

Department of Health and Ageing

**Evaluation of the Better Access to Psychiatrists, Psychologists and
General Practitioners through the Medicare Benefits Schedule
(Better Access) Initiative**

Component D: Consultation with Stakeholders

Final Report
Executive Summary

June 2010

Contents

Glossary	1
Explanatory notes	2
Mental health in Australia	3
The Better Access initiative	4
Evaluation method	5
Summary of key findings	6
Improved access to mental health services	6
Appropriateness of services provided	8
Compliance with guidelines for the Better Access initiative	10
Options for improvement	15

Glossary

AASW	Australian Association of Social Workers
ACAT	Aged Care Assessment Team
ACCP	Australian College of Clinical Psychologists
ACMHN	Australian College of Mental Health Nurses
AGPN	Australian General Practice Network
AHP	Allied Health Providers comprising occupational therapists, psychologists and social workers approved to provide focussed psychological strategies through the Better Access initiative
AIHW	Australian Institute of Health and Welfare
APS	Australian Psychological Society
ATAPS	Access to Allied Psychological Services
BUPA	BUPA Australia (owner of MBF)
CALD	Cultural and Linguistically Diverse Communities
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive behaviour therapy
CPD	Continuing Professional Development
CPE	Continuing Professional Education
Divisions	Divisions of General Practice
DoHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
EPC	Enhanced Primary Care program
FPS	Focussed psychological strategies
GP(s)	General Practitioner(s)
HACC	Home and Community Care Program
HBA	HBA health insurance fund
HCF	HCF health insurance fund
MAHS	More Allied Health Services Program
MBF	MBF health insurance fund
MBS	Medicare Benefits Schedule
Medibank	Medibank Private health insurance fund
MHPA	Mental Health Professionals Association
MHPN	Mental Health Professionals Network
NET	Narrative Exposure Therapy
NGO(s)	Non government organisation(s)
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OTA	Occupational Therapy Australia
PHAMs	Personal Helpers and Mentors program
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
TIS	Translating and Interpreting Service
VoIP	Voice over Internet Protocol

Explanatory notes

Descriptors used within this report

Stakeholders varied in terms of the method through which they provided their information to the evaluation. Where possible, this report describes stakeholders in accordance with these methods as follows:

Interviewees – individuals who provided their information within the context of a face to face or telephone interview or focus group.

Respondents – individuals who provided their information within the context of a survey.

Stakeholders – individuals who were nominated by a peak professional representative body or state or territory health department to speak on behalf of the organisation.

Similarly, there is variation within this report with respect to the following terms:

Individuals – people within the community who may or may not be in receipt of services through the Better Access initiative.

Clients – the term used by Allied Health providers for the people to whom they provide services.

Consumers – people within the community who are consumers of mental health services, which may include services through the Better Access initiative.

Patients – the term used by psychiatrists and GPs for the people to whom they provide services.

Stakeholder views

This report presents a summary of consultations undertaken to end August 2009. The purpose of this report is to provide an indication of the range of opinions and comments that have been expressed by stakeholders interviewed. Unless otherwise indicated, the views expressed are those of individuals interviewed.

Following each consultation, a summary of key points was prepared, and then forwarded to the interviewees and stakeholders for comment, amendment and/or the inclusion of any additional information they wished to raise. In most cases, either a confirmation that the notes reflected the issues raised in the interview, and/or inclusion of some points of clarification or additional issues thought of subsequent to the interview, were received. In some cases, interviewees were asked to clarify issues through further discussion or to follow-up on any additional information that had been provided. Where responses were not received, it was assumed that the interviewee agreed with the notes provided. No further follow-up was undertaken.

As the groups and individuals consulted reflected a heterogeneous range of opinions the review has sought to capture the range of comments and opinions expressed and provide some indication of the relative strength of opinion by indicating whether an issue was expressed by nearly all, most, many, some, or few stakeholders. It should be noted that a numeric weighting of this nature is not necessarily an indication of strength or validity of the opinion expressed as this may vary in respect to the background, breadth of experience and understanding of the initiative by the respective stakeholders.

In respect to stakeholder comments on patterns of service utilisation across geographical areas and/or population groups these have not been validated against Medicare data and reflect only the comments of stakeholders consulted. Where supporting information has been provided the source of this information has been identified.

Mental health in Australia

The 2007 National Survey of Mental Health and Wellbeing¹ found that approximately one in five Australians experience symptoms of a mental disorder within any 12-month period.

The experience of mental disorder is highest in the younger age groups (16-24 years) where more than one-quarter experienced symptoms of a mental disorder in any one year. Mental disorders are also more common among people with chronic physical health conditions, with 28 per cent experiencing symptoms in a 12-month period compared to 18 per cent in the general population. Anxiety disorders are the most prevalent mental disorder in all age groups.

Despite the high prevalence of mental disorder in the general population, only 38 per cent of adults and 25 per cent of children with a mental disorder had sought treatment. Women and people aged over 35 years were the most likely to have accessed services. Individuals with affective disorders (for example depression, manic-depression) were more likely to access services (49.7 per cent) compared to those with anxiety disorders.

Mental health services are funded and provided from multiple sources and delivered by a range of professionals and organisations. Services are offered through primary care (including general practice, community nurses and allied health professionals), and from specialised mental health services (such as private psychiatrists, public community-based mental health services, public and private acute and psychiatric hospitals, and specialised residential mental health care facilities).

While private psychiatrists and private psychiatric hospitals treat both common and severe mental health problems, public community and inpatient mental health services are focussed on the delivery of services to individuals with the most severe mental health problems. This group of people make up approximately three to four per cent of

¹ Australian Bureau of Statistics *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*. October 2008.

the population or about 15 per cent of the total number of people who may experience a mental health disorder in any one year.

General practice is the most common service accessed for treatment of mental disorders and is the focal point for the delivery of mental health services to people with higher prevalence disorders not treated through the public mental health system. Prior to the Better Access initiative, treatment options for individuals with higher prevalence disorders were largely limited to services provided through general practice and Divisions of General Practice, private psychiatrists, private psychiatric clinics and counsellors and therapists in private practice. The availability and affordability of services was a major barrier in access to services for individuals in the community with common mental health disorders.

The Better Access initiative

Since the mid-1990s, federal and state/territory governments have been working together, through the National Mental Health Strategy and successive National Mental Health Plans, to coordinate mental health care at the national level. In July 2006, the Council of Australian Governments (COAG) agreed to strengthen the capacity of the mental health service system through a range of actions outlined in the *COAG National Action Plan on Mental Health 2006-2011*.

The *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative is part of the Australian Government's contribution to the COAG National Action Plan. Introduced in November 2006, the Better Access initiative provided changes to the Medicare Benefits Schedule (MBS) and introduced education and training for the mental health workforce. It aimed to encourage more general practitioners (GPs) to participate in the provision of mental health services, improve access to psychiatrists and enhance the availability and affordability of psychological services provided by psychologists, social workers and occupational therapists in private practice.

Changes to the MBS introduced in November 2006, and refined in the 2009-10 Federal Budget, provide a structured framework within which GPs can provide early intervention, assessment and management of people with mental disorders, and refer to community based mental health care providers. These changes include:

- a range of new GP Mental Health treatment items to better remunerate GPs for the time to effectively manage and provide quality mental health care to their patients;
- a new item for psychiatrist consultation with a new patient referred by a GP, coupled with expanded rebates for existing items related to patient assessment and preparation or review of a treatment plan to be carried out by a GP; and
- new items for allied mental health services – Psychological Therapy (eligible clinical psychologists) and Focussed Psychological Strategies (eligible psychologists, social workers and occupational therapists).

The Department of Health and Ageing (DoHA) engaged a number of external consultants to assist with the *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative. The evaluation was undertaken to assess the accessibility, appropriateness and effectiveness of primary mental health care provided to people with diagnosed mental health disorders under the Better Access initiative.

A modular approach to the evaluation is being undertaken examining consumers and their outcomes; analysis of MBS and PBS data; analysis of allied health workforce supply and distribution; stakeholder consultation; evaluation of major education and training projects; and analysis of the Second National Survey of Mental Health and Wellbeing.

Evaluation method

KPMG was contracted to undertake the Stakeholder Consultation component of the evaluation to develop an understanding of:

- perceived benefits and experiences of stakeholders in relation to access, appropriateness and effectiveness of the services;
- impact of education and training activities undertaken as part of the Better Access initiative on existing practices and the treatment of patients; and
- interaction between the Better Access initiative and other related initiatives.

KPMG adopted a staged approach to the consultation with national, state, regional and sub-regional stakeholders. These comprised psychiatrists, paediatricians, psychologists, general practitioners, social workers, occupational therapists, public mental health providers, non-government mental health providers, private hospitals, private health insurers, counsellors and therapists not eligible to provide services through the Better Access initiative and consumers and carers and their representative bodies. The consultations included individual and small group consultations, workshops, teleconferences of regional and remote service providers, consumers and carers and an online survey of service providers, consumers and carers. The consultations utilised a semi-structured approach with participants being provided with background information on the project and key issues to be discussed. As new issues were identified, these were discussed and probed in subsequent consultations. In excess of 1,300 individuals were consulted in the course of the project.

The strength of the approach adopted was the breadth of stakeholders consulted. Participants in the consultations were able to provide a richness of detail in their perceptions of the impact of the Better Access initiative on consumers and the wider mental health system.

A major limitation of the consultation process was that representatives of the professional bodies consulted with were familiar with and professionally engaged in the

Better Access Initiative and individuals participating in the consultations (via teleconferences, small group consultations and direct contact with the project) selected themselves. Almost by definition, the individuals participating in the consultations were likely to be those with stronger opinions one-way or the other, than would occur in a random sample of service providers, consumers and carers. The stepwise process of the evaluation also meant that, although issues that were raised later in the evaluation, were tested in subsequent consultations, it was difficult to assess the relative strength of this opinion across stakeholders. Within the context of this potential for participant bias, the evaluation has not quantified the number of respondents holding a particular view but endeavoured to provide a broad indication of the weight of opinion in relation to specific issues.

Summary of key findings

Achievement of key objectives

The Better Access initiative seeks to improve outcomes for people with mental health disorders through the following objectives:

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

Across all stakeholder groups the overwhelming view was that the Better Access initiative was effective in achieving the first of the above three objectives and that it was too early to tell in respect to the fourth.

Encouraging more GPs to participate in early intervention, assessment and management of patients with mental disorders

The predominant message from GPs were that they were doing more mental health work than ever before. The new MBS items for GPs were welcomed as recognising the effort in assessing individuals with mental health problems and developing care plans and treatment options. Most GPs noted that the capacity to refer patients to an allied health professional (AHP) provided the referral options to encourage and allow them to manage more patients with mental health problems.

Psychiatrists noted that with the new and expanded items for psychiatrists to undertake patient assessments and care plans, GPs were more willing and capable of managing more patients and more complex patients than before the Better Access initiative.

Nearly all AHPs noted that the number of GPs referring patients was expanding, AHP stakeholders were uncertain whether this was a feature of increased GP activity or the increased development of referral pathways.

Many public mental health providers noted an increased capacity to refer patients to their GP for common mental health problems, and the capacity for GPs to develop and coordinate treatment options.

Nearly all representatives of consumer groups and NGO mental health providers also noted the increased awareness and increased role of GPs in managing mental health problems.

Encouraging private psychiatrists to see more patients

All psychiatrists consulted indicated that the new MBS item for consultation with a patient referred by a GP and expanded rebates for existing items related to patient assessment and preparation or review of treatment plans to be carried out by a GP was effective in encouraging psychiatrists to see more patients. It was noted by most psychiatrists that they and many of their colleagues were now able to allocate scheduled timeslots to see new patients. They reported a greater preparedness to see new patients knowing that the GP would provide the patient's ongoing management and that alternative specialist mental health treatment options were available through AHPs.

Many GPs also reported that it was now somewhat easier to have a patient seen by a psychiatrist than prior to the Better Access initiative, although it was highlighted by both GPs and consumers that it remained difficult to gain access to a private psychiatrist, particularly a psychiatrist with low fees or who bulk billed. The GPs and consumers that discussed this difficulty in accessing psychiatrists predominately perceived it to be a result of there being too few psychiatrists.

A very small number of psychiatrists expressed hesitations about the Better Access initiative. This related to concerns of patients being 'held onto' by a GP and not being referred to a psychiatrist and/or inappropriately referred to an AHP for focussed psychological interventions when assessment and treatment by a psychiatrist would be more appropriate and achieve a better outcome for the patient. Most perceived this is an issue for increased education and training rather than an inherent problem with the initiative.

Providing referral pathways for appropriate treatment of patients with mental disorders

It was reported by all stakeholder groups that the Better Access initiative had both developed treatment options and developed and improved upon existing referral pathways between GPs, psychiatrists and AHPs. Service providers and consumers demonstrated an effective understanding of how these pathways worked and reported that referrals were initiated by all service provider groups (with AHPs and psychiatrists encouraging non-referred individuals seeking treatment to see their GP) and consumers initiating referrals by raising mental health issues with their GP and seeking a referral to an AHP.

Supporting GPs and primary care service providers through education and training to better diagnose and treat mental illness.

At the time of the consultations very little of the training planned to be provided through the Better Access initiative had commenced. As such, the majority of GPs and AHPs were unable to comment on the impact of the planned education and training on the diagnosis and treatment of mental illness.

The sole stakeholder who had participated in the rollout of the education and training that was just commencing in their local area identified the approach as positive in respect to both content and the opportunity to develop referral networks across GPs, psychiatrists and AHPs.

Constraints and opportunities

While reporting the success of the Better Access initiative, stakeholders noted that the improvements in access to services and referral pathways did not equally benefit all communities and population groups. All consumer groups and public mental health providers, nearly all GP and psychiatrists and most AHPs noted that some communities and populations benefited more than others and that many communities and population groups experienced barriers in access to service that included affordability of gap payments, service availability and appropriateness of the service model to their particular needs. The small number of stakeholders from very remote communities suggested that the Better Access initiative made it more difficult to access services because of reduced availability of AHPs to provide 'fly in, fly out' services through ATAPS or industry supported health care programs.

A more detailed discussion of the outcomes of the Better Access initiative, identified constraints and opportunities for improvement identified in the consultations follows.

Improved access to mental health services

It would appear from views expressed in the consultations and the volume of services funded through the Better Access initiative that the initiative has improved access to, and affordability of, mental health services in the community. The rapid increase in the volume of Better Access MBS items processed appears to suggest an increase in the

number of individuals accessing services for mental health problems through GPs, psychologists, social workers and occupational therapists (see Figure 1 below).

This is also self evident when we consider that a rebate is now provided for services that were previously only available to a limited number of individuals with capacity to pay the full cost of private service delivery and the relatively small number of individuals accessing services through GPs with Level Two mental health skills training², ATAPS, psychiatrists who 'bulk billed', services provided through other funding sources (for example DVA, Workers' Compensation, Victims of Crime) and a number of NGOs providing telephone crisis counselling and/or counselling services to selected client groups (for example in the areas of early intervention services, domestic violence, sexual assault, gender issues, etc).

Not only has the Better Access initiative increased affordability and access to AHPs that were in private practice prior to the initiative, the rebate and increased utilisation has allowed AHPs to expand their practices and new practices to be established, increasing access across geographic areas and to a wider section of the population. However, improvements in access have not been equal across geographical areas and populations and though overall access has improved some locales and population groups experience poorer levels of access than others.

Better Access has also succeeded in its aim to encourage more general practitioners (GPs) to participate in the provision of mental health services. Improving access to psychiatrists has been less successful although in some sites where the uptake of the new item numbers has been facilitated it has succeeded in improving access to psychiatry services.

² Level-2 GPs refers to GPs who have completed mental health training as described under the MBS schedule.

Figure 1: Number of services funded through the Better Access initiative

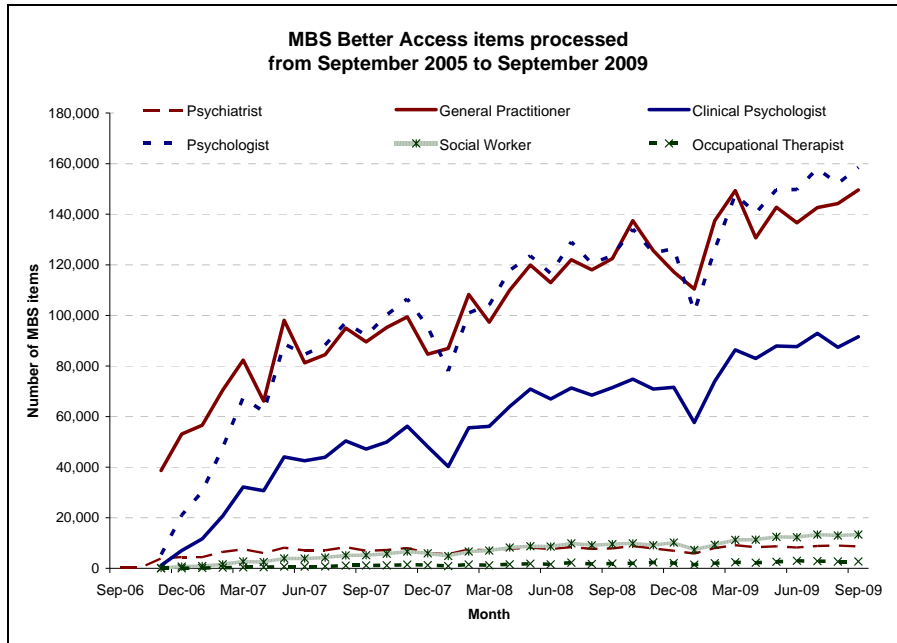


Figure 1 is based on Medicare Australia data and demonstrates continuing high rates of growth for services provided by GPs, psychologists and clinical psychologists. For and GPs, there was almost a 300 per cent increase in the number of MBS items processed each month between November 2006 and September 2009. This increase is artificially inflated as GPs have been the predominant provider of mental health services in the community for many years and much of the identified increase may reflect utilising the newly available specific item number for mental health services, instead of previously utilised general item numbers.

GPs also reported that the new MBS items provided a more adequate remuneration for the time spent providing mental health services and that they were now doing more mental health work than ever before. Overall, the Divisions of General Practice reported that the Better Access initiative was well established and strongly supported by GPs, particularly in relation to the capacity to refer patients to AHPs to receive focussed psychological strategies. Though most GPs were strongly supportive of Better Access, a number thought that there was scope to further improve access by continuing to enhance GP awareness of the Better Access initiative and improve their skills in mental health diagnosis and preparing Mental Health Treatment Plans.

Nearly all psychiatrists providing responses perceived the new MBS items as an effective means to encourage psychiatrists to accept new referrals and as supporting their tertiary assessment and consultation role. A number of psychiatrists reported setting aside regular appointment slots for new referrals. A number of GPs also reported a perceived improvement in access to psychiatrists as a result of the Better Access initiative. However, most GPs, AHPs and consumers also reported that it still remained difficult to access psychiatrists, particularly for patients who needed to be bulk billed or charged a reduced fee. This was perceived to be in part a result of a general shortage of psychiatrists. In some areas where the uptake of the item numbers

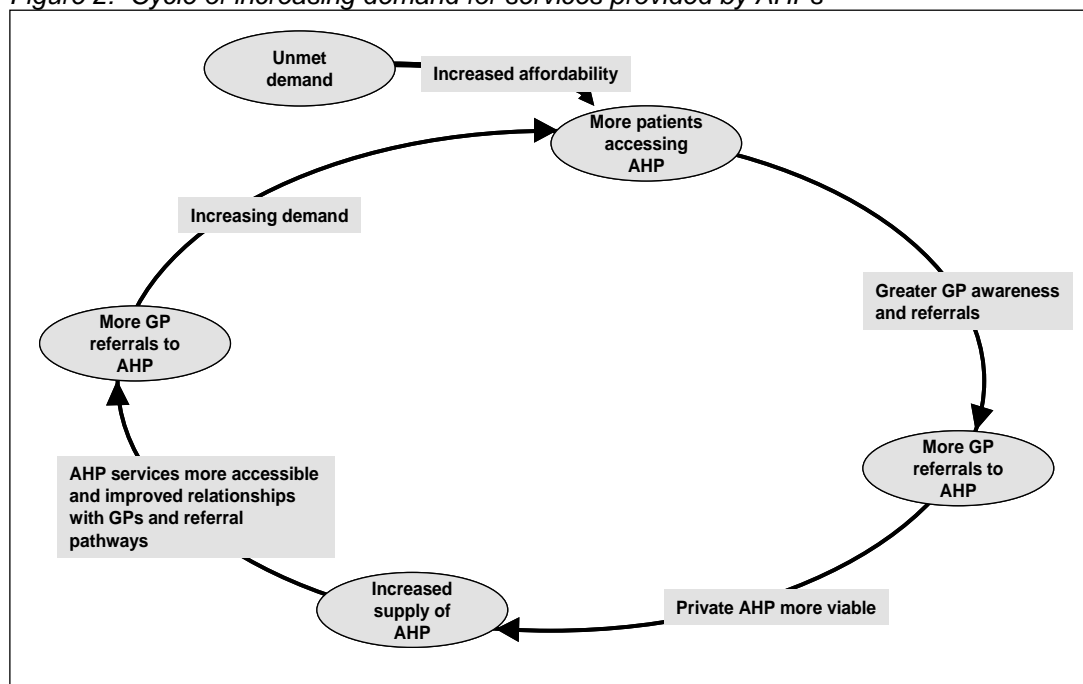
was supported there was a greater shift in psychiatry work practices increasing the number of new patients able to benefit from psychiatric input into their care. (UPASA in SA; GLAS in Brisbane).

There was also an increase in the number of services provided by psychologists. Prior to the Better Access initiative, Commonwealth mental health funding was limited to services provided through ATAPS and MAHS³, both of which had capped budgets administered by the local Divisions of General Practice.

Prior to the Better Access initiative, Medicare funding for mental health services was not available to social workers and occupational therapists. Stakeholders from within these groups suggested that the relatively low growth in services provided by these professions may be reflective of the relatively small number of providers in private practice.

Most AHPs interviewed (predominately psychologists), when commenting on the high rate of growth in services indicated in Figure 1 thought that the level of growth was unsurprising and that it would continue as a result of high levels of unmet demand in the community, increased affordability of services, increasing awareness of service availability by GPs and consumers, increasing referrals to AHPs from GPs and increasing supply of AHPs. Through consecutive consultations the review explored with AHPs the factors contributing to increased service utilisation to develop the conceptual framework identified in Figure 2 below.

Figure 2: Cycle of increasing demand for services provided by AHPs



³ More Access to Allied Health Services Program (MAHS) is not dedicated mental health funding, although it is used by some Divisions to provide mental health services.

All stakeholders and interviewees were unanimous in reporting a real increase in the number of people receiving allied health services through the Better Access initiative. Though it was noted that some of the service increase would comprise pre-existing clients of established AHPs now claiming the MBS rebate (i.e. people who were receiving or would have received services without the Better Access initiative), the effect of any shift in billing arrangements was perceived by AHPs as relatively minor and most of the growth after the first few months was perceived to be a result a real increase in the number of individuals treated.

Children were reported by GPs, AHPs and consumers as one group most benefiting from improved access to mental health services as a result of the Better Access initiative, although limitations were identified with the current items not facilitating services to parents in the absence of the child. AHPs also reported that increasing numbers of men and older people were accessing the services as awareness of mental health issues and service availability increased and stigma associated with accessing mental health services decreased. The later factor was seen by many AHPs and consumer representatives to be a result of wider mental health promotion strategies (such as awareness and prevention strategies around depression) leading to greater understanding of mental health issues in the community and local networks of knowing people who have used and found mental health services useful – ‘word of mouth referrals’. AHPs also reported an increasing complexity of individuals accessing the service as referral networks with GPs strengthened.

Although improved access to services was reported throughout the consultation process, a number of inequalities in access to services were identified. Disparities were reported to be present across a range of domains.

- Though children were a major beneficiary of the Better Access initiative because of the few services previously available, nearly all AHPs working with children expressed concern that the lack of MBS items to see parents or carers without the child present or provide family therapy meant that many children were not receiving the most appropriate care for their needs. Most AHPs and GPs also saw affordability of families to meet gap payments as a factor limiting access for children.
- Similarly, though many AHPs reported increasing utilisation by older people, many GPs and AHPs also reported that older patients faced issues of affordability of gap payments and AHPs working with older patients reported limitations on providing services to patients resident in nursing homes.
- Affordability of services for youth was also reported by GPs, NGO mental health providers, AHPs working with youth and consumers. It was also noted by AHPs that while youth had less capacity to pay a gap payment the cost of working with youth can be higher due to more time being required to engage with young adults, higher likelihood of comorbidities (such as drugs) and/or social welfare problems (e.g accommodation, income, employment) requiring engagement with other agencies and professionals and missed appointments.
- Issues of affordability were also reported for people on low incomes and those living in low socio economic communities. GPs were particularly aware of affordability of

gap payments for low income patients and the challenges of finding 'no gap' AHPs. Affordability was also an issue raised in all the small area consultations and discussions with consumers. A number of GPs and the small area consultations also noted less services being located in lower income areas and patients from these areas facing difficulties in both affordability and availability of services. Most AHPs also reported the difficulty of having a no gap fee given the level of MBS rebate that was available.

- The very few GPs, and AHPs and public mental health service providers working with Aboriginal and Torres Strait Islander communities also identified the challenges that people from these communities faced in relation to affordability and model of care. It was noted by these respondents that the need to be accepted within the community and develop wider family and community solutions to problems did not fit well with a fee for service model of care. Though several psychologists reported successful interventions based on the provision of secondary consultation services to local Aboriginal Health Workers, these were not funded through the Better Access initiative. Of those commenting on access by Aboriginal and Torres Strait Islander clients, it was generally believed that services for these communities may be more appropriately funded through alternative programs such as ATAPS or Aboriginal and Torres Strait Islander health services.
- Issues of challenges of providing an affordable and culturally appropriate model of care were also identified by GPs, AHPs, public mental health and NGO service providers working with culturally and linguistically diverse communities. As with working with Aboriginal and Torres Strait Islander people, the investment of time required to develop linkages with the community and other resources within the community is not returned in a fee for service model.
- The small number of GPs and consumers from remote areas reported that access to mental health services in these communities may have decreased. The GPs suggested that this was a result of the increased financial viability of private practice in metropolitan and regional areas, driving a reduction in the number of AHPs who may have otherwise worked in rural and remote communities through ATAPS. It was noted by one GP that not only was it more difficult to recruit AHPs, the cost to the Division had doubled.

Appropriateness of services provided

Nearly all interviewees across all stakeholder groups reported that the Better Access initiative had been successful in facilitating access to appropriate and evidence based mental health care and achieving positive outcomes for clients. It was also perceived that services were being provided to the intended target groups and that assessment, eligibility and treatment guidelines were being complied with.

Interviewees highlighted that, prior to the Better Access initiative; most individuals with a mental health problem were either untreated or received very limited treatment options. Consumers and NGO service providers reported that for many patients, the only treatment option was that provided by their GP. A strong theme reported by all stakeholder groups in the consultations was that, since the introduction of Better Access, individuals with a mental health problem have the opportunity to access

focused psychological strategies through the development of a comprehensive GP Mental Health Treatment Plan and referral to an AHP.

Consumers surveyed did not generally perceive any changes in the behaviour of their GP as a result of the Better Access initiative, and very few had had formal counselling sessions with them. Consumers interviewed generally had positive opinions in relation to their GP with very few (less than five per cent) reported strongly negative perceptions. Respondents critical of their GP were those who had no or very limited choice in GPs due to limited availability in their local area.

Limitations in the appropriateness of care provided were identified in relation to specific population groups and were perceived by AHPs to be a result of eligibility and administrative criteria relating to who can access services and the type of services that can be provided through the Better Access initiative.

GPs and AHPs working with individuals with complex needs, noted that these patients tended to require more intensive or different therapies than are covered by the Better Access initiative. In discussing this issues AHPs also noted that it was often difficult to identify clients with more complex problems on initial assessment as they often presented with a more straightforward condition such as mild depression or anxiety.

For children, AHPs working with children reported that the main constraint in the model of care related to the capacity to see the whole family or seeing the parents without the child present. It was noted that the Better Access initiative provides no MBS item for family therapy or seeing parents without the child being present.

Issues raised relating to working within Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities related primarily to the requirements for cultural sensitivity and the time required to engage with and be accepted by the community in order to work effectively. GPs, AHPs and public mental health service providers working with these communities reported that, in many instances, the most appropriate intervention by a mental health practitioner may be to work with workers located in the community, providing secondary consultation services and liaising with these workers to provide broader support to the individual. It was noted that the Better Access initiative provides no MBS items for secondary consultation services or case planning services provided by AHPs.

Several AHPs working with rural and remote communities, Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities and more complex and specialised treatment areas suggested that access and appropriateness of may be improved through the provision of MBS items for internet and telephone based therapy. This was identified as working well by several psychologists providing services of this type to residents in remote and rural areas and an Aboriginal counselling service providing telephone counselling.

There was also some questioning from some stakeholders as to whether the private practitioner model funded through the Better Access initiative is an appropriate model to engage with, provide services to and achieve the best outcomes for these population groups. These stakeholders considered that ATAPs or funding targeted to identified communities may be a more appropriate model.

Compliance with guidelines for the Better Access initiative

Overall, the perception of all stakeholders was that the services were being provided in compliance with the guidelines for the Better Access initiative. However, there appeared a wide variation in interpretation of the guidelines in respect to client eligibility and services that can be provided. The perception of most GPs and AHPs was that the eligibility criteria were broad enough to include most mental health conditions. Similarly, most AHPs indicated that the choice of intervention was based on the needs of the client and that most therapies would fall within the definitions of interpersonal therapy.

A number of providers (around one-third) indicated that the number of sessions available through the Better Access initiative did influence the choice and planning of interventions to try and remain within the approved number of sessions. The restricted number of sessions available was a concern of most AHPs with respect to providing services to clients with longstanding and/or more complex mental health problems.

A small number of GP, psychiatrists and psychologists raised concerns about some individuals in situational or relationship difficulties who were not eligible for services under the Better Access initiative being referred under a loose definition of anxiety or depression. A further concern of these respondents was the lack of outcome measurement and evidence base for services being provided.

The issue of who was referred was identified as the responsibility of the GP as the 'gatekeeper' to services through the Better Access initiative. While GPs and AHPs generally reported the importance of GPs maintaining the responsibility for making referrals, there was debate as to the requirement for GPs to maintain ongoing responsibility for the patient care under the GP Mental Health Treatment Plan.

The Better Access guidelines require a comprehensive diagnosis and treatment plan prior to the commencement of therapy. The majority (73 per cent) of respondents to the AHP survey reported that the information provided in the GP Mental Health Treatment Plan as good or fair and notably and 72 per cent of respondents reported that they had not received inappropriate referrals. Similarly in the consultations most AHPs reported that most GP referrals were appropriate and treatment plans were helpful. AHPs expressing concern in relation to appropriateness of GP referrals and information in the treatment plan noted that these were in respect to a minority of cases and that the quality of treatment plans was improving.

A number of psychologists and social workers and a small number of GPs argued that the Mental Health Treatment Plan could be undertaken by the AHP in instances where the AHP was assuming responsibility for the care and management of the client's mental health disorder. GPs reported, in some instances, that they were approached by an individual for a referral where they had not been involved and were not going to become involved in the ongoing management of the patient's mental health disorder. In this situation, a GP Mental Health Treatment Plan was perceived as adding little value to the treatment process.

They argued that it may be more appropriate to provide a referral to the AHP as they would refer to most other specialists.

Effectiveness of services provided

Overall, stakeholders and interviewees believed that the Better Access initiative has resulted in improved outcomes for clients. However, all service providers and professional groups noted that there had been no formal evaluation of client outcomes and that the quality and effectiveness of services provided were likely to vary across individual practitioners. A few service providers and consumers provided anecdotal evidence of poor outcomes following the provision of treatment under the Better Access initiative. GPs and psychiatrists indicated that feedback from their patients on the helpfulness of services received from AHPs was the primary indicator of the quality of service provided by individual AHPs. This information was used to inform subsequent referrals. Within this context, a number of GPs and psychiatrists reported an informal filtering of referrals to AHPs based on their perception of the quality of care provided and a matching of client need to AHP expertise.

Overall, consumers and carers reported high levels of perceived helpfulness of services provided.

Impact on the mental health system

Most managers of public mental health services reported a perceived migration of psychologists from the public sector to the private sector as a result MBS funding availability through the Better Access initiative. The shift, where it was reported, was not as great as expected, and a consistent view of psychology organisations and several state and territory health departments was that, where it occurred, it was primarily a move towards a mix of public and private practice. From consultations across states and territories it appeared to the evaluators that representatives from smaller jurisdictions were reporting a more pronounced shift than those from the larger states.

A concern across public providers and psychology organisations was that this shift, where occurring, was most likely to be in the more senior positions and that this may have a longer term impact on the capacity to provide training and supervision to trainee psychologists entering the workforce. It was suggested by several organisations that there may be a need to consider new employment arrangements incorporating private practice for psychologists and shared training arrangements across the public and private sector – similar to that in place for the medical workforce. Public mental health providers reported very little, if any, shift in employment practices for occupational therapists and social workers.

There were comments from the small area consultations and consultations with AHP representative bodies that the Better Access initiative may be having an impact on the distribution of the allied health workforce in private practice. This was identified as occurring at three levels:

- 1 responding to capacity to attract gap payments, there may be a relocation of providers to more affluent areas where higher fees can be charged;
- 2 the MBS payments have provided the ability for AHPs to establish practices in areas that would not otherwise be financially viable; and

- 3 new service models are developing with AHPs co-locating with GP practices to provide a more comprehensive service and facilitate cross referral.

These changes, where reported, do not appear to be very marked at this point in time.

A potentially more serious unintended impact of the Better Access initiative reported by GPs in remote rural areas may be the capacity to recruit AHPs to ATAPS and MAHS in remote areas and/or challenging communities. One remote area reported that the cost of sessional payments by psychologists through ATAPS had doubled to match the MBS rebate to clinical psychologists, and two reported that it was more difficult to attract staff.

Impact on workforce and models of care

During the consultation process, stakeholders and interviewees were asked to comment about a number of aspects relating to the skills of the mental health workforce, and the nature of the way they work together under the Better Access initiative. Overall, providers and professional bodies did not believe that the Better Access initiative had promoted interdisciplinary primary mental health care. Providers from AHPs and medical professions identified a number of barriers to providing interdisciplinary care. These included:

- absence of an MBS item for case conferencing limiting information sharing, integrated care planning and coordinated care;
- confusion among AHPs about the confidentiality of patient information and the need for greater clarification on exchanging information between AHPs and GPs; and
- limited understanding of the professional roles and capabilities between the different allied health professions, a factor perceived to be limiting referrals to social workers and occupational therapists and the provision of multidisciplinary care.

It was also noted by GPs, AHPs and public mental health providers that, although the public mental health system provided services to individuals with more acute, complex and/or chronic conditions than did the Better Access initiative, the two service systems complemented each other and that there was some commonality of patients. Services through the Better Access initiative were perceived as a valuable referral option for patients contacting, but not requiring services through, the public mental health system and also for post acute support for some individuals. Consumers and carers also perceived services through the Better Access initiative as important for many individuals with more complex and longer standing problems who may not have been able to access psychological therapies through the public mental health system.

The small area consultations and several consultations with AHPs in rural and regional areas reported that, in areas where public mental health services are not available or are more difficult to access, individuals with higher acuity and more complex care needs are being managed by GPs and AHPs through the Better Access initiative. Sometimes, this is in conjunction with ATAPS and other funding that is available.

At the time of the evaluation, Better Access specific training through the Mental Health Professionals Network (MHPN) had only recently commenced. As such, the consultations did not identify any significant improvements in access to training for GPs and AHPs.

Client characteristics

Though AHPs noted a broad range of clients using services, generally clients tended to have a diagnosis of moderate to severe anxiety or depression, largely reflective of the prevalence of these conditions in the general population. Most services were provided in metropolitan areas, reflective of the geographic dispersion of the population and location of AHPs. Services were mainly provided to adults, with some children, fewer older people and few, if any, individuals in nursing homes receiving services. Access by Aboriginal and Torres Strait Islander people and individuals from culturally and linguistically diverse communities was described as low. Importantly, it was noted by AHPs that they rarely 'turned away' referrals and that the characteristics of individuals receiving services was determined by the referring GPs.

It was generally reported that the Better Access initiative was well established and that psychiatrists, GPs, AHPs and other mental health services in the community were well aware of services available and how the referral process operated. It was noted by GPs and AHPs that referral processes and pathways are continuing to improve as the Better Access initiative matures. There was also a perception reported by GPs, AHPs, consumers and carers that general awareness in the community as to availability of services through the Better Access initiative was increasing.

Despite the generally positive consumer outcomes reported by AHPs and GPs, the Better Access initiative was perceived by psychiatrists, GPs and AHPs as having minimal, if any, impact on the level of medications prescribed for mental disorders. Generally, it would appear from the consultations that the Better Access initiative operated as a complementary treatment option to pharmacological interventions:

a small number of GPs noted that referral to an AHP sometimes allowed trialling non medical interventions or a treatment option for patients reluctant to accept medication;

AHPs noted that some individuals initiating referrals to an AHP did so as they wanted an alternative to medication; and

a small number of GPs and AHPs also noted that, on occasions, AHPs would refer back to the GP for a medication review to maximise the impact of the psychological therapies.

GPs, consumers and carers identified the 'gap' payment required for services provided by AHPs as an issue. The fee charged by AHPs and subsequent gap payment varied across providers, though many reported having an informal discounting process for clients in necessitous circumstances.

A contentious issue between clinical psychologists, psychologists and social workers was the differential Medicare rebate paid for services provided by clinical

psychologists. It was argued by a number of psychologists and social workers that the difference in 'gap' allowed clinical psychologists who received a rebate of \$37 to \$46 per session more than a psychologist or social worker, to charge a lower gap. It was then argued that the lower 'out of pocket' cost to patients in turn encouraged GPs to refer patients to, and patients to seek referrals to, clinical psychologists resulting in the provision of services that were at a higher cost to Medicare. Though outside the scope of Component D of the evaluation, the issue of whether clinical psychologists offered a materially different service and achieved better outcomes for patients than did psychologists, social workers or occupational therapists was also questioned by many psychologists and social workers.

Prior to the Better Access initiative, there were a range of counsellors, psychotherapists and therapists providing fee-for-service counselling and therapy services in the community. Representatives of counsellors, psychotherapists and therapists not eligible to be approved providers under the Better Access initiative perceived the MBS rebate available through the initiative as providing an unfair competitive advantage to approved providers and having a detrimental effect on the financial viability of their members. These representative bodies also expressed concern that the Better Access initiative does not provide scope for psychoanalysis and long-term psychotherapy for more severe psychological disorders⁴ and that an expansion of eligibility to include their members would expand the availability of services and improve access to services.

Insurers consulted supported the Better Access initiative as it was seen as providing better outcomes for their members in the long term and prevented unnecessary hospitalisation. Subsequent to the introduction of the Better Access initiative, where members may have previously accessed psychologists and occupational therapists through their ancillary insurance cover, they can now do so only after they have accessed all services available through Medicare. As per MBS guidelines, ancillary cover is not available to pay the gap between the fee charged and MBS rebate paid.

Perceptions of consumers and carers

Consumers, carers, and consumer and carer advocacy groups were unanimous in their support for the Better Access initiative. The initiative is highly valued by consumers and carers and perceived as providing improved mental health outcomes. Many consumers and carers reported the benefits that they have realised through services provided through the Better Access initiative as life changing. They feel better, and feel able to take more control over their life; it has improved their life and that of their families. For many consumers with a long history of anxiety or depression, access to psychological therapies through the Better Access initiative has allowed them to gain improvements previously unavailable through their GP, psychiatrist or episodic admissions to a psychiatric hospital. These consumers reported that they are able to return to, or remain in the workforce, and the instances of self harming behaviours have reduced, as have the number of times they have been admitted to hospital because of their mental health problems.

⁴ Nor was it the intent of the Better Access initiative to do so

For consumers with higher prevalence disorders who are not able to receive services through the public mental health system, the Better Access initiative provides a rebate for services provided by allied health professionals. Consumers and carers reported that, without this rebate, many consumers would be simply unable to afford and unable to access such mental health services, or at least at such an intensive level. They reported that many individuals with higher prevalence mental disorders simply went without services or were reliant solely on their GP for assistance with their mental health problems.

Options for improvement

Based on feedback received from GPs, AHPs, consumers and carers, the key consideration was how to improve awareness of, and access to, mental health services for all sections of the community. The overwhelming view of GPs, AHPs, consumers and carers was that nearly all referrals were appropriate and clients received benefit from services provided by an AHP. Public mental health services recognised the value of the Better Access initiative but questioned how well it targeted scarce mental health resources relative to existing unmet need in the community. NGOs valued the contribution of the Better Access initiative to improved options for people with a mental illness, but expressed concern about the needs of people with more complex needs who may not be able to afford the gap payments associated with the Better Access initiative, and require a longer term period of support and intervention than is available through the Better Access initiative.

The strongest view supported by nearly all GPs, AHPs, consumers and carers was that strategies should be enacted to increase awareness of, and access to, mental health services through the Better Access initiative. AHPs, consumers, carers and NGOs reported the perception that GP awareness was the key impediment to improving access and that increasing GP awareness would increase the number of people being referred to AHPs.

Contrasting with the arguments to continue to increase access and utilisation was the view of stakeholders not as directly engaged in the Better Access initiative to consider strategies to better target services to populations most in need. While highly supportive of the Better Access initiative in addressing the needs of individuals with high prevalence disorders, a key concern underlying their view was that, in the light of high levels of unmet need in the community, resources could be better targeted to achieve equitable access and monitored to ensure effectiveness.

The consultation process identified a range of potential options to improve access for these groups including:

- managing the allocation of provider numbers on a regional or area basis to ensure service provision in disadvantaged areas;
- increasing the rebate and means testing eligibility to drive supply to lower socio economic areas;

- holding the rebate constant for existing items and increasing the rebate for services eligible only to selected population groups;
- funding and targeting ATAPS and MAHS to priority population groups;
- introducing secondary consultation MBS items for targeted population groups;
- introducing MBS items for telephone, internet and Voice over Internet Protocol (VoIP) services to residents of rural and remote communities or special need groups requiring particular language skills or cultural sensitivities; and
- introducing additional items for specific conditions and/or population groups.

Table 1 below outlines how these options relate to the specific population groups are identified.

Table 1: Options to improve effectiveness and equity in access

Strategy	Low income earners	Remote areas	Aboriginal and Torres Strait Islander peoples	CALD communities	Older people	Children	Chronic and complex needs
Managing geographic allocation of provider numbers to enhance equity	✓	✓	✓	✓			
Increasing rebate and means testing eligibility	✓						
Introducing outcome reporting to monitor effectiveness	✓	✓	✓	✓	✓	✓	✓
Holding rebate constant on existing MBS items and introducing new MBS items for selected population groups	✓	✓	✓	✓	✓	✓	✓
Enhance funding and target ATAPS and MAHS to priority population groups	✓	✓	✓	✓	✓	✓	✓
Introducing secondary consultation MBS items for targeted population groups		✓	✓	✓	✓	✓	✓
Introducing MBS items for remote telephone, internet and VOIP services to rural and remote areas and special needs groups		✓	✓	✓			