

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.^{21 22 23 24} 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).²⁵

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

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

²² 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 p1

²³ 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.

²⁴ 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.

²⁵ 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.²⁶

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 VOIP²⁷ 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:

²⁶ 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/

²⁷ 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 services²⁸ 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.²⁹ 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

²⁸ 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.

²⁹ 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.³⁰

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

³⁰ 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.”*³¹

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.³²

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).

³¹ 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 p 1.

³² 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.³³ 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”.³⁴

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.³⁵

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.³⁶ 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.

³³ Beyond Blue “Depression in the Elderly” Synergy No 2, 2004

³⁴ AIHW (2008)

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

³⁶ 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.³⁷

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

³⁷ 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

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	
• 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	