4.5 Service effectiveness

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

4.5.1 Summary of perceptions on effectiveness

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

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

4.5.2 Better client outcomes

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

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

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

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

- The APS conducted a survey of 2,223 clients who had received psychological services under the Better Access initiative.[56] When asked to indicate the level of improvement they had experienced as a result of psychological treatment, 90 per cent of respondents indicated that treatment had resulted in significant (45 per cent) or very significant (45 per cent) improvement. There was no significant difference in perceived effectiveness between clients from different geographical location, socio-economic groups, client gender or age group.

- The Australian College of Clinical Psychologists (ACCP) reported that a survey of its own members demonstrated similar results (as provided during the consultation process). According to the ACCP reported survey, 85 per cent to 99 per cent of patients reported improvement in psychological well being following treatment through the Better Access initiative. The findings from the APS and ACCP surveys are similar to the results of the online survey, reported above.

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

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

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

[53] Carey, Timothy A. Rickwood, Debra J. Baker, Keith. 'What does $27,650,523.80 worth of evidence look like?' Centre for Allied Psychology, University of Canberra, (2009) p 17.
[54] Grant A Blashki, Leon Piterman, Graham N Meadows, David M Clarke, Vasuki Prabaharan, Jane M Gunn and Fiona K Judd, "Impact of an educational intervention on general practitioners' skills in cognitive behavioural strategies: a randomised controlled trial", Medical Journal of Australia (2008) Vol. 188 P. S129.
[55] Carey et al (2009)
[56] APS (2008).

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

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

- Ninety per cent of respondents agreed that the Better Access initiative has contributed to improved outcomes for people with anxiety or depression related disorders, with only six per cent disagreeing and four per cent unsure.

- Sixty five per cent and 64 per cent agreed that improved outcomes are being achieved for older people and for children and young people respectively, with only nine and ten per cent disagreeing.

- Fifty per cent agreeing improved outcomes are being achieved for people with substance abuse disorders and 15 per cent disagreeing.

- Only sixteen per cent agreeing that improved outcomes are being achieved for Aboriginal and Torres Strait islander people or people living in remote communities.

- Approximately one-third of respondents agreeing that improved outcomes are being achieved for people living in rural communities (32 per cent) and people from culturally and linguistically diverse communities (27 per cent).

[57] See note 12 on page 26

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

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

4.5.3 Impact of capped sessions on treatment and outcomes

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

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

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

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

4.6 Mental health care system

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

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

4.6.1 Summary of impact on the mental health system

Most managers of public mental health services reported a perceived migration of psychologists from the public sector to the private sector as a result MBS funding availability through the Better Access initiative. The shift, where reported, was not as great as expected, and a consistent view of psychology organisations and several state and territory health departments was that, where it occurred, it was primarily a move towards a mix of public and private practice. The shift would appear to have been most felt in the smaller states and territories. A concern across public providers and

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

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

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

- responding to capacity to attract gap payments, there may be a relocation of providers to more affluent areas where higher fees can be charged;
- the MBS payments have provided the ability for AHPs to establish practices in areas that would not otherwise be financially viable; and
- that new service models are developing with AHPs co-locating with GP practices to provide a more comprehensive service and facilitate cross referral.

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

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

4.6.2 Impact on public mental health workforce

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

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

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

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

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

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

Table 7: AHPs working in public and private practice

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

[59] This issue may warrant consideration in Component C of the evaluation: Analysis of allied mental health workforce supply and distribution.
[60] Chi-squared 0.58, degrees of freedom = 3, P 0.90

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

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

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

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

[61] Associate Professor John Gleeson, Associate Professor Warrick Brewer, "Implications of the introduction of the Better Access initiative for the public mental health psychology workforce" InPsych June 2008 Accessed 19 March 2009 http://www.psychology.org.au/inpsych/changing_landscape.
[62] Dr Rosemary Kelly, Dr Ruth Perkins "Clinical Psychologists, private practice and employment in the public health sector in Victoria" InPsych June 2008 Accessed 19 March 2009.
[63] Kelly et al (2009)
[64] Carey, Timothy A. Rickwood, Debra J. Baker, Keith. 'What does $27,650,523.80 worth of evidence look like?' Centre for Allied Psychology, University of Canberra, 2009.

associated with the loss of experienced clinical psychologists (particularly that associated with the Better Access initiative) were identified as including:[65]

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

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

[65] Kelly et al (2009)

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

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

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

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

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

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

4.6.3 Distribution of allied health professionals

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

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

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

4.6.4 Interaction with other related programs

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

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

[66] See section 4.3.1 on page 55

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

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

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

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

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

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[67] Note: This may be an inappropriate use of Better Access and ATAPS and in breach of MBS rules.

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

[69] Bassilios et al (2009)

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

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

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

4.7 Skilled, knowledgeable, integrated workforce

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

4.7.1 Summary of impact on workforce and models of care

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

- absence of an MBS item for case conferencing limiting information sharing, integrated care planning and coordinated care;

- a confusion among AHPs about the confidentiality of patient information and the need for greater clarification on exchanging information between AHPs and GPs; and

- limited understanding of the professional roles and capabilities between the different allied health professions, a factor perceived to be limiting referrals to social workers and occupational therapists and the provision of multidisciplinary care.

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

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

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

4.7.2 Provision of interdisciplinary primary mental health care

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

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

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

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

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

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

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

[70] Urbis (2008).

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

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

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

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

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

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

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

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

4.7.3 Access to primary mental health care training

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

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

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

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

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

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

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

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

[71] APS (2008)

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

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

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

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

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

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

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

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

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

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

4.8 Informing the summative evaluation

This section presents the key findings relating to:

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