4.8.1 Summary of summative findings

Although AHPs noted a broad range of clients using services, generally clients tended to have a diagnosis of moderate to severe anxiety or depression, largely reflective of the prevalence of these conditions in the general population. Most services were provided in metropolitan areas, reflective of the geographic dispersion of the population and location of AHPs. Services were mainly provided to adults, with some children, fewer older people and few, if any, individuals in nursing homes receiving services. Access by Aboriginal and Torres Strait Islander people and individuals from culturally and linguistically diverse communities was described as low. Importantly, it was noted by AHPs that they rarely 'turned away' referrals and that the characteristics of individuals receiving services was determined by the referring GPs.

It was generally reported that the Better Access initiative was well established and that psychiatrists, GPs, AHPS and other mental health services in the community were well aware of services available and how the referral process operated. It was noted by GPs and AHPs that referral processes and pathways are continuing to improve as the Better Access initiative matures. There was also a perception by GPs, AHPs, consumers and carers that general awareness in the community as to availability of services through the Better Access initiative was increasing.

Despite the generally positive consumer outcomes reported by AHPs and GPs, the Better Access initiative was perceived by psychiatrists, GPs and AHPs as having minimal, if any, impact on the level of medications prescribed for mental disorders. Generally, it would appear from the consultations that the Better Access initiative operated as a complementary treatment option to pharmacological interventions:

- a small number of GPs noted that referral to an AHP sometimes allowed trialling non medical interventions or a treatment option for patients reluctant to accept medication;

- AHPs noted that some individuals initiating referrals to an AHP did so as they wanted an alternative to medication; and

- a small number of GPs and AHPs also noted that, on occasions, AHPs would refer back to the GP for a medication review to maximise the impact of the psychological therapies.

GPs, consumers and carers identified the 'gap' payment required for services provided by AHPs as an issue. The fee charged by AHPs and subsequent gap payment varied across providers, though many had an informal discounting process for clients in necessitous circumstances. A contentious issue between clinical psychologists, psychologists and social workers was the differential Medicare rebate paid for services provided by clinical psychologists. This was seen to contribute to the 'gap' differential and had the effect of allowing clinical psychologists who received a rebate of $37 to $46 per session more than a psychologist or social worker, to charge a lower gap. The lower 'out of pocket' cost to patients in turn encouraged GPs to refer patients to, and patients to seek referrals to, clinical psychologists. Though a saving to patients, this created a perverse incentive for patients to utilise services that were at a higher cost to

Medicare. The issue of whether clinical psychologists offered a materially different service and achieved better outcomes for patients than did psychologists, social workers or occupational therapists was also questioned by many psychologists and social workers, although this issues was outside of the scope of Component D of the evaluation.

Prior to the Better Access initiative there were a range of counsellors, psychotherapists and therapists providing fee-for-service counselling and therapy services in the community. Representatives of counsellors, psychotherapists and therapists not eligible to be approved providers under the Better Access initiative perceived the MBS rebate available through the initiative as providing an unfair competitive advantage to approved providers and having a detrimental effect on the financial viability of their members. These representative bodies also expressed concern that the Better Access initiative does not provide scope for psychoanalysis and long-term psychotherapy for more severe psychological disorders[72] and that an expansion of eligibility to include their members would expand the availability of services and improve access to services.

The Better Access initiative appears to have had some impact on private health insurers. Insurers consulted supported the Better Access initiative as it was seen as providing better outcomes for their members in the long term and prevented unnecessary hospitalisation. Subsequent to the introduction of the Better Access initiative, where members may have previously accessed psychologists and occupational therapists through their ancillary insurance cover, they can now do so only after they have accessed all services available through Medicare. As per MBS guidelines, ancillary cover is not available to pay the gap between the fee charged and MBS rebate paid.

4.8.2 Characteristics of individuals accessing the Better Access initiative

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

Table 11 below highlights the more general client characteristics reported.

[72] Nor was it the intent of the Better Access initiative to do so, see note 12 on page 26

Table 11: Better Access client characteristics reported by AHPs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- increased awareness that services are available and word of mouth referrals leading to client initiated referrals;

- accessing mental health services is now being seen as more normal and there is reduced stigma associated with seeking mental health care;

- receiving treatment from a AHP carries less stigma than treatment by a psychiatrist; and

- increased penetration and awareness of service availability in the local community and sub groups in the community.

4.8.3 Awareness of the Better Access initiative

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

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

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

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

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

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

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

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

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

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

- A small number of consumer groups, NGO groups and individual consumers reported instances of clients presenting to GPs and not being advised of the availability of the Better Access initiative, but only being offered medication;

- one rural GP receiving the background information on the evaluation through the RACGP and then contacting the evaluation team to request information on how the Better Access initiative worked, reported they were the sole GP across a number of rural communities and had never heard of Better Access;

- All AHPs reporting that a number of referrals they receive from GPs contains minimal documentation, noting this is in a minority of cases and the general level of documentation is improving;

- Most AHPs reporting that in a small number of instances they have received inappropriate referrals from GPs, noting that generally the quality of information is good and that the numbers of inappropriate referrals were perceived as decreasing; and

- All GPs reporting instances of receiving minimal information in documentation and reports from AHPs, again noting that the quality of reporting in improving

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

4.8.4 Impact on use of medications

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

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

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

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

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

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

Table 12: GP services reported as being received by consumers

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

4.8.5 Other consequences

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

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

4.8.6 Differential rebates for allied health providers

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

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

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

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

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

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

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

4.8.7 Impact on non approved counsellors

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

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

- the Better Access initiative does not provide scope for psychoanalysis and long-term psychotherapy for more severe psychological disorders;

- that their professional members who are not clinical psychologists, general psychologists, occupational therapists or social workers are not eligible to provide the Better Access initiative services; and

- the introduction of the Better Access initiative has had a detrimental effect on the professional practices of their members by introducing an element of subsidised competition into the market.

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

4.8.8 Impact on private health insurance

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

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

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

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

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

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

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

- A small number of Divisions of General Practice and individual GPs reported ongoing confusion as to the Better Access initiative MBS item numbers, more so than other areas of the MBS, and identified the need for greater clarity within the MBS itself and/or more training and information from Medicare.

- In small area consultations GPs and AHPs reported that when they contacted Medicare they often received contradictory advice. They identifies a need for clarification and simpler explanations of mental health items within the MBS.

- Several GPs reported that if they code an item 23 (professional attendance – MBS rebate $33.55) and later in the same day (they may have asked the patient to come back for a longer consultation as per the intention of the Better Access initiative) they code an item 2710 for the preparation of a GP Mental Health Treatment Plan (MBS rebate $156.85), the MBS computer system only approves the Item 23. This means that the patient takes the completed Treatment Plan to the AHP who initiates treatment and bills the patient. The patient then presents to Medicare seeking their rebate and is advised that there is no approved Treatment Plan and therefore they are not eligible for a rebate. Additional to the stress and anxiety this causes the patient, it adds another administrative process for the GP and/or AHP who then need to work out what has gone wrong. Several AHPs also reported instances of the client reporting that the payment of the rebate had not been approved though the patient had a Treatment Plan. One consumer also reported a similar instance on non payment when it appeared the paperwork was OK, but that this was 'fixed up' when they talked to the AHP [75]

[75] Though only identified by a few GPs, AHPs and consumers this may be a technical issue warranting further investigation and clarification.

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

4.9 Consumer and carer feedback

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

4.9.1 Summary of findings from consumers and carers

Consumers, carers, and consumer and carer advocacy groups were unanimous in their support for the Better Access initiative. The initiative is highly valued by consumers and carers and perceived as providing improved mental health outcomes. Many consumers and carers reported the benefits that they have realised through services provided through the Better Access initiative as life changing. They feel better, and feel able to take more control over their life; it has improved their life and that of their families. For many consumers with a long history of anxiety or depression, access to psychological therapies through the Better Access initiative has allowed them to gain improvements previously unavailable through their GP, psychiatrist or episodic admissions to a psychiatric hospital. These consumers reported that they are able to return to, or remain in the workforce, and the instances of self harming behaviours have reduced, as have the number of times they have been admitted to hospital because of their mental health problems.

For consumers with higher prevalence disorders who are not able to receive services through the public mental health system, the Better Access initiative provides a rebate for services provided by allied health professionals. Consumers and carers reported that, without this rebate, many consumers would be simply unable to afford and unable to access mental health services, or at least at such an intensive level. Many simply went without services or were reliant solely on their GP for assistance with their mental health problems.

4.9.2 Satisfaction with services

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

Table 14: Consumer perception on degree services met needs

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

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

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

Table 15: Consumer rated likelihood of referring family or friend

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

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

4.9.3 Affordability of services

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

[76] None of the consumers interviewed reported seeing an occupational therapist

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

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

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

Table 16: Consumer perception on affordability of services

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

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

4.9.4 Access to services

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

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

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

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

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

Table 17: Consumer rated availability of services

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

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

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

Table 18: Consumer rated waiting time for services

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

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

Consumers did not generally perceive any changes in the behaviour of their GP as a result of the Better Access initiative, and very few had had formal counselling sessions with them. Consumers interviewed generally had positive opinions in relation to their GP with very few (less than five per cent) reporting strongly negative perceptions. Respondents critical of their GP were those who had no or very limited choice in GPs due to limited availability in their local area.

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

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

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

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

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

4.9.5 Recommendations of consumers

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

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