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 training38, 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.

[38] 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 the 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[39] 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:

[39] 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."[40]

[40] 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".*[41]

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).*[42]

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

[41] Comment by social worker in online survey of allied health professionals.
[42] 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.[43]

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.[44]

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*."[45] Often further complicating these consumers' care is the barrier of language.

[43] 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

[44] URBIS (2008)

[45] 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. [46]

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). [47]

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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[46] URBIS (2008)

[47] 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 series 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[48]. 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[49] (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

[48] It is possible that AHPs over estimate the proportion of poor quality Treatment Plans. AHPs reported that generally Treatment Plans met the MBS requirements.
[49] 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.'[50, 51]

[50] 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[52]

Level of disorder	Per cent
Severe	**35**
Moderate	**46**
Mild	**19**
	100

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.

[51] See note 12 on page 26.
[52] Australian Psychological Society "Survey of members providing Medicare-funded services under the Better Access initiative" InPsych June 2008 p. 36 Provided March 2009