

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

June 2010

## **Contents**

|   |            |
|---|------------|
| Glossary  | 1          |
| Explanatory notes   | 2          |
| Executive summary   | 4          |
| <b>1 Background and introduction</b>                        | <b>10</b>  |
| 1.1 Mental health in Australia                              | 10         |
| 1.2 Mental health services in Australia                     | 11         |
| 1.3 The Better Access initiative                            | 12         |
| 1.4 Better Access initiative and other programs             | 14         |
| <b>2 Project objectives</b>                                 | <b>16</b>  |
| 2.1 Detailed evaluation criteria                            | 17         |
| <b>3 Methodology</b>  | <b>20</b>  |
| 3.1 Approach  | 20         |
| 3.2 Phasing of consultations                                | 21         |
| 3.3 Scope of consultations                                  | 22         |
| <b>4 Outcome of consultations</b>                           | <b>26</b>  |
| 4.1 Structure of reporting of outcomes                      | 26         |
| 4.2 Improved access to mental health services               | 27         |
| 4.3 Service appropriateness                                 | 55         |
| 4.4 Compliance with the Better Access initiative guidelines | 63         |
| 4.5 Service effectiveness                                   | 69         |
| 4.6 Mental health care system                               | 73         |
| 4.7 Skilled, knowledgeable, integrated workforce            | 81         |
| 4.8 Informing the summative evaluation                      | 88         |
| 4.9 Consumer and carer feedback                             | 100        |
| <b>5 Discussion</b>   | <b>106</b> |
| 5.1 Potential bias within the evaluation findings           | 106        |
| 5.2 Access and affordability                                | 107        |
| 5.3 Options discussed to improve access                     | 108        |
| 5.4 Appropriateness, effectiveness and evidence based care  | 114        |
| 5.5 Workforce education and training                        | 116        |
| <b>Addendum 1: Responding to the evaluation questions</b>   | <b>118</b> |

## **Glossary**

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

## **Appendices**

- Supplementary to the report Attachment 1 details responses to online survey of: allied health providers, GPs and psychiatrists, public mental health providers, NGO mental health providers, consumers and carers.

## **Executive summary**

### **Background**

Approximately one in five Australians will experience symptoms of a mental disorder within any twelve month period.

A comprehensive public mental health system is in place, working collaboratively with the Non Government Organisations (NGO) and primary mental health system to support individuals with chronic and severe, low prevalence mental health disorders. This group of individuals comprise approximately three to four per cent of the total population or about 15 per cent of the total number of people who may experience a mental health disorder in any one year.

Prior to the Better Access initiative people with high prevalence mental health disorders, the majority of people experiencing a mental health disorder, had limited access to affordable psychological therapies. 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 to encourage more general practitioners (GPs) to participate in the provision of mental health services, to improve access to psychiatrists and enhance the availability and affordability of psychological services provided by psychologists, social workers and occupational therapists in private practice.

This report presents the findings from the stakeholder consultation undertaken as a component of the evaluation of the Better Access initiative. The consultations obtained the views of approximately 1200 individuals comprising representatives of professional bodies providing mental health services, individual service providers, public mental health service providers, non government (NGO) mental health service providers, private mental health hospitals, health insurers, consumers and carers.

### **Achievement of key objectives**

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

- 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;
- Encouraging private psychiatrists to see more new patients;
- 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
- 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. Though 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. GPs and consumers discussing difficulty in accessing psychiatrists, predominately perceived this as 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

The overwhelming finding is that the Better Access initiative has made services more accessible to and more affordable by individuals experiencing high prevalence mental health disorders. GPs are providing more mental health services than ever before. There are now more allied health providers (AHPs) operating in private practice and services are more affordable. There has been some change to the way some psychiatrists provide care, increasing the number of new people able to access psychiatric input into their care.

For many consumers the Better Access initiative has allowed them to access psychological services that would not otherwise have been affordable or accessible. It has resulted in services becoming available in communities where there were previously no psychological health services. The Better Access initiative is highly valued by consumers and carers.

The improvements in access to mental health services have not been enjoyed equally across geographical communities and population groups. Metropolitan areas appear to enjoy better access to services than do rural and regional areas: to a large degree this is a reflection of general rural health workforce constraints. Due to the affordability of gap payments more affluent areas appear to enjoy greater access than poorer areas, and there is some suggestion from the consultations that there may be some shift of AHP services to more affluent areas as a result of the Better Access initiative. Conversely, some argue that over time market forces will result in a redistribution of AHPs to areas of fewer services to capture demand. In the face of high levels of unmet demand this may take some time.

Paradoxically there is the suggestion from some remote stakeholders that the increased revenue available to AHPs through the Better Access initiative has reduced the attractiveness of engagement to provide services through the Access to Allied Psychological Services (ATAPS) program and reduced service availability in rural and remote communities.

Some groups notably individuals from culturally and linguistically diverse communities, youth, older people and Aboriginal and Torres Strait Islander people also receive

poorer access to services for a range of reasons. There is some questioning from some stakeholders as to whether the fee for service 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. A range of options to improve access within the Better Access initiative were suggested. These included the introduction of secondary consultation MBS items to provide direction and support to other workers working with disadvantaged communities, fostering their effectiveness in working in these communities. Another suggestion was the approval of an MBS item for internet and/or telephone based services to people living in remote communities or individuals requiring a bilingual therapist, or a therapist with a particular area of expertise.

Children were identified as one group that have greatly benefited from the introduction of the Better Access initiative due to the few services previously available. However, a key remaining constraint reported by respondents was that there was no MBS Item for the provision of family therapy or to see the parents (or carers) without the child present. Expansion of the MBS to include these services was seen as a valuable means to further improve the quality and efficacy of services provided to children.

It is noted that the intent of the Better Access initiative was to provide services to individuals with high prevalence mental health problems, many of whom would be effectively treated within the maximum of the 18 sessions available. That relatively low service users are the main persons accessing the services is reflected in the most current data reporting an average of five sessions per individual and suggests the Better Access Initiative is reaching its primary target group. Yet many GPs, AHPs, NGO mental health providers, public mental health providers, consumers and carers are reporting that individuals with lower prevalence and more chronic conditions are accessing services through the Better Access initiative. The concern of GPs, AHPs, consumers and carers is that for this group 18 sessions may not be enough and additional MBS items may be required to facilitate more intensive treatment plan coordination and consultation with other service providers supporting the individual in the community.

GPs, AHPs and public mental health providers also perceive the Better Access initiative as working with and complementing the public mental health system. Noting the difference in the primary target population, public mental health providers value the referral options that the Better Access initiative provides for individuals whose condition is not such that they would receive public mental health services.

## **Improved affordability**

Improved affordability of psychological services provided by AHPs was perceived as another key outcome of the Better Access initiative. Despite the rebate, the gap fee remained a concern for many consumers and was a real barrier for low socio economic groups and restricted their access to services. General psychologists, social workers, occupational therapists and consumers questioned the higher rebate paid to clinical psychologists. There is also the potential that the higher rebate allows clinical psychologists to charge a lower gap payment, resulting in consumers utilising services that are a higher cost to Medicare but lower out of pocket cost to the consumer.

## **Operational issues**

The Divisions of General Practice (Divisions) report that the Better Access initiative has largely been implemented and GPs are aware of, and using the MBS items. The feedback from AHPs and consumers, carers and a small number of GPs suggests that the awareness and /or use of the Better Access initiative MBS items is still an area of development.

Overall though the majority (73 per cent) of allied health respondents reported the information provided in the GP mental Health Care Plan they received as good or fair and notably, 72 per cent of respondents reported that they had not received inappropriate referrals. (Attachment 1)

A small number of AHPs report receiving poor quality Mental Health Treatment Plans (Treatment Plan) and consumers and carers express concerns as to levels of GP awareness. AHPs also noted that the number of poor quality Treatment Plans was a small proportion of plans received and that the general quality was improving over time.

Conversely, GPs report poor quality reports from AHPs. Both GPs and AHPs note that the quality of information being exchanged and quality of referrals is improving as the Better Access initiative matures. It is noted that at the time of the consultations the primary care training planned as a component of the Better Access initiative was only just commencing.

A perception reported by most AHPs and some GPs was that there would be merit in considering a more simplified referral process to AHPs. It was reported by many AHPs and some GPs that a GP Treatment Plan was not required in all instances, particularly where the GP did not have an ongoing role in the management of the patient's mental health issues. Though supporting a more simplified referral process, most AHPs and nearly all GPs supported GPs retaining the gate keeping and referral role.

The implementation of the education and training program may go some way to addressing these issues and further improving awareness of and access to the Better Access initiative. This would also provide the capacity for a greater clarity on the intended target population and services that can be provided. However, the access to services by individuals with low prevalence disorders appears to be relatively widespread and is perceived and valued by service providers and consumers alike as an important component of care.

# 1 Background and introduction

Mental health has been designated as one of Australia's National Health Priority Areas, in view of its major impact on the population's health. 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.

## 1.1 Mental health in Australia

In 1997, a *National Survey of Mental Health and Wellbeing* found that nearly one-fifth of Australians aged 16 years and over had experienced symptoms of a mental disorder in the preceding 12 months.<sup>1</sup> Ten years later, the second survey (the *2007 National Survey of Mental Health and Wellbeing*) found similar results. In 2007, an estimated 3.2 million Australians (20 per cent of the 16-85 year old population) had experienced symptoms of a mental disorder in the preceding 12 months, while an estimated 7.3 million Australians (45 per cent of the population aged between 16 and 85 years) had experienced a mental disorder at some time during their lives.<sup>2</sup>

The 2007 Survey also found that:<sup>3</sup>

- in the 12 months prior to the Survey, 14.4 per cent of Australians aged between 16 and 85, had experienced anxiety disorders, while 6.2 per cent and 5.1 per cent had experienced affective disorders or substance use disorders respectively;
- more than a quarter (26 per cent) of the youngest age cohort (16-24 years) had experienced symptoms of a mental disorder in the previous 12 months;
- anxiety disorders were the most prevalent in all age groups; and
- mental disorders were more common among people with chronic physical health conditions than among those with no such conditions (28 per cent compared to 18 per cent).

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<sup>1</sup> Australian Bureau of Statistics *1997 National Survey of Mental Health and Wellbeing*, Canberra. Australian Bureau of Statistics.

<sup>2</sup> Australian Institute of Health and Welfare. "Mental health services in Australia 2006-07". *Mental Health Series* Number 11, August 2009.

<sup>3</sup> Australian Bureau of Statistics *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*. October 2008.

## 1.2 Mental health services in Australia

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).

Despite the high prevalence of mental disorders within the Australian population, the *1997 National Survey of Mental Health and Wellbeing* found that only 38 per cent of adults and one-quarter of children and young people with a mental disorder had sought assistance from a health service<sup>4</sup>. When these people did access a health service, most consulted a general practitioner. The *2007 Survey* found that, for the estimated 3.2 million Australians aged between 16 and 85 having symptoms of a mental disorder in the preceding 12 months<sup>5</sup>:

- only 34.9 per cent had accessed services for their symptoms;
- general practice was the most common service accessed (24.7 per cent);
- women, people aged 35 years and over, and people residing in major cities were more likely to have accessed services; and
- people with affective disorders were more likely to have accessed services (49.7 per cent) compared to those with anxiety disorders (22 per cent), despite the latter being more prevalent.

While general practice continues to be the most common health service accessed by people for mental disorders, general practitioners have experienced numerous barriers to the provision of quality mental health care services. These have included the time required to perform appropriate assessments and deliver focussed psychological strategies by Level Two trained GPs, especially within the context of a busy fee-for-service practice environment, inadequate education and training options, and poor access to specialist support.<sup>6</sup>

The Better Access initiative seeks to address these barriers, and thereby enhance the provision of quality mental health services for common mental disorders.

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<sup>4</sup> Australian Bureau of Statistics 1997 op cit.

<sup>5</sup> Australian Bureau of Statistics, 2008, op.cit.

<sup>6</sup> Australian General Practice Network 2007 *Better Access initiative Orientation Manual*, ACT, Australia.

### **1.3 The Better Access initiative**

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

- by 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;
- by encouraging private psychiatrists to see more new patients;
- by 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
- by supporting GPs and primary care service providers through education and training to better diagnose and treat mental illness.

There are two key mechanisms through which the Better Access initiative seeks to achieve these objectives:

- changes to the Medicare Benefits Schedule; and
- support for the provision of education and training for the mental health workforce.

#### **1.3.1 Changes to the MBS**

The specific changes to the MBS through the Better Access initiative were introduced in November 2006. They 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. The new items are the Preparation of a GP Mental Health Treatment Plan (item 2710), the Review of the GP Mental Health Treatment Plan (item 2712), and the GP Mental Health Treatment Consultation (item 2713) which supports ongoing management of patients with mental disorders, through extended consultation provisions for patients with a primary diagnosis related to a mental disorder. There were no mandated training requirements for GPs related to the use of these new items when the initiative was introduced.
- a new item for psychiatrist consultation with a new patient referred by a GP (item 296), coupled with expanded rebates for existing items for psychiatrists related to patient assessment and preparation or review of a treatment plan to be carried out by a GP (items 291 and 293). These changes seek to promote consultation and liaison between GPs and psychiatrists.

- new items for allied mental health services – Psychological Therapy (eligible clinical psychologists) and Focussed Psychological Strategies<sup>7</sup> provided by eligible clinical psychologists (items 80000, 80005, 80010, 80015 and 80020), psychologists (items 80100, 80105, 80110, 80115 and 80120), social workers (items 80150, 80155, 80160, 80165, 80170 and 81005) and occupational therapists (items 80125, 80130, 80135, 80140 and 80145). These items are subject to receipt of an appropriate referral from GPs, psychiatrists and paediatricians, in accordance with a GP Mental Health Treatment Plan or psychiatrist assessment and treatment plan. The services are capped at 12 per calendar year, and only available to allied health professionals who have registered with Medicare Australia, and satisfied specific eligibility criteria. Additional services are available to people for exceptional circumstances.

The 2009-10 Federal Budget announced two new measures under the Better Access Initiative. These were:

1. Medicare Benefits Schedule - Better Access Initiative - Continuing Professional Development (CPD).

From 1 July 2011 all general psychologists, social workers and occupational therapists will need to meet mandatory Continuing Professional Development (CPD) requirements to continue to be able to access the MBS items when providing FPS services under the Better Access initiative. Any allied mental health professional registered with Medicare Australia to provide FPS, who has not undertaken the required CPD by that time will be removed from the list of eligible providers.

2. Medicare Benefits Schedule - Better Access Initiative - improved targeting for the most in need and better quality of services.

This measure consists of three elements:

- changing the name of the “GP Mental Health Care Plan” to “GP Mental Health Treatment Plan” to better reflect what it is intended to do;
- requiring that GPs document a diagnosis of a mental disorder in the Plan; and
- the introduction of a new Medicare item for GPs who have not completed Mental Health Skills Training.

The first two components were implemented from 1 July 2009. The third component will be implemented from 1 January 2010 to allow sufficient time for GPs to undertake the training.

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<sup>7</sup> MBS item numbers

The mental disorders covered within the new MBS provisions through the Better Access initiative are as follows.<sup>8</sup>

- Alcohol use disorders
- Chronic psychotic disorders
- Bipolar disorder
- Phobic disorders
- Generalised anxiety
- Adjustment disorder
- Unexplained somatic complaints
- Eating disorders
- Sexual disorders
- Conduct disorder
- Bereavement disorders
- Drug use disorders
- Acute psychotic disorders
- Depression
- Panic disorder
- Mixed anxiety and depression
- Dissociative (conversion) disorder
- Neurasthenia
- Sleep problems
- Hyperkinetic (attention deficit) disorder
- Enuresis
- Mental disorder, not otherwise specified

### **1.3.2 Education and training**

The second mechanism through which the Better Access initiative seeks to improve outcomes for people with mental disorders consists of support for the provision of education and training to the mental health workforce. This includes education and training activities designed to:

- increase awareness of MBS changes to improve access to mental health services;
- provide multidisciplinary training opportunities to develop referral networks and foster interdisciplinary care between Better Access providers; and
- enhance the expertise of providers in working within multidisciplinary teams and promoting best practice.

## **1.4 Better Access initiative and other programs**

The Better Access initiative builds on the range of initiatives funded through the Better Outcomes in Mental Health Care Program (BOiMH) by providing GPs with increased referral pathways options and better remuneration. The Access to Allied Psychological Services (ATAPs) component of BOiMH, in which the Divisions of General Practice operate as fund holders, continues to be available. GPs cannot refer patients to allied health professionals through the Better Access initiative and ATAPs at the same time. However treatment can be provided through both programs within a single calendar

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<sup>8</sup> Ibid.

year, if the total number of services provided under both does not exceed the maximum allowable in the calendar year.

GPs who provide Focussed Psychological Strategies themselves, rather than referring patients to allied health professionals, continue to be required to undertake Level One and Level Two training accredited by the General Practice Mental Health Standards Collaboration.

The Better Access initiative also complements other national programs and initiatives that focus on providing primary mental health care for people with mental disorders, such as the Mental Health Nurse Incentive Program, the More Allied Health Services Program and the Mental Health Services in Rural and Remote Areas initiative.

## 2 Project objectives

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.

DoHA has adopted a modular approach to the implementation of the evaluation, with six components each contributing to the summative evaluation (see Table 1 below).

*Table 1 – Components of the Evaluation of the Better Access initiative*

| Evaluation component/ domain |   | Access | Appropriateness | Effectiveness | Impact on health system | Skilled, knowledgeable, integrated workforce |
|------------------------------|---|--------|-----------------|---------------|-------------------------|--|
| A                            | A study of consumers & their outcomes                             | ✓      | ✓✓              | ✓✓            | ✓                       | -  |
| B                            | Analysis of MBS and PBS data                                      | ✓✓     | ✓               | -             | ✓✓                      | -  |
| C                            | Analysis of allied health workforce supply & distribution         | ✓✓     | -               | -             | ✓✓                      | -  |
| D                            | Stakeholder consultation  | ✓✓     | ✓✓              | ✓             | ✓✓                      | ✓✓   |
| E                            | Evaluation of major education and training projects               | -      | ✓               | -             | ✓                       | ✓✓   |
| F                            | Analysis of Second National Survey of Mental Health and Wellbeing | ✓✓     | ✓✓              | -             | -                       | -  |

KPMG was contracted to undertake Component D of the evaluation – Stakeholder Consultation. Component D involved the design and establishment, collection and reporting of information from a range of stakeholders, including peak professional organisations and consumer and carer organisations with an interest in the Better Access initiative.

The objective of the stakeholder consultation component was to develop an understanding of the:

- 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.

The results of the stakeholder consultation component will be considered along with results from the other components of the evaluation. To assist this process, DoHA arranged several meetings of key evaluators from each component to exchange information and share findings and possible implications with respect to the key evaluation questions.

## **2.1 Detailed evaluation criteria**

Prior to KPMG's engagement, DoHA identified 16 key evaluation questions to be explored through the consultation component. Our approach has grouped these questions into six key domains. These include:

- service accessibility;
- service appropriateness;
- service effectiveness;
- the system of mental health care;
- the level of skill, knowledge and integration within the mental health workforce; and
- issues informing the summative evaluation.

These domains represent areas in which the Better Access initiative is expected to have an impact. Each of the individual evaluation questions developed by DoHA was grouped into one of these domains. The questions within each domain are listed below.

### **2.1.1 Service accessibility**

- To what extent has the Better Access initiative provided access to mental health services for people with mental health disorders? Across all of Australia? Across all age groups?
- To what extent has the Better Access initiative provided access to affordable care?
- To what extent has the Better Access initiative provided equitable access to populations in need (in particular people living in rural and remote areas, children and young people, older persons, Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds)?

### **2.1.2 Service appropriateness**

- To what extent has the Better Access initiative provided evidence-based mental health care to people with mental health disorders?
- To what extent has the Better Access initiative provided services that match client needs and expectations?

### **2.1.3 Service effectiveness**

- To what extent has the Better Access initiative improved health outcomes for people with a mental health disorder?

### **2.1.4 Mental health care system**

- To what extent has the Better Access initiative impacted on the supply and distribution of the psychologist, social worker and occupational therapist workforce?
- How has the Better Access initiative interacted with other related programs/initiatives, including the Better Outcomes in Mental Health Program and the More Allied Health Services Program?

### **2.1.5 Skilled, knowledgeable, integrated workforce**

- To what extent has the Better Access initiative provided interdisciplinary primary mental health care for people with mental disorders?
- Are professionals aware of how to access appropriate primary mental health care training?
- Are professionals accessing appropriate education and training (for example multidisciplinary or profession specific training)?

### **2.1.6 Informing the summative evaluation**

To inform these summative evaluation questions, the consultation process will also focus on the following additional questions / issues:

- What are the characteristics, including clinical characteristics, of consumers receiving Medicare rebateable Better Access mental health services?
- Are professionals, consumers and carers aware of the Better Access initiative?

- Has the Better Access initiative impacted on the use of medications prescribed for the treatment of mental disorders, in particular anti-depressants?
- Has the introduction of the Better Access initiative changed how and where professionals practice (for example, movement to another location, change from public to private sector, or change in the mix of public and private sector work)?
- Are there any unintended consequences for stakeholders due to the introduction of the Better Access initiative?

## 3 Methodology

### 3.1 Approach

A staged approach to consultation was undertaken, comprising national, state, regional and sub-regional stakeholders from a range of backgrounds. To address the evaluation questions, the project utilised a number of methods to access stakeholder opinion. These included:

- individual and small group interviews conducted either face-to-face or by teleconference;
- workshops and focus groups; and
- online surveys.

A broad range of stakeholders with an interest in the Better Access initiative were included in the consultation process. The types of stakeholders and the mechanisms through which consultation with them occurred are summarised in the following table (Table 2).

*Table 2 – Stakeholder types consulted and mechanisms of consultation*

| Stakeholder type   | Mechanism and approximate number of persons consulted <sup>9</sup>  |
|--|---|
| National Peak Agencies (including non approved providers)        | Individual consultations – face to face / teleconferences, N = 53 persons<br>Submissions, N = two submissions   |
| State/Territory Peak Agencies (including non approved providers) | Individual consultations – face to face / teleconferences, N = 20 persons   |
| NGO mental health service providers                              | Specific NGO workshops (Brisbane, Darwin, Alice Springs, Perth) and interviews, N = 15 persons<br>Small area workshops, N= five persons<br>Online survey, N = 48 persons  |
| Public mental health service providers                           | Individual consultations with jurisdictional Health Department representatives – face to face/ teleconference , N= 20 persons<br>Small area workshops, N = five persons<br>Online survey , N= 230 persons<br>Submission, N = one submission |

<sup>9</sup> Numbers are approximate and though individuals are only counted once they may have represented multiple organisations.

| Stakeholder type  | Mechanism and approximate number of persons consulted <sup>9</sup>  |
|---|---|
| Private inpatient mental health services  | Individual consultations – face to face/ teleconferences, N= 15 persons   |
| Private health insurers   | Contact with individual insurers lead to their written responses to the evaluation questions, N = three written responses   |
| Individual private providers (including psychiatrists and approved allied health providers) | Individual (or small group) consultations – face to face/ teleconferences, N = 17 persons<br>Small area workshops, N = 26 persons<br>Online survey, N = 418 persons<br>Submission, N= two submissions             |
| General Practitioners   | Individual (or small group) consultations – face to face/ teleconferences (excluding national and state peak agencies), N = 15 person<br>Small area workshops, N = 12 persons<br>Online survey , N = 193 persons  |
| Consumers and carers  | Carer and consumer small group workshops, interviews and teleconferences, N = 57 persons<br>Small area workshops, N = three persons<br>Online survey (specific surveys for consumers and carers), N = 155 persons |

Note: The project received a significant number of unsolicited contacts and submissions from individual practitioners and representatives of smaller organisations not included within the agreed list of key stakeholders. These contacts included individual approved and non-approved providers, sub-specialty groups such as grief and bereavement counsellors and private practice psychologists groups. These direct contacts were responded to as required through telephone interviews.

### 3.2 Phasing of consultations

The consultations were undertaken at a national, state and, where appropriate, regional and sub-regional level to ensure as broad and representative a cross section of stakeholders as practicable. The consultation process was to be streamed around each of the identified stakeholder groups, although learnings and issues identified within one group were at times presented for consideration and comment by subsequent groups to allow for more in depth exploration of particular issues.

### **3.3 Scope of consultations**

During the engagement period, more than 1300 people (representing themselves or a particular group or organisation) were consulted. These included:

- Semi structured interviews (face to face or teleconference) of more than 200 people, each interview on average taking 45 to 90 minutes;
- Semi structured group teleconferences of approximately 60 people, each teleconference taking on average 60 to 90 minutes.
- workshops of more than 40 people, each workshop taking on average two to three hours; and
- online surveys, completed by in excess of 1000 people.

#### **3.3.1 Consultation with psychiatrists**

Overall the views of approximately 31<sup>10</sup> psychiatrists were obtained in the course of the evaluation through formal and informal direct consultation (24) or participation in the online survey (seven). These represented a cross section of psychiatrists working in the private and public mental health system. Many psychiatrists consulted occupied two or more roles, for example being both the RANZCP representative and director of a public mental health service, RANZCP nominee and private psychiatrist, working in both a public mental health service and having a private practice. The range of backgrounds included:

- Nominees of the national, state and territory branches of the RANZCP
- Psychiatrists acting within their role as a Director of a public mental health services
- Psychiatrists participating in the small area consultations
- Individual psychiatrists contacting the evaluation
- Psychiatrists working within private hospitals

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<sup>10</sup> In some instances the professional grouping of individual participants in the group consultations was not clearly identified.

### **3.3.2 Consultation with paediatricians**

The Royal Australasian College of Physicians (RACP), representing paediatricians was consulted during the evaluation. Two paediatricians participated in the online survey.

### **3.3.3 Consultation with general practitioners**

Overall approximately 220 GPs participated in the project. The evaluation had face-to-face or telephone consultation with representatives of 11 GP national and state/territory professional bodies and conversations with four GPs who initiated contact with the evaluation. Three of the GPs consulted also had conjoint appointments with the public mental health system, while the remainder worked in private practices. Approximately 15 GPs or GP representatives were consulted in person through the small area consultations or through direct contact with the project. Three of these GPs were from rural areas. There were a total of 193 GPs who participated in the online survey.

### **3.3.4 Consultation with non government organisations**

Excluding peak consumer and carer organisations (reported separately) the evaluation consulted with representatives of 15 NGOs through face-to-face interviews, teleconference and small area consultations. A total of 48 employees or members of NGOs participated in the online survey.

### **3.3.5 Consultation with psychologists**

There was extensive contact with both clinical and other psychologists throughout the evaluation. This included face to face and telephone interviews with 30 psychologists representing national (17) and jurisdictional (13) groups. More than 17 psychologists also attended the small area consultations or the rural and remote practitioner teleconferences. Two hundred and sixty psychologists participated in the online survey, approximately half of which were clinical psychologists. Two submissions were received from organisations representing psychologists. In total approximately 307 psychologists participated in the project.

### **3.3.6 Consultation with social workers**

Social workers were also well represented with approximately 168 social workers participating in the project. Three representatives of social work bodies at a national or jurisdictional level were consulted through face-to-face interviews. Approximately ten social workers participated in the small area consultations or the rural and remote practitioner teleconference and five social workers initiated telephone contact with the evaluation. One hundred and fifty social workers responded to the online survey.

### **3.3.7 Consultation with occupational therapists**

Ten representatives of occupational therapy groups were consulted through telephone or face-to-face interviews. Only one occupational therapist however, responded to the online survey.

### **3.3.8 Consultation with public mental health providers**

Representatives from all eight state and territory mental health branches were interviewed via teleconference or in person. In NSW, Directors of Mental Health from each area health service were also consulted. As such, approximately 20 individuals who had responsibilities in overseeing mental health services in the public sector were included in the consultation process. In addition, 230 public mental health service providers responded to the online survey. One submission was received from a public mental health service.

### **3.3.9 Consultation with non-accredited mental health providers**

Approximately 10 individuals who represented groups inclusive of non-accredited mental health providers at a national or state/territory level were consulted. One individual practitioner was interviewed via telephone. It should be noted that some of these groups included individuals who were also approved Medicare providers (e.g. a psychologist who was a member of an association representing psychotherapists). Two submissions were received from organisations representing non-accredited mental health providers.

### **3.3.10 Consultation with consumers and carers**

Approximately 215 consumers and carers were consulted through a number of different mechanisms during the evaluation. Through face-to-face meetings, small groups and teleconferences approximately 60 consumers and carers were consulted. One hundred and twenty five consumers and 30 carers participated in the online survey. Three consumer representatives attended small area workshops. A member of the evaluation team also attended and met with consumers and carers at the 19<sup>th</sup> National Mental Health Services Conference.

### **3.3.11 Private hospitals and insurers**

Representatives from three different private psychiatric hospitals were consulted including eight individuals in face-to-face consultations. Three private health insurers were consulted, each providing a written response. One peak body which represented both of these groups was consulted.

### **3.3.12 Submissions**

The evaluation received five written submissions. Written submissions have been forwarded to DOHA and key themes included in this report.

## 4 Outcome of consultations

### 4.1 Structure of reporting of outcomes

This section reports on the outcome of consultations with stakeholder groups. Commentary is structured according to the key domains identified in section 3.1 of this report, expanded to include a specific section on consumer and carer perspectives of the Better Access initiative. The domains include:

- service accessibility;
- service appropriateness;
- service effectiveness;
- impact on the mental health system;
- the level of skill, knowledge and integration within the mental health workforce;
- additional issues informing the summative evaluation; and
- consumer and carer perspectives on the Better Access initiative.

Addendum 1 reports the outcome of consultations in response to each of evaluation questions outlined in section 2.1.

The comments reported reflect the views of individuals interviewed and should not be assumed to reflect the official position of any particular statutory or professional representative body unless specifically identified as such.

The commentary in this section endeavours to provide an objective representation of the range of opinions expressed and does not reflect the opinion or views of KPMG. Because of the number of consultations undertaken, it is likely that the particular opinion of some individuals in relation to specific issues may not be fully captured in the commentary. This is most likely to be a result of the specific comment being incorporated into more general themes.

Although a common core of issues were explored in each consultation, due to the semi-structured format for the face-to-face and telephone consultations, some issues were only examined in a few cases. The key issues of importance to participants also influenced the content of the consultation, and this varied across consultations. Where new issues were raised during a particular consultation, the evaluation endeavoured to explore these in subsequent consultations.

Given variations in the priorities of focus across consultations and the timing within the consultation staging at which new issues were raised, it is difficult to provide a detailed quantification of the range of opinions expressed. The evaluation does however provide an indicative weighting of the relative strength of opinion by both reporting the approximate number of participants having expressed a particular or similar opinion or the relative strength of the opinion expressed. Where a comment or opinion expressed has been subsequently identified as an error in understanding of the Better Access initiative by the respondent, and the evaluation team has identified that error, this is indicated in the commentary.

## **4.2 Improved access to mental health services**

This section presents the key findings related to the impact of the Better Access initiative on service accessibility, focusing on the following evaluation questions:

- To what extent has the Better Access initiative provided access to mental health services for people with mental health disorders? Across all of Australia? Across all age groups?
- To what extent has the Better Access initiative provided equitable access to populations in need (in particular people living in rural and remote areas, children and young people, older persons, Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds)?
- To what extent has the Better Access initiative provided access to affordable care?

### **4.2.1 Summary of improvements in access**

Almost all stakeholders and interviewees consulted during the course of the evaluation reported that the Better Access initiative had improved access to mental health services across all population groups in the community. This is supported by Medicare data reporting the growth in the number of services funded through the Better Access initiative (see Figure 1 below).

Figure 1: Number of MBS Better Access items processed by month

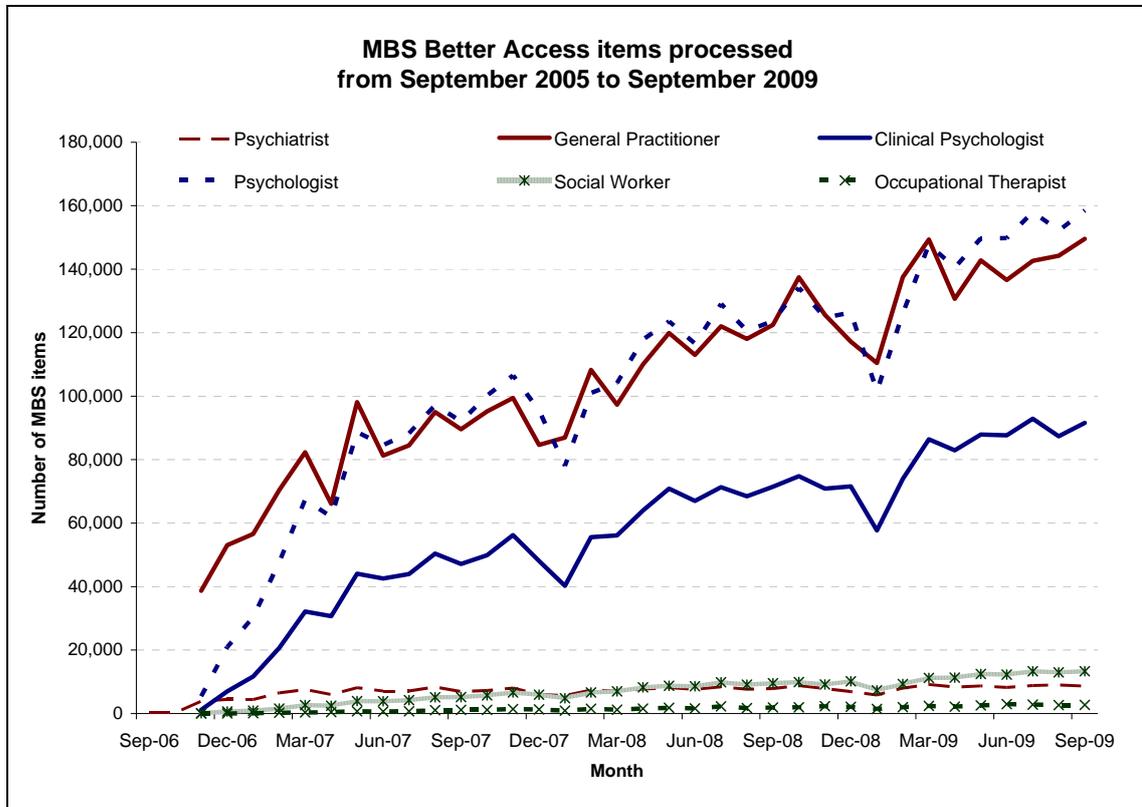


Figure 1 is based on Medicare Australia data and demonstrates continuing high rates of growth for services provided by GPs, psychologists and clinical psychologists. For and GPs, there was a 300 per cent increase in the number of services funded between November 2006 and September 2009. This increase 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.

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. Unfortunately 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 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)

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 allied health providers 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 their skills in mental health diagnosis and preparing mental health treatment plans.

The growth in services provided by general psychologists is similar to that for psychiatrists and GPs. Prior to the Better Access initiative, Medicare funding was limited to services provided through ATAPS and MAHS<sup>11</sup>, both of which had capped budgets administered by the local Division of General Practice. Separate funding of clinical psychologists is a new item number within the Better Access initiative.

Prior to the Better Access initiative, Medicare funding for mental health services (with the exception of MAHS) was not available to social workers and occupational therapists. The relatively low growth in services provided by these professions is most likely reflective of the relatively small number of providers in private practice.

Most AHPs interviewed (predominantly 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 to increase as a result of high levels of unmet demand in the community, more practitioners entering the market, increasing GP and consumer awareness further driving demand and referral networks expanding and becoming more established .

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 as relatively minor.

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, though opportunities to further improve access and outcomes for children were also noted. AHPs also reported that increasing numbers of men and older people were accessing the services as awareness 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

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<sup>11</sup> 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.

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 was reported throughout the consultation process, a number of inequalities in access to services were identified. Disparities in access were reported in relation to people living in rural and remote communities, people living in low socio economic communities, children and young people, older persons, Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds. For many of these groups affordability of gap payments remained an issue. GPs and AHPs working with clients from these groups also identified that longer time periods required to engage with clients, family, carers and the broader community and higher likelihood of missed appointments as a result of affordability and other challenges the individual patient may experience (for example distance, access to transport, other comorbidities) limited the commercial viability of working with these populations. In respect to children, many respondents working with children noted that the lack of an MBS rebate to provide family therapy or see families and/or carers without the child being present limited the scope of work that could be done with children.

The areas of inequality most noted by interviewees consulted related to people living in rural and remote communities, culturally and linguistically diverse communities and low socio-economic communities. The small number of practitioners in remote areas reported that access to mental health services in these communities may have decreased as a result of the increased financial viability of private practice in metropolitan and regional areas reducing the number of AHPs who may have otherwise worked in remote communities through ATAPs.

Access to mental health services by Indigenous Australian received very little comment by participants in the consultations. 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 people, it was generally believed that services for these communities may be more appropriately funded through alternative programs such as Better Outcomes or Aboriginal and Torres Strait Islander health services.

#### **4.2.2 Improved access to psychiatrists**

The consultation found that though the Better Access Initiative has been successful in encouraging private psychiatrists to see more new patients, the view of most stakeholder groups was that access remained limited due to workforce shortages and the general availability of psychiatrists.

Overall, most psychiatrists nominated by the RANZCP reported that the Better Access initiative had increased access to psychiatrists and the specialist skills provided by psychiatrists. These psychiatrists welcomed the new MBS item numbers for initial consultations, Assessment and Treatment Plans and to review Treatment Plans. They

saw the new MBS item numbers as an effective means to encourage psychiatrists to accept new referrals. This positive support for the Better Access initiative is mirrored in the growth in the Better Access initiative services provided by psychiatrists (see previous Figure 1 page 23). As such, it is likely that the opinion of this group of psychiatrists, in respect of the improved access to services, is more reflective of the profession as a whole.

Psychiatrists supported the Better Access initiative for the following reasons:

- The remuneration for the new MBS items was perceived to be more reflective of the time required to assess a client and prepare a report.
- The focus on assessment and review, with the Treatment Plan to be carried out by the referring GP, meant that there was not an expectation that the psychiatrist would have ongoing management of the patient. It was reported that psychiatrists with a full caseload would previously have been reluctant to accept a new referral for assessment where they would also have to assume ongoing patient care.
- Due to the level of remuneration and ongoing patient management by the GP, psychiatrists were able to set aside dedicated slots within their appointment schedule to assess and/or review new patients.
- The tertiary assessment and referral focus of the new MBS items was professionally rewarding and an appropriate and cost effective use of the specialist skills of psychiatrists.
- Providing a mechanism to assess and review more patients increased access to psychiatrists and went some way in addressing the high level of unmet demand in the community. One psychiatrist noted that they, and a number of their colleagues, now allocated appointment slots for initial assessments, Treatment Plans and Treatment Plan reviews, and that waiting times for new assessments had reduced from up to six months to within six weeks.

A small number of GPs also noted that access to psychiatrists had improved, though most GPs indicated that it still remained difficult to access psychiatrists and that there were very few psychiatrists available to see patients, particularly patients who needed to be 'bulk billed' or charged a reduced fee. Where psychiatrists were accepting the new item numbers and were able to bulk bill, the Better Access initiative changes were highly valued by both psychiatrists and GPs.

Psychiatrists working within the public mental health system or private hospital system were less able, or were unable, to comment on whether there had been changes in the level of access to psychiatrists.

From the perspective of most public mental health providers, NGO providers, consumers, carers or allied health providers, there was little if any discernible improvement in access to psychiatrists as a result of the Better Access initiative. The over-riding issue raised by nearly all groups was the ongoing difficulty in accessing

psychiatrists due to workforce shortages. The shortage of psychiatrists was most marked in rural and regional areas.

It was noted by one GP that many psychiatrists worked in small, private practices and did not utilise online Medicare billing. This meant that patients receiving a management Treatment Plan (MBS Item 291) may be required to pay between \$355.50 (85 per cent of the scheduled fee – bulk billed patients) to more than \$418.20 (scheduled fee) before receiving the Medicare Rebate. This out of pocket expense was seen as a major deterrent to patients seeing a psychiatrist. Interestingly, one consumer from a small, rural community indicated that access to psychiatrists was easier than access to allied health providers because of a lower gap payment. Several consumers and carers reported the high, up-front fee being an unaffordable barrier in access to psychiatrists.

A further concern raised by some GPs was that the frequency of a Treatment Plan review by a consulting psychiatrist (once in a 12-month period) is insufficient for more complex patients and as such did not improve access for this group of individuals<sup>12</sup>.

It is of note that one psychiatrist interviewed indicated that psychiatrists within the region in which they worked had decided not to utilise the new item numbers as they did not feel that single assessments provided appropriate quality care.

There was no indication that the Better Access initiative had increased the number of psychiatrists practising in the community. A small number of interviewees noted that the increased competition from AHPs for the provision of focussed psychological therapies may result in some psychiatrists reducing their number of psychotherapy patients to provide more psychiatrist specific specialist care and/or increase the turnover of patients through their practices. One principal public health psychiatrist reported that the Better Access initiative had resulted in two psychiatrists returning to part-time, public sector practice because of increased competition from AHPs. This was reported as a positive outcome of the Better Access initiative.

#### **4.2.3 Improved access to general practitioners**

Through the consultations it appears that the Better Access Initiative has been successful in encouraging more GPs to participate in early intervention, assessment and management of patients with mental disorders and streamline access to appropriate psychological interventions in primary care. The operation of the Better Access initiative in relation to the interface between GPs and psychiatrists appears to be working well and is effective in providing secondary consultation to support and improve the skills and confidence of GPs in managing patients with a mental health disorder. The interface between GPs and AHPs has been valuable in providing referral and treatment options for patients who would benefit from focussed psychological strategies.

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<sup>12</sup> Issues relating to access by individuals with more complex problems was raised across stakeholder groups and is reflected in this report. It should be noted that the primary intent of the Better Access initiative was to improve access to mental health services by individuals with high prevalence disorders as outlined in section 1.3.1.

The predominant message from the GP consultations was that GPs are doing more mental health work than ever before. This is also reflected in the Medicare data on the number of services funded through the Better Access initiative (Figure 1, page 28) and responses from AHPs, public mental health providers and NGO consultations. It was noted that the growth in mental health activity is occurring within the context of increasing and competing demand from an ageing population and other health priorities including asthma, cancer and diabetes.

It was acknowledged during the consultations that a component of the growth in the Better Access initiative services by GPs was partly an artefact of activity that was previously coded as a long consultation or Enhanced Primary Care (EPC) item now being coded as the Better Access initiative.<sup>13</sup> However, the overwhelming indication was that there was a real increase in the number of mental health services provided.

Interviewees noted that, although all GP practices would have a high proportion of patients with mental health problems, prior to the Better Access initiative many of these patients would have received minimal mental health treatment or their GPs may have been reluctant to explore the mental health components of presenting problems. One carer commented that their experience prior to the Better Access initiative was that some GPs were reluctant to address mental health issues as it “*moved them out of their comfort zone*”<sup>14</sup>.

The Division of General Practice representatives in one state estimated that between 20 to 30 per cent of GPs provided minimal mental health care. Several psychiatrists and GP representative bodies that were subsequently interviewed reported that this appeared a reasonable estimate. The reasons for this were seen to include:

- inadequate remuneration for the time required to assess and develop a Mental Health Treatment Plan;
- a lack of skills and confidence by GPs to engage in mental health treatment;
- some overseas-trained GPs (particularly from non-English speaking countries) have a different cultural awareness of mental health and how it should be treated. This is compounded by mental health training not being a core requirement for accreditation in Australia and so being a lower priority for overseas-trained doctors studying for their Australian accreditation; and
- mental health was not a primary area of clinical interest to some GPs and these GPs may fail to recognise a mental illness underlying a somatic presentation.

The Division of General Practice representatives perceived the Better Access initiative as addressing these issues:

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<sup>13</sup> The degree to which new item numbers are displacing activity which may have previously been coded differently is an area that may warrant investigation in Component B of the evaluation: Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) Administrative Data.

<sup>14</sup> Quote from rural carer participating in consumer and carer teleconferences in relation to problems in gaining services to treat depression experienced by their partner.

- by providing a higher MBS rebate for Treatment Plans and Treatment Plan reviews, thus providing the incentive and financial viability for GPs to undertake mental health assessments and prepare Treatment Plans;
- by improving access to psychiatrists for patients' assessments and advice for ongoing patient management, thereby increasing GP confidence and skills to manage patients;
- where the GP did not feel they had the expertise to provide focussed psychological interventions, they could refer the patient to a psychiatrist or AHP; and
- the information, training and networking opportunities with other mental health service providers implemented concurrently with the Better Access initiative has increased GP awareness of, and focus on, the mental health needs of patients.

Reflective of the wider comments from GPs, one GP reported:

*“This initiative is the single most important factor that has changed my working life in the past 5 years. Prior to this, dealing with mental health problems was nothing short of a titanic struggle for the average busy GP. Since referral to a psychologist with Medicare subsidy has been possible, GPs have not had to re-invent the wheel every time we saw a patient with high prevalence disorder (anxiety disorders or depression). I largely do not bother psychiatrists with these problems which are usually fairly straightforward for psychologists to deal with, often working with GPs as prescribers. Instead, psychiatrists are now used more appropriately to see people with mental illness that is more severe, or with psychotic disorders.<sup>15</sup>”*

As GPs are the gatekeepers for access to psychiatrists and AHPs, changing their behaviour was perceived as a key component in improving overall access to mental health services. GPs, GP stakeholder groups, psychiatrists, allied health providers, NGOs and consumers all reported a perception that GPs appeared to be more aware of mental health service options for their clients. It was noted that this change has been progressive and would continue to develop as the Better Access initiative matured.

GPs and other stakeholders reporting improved access to mental health services noted:

- awareness of the Better Access initiative by Divisions of General Practice and GPs consulted;
- increasing referrals to psychiatrists;
- increasing referrals to allied health providers; and
- increasing numbers of patients driving referrals through the Better Access initiative by presenting to GPs and asking for a referral to an AHP.

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<sup>15</sup> Comment received in the online survey.

Tempering the perceived increase in mental health services provided by GPs, only 51 per cent of GPs participating in the survey agreed with the statement that *Better Access has contributed to more GPs providing mental health services*, with 17 per cent disagreeing with this statement and 31 per cent indicating that they were unsure.

A small number of GPs also questioned the level of awareness of the Better Access initiative among their colleagues and suggested that some GPs may be claiming the provision of Mental Health Treatment Plans due to the financial incentive of the MBS Item number, rather than reflective of the service being provided. A very small proportion of GPs, AHPs, consumers and carers consulted, also expressed this view.

A small number of individual GPs engaging in the consultations (not Division of General Practice or RACGP representatives) reported that some of their colleagues were not well aware of the Better Access initiative, the requirements to claim the Better Access initiative item numbers and referral through the Better Access initiative.

That some GPs may not be fulfilling the intent of the Mental Health Treatment Plan was also reflected in the perception by AHPs that many (possibly 20 to 30 per cent) of Mental Health Treatment Plans that they received contained insufficient information to inform the treatment approach, with some containing no information on diagnosis or reason for referral. Overall though the majority (73 per cent) of respondents reported the information provided in the GP mental Health Care Plan as good or fair and notably, 72 per cent of respondents reported that they had not received inappropriate referrals. (attachment 1)

Approximately a third of consumers and carers complained that their GP did not spend enough time with them and a smaller number (less than ten per cent) reported that they were not aware of their GP preparing a Mental Health Treatment Plan prior to referral to an AHP. Consumers and carers participating in the evaluation through the teleconference and online survey were also more likely to report that GP awareness of availability of the Better Access initiative remained an issue.

It should be noted that of those stakeholders expressing concerns about GP awareness of and use of MBS items through the Better Access initiative, nearly all reported that awareness of the Better Access initiative and quality of Mental Health Treatment Plans and information provided to consumers was improving. This was perceived as a natural maturing of the Better Access initiative over time.

#### **4.2.4 Improved access to allied health providers**

The provision of referral pathways for appropriate treatment for patients with mental disorders and MBS Items for psychological treatments provided by clinical psychologists and appropriately trained psychologists, social workers and occupational therapists has improved access to mental health treatment.

Improved access to focussed psychological services provided by allied health providers was a consistent theme across all of the stakeholder consultations. This is also

reflected in the reported number of services provided (see *Figure 1, page 23*), with growth most marked in the number of services provided by psychologists.

Most AHPs interviewed (predominately psychologists), when commenting on the high rate of growth in services indicated in **Error! Reference source not found.** 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 and as GP awareness of AHP services and referral networks continued to develop. Unlike Access to Allied Psychological Services (ATAPS), the budget for the Better Access initiative is not capped. The only constraint to the number of individuals receiving services is the level of approved demand (via the GP Assessment and Treatment Planning process) and the supply of AHPs. Within this context, a cycle of increasing demand and supply was identified as progressing through the following stages:

- A high level of unmet demand in the community, with up to one in five adults having experienced a mental disorder in the preceding 12 months<sup>16</sup> and less than half receiving treatment<sup>17</sup>. This demand was not being met by public mental health services, and most individuals receiving services through the Better Access initiative would have otherwise remained untreated.
- The Better Access initiative increases the affordability of services in the private sector and more people can access services.
- Concurrent with the increase in affordability of AHP services, strategies to encourage GPs to participate in early intervention, assessment and management of patients with mental disorders and to streamline access to appropriate psychological care further drives referrals to AHPs.
- The availability of the MBS rebate and subsequent increased demand for services has increased the viability of private practice, leading to an increase in the number of approved providers.
- The increased availability of providers (number of providers and locations serviced) makes services easier to access, leading to more referrals.
- As awareness and availability of the Better Access initiative has increased, GPs are making more referrals as an adjunct or alternative to pharmacological interventions and/or in response to referral requests from clients. The issue of psychological strategies as an adjunct or alternative to pharmacological interventions is discussed further in section 4.8.4.

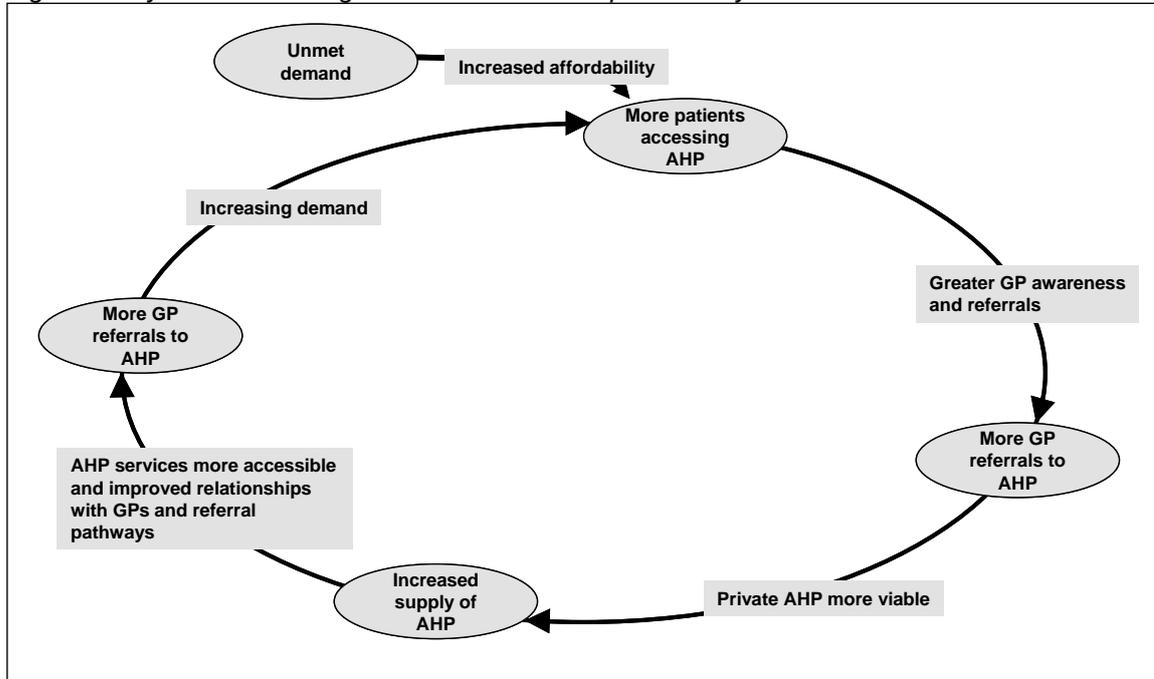
Through consecutive consultations the review explored with AHPs the factors contributing to increased service utilisation to develop the conceptual framework identified in *Figure 2* below.

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16 Australian Bureau of Statistics 1999. Issue 4327.0: National Survey of Mental Health and Wellbeing of Adults: Users' Guide, 1997.

17 Harris MF, Silove D, Kehag E et al (1996) Anxiety and depression in general practice patients: prevalence and management . *Medical Journal of Australia* 1996; 164:526-529.

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



Although poorer access to AHPs by disadvantaged groups in the community was reported by GPs, public mental health service providers, NGO and consumer and carer representatives<sup>18</sup>, it was not generally noted by the AHPs interviewed.

One teleconference with AHPs discussed poorer access by disadvantaged groups and noted that this was a result of GPs failing to refer these client groups. This issue was also reported in two of the small area consultations. In one consultation a bilingual AHP already engaged in working with the local refugee community though their experience working in the public mental health system complained that they were not receiving referrals through local GPs though demand was known to be high. In another consultation a psychologist experienced in working with the local community of Aboriginal and Torres Strait Islander people reported that they received very few referrals from local GPs.

Most AHPs reported that the Medicare rebate was too low and that it failed to reimburse for reports and consultation with other service providers (particularly an issue for clients with more complex needs). AHPs identified the gap payment required to meet the cost of service provision as a difficulty and barrier in access for some individuals. General psychologists and social workers were particularly concerned about the higher rebate paid for services provided by clinical psychologists. They reported that the costs of service provision were equivalent and the range of services and outcomes being achieved across professional groups was similar and a differential payment was not justified. They argued that the higher rebate to clinical psychiatrists allowed them to charge higher fees and a lower gap payment, resulting in a service,

<sup>18</sup> Inequity in access across population groups was noted by representatives of consumer and carer organisations and difficulty in accessing services was reported by consumers and carers from regional, rural and remote areas.

which though more expensive, was cheaper to the client and provided them with an unfair competitive advantage. They argued that they should receive the same rebate as clinical psychologists and that this would allow them to charge lower gap and improve access to services.

Consumers and carers participating in the online survey and teleconferences generally perceived AHP services as affordable, but this may be partially explained by the relatively high numbers seeing clinical psychologists who were able to charge a minimum gap fee or bulk bill. Approximately half of the consumers responding to the online survey perceived services as affordable, as did more than three-quarters of those participating in the consumer teleconferences. Consumers generally argued that the perceived benefit of the service outweighed the cost. As one carer noted:

*"I have been in the caring role since before the Better Access initiative. If this was in place during our time it would have given us more choice at a lot less expense."*<sup>19</sup>

It is possible that the reporting of affordability by consumers may reflect a bias in the socio economic profile of consumers participating in the evaluation. A couple of consumers in receipt of pensions or benefits indicated that gap payments precluded them from accessing the local AHP.

The issue of gap payments and affordability was a strong theme with consumers, particularly for consumers with a longer history of mental health disorder. A number of consumers from regional areas reported that though AHPs were available in their local area, they were unaffordable. One consumer reported driving over 200km to the city for appointments with a psychiatrist as the gap payment was less than that charged by the local psychologist.

#### **4.2.5 Improved access across Australia**

Across all states and territories, all interviewees reported improved access to mental health services as a result of the Better Access initiative. Respondents across all states and territories also reported that the Better Access initiative was relatively well established, that GPs were generally aware of the Better Access initiative and that referral pathways were developing as the Better Access initiative matured.

The major limiting factors to access were the variations in the distribution of psychiatrists, GPs and AHPs across and within the states and territories and the gap payments remained an issue especially for people from a low socioeconomic background. This was perceived to be reflective of general health workforce issues and not specific to the Better Access initiative.

Interviewees noted that the Better Access initiative increased the range of communities able to access mental health services because of AHPs establishing local practices and/or having skills specific to the local community.

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<sup>19</sup> Comment of carer responding to the online survey.

Several NGO services indicated that as a result of the Better Access initiative, services were now available in areas where there were none previously. This included communities where the AHP was the sole mental health provider. They also reported that, due to the specialisation and area of interest of some AHPs, there are now more services available for special needs groups.

Public mental health providers also indicated that, as a result of the Better Access initiative, there were more referral options for individuals contacting their services.

A couple of AHP peak representative bodies noted that, as the Better Access initiative increased the financial viability of private practice, AHPs were not tied to working in areas where they could work part-time in public practice. This was reported as a positive factor in increasing the ability of AHPs to establish practices in areas where there were few public mental health services. One AHP representative suggested that, as a result of the Better Access initiative, the market would work to improve equitable access as practitioners established practices in areas to capture local demand and where there were previously few other services.

Conversely, there was a more strongly represented view that the Better Access initiative, although increasing overall access, would not necessarily address inequity in access across population groups and geographical locations. A number of public mental health providers, and GP, NGO and psychiatrist representative groups noted that there was no incentive built within the current rebates that encouraged the provision of services to disadvantaged communities or higher need individuals. In local consultations, all providers noted that AHPs tended to be located in the more affluent areas of the community. The socio demographic inequity in service provision and access to services was seen to relate to:

- the disparity in rebate and recommended fee for AHPs, particularly general psychologists, social workers and occupational therapists, requiring gap payments;
- no means testing of the rebate or level of rebate;
- no financial incentive to bulk bill priority population groups. It was further noted that the administrative delays of up to five weeks between the lodgement of the Medicare Item number and payment further discouraged bulk billing; and
- disadvantaged communities and higher need individuals often requiring a greater level of input and effort than that reflected in the Medicare Items. This may include case conferencing with other agencies, preparation of reports, secondary consultation and liaison and information sharing.

In contrast, only one AHP noted that this was possibly a legacy of the distribution of AHP practices prior to the Better Access initiative being implemented and that there would be an expansion into poorer areas as the workforce increased and there was increasing competition for clients in the more established areas.

One rural and remote Division of General Practice identified a perverse effect of the Better Access initiative reducing services to rural communities. The Division reported that, prior to the Better Access initiative, it was able to recruit clinical psychologists to provide a 'fly in fly out' service through ATAPS, at a fee of \$55 per session plus travel and accommodation costs, two days per week. Subsequent to the Better Access initiative, providers increased their fee to \$125 per session (reflective of the MBS rebate) plus expenses, effectively halving the number of sessions that could be provided through ATAPS. The Division indicated that, in response to this difficulty, DoHA agreed to allow the AHP to bulk bill patients on the second day of their visit in order to maintain the same volume of services. (Note: the stakeholder was referring an exception under section 19(2) of the Health Insurance Act<sup>20</sup>.) While maintaining the same volume of services, this more than doubled the cost of service provision paid for by the Commonwealth. The Division felt that this solution was not sustainable as they were finding it increasingly difficult to attract AHPs to provide outreach services to remote communities. The Division reported that AHPs were increasingly reluctant to undertake the additional travel time, expend the effort required to provide services within disadvantaged communities and experience the disruption to their urban practices for less money than they can make from their practice in the city or larger regional centre.

One consumer from a remote mining community reported that, prior to the Better Access initiative, the mining company had provided 'fly in fly out' psychologists but, subsequent to the Better Access initiative, they were no longer able to recruit to this position and the service had ceased. The respondent noted that there were now no mental health services available in this community, other than those provided through the local Aboriginal Medical Service. It was reported that services from the Indigenous health service were not available to mine employees or their families except in an emergency.

Most public providers reported increased difficulty in recruiting and retaining clinical psychologists as a result of the Better Access initiative, reducing the availability of clinical psychologists to the public mental health system. Conversely, most clinical psychologists reported that it was a devaluing of skills and expertise in the public mental health system that resulted in a shift to private practice and that the Better Access initiative was a facilitator, rather than a cause, of this shift.

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<sup>20</sup> Sub-section 19(2) of the HIA states that a Medicare benefit is not payable in respect of a professional service that has been rendered by or on behalf or under arrangement with:

- (a) the Commonwealth;
- (b) a State;
- (c) a local government body; or
- (d) an authority established by a law of the Commonwealth, a law of the State or a law of an internal territory.

A Medicare benefit is not payable unless the Commonwealth Minister for Human Services and Health directs otherwise.

A consistent theme from social workers participating in the consultations and online survey was that there appeared to be a bias in referrals to psychologists by GPs and that GPs did not have a full understanding of the expertise and services offered by mental health social workers. A number of consumers participating in the consultations and online survey also perceived a bias towards psychologists at the expense of other AHPs.

The online survey of GPs provided more detailed information on GP referral patterns, Table 2 below. Though 77 per cent of GPs reported referring to clinical psychologists, less than 60 per cent reported referring to psychologists and only 20 per cent to social workers and ten per cent reported referring to occupational therapists.

*Table 2: GP referrals to allied health professionals*

| GPs referring to                                | Number of GPs | Per cent of GPs |
|---|---------------|-----------------|
| Psychiatrist                                    | 124           | 61%             |
| Clinical psychologist                           | 157           | 77%             |
| Psychologists                                   | 120           | 59%             |
| Social worker                                   | 40            | 20%             |
| Occupational therapist                          | 21            | 10%             |
| Total respondents reporting nature of referrals | 203           |                 |

Exploring this further with a number of GPs in later consultations suggested that GPs may have a limited understanding of the expertise of social workers and occupational therapists. GPs reported that they generally felt more comfortable referring to psychologists. In subsequent consultations stakeholders and interviewees proposed a range of reasons, when queried. These included the following:

- Numerous GPs reported being more familiar in working with psychologists through ATAPS, due to a historically greater number of psychologists in private practice.
- When asked about why they referred to psychologists rather than social workers, GPs often stereotyped social workers as ‘helping people with social problems’ and occupational therapists as ‘working with children’.
- Many GPs perceived psychologists as offering a more ‘evidence based’ and medical model of care, consistent with their own practice.
- GPs indicated that they received more information from psychologists on the practices in their local area, the range of services provided by psychologists and their areas of expertise.
- In a number of Divisions of General Practice, the Australian Psychological Society (APS) had been proactive in producing referral directories of local psychologists and distributing these to GPs.

- A few psychiatrists noted that GPs had less experience in working within multidisciplinary care teams as part of their clinical training, and were not exposed to the clinical expertise of mental health social workers and occupational therapists.
- Social workers reported feeling less comfortable approaching GPs in relation to the services they provided than did psychologists. Social workers also appeared less comfortable and confident with the concept of private practice as a business.

A number of social workers and occupational therapists suggested that their representative bodies had not been as proactive as the APS in supporting and advocating on behalf of social workers in private practice. This was perceived to be due to private practice mental health work being only a small component of the cross section of activity undertaken by social workers and occupational therapists.

The online survey of GPs collected information of factors influencing GP choice of AHP to refer to, Table 3 below. Professional skill and competence was sighted as primary reason by 93 per cent of GPs, followed by cost (85 per cent), location (74 per cent) and area of specialisation (50 per cent). Professional group was only reported by 34 per cent of GPs as a factor and information on waiting times by 27 per cent of GPs. One GP indicated that they did not refer to AHPs.

*Table 3: Factors influencing GP choice of referral*

|  |     |     |
|--|-----|-----|
| Professional skill and competence                                  | 122 | 93% |
| Cost   | 112 | 85% |
| Established relationship   | 97  | 74% |
| Location   | 89  | 68% |
| Area of specialisation   | 66  | 50% |
| Professional group   | 45  | 34% |
| Information on waiting times                                       | 36  | 27% |
| Not Applicable i.e. do not refer to allied health professionals    | 1   | 1%  |
| Total respondents reporting factors influencing choice of referral | 131 |     |

It was also notable in the course of the consultations that the APS demonstrated a higher level of organisational efficiency and established communication networks than did either the Australian Association of Social Workers (AASW) or Occupational Therapy Australia (OT Australia). It was easier for the evaluation to identify and access the appropriate spokesperson for the APS at a national and statewide level for interview than it was for the AASW and OTA: information was more quickly disseminated through the APS to its members and appeared to capture a greater proportion of members.

#### 4.2.6 Improved access across age groups

There was a clear consensus across all groups and individuals participating in the evaluation that there has been improved access across all age groups.

There was a consistently high perception that improvements in access have been most marked for children with more common mental health problems, for whom few, if any, public mental health services were previously available.

Despite these improvements in access, stakeholders and interviewees also noted that children and older people remain relatively disadvantaged in access to mental health services, as discussed in the following sections.

#### 4.2.7 Access by people living in rural and remote areas

Poorer access to mental health services for people living in rural and remote communities was the most common area of inequity identified by all stakeholder groups. For mental health professionals, this was recognised as reflective of broader rural workforce challenges and as not being specific to the Better Access initiative.

While stakeholders believed that the Better Access initiative was a successful model for the urban context, there were concerns about its application in rural areas. The main issue facing clients seeking mental health services in rural and remote areas was the limited availability of psychologists and other allied health professionals, a factor also confirmed in the literature.<sup>21 22 23 24</sup> The Australian Institute of Health and Welfare (AIHW) also reports poor access to allied mental health services provided by psychologists, social workers and occupational therapists in outer regional and remote areas (25 and 22 services per 1,000 population, respectively) compared to access in major cities and inner regional areas (33 and 34 services per 1,000 population, respectively).<sup>25</sup>

Results from a recent workforce survey administered by the APS were somewhat more optimistic, showing that around 26 per cent of psychologists currently providing

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<sup>21</sup> URBIS 'Environmental Scan Component of the Mental Health Professionals' Association Multidisciplinary Training Resource Program' Final Report January 2008.

<sup>22</sup> Rural Doctors Association of Australia "New mental health items 'out of reach' for rural patients" (2006) Accessed 19 March 2009 [http://www.rdaa.com.au/uploaded\\_documents/New\\_per\\_cent20mental\\_per\\_cent20health\\_per\\_cent20items\\_per\\_cent20'out\\_per\\_cent20of\\_per\\_cent20reach'\\_per\\_cent20for\\_per\\_cent20rural\\_per\\_cent20patients\\_per\\_cent20--\\_per\\_cent20October\\_per\\_cent202006.htm](http://www.rdaa.com.au/uploaded_documents/New_per_cent20mental_per_cent20health_per_cent20items_per_cent20'out_per_cent20of_per_cent20reach'_per_cent20for_per_cent20rural_per_cent20patients_per_cent20--_per_cent20October_per_cent202006.htm) p1

<sup>23</sup> Eckert, K.A., Wilkinson, D., Taylor, A.W., Stewart, S, Tucker, G.R., 2006. "A population view of mental illness in South Australia: Broader issues than just location". Rural and Remote Health, 6, 541 p11.

<sup>24</sup> Australian General Practice Network "Mental health Medicare measures welcome, but equity at risk" (2006) Accessed 19 March 2009 [http://www.agpn.com.au/site/index.cfm?module=MEDIA&PageMode=indiv&page\\_id=15740&leca=16p1](http://www.agpn.com.au/site/index.cfm?module=MEDIA&PageMode=indiv&page_id=15740&leca=16p1).

<sup>25</sup> Australian Institute of Health and Welfare "Mental health services in Australia 2005–06" (Canberra 2008)

Medicare funded services are outside a metropolitan area. However, the survey also identified a diminishing workforce with increasing remoteness and strongly recommended assessment of the nature of the rural and remote psychology workforce and the factors that might contribute to future growth.<sup>26</sup>

AHPs reported that as a consequence of the lower numbers of AHPs outside cities there are longer waiting lists for Medicare approved mental health practitioners in rural and regional areas, especially when compared to their urban counterparts. Psychologists reported that relative to other professional groups, the waiting lists for clinical psychologists were the longest. Public provider and GP participants in one small area consultation and two participants consumer participants in teleconference offered anecdotal reports of psychologists moving away from rural and remote areas and relocating to the city in order to capitalise on the new business opportunities available following the introduction of the Medicare rebate, with subsequent further strain on the limited resources available in these areas.

Where instances of services being developed in rural areas were identified in the consultations, these appear to be to more lifestyle friendly locations, for example popular regional locations.

A range of options were proposed by AHPs to improve access for rural communities. These included:

- Introducing items for secondary consultation to allow AHPs to support local workers (NGOs, Aboriginal Medical Services, local mental health workers) to provide services in these communities, including specialised supervision to work with individuals with complex care needs.
- One psychology practice group advocated the provision of online therapy using telephone and/or VOIP<sup>27</sup> and webcam. They were already providing this service to some clients and noted that this model of care was operating in other areas of health service delivery and broader education and community service provision.

Several respondents to the public provider online survey suggested expanding the range of approved the Better Access initiative providers to include mental health nurses in rural areas as a means to improve access to mental health services in rural communities. Similarly, a couple of NGO providers suggested including Aboriginal Health Workers within the approved range of providers.

Countering the argument for expanding the scope of approved providers was a much stronger response from public providers and the Divisions of General Practice suggesting that private practice sessional-based services were not an effective means of providing services to these populations. They recommended:

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<sup>26</sup> Dr Louise Roufeil, Anne Lipzker, "Psychology Services in Rural and Remote Australia" InPsych October 2007 Accessed 19 March 2009  
[http://www.psychology.org.au/publications/inpsych/rural\\_remote/](http://www.psychology.org.au/publications/inpsych/rural_remote/)

<sup>27</sup> Voice Over Internet Protocol.

- maintaining and expanding the Division of General Practice budget holding to provide services on a contract or block grant basis, a view expressed by most Divisions of General Practice and many GPs;
- enhanced funding to public mental health services to provide population based mental health services, a view expressed by most public providers; and
- enhanced funding to NGOs to provide population based mental health services, a less commonly expressed view of some NGOs.

In general, the key issue in relation to access by rural communities was the availability of workforce. Overall it was felt that, due to a small, dispersed and generally poorer population, the private practice model was limited in its application to small rural and remote communities. It was noted that a number of Divisions are currently using ATAPS funding to target specific population groups, including outreach services<sup>28</sup> to areas with no services and into Indigenous and culturally and linguistically diverse communities. As indicated in the preceding section, one rural Division noted the impact of the Better Access initiative on the cost of recruiting AHPs through ATAPS, particularly clinical psychologists.

Northern Territory (NT) stakeholders described particular challenges faced in delivering mental health services to their population. In the NT, general practitioners largely operate out of Territory-funded facilities and therefore their use of MBS item numbers is low. Given that the Better Access initiative is linked to the MBS system, the NT population are subsequently much less likely to be able to access mental health services through the Better Access initiative. Similar problems were reported in remote areas of Queensland.

A number of psychiatrists in public practice suggested that, as the capacity to refer to an AHP was limited by GP availability, access would improve if they could refer directly to AHPs.

Representatives of psychotherapists and counsellors not within the provider groups eligible for a MBS provider number strongly argued for the expansion of eligibility to their members. They argued that their members were underutilised in rural and remote areas, despite significant demand for mental health services. These stakeholders claimed that there were more members likely to be located in rural and regional setting.<sup>29</sup> They also suggested that, because of the availability of the Medicare rebate influencing individuals to choose an approved AHP, they had a greater level of availability. They argued that providing Medicare provider numbers to accredited members of the organisations would lead to an immediate increase in access to services. They indicated that, due to the rebate, individuals would join waiting lists to see approved AHPs rather than non approved counsellors, and that there had been a decrease in their waiting lists and demand for their services. Non-approved counsellors

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<sup>28</sup> Component B of the evaluation: Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) Administrative Data will be able to examine distribution of individuals receiving services by poverty rates by postcode.

<sup>29</sup> No evidence was received to support this assertion.

reported that the reduction in demand for their services threatened the financial viability of their services, particularly in rural and remote areas.

Three AHPs observed that there may be an increasing proportion of general psychologists, social workers and occupational therapists being recruited to ATAPS because of the lower Medicare rebate payable to these professional groupings, making service provision through ATAPS relatively more financially attractive than they are to clinical psychologists.

#### **4.2.8 Access by people living in poorer communities**

Stakeholders at a government department level and a few GPs and NGOs reported perceived inequalities in access associated with the socio economic status of the community served. Poorer communities were perceived as less able to access the Better Access initiative services due to:

- fewer GPs and AHPs providing services in these communities;
- gap payments precluding access to AHPs (and in some instances GPs) and very few AHPs offering 'bulk billing';
- limited public transport, in turn limiting access to services, both within the local area and to other areas where services are located; and
- potentially a lower likelihood of individuals recognising and seeking help for a mental health problem.

Additional to the equity issues, state and territory health departments reported a need for reporting of the Better Access initiative service utilisation by local government area to better target the provision of public mental health services, to address inequities in access.

Although not noted by peak GP and AHP bodies, the variation in access related to poverty was highlighted in both the local consultations and consultations with some peak NGO organisations. The small local area consultations incorporated areas defined by Division of General Practice boundaries. As such, local providers were aware of and able to comment on any inequities in access to services at a local level.

#### **4.2.9 Access by children and young people**

The consultations identified that the Better Access initiative had assisted in improving access to mental health services for children and young people. Increasing access to mental health services by children was a strong theme from the consultations while noting the opportunities to further improve access and clinical outcomes for children and their families.

Previously, low cost treatment options for children with mental health problems were through the very few child and adolescent psychiatrists in private practice (who bulk billed or had a low or sliding fee scale), outpatient departments of the children's hospitals or the public mental health child and adolescent mental health service (CAMHS). Stakeholders emphasised that CAMHS were generally aimed at the most severely ill, and were usually associated with chronically long waiting lists. Services for children and young people are described as fragmented and highly localised.<sup>30</sup>

Families requiring mental health services for their children were largely forced to rely on the private system for which there was no rebate available. As such, the Better Access initiative was perceived as providing an additional route for children to access mental health services in a much more timely manner, providing intervention before the young person became acutely unwell, and addressing the psychological problems underlying behavioural and learning problems. The Better Access initiative has allowed a number of providers with expertise in child and adolescent mental health to enter the private system. The inclusion of occupational therapists, psychologists and social workers within the group of approved providers allows GPs to refer to the professional with the most appropriate skills and experience to address the needs of the child.

It was also noted that paediatric referrals are coming via paediatric surgeons through the paediatrician. A number of AHPs suggested that paediatric surgeons also be given delegation to refer to the Better Access initiative providers.

Respondents noted that the key areas for improvement in respect to services for children were to expand the range of MBS items to include the provision of family therapy and sessions with family and carers at which the child was not present.

In respect to services for youth and young adults many stakeholders and interviewees (GPs, AHPs and NGOs) noted that traditional professional providers and the Better Access initiative service models did not provide adequate access by youth for the following reasons:

- higher likelihood of cancellations, 'no shows' and no payment for 'no shows', reducing the financial viability for providers in providing a service on a sessional payment basis;
- limited capacity to pay gap fees required to sustain financial viability;
- longer periods of engagement required to develop a therapeutic relationship;
- high likelihood of co-morbidities such as substance abuse;
- longer engagement and co-morbidities requiring more sessions than available through the Better Access initiative; and

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<sup>30</sup> Department of Health and Ageing, National Mental Health Working Group "Responding to the Mental Health Needs of Young People in Australia" (Canberra 2004)

- often the need to engage with other services providing support to the client not funded through the Better Access initiative.

Like other priority population groups, stakeholders suggested that services to youth were better provided as service specific funding, such as funding to youth services or Headspace. These services are able to provide services within a more appropriate and youth friendly culture and incorporating non-traditional approaches to client engagement.

Consultation with Headspace programs indicated a difficulty in becoming self-funding because of the limited capacity of youth to pay gap payments to AHPs and high rates of cancellations and no shows limiting a Medicare based revenue stream.

#### **4.2.10 Access by older persons**

Overall, issues of access relating to age were not commonly mentioned by stakeholders during the consultation process. Subsequently, this was explored more closely in the local consultations.

One issue identified by a few providers was the fact that nursing home residents are essentially excluded, as they are unable to visit the allied health professional for treatment. GPs can contribute to the management of mental health problems of nursing home residents under the EPC Team Care Arrangements: however, *“given the complex care needs for such residents, the five allowable MBS allied health services per year are rarely (available to be) used for referral to mental health professionals.”*<sup>31</sup>

The Australian General Practice Network (AGPN) recommends that nursing home residents be made eligible for GP Mental Health Treatment Plans to promote access. This suggestion was also made by a small number of psychiatrists and GPs in the online survey. Another group of psychologist practitioners suggested that access could be improved by allocating ATAPs funding for use in nursing homes and for therapists visiting clients in their environment, rather than requiring the client to attend a clinic.<sup>32</sup>

A number of AHPs working with older people also identified the additional cost of providing in-home visits to older people and consultation with other services involved in care that was not reflected in the MBS item numbers. It was argued that enhanced funding is required for home visits and additional MBS items are required to cover care planning and case conferencing for AHPs, similar to EPC items available to GPs. AHPs working with older people tended to perceive themselves as part of a multi-disciplinary care team and indicated high levels of networking and integration with local aged care teams (e.g. Aged Care Assessment Teams - ACATs), primary care services, home nursing and home and community care (HACC).

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<sup>31</sup> Australian General Practice Network, “AGPN calls for Better Access to Mental Health for residents of nursing homes” (2008) Accessed 19 March 2009 [http://www.agpn.com.au/client\\_images/236361.pdf](http://www.agpn.com.au/client_images/236361.pdf) p 1.

<sup>32</sup> It is recommended that Component B of the evaluation: Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) Administrative Data examine ATAPS and Better Outcome data to assess whether older people are accessing mental health service by alternative pathways.

The difficulty faced by nursing home residents in accessing mental health care can be considered in light of the large population of older people with significant depressive symptoms.<sup>33</sup> AIHW reports from 2006-07 identify an estimated 1,071 mental health related encounters per 1,000 population for persons aged 65 years or more, which is “a much higher rate than any other age group”.<sup>34</sup>

The need for outreach services for older people was also raised in respect to the frailty and/or limited mobility of many older people and for disorders such as phobias where exposure treatments are prescribed. AHPs and GPs discussing the needs of older people indicated that there was a strong evidence base for outreach services to the home environment for older people and that these interventions were effective.

#### **4.2.11 Access by Aboriginal and Torres Strait Islander people**

Very few stakeholders or interviewees identified Aboriginal and Torres Strait Islander people as a priority population group experiencing higher need or poorer access to services. When directly questioned, most providers indicated that they had not considered the Indigenous community and their ability to access the Better Access initiative related mental health services.

The failure of stakeholders and interviewees to consider the mental health needs of Aboriginal and Torres Strait Islander people should be considered in light of the prevalence of mental illness in these communities, which is approximately twice that of non-Aboriginal and Torres Strait Islander people. The reported rate of high or very high levels of psychological distress was 26.6 per cent for Aboriginal and Torres Strait Islander people (National Aboriginal and Torres Strait Islander Health Survey, 2004-05) compared to 13.1 per cent for non-Aboriginal and Torres Strait Islander people (National Health Survey, 2004-05). Further, with increasing remoteness, Aboriginal and Torres Strait Islander people reported an increasing level of psychological distress. A similar pattern was not observed for non-Indigenous Australians.<sup>35</sup>

Mental health service usage rates of Aboriginal and Torres Strait Islander people appear to be similar to non-Indigenous persons, at 479 GP encounters per 1,000 population, compared to 468 per 1,000 population.<sup>36</sup> Given that the rate of psychological distress in Indigenous communities is much higher than non-Indigenous Australians, these similar encounter rates may indicate that Indigenous Australians are not accessing GPs for mental health issues at a rate comparable to their needs.

Stakeholders discussed a range of difficulties that Aboriginal and Torres Strait Islander communities faced in accessing mental health services. One of the barriers facing Aboriginal and Torres Strait Islander communities is that of appropriateness, with stakeholders noting that working within Aboriginal communities required acceptance into the community and an understanding of the Aboriginal perception of wellness.

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<sup>33</sup> Beyond Blue “Depression in the Elderly” Synergy No 2, 2004

<sup>34</sup> AIHW (2008)

<sup>35</sup> Australian Institute of Health and Welfare, “Aboriginal and Torres Strait Islander Health Performance Framework 2008 report: detailed analyses” (Canberra 2009)

<sup>36</sup> AIHW (2008)

When combined with the issues of socioeconomic status and geographic location typical of many Indigenous groups, access to mental health services was recognised as difficult.

One AHP practitioner, with well-established ties and working closely with the local Aboriginal community, reported that the MBS rebate was inadequate to cover the additional costs associated with providing outreach services into the community and time involved in working with the client's family and wider community. The interviewee noted that, although demand was high, he was unable to afford to extend his practice further into the community and was dependent upon non-Indigenous clients to maintain financial viability.

Several psychologists reported successful interventions based on secondary consultations provided to local Aboriginal health workers. These were arranged through a variety of funding sources, other than the Better Access initiative. The psychologists suggested that the funding of client specific secondary consultation services to local workers in Indigenous communities would provide the skills, support and supervision for local workers (funded through other Commonwealth and State programs) to provide effective mental health care to less complex cases within these communities. Several psychologists and two social workers reported successful instances of providing remote secondary consultation to Aboriginal health workers and the client's family to develop and implement effective interventions around clients experiencing phobias responsive to exposure therapy and implementing cognitive behaviour therapy (CBT) for clients with anxiety and/or depressions.

One group of approved Aboriginal counsellors specialising in Aboriginal mental health reported an extensive statewide telephone based practice, growing rapidly through word of mouth referral and their relationships with Indigenous communities. The program was funded through NGOs, cross subsidisation from training and development opportunities, and volunteer hours. The capacity to expand and train additional AHPs in working with Indigenous communities was constrained by the need for 'face to face' rather than telephone-based services to receive the MBS rebate.

An alternative, and more widely held view, was that services into Indigenous communities may be better funded through alternative programs, such as Better Outcomes or as a component of health funding for Aboriginal and Torres Strait Islander health services.

#### **4.2.12 Access by people from culturally and linguistically diverse backgrounds**

It was recognised that culturally and linguistically diverse (CALD) communities also experienced considerable difficulty in accessing mental health services through the Better Access initiative. It is notable that this issue was raised by most public mental health representatives, one RACGP representative and two RANZCP representatives and several GPs in rural and remote areas. When questioned about the issue, several other GP and AHP interviewees reported that they had not considered access issues

for CALD communities, and were unaware of specific difficulties these groups may face.

The major challenge identified for CALD communities was one of language. While GPs can access the Australian Government's Translating and Interpreting Service (TIS) without charge, stakeholders and interviewees noted that there is no interpreting service available for allied health professionals. Communication with mental health clients under the Better Access initiative without interpreter support, unless by a bilingual AHP, was therefore deemed virtually impossible and a clear barrier to accessing services. As a result, interventions may be reliant on informal or untrained interpreters such as family or community members, in turn raising other difficulties.

Where interpreters are used (whatever the source), the additional time required in working with a client using an interpreter is not recognised. This more than halves the therapy time available to clients receiving services through an interpreter.

The communities' understanding and perceptions of mental health and mental health treatments also limit access to mental health services. Access to these communities may require a period of engagement and cultural sensitivity to increase awareness and acceptance. One opinion is that there should be more training and awareness campaigns targeting these communities through local community networks, while also increasing awareness and cultural sensitivity of local GPs and AHPs. An alternative view was that services targeted to CALD communities may be better funded through ATAPS and/or block funding to established CALD specific health services.

When questioned about reduced access by CALD communities and other disadvantaged groups, a small number of AHPs suggested that this was an issue for GPs who drive the referrals, rather than one for AHPs. They perceived it as the responsibility of the GP to make the referral, and that improving access by CALD and other disadvantaged groups was not something that they could readily influence.

#### **4.2.13 Access by individuals with complex care needs**

Overall, GPs, AHPs and public mental health providers perceived the Better Access initiative as providing services complementary to those provided by public mental health services. The Better Access initiative clients tended to have lower chronicity, less complexity, fewer co-morbidities, and were more able to manage their own care than clients of the public mental health system.

However, AHPs also noted an increasing complexity in the profile of clients referred to AHPs as the Better Access initiative has evolved. In part, this was attributable to the revelation of more complex issues underlying what appeared to be more simple presenting problems. More importantly, the increasing complexity of referrals was seen as a product of the maturing of the Better Access initiative. As relationships, trust and referral pathways developed between GPs, psychiatrists, AHPs and local support services, the complexity of those referred increased.

AHPs with well-established practices and relationships with local GPs, psychiatrists and community support services reported managing very complex cases with extensive mental health histories. These AHPs were also more likely to report positive working relationships with local public health providers, based not on formal structures but on relationships with individual public mental health providers. In some instances, these clients were receiving case management from NGO organisations, the public mental health system and/or intensive informal support from families and friends. These providers also reported a capacity to work with the local GP in accessing both the Better Access initiative and ATAPS to provide the intensity and continuity of care required. It was noted in the consultations that the number of sessions being required was increasing and up to 18 sessions was not unusual.<sup>37</sup>

The local consultations suggested that the complexity of the caseload referred was also in part a reflection of the capacity of the local public mental health system. Where public mental health services were not available or were overstretched, complex clients were more likely to be referred to an AHP through the Better Access initiative.

Concerns raised by a number of consumer organisations representing more complex patient groups and relayed by a number of public mental health providers were that:

- The Better Access initiative is not available to all clients with more complex needs who may also benefit from the services offered through the Better Access initiative;
- the model of care and number of sessions available was often not adequate for this client group who may require more intensive and longer term interventions; and
- given a perceived under resourcing for this client group, the allocation of an uncapped budget to a client group with lower acuity problems was perceived as a poor prioritisation and inequitable allocation of resources.

#### **4.2.14 Overview of access from online survey**

The responses to the online survey of GPs, psychiatrists, paediatricians and allied health providers were reflective of the issues identified through stakeholder interviews. Attachment 2 details the survey responses received. Table 4 below summarises the survey responses in respect to improvements in access to mental health services as a result of the Better Access initiative.

In relation to availability of service, almost 90 per cent of all Better Access initiative providers (GPs, psychiatrists and AHPs) reported more allied health services in the community. The impact on GP services was less marked, with almost 55 per cent perceiving an increase in GPs providing mental health services and more than one-third perceiving no increase in GP provision of mental health services. Only 15 per cent of respondents thought the Better Access initiative had contributed to psychiatrists

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<sup>37</sup> Changes in the number of sessions per individual as Better Access has developed can be identified in Component B of the evaluation: Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) Administrative Data.

being more accessible, with half of GPs and one-third of AHPs not perceiving psychiatrists as being more accessible as a result of the Better Access initiative.

The population groups for whom most respondents agree access had improved are reflective of the Better Access initiative target group, with 96 per cent of respondents agreeing access had improved for individuals with anxiety and depression related disorders.

Most (more than 70 per cent) of all GP, psychiatrist and AHP respondents also agree that access had improved for children and young people and older people. The level of agreement about improvements in access for older people is interesting relative to the numerous comments about constraints of providing services to this group of individuals in the community.

A key area of difference in GP and AHP perceptions was in relation to improved access for individuals with a substance abuse disorder. Sixty-two per cent of AHPs agreed that this group experienced improved access compared to 36 per cent of GPs. In all, half of respondents agreed access to mental health services had improved for individuals with substance abuse disorders.

There was not a strong perception that the Better Access initiative had resulted in more services for people from culturally and linguistically diverse communities or improved access for individuals from these communities. Only one-quarter of respondents agreed there were more services and one-third that access had improved.

Almost two-thirds of all respondents were unsure whether access to mental health services had improved for Aboriginal and Torres Strait Islander people through the Better Access initiative and three-quarters were unsure of any improvements in access for residents or remote communities. The high uncertainty is an artefact of few respondents from rural and remote communities.

**Table 4: Summary of GP and AHP survey responses in relation to the Better Access initiative**

| <b>To what extent do you agree with the following statement: Better Access has contributed to (Per cent of and number of valid responses):</b> |  |                 |               |                |  |                 |               |                |                                    |                 |               |                |  |
|--|--|-----------------|---------------|----------------|--|-----------------|---------------|----------------|------------------------------------|-----------------|---------------|----------------|--|
| <b>Contribution of Better Access to:</b>   | <b>Survey of allied health providers</b> |                 |               |                | <b>Survey of GPs, psychiatrists and paediatricians</b> |                 |               |                | <b>Respondents to both surveys</b> |                 |               |                |  |
|  | <b>Agree</b>                             | <b>Disagree</b> | <b>Unsure</b> | <b>Valid N</b> | <b>Agree</b>   | <b>Disagree</b> | <b>Unsure</b> | <b>Valid N</b> | <b>Agree</b>                       | <b>Disagree</b> | <b>Unsure</b> | <b>Valid N</b> |  |
| • more allied health professionals providing mental health services in the community   | 90%                                      | 2%              | 8%            | 412            | 83%  | 5%              | 12%           | 203            | 87%                                | 3%              | 9%            | 615            |  |
| • more GPs providing mental health services  | 54%                                      | 9%              | 37%           | 414            | 53%  | 14%             | 33%           | 193            | 54%                                | 10%             | 36%           | 607            |  |
| • psychiatrists being more accessible  | 15%                                      | 33%             | 51%           | 410            | 15%  | 50%             | 35%           | 147            | 15%                                | 38%             | 47%           | 557            |  |
| • more culturally and linguistically diverse mental health services  | 26%                                      | 15%             | 59%           | 414            | 24%  | 20%             | 56%           | 185            | 25%                                | 17%             | 58%           | 599            |  |
| • making mental health services more accessible for people with anxiety or depression related disorders  | 97%                                      | 1%              | 2%            | 418            | 95%  | 2%              | 3%            | 199            | 96%                                | 1%              | 2%            | 617            |  |
| • making mental health services more accessible for children and young people  | 72%                                      | 4%              | 24%           | 417            | 67%  | 9%              | 23%           | 196            | 71%                                | 6%              | 23%           | 613            |  |
| • making mental health services more accessible for older people (i.e. those aged 65 + years)  | 72%                                      | 5%              | 23%           | 415            | 67%  | 10%             | 24%           | 198            | 70%                                | 6%              | 23%           | 613            |  |
| • making mental health services more accessible for people with substance use disorders  | 62%                                      | 7%              | 31%           | 413            | 36%  | 28%             | 35%           | 192            | 54%                                | 14%             | 32%           | 605            |  |
| • making mental health services more accessible for people living in rural communities   | 38%                                      | 10%             | 53%           | 413            | 29%  | 10%             | 60%           | 191            | 35%                                | 10%             | 55%           | 604            |  |
| • making mental health services more accessible for people from culturally and linguistically diverse backgrounds                              | 37%                                      | 9%              | 54%           | 416            | 22%  | 16%             | 62%           | 196            | 32%                                | 11%             | 56%           | 612            |  |
| • making mental health services more accessible for Aboriginal and Torres Strait Islander people   | 20%                                      | 14%             | 66%           | 415            | 21%  | 13%             | 66%           | 188            | 21%                                | 14%             | 66%           | 603            |  |
| • making mental health services more accessible for people living in remote communities  | 15%                                      | 14%             | 71%           | 415            | 12%  | 12%             | 76%           | 189            | 14%                                | 14%             | 73%           | 604            |  |

## **4.3 Service appropriateness**

This section presents the key findings related to the impact of the Better Access initiative on service appropriateness. Further key issues that emerged during the consultations were the degree of compliance with the Better Access initiative guidelines regarding eligibility and approved psychological interventions, and the degree to which the Better Access initiative was addressing unmet need in the community. These issues are also discussed in this section.

### **4.3.1 Summary of improvements in appropriateness**

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. For many patients, the only treatment option was through their GP. Very few free or low cost focused psychological services were available. These included GPs with Level Two mental health skills training<sup>38</sup>, 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). Although private mental health services were available in the community, these were unaffordable to many individuals.

A strong theme from the consultations was that, since the introduction of Better Access, individuals with a mental health problem have the opportunity to access focused, psychological strategies as a component of a comprehensive GP Mental Health Treatment Plan.

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.

For individuals with complex needs, it was noted that they tended to require more intensive or different therapies than are covered by the Better Access initiative. It was 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.

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<sup>38</sup> Level-2 GPs refers to GPs who have received mental health training as described under the MBS schedule.

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 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 report 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.

It was also noted that access to appropriate services by rural and remote communities, individuals with specialised needs and Indigenous and culturally and linguistically diverse communities 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 rural areas and an Aboriginal counselling service providing telephone counselling.

There was 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.

#### **4.3.2 Provision of evidence based care**

Nearly all AHPs reported that they provided evidence based mental health care. A small number of interviewees (less than five to 10 per cent of all individuals interviewed) questioned the evidence base of some of the interventions provided by AHPs and noted that, without any outcome reporting, it was difficult to know the degree to which services were meeting the needs of clients and achieving improved outcomes for clients. Respondents citing this concern were more likely to be psychiatrists, Level Two-trained GPs and public mental health providers. A small number of AHPs with extensive private practice experience also expressed this perception. Some of this group were concerned that the lack of outcome reporting might lead to a diminution of the quality of mental health care and means to regulate providers of poor quality care. Associated with this was a wider concern about the effectiveness of the Better Access initiative to target resources to populations of greatest need. Some interviewees within this small group believed that, rather than funding the Better Access initiative, services would have been better allocated to publicly provide mental health services and/or Divisions of General Practice to provide targeted mental health services. Other interviewees expressed concern about the expansion of the provider base to include

GPs without Level Two mental health training and general psychologists, social workers and occupational therapists. The argument about restricting MBS provider numbers to clinical psychologists was presented by a very small number of clinical psychologists.

Essentially, among the interviewees, a small number were critical of the lack of outcome reporting, and this was associated with a more general critique of the Better Access initiative. This group were not specific to any one state or professional group. They tended to be individuals engaged with the public health system or Divisions of General Practice who had a more 'system-wide' view of mental health priorities and service delivery. The information they provided in interview indicated a high level of familiarity with incidence and prevalence data, service models and research findings. As a group, they were well informed and highly articulate, often involved in teaching and research. While acknowledging the Better Access initiative improved accessibility, affordability and that many people experienced improved outcomes, their core criticism was that, with respect to high levels of mental health demand in the community:

- The Better Access initiative was not an effective means to prioritise and target services;
- The Better Access initiative did not lead to integrated and coordinated care, but supported an individualised service model;
- There was limited capacity to regulate quality;
- Uncapped funding for the Better Access initiative would limit available funds for services targeted to high need population groups; and
- High need and special need population groups would have limited benefit from the Better Access initiative.

Contrasting the views of this group, another small group of GPs and psychiatrists were strongly supportive of the Better Access initiative. This group cited the incidence of untreated anxiety and depression in the community and the debilitating affect that this had on the individuals, their families and the wider community and economy. This group were also informed and articulate, citing the evidence for their views. In support of the Better Access initiative, they argued:

- the Better Access initiative was an effective means of providing services to high prevalence mental disorders in the community;
- the Better Access initiative was consistent with the overall Medicare approach and built upon the core role of GPs as the key primary care provider;
- as the Better Access initiative essentially represented an expansion of the same range of services and to the same client group as Better Outcomes, the findings of approved client outcomes for Better Outcomes were transferable to the Better Access initiative;

- as the gatekeeper to service through the development and review of the Plan, the GP can ensure appropriateness of referrals and monitor and control quality (through who they refer to, based on patient feedback and assessment in the Plan Review); and
- the respective professional bodies have mechanisms in place to ensure professional standards are met.

Most interviewees expressed neither of these two differing and strongly held perceptions on the value of the Better Access initiative. Most individuals commented in relation to overall access to services and the perceived appropriateness and effectiveness of services they, their colleagues or members of their professional organisation provided. The more widespread view was that, though there will always be some poor performers within any professional group, overall, the services provided through the Better Access initiative were of a high standard.

### **4.3.3 Matching client needs and expectations**

The overriding opinion from all stakeholder groups and interviewees was that the Better Access initiative facilitated the delivery of appropriate mental health care, matching services with clients' needs and expectations. Referrals were generally made on the basis of which individual practitioner would best meet the needs of the individual client. The matching of client and AHP was most commonly made on the basis of the GPs' knowledge of the AHP and the services that they provide. This was perceived to be an integral part of the GP gatekeeper role and was based on the GPs' awareness of, and familiarity with, services provided by local AHPs.

GPs commonly reported that, as a result of the Better Access initiative, local resources had been developed (either by their local Division or local allied health providers) that provided information on AHPs and other mental health and support services in the local area. GPs reported that having these resources assisted them in the referral process and that they were useful in matching the needs of clients to AHP providers. For example, when presented with a new mother with post-natal depression, using the resources available, GPs were more able to find a local allied mental health professional that has expertise in this area. Similar views were echoed by psychiatrists, who reported that being able to access a range of different professionals facilitated the matching of professional skill and interests to the client's needs.

Within the consultations, a common view amongst social workers was that their expertise was not generally recognised by GPs and that GPs were more likely to refer to a psychologist rather than to a social worker. As many social workers had highly developed skills in working with particular client groups, it was perceived that this may result in individuals within these client groups receiving a less appropriate referral. A number of GPs noted that the bias towards psychologists was also reflected in the title for the program and that referrals refer to the '*Better Access to Psychiatrists, Psychologists and General Practitioners Scheme*'. In summary, many social workers perceived that, because of a referral bias by GPs, clients were not always being

referred to the service provider with the skills and experience most appropriate to their needs.

The perception of GP bias skewing referrals was also expressed by a small number of psychologists who reported a perception that some GPs were referring only to psychologists with whom they had an established relationship, rather than a referral based on an assessment of client needs. They felt that this may be because of a history of referrals established through ATAPS or, in some cases, GPs referring only to psychologists located within their own practices to maximise practice revenue.

The consultation process brought to light a number of challenges associated with ensuring that services matched the needs of all client groups. Particular issues were identified in delivering appropriate care to complex clients, children, Indigenous groups and consumers from culturally and linguistically diverse backgrounds. In addition, a group of providers who practised therapies outside those covered by the Better Access initiative raised concerns about their ability to provide appropriate care to their clients.

#### **4.3.4 Appropriateness of services for individuals with complex needs**

Across stakeholder groups, it was noted that clients with complex disorders<sup>39</sup> or co-morbidities faced difficulties in accessing appropriate care under the Better Access initiative. It was argued that these clients tend to require more intensive or different therapies to those covered through the Better Access initiative and therefore their needs could not be appropriately or comprehensively met through the services provided under Better Access. AHPs did acknowledge, however, that identifying these clients at the outset could be difficult, as they often presented as having a more straightforward condition, such as a mild depression or anxiety, which would be amenable to the treatments available through the Better Access initiative.

When this perception was raised in subsequent consultations, it received widespread endorsement and would appear to have the agreement of most stakeholders and interviewees. Importantly, this was not perceived as an issue of preference for a more intensive psychotherapeutic approach, but was based on the needs of the client.

A number of psychiatrists, psychologists and social workers expressed concern that short-term CBT type therapy was being considered as the treatment of choice for what are often complex problems. A number of psychiatrists expressed concern that people who have a physiological problem or require medication or medication reviews were either not being referred, or referral was delayed and the quality of care for these patients was deteriorating. Several senior and highly experienced psychologists and social workers expressed concern about the skills base of new practitioners entering the field and their lack of skills leading to the adoption of simplistic and rote interventions. One psychologist responding to the online survey commented that, although access has improved, quality may have reduced, for example:

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<sup>39</sup> See note 12 on page 26

*“Many GPs seem to have a standard practice of diagnosing every patient that needs a psychological referral, sometimes without consent or discussion. Many GPs and patients falsely believe that a 30-year problem can be fixed in 6-12 sessions. Access to training has increased but primarily the training is only in CBT. CBT has been promoted or at least accepted blindly as a panacea, when in fact in the long term research it is not better than other therapies.”<sup>40</sup>*

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<sup>40</sup> Comment by psychologist in online survey of allied health professionals.

This view was also reflected by a social worker who commented:

*“The restrictions on number of sessions under Better Access means that allied health professions cannot provide longer term treatment to people who require this type of care. They are still forced to see psychiatrists in the public or private sector and this is often not the most appropriate form of care as it tends to rely more on psychopharmacology than other more effective interventions such as counselling and psychotherapy”.*<sup>41</sup>

#### **4.3.5 Appropriateness of services for children**

Another group for whom appropriate care was difficult to provide under the Better Access initiative although overall access has improved, were children and young people. A number of service providers, especially those who worked with children, highlighted that appropriate treatment for young people typically involved engagement of the whole family, such as through family therapy sessions. Given that there is no Medicare item number for seeing family members or provision of family therapy under the Better Access initiative, providing appropriate treatment for children was difficult.

In discussion on services for children, most AHPs reported that the lack of Medicare items for seeing family members, provision of family therapy or other secondary consultations was limiting the appropriateness of services that could be provided to children.

#### **4.3.6 Appropriateness of services for Aboriginal and Torres Strait Islander communities**

As indicated in section 4.2.11, when questioned a number of GP and AHP representatives queried the appropriateness of the Better Access initiative model in providing mental health services to Aboriginal and Torres Strait Islander communities. They noted that, when working within these communities, there are a number of critical differences. Acceptance into the community is an essential first step, with reports that Aboriginal and Torres Strait Islander communities were often reluctant to accept outside psychologists into their communities, a view also reflected in the following quote from the URBIS (2008) environmental scan of mental health professionals:

*“You can’t put someone [mental health professional] in here and expect people to come straight away, there has to be a build up in trust first.”* (NSW site visit).<sup>42</sup>

As such, the usual ‘point to point’ approach used to provide mental health services was identified as not culturally appropriate in an Indigenous setting.

An understanding of the Aboriginal perception of wellness was recognised as important in providing mental health services to Aboriginal and Torres Strait Islander communities

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<sup>41</sup> Comment by social worker in online survey of allied health professionals.

<sup>42</sup> URBIS (2008)

as was the long term and intergenerational impact of the 'Stolen Generation'. Further, client treatment needs often coexist with or are complicated by additional physical co-morbidity.<sup>43</sup>

A number of stakeholders provided suggestions in relation to improving the appropriateness of care for Aboriginal and Torres Strait Islander communities. These included increasing training of Aboriginal and Torres Strait Islander people with local ties so that they could service their community directly. It was also suggested that psychologists and other mental health practitioners work in a secondary consultation role with Aboriginal Health Workers who would then work directly with the individual requiring care. The literature supports these suggestions by stakeholders, identifying the need for culturally competent services, and recommending links between the specific and mainstream systems.<sup>44</sup>

#### **4.3.7 Appropriateness of services for culturally diverse communities**

As discussed in section 4.2.12 consumers from culturally diverse backgrounds may have a range of particular needs in relation to their mental health care. These needs can be quite specific, varying because of the client's particular experiences (e.g. refugee) or because of the culture from their homeland (e.g. views on mental disorders and likely treatments). Because of these needs, mental health practitioners usually require particular skills and understanding to deliver appropriate care. For example, Tilby and others write that "*African communities reported the absence of equivalent words for the term 'depression' in any of the local languages (Amharic, Tigrinya, or Sudanese Arabic dialects). The closest terms were anger, craziness, anxiety, self-pity, constant worry, grief, discomfort, frightened and sadness.*"<sup>45</sup> Often further complicating these consumers' care is the barrier of language.

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<sup>43</sup> Dr Jill Benson, "A Culturally Sensitive Consultation Model", Health in Human Diversity Unit, Discipline of General Practice, University of Adelaide, South Australia Migrant Health Service, Nunkuwarrin Yunti, and Parklands Medical Practice, Adelaide, South Australia Volume 5, Issue 2, 2006 ISSN: 1446-7984 Accessed 19 March 2009 <http://www.auseinet.com/journal/vol5iss2/benson.pdf>

<sup>44</sup> URBIS (2008)

<sup>45</sup> Tilbury F., Slee R., Clark S., O'Ferrall I., Rapley M., Kokanovic R, "Listening to Diverse Voices": understandings and experiences of, and interventions for, depression among East African migrants" Synergy No 2, 2004 p 3

Given the particular needs of many clients from culturally diverse communities, providing care that is appropriate is a significant challenge. A number of GPs highlighted the difficulty in finding mental health professions with the necessary skills and experience to care for these consumers. GP and AHP stakeholders commenting on this issue proposed a number of suggestions, some of these being supported in the literature. For example, in order to facilitate consumer access to the necessary expertise, tools such as a register that highlights professions with expertise in service provision for CALD communities have been recommended.<sup>46</sup>

Another issue, raised solely in the literature, relates to the appropriateness of the therapies covered by the Better Access initiative to consumers from a range of culturally and linguistically diverse backgrounds. There is considerable debate in relation to this issue. However, there has been a number of studies that have shown the effectiveness of Cognitive Behavioural Therapy (CBT) (irrespective as to if an interpreter was required), Testimonial psychotherapy and Narrative Exposure Therapy (NET).<sup>47</sup>

## **4.4 Compliance with the Better Access initiative guidelines**

### **4.4.1 Summary of compliance with guidelines**

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 (possibly 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 problems.

A small number of GPs, 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.

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<sup>46</sup> URBIS (2008)

<sup>47</sup> Kate E Murray (Arizona State University), Graham R Davidson (University of the Sunshine Coast), Robert D Schweitzer (Queensland University of Technology) "Psychological Wellbeing of Refugees Resettling in Australia - A Literature Review prepared for The Australian Psychological Society" Australian Psychological Society (2008)

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. Though there was the need for a comprehensive diagnosis and treatment plan prior to the commencement of therapy, a number of AHPs and a small number of GPs argued that this function 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 refer the patient to an AHP as they would refer to most other specialists.

Only a minority of respondents expressed concerns about the value and adequacy of GP Mental Health Treatment Plans. The majority (73 per cent) of respondents reported the information provided in the GP mental Health Care Plan as good or fair and notably, 72 per cent of respondents reported that they had not received inappropriate referrals. Of the stakeholders expressing concerns about GP awareness of and use of MBS items through the Better Access initiative, nearly all reported that awareness of the Better Access initiative and quality of Mental Health Treatment Plans and information provided to consumers was improving.

#### **4.4.2 Assessment and eligibility**

The general assessment of all stakeholder groups was that the Better Access initiative services were being provided to the intended target group. This is also reflected in the results of the online survey (Table 2, page 54), with more than 95 per cent of respondents reporting that the Better Access initiative had improved access to mental health services for people with anxiety and depression related disorders.

However, many interviewees also noted that despite the specificity of the MBS descriptors for Better Access the interpretation of the list of eligible disorders was so broad that almost any individual could be considered eligible. A number of GP and AHP providers argued strongly that it was appropriate to provide services through Better Access to individuals with more complex disorders and that many of these would come within the MBS descriptors of alcohol use disorders, drug use disorders, chronic psychotic disorders, acute psychotic disorders, bipolar disorder, depression, mixed anxiety and depression or mental disorder, not otherwise specified. Several instances at an individual provider and Division of General Practice level were identified of AHPs and GPs working collaboratively to manage and support individuals with chronic or complex mental health disorders and care needs. This also involved working with other support services in the community including Personal Helpers and Mentors (PHAMs), NGO services and public mental health providers to develop a package of care for the individual receiving care.

For consumers and carers the most important issue was being able to access psychological services that were not previously available and/or affordable and the benefit to them in the management and treatment of their mental health disorder.

A small number of psychiatrists, GPs and AHPs raised concerns about the types of clients receiving treatment through the Better Access initiative. They contended that some clients receiving the Better Access initiative funded services did not have a diagnosis of a mental health disorder, and were referred on the basis of a loose definition of anxiety or depression. It was reported that these clients were typically people in situational crises or relationship difficulties who needed supportive counselling, yet did not necessarily need the services offered under the Better Access initiative.

There was debate about whether the responsibility for 'filtering' appropriate clients lay solely with GPs, or whether the allied health professional providing the mental health care should assess the clients' eligibility for service through the Better Access initiative.

A sound and accurate assessment and diagnosis may be considered the first step in the provision of evidence based mental health care. However, some AHPs and Level Two trained GPs expressed concern as to the accuracy and comprehensiveness of assessments and diagnoses of many GPs, possibly up to 20 or 30 per cent of Treatment Plans<sup>48</sup>. A minority of AHPs reported receiving Treatment Plans that ranged from incomplete (one was quoted as stating "*thank you for seeing this patient*") to comprehensive and detailed.

Approximately five or six GPs<sup>49</sup> (at least three of whom were Level Two trained) suggested that the variation in quality of Treatment Plans and Treatment Plan reviews was due to there being no mandatory training requirements for GPs to participate in the Better Access initiative. The Level Two trained GPs commenting on this issue perceived this as a reduction in the quality of mental health care provided by GPs. Conversely, they also acknowledged that allowing all GPs to refer to AHPs through the Better Access initiative allowed more patients requiring psychological interventions to access these services when they were not available through the GP.

While maintaining that GPs should retain the referral gateway to AHPs, a number of GPs and AHPs questioned whether the GP should be required to prepare a Mental Health Treatment Plan and Treatment Plan review if they did not have the skills to do so and its sole purpose was compliance with the referral guidelines.

AHPs reported that generally, irrespective of the referral source, a complete assessment needs to be made of each new referral to determine the most appropriate course of intervention and that the assessment and Treatment Plan provided by the GP added little value to the treatment process. This may highlight an existing lack of understanding of providers on their differing skills and roles and how best to work together in multidisciplinary primary mental health provision. It is hoped that this will be

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<sup>48</sup> It is possible that AHPs over estimate the proportion of poor quality Treatment Plans. AHPs reported that generally Treatment Plans met the MBS requirements.

<sup>49</sup> Out of out of 15 individual GPs consulted and national and state and territory GP representatives

addressed in the role out of the Education and Training arm of the initiative. Some AHPs suggested that the referring GP should have the option to refer to an AHP using a more general MBS referral item not requiring a Treatment Plan, with the Treatment Plan and Treatment Plan review then being completed by the AHP. It was perceived by some that this approach would lead to more accurate diagnosis and comprehensive Treatment Plans. The advantages of transferring the assessment process (and Item number) to the AHP receiving the referral were raised by psychologists and social workers. This suggests that some AHPs are at an early stage in their understanding of the key role of the generalist GP in the meeting the needs of people with mental health problems in the community and highlights the importance of ongoing multidisciplinary professional development

GPs were less supportive of the transfer of the assessment and gatekeeping function to AHPs. A small number of GPs argued that though retaining the referral role, in some instances this should not require a GP Mental Health Treatment Plan. Referral would be through referral letter, as with referrals to other specialists. Such instances may include instances where:

- the patient was largely unknown to the GP and presented expressly seeking a referral to a specific AHP, with the GP, in essence, being asked to endorse the requested referral. This was perceived as placing the GP in a difficult position; the GP may not know the patient's history, may not know the AHP or services being offered, and may be unlikely to have an ongoing role in the management of the patient's mental health problem. In this instance, the GP Mental Health Treatment Plan was perceived as adding little value to the treatment process;
- the GP is not comfortable in relation to undertaking an assessment or have the time, experience, expertise or capacity to develop a Mental Health Treatment Plan and would simply prefer to refer the patient for assessment and treatment to an AHP. In this instance, it was suggested that the need to prepare a Mental Health Treatment Plan may prove a barrier in these patients being referred. Both of these instances highlight the importance of the role out of education for AHP to increase their understanding on the initiative and the benefits of linking the patient to a GP, and with GPs to enhance their confidence and competence in value adding to the patients care. (can reference WA Duty of Care Report)

#### **4.4.3 Approved interventions**

Although all AHPs argued that the services they provided were appropriate to the needs of their clients, the perceptions on the degree to which the services provided evidence based care varied. There was debate by various AHPs as to the evidence base of approved and non-approved interventions. Despite the specificity of the approved interventions within the MBS descriptors, many AHPs argued that most interventions would fall within the definition of interpersonal therapy and that they would choose the most appropriate intervention for the needs of the client.

However, a consistent concern raised by psychoanalysts through the consultation process related to the types of therapies that were able to be delivered through the Better Access initiative. While a high proportion of the psychoanalysts were Medicare approved mental health practitioners (e.g. psychologists), they argued that restricting the types of therapies allowed under the Better Access initiative was in turn limiting the effectiveness of their treatments. They suggested that the most appropriate model would allow for a broader range of approaches to be used, including psychoanalytic techniques. In addition to their concerns about the types of therapies to be included as part of the Better Access initiative, they contended that the 12 session per year limit was inadequate, and that many patients required a longer course of therapy to meet their needs. While they acknowledged that the Better Access initiative funded therapies such as cognitive behavioural therapy were useful, they argued that their usefulness and appropriateness was limited to certain patient populations.

The outcome and number of interventions provided will be more fully explored in Components A and B of the evaluation.

#### **4.4.4 Addressing unmet need in the community**

Associated with the concept of appropriateness, interviewees raised the issue of whether services were reaching those individuals most in need. Amongst some stakeholders and interviewees, including psychiatrists, GPs, AHPs, and state and territory health departments, was a perception that those experiencing the improved access were the 'worried well' and those who were traditionally good 'help-seekers'. They contended that those accessing services through the Better Access initiative would have accessed mental health services anyway, either self-funding or using private health insurance to minimise out-of-pocket expenses.

Similarly, there were reports from a small minority of psychiatrists, GPs, AHPs and public mental health providers that the Better Access initiative was being used to provide services for those who were not particularly 'unwell', questioning whether those receiving care actually had a mental disorder and needed the specialist assistance provided by either a clinical psychologist or other allied health professional.

Only a small proportion of psychologists contended strongly that the Better Access initiative services should be more effectively targeted to clients with milder mental health issues. They argued that early, effective interventions provided through qualified practitioners would lead to better patient outcomes and minimisation of future burden on the public mental health system.

Concerns about the level of illness experienced by those accessing the Better Access initiative have been raised in other forums. The URBIS environmental scan highlighted concerns that "*services are not reaching chronically ill and disadvantaged people*". According to the report, mental health professionals consulted frequently cited concerns that practitioners were opting to see the 'worried well' rather than people with significant and chronic illness.<sup>50, 51</sup>

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<sup>50</sup> URBIS (2008)

Other sources of information, however, indicate that it is not just those with mild illness that are accessing mental health services through the Better Access initiative. Both GPs and AHPs reported increasingly complex patients accessing services.

Table 5 below presents data from a 2008 survey conducted by the Australian Psychological Society. According to surveyed psychologists, of those presenting for treatment through the Better Access initiative, most were moderate (46) or severe (35 per cent), while a relatively smaller group (19 per cent) were classified as mild.

*Table 5: Level of disorder of clients who presented to surveyed psychologists<sup>52</sup>*

| Level of disorder | Per cent   |
|-------------------|------------|
| <b>Severe</b>     | <b>35</b>  |
| <b>Moderate</b>   | <b>46</b>  |
| <b>Mild</b>       | <b>19</b>  |
|                   | <b>100</b> |

Source: Australian Psychological Society, 2008

The perception of approximately one-third of clients experiencing more severe disorders, one-third moderate and one-third mild was one generally expressed in the stakeholder interviews across AHP groups. Although the morbidity of the client group was reported to vary over time, the reason for a general balance across groups was attributed to a range of factors:

- the general nature of clients being referred through GPs;
- although clients with more severe disorders are over represented in respect to the incidence in the general community, they are often presenting after having tried many other interventions and/or due to the limited availability of public mental health services;
- AHPs trying to balance the number of clients with more severe disorders with more moderate and mild clients to achieve a more balanced and clinically sustainable practice (to avoid 'burnout');
- more severe clients often had co-morbidities, required more time (in session and out of session) and were more likely to require discounted fees so numbers had to be capped to maintain a financially viable practice; and
- AHPs often used higher income clients with more mild to moderate disorders to allow fee discounting to low income individuals with more severe disorders and a balance was required to achieve this.

<sup>51</sup> See note 12 on page 26.

<sup>52</sup> Australian Psychological Society "Survey of members providing Medicare-funded services under the Better Access initiative" InPsych June 2008 p. 36 Provided March 2009

## **4.5 Service effectiveness**

This section presents the key findings related to the extent has the Better Access initiative improved health outcomes for people with a mental health disorder.

### **4.5.1 Summary of perceptions on effectiveness**

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 the perception of the GP or psychiatrist 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.

### **4.5.2 Better client outcomes**

Generally, service providers and professional groups reported that they believed the Better Access initiative had improved outcomes for clients. They considered that the Better Access initiative was particularly effective for clients with high prevalence, uncomplicated disorders. There was also acknowledgement by groups providing treatment for children and young people that the Better Access initiative had been effective in this cohort, as the improved access to early intervention had assisted in preventing the progression to a more serious illness.

All groups acknowledged that their beliefs about service effectiveness were largely based on anecdotal evidence since there has been no formal evaluation of client outcomes (this will be explored in Component A). Of the 110 consumers rating the helpfulness of the services they received from an AHP in the online survey, 41 per cent reported that the services had made them feel much better, a further 41 per cent reported the services received made them feel somewhat better, 14 per cent felt that the services did not make much difference and 4 per cent reported that the services made them feel worse. Reflective of the reported helpfulness, 85 per cent of 118 respondents reported that, if a family member or friend were experiencing a mental health problem, they would most certainly (66 per cent) or possibly (19 per cent) recommend that they seek a referral to a therapist from their GP through Medicare.

A number of psychiatrists, GP stakeholders and public mental health providers suggested that outcome measures needed to be taken and reported to Medicare in order to determine service effectiveness. The Better Access initiative was viewed as an unprecedented opportunity to inform, develop and strengthen the existing evidence-base for psychological treatments.<sup>53</sup> The literature suggests a need to develop an evidence base on the effectiveness of treatments in practice, including those treatments administered by GPs,<sup>54</sup> occupational therapists, psychologists and social workers.<sup>55</sup>

In order to gain a more concrete view about client outcomes, two professional groups had recently administered surveys.

- The APS conducted a survey of 2,223 clients who had received psychological services under the Better Access initiative.<sup>56</sup> When asked to indicate the level of improvement they had experienced as a result of psychological treatment, 90 per cent of respondents indicated that treatment had resulted in significant (45 per cent) or very significant (45 per cent) improvement. There was no significant difference in perceived effectiveness between clients from different geographical location, socio-economic groups, client gender or age group.
- The Australian College of Clinical Psychologists (ACCP) reported that a survey of its own members demonstrated similar results (as provided during the consultation process). According to the ACCP reported survey, 85 per cent to 99 per cent of patients reported improvement in psychological well being following treatment through the Better Access initiative. The findings from the APS and ACCP surveys are similar to the results of the online survey, reported above.

Contrary to the improvements generally reported by consumers and indicated in the APS survey, several stakeholders and consumers expressed the view that the Better Access initiative had not improved client outcomes.

As indicated in relation to access to mental health services, a small number of psychiatrists expressed concern that the Better Access initiative had resulted in patients receiving inappropriate treatment from AHPs and experiencing delays in referral to a psychiatrist, resulting in a poorer outcome for clients. This perception was expressed by a minority of psychiatrists and was not in all cases a criticism of the Better Access initiative as an initiative, but reflective of the range of skills and expertise available within the community.

Similarly, whilst largely supportive of the Better Access initiative, a private hospital reported that they had heard of people who had not been well managed through the

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<sup>53</sup> Carey, Timothy A. Rickwood, Debra J. Baker, Keith. 'What does \$27,650,523.80 worth of evidence look like?' Centre for Allied Psychology, University of Canberra, (2009) p 17.

<sup>54</sup> Grant A Blashki, Leon Piterman, Graham N Meadows, David M Clarke, Vasuki Prabakaran, Jane M Gunn and Fiona K Judd, "Impact of an educational intervention on general practitioners' skills in cognitive behavioural strategies: a randomised controlled trial", Medical Journal of Australia (2008) Vol. 188 P. S129.

<sup>55</sup> Carey et al (2009)

<sup>56</sup> APS (2008).

Better Access initiative-funded services having a crisis and requiring admission. Anecdotal examples of this kind were also reported by a minority of public providers. Generally, comments of this nature were reflective of a recognition of the range of complexity of patients (i.e. some clients do have complex conditions and will require admission) and that, in some instances, the patient could have been managed better by the AHP. Only for the sub group of stakeholders and interviewees critical of the Better Access initiative as a model of care was this presented as a criticism of the model itself.

Concerns about the effectiveness of the Better Access initiative for particular client groups were also raised. One state and territory health department expressed doubts about the outcomes achieved for Aboriginal and Torres Strait Islander clients or those from culturally or linguistically diverse backgrounds. It was also argued by clinical psychologists that the Better Access initiative was not effective for people with low prevalence and more complex disorders requiring longer interventions<sup>57</sup>. The queried effectiveness of the Better Access initiative in treating special needs groups was also reflected in the online survey of GPs, psychiatrists and paediatricians and survey of allied health providers. The surveys found lower levels of agreement that the Better Access initiative resulted in improved outcomes for special needs groups than it did for people with anxiety and depression related disorders, older people and children and young people. The results from the surveys are summarised below and in table 4.

- Ninety per cent of respondents agreed that the Better Access initiative has contributed to improved outcomes for people with anxiety or depression related disorders, with only six per cent disagreeing and four per cent unsure.
- Sixty five per cent and 64 per cent agreed that improved outcomes are being achieved for older people and for children and young people respectively, with only nine and ten per cent disagreeing.
- Fifty per cent agreeing improved outcomes are being achieved for people with substance abuse disorders and 15 per cent disagreeing.
- Only sixteen per cent agreeing that improved outcomes are being achieved for Aboriginal and Torres Strait islander people or people living in remote communities.
- Approximately one-third of respondents agreeing that improved outcomes are being achieved for people living in rural communities (32 per cent) and people from culturally and linguistically diverse communities (27 per cent).

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<sup>57</sup> See note 12 on page 26

*Table 6: Summary of GP and AHP response in relation to Outcomes*

| To what extent do you agree with the following statement: Better Access has contributed to (Per cent of and number of valid responses): |                                   |          |        |         |   |          |        |         |                             |          |        |         |  |
|---|-----------------------------------|----------|--------|---------|---|----------|--------|---------|-----------------------------|----------|--------|---------|--|
| Contribution of Better Access to:   | Survey of allied health providers |          |        |         | Survey of GPs, psychiatrists and paediatricians |          |        |         | Respondents to both surveys |          |        |         |  |
|   | Agree                             | Disagree | Unsure | Valid N | Agree   | Disagree | Unsure | Valid N | Agree                       | Disagree | Unsure | Valid N |  |
| • improved mental health outcomes for people with anxiety or depression related disorders   | 95%                               | 1%       | 3%     | 329     | 82%   | 14%      | 5%     | 200     | 90%                         | 6%       | 4%     | 529     |  |
| • improved mental health outcomes for people with substance use disorders   | 58%                               | 5%       | 36%    | 327     | 37%   | 31%      | 32%    | 194     | 50%                         | 15%      | 35%    | 521     |  |
| • improved mental health outcomes for Aboriginal and Torres Strait Islander people  | 18%                               | 9%       | 73%    | 326     | 11%   | 23%      | 66%    | 194     | 16%                         | 14%      | 71%    | 520     |  |
| • improved mental health outcomes for people living in rural communities  | 36%                               | 8%       | 56%    | 326     | 24%   | 19%      | 57%    | 194     | 32%                         | 12%      | 56%    | 520     |  |
| • improved mental health outcomes for people living in remote communities   | 20%                               | 9%       | 72%    | 327     | 10%   | 19%      | 71%    | 193     | 16%                         | 13%      | 71%    | 520     |  |
| • improved mental health outcomes for people from culturally and linguistically diverse backgrounds                                     | 32%                               | 7%       | 61%    | 326     | 19%   | 23%      | 58%    | 193     | 27%                         | 13%      | 60%    | 519     |  |
| • improved mental health outcomes for children and young people   | 70%                               | 4%       | 26%    | 328     | 54%   | 20%      | 25%    | 197     | 64%                         | 10%      | 26%    | 525     |  |
| • improved mental health outcomes for older people (i.e. those aged 65 + years)   | 69%                               | 3%       | 28%    | 324     | 58%   | 17%      | 24%    | 195     | 65%                         | 9%       | 26%    | 519     |  |

### **4.5.3 Impact of capped sessions on treatment and outcomes**

Most allied health providers argued that the limited number of sessions reduced the effectiveness of the Better Access initiative for those with complicated, complex disorders<sup>58</sup>. There was also a variation in the perception of different providers as to the number of sessions that were available and what constituted 'exceptional circumstances' for the purposes of receiving 18 sessions.

The consultations suggest that there was also variation across providers as to how the defined target group and number of sessions influenced their practice. Some (slightly more than half) complied with the intent of the Better Access initiative and targeted services to clients who would improve within 6-12 sessions.

Others (a significant minority) continued to work within the same population and model of care they had historically used and provided the number of sessions they assessed the patient to require. They were more inclined to utilise the full 18 sessions available through the Better Access initiative.

The overall perception to emerge from the consultations with AHPs was that the limited number of sessions was a consideration in determining the treatment intervention.

## **4.6 Mental health care system**

This section presents the key findings related to the impact of the Better Access initiative on other components of the wider mental health system.

In considering these aspects, it is important to note that a number of changes in aspects of the mental health care system have occurred since the introduction of the Better Access initiative. These changes relate to the supply and distribution of the occupational therapist, psychologist and social worker workforce, and the manner in which the Better Access initiative interacts with the Better Outcomes in Mental Health Program, including ATAPS.

### **4.6.1 Summary of 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 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. The shift would appear to have been most felt in the smaller states and territories. A concern across public providers and

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<sup>58</sup> As discussed in note 12 page 26 the intent of the Better Access initiative is not to provide treatment to individuals with complicated and complex disorders. The average number of sessions provided through the Better Access initiative is five sessions per individual treated (Source: DOHA advice 14 September 2009).

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 the 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 was noted 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:

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

#### **4.6.2 Impact on public mental health workforce**

Throughout the consultation process, providers, professional groups and health departments consistently reported that they had expected a significant shift to the private sector of psychologists from the public mental workforce following the introduction of the Better Access initiative. On the whole, these stakeholders held the view that little, if any, of this shift had in fact occurred. What shift had occurred appeared to be limited to clinical psychologists and though the numbers were small the effect on services, education and training had the potential to be significant.

Stakeholders from a number of state and territory health departments and one psychologist professional body believed that there had been little shift from the public to private sector of the AHP workforce following the introduction of the Better Access initiative. To support their claim, two state and territory health departments reported that they had low (or comparatively lower) rates of vacancies in their public mental health workforce. It was argued that there may have been an initial shift, or interest in

a shift, but little of this movement was either long lasting or realised. Psychologist groups commented that many providers had shown interest in private practice, but realised the challenges in setting up a new business, even with the likely new client base through the Better Access initiative. As an example, during consultations, it was identified that, since the introduction of the Better Access initiative, the number of social workers in Australia with provider numbers increased from approximately 250 to 900. Given that concomitant shifts in the social worker workforce away from the public sector were not similarly reported, it is likely that, while social workers attained provider numbers, this may be the result of:

- social workers with already established private practices obtaining a provider number;
- social workers re-entering the workforce; and
- social workers in the public sector providing part-time public and part-time private practice.

It was noted by AHPs, particularly psychologists, that the low level of MBS rebate encouraged a ‘cottage industry’ approach to service delivery. This attracted providers with a supplementary income who worked from their own home. This may partially explain the apparent increase in providers. It would be valuable to examine the number of services provided by providers to estimate the change in the number of AHPs engaged in fulltime practice.<sup>59</sup>

The online survey of AHPs indicated that overall 33 per cent of respondents worked in both the public and private sector. Though not significant<sup>60</sup> a greater proportion of social workers worked in both public and private practice than did psychologists or clinical psychologists, Table 7 below.

Table 7: AHPs working in public and private practice

| Profession             | Number | Per cent | Number | Per cent |     |      |
|------------------------|--------|----------|--------|----------|-----|------|
| Clinical Psychologist  | 44     | 34%      | 85     | 66%      | 129 | 100% |
| Psychologist           | 29     | 22%      | 104    | 78%      | 133 | 100% |
| Social Worker          | 66     | 43%      | 87     | 57%      | 153 | 100% |
| Occupational Therapist |        | 0%       | 1      | 100%     | 1   | 100% |
| Grand Total            | 139    | 33%      | 277    | 67%      | 416 | 100% |

<sup>59</sup> This issue may warrant consideration in Component C of the evaluation: Analysis of allied mental health workforce supply and distribution.

<sup>60</sup> Chi-squared 0.58, degrees of freedom = 3, P 0.90

There were consistent views presented from psychology organisations and several state and territory health departments that any shift in workforce that had occurred was of practitioners moving towards a part time role, working across public and private sectors. One concerning aspect of this shift, however, was that the groups perceived to be moving towards a part time role may be the more senior clinicians. An APS survey undertaken in February 2008 of psychologist staff at Melbourne public hospitals indicated that, while only 12 per cent of P2 level psychologists were considering leaving the public sector, 41 per cent of P3 level psychologists were intending to reduce their hours of work for private practice in the next 12 months. A number of respondents raised similar issues as a matter of concern. Reasons for preparation to leave were relatively evenly distributed over increased opportunities and remuneration, greater flexibility, and autonomy.<sup>61</sup> A number of psychologist bodies and State and Territory health departments suggested that incentives should be established to attract psychologists to remain in the public system, for example, by developing models that provide private practice rights for psychologists employed in the public sector.<sup>62</sup>

While, when considered as a whole, the shift to the private sector appears to be small at a national level, differences between jurisdictions were reported. Specifically, the smaller states reported that the Better Access initiative has had a significant impact on the public psychologist workforce, with practitioners either moving to private practice or reducing hours. One State health department reported that occupational therapists had been used to fill positions left vacant by psychologists. Another small state health department was concerned about the lower levels of experience and skill of the psychologist workforce remaining in the public sector following the migration of more senior staff. These two states represented a minority opinion.

A number of psychologists and psychologist groups raised concerns about the consequences of the perceived shift by experienced practitioners to the private sector on the capacity of the public sector to provide adequate supervision for trainee psychologists. It was highlighted that using the private sector as an alternative training environment raised a number of challenges, as many clients who attend private clinics are reluctant to allow students to either sit in on sessions or to accept therapy from a student. One group practice of psychologists suggested that, to address this challenge, an enhanced rebate could be provided by Medicare to clients who agree to receive therapy from a trainee or to have a student sit in on a session.

Concerns that the loss of experienced public sector clinical psychologists may result in diminished quality of care<sup>63 64</sup> were also highlighted in the literature. Difficulties

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<sup>61</sup> Associate Professor John Gleeson, Associate Professor Warrick Brewer, "Implications of the introduction of the Better Access initiative for the public mental health psychology workforce" InPsych June 2008 Accessed 19 March 2009 [http://www.psychology.org.au/inpsych/changing\\_landscape](http://www.psychology.org.au/inpsych/changing_landscape).

<sup>62</sup> Dr Rosemary Kelly, Dr Ruth Perkins "Clinical Psychologists, private practice and employment in the public health sector in Victoria" InPsych June 2008 Accessed 19 March 2009.

<sup>63</sup> Kelly et al (2009)

<sup>64</sup> Carey, Timothy A. Rickwood, Debra J. Baker, Keith. 'What does \$27,650,523.80 worth of evidence look like?' Centre for Allied Psychology, University of Canberra, 2009.

associated with the loss of experienced clinical psychologists (particularly that associated with the Better Access initiative) were identified as including:<sup>65</sup>

- reduced availability of clinical psychology services to clients with complex and ongoing needs;
- loss of experienced supervisors at all professional levels, including students, provisionally registered psychologists, registered psychologists wishing to satisfy the requirements of professional bodies or psychologists employed in the public sector;
- difficulty in recruiting psychologists to new or vacant positions;
- specialist services being put at risk; and
- multi-disciplinary teams without psychologists.

Responses to the online survey of public providers are supportive of the information derived from the consultations. Of the 229 responses, 49 were from respondents identifying themselves as administrative manager or service director. Highest responses were from South Australia (17 respondents) and NSW (13 respondents). Twenty-one of the 49 respondents (42 per cent) reported that the Better Access initiative had reduced their organisation's ability to recruit and retain psychologists. Fewer respondents reported an impact on psychiatrists, social workers or occupational therapists. Numbers of respondents were too low to make meaningful comparisons across states. Responses are provided in Table 8, below.

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<sup>65</sup> Kelly et al (2009)

*Table 8: Impact of the Better Access initiative on public mental health workforce*

| The Better Access initiative has reduced my organisations ability to recruit and retain: | Agree | Unsure | Disagree | No response |
|--|-------|--------|----------|-------------|
| Psychologists  | 21    | 12     | 12       | 4           |
| Social workers   | 4     | 14     | 27       | 4           |
| Psychiatrists  | 3     | 19     | 23       | 4           |
| Occupational therapists  | 2     | 24     | 19       | 4           |

Though there was some variation in opinion between state and territory health departments and between psychologists as to the extent, if any of a shift in the psychologists to the private sector the overall deduction from the consultations is that there is some shift, the degree to which is unknown and varies across States and Territories and local areas.

In contrast, states, territories and the respective professional bodies held that view these been little if any impact from the Better Access initiative on the occupational therapy and social worker workforce. Occupational therapy, psychology and social work professional bodies acknowledged that the move towards private practice was relatively easier for psychologists, who as a profession had a strong history in the private sector. Conversely, fewer occupational therapists and social workers had experience in private practice, making the move away from the public domain relatively more challenging. The lower MBS rebate for occupational therapists, general psychologists and social workers also made the move from the public sector less rewarding than for clinical psychologists.

One occupational therapist working in private practice reported that he had obtained his Better Access initiative provider number but then found that the level of rebate meant that it was not viable to provide services to clients through the Better Access initiative. The provider continues to see only clients through DVA, workers compensation and other compensable patients, or on a full fee paying basis. A social worker also reported that it was “*not worth the effort*” to see clients through the Better Access initiative.

At the training level, there were a number of reports of changes in activity since the introduction of the Better Access initiative. One psychologist group interviewed reported that a university which, while not increasing the total number of psychologists in training, had increased the proportion of students in clinical psychology. In keeping with this trend, a health department from another jurisdiction reported that the number of registered clinical psychologists had also increased since the introduction of the Better Access initiative. One university reported decreasing the supervised training hours for students because of the difficulty in attracting clients. The Better Access initiative also appeared to have impacted on general psychology, with a state psychologist registration board reporting increasing numbers of trainee psychologists seeking to enter private practice.

### **4.6.3 Distribution of allied health professionals**

The capacity for AHPs to establish practices in response to market demand or personal preference was reported as driving a change in the geographic distribution of allied health professionals. This was identified as an issue of concern by a range of stakeholders during the consultation process. Changes in distribution were not equally apparent in all allied health professions.

As discussed in the section on service accessibility, there is a perceived maldistribution of the mental health workforce, with disproportionately higher numbers of AHPs available in metropolitan areas compared to rural and remote regions. A small number of GPs, psychologists, social workers and public mental health providers reported through small area consultations and teleconferences that since the introduction of the Better Access initiative there had been a further shift in location of providers, particularly psychologists, with a movement of practitioners away from rural and remote regions, to metropolitan areas. These stakeholders believed the main cause of this shift was that practitioners thought that they would be able to “cash in” on the client base made available through the Better Access initiative more effectively in urban areas. It was argued that, for practitioners to make the best of opportunities available through the Better Access initiative, they needed good ties with a referral base, i.e. general practitioners. They contended that GPs were more concentrated in metropolitan areas and, as such, they also should move to these regions. While stakeholders reported such movement in relation to psychologists, no similar trends were ascribed to either occupational therapists or social workers.

Not only did professional stakeholders report a move in a geographical sense, but there were some accounts of practitioners moving their worksites within their existing townships. State and Territory health departments and providers themselves described new models emerging since the introduction of the Better Access initiative, including psychologists starting group practices or psychologists and social workers attaching themselves to an existing GP practice.

### **4.6.4 Interaction with other related programs**

As part of the consultation process, stakeholders and interviewees were asked to comment on the nature of the interaction between the Better Access initiative and existing mental health programs such as Better Outcomes. Most psychiatrists and GPs and some psychologists identified the Better Access initiative as complementary to existing initiatives, and as having a positive influence on the level of engagement of GPs in the range of mental health options available. Some negative influences were also identified, such as the lower numbers of GPs reportedly seeking and retaining Level Two mental health accreditation.<sup>66</sup>

Most GPs and Divisions reported ATAPS as being targeted to individuals unable to afford the gap payment usually required through the Better Access initiative and/or targeted to populations with particular needs, such as rural and remote communities,

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<sup>66</sup> See section 4.3.1 on page 55

Indigenous communities or possibly even to promote access for older clients. A small number of Divisions and GPs also reported the use of ATAPS funds to provide additional therapy sessions to clients with complex care needs who had exhausted the 18 sessions provided through the Better Access initiative<sup>67</sup>.

A similar picture is presented by data analysed by the University of Melbourne in the evaluation of Better Outcomes. The results of this study indicated that the introduction of the Better Access initiative had not reduced demand for ATAPS, with the demand for services provided by both programs continuing to rise steadily.<sup>68</sup> Several GP stakeholders and interviewees indicated a perceived flattening of demand for ATAPS following implementation of the Better Access initiative, but that demand for ATAPS was now increasing. The Better Access initiative has provided an incentive for most Divisions interviewed to rethink the targeting of ATAPS and how other services provided through Better Outcomes, MAHS and the Better Access initiative work together to improve access to mental health services.

Of note was the finding that the majority of sessions delivered through the Better Access initiative occurred in urban areas, while the provision of sessions through the ATAPS program have been relatively more equally distributed, indicating that these services may have a “*relatively greater reach in rural areas*”.<sup>69</sup>

A number of GPs and GP representative groups noted that, since the introduction of the Better Access initiative, there had been greater engagement of GPs in issues relating to mental health. As a consequence, these GPs were undertaking greater scrutiny of the range of provisions available to administer mental health care. These stakeholders reported that there had been increased interest in how various components of the system could be used together to maximise the benefit for the patient; for example, the use of EPC items for case conferencing with other professionals (particularly as there was no funding for this activity under the Better Access initiative). The increased engagement and interest in other mental health initiatives was viewed as a positive consequence of the Better Access initiative.

It should be noted, however, that despite increased interest in the available programs, a number of GPs reported a lack of clarity relating to which programs should be used for which patients. The issue of awareness of how the MBS items are to be used was confusing for both GPs and AHPs, with both reporting difficulty in obtaining information and clarity from Medicare. A number of Level-2 trained GPs reported that, based on enquiries from colleagues, the mental health item numbers were the least understood. Both GPs and AHPs reported that understanding of how the MBS system operates was improving as the Better Access initiative matured. GPs noted that the experience with the Better Access initiative item numbers was no different to that when other new initiatives were implemented and requires ongoing information and training from the Divisions.

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<sup>67</sup> Note: This may be an inappropriate use of Better Access and ATAPS and in breach of MBS rules.

<sup>68</sup> Bassilios, B., Fletcher, J., Pirkis, J., King, K., Kohn, F., Blashki, G. Burgess, P. 2009. Evaluating the access to allied psychological services component of the better outcomes in mental health care program. University of Melbourne. Centre for Health Policy, Programs and Economics.

<sup>69</sup> Bassilios et al (2009)

Not all of the interactions between mental health programs were viewed as positive. A number of GPs noted that, since the introduction of the Better Access initiative, fewer Level Two trained GPs had maintained their qualifications. It was suggested that these GPs were either simply referring patients on to AHPs under the Better Access initiative or, if providing focussed psychological strategies (FPS) themselves, were doing so using long consultation item numbers.

Another negative interaction between the two programs reported by one Division of General Practice related to the availability of AHPs in some areas. They reported that, in areas where there were shortages of AHPs (e.g. rural regions), the introduction of the Better Access initiative has led to increased competition for their services. Further, they reported that, since the Better Access initiative, fewer AHPs bulk billed and, given that ATAPS services were often targeted to those in most need, this had created an additional barrier to access.

One GP group identified that one effect of the Better Access initiative was that other initiatives implemented as part of the National Action Plan on Mental Health (e.g. the Mental Health Nurse Incentive Program or Personal Helpers and Mentors Program) have not been rolled out as far as initially expected. As a consequence, this stakeholder believed that clients who would have otherwise been supported through these other initiatives (i.e. those with more severe or complex illnesses) have instead relied more heavily on services available through Better Access. This has placed a degree of stress and expectation on the service provider through the Better Access initiative to do more than was originally intended.

## **4.7 Skilled, knowledgeable, integrated workforce**

This section presents the key findings related to the impact of the Better Access initiative on the development of a skilled, knowledgeable and integrated workforce.

### **4.7.1 Summary of 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 AHP 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;
- a 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 suggest 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.

As indicated in section 1.3, a key objective of the Better Access initiative was to improve outcomes for people with mental disorders through supporting GPs and primary care services by providing education and training to better diagnose and treat mental illness. At the time of the consultations, Better Access specific training through the Mental Health Professional Network (MHPN) had only recently commenced. As such, the consultations did not identify any significant improvements in access to training for GPs and AHPs.

#### **4.7.2 Provision of interdisciplinary primary mental health care**

The overwhelming view provided by professional bodies, health departments and providers was that the Better Access initiative had not promoted the provision of interdisciplinary primary mental health care. Professional groups representing both medical practitioners and AHPs reported that interaction between health professionals primarily consisted of a written referral from the GP to the AHP to initiate therapy, and a written report back to the GP from the AHP following treatment. Notably, these stakeholders thought that this level of interaction was inadequate.

AHPs and medical practitioners most commonly cited the absence of a Medicare item number for case conferencing as the principal barrier to coordinated care. Representatives from all AHPs argued that, without specific remuneration for multidisciplinary activities, there was little incentive for treating clinicians to participate. They noted that the issue of remuneration for non-direct client work was a particular issue for occupational therapists, general psychologists and social workers because of the lower rebate payable for the services that they provide.

Another barrier to the provision of coordinated interdisciplinary care was concerns regarding patient confidentiality. It was reported by a health department that some allied health professionals believed that they could not report back to GPs about the client's treatment and progress without breaching client confidentiality. Subsequently, it was suggested that there was a need for clarification about the necessity of information sharing between mental health professionals and the GPs and interdisciplinary care of the client.

A further barrier to interdisciplinary care identified by AHPs and GPs was the lack of understanding of professional roles and capabilities between professional groups. Through the consultation process, it became evident that different professional groups believed that some providers from other professional groups did not fully understand their role and skills in the provision of mental health care. For example, some GPs reported that they were unclear about when to refer to a social worker or an occupational therapist versus a psychologist. Similar views were evident in the November 2007 survey of mental health professionals undertaken for the Mental Health Professional Association (MHPA) which highlighted that "*there is limited understanding of the specific roles that occupational therapists and social workers have in regard to the Better Access initiative*".<sup>70</sup> Some, although not all, of these same provider groups recognised that the lack of understanding between professions was a significant hurdle to comprehensive multidisciplinary care. Additionally some of the comments from AHP suggest they have limited understanding of the role and capabilities of the general practitioner in providing primary mental health services within a generalist paradigm.

Some providers identified the geographic separation of medical practitioners and AHPs as a barrier in the provision of coordinated and integrated care. A number of GPs and AHPs recognised that some of the most effective communication occurred incidentally (i.e. 'corridor conversations'), and that the separate offices of AHPs and GPs meant that this type of interaction did not occur. This perspective was also supported by the views of AHPs who had established practices within existing GP surgeries. These AHPs reported that the co-location had not only fostered professional respect, but also facilitated effective discussions on patient care which they perceived may not have occurred without the same level of proximity.

There was also a variation in the degree to which the Better Access initiative is perceived as a component of a comprehensive and integrated mental health system. One Division of General Practice reported that they saw they had no role in the development of relationships and referral pathways between GPs and AHPs, as AHPs were private businesses and should develop their business as best they could by contacting GPs individually. Contrasting this position, most Divisions provided some support in developing referral directories, facilitating enquiries from GPs for information on AHPs in the local area, and providing networking opportunities across local mental health services.

AHPs and public mental health service providers also reported limited contact with each other in relation to patient management. In part, this may be reflective of the

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<sup>70</sup> Urbis (2008).

Better Access initiative and the public mental health system working as complementary components of the wider health system and having different patient groups.

AHPs reported being frustrated in attempts to liaise with public mental health providers in relation to the provision of out-of-hours crisis care and/or supporting clients who may be at risk of self-harming, and presentation to the local Emergency Department. The general view of AHPs was that the public mental health system was not geared to work proactively to manage clients to remain in the community and did not want to know about the case unless a crisis intervention was required. Most AHPs also expressed concern about the lack of contact from the public mental health service if a client was admitted to hospital and in discharge planning. GPs attending consultations in which these issues were raised noted that this was an issue the Divisions had expended significant time and resources in addressing through GP liaison programs, and was an area that could benefit from further improvement.

Public mental health providers acknowledged a lack of integration with the Better Access initiative. Some public mental health providers perceived the requests for engagement from AHPs as a “dumping” of patients. They suggested that, if the individual was a client of the AHP, the AHP should manage the client as that was what they were being paid for. More frequently, the reasons provided for the lack of integration were the high demand pressures on the public mental health system and the inability to allocate the resources requested. A number of jurisdictions had proactive policies in place to better integrate with the Better Access initiative, such as policies for notification on admission and pre discharge and routinely considering the Better Access initiative as one service option in case planning.

The critical views of the Better Access initiative were tempered by the results of the online survey of public providers, more suggestive of an interplay between public mental health services and an overlap in client group. Overall, respondents indicated that workers within their organisations were aware of services offered by the Better Access initiative (62 per cent); that services offered by the Better Access initiative complemented the services their public mental health service provided (66 per cent); that the Better Access initiative increased referral options for individuals using their services (63 per cent); and that the Better Access initiative improved the mental health system. Interestingly, around 20 per cent of respondents rated themselves as unsure of the above questions, suggestive of opportunities for better education of public health providers of services available through the Better Access initiative.

That there is an overlap in client group between the Better Access initiative and the public mental health system was noted by a majority of AHPS and is also supported by the results of the online survey of public mental health providers. Fifty four per cent of respondents to the online survey of public mental health providers disagreed with the statement that “*Better Access has no real impact on the client group my service works with*”; 24 per cent of respondents disagreeing with the statement that “*Better Access provides referral options for people they would not normally provide services to*”; and 21 per cent reporting a perception that “*Better Access has reduced demand for their public mental health services*”. The responses to online survey questions of public mental health providers exploring the relationship between the Better Access initiative and public mental health services are reported in Table 9 below.

*Table 9: Interface between the Better Access initiative and public mental health services*

| In relation to the public mental health service in which the respondent works  | Agree per cent | Unsure per cent | Disagree per cent | N/A per cent |
|--|----------------|-----------------|-------------------|--------------|
| Better Access complements the services that my organisation provides   | 66%            | 20%             | 14%               | 1%           |
| Workers are aware of services offered by the Better Access initiative  | 62%            | 17%             | 11%               | 2%           |
| Worker within my organisation know how to refer people to services available through the Better Access initiative                          | 49%            | 24%             | 21%               | 6%           |
| The Better Access initiative has increased options for referral for individuals using my service   | 63%            | 18%             | 18%               | 0%           |
| The Better Access initiative has improved the mental health system   | 56%            | 27%             | 17%               | 0%           |
| The Better Access initiative provides referral options for people contacting my organisation who we would not normally provide services to | 52%            | 21%             | 24%               | 2%           |
| The Better Access initiative has reduced demand for the services that my organisation provides   | 21%            | 28%             | 51%               | 1%           |
| The Better Access initiative has had no real impact on the client group that my service works with   | 26%            | 19%             | 54%               | 2%           |

The distribution of responses across states and the client profile of respondents limit the analysis of response by state or service type.

#### **4.7.3 Access to primary mental health care training**

The degree to which the Better Access Initiative has contributed to increased education and training to better diagnose and treat mental illness was difficult to assess at the time of consultations as the rollout of planned training was just commencing.

During the consultations, providers, professional groups and State and Territory health departments were asked to provide opinions about whether those delivering the care were aware of, and were accessing, primary mental health training. In response to these questions, stakeholders largely focussed on the training needs of GPs. In relation to awareness of available training, it was suggested that GPs knew about the training, or where to get information about available training.

GPs, GP representative bodies and State and Territory health departments all provided views about the extent to which GPs were accessing primary mental health training. Many of these stakeholders and interviewees believed that GPs were not accessing primary mental health training at a level required to deliver high quality primary mental health care. At the time of the consultations very little of the training planned to be provided had commenced.

A significant number of AHPs and Level Two trained GPs raised concerns about the level of mental health skills by GPs who had not received mental health training. They argued that, under the Better Access initiative, GPs now held significant power in relation to mental health care assessment and planning, but did not necessarily have the skills to undertake these tasks and that training to acquire these skills was not mandatory.

A number of AHPs, particularly clinical psychologists, also argued that the information contained within the Mental Health Treatment Plan did not replace the need for them to conduct their own assessment and treatment plan. Supporting this argument was a recent APS survey that found many psychologists judged the information provided by GPs to be inadequate and that they needed to conduct their own full diagnostic assessment of 86 per cent of clients referred under the Better Access initiative.<sup>71</sup>

Though not replacing the need for the AHP to undertake their own assessment and care plan, it would seem that generally the information provided in the GP Mental Health Care Plan was helpful. In the consultation survey the majority (73 per cent) of respondents reported the information provided in the GP mental Health Care Plan as good or fair and notably, 72 per cent of respondents reported that they had not received inappropriate referrals. The survey also noted that the quality of Mental Health Treatment Plans and information provided to consumers was improving.

A small number of psychiatrists also raised concerns about GPs' skills in mental health assessment and referral. Examples were given of patients being sent to a psychologist instead of a psychiatrist, with subsequent delays in appropriate care. An AHP professional group also raised issues about patient assessment by GPs and their ruling out of medical causes, for example a heart related medical condition being misdiagnosed as an anxiety disorder. Most AHPs reported examples of clients who self referred and rather than a referral by a GP. Some GPs raised concerns about the service provided by the AHP. The time delay in the role out of professional education and training meant that this had not occurred to any extent at the time of the consultations being conducted and the above comments highlight the importance of multidisciplinary education and training being provided to all professionals involved in primary mental health service delivery.

In response to concerns about the GPs' skill levels in relation to primary mental health care, a number of professional groups argued that relevant training should be mandated. They contended that often those GPs in most need of training may well be those avoiding it. All AHP in addition to GPs are now required to participate in ongoing professional education in this area.

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<sup>71</sup> APS (2008)

A number of GP and AHP bodies reported that at the inception of the Better Access initiative, they were provided with a small amount of funding to provide their members with basic information about the Better Access initiative. The information focussed on topics such as how to attain a Medicare provider number or the type of information required to write a Mental Health Treatment Plan. In some areas, local groups developed referral databases of AHPs for GPs. The focus of these activities was to provide information about how health professionals could use the new system, as opposed to upskilling them in relation to Treatment Planning and best practice in primary mental health care.

Critical to interpretation of the views presented about primary mental health training was the fact that the Better Access initiative specific training had only recently become available. Aside from this basic information, it was clear that providers had had little access to any specific the Better Access initiative training. It was reported that the planned interdisciplinary training through the MHPN had been delayed. One professional group reported that specific training had only recently commenced, but was now available, with plans to complete 250 workshops by the end of the 2008/09 financial year. This MHPN training reportedly focussed on understanding the respective roles and skills of the interdisciplinary team, improving referral networks and the provision of good clinical practice. An important aspect of these workshops was that each of the core professional groups (e.g. APS, RANZCP, RACGP, AASW and Australian College of Mental Health Nurses - ACMHN) had agreed to award continuing professional development points for attending these workshops.

Given that the MHPN workshops were only recently made available, it was unsurprising that the level of awareness in relation to this training was low. When asked about primary mental health training, GP representative bodies and individual GPs referred almost exclusively to the Better Outcomes training, rather than any training specific to the Better Access initiative.

When questioned about the awareness of their members in relation to primary mental health care training in general, GP professional bodies generally considered that most GPs knew either what training was available, or how to get information about training options. These stakeholders reported that information was widely circulated by Divisions, using targeted advertising, and publicising through existing Divisional Networks. They also identified Divisional Mental Health Liaison Officers as being central to providing information and promoting awareness. Apart from the GP professional bodies, no other stakeholder groups offered views about the level of awareness of GPs (or other medical practitioners) in relation to available primary mental health training.

The online survey of GPs, psychiatrists and paediatricians, and online survey of allied health providers explored the impact of the Better Access initiative on training.

Of the 193 GPs responding to the survey, 78 (40 per cent of total GPs) reported that the Better Access initiative had improved access to clinical training. Psychiatrists and paediatricians responding to the survey did not address this question.

Of the 417 allied health providers responding to the survey questions on training, 152 (34 per cent) reported that the Better Access initiative had affected access to clinical training within their discipline and, of these, 96 per cent (or 23 per cent of total respondents) reported that it had improved access to training. Of the AHPs 37 respondents (9 per cent of total respondents) responded that the Better Access initiative did not improve access to clinical training.

Responses from the online survey of GPs, psychiatrists and paediatricians and online survey of allied health providers exploring access to training are presented below.

*Table 10: Impact of the Better Access initiative on access to clinical training*

| Has the Better Access Initiative (reponses)               | Clinical   |                       |              |               | Total      |
|---|------------|-----------------------|--------------|---------------|------------|
|   | GP         | psychologist          | Psychologist | Social worker |            |
| Affected access to clinical training in your discipline   | 87         | 47                    | 43           | 52            | 229        |
| If access affected, has it improved access - YES          | 78         | 33                    | 20           | 43            | 174        |
| If access affected, has it improved access - NO           | 7          | 9                     | 23           | 5             | 403        |
| If access affected, has it improved access – Nil response | 2          | 5                     | 0            | 4             | 11         |
| <b>Total valid responses</b>                              | <b>193</b> | <b>131</b>            | <b>133</b>   | <b>153</b>    | <b>610</b> |
| Has the Better Access Initiative (per cent )              | GP         | Clinical psychologist | Psychologist | Social worker | Total      |
| Affected access to clinical training in your discipline   | 45%        | 36%                   | 32%          | 34%           | 38%        |
| If access affected, has it improved access - YES          | 40%        | 25%                   | 15%          | 28%           | 29%        |
| If access affected, has it improved access - NO           | 4%         | 7%                    | 17%          | 3%            | 66%        |
| If access affected, has it improved access – Nil response | 1%         | 4%                    | 0%           | 3%            | 2%         |

## 4.8 Informing the summative evaluation

This section presents the key findings relating to:

- characteristics of consumers receiving Medicare rebateable Better Access mental health services;
- service provider, consumer and carer awareness of the Better Access initiative;
- impact of the Better Access initiative on the use of medications; and
- other unintended consequences for stakeholders.

#### **4.8.1 Summary of summative findings**

Although 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 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 had 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. This was seen to contribute to the 'gap' differential and had the effect of allowing clinical psychologists who received a rebate of \$37 to \$46 per session more than a psychologist or social worker, to charge a lower gap. The lower 'out of pocket' cost to patients in turn encouraged GPs to refer patients to, and patients to seek referrals to, clinical psychologists. Though a saving to patients, this created a perverse incentive for patients to utilise services that were at a higher cost to

Medicare. 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, although this issues was outside of the scope of Component D of the evaluation.

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 disorders<sup>72</sup> and that an expansion of eligibility to include their members would expand the availability of services and improve access to services.

The Better Access initiative appears to have had some impact on private health insurers. 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.

#### **4.8.2 Characteristics of individuals accessing the Better Access initiative**

Overall, the Better Access initiative was seen as complementing the public mental health system and providing services to a cross section of clients. During the consultation process, stakeholders and interviewees identified a number of characteristics of consumers receiving mental health services under the Better Access initiative.

Table 11 below highlights the more general client characteristics reported.

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<sup>72</sup> Nor was it the intent of the Better Access initiative to do so, see note 12 on page 26

*Table 11: Better Access client characteristics reported by AHPs*

| Characteristic      | Typical Better Access consumer   |
|---------------------|--|
| Diagnosis           | Anxiety and/or depression.   |
| Severity of illness | Moderate to severe.  |
| Geographic location | Metropolitan more than rural.  |
| Age                 | Primarily adults, some children, fewer older people and few, if any, in nursing homes.                               |
| Cultural background | Few from Aboriginal and Torres Strait Islander people and few from culturally and linguistically diverse communities |

A more detailed discussion of those receiving mental health services within the Better Access initiative are reported in the preceding sections of this report examining access and appropriateness of services.

As noted in the discussion on access, many respondents reported perceived inequalities in access with individuals from rural and remote communities, poorer communities, children and young people, older persons, Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds being under represented in the profile of clients using the service.

In discussions of appropriateness, stakeholders and interviewees indicated that the profile of clients accessing the Better Access initiative services was largely reflective of the client group defined in the Medicare guidelines. Better Access providers reported providing services appropriate to the needs of individuals referred or suggesting an alternative referral. Although most AHPs interviewed reported an informal arrangement of cross subsidisation of poorer clients by 'bulk billing' or charging reduced fees for these clients, this was not formalised and generally not advertised. Often it was restricted to existing clients whose circumstances changed during the course of treatment. AHPs did not report a proactive approach to targeting services to high need populations and indicated that they did not think it would be financially viable to do so.

The focus on 'who comes through the door', without a prioritisation based on clinical need or capacity to pay, was seen by state and territory government health departments and public mental health providers as a key limitation of the Better Access initiative. Conversely, when questioned, AHPs indicated that referrals were generated by GPs and it was the GP who determined the profile of referrals.

Both AHPs and public mental health providers perceived the primary differentiator in clients receiving public mental health services and services through the Better Access initiative to be that public mental health clients tended to have a higher level of chronicity, be more complex with more co-morbidities, less able to manage their own day-to-day affairs and more likely to require case management. In areas where there were no public mental health services or available public mental health services were unable to meet demand, the Better Access initiative provided therapy to this more chronic, more complex, poorer functioning client group, including clients with long standing mental health conditions including bipolar disorder and chronic psychoses. In

this situation, AHPs treated these more complex clients with the support of GPs and psychiatrists.

Discussion with local AHPs indicated that the profile of clients is changing over time and a much more diverse client group is emerging.

AHPs reported that initial referrals comprised a high proportion of women and clients with more simple anxieties and mood disorders. A number of them reported that the general client group was now expanding to include:

- more men, particularly men in their 50s and 60s, and accessing services for the first time;
- more children being referred by paediatricians;
- older people; and
- more complex clients who are referred as an alternative or adjunct to GP medication management of more complex disorders.

There was also a perception among most AHPs that the complexity of clients was increasing and that they are managing a number of clients who would otherwise be managed by the public mental health service, because public mental health services are not available. Many of these clients have a long history of involvement with the public mental health system and include clients with bipolar disorders or chronic psychoses, and clients requiring case management, with the case management provided by parents and family supports. The increasing complexity of referrals is requiring more intensive and longer interventions, and treatment periods of 12-18 sessions are now becoming more common. It also appeared that in areas with poor access to public mental health services, AHPs and GPs were managing caseloads with a greater proportion of clients with multiple comorbidities and lower prevalence disorders.<sup>73</sup>

The change in client profile is primarily perceived to be a result of a maturing of the practices of the Better Access initiative and:

- very little capacity in the public mental health system to provide therapy;
- developing of trust and relationships and referral pathways between GPs and AHPs;
- very few psychiatrists, with those who are available having limited capacity to provide therapy, resulting in GPs referring to AHPs;

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<sup>73</sup> The treatment of more complex and chronic patients is not the intent of the Better Access initiative (see note 12 on page 26) and the 12-18 sessions being more common does not appear to be supported by the average number of sessions provided through the Better Access initiative being five session (see note 58 on page **Error! Bookmark not defined.**).

- increased awareness that services are available and word of mouth referrals leading to client initiated referrals;
- accessing mental health services is now being seen as more normal and there is reduced stigma associated with seeking mental health care;
- receiving treatment from a AHP carries less stigma than treatment by a psychiatrist; and
- increased penetration and awareness of service availability in the local community and sub groups in the community.

### **4.8.3 Awareness of the Better Access initiative**

Generally, it was reported by all stakeholders that the Better Access initiative was now well established, awareness amongst GPs was high and that this would continue to improve as the Better Access initiative matured.

Psychiatrists and RANZCP representatives reported that the Better Access initiative was largely well established.

GPs and GP representative bodies were of the opinion that the Better Access initiative was now well established and referral pathways were continuing to evolve. The degree of progress and implementation varied across Divisions as did the reported level of engagement and commitment of resources to building relationships and referral pathways with AHPs. Overall, GP representatives were pleased with the degree of progress achieved in implementing the Better Access initiative.

All AHP provider bodies were very interested in participating in the evaluation and supportive of their members moving into private practice. The APS appeared the most proactive in developing resources and supporting members engaged in private practice: less so were the OT Australia and AASW. APS resourcing of members included the development of directories of members for GPs, proactively lobbying on behalf of members and initiating research showing the efficacy of psychological interventions provided through the Better Access initiative.

Public mental health providers were also aware of the Better Access initiative and, although most were proactive in building partnerships with GPs, they had varying levels of interactions with AHPs.

Private psychiatric hospitals were aware of the Better Access initiative, but had no direct contact with the Better Access initiative. This was due to engagement with primary mental health care services being via the admitting psychiatrist and, through the psychiatrist, with the patient's GP. An exception is Belmont Private Hospital in Brisbane who has developed in partnership with the Brisbane South Division coordinated access to psychiatrists under Better Access through the GLAS program. This innovative program recently won the **2009 Australian Private Hospital**

**Association Award for Ambulatory Care** for its General Practice Liaison and Assessment Service (GLAS).

Peak state mental health NGOs were aware of the Better Access initiative and reported a number of organisations exploring the possibility of, or currently accessing services through the Better Access initiative to improve access to services for their clients.

There was also a perception by GPs, AHPs, NGOs and consumer groups that general awareness in the community of service availability through the Better Access initiative was increasing. Both GPs and AHPs reported increasing numbers of individuals directly requesting services from, or referral to, an AHP for treatment of their mental health problems.

Despite the overall positive comments in relation to awareness of the Better Access initiative by GPs, there were some reported instances evidencing poor GP awareness. These included:

- A small number of consumer groups, NGO groups and individual consumers reported instances of clients presenting to GPs and not being advised of the availability of the Better Access initiative, but only being offered medication;
- one rural GP receiving the background information on the evaluation through the RACGP and then contacting the evaluation team to request information on how the Better Access initiative worked, reported they were the sole GP across a number of rural communities and had never heard of Better Access;
- All AHPs reporting that a number of referrals they receive from GPs contains minimal documentation, noting this is in a minority of cases and the general level of documentation is improving;
- Most AHPs reporting that in a small number of instances they have received inappropriate referrals from GPs, noting that generally the quality of information is good and that the numbers of inappropriate referrals were perceived as decreasing; and
- All GPs reporting instances of receiving minimal information in documentation and reports from AHPs, again noting that the quality of reporting is improving

Stakeholders and interviewees who expressed concern in relation to awareness of the Better Access initiative in the community and how the Better Access initiative works did so while also reporting that these instances were in the minority of cases, and awareness of and operation of the Better Access initiative was improving.

#### **4.8.4 Impact on use of medications**

Overall, psychiatrists, GPs and AHPs perceived that the Better Access initiative had had minimal, if any, impact on the level of medications prescribed for the treatment of

mental disorders, in particular anti-depressants. A number of AHPs and GPs did however highlight that the Better Access initiative had facilitated access to another treatment option for patients presenting with mental disorders or as an alternative to medication in the first instance.

A small number of AHPs and GPs reported incidences of patients being referred back to GPs by the AHP for prescriptions, with the view of maximising the effectiveness of the psychological therapies. One group practice of psychologists provided the results of a survey involving 130 of their recent clients. Of this sample, 48 per cent of clients did not take medication at the time of referral. These psychologists reported that GPs often refrained from prescribing medication until psychological therapy had been trialled. A number of GPs noted that the push to try non pharmaceutical interventions also came from patients and that well established relationships with AHPs allowed this to be trialled while closely monitoring the patients' condition.

Five or six senior GPs and GP representatives reported that, given the relatively 'low level' of mental health training within general practice, the impact of the Better Access initiative on GP prescribing practices would be minimal. These interviewees identified the role of pharmaceutical company representatives as the most significant driver of prescribing practices and were of the opinion that, until enhanced mental health training and strategies to counter the promotional activities of pharmaceutical representatives were enacted, prescribing practices were unlikely to change significantly.

Offsetting these concerns is evidence that 25 per cent of GPs underwent mental health training as part of Better Outcomes, that GPs under Better Outcomes were required to undertake ongoing professional development and that younger GPs are being exposed to higher levels of mental health training during their postgraduate studies.

The online survey of consumers provided an indication of which services were provided by the GP, Table 12 below. Of the 125 consumers who reported that they had seen a GP for their mental health disorder in the past 12 months 27 per cent received a treatment plan, 30 per cent received medication and 16 per cent were referred to a AHP (some consumers received a combination of the above). Of the 34 receiving a treatment plan, 19 (56 per cent) were referred to a AHP. Of the 20 consumers referred to a AHP, 13 (65 per cent) also received medication.

*Table 12: GP services reported as being received by consumers*

| <b>Services received from GP</b>              | <b>Number</b> | <b>Per cent</b> |
|---|---------------|-----------------|
| Seen GP in last 12 months                     | 125           |                 |
| Received medication                           | 38            | 30%             |
| Received a Treatment Plan                     | 34            | 27%             |
| Referral to a psychiatrist                    | 7             | 6%              |
| Referral to a AHP                             | 20            | 16%             |
| Received a Treatment Plan and referred to AHP | 19            | 15%             |
| Received medication and referred to AHP       | 13            | 10%             |

#### 4.8.5 Other consequences

During the course of consultations, a range of unintended consequences and issues were identified. Key among these were:

- the impact of the Better Access initiative on non-approved therapists and counsellors;
- strongly differing opinions as to the rationale for differential payments levels for clinical psychologists, general psychologists, occupational therapists and social workers;
- operational issues in relation to the Better Access initiative MBS items; and
- the impact on private health insurance.

#### 4.8.6 Differential rebates for allied health providers

The differential rebates for clinical psychologists, general psychologists and occupational therapists and social workers were a highly contentious issue and the subject of considerable debate, particularly within the psychology profession. Table 13 provides examples of the range of rebates paid for the provision of focused psychological strategies lasting more than 50 minutes for professional attendance in consulting rooms and at a place other than consulting rooms.<sup>74</sup>

*Table 13: Example of differential rebate –Provision of FPS greater than 50 minutes*

| Allied health provider        | In consulting rooms |                 | Other places |                 |
|-------------------------------|---------------------|-----------------|--------------|-----------------|
|                               | Item number         | Rebate paid     | Item number  | Rebate paid     |
| <b>Clinical psychologist</b>  | <b>80010</b>        | <b>\$115.05</b> | <b>80015</b> | <b>\$134.60</b> |
| <b>General Psychologist</b>   | <b>80110</b>        | <b>\$78.40</b>  | <b>80115</b> | <b>\$98.40</b>  |
| <b>Occupational therapist</b> | <b>80135</b>        | <b>\$69.10</b>  | <b>80140</b> | <b>\$89.00</b>  |
| <b>Social worker</b>          | <b>80160</b>        | <b>\$69.10</b>  | <b>80165</b> | <b>\$89.00</b>  |

General psychologists, occupational therapists and social workers argued that the differential failed to reflect experience or specialist skills developed by AHPs across professional groups and did not necessarily reflect a variation in service provided to clients. Occupational therapists and social workers perceived the lower level of rebate as unfair, arguing that the services provided were of a comparable quality and, in many cases, providers utilised the same range of interventions. Social workers reported that the differential in payment is not reflected in payments to allied health providers approved to provide services through the Family Law Court, Department of Veterans'

<sup>74</sup> MBS online data accessed 7 July 2009. Link.  
<http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=80160&qt=ItemID>

Affairs or Commonwealth Rehabilitation Service. (The evaluation has not examined payment schedules for allied health providers under other Commonwealth contracting arrangements.) Only the APS and clinical psychologists perceived the difference in rebate as a valid reflection of the additional training and skills of clinical psychologists.

Most GPs and psychiatrists acknowledged that the variation in payment failed to capture the expertise of individual providers. However, GPs generally reported feeling more confident referring a patient to a clinical psychologist. It was suggested by some psychiatrists and social workers that GPs have not had the professional exposure to clinical occupational therapists and social workers in their training and professional practice to understand the services offered by these professions.

#### **4.8.7 Impact on non approved counsellors**

A range of counsellors and therapists who are not eligible to be approved Better Access initiative providers have well established practices. Consultations were undertaken with the national and some state branches of organisations that represented these groups.

Although having in-principle support of the Better Access initiative and the improved access to services offered by the Better Access initiative, non-approved counsellors had three primary concerns:

- the Better Access initiative does not provide scope for psychoanalysis and long-term psychotherapy for more severe psychological disorders;
- that their professional members who are not clinical psychologists, general psychologists, occupational therapists or social workers are not eligible to provide the Better Access initiative services; and
- the introduction of the Better Access initiative has had a detrimental effect on the professional practices of their members by introducing an element of subsidised competition into the market.

They also noted that expansion of the Better Access initiative to include their professional members would expand the available workforce and improve access to services.

#### **4.8.8 Impact on private health insurance**

In the course of the evaluation, the evaluation contacted three major health insurers: MBF (BUPA), HCF and Medibank.

Health Insurers reported a limited stake in the Better Access initiative but, in general, supported improved access to focussed psychological strategies in the community as they deliver better outcomes for patients in the long term and prevent unnecessary hospitalisation. Health Insurers have experienced some difficulty with members who wished to claim against both the Medicare rebate and Health Insurer rebate (double dipping), which required Insurers to adjust their policies accordingly.

Prior to the introduction of the Better Access initiative, all three providers offered rebates for services provided by occupational therapists and psychologists, but not social workers. Since the introduction of the Better Access initiative, there has been no change made to business rules in relation to these services. For members to receive a rebate provided by occupational therapists and psychologists, the service providers need to be recognised by the fund and customers must be on a level of cover offering benefits for these services.

Members are able to access rebates from Medicare and their policy, but not both for the same claim. As per the MBS guidelines, they are not able to use their private health insurance ancillary cover to cover the gap between the charge and the Medicare rebate for these services.

Members can only claim services through their private health insurance once they have accessed all available services under the Better Access initiative. One fund reported that subsequent to the introduction of the Better Access initiative there has been an apparent decrease psychology treatments claimed and members claiming rebates for psychology treatments.

#### **4.8.9 Operational issues in relation to the Better Access initiative MBS items**

Several operational issues relating to the Better Access initiative were reported during the course of consultations. These were perceived as impeding the efficient operation of the Better Access initiative and included the following:

- A small number of Divisions of General Practice and individual GPs reported ongoing confusion as to the Better Access initiative MBS item numbers, more so than other areas of the MBS, and identified the need for greater clarity within the MBS itself and/or more training and information from Medicare.
- In small area consultations GPs and AHPs reported that when they contacted Medicare they often received contradictory advice. They identified a need for clarification and simpler explanations of mental health items within the MBS.
- Several GPs reported that if they code an item 23 (professional attendance – MBS rebate \$33.55) and later in the same day (they may have asked the patient to come back for a longer consultation as per the intention of the Better Access initiative) they code an item 2710 for the preparation of a GP Mental Health Treatment Plan (MBS rebate \$156.85), the MBS computer system only approves the Item 23. This means that the patient takes the completed Treatment Plan to the AHP who initiates treatment and bills the patient. The patient then presents to Medicare seeking their rebate and is advised that there is no approved Treatment Plan and therefore they are not eligible for a rebate. Additional to the stress and anxiety this causes the patient, it adds another administrative process for the GP and/or AHP who then need to work out what has gone wrong. Several AHPs also reported instances of the client reporting that the payment of the rebate had not been approved though the patient had a Treatment Plan. One consumer also reported a similar instance on non payment when it appeared the paperwork was OK, but that this was 'fixed up' when they talked to the AHP <sup>75</sup>

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<sup>75</sup> Though only identified by a few GPs, AHPs and consumers this may be a technical issue warranting further investigation and clarification.

Similarly, the evaluation was advised that if, after 12 sessions within a calendar year, a GP approves a further six sessions due to exceptional circumstances, the MBS system defaults to not approving the referral. KPMG understands that the MBS computer system should flag the refusal and the referral should then be reviewed by an MBS officer, who notes the coded exceptional circumstances and then manually approves the referral. In practice, the evaluation was advised that this does not occur and it is the GP or AHP who has to rectify the situation after the client has been refused the rebate.

## **4.9 Consumer and carer feedback**

This section reports on the outcome of consultation with consumers and carers.

### **4.9.1 Summary of findings from 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.

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 mental health services, or at least at such an intensive level. Many simply went without services or were reliant solely on their GP for assistance with their mental health problems.

### **4.9.2 Satisfaction with services**

Consumer respondents to the online survey also reported high levels of satisfaction with the services that they received: 70 per cent were satisfied, 18 per cent were dissatisfied and 13 per cent unsure (see Table 14 below).

*Table 14: Consumer perception on degree services met needs*

**Overall, did the services meet your needs? (number of respondents)**

| Region         | Very satisfied | Satisfied | Neither satisfied or dissatisfied | Dissatisfied | Very dissatisfied | Did not respond | Total      |
|----------------|----------------|-----------|-----------------------------------|--------------|-------------------|-----------------|------------|
| Major City     | 31             | 27        | 12                                | 5            | 5                 | 6               | 86         |
| Inner Regional | 3              | 11        | 2                                 | 2            | 2                 |                 | 20         |
| Outer Regional | 2              | 5         |                                   | 2            | 3                 |                 | 12         |
| Remote         |                |           | 1                                 |              |                   |                 | 1          |
| Very Remote    |                |           |                                   | 1            |                   |                 | 1          |
| (blank)        |                | 1         |                                   | 1            |                   | 3               | 5          |
| <b>Total</b>   | <b>36</b>      | <b>44</b> | <b>15</b>                         | <b>11</b>    | <b>10</b>         | <b>9</b>        | <b>125</b> |

A better indicator of the valuing of the Better Access initiative by consumers is that 86 per cent of respondents to the online survey would recommend the services to a family member or friend, with only five per cent indicating that they would not recommend referral (see the Table 15 below).

*Table 15: Consumer rated likelihood of referring family or friend*

**If a family member or friend were experiencing a mental health problem, would you recommend to them that they seek a referral to a therapist from their GP through Medicare?(number of respondents)**

| Region         | Yes, certainly | Possibly  | Not sure  | Unlikely | No       | Did not respond | Total      |
|----------------|----------------|-----------|-----------|----------|----------|-----------------|------------|
| Major City     | 58             | 15        | 6         | 1        |          | 6               | 86         |
| Inner Regional | 15             | 3         |           | 1        | 1        |                 | 20         |
| Outer Regional | 5              | 1         | 3         | 2        | 1        |                 | 12         |
| Remote         |                |           | 1         |          |          |                 | 1          |
| Very Remote    |                | 1         |           |          |          |                 | 1          |
| (blank)        |                | 2         |           |          |          | 3               | 5          |
| <b>Total</b>   | <b>78</b>      | <b>22</b> | <b>10</b> | <b>4</b> | <b>2</b> | <b>9</b>        | <b>125</b> |

### 4.9.3 Affordability of services

For those consumers and their families who were previously obtaining services from private providers, the Better Access initiative has made services more affordable. For people on a low income, struggling to pay \$80 to \$150 per week to see a private psychologist or social worker,<sup>76</sup> it meant that they and their family had to go without other things. A couple of consumers reported missing meals because of the cost of therapy, while others reported the financial drain on their families. Consumers who experienced financial hardship as the result of the cost of therapy, either paying the full cost or after the MBS rebate, reported that they did so as the benefit of the therapy outweighed its cost.

<sup>76</sup> None of the consumers interviewed reported seeing an occupational therapist

Consumers seeing social workers and psychologists through the Better Access initiative were most likely to talk about the unfairness of the lower rebate paid for seeing these professionals, compared to that for seeing a clinical psychologist, particularly when they valued the services of the psychologist or social worker and/or were seeing them because of their professional background and expertise in a particular area of treatment or therapy. Three consumers expressed concern that they did not receive a rebate for the counsellor that they were seeing but did not want to change providers because of the perceived value of the therapy being provided.

Overall, the consumers interviewed reported improved affordability. Approximately half of those interviewed thought services were affordable, while many of the consumers interviewed were receiving low gap or no gap services. Of the consumers responding to the online survey, 56 per cent agreed with the statement that, as a result of the Better Access initiative, mental health services were now more affordable (see the Table 16 below).

While the MBS rebate has increased affordability, many AHPs still charge a gap payment and affordability remains a barrier in access to service for many people from low socio economic backgrounds. Thirty six per cent of consumers responding to the question on affordability strongly disagreed (14 per cent) or disagreed (22 per cent) with the statement that services were affordable.

*Table 16: Consumer perception on affordability of services*

**Overall, to what extent do you agree that the services were affordable? (number of respondents)**

| Region         | Strongly Agree | Agree     | Unsure    | Disagree  | Strongly Disagree | Did not respond | Total      |
|----------------|----------------|-----------|-----------|-----------|-------------------|-----------------|------------|
| Major City     | 14             | 31        | 6         | 20        | 11                | 4               | 86         |
| Inner Regional | 3              | 8         | 3         | 3         | 3                 |                 | 20         |
| Outer Regional | 1              | 7         | 1         | 1         | 2                 |                 | 12         |
| Remote         |                | 1         |           |           |                   |                 | 1          |
| Very Remote    |                |           |           | 1         |                   |                 | 1          |
| (blank)        |                | 1         |           |           | 1                 | 3               | 5          |
| <b>Total</b>   | <b>18</b>      | <b>48</b> | <b>10</b> | <b>25</b> | <b>17</b>         | <b>7</b>        | <b>125</b> |

#### **4.9.4 Access to services**

Consumers in some regional areas reported that the real increase in the number of AHPs meant that services were now available in areas where previously there were no mental health services. The consultation process included very few consumers from rural and remote areas. Those that did participate in the teleconferences from more remote areas indicated that service availability was the major impediment to access and that this had not improved through the Better Access initiative. One consumer from a remote area reported service availability reducing as a result of the Better Access initiative and AHPs being less willing to provide 'fly in fly out' services.

Forty seven per cent of consumers responding to the question on service availability in the online survey agreed that services were available in their local area and 53 per cent did not think services were available (32 per cent) or did not know whether services were available or not (21 per cent). Neither of the respondent from the remote and very remote areas thought services were available in their local area (see Table 17 below).

The option of remote access teleconferencing or VOIP based therapy was also discussed. This was perceived by consumers as less satisfactory than face to face counselling but a valuable option for:

- people living in areas where there were no mental health services;
- individuals with particular problems requiring more specialised expertise;
- individuals who do not speak English well and require a therapist who can speak their own language; or
- individuals who, because of the size of the community and relations within the community, may not want to see the sole psychologists in town.

In these situations, consumers also identified the potential emotional and psychological intensity of therapy and suggested that individuals receiving remote therapy would benefit from access to a local support person (this may be a generalist health worker, local service provider, friend) who could also talk with the therapist to understand how to help the individual receiving therapy.

*Table 17: Consumer rated availability of services*

**Overall, to what extent do you agree that allied health providers (psychologists, social workers and occupational therapists) were available in your local area? (number of respondents)**

| Region         | Strongly Agree | Agree     | Unsure    | Disagree  | Strongly Disagree | Did not respond | Total      |
|----------------|----------------|-----------|-----------|-----------|-------------------|-----------------|------------|
| Major City     | 7              | 38        | 17        | 11        | 9                 | 4               | 86         |
| Inner Regional |                | 5         | 7         | 4         | 4                 |                 | 20         |
| Outer Regional | 1              | 3         | 1         | 3         | 4                 |                 | 12         |
| Remote         |                |           |           |           | 1                 |                 | 1          |
| Very Remote    |                |           |           | 1         |                   |                 | 1          |
| (blank)        |                | 1         |           |           |                   | 4               | 5          |
| <b>Total</b>   | <b>8</b>       | <b>47</b> | <b>25</b> | <b>19</b> | <b>18</b>         | <b>8</b>        | <b>125</b> |

Waiting times were generally reported as acceptable in the consultations, with long waits being reported where a particular provider was desired. Sixty one per cent of consumer respondents to the online survey rated waiting time for AHPs as acceptable (see the Table 18 below).

*Table 18: Consumer rated waiting time for services*

**Q7. Overall, to what extent do you agree that waiting times for the services were acceptable? ?(number of respondents)**

| <b>Region</b>      | <b>Strongly Agree</b> | <b>Agree</b> | <b>Unsure</b> | <b>Disagree</b> | <b>Strongly Disagree</b> | <b>Did not respond</b> | <b>Grand Total</b> |
|--------------------|-----------------------|--------------|---------------|-----------------|--------------------------|------------------------|--------------------|
| Major City         | 13                    | 39           | 9             | 11              | 11                       | 3                      | 86                 |
| Inner Regional     | 1                     | 10           | 2             | 2               | 4                        | 1                      | 20                 |
| Outer Regional     | 1                     | 6            | 1             | 1               | 3                        |                        | 12                 |
| Remote             |                       | 1            |               |                 |                          |                        | 1                  |
| Very Remote        |                       |              |               |                 | 1                        |                        | 1                  |
| (blank)            |                       |              |               | 1               |                          | 4                      | 5                  |
| <b>Grand Total</b> | <b>15</b>             | <b>56</b>    | <b>12</b>     | <b>15</b>       | <b>19</b>                | <b>8</b>               | <b>125</b>         |

Consumers 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) reporting 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.

Fifty nine per cent of consumers responding to the online survey reported that their GP had developed a Mental Health Treatment Plan for them and 38 per cent indicated that they had not.

In the teleconferences with consumers, participants reported that they felt the level of awareness of GPs of the Better Access initiative and the provision of information to consumers on options for referral to an AHP could be improved. Many reported that their GPs were still hesitant of how to best work with people living with a mental illness, and expressed a desire for better education for GPs, both in terms of the Better Access initiative itself, and more broadly in terms of mental health. Approximately a third of consumers reported that they initiated the referral to the AHP rather than the GP. Consumers continued to report instances of themselves or acquaintances going to see their GP and only being offered medication.

Consumers generally thought that up to 18 sessions was sufficient for more simple problems or maintenance support. Most did however feel that more sessions may be required when more intensive problems were being experienced, at times of high external stress or at the commencement of therapy for more complex problems. It was also noted by a number of consumers that, as the number of sessions related to a calendar year, it could be more difficult for individuals commencing therapy at the beginning of the year to receive a rebate for the number of sessions that they needed. Generally, nearly all consumers thought that there should be scope for more sessions where the situation warranted it and that this should be the decision of the treating therapist and individual consumer.

The overall process of referral and rebate (how the system worked) was generally seen as operating well. Consumers receiving services through the Better Access initiative appeared to have a sound understanding of how it operated and once the first payment was made and rebate received, the processes were reported as operating adequately. For some the first up-front payment was difficult financially. A couple of consumers

reported that they were bulk billed and the payment and rebate transferred to their account at the psychologist's office. This was perceived as an ideal situation by most consumers.

#### **4.9.5 Recommendations of consumers**

The key recommendations from consumers on how the Better Access initiative could be improved were:

- Reduce the gap fee for seeing allied health providers.
- Introduce a more equal rebate for all approved allied health professionals.
- Provide capacity for more than 18 sessions where this was assessed as required by the therapist and consumer.
- Review the purpose and format of the Mental Health Treatment Plan.
- Provide better education for GPs on how to work with clients living with a mental illness.
- Provide better education for GPs and consumers on client rights under the Better Access initiative.
- Enhance the availability of services in rural and remote areas.

## **5 Discussion**

### **5.1 Potential bias within the evaluation findings**

A major limitation of the stakeholder consultation process was the reliance on a self-selected sample of representatives of professional bodies, individual mental health service providers and consumers and carers to provide comment on the Better Access initiative.

Almost by definition, the nominees of the respective professional bodies were professionals with a higher level of interest and commitment to mental health and mental health reform than perhaps would be present in a random sample of the membership base. Similarly, individuals participating in the consultations were likely to be those with particularly strong opinions one way or the other, than would occur in a random sample of service providers and consumers and carers. It is also likely that the individual GPs and AHPs consulted were more likely to be professionals who, in their practice, complied with the intent and requirements of the Better Access initiative than might be the case in a random sample of GPs and AHPs. Thus when commenting on quality (including accuracy of diagnosis, comprehensiveness of reports, compliance with the Better Access initiative guidelines) they were likely to be doing so with an expectation that reports from other providers would be reflective of the effort they put into their own.

The GPs providing comment on the quality of AHP reports indicated that they provided comprehensive reports to AHPs, but for many patients they received minimal information in the reports from AHPs. AHPs indicated that they provided comprehensive reports to GPs but for many clients the documentation from GPs was described as providing either minimal or incorrect information. Each professional group is in effect commenting on the broader cross section of documentation that they receive and thus the views of both GPs and AHPs may be consistent and accurate.

Interestingly, there was a strong consistency of findings in respect to key issues from across stakeholder groups, individual providers, consumers, carers and those who may be considered external observers of the Better Access initiative - the NGOs and public mental health providers engaged in the delivery of mental health services. The general consistency in findings increases the likelihood that the findings of the consultations may be generally representative of the wider opinions of GPs, AHPs, consumers, carers and other stakeholders who did not engage in the consultation process.

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.

## **5.2 Access and affordability**

It would appear from the consultations and 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. This is also self evident when we consider that a rebate is now provided for services that were previously only available to individuals with a capacity to pay the full cost of private service delivery and a relatively small number of individuals accessing services through private health insurance, ATAPs, MAHS, DVA, Aboriginal Medical Services, workers compensation and other government programs<sup>77</sup>. 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.

The Better Access initiative is strongly supported by GPs, AHPs, consumers and carers, and is seen as an important step in addressing the needs of individuals with high prevalence disorders in the community. Consumers noted that concurrent with the Better Access initiative, there has been an increasing recognition and acceptance of mental illness in the community, a reduction in the stigma associated with mental illness and an increasing willingness to seek out assistance. The responses from members of organisations such as 'Beyond Blue' were strongly supportive of the initiative and highlighted the difficulties of people with a high prevalence mental illness being able to access affordable mental health services prior to the Better Access initiative.

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. 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.

Organisations representing psychotherapists and counsellors not eligible to receive MBS rebates through the Better Access initiative were supportive of the Better Access initiative in improving access and affordability of mental health services. Their concern was the exclusion of their members and the detrimental impact that the rebate through the Better Access initiative had on their referrals and financial viability of their businesses. They also argued that the expansion of the Better Access initiative to include their members and the services provided would improve access to services.

Contrasting the strong arguments to increase access from GPs, AHPs and consumers, carers and non-approved counsellors was concern expressed by some psychiatrists,

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<sup>77</sup> These vary across jurisdictions and include Victims of Crime Compensation, programs for adults removed from their families as children, NGO counselling services, etc.

public mental health providers and NGOs that services through the Better Access initiative were not being targeted to specific high need groups in the community. Some consumers and carers also raised the issue of better targeting of resources.

In short two contrasting views emerged from the consultations. The strongest view supported by nearly all GPs, AHPs, non-approved counsellors, 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.

The gap payment also presented a barrier for many accessing AHP services, with 36 per cent reporting that services were not affordable. Affordability compounded other problems that people from lower socio economic groups, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, people residing in rural and remote areas, young people and the elderly in nursing homes experienced. For these groups there were also practical problems in relation to availability of and access to local linguistically and culturally appropriate services.. 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 population groups when a broader system approach and greater level of engagement with the wider community may be required.

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.

### **5.3 Options discussed to improve access**

Most AHPs proposed that access to mental health treatment would be improved by strategies to increase GP awareness of services They argued that equitable access will be achieved through increased awareness of service availability, higher levels of service provision and incentives to address the needs of identified priority population groups (children, youth, older people) and disadvantaged populations (Aboriginal and Torres Trait Islander people, culturally and linguistically diverse communities and remote communities). Such an approach would be likely to further drive demand and maintain or accelerate the high growth trends in services funded through the Better Access initiative. It is likely that most AHPs would be highly resistant to strategies to contain demand growth and/or refocus service priorities.

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, who felt it was important 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.

If the Better Access initiative continues unchanged, given the high prevalence of mental health disorder in the population, it is likely that the cycle of demand growth (Figure 2 page 37) driven by increasing numbers of AHPs and consumer awareness and expectations for service will continue.

Although all existing, new and potential consumers benefit from the increased affordability and access to services, this has not resulted in equitable access to services. AHPs report that the Medicare rebate for services provided through the Better Access initiative is insufficient to cover the expense of practice and the recommended fee schedule for all professional groups is higher than the rebate. AHPs indicate a gap payment is required to maintain financial viability. As the MBS rebate is universal, it is easier to develop a client base with the capacity to meet a gap payment and to increase the level of gap payment when services are provided in more affluent areas. Based on the consultations, it is likely that an analysis of postcode of service provider and postcode of service user would demonstrate a disproportionate concentration of AHPs and service utilisation in higher socioeconomic areas.

It is most likely that the increased affordability is currently the main driver for utilisation trends and proponents for continuing to increase referrals argue that as the market becomes saturated with providers, there will be a decline in fees as providers seek to expand the potential market for services, and a gradual dispersal of services to lower socioeconomic areas to capture demand and thus moving to a more equitable distribution of services. A key factor in this is the differential between the MBS scheduled fee and the fee perceived by service providers as offering a financially viable return on the service provided.

However, leaving the market unchecked by supply constraints to improve equity in access carries four major risks:

- 1 While there is a requirement for a gap payment, some sections of the community will continue to be excluded from services, particularly disadvantaged communities where, because of comorbidities, the time required to consult and liaise with other professionals, the increased likelihood of appointment 'no shows', etc., AHPs report that it is not viable to provide low fee or bulk billed services.
- 2 It is more likely that new and less experienced practitioners entering the market will feel the most pressure to provide services at low cost and locate in lower socioeconomic areas to capture the latent demand and develop caseloads. This may result in the least experienced clinicians endeavouring to manage some of the more complex and difficult to manage clients.
- 3 As the established markets become saturated with providers, the financial incentive will be to retain existing clients as long as possible and expand the scope of services to include clients not within the client group defined by Medicare. There are already reports of group practices of psychologists establishing with signage

stating they bulk bill for a range of problems including parenting and relationship problems.

- 4 In view of the high reported prevalence of mental illness into the community, the high rates of growth in the Better Access initiative funded services are likely to continue, in turn consuming a greater proportion of the health budget and displacing higher priority mental health needs funded through capped budget allocations.

There are also some groups in the community for whom most stakeholders and respondents would agree that the current the Better Access initiative service model is not appropriate. These groups as identified through the consultations are:

- *People on a low income:* These people often face the dual difficulty of being unable to afford the gap payment for services that are available and are most likely to be living in communities where there are few, if any, services available and have reduced capacity (because of cost and poor public transport) to travel to areas where services are available.
- *Remote communities:* There is little indication that the Better Access initiative has improved services to residents in rural and remote communities. There is anecdotal evidence that Divisions of General Practice and other outreach service providers (for example public mental health providers, mining companies) are having to increase sessional fee payments to outreach providers in order to compete with the Better Access initiative payments. Within a capped budget, this cost increase leads to a reduction in the volume of services provided. This is compounded by increasing difficulty in attracting staff to provide outreach services as a result of the improving financial viability of their home practices.
- *Aboriginal and Torres Strait Islander communities:* Understanding of, and sensitivity to, the needs of Aboriginal and Torres Strait Islander people and engagement with the community and wider family network is a prerequisite to working in these communities. Challenges in working in these communities is often compounded by the remoteness of the community and need to communicate in the local community language. Services funded on a 'fly in fly out' sessional payment basis are often not appropriate and do not account for the time taken to engage with the community and more systems model of intervention.
- *Culturally and linguistically diverse communities:* Additional to the cultural sensitivities required to work within these communities, there may be language barriers. Currently interpreter fees and time required to work through interpreters are not reflected in the MBS items and rebate.
- *Older people:* The current MBS items do not account for the additional cost of providing services to older people in residential care or their home environment. Nor do they recognise the requirement for multidisciplinary care planning and management required for older people.

- *Children:* The key restriction of the current model is the exclusion of secondary consultation services. There is no MBS item for sessions with the child's family or carers without the child being present, or group work with the child's family or carers.
- *Youth:* 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.
- *People with complex care needs:* A key issue raised by many stakeholders is that 18 sessions is inadequate for people with long standing and complex care needs and the need for multidisciplinary care planning and secondary consultation to effectively work with this client group.

Issues of access for some of these groups (for example individuals with low prevalence disorders, Aboriginal and Torres Strait Islander people) are compounded by jurisdictional issues relating to which funding body has primary responsibility for service provision to these groups (including OATSIH, DOHA, state and territory health departments).

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;
- introducing outcome reporting to monitor and drive effective practice;
- introducing provider audits to ensure services are being provided to the eligible population and requirements of service are complied with;
- 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 VOIP services to residents of rural and remote communities or special need groups requiring particular language skills or cultural sensitivities;

- introducing additional items for specific conditions and/or population groups.

How these options relate to the specific population groups are identified in Table 19 below.

Table 19: Options to improve effectiveness and equity in access

| Strategy  | Low income earners | Remote areas | Aboriginal and Torres Strait Islander people | 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 |                    | ✓            | ✓  | ✓                |              |          |                           |

## **5.4 Appropriateness, effectiveness and evidence based care**

Although GPs and AHPs report providing appropriate and effective evidence based care, the lack of outcome reporting and concerns identified in the consultations as to the adequacy of documentation exchanged between providers is suggestive that in some cases the intent and guidelines for the Better Access initiative are not being complied with. As such there may be benefit in a more stringent appraisal of the effectiveness of services being provided. It is expected that this will be undertaken through the random recruitment of providers and consumers into Component A of the evaluation. A greater understanding of clients receiving services and outcomes being achieved, relative to the mix and intensity of services being provided, will better inform the appraisal of options to improve equity in access and target services to maximise outcomes.

The operation of the Better Access initiative in relation to the interface between GPs and psychiatrists appears to be working well and is effective in providing secondary consultation to support and improve the skills and confidence of GPs in managing patients with a mental health disorder.

However, the interface of GPs and AHPs appears to operate primarily on a point-to-point referrals with scope to improve the exchange of information between the GP and treating AHPs. Where clients with more complex problems require coordinated care planning with the GP and or other services (such as PHAMS, HACC, public mental health services, NGOs), there is no MBS item to support this process. This is particularly an issue for providers other than clinical psychologists, where the MBS rebate (and thus average fees that can be charged and capacity to absorb this into general costs) are much lower. The identified need for additional MBS items to foster coordinated care management is discussed in the preceding section.

A theme from the consultations was that where a GP Mental Health Treatment Plan is being undertaken solely as a prerequisite to referral to a AHP and the GP has little ongoing involvement with the patient, or management of the patient's mental health problem, it may be adding an unnecessary cost burden to the Better Access initiative

The intent of the GP Mental Health Treatment Plan was to recognise and remunerate the additional time required to undertake a comprehensive mental health assessment and develop a Treatment Plan. The increase in the number of services provided through this MBS item number has been dramatic, although this increase is subject to artefact given the majority of those with mental health problems in the community have in the past received care from their GP, and a significant proportion of the increase reflects changes in the item numbers rather than an increase in services. Despite this there is an increase in mental health services provided by GPs indicating that one of the objectives of this initiative has been achieved. Further, consumers surveyed generally had positive opinions in relation to their GP with very few (less than five per cent) reporting strongly negative perceptions".

Some GPs also expressed concern about the Plan as a prerequisite for referral and questioned its value when it was being produced to meet the requirements of the referral process, rather than as a tool for assessment and care planning. When its primary purpose was to secure the referral to the AHPs, GPs perceived little value in the Plan and many indicated a simpler referral would be more appropriate.

A number of AHPs and GPs suggested a more simplified referral process (a minority of respondents) and that there was the potential that the requirement for a GP Mental Health Treatment Plan, may itself act as a deterrent in access to mental health services due to a reticence of GPs to prepare a Treatment Plan. It was suggested that this may be as a result of such factors as time constraints, awareness of mental health issues, culturally different perceptions of mental health and/or in other cases patients not wishing to discuss mental health issues with their GP.

Many AHPs proposed that they should be able to receive referrals directly and that the assessment function and ensuring compliance with eligibility criteria transfer from the GP to them. Compliance with guidelines would be regulated in the same way it would be for GPs. Under this proposal, clients may present direct to an AHP or be referred through a GP with or without a Plan. Although improving and streamlining access, this approach may fragment patient care and does not contribute to service integration and coordination, and, most importantly, would remove the current gate keeping role of GPs. It is also most likely to accelerate demand growth and budgetary pressures. Within the context of the National Health and Hospitals Reform Commission's recommendations for a greater reliance on evidence-based outcomes to prioritise resource allocation and the importance of coordinated primary care based on general practice, this may not be a preferred solution.

There would appear to be an argument by some, especially AHPs, to remove the requirement for a GP Mental Health Treatment Plan as a prerequisite to referral to an AHP. A simpler referral, as occurs with other specialist referrals, might lead to some cost savings, but may reduce coordinated and integrated service provision, and remove a key plank of the Better Access Initiative to improve access to GPs for those with mental health problems. Within this model, the GP Mental Health Treatment Plan could be retained as an MBS Item number and the GP may choose to utilise this where they feel the extended consultation and Treatment Plan is a requirement of effective management of the individual presenting patient. Claiming against this MBS item could be monitored in the same way that Medicare monitors and acts to regulate other areas of potential over servicing.

A random audit of GP Mental Health Treatment Plans and AHP reports for comprehensiveness and compliance with guidelines would provide a benchmark measure of the potential savings through a change in the referral requirements and comparator for monitoring claim rates against this item.

A paradox of the Better Access initiative is that clinical psychologists can provide focussed psychological strategies in any setting and attract the same rebate for doing so, unless it is an outreach service in which a marginally higher rebate is payable. Level-2 trained GPs can only receive the higher rebate for provision of approved focussed psychological strategies when these are provided in an accredited GP

practice. This regulation is a legacy of the pre Better Access service model where limiting funding to accredited GP practices served as a proxy indicator of service quality. The result now is that Level-2 trained GPs attract a lower rebate if they provide a mental health service in what may be a more suitable mental health environment that is not an accredited GP practice. It does for example act as a financial barrier to Level-2 trained GPs working within a youth specific Headspace service where they would attract a lower rebate than working in an accredited non-youth and non-mental health specific GP practice. Removing this restriction on Level-2 trained GPs may improve access without a significant impact on cost.

## **5.5 Workforce education and training**

At the time of consultation there had been limited roll-out of the Better Access initiative training to psychiatrists, GPs and AHPs. Professionals were well aware of training opportunities available through their respective professional bodies and how to access them. Professional bodies reported that providers were accessing training.

Where multidisciplinary training was provided, this was welcomed as an opportunity to network, develop referral pathways and importantly share information on the clinical strengths that different professionals bring to mental health care.

A number of psychologists expressed concern that some of the training provided by the APS was too academic and intervention specific, and failed to capture the complexities of managing real patients. Within this context vignette based training was seen as a valuable means to provide new practitioners with the practical skills and referral networks required to develop their practice. For social workers, training in how to develop and operate a private practice was perceived as valuable for a workforce transitioning from employment in the public mental health system to private practice.

Although nearly all providers acknowledged the value of multidisciplinary training, the degree to which this was being implemented at a local level varied. The perception of the evaluation was that, as training was primarily being arranged by the professional bodies, it tended to be profession specific and failed to actively include other professions. Through the MHPN, key peak organisations have endorsed CPE points for their members. It is noted that OTA had not been included at the time of the evaluation.

There was a general recognition of the central role of the Divisions of General Practice in developing primary practice at the local level, and most AHPs agreed with the concept that the Divisions were well placed to facilitate multidisciplinary mental health training at a local level to complement profession specific training developed by the respective professional bodies. A challenge for social workers and occupational therapists was that, as with GPs, mental health was only a small component of activity provided by this professional group. As such a number of social workers did not feel that the AASW and OTA was as proactive in supporting mental health training for their members and advocating on their behalf as was the APS for its members.

- Public mental health providers and a number of psychologists in private practice questioned what impact the reduction of clinical psychologists within the public sector would have on the supervision and training of psychologists in the future. They questioned where the supervision and exposure to a broad range of clients and working within multidisciplinary teams would come from the Better Access initiative appeared also to be impacting on clinical training in universities. It was reported that one university had reduced its supervised training hours requirement because referrals to the university clinic had reduced as a result of the Better Access initiative. A suggestion by several psychologists in private practice was that the development of funded rotational placements across public and private practices would be an important contributor to maintaining training opportunities. Similar issues are likely to affect mental health training for social workers and occupational therapists, if there is a migration of more experienced practitioners to private practice.

## **Addendum 1: Responding to the evaluation questions**

This section of the report summarises the findings reported in section 4 in respect to each of the evaluation questions to be addressed by the consultation process.

### **1 To what extent has the Better Access initiative provided access to mental health services for people with mental health disorders? Across all Australia? Across all age groups?**

With the exception of stakeholders providing mental health services to or living in remote communities, all stakeholder groups agreed that the Better Access initiative had improved access to mental health services. While reporting the success of the Better Access initiative stakeholders also 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.

Groups identified by stakeholders as experiencing relatively poorer access included: people on low incomes, people living in socio disadvantage communities, children, youth, older people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities and people with complex care 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 number of stakeholders suggested that some of the growth in services through the Better Access initiative reflected a shift in billing arrangements. It was argued that many AHPs were providing services prior to the Better Access initiative and for clients using these services, access had not improved although affordability had, with a cost shift to Medicare. The online survey of AHPs indicated that 21 per cent of providers had been in practice for less than two years, 29 per cent from two to five years and 50 per cent for six years or more.

A number of Divisions of General Practice indicated that more equitable access would be achieved if utilisation data was available at a Divisional level. This would assist the Divisions in identifying areas of relatively poor access as a basis for the developing and targeting education and awareness strategies, and prioritising mental health training within other areas of training and professional development.

**2 To what extent has the Better Access initiative provided access to affordable care?**

Overall, the MBS rebate has made mental health services more affordable for consumers as it provides a rebate for services, whereas previously the full cost of services was borne by the consumer. For some consumers it has provided access to care with minimal or no out of pocket expenses.

Most AHPs reported that the Better Access initiative allowed them to provide services to some individuals at low or no out of pocket cost to the consumer. This was achieved by charging full fees to those who could afford them. Generally, low or gap fees were provided to individuals whose financial situation had changed during the course of treatment. There were indications from metropolitan areas, that some 'bulk billing' practices had been established using a business model based on achieving high volumes of patient throughput and often using more junior psychologists. How widespread this is was not reported.

AHPs indicated that their fees were set within the recommended fee schedule of the respective professional body and that this had not changed significantly (allowing for CPI growth) following the introduction of the Better Access initiative. Although there were suggestions from some stakeholders that fees for individual providers had increased subsequent to the Better Access initiative, the availability of the MBS rebate meant that the consumer out of pocket expense was reduced. Paradoxically, the out of pocket expenses for the most expensive services (psychiatrists and clinical psychologists) was often less than general psychologists, social workers and occupational therapists, because services provided by psychiatrists and clinical psychologists attracted a higher level of rebate.

Stakeholders and interviewees providing mental health services to, or living in, remote communities reported that the cost of recruiting AHPs to provide 'fly in fly out' services had increased as a result of the Better Access initiative. As services were provided at low or no cost to consumers, this had not affected the cost to consumers but in some instances had reduced service availability. Consumers in remote communities reported that where service availability was reduced as a result of the Better Access initiative, they were either unable to access services or experienced increased travel costs to access services elsewhere.

For consumers with private health insurance it may have reduced out of pocket expenses as the Medicare rebate is higher than the rebate provided by most private health funds. The private health funds consulted indicated that they now paid the rebate to providers once the approved number of sessions through the Better Access initiative (up to 18 sessions per calendar year) was exhausted.

**3 To what extent has the Better Access initiative provided equitable access to populations in need? (in particular people living in rural and remote areas, children and young people, older persons, Indigenous Australians, people from culturally and linguistically diverse backgrounds)**

Improvements in access to mental health services have not been equitable across geographical areas and population groups.

In respect to geographical location the consultations suggest that:

- overall individuals living in metropolitan areas experienced the highest level of access. This was followed by individuals living in regional areas.
- although the number of providers establishing practices in regional and rural centres may be small, because of the few services existing in these areas the impact is relatively large. In some rural communities, the AHP providing services through the Better Access initiative may be the only mental health service available.
- it is likely that there has been little improvement in access to services for people living in remote communities and there are suggestions that the Better Access Initiative may have resulted in reduced access by this population group.
- within metropolitan areas, individuals living in higher socio-economic metropolitan areas enjoyed the highest level of access.
- there is the suggestion that there may be some distribution of services away from lower socio-economic metropolitan areas to exploit the demand growth in higher income areas as a result of the Better Access initiative.

In respect to population characteristics:

- Individuals with anxiety and depression related disorders appear to be the group experiencing the most improvement in access to mental health services.
- Children were the group perceived to be receiving the second most benefit, due to the very few services previously available. However, it must be noted that barriers in access for children still remain in respect to gap payments and range of services that are available through Medicare.
- Young people also benefited because of the limited services previously available. Constraints were identified in respect to gap payments for young people and the appropriateness of a fee for service model of care for this population group. Innovations, such as Headspace, working in conjunction with Better Access appear to be contributing to improved models of care for disadvantaged young people with mental health problems.
- Although older people were reported as a high need group, restricted capacity to provide services in the person's home environment and engagement in multidisciplinary care reduced access by this population and the appropriateness of services that could be provided.

- Most stakeholders and interviewees did not know what difference, if any, the Better Access initiative made to access by Aboriginal and Torres Strait Islander people. Those who provided comment in relation to access by Aboriginal and Torres Strait Islander people, including stakeholders with a responsibility for provision of services to rural and remote communities and Aboriginal and Torres Strait Islander people, suggested that it made little if any difference. Based on perceptions of remote stakeholders, it is likely to have reduced access. Conversely, approvals by the Commonwealth to waive section 19(2) of the Health Insurance for Aboriginal Medical Services may have increased the funding for mental health services by allowing the MBS rebate for Aboriginal Medical Services. The lack of knowledge on access by Indigenous Australian is most likely to reflect the demographic base of the sample surveyed.
- Few stakeholders and interviewees reported improved access by individuals from culturally and linguistically diverse communities. Lack of interpreter services and recognition of extra time involved in providing services for this population group remains a major barrier in access for individuals whose primary language is other than English.
- Individuals with complex needs, requiring more intensive and/or coordinated and multidisciplinary treatment are experiencing poorer access to services through the Better Access initiative. This was as a result of the requirement for more treatment sessions and the MBS item numbers not reflecting the need for case conferencing, care planning and report preparation for this client group<sup>78</sup>.
- AHPs generally perceived themselves as non-discriminatory in managing referrals. A number of AHPs argued that low referrals of special needs groups reflected a failure of GPs to identify, assess and refer individuals to AHPs.
- GPs identified gap payments for AHPs as a barrier in access to referrals and generally sought to understand the specific expertise and fees of the respective AHP prior to making a referral.

#### **4 To what extent has the Better Access initiative provided evidence-based mental health care to people with mental health disorders?**

Most GPs and AHPs perceived the Better Access initiative as providing evidence based care. GPs reported that they received feedback from their patients on the care received from AHPs and referred patients to AHPs they felt provided appropriate and effective care.

AHPs reported that they provided services consistent with principals of best practice and interventions known to work. As a group, psychologists were more likely to cite research and outcome studies to support the interventions employed.

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<sup>78</sup> See note 12 on page **Error! Bookmark not defined.**

Most GPs and AHPs acknowledged that within any professional group there will be a minority of providers providing poor quality or inappropriate care. Generally, it was felt that this should be managed by the respective professional body and/or existing Medicare audit processes.

Approximately ten per cent of stakeholders, primarily psychiatrists and Divisions of General Practice, indicated that without outcome reporting it was difficult to know what services were being provided and questioned the evidence base and effectiveness of many services being provided. Within this group approximately half were highly critical of most aspects of the Better Access initiative.

**5 To what extent has the Better Access initiative provided services that match client needs and expectations?**

Most GPs, AHPs and consumers and carers reported that the Better Access initiative provided services that matched client needs and expectations. The principal area of concern was the restriction of the rebate to 18 sessions per individual per calendar year. This was perceived as inadequate for individuals with more complex and longstanding problems.

GPs reported that, through the assessment and Treatment Plan, they identified the individual patients' needs and used this to make the referral. Information on AHPs was based on information provided by local AHPs or their respective professional bodies and feedback from other patients.

Consumers interviewed generally had positive opinions in relation to their GP with very few (less than five per cent) reporting strongly negative perceptions" ..

Overall though the majority (73 per cent) of respondents reported the information provided in the GP mental Health Care Plan as good or fair and notably, 72 per cent of respondents reported that they had not received inappropriate referrals. (Attachment 1). AHPs also indicated that they undertook a comprehensive client assessment prior to commencing treatment.

Overall AHPs reported that the referrals from GPs were appropriate to the services that they provided.

**6 To what extent has the Better Access initiative improved health outcomes for people with a mental health disorder?**

Nearly all GPs, AHPs, and consumers and carers reported that the Better Access initiative improved health outcomes for individuals with a mental health disorder. As with access to evidence based care, a number of stakeholders raised the issue of how do you know of outcomes being achieved if outcomes are not being measured and reported. As a professional group, psychologists were more likely to report the use of standardised outcome measures as a component of the treatment provided. The APS has undertaken research demonstrating positive outcomes similar to the findings from the consultations and online survey.

It was noted that:

- A small number of psychiatrists expressed concern that the Better Access initiative was resulting in some patients receiving poor quality and/or inappropriate care and that referrals to a psychiatrist were being delayed. These delays meant that patients were not gaining the relief as early as they otherwise would.
- A very small number of GPs expressed concern that some patients were seeking referrals to AHPs unknown to the GP and that they received poor quality care not resulting in any improvement.
- A number of AHPs reported that, because of the Better Access initiative, individuals were able to access their services and were obtaining better outcomes than previously obtained through GPs, psychiatrists and what, at times, was a long period of engagement with the public mental health system.
- A few consumers and carers reported that services received from GPs, psychiatrists or AHPs had not helped or had made matters worse.

The perception of the evaluation is that approximately five per cent of respondents expressed no benefit or a deterioration in outcome because of services provided through the Better Access initiative. The number of respondents reporting no or poor outcomes was very small: these included comments in relation to psychiatrists (from consumers and AHPs), GPs (from AHPs and consumers) and AHPs (from psychiatrists, GPs and consumers). The low number of respondents expressing poor outcomes is similar to the results of the APS survey on client outcomes.

**7 To what extent has the Better Access initiative impacted on the supply and distribution of the psychologist, social worker and occupational therapist workforce?**

The perception of representatives (State and Area Directors) of public mental health providers interviewed was that the Better Access initiative had made it more difficult to attract and retain psychologists. The perceived extent varied across and within States and Territories, with larger states less likely to perceive it as a significant issue. There was only a marginal, if any, perceived impact on social workers or occupational therapists.

Several jurisdictions reported either considering or having implemented changed employment practices for clinical psychologists to facilitate recruitment and retention. These included supporting private practice opportunities.

Several public health representatives reported that they had filled clinical psychology positions with other allied health professionals.

When discussed in interview with clinical psychologists, most disagreed that the Better Access initiative was a reason for clinical psychologists moving from the public mental health system to private practice. They did note however, that the higher and more reliable income available through private practice provided the means to exit the public mental health system and was an incentive for many new practitioners. The principal reasons given by clinical psychologists for leaving the public mental health system to work in private practice included:

- Under resourcing of the public mental health system;
- A deskilling of profession specific skills through working within a generic mental health worker model; and
- A lack of recognition and devaluing of their skills and contribution.

**8 *How has the Better Access initiative interacted with other related programs / initiatives, including the Better Outcomes in Mental Health Program and the More Allied Health Services Program?***

The interaction of the Better Access initiative with ATAPs and MAHS has varied across Divisions of General Practice.

Some Divisions reported no change to the operation of ATAPs and MAHS subsequent to the introduction of the Better Access initiative. GPs continued to determine referrals to these programs based on budget availability and the assessed need of patients (including an informal assessment of the patient's capacity to pay for services through the Better Access initiative)

Other Divisions reported that they had redirected ATAPs and MAHS funding to low income and special needs groups best served on a population basis, for example culturally and linguistically diverse communities, and Indigenous communities.

One Division reported using ATAPs funding to 'top up' or provide additional services after the 18 the Better Access initiative sessions had been exhausted<sup>79</sup>.

**9 *To what extent has the Better Access initiative provided interdisciplinary primary mental health care for people with mental disorders?***

Although most AHPs interviewed indicated that, when required, they would liaise with the GP, NGO or public mental health provider, it was generally agreed across stakeholder groups that the Better Access initiative did not provide well-coordinated interdisciplinary or multidisciplinary care.

Though generally positive in relation to quality of information provided in GP Mental Health Care Plans and reports from the AHP, both GPs and AHPs reported that a proportion of the information being exchanged (possibly up to 20 or 30 per

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<sup>79</sup> This is an inappropriate use of ATAPS funding under MBS guidelines

cent)<sup>80</sup> was perceived as being of a poor quality, with each group being critical of reports being received from the other group. This critique of quality was likely to be a result of self-selection of respondents. GPs and AHPs responding comprised those with a commitment to mental health and a perception of the quality of the reports that they provided and were comparing these to the reports they received from a cross section of providers. As such this would include those who provide less than optimal reports. Further information reported in the consultations corroborating the comments of AHPs and GPs on the perceived quality of reports and documentation exchanged between GPs and AHPs, and some potential reasons for this include:

- A perception of a cross section of stakeholders was that 'point to point' referrals and lack of collaborative care planning did not encourage coordinated care. Though GP Mental Health Care Plans were being completed for the referral, stakeholders raising this issue questioned the degree to which joint planning was occurring. As with the concerns in respect to quality of information being exchanged this was only an issue for a minority of respondents.
- Many AHPs were unclear that the Better Access initiative was part of a multidisciplinary care team and cited privacy concerns as to the reason for not providing information to the GP.
- Many AHPs noted that the Better Access initiative does not provide MBS Item numbers to AHPs to prepare reports, participate in multidisciplinary care planning or provide secondary consultation services.
- During the consultations some GPs were unable to explain and/or indicated that they did not understand the expertise and service offerings of mental health social workers and occupational therapists. This limited their capacity to engage in effective interdisciplinary care.
- Some AHPs lacked an understanding of the roles and capabilities of general practitioners

#### **10 Are professionals aware of how to access appropriate primary mental health care training?**

This is a difficult question to comment on as at the time of evaluation, very little of the planned training had commenced. Interviewees provided isolated instances of the Better Access initiative training initiatives. As a group psychiatrists, GPs and AHPs were aware of what training was being provided and available through their respective professional bodies, but there was little awareness of training specific to the Better Access initiative.

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<sup>80</sup> This is a best estimate from consultations with individuals and groups of GPs and AHPs. Note also all groups indicated that the quality of information being exchanged is improving

The MHPN had only just commenced and key peak organisations had endorsed CPE points for their members. At the time of evaluation the OTA had not been included.

Where the Better Access initiative training had occurred, cross professional training was highly valued as an opportunity for professional networking and information sharing.

The Divisions of General Practice play an important role in the provision of locally based training in primary care, including primary mental health care. There was variation across Divisions in the extent to which they invited other disciplines to participate in the training that they provide. Some Divisions encouraged AHPs to attend primary mental health training, while one only invited public mental health providers to attend.

Of the allied health professional bodies, the APS appeared to be the most organised in respect to clinical training for their members. The AASW also organised clinical training and in one state had arranged information sessions on working in private practice. This was well received and seen as an important step for AHPs transitioning from the public mental health system to private practice. The perception of many of the social workers and occupational therapists interviewed was that as mental health was only one component of the activity provided by their profession their respective representative bodies were not as proactive in supporting mental health training and advocating on their behalf as was the APS.

The relatively low impact of the Better Access initiative on clinical training was reflected in the online surveys. Forty per cent of GPs and 23 per cent of AHPs responding to the survey agreed with the statement that “the Better Access initiative had improved access to clinical training”.

In relation to developing local networking and training opportunities, a significant number of psychologists and social workers thought that the Divisions of General Practice were best placed to coordinate this process.

**11 Are professionals accessing appropriate education and training (for example multidisciplinary or profession specific training)?**

Professional bodies reported that their members are accessing the mental health training that they provide. The scope, frequency and relationship of training to continuing professional development (CPD) and continuing professional education (CPE) points varies across professions and jurisdictions. It would appear that most training is a core component of the function of the professional body and is not a result of the Better Access initiative. Most of the training reported by interviewees appeared to be profession specific and clinically based.

A concern noted by a number of GP and AHP providers is that those professionals whose practice may most benefit from training may be the least likely to access training.

A shared perception of GP representatives and a number of individual GPs was that approximately a third of GPs did not provide or only provided minimal mental health care. This proportion was perceived as higher in rural and remote areas where overall demand pressures are higher; competing demand from patients with acute and chronic physical conditions is higher; and there is a greater proportion of GPs who are overseas trained and may not have had the same exposure to mental health training as Australian trained colleagues and/or a different cultural based perception of mental health. A number of Level-2 trained GPs and a range of GP stakeholders noted that mental health training was not a prerequisite for accreditation with the RACGP<sup>81</sup> and that in training for accreditation, mental health training by overseas trained doctors may be assessed as a relatively low priority. These stakeholders and interviewees also commented that the Better Access initiative removed the financial incentive for GPs to undertake additional mental health training. There is now a requirement for all providers to access ongoing professional development to participate fully in this initiative.

AHPs discussed a similar issue in relation to the varying accreditation requirements across professional groups as to what constituted CPD and the level of CPD required to maintain professional registration and/or accreditation. A number of AHPs perceived an advantage in a common mandatory level of CPD for ongoing accreditation<sup>82</sup>.

## **12 What are the characteristics, including clinical characteristics, of consumers receiving Medicare rebateable Better Access mental health services?**

The view of most psychiatrists, GPs and AHPs was that the Better Access initiative client group primarily reflected the intended population of individuals with high prevalence mental health disorders. Ninety seven per cent of AHPs and 95 per cent of GPs agreed with the statement that “Better Access made services more accessible for individuals with anxiety and depression related mental health disorders”.

During consultations, it was noted that a significant and growing number of individuals with more complex problems are being treated and require more intensive and longer interventions. A number of AHPs reported an apparent expansion of the service into more complex and harder to reach client groups as the Better Access initiative has matured. This has included increasing numbers of middle aged men, older people and people with more complex problems. This was perceived as resulting from increased availability, greater awareness of mental health issues and less stigma associated with seeing an AHP compared to a psychiatrist.

Most AHPs indicated that their client group also included clients with complex and chronic care needs. For these clients the Better Access initiative, although not meeting all the sessions required, did help defray costs. AHPs noted that the

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<sup>81</sup> This comment will be checked with the RACGP for amendment and/or comment in the final report.

<sup>82</sup> The requirement for mandatory ongoing CDP was introduced in the last federal budget and is currently being developed.

differentiator between clients with complex care needs using the Better Access initiative and those using public mental health services was firstly capacity to pay and secondly the ability, or having a friend/family member who can assist them, to manage their own day to day affairs.

A concern expressed by a number of stakeholders was that the Better Access initiative may be, because of location of services and gap fees, primarily servicing more affluent consumers. This could not be ascertained from the self-selected sample of participants in consultations and on line surveys.

### **13 Are professionals, consumers and carers aware of the Better Access initiative?**

All professional bodies and individual providers consulted were well aware of the Better Access initiative.

The RACGP and Divisions of General Practice indicated that significant training and education had been undertaken with the introduction of the Better Access initiative and that most, if not all GPs, would be aware of the initiative. It was noted that, as with other new initiatives, there is a period of phasing in as awareness grows and that this will be reflected in growth in service utilisation and quality of Mental Health Treatment Plans and Treatment Plan Reviews. This was seen as a natural maturing of the Better Access initiative.

By definition, all AHPs consulted were aware of the Better Access initiative as they had sought to become approved providers. As with GPs, the AHP representative bodies and individuals reported a phase-in period and maturing of the Better Access initiative as confusion about item numbers, claiming and reporting were clarified.

Although both GPs and AHPs expressed concern about the quality of information being provided in Mental Health Treatment Plans and reports, it was acknowledged that this was improving, and had improved significantly since the Better Access initiative has been implemented. AHPs expressed concern that the lack of referrals from some GPs suggested an awareness issue.

NGOs and consumers and carers expressed much more concern about the level of GP awareness and cited examples of cases presenting to GPs and not receiving help, being provided with only the option of medication or being refused a referral to an AHP. Action to increase GP awareness was a key recommendation from the consumer consultations.

Public mental health service providers indicated a high level of awareness of the Better Access initiative and perceived the Better Access initiative as complementing the public mental health system and providing referral options for patients. Sixty five per cent of public mental health service providers responding to

the online survey reported that workers in their organisation were aware of the Better Access initiative.

**14 Has the Better Access initiative impacted on the use of medications prescribed for the treatment of mental disorders, in particular anti-depressants?**

Psychiatrists indicated that, as a specialist service, they only received referrals for more complex patients and that the Better Access initiative had not influenced their prescribing practices. A small number of psychiatrists expressed concern that the Better Access initiative may have contributed to delays in patients receiving referral to a psychiatrist and effective treatment.

A number of GP representatives and individual GPs indicated that the influence of pharmaceutical marketing was the major driver of inappropriate prescribing practices and in the words of one GP:

*“Until you get the drug reps out of GP surgeries you will not change inappropriate prescribing”<sup>83</sup>*

Responses from GPs indicated that the Better Access initiative impacted on prescribing practices in four main ways:

- 1 The provision of psychological interventions as an adjunct to medication was identified as consistent with the principles of best practice.
- 2 It provided the option to trial psychological options as an alternative to medication or adjunct to milder medication options (for example lower dose treatments or use of natural remedies).
- 3 For some patients who did not want medication, it provided a ‘supervised and monitored’ treatment option that could be reviewed by the GP and AHP.
- 4 Feedback from the AHP assisted the GP to review medication needs and adjust medications accordingly.

Most of the consumers indicated that the Better Access initiative provided better outcomes than previous medication-only treatments that they had received.

**15 Has the introduction of the Better Access initiative changed how and where professionals practice? (e.g. movement to another location, change from public to private sector, or change in the mix of public and private sector work)**

Psychiatrist and GP stakeholder groups indicated that it is unlikely the Better Access initiative has had any impact on where psychiatrists and GPs practice. One senior public mental health psychiatrist indicated two instances of psychiatrists

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<sup>83</sup> GP stakeholder representative and GP educator in stakeholder interview

returning to part time public practice as a result of the Better Access initiative reducing referrals. This was not perceived as typical by other psychiatrists consulted subsequently.

The rate of increase in the number of psychiatric and GP services provided through the Better Access initiative may be partially explained by a recoding of activity already being undertaken but is suggestive of a change in how services are provided.

- Psychiatrists report the Better Access initiative has increased the number of assessments and reviews being undertaken for patients who continue to be managed by their local GP.
- The increase in GP Mental Health Treatment Plans and Treatment Plan review and referrals to AHPs is suggestive of a real increase in the number of mental health services being provided by GPs.

There is clear indication from public mental health providers and clinical psychologists that the Better Access initiative has corresponded with a shift in clinical psychologists from public to private practice, making it more difficult to recruit and retain clinical psychologists and provide professional supervision by clinical psychologists in the public mental health system. There is less evidence of a corresponding shift for general psychologists, social workers and occupational therapists. This is most likely due to the lower rebate paid for these professions.

The increased demand for AHPs as a result of the Better Access initiative and improved financial viability of private practice appears to have increased the pricing of AHP services through ATAPs and reduced the availability of AHPs to work in remote communities through ATAPs.

There were anecdotal reports that most new practices are establishing in higher socioeconomic areas and that there been some shift in practices from lower socioeconomic areas to more affluent areas to meet increased demand and due to the potential to realise higher 'gap' payments in these areas.

A number of AHPs noted that, in the longer term, the Better Access initiative will impact on training and supervision available in the public mental health system, the area where most practitioners have developed their clinical skills base. They identified the need to develop training and supervision opportunities that extended across the public mental health system and private practice so as to maintain the skills base of new professionals entering private practice.

**16 *Are there any unintended consequences for stakeholders due to the introduction of the Better Access initiative?***

The principal unintended consequences to the Better Access initiative identified by stakeholders and interviewees include:

- A deterioration in access to mental health services in remote areas as a result of increased price competitiveness of providing practice in metropolitan and regional areas, and a reduction in the attractiveness of contracted services through ATAPs in remote areas.
- A number of AHPs and GPs suggesting a more simplified referrals process ( a minority of respondents) suggested that there was the potential that the requirement for a GP Mental Health Treatment Plan, rather than a more simple MBS referral, not requiring a Treatment Plan, may act as a deterrent in access to mental health services due to a reticence of GPs to prepare a Treatment Plan (it was suggested that this may be as a result factors such as as time constraints, mental health awareness, culturally different perceptions of mental health) or in other cases patients not wishing to discuss mental health issues with their GP.
- The potential that the removal of the financial incentives to undertake GP Level Two mental health training is leading to a reduction in GP mental health skills.
- Reduction in supervision and training opportunities for psychologists should there be significant migration of clinical psychologists from the public mental health system to private practice.
- The exclusion of individuals from culturally and linguistically diverse communities from the Better Access initiative through the failure to provide access to the Commonwealth Interpreter Services for AHPs.
- The impediment to multidisciplinary care by not having case conferencing and secondary consultation MBS item numbers available to AHPs.
- The impediment to services to children by not having a secondary consultation MBS item numbers, allowing the AHP to meet with parents without the child present.