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

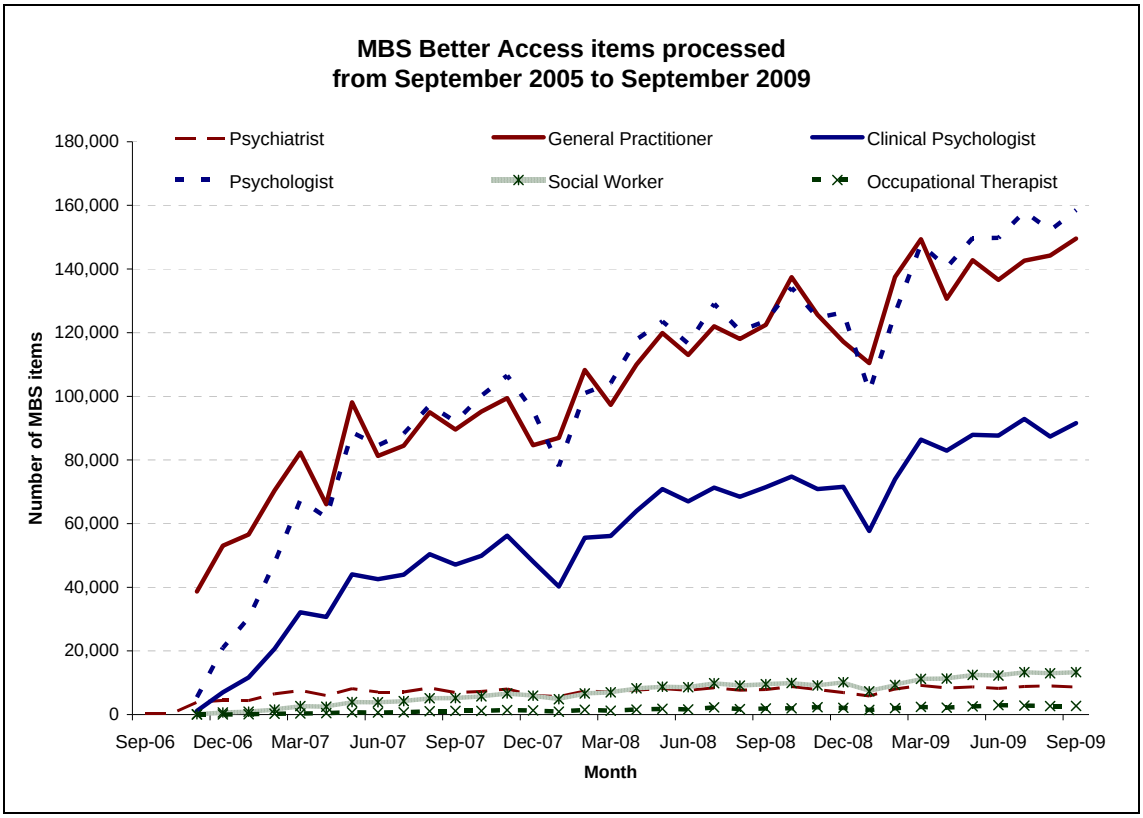


Figure 1 is based on Medicare Australia data and demonstrates continuing high rates of growth for services provided by GPs, psychologists and clinical psychologists. For and GPs, there was a 300 per cent increase in the number of services funded between November 2006 and September 2009. This increase 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[11], 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

[11] 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[12].

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.

[12] 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.[13] 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*"[14].

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:

[13] 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.

[14] 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.*[15]*"*

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.

[15] 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[16] and less than half receiving treatment[17]. 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.

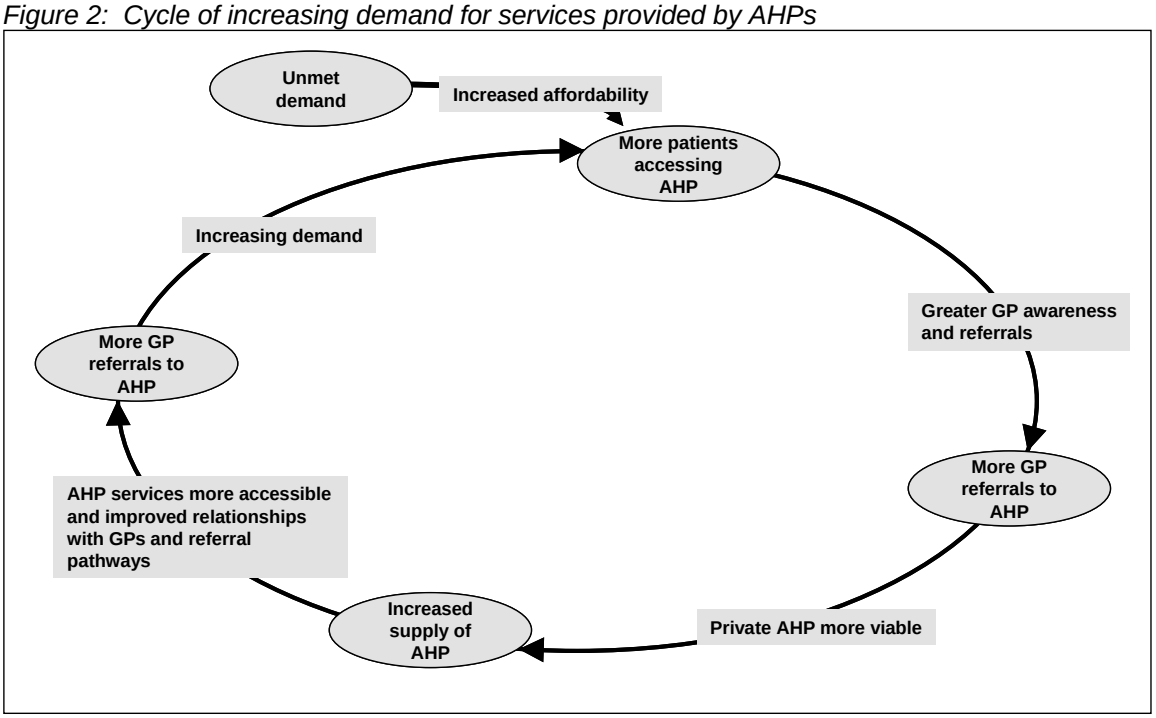
- The increased availability of providers (number of providers and locations serviced) makes services easier to access, leading to more referrals.

- 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.

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 at (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[18], 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,

[18] 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."*[19]

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.

[19] 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[20].) 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.

[20] 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.