental illnesses and this system does not suit the people with serious mental illness. And they keep sending them back to me saying, 'Please refer to a psychologist for Better Access' and it's really not suitable. But that's about being cost driven I think, from State funding to Federal funding."

"I have seen Centrelink abuse the system ... where somebody has been on a disability payment due to mental health problems like a chronic anxiety disorder, and they send them to me to get a mental health plan done so that they can send them to a psychologist to get them back into the workplace. But they've already made the appointment to see the psychologist to who it's going to be. Twice that's happened. Some of my patients haven't engaged with it, they have come back saying that they

didn't find it helpful, but that's not necessarily a drawback, that's just that it doesn't suit some people, I think."

Perceived positive impacts for consumers

Almost all of the GPs (31, or 97%) felt that being able to provide psychological services via Better Access had benefited consumers under their care. Table 52 provides a breakdown of the kinds of benefits these GPs discussed.

Table 52: Perceived positive impacts for consumers (n=32)*

	Freq	%
Specialist care	16	50%
Improvement in mental health status	11	34%
Reduces financial strain	10	31%
Treatment choice	6	19%
Ease burden on public sector mental health services	3	9%

* Multiple responses permitted

The main perceived benefit, reported by 16 GPs (50%), was consumers' improved access to providers with specialist skills in mental health care. Six GPs (19%) made similar observations, talking in terms of the treatment options made available by the increased access to specialist providers. The quotations below illustrate these points:

"They've had more access to long consults, I suppose, with more of a chance to talk and whilst I like doing that, I am happy doing that, I feel comfortable and I feel trained to do that, I don't have enough time to fill the demands ... There is a huge demand for that kind of thing and I feel that being able to refer out to that just for people who couldn't afford it previously has been a huge help to their access to things to help with largely depression and anxiety, OCD and even psychosis and things like that. It's been a great help to them I think, because they are not having to wait longer and longer to get in. They can usually see a psychologist in a week or two. Also they [psychologists] are better trained for it. Many things I do feel comfortable with, but many of them I am sure they get a better treatment from the psychologist."

"They're getting more specific psychological care from someone who's got more training than I have and more expertise in that area."

"The numbers have allowed identification of problem areas and then ... enabled referrals on to more pertinent allied health services, so if it's out of area of expertise then that patient is referred on to a psychologist and then that has a positive outcome for them."

"Absolutely, in that they are able to access more appropriate care. Previously most of my patients wouldn't have been able to afford a private psychologist and may have ended up going to a psychiatrist instead, which was not necessarily appropriate for their care, or to a social worker, counsellor, and that may not also have been appropriate for their care ... I think I see patients getting better in greater numbers and more quickly. And I think I see more patients who improve, but that's only anecdotal."

Another recurring theme was the perception that Better Access had improved mental health outcomes for consumers. GPs reported that they had taken consumers off medication, and had noticed sustainable and long-term changes in them. Some commented on consumers being able to return to work. Eleven GPs (34%) made comments of this sort:

“... Now I get probably somewhere between 80%-90% of my patients off medication, and that was much harder when they hadn't had the counselling and the psychological treatments that helped make the changes in the behaviour and the thinking. It's more than 80% but less than 90% of patients, somewhere around that I reckon, that I get off medication. I make the first attempt at six months, [although] I think it's probably more about 18 months to two years that people ... [see] the sustainable change. And now I probably have a larger number that don't even go on medication, that we actually send to the psychologists and that's enough. That would probably only be about one instance.”

“We have lot of patients benefited. [A] lot of them [are] stabilised at work, [a] lot of them return to work, [a] lot of them [have] kept their work after short crisis and [are] really good in fact. They're on medication, [GP] counselling and psychologist counselling ... [it] makes a big difference for them. There is bipolar and all, so that's something difficult, but in general, depression and family issues or, I mean not chronic mental issues, they make big difference for patient.”

Another consumer benefit, mentioned by ten GPs (31%), was that Better Access made psychological care affordable for patients. The comments below illustrate this point:

“Definitely. Just the fact that they can access psychologists. The majority of the people that I would have referred would not financially have been able to afford to go to a psychologist privately, and the help that they have received in being able to access that service has been wonderful ... I think it's been a huge benefit to the patients, and that's something that's very hard to quantify ... in terms of dollars. How can you put happiness or peace of mind or lack of anxiety and stress, you know, it's hard to put a dollar on that, in what the person's feeling.”

“Financially, it has helped the patients a lot. Instead of them having to pay a lot more out-of-pocket, they claim the bulk of it so that's been a great help. I don't refer as much to psychiatrists now, but then again I never did. I used to handle most of these things myself.”

A final, less commonly cited benefit included a reduced burden on the public mental health sector. This was mentioned by three GPs (9%).

Perceived negative impacts for consumers

Two thirds of all GPs (21, or 66%) perceived there to be no negative impacts of Better Access for consumers. Eleven (34%) articulated some negative impacts, often qualifying their statements with the assertion that there were many positive impacts as well. Table 53 lists the negative impacts that they mentioned.

Table 53: Perceived negative impacts for consumers (n=32)*

	Freq	%
Waitlist	3	9%
Not enough sessions	2	6%
Affordability	2	6%
Confidentiality/ public access	2	6%
Service gaps	1	3%
Patients' preference	1	3%

* Multiple responses permitted

Three GPs (9%) noted that the referral process sometimes created delays for consumers, because they had to see the GP before they could see the psychologist. One put it this way:

“Just the delay in that they have to book ahead a time with me when I have got half an hour to do it which will delay the access ... To access directly the psychologist for instance there wouldn't be this wait.”

Two GPs (6%) indicated that sometimes the restrictions on the number of available sessions posed problems. One said:

“Only when needy patients reach their maximum number of sessions it can be difficult, but that's not often. Usually we manage that quite well. Occasionally that can be difficult when there's a gap.”

Two GPs (6%) felt that the cost of the “gap” payment remained prohibitive for some consumers. One summarised this sentiment the following way:

“I don't know if it's a negative impact or not, but I think there are still a lot of costs involved to the patient ... in seeing a psychologist. There is still a lot of disparity in fees and if it's not a clinical psychologist just a normal psychologist and they're charging the full whack – \$150 or whatever – [there are] big gaps. Sometimes I don't know what those gaps are going to be so that might be a negative impact – that the patient actually ends up paying bigger gaps than either they or I anticipated. It's just a thought but I think it still comes sometimes at quite a cost, though we have got the ATAPS scheme to fall back on as well ...”

Two GPs (6%) indicated that consumers had approached them with concerns about the confidentiality of their information. These GPs indicated that a perception that their privacy might be breached sometimes acted as a disincentive to seeking care. One of these GPs explained this in the following manner:

“I have had a couple of people who have enquired about the fact that they then have a mental health item number through the HIC and I've given them that brochure that we have about it, and so some have chosen not to participate ... I had one patient who is a psychologist herself who didn't want to do things through the mental health care plan system because she had concerns about confidentiality amongst [the] bureaucracy I suppose.”

One GP (3%) commented on false positives and false negatives in terms of referrals, noting that some consumers with minimal need for mental health care were being referred to psychologists, and others with high levels of need were “slipping through the net”. Another reported that some consumers preferred to see GPs for counselling rather than be referred to another provider.

Additional comments

GPs were given the opportunity to provide additional comments regarding Better Access. Thirty (94%) took the opportunity to expand on some of the issues that they had raised in response to earlier questions. In particular, 18 GPs (56%) reiterated that Better Access was an extremely positive initiative, both for themselves as providers and for consumers. They made summary statements like:

“In summary, that it is a simple system that's working very well, with positive outcomes. Definitely a lot of positive outcomes.”

“I actually think that it's the single change in Medicare, over the last 10 years, that has probably made the most difference to my working life, you know, had the most benefit. I think it's really critical for GPs and patients that access to psychologists continues ...”

“I think it's an excellent scheme and I hope it continues with a greater benefit for myself. At the same time, I believe the rebate is quite appropriate for the services I provide.”

Seven GPs (22%) expressed a desire for clarity from Medicare regarding rebates, legal and auditing obligations, and item descriptions, and greater consistency among doctors in preparing mental health plans. The comments below are typical of their responses:

“[I'd] like to have it very clear what is the minimum Medicare requires in a referral to [avoid being] audited ... I'd love to see it changed to just a comprehensive letter ... rather than the standardised form that isn't necessary, in my opinion, for all the patients. I also feel well I am putting a lot of effort into these and I know that a lot of other doctors are, but I also know that a lot of other doctors aren't, and we are getting the same money for them and that doesn't feel fair. I have been working for 18 years in general practice and I have never been audited, so I think unless you really stick out as being vastly different to the majority, you don't get audited. Therefore, I feel ... you can get away with writing a brief standardised referral like 'Depression', 'Goals: To feel better', 'Action: See psychologist', and I feel like I am putting a lot more into them. I think given the money that's paid, more should be put into them. I think at the moment it's too much and then people are getting away with really crappy referrals as well and that doesn't seem fair.”

“More explanation about the different item numbers, but that's something I have to look into with Medicare ... explore ... You know what I could benefit with is a list of the item numbers under mental health printed in concise form [with an explanation of] what they all are paying for. [That] would be beneficial.”

Three GPs (9%) stressed that although Better Access was a positive initiative, it did not meet the mental health needs of all consumers. Their views are summarised in the following statement:

“In general I think it's been good. Possibly it's ... still not getting to the neediest of psychological therapy. I think possibly that people who access the scheme are sometimes better informed and more together. On the other hand, it's good to have it there and, yes, on the whole I think it's been a good scheme. [We] just have to try and make sure that ... the people who really need it can access it as a money thing.”

Chapter 8: Discussion and conclusions

Summary of key findings

Characteristics of Better Access consumers

Medicare data show that two thirds of Better Access consumers are female, and that three quarters are aged below fifty. Location-wise, around three quarters reside in metropolitan areas, and about half live in areas that make up the two quintiles of least disadvantage. Our consumer samples were broadly representative of all Better Access consumers, although our sampling strategy resulted in some over-representation by consumers in rural areas and consumers in areas of relatively greater disadvantage.

Notwithstanding these relatively minor discrepancies, our study provides the first clinical profiles of Better Access consumers that are based on systematically-collected data. Data collected via our minimum dataset suggest that Better Access consumers are not “the worried well”. The vast majority (over 90%) of our participating consumers had diagnoses of depression and/or anxiety (with or without co-morbid conditions), and many (over 80%) had high or very high levels of psychological distress. Our data also refute the suggestion that many Better Access consumers are people who were already “in the system” – around half of our consumers had no previous history of mental health care.

Outcomes of Better Access care for consumers

Participating consumers who received care from clinical psychologists, registered psychologists and GPs under Better Access shifted from having high or very high levels of psychological distress to having much more moderate levels of psychological distress (as assessed by the K-10). Consumers who received care from clinical psychologists and registered psychologists also showed shifts from moderate or severe levels of depression, anxiety and stress to having normal or mild levels of these conditions (as assessed by the DASS-21). These consumers clearly achieved positive outcomes, as assessed by these standardised measures. These outcomes were not only statistically significant; they were clinically meaningful too.

Our analyses of predictors of outcome should be treated with caution; the numbers in each of the three analyses were relatively low, which means that the results are conservative. Factors which did not appear to be significant predictors of outcome may in fact have emerged as significant had the numbers been greater. Nonetheless, the analyses allow us to make some early observations. Perhaps most importantly, our findings suggest that, in the main, socio-demographic factors did not appear to have a major influence on outcomes; equivalent outcomes were achieved irrespective of whether the consumer was male or female, young or old, or wealthy or struggling financially. Instead, clinical and treatment variables were generally the ones that made a difference. For consumers recruited by all three types of providers, those with worst baseline manifestations of psychological distress (i.e., higher pre-treatment K-10 scores) made the greatest gains. For consumers recruited by clinical psychologists, no other variables were predictive of outcomes. For consumers recruited by registered psychologists, those who had completed treatment or were still in treatment experienced greater gains than those for whom treatment was incomplete, and those in metropolitan areas showed lesser improvement than their rural counterparts. For consumers recruited by GPs, those who had six sessions of care experienced optimal outcomes, and those who had no previous history of mental health care showed greater levels of improvement than those who had received mental health care in the past.

Consumers' experiences with receiving care through Better Access

Participating consumers were extremely positive about Better Access, and their reports were consistent with the above findings with respect to their characteristics and outcomes. They provided corroboration for the suggestion that, as a group, Better Access consumers have significant mental health problems and are experiencing high levels of psychological distress; the most common triggers to their seeking care were a deterioration in their mental health and wellbeing observed by themselves or others, and specific traumatic events. Their subjective reports of improvement provided further evidence that Better Access is achieving positive consumer outcomes; the majority indicated that they had experienced significant changes for the better in terms of their mental health and their ability to cope with stressful situations, and that often this had gone hand-in-hand with rejuvenated outlook and/or improved life circumstances. They commonly spoke of improvements in their mental health, discussing reductions in symptoms and commenting on the strategies they had learnt to modify maladaptive thought patterns and change negative behaviours. The majority attributed these changes, at least in part, to the care they had received through Better Access.

Many consumers had experienced hurdles to accessing mental health care in the past – often related to cost – and they appreciated the fact that Better Access had made mental health care more readily available. They experienced extremely high levels of satisfaction with the care they received from the various providers. They appreciated the professional skills and competencies of these providers, often commenting on their ability to establish rapport, their communication skills, their listening abilities, their kindness, their empathy and their non-judgemental approach. Consumers also expressed satisfaction with the advice, strategies and guidance that they received from these providers. In addition to being positive about the clinical care offered by the Better Access providers, most consumers indicated that they found the process of dealing with Medicare very straightforward.

Relatively speaking, consumers had few complaints about Better Access. Those who did identify negative aspects tended to focus on the restricted number of sessions, or on residual difficulties with out-of-pocket payments. Some also found the process of “opening up” about their mental health issues quite confronting.

Providers' experiences with delivering care through Better Access

Participating clinical psychologists, registered psychologists and GPs were extremely positive about the Better Access initiative. Again, many of their views tallied with the evidence provided above with respect to the profiles of and outcomes for consumers. Many commented that they are now providing mental health care to a greater number of people, and that their caseloads include proportionally more people who have complex needs, are on low incomes, and would not have been able to access mental health care in the past. Many also mentioned that they are now in a better position to meet these consumers' needs because they can provide timely, comprehensive and integrated care. They perceived this to have direct benefits for consumers in terms of improved access and affordability of care, and, consequentially, improvements in their mental health status, understanding of mental health symptoms and how to manage them, and relapse prevention.

Participating providers were also positive about the processes associated with Better Access. In particular, they noted that the Better Access model of service delivery, which relies on psychologists and GPs collaborating with each other, has generally worked well. Each party has developed an increased appreciation of the role of the other in providing mental health care. The reporting requirements of Better Access have improved the two-way communication

between these providers. In the main, these providers have had positive experiences with dealing with Medicare.

Participating providers reported few negative impacts of Better Access. Sometimes communication has been sub-optimal; psychologists have not always received adequate referral information from GPs, and GPs have sometimes felt that they do not get sufficient feedback from psychologists about consumers' progress. Some psychologists and GPs have experienced administrative issues, such as difficulties with the interface between their own local systems and the Medicare system. Some GPs sought greater clarity around the "rules" of Better Access, and some psychologists questioned some of its restrictions on the number of sessions and forms of therapy that they could provide. Some psychologists were critical of the fact that GPs acted as the "gatekeeper" to their care. Some psychologists also commented on the level of the rebate, calling for it to be brought in line with the Australian Psychological Society's recommended rate. Some registered psychologists questioned the level of reimbursement for their services, arguing that they should receive the same payments as clinical psychologists.

Study limitations

Our response rates for participating clinical psychologists, registered psychologists and GPs were 8%, 8% and 3%, respectively. These sorts of response rates are common for studies of this kind.¹² Higher response rates would obviously have been desirable, but the samples were broadly representative of the groups from which they were selected, which engenders some confidence in the generalisability of the findings.

We could not calculate precise response rates for consumers because we were not privy to how many consumers each provider approached. We also have no way of ascertaining whether providers did approach their next 20 consecutive new consumers, or whether they were more selective. However, what we can say is that, ultimately, our samples of consumers were fairly representative of the groups from which they were drawn although participating consumers tended to be more disadvantaged than the overall pools of Better Access consumers, both in terms of being less likely to live in capital cities and more likely to live in areas of socio-economic disadvantage. They may therefore previously have had more limited access to mental health care. These characteristics may have meant they had particularly valuable insights about Better Access.

One further point to make about our samples of consumers is that those who did not speak English were "out of scope". This decision was made for resourcing reasons; we did not have the capacity to translate the interviews/surveys into other languages, or to make use of interpreters. We acknowledge, however, that this strategy introduced a systematic bias. The characteristics of Better Access consumers from culturally and linguistically diverse backgrounds may be different from those of their English-speaking peers, as may their clinical outcomes. They may also have different experiences of receiving care through Better Access.

Our evaluation relied heavily on outcome data collected from consumers via standardised measures and entered into the minimum dataset by providers. We acknowledge that this created some potential for data distortion, but the only way to have countered this would have been for us to recruit, follow and assess consumers ourselves, and this was not feasible from a practical or an ethical perspective. Our data collection was similar to other major real-world data collection exercises (e.g., the collection of routine outcome data in public sector mental health services across Australia). We also had the opportunity to "triangulate" our findings from the outcome data with our findings from the consumer interviews/surveys. Both pointed in a similar direction, giving us confidence in the data from our outcome measures.

Our interview/survey data collection relied on self-report. It examined the experiences of consumers and providers, so there were no right or wrong answers, but participants may have given responses that they felt were socially desirable in some way. There may also have been some biases in their likelihood of recalling particular experiences. Again, we would argue that the fact that there was a high level of correspondence between the different data sources strengthens the conclusions that can be drawn. For example, providers' perceptions of the benefits of Better Access for consumers aligned with consumers own reported experiences, and consumers' positive views of improvements in their mental health were consistent with the arguably more objective indicators of outcome taken from the standardised measures.

Interpreting the findings

The above findings are perhaps best interpreted in the light of the two key evaluation questions outlined in the Better Access evaluation framework and articulated in Chapter 1. To reiterate, these are:

- To what extent has the Better Access initiative achieved its objectives?
- To what extent has the Better Access initiative been an effective response to the need for primary mental health care for people with high prevalence mental disorders?

To what extent has the Better Access initiative achieved its objectives?

The current study provides evidence about the achievement of two of the stated objectives of Better Access:

- Encouraging more GPs to participate in early intervention, assessment and management of patients with mental disorders and streamlining access to appropriate psychological interventions in primary care; and
- Providing referral pathways for appropriate treatment of patients with mental disorders, including by psychiatrists, GPs, clinical psychologists, registered psychologists and other appropriately trained allied mental health professionals.

The current study certainly suggests that GPs are in a better position to play an important role in primary mental health care. According to those who participated in interviews/surveys, they are seeing proportionally more consumers with mental health problems, and are feeling better equipped to deal with them in an appropriate fashion. They can refer these consumers to specialised providers in the knowledge that the care they will receive will usually be low cost and high quality and will yield positive outcomes. They will not "lose" these consumers to the system; they will receive reports back from the psychologist (or other allied health professional), and will review consumers' progress at set points in their care.

The study also suggests that clinical and registered psychologists are an appropriate and effective point in the referral pathway. They have established two-way communication channels with referring GPs which are generally working well. They are providing evidence-based therapies (e.g., CBT) to consumers who have complex needs and may previously have had difficulty accessing psychological services for reasons of affordability. These consumers are experiencing gains in their mental health and wellbeing.

To what extent has the Better Access initiative been an effective response to the need for primary mental health care for people with high prevalence mental disorders?

The current study also suggests that Better Access has been effective in increasing treatment rates. Providers are offering psychological care to a greater number of consumers with disorders like depression and anxiety, many of whom are “new” to mental health care. These consumers value the care they are receiving. They recognise the specialised skills of the providers involved in delivering this care, and are satisfied with the nature of this care. Many report that they have learnt strategies that have led to improvements in their mental health and wellbeing. These reported positive outcomes correspond with significant gains on standardised outcome measures.

Conclusion

The findings suggest that Better Access is playing an important part in meeting the community’s previously unmet need for mental health care. The initiative has improved access to services for consumers who have clinically-diagnosable disorders and are experiencing considerable psychological distress. These consumers’ mental health status improves markedly during the course of their care; their symptoms reduce, their psychological distress diminishes, and their overall wellbeing improves. They are extremely positive about Better Access, appreciating the fact that it enables them to receive free or low-cost services from specialised providers. The providers are also positive, enjoying the role they are playing in facilitating access to quality care.

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Appendix 1: K-10

For all questions, please fill in the appropriate response circle. Fill in the circles like this: ●
Please do not tick or cross the circles.

In the past 4 weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
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1. About how often did you feel tired out for no good reason? ————
2. About how often did you feel nervous? ————
3. About how often did you feel so nervous that nothing could calm you down? ————
4. About how often did you feel hopeless? ————
5. About how often did you feel restless or fidgety? ————
6. About how often did you feel so restless you could not sit still? ————
7. About how often did you feel depressed? ————
8. About how often did you feel that everything is an effort? ————
9. About how often did you feel so sad that nothing could cheer you up? ————
10. About how often did you feel worthless? ————

Appendix 2: DASS-21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Appendix 3: Interview/survey questions for providers

Questions for clinical psychologists and registered psychologists

1. **In the last year approximately how many clients have you seen whose treatment has been partially or fully funded via the Medicare item numbers for psychological services?**
2. **Have the Medicare item numbers for psychological services had an impact on your consultations with clients? [For example: Have the Medicare item numbers had an impact on your overall caseload? Have you found the Medicare item numbers make any difference to the way in which you consult with individual clients?]**
3. **How have you found the process of communicating with other mental health care providers? [For example: How appropriate have you found the GP referrals? How have you found the referral information provided in the GP mental health care plan? What referral information from the GP would be most useful to you? How have you communicated information about the consumer back to the GP during and after treatment?]**
4. **How have you found the process of communicating with other mental health care providers? [For example: How appropriate have you found the GP referrals? How have you found the referral information provided in the GP mental health care plan? What referral information from the GP would be most useful to you? How have you communicated information about the consumer back to the GP during and after treatment?]**
5. **How have you found the logistics of billing Medicare for delivering psychological services? [For example: What was your experience of registering with Medicare as eligible to provide services? How about the billing process itself? Have you adopted a particular charging policy (e.g., bulk-billing clients on low incomes)?]**
6. **Have you found that being able to provide psychological services via the Medicare item numbers has had positive impacts for you? If so, what have these impacts been?**
7. **Have you found that being able to provide psychological services via the Medicare item numbers has had negative impacts for you? If so, what have these impacts been?**
8. **Would you say that your being able to provide psychological services via the Medicare item numbers has benefited clients under your care? If so, in what way?**
9. **Would you say that your being able to provide psychological services via the Medicare item numbers has had any negative impacts for clients under your care? If so, in what way?**
10. **Are there any additional comments you'd like to make about the Medicare item numbers for psychological services?**
11. **Sex (Tick response):**
[] Male
[] Female

12. Age group (Tick response):

- ≤29
- 30-39
- 40-49
- 50-59
- 60-69
- ≥70

13. On average, how many hours per week do you currently spend working in a private practice setting where you see clients with mental health problems?

14. On average, how many clients with mental health problems do you see in a private practice setting per week?

Questions for GPs

- 1. In the last year approximately how many patients have you seen whose treatment has been partially or fully funded via the Medicare item numbers for psychological services?**
- 2. Have the Medicare item numbers for psychological services had an impact on your consultations with patients? [For example: Have the Medicare item numbers had an impact on your overall caseload? Have you found the Medicare item numbers make any difference to the way in which you consult with individual patients?]**
- 3. How have you found the process of communicating with other mental health care providers? [For example: Have you found that the item numbers have facilitated collaborative care arrangements between yourself and other mental health care providers, such as private psychiatrists and psychologists?]**
- 4. How have you found the logistics of billing Medicare for delivering psychological services? [For example: What was your experience of registering with Medicare as eligible to provide services? How about the billing process itself? Have you adopted a particular charging policy (e.g., bulk-billing patients on low incomes)?]**
- 5. Have you found that being able to provide psychological services via the Medicare item numbers has had positive impacts for you? If so, what have these impacts been?**
- 6. Have you found that being able to provide psychological services via the Medicare item numbers has had negative impacts for you? If so, what have these impacts been?**
- 7. Would you say that your being able to provide psychological services via the Medicare item numbers has benefited patients under your care? If so, in what way?**
- 8. Would you say that your being able to provide psychological services via the Medicare item numbers has had any negative impacts for patients under your care? If so, in what way?**
- 9. Are there any additional comments you'd like to make about the Medicare item numbers for psychological services?**
- 10. Sex (Tick response):**
 - Male
 - Female

11. Age group (Tick response):

≤29

30-39

40-49

50-59

60-69

≥70

12. On average, how many hours per week do you currently spend working in a private practice setting where you see patients with mental health problems?

13. On average, how many patients with mental health problems do you see in a private practice setting per week?

Appendix 4: Interview/survey questions for consumers

1. **Was it a psychiatrist, psychologist or GP who asked you to participate in the evaluation?**
 Psychiatrist
 Psychologist
 GP

2. **Had you seen a psychiatrist, psychologist or GP for psychological services prior to 1 November 2006?**

Psychiatrist Yes No Not sure
Psychologist Yes No Not sure
GP Yes No Not sure

3. **Has cost been a barrier to your seeking care from a psychiatrist, psychologist or GP for psychological services in the past?**

Psychiatrist Yes No Not sure
Psychologist Yes No Not sure
GP Yes No Not sure

4. **Have there been other barriers to your seeking psychological care from any of these providers?**

5. **Thinking about your recent visits to the provider who asked you to participate in the evaluation, can you describe what prompted you to seek care from this provider?**

6. **If you did not continue with you psychological care or referral can you please tell me a little about why you discontinued?**

7. **How did you find the process of receiving psychological services that were refundable by Medicare?**

8. **Were you satisfied with the care you received from the psychiatrist, psychologist or GP? What aspects of the care were good or bad?**

9. **Have you noticed any change in your health and wellbeing since seeing the psychiatrist, psychologist or GP? To what extent would you attribute any change to the care provided by this provider?**

10. **Sex :**
 Male
 Female

11. **Age grouping :**
 ≤29
 30-39
 40-49
 50-59
 60-69
 ≥70