5 Discussion

5.1 Potential bias within the evaluation findings

A major limitation of the stakeholder consultation process was the reliance on a self-selected sample of representatives of professional bodies, individual mental health service providers and consumers and carers to provide comment on the Better Access initiative.

Almost by definition, the nominees of the respective professional bodies were professionals with a higher level of interest and commitment to mental health and mental health reform than perhaps would be present in a random sample of the membership base. Similarly, individuals participating in the consultations were likely to be those with particularly strong opinions one way or the other, than would occur in a random sample of service providers and consumers and carers. It is also likely that the individual GPs and AHPs consulted were more likely to be professionals who, in their practice, complied with the intent and requirements of the Better Access initiative than might be the case in a random sample of GPs and AHPs. Thus when commenting on quality (including accuracy of diagnosis, comprehensiveness of reports, compliance with the Better Access initiative guidelines) they were likely to be doing so with an expectation that reports from other providers would be reflective of the effort they put into their own.

The GPs providing comment on the quality of AHP reports indicated that they provided comprehensive reports to AHPs, but for many patients they received minimal information in the reports from AHPs. AHPs indicated that they provided comprehensive reports to GPs but for many clients the documentation from GPs was described as providing either minimal or incorrect information. Each professional group is in effect commenting on the broader cross section of documentation that they receive and thus the views of both GPs and AHPs may be consistent and accurate.

Interestingly, there was a strong consistency of findings in respect to key issues from across stakeholder groups, individual providers, consumers, carers and those who may be considered external observers of the Better Access initiative - the NGOs and public mental health providers engaged in the delivery of mental health services. The general consistency in findings increases the likelihood that the findings of the consultations may be generally representative of the wider opinions of GPs, AHPs, consumers, carers and other stakeholders who did not engage in the consultation process.

Within the context of this potential for participant bias the evaluation has not quantified the number of respondents holding a particular view but endeavoured to provide a broad indication of the weight of opinion in relation to specific issues.

5.2 Access and affordability

It would appear from the consultations and volume of services funded through the Better Access initiative that the initiative has improved access to, and affordability of, mental health services in the community. This is also self evident when we consider that a rebate is now provided for services that were previously only available to individuals with a capacity to pay the full cost of private service delivery and a relatively small number of individuals accessing services through private health insurance, ATAPs, MAHS, DVA, Aboriginal Medical Services, workers compensation and other government programs[77]. Not only has the Better Access initiative increased affordability and access to AHPs that were in private practice prior to the initiative, the rebate and increased utilisation has allowed AHPs to expand their practices and new practices to be established, increasing access across geographic areas and to a wider section of the population.

The Better Access initiative is strongly supported by GPs, AHPs, consumers and carers, and is seen as an important step in addressing the needs of individuals with high prevalence disorders in the community. Consumers noted that concurrent with the Better Access initiative, there has been an increasing recognition and acceptance of mental illness in the community, a reduction in the stigma associated with mental illness and an increasing willingness to seek out assistance. The responses from members of organisations such as 'Beyond Blue' were strongly supportive of the initiative and highlighted the difficulties of people with a high prevalence mental illness being able to access affordable mental health services prior to the Better Access initiative.

From GPs, AHPs, consumers and carers, the key consideration was how to improve awareness of, and access to, mental health services for all sections of the community. Public mental health services recognised the value of the Better Access initiative but questioned how well it targeted scarce mental health resources relative to existing unmet need in the community. NGOs valued the contribution of the Better Access initiative to improved options for people with a mental illness, but expressed concern about the needs of people with more complex needs who may not be able to afford the gap payments associated with the Better Access initiative, and require a longer term period of support and intervention than is available through the Better Access initiative.

Organisations representing psychotherapists and counsellors not eligible to receive MBS rebates through the Better Access initiative were supportive of the Better Access initiative in improving access and affordability of mental health services. Their concern was the exclusion of their members and the detrimental impact that the rebate through the Better Access initiative had on their referrals and financial viability of their businesses. They also argued that the expansion of the Better Access initiative to include their members and the services provided would improve access to services.

Contrasting the strong arguments to increase access from GPs, AHPs and consumers, carers and non-approved counsellors was concern expressed by some psychiatrists,

[77] These vary across jurisdictions and include Victims of Crime Compensation, programs for adults removed from their families as children, NGO counselling services, etc.

public mental health providers and NGOs that services through the Better Access initiative were not being targeted to specific high need groups in the community. Some consumers and carers also raised the issue of better targeting of resources.

In short two contrasting views emerged from the consultations. The strongest view supported by nearly all GPs, AHPs, non-approved counsellors, consumers and carers was that strategies should be enacted to increase awareness of, and access to, mental health services through the Better Access initiative. AHPs, consumers, carers and NGOs reported the perception that GP awareness was the key impediment to improving access and that increasing GP awareness would increase the number of people being referred to AHPs.

The gap payment also presented a barrier for many accessing AHP services, with 36 per cent reporting that services were not affordable. Affordability compounded other problems that people from lower socio economic groups, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, people residing in rural and remote areas, young people and the elderly in nursing homes experienced. For these groups there were also practical problems in relation to availability of and access to local linguistically and culturally appropriate services.. There was also some questioning from some stakeholders as to whether the private practitioner model funded through the Better Access initiative, is an appropriate model to engage with, provide services to and achieve the best outcomes for population groups when a broader system approach and greater level of engagement with the wider community may be required.

The overwhelming view of GPs, AHPs, consumers and carers was that nearly all referrals were appropriate and clients received benefit from services provided by an AHP.

5.3 Options discussed to improve access

Most AHPs proposed that access to mental health treatment would be improved by strategies to increase GP awareness of services They argued that equitable access will be achieved through increased awareness of service availability, higher levels of service provision and incentives to address the needs of identified priority population groups (children, youth, older people) and disadvantaged populations (Aboriginal and Torres Trait Islander people, culturally and linguistically diverse communities and remote communities). Such an approach would be likely to further drive demand and maintain or accelerate the high growth trends in services funded through the Better Access initiative. It is likely that most AHPs would be highly resistant to strategies to contain demand growth and/or refocus service priorities.

Contrasting with the arguments to continue to increase access and utilisation was the view of stakeholders not as directly engaged in the Better Access initiative, who felt it was important to consider strategies to better target services to populations most in need. While highly supportive of the Better Access initiative in addressing the needs of individuals with high prevalence disorders, a key concern underlying their view was

that, in the light of high levels of unmet need in the community, resources could be better targeted to achieve equitable access and monitored to ensure effectiveness.

If the Better Access initiative continues unchanged, given the high prevalence of mental health disorder in the population, it is likely that the cycle of demand growth (Figure 2 page 37) driven by increasing numbers of AHPs and consumer awareness and expectations for service will continue.

Although all existing, new and potential consumers benefit from the increased affordability and access to services, this has not resulted in equitable access to services. AHPs report that the Medicare rebate for services provided through the Better Access initiative is insufficient to cover the expense of practice and the recommended fee schedule for all professional groups is higher than the rebate. AHPs indicate a gap payment is required to maintain financial viability. As the MBS rebate is universal, it is easier to develop a client base with the capacity to meet a gap payment and to increase the level of gap payment when services are provided in more affluent areas. Based on the consultations, it is likely that an analysis of postcode of service provider and postcode of service user would demonstrate a disproportionate concentration of AHPs and service utilisation in higher socioeconomic areas.

It is most likely that the increased affordability is currently the main driver for utilisation trends and proponents for continuing to increase referrals argue that as the market becomes saturated with providers, there will be a decline in fees as providers seek to expand the potential market for services, and a gradual dispersal of services to lower socioeconomic areas to capture demand and thus moving to a more equitable distribution of services. A key factor in this is the differential between the MBS scheduled fee and the fee perceived by service providers as offering a financially viable return on the service provided.

However, leaving the market unchecked by supply constraints to improve equity in access carries four major risks:

1. While there is a requirement for a gap payment, some sections of the community will continue to be excluded from services, particularly disadvantaged communities where, because of comorbidities, the time required to consult and liaise with other professionals, the increased likelihood of appointment ‘no shows’, etc., AHPs report that it is not viable to provide low fee or bulk billed services.

2. It is more likely that new and less experienced practitioners entering the market will feel the most pressure to provide services at low cost and locate in lower socioeconomic areas to capture the latent demand and develop caseloads. This may result in the least experienced clinicians endeavouring to manage some of the more complex and difficult to manage clients.

3. As the established markets become saturated with providers, the financial incentive will be to retain existing clients as long as possible and expand the scope of services to include clients not within the client group defined by Medicare. There are already reports of group practices of psychologists establishing with signage

stating they bulk bill for a range of problems including parenting and relationship problems.

4 In view of the high reported prevalence of mental illness into the community, the high rates of growth in the Better Access initiative funded services are likely to continue, in turn consuming a greater proportion of the health budget and displacing higher priority mental health needs funded through capped budget allocations.

There are also some groups in the community for whom most stakeholders and respondents would agree that the current the Better Access initiative service model is not appropriate. These groups as identified through the consultations are:

- *People on a low income*: These people often face the dual difficulty of being unable to afford the gap payment for services that are available and are most likely to be living in communities where there are few, if any, services available and have reduced capacity (because of cost and poor public transport) to travel to areas where services are available.

- *Remote communities:* There is little indication that the Better Access initiative has improved services to residents in rural and remote communities. There is anecdotal evidence that Divisions of General Practice and other outreach service providers (for example public mental health providers, mining companies) are having to increase sessional fee payments to outreach providers in order to compete with the Better Access initiative payments. Within a capped budget, this cost increase leads to a reduction in the volume of services provided. This is compounded by increasing difficulty in attracting staff to provide outreach services as a result of the improving financial viability of their home practices.

- *Aboriginal and Torres Strait Islander communities:* Understanding of, and sensitivity to, the needs of Aboriginal and Torres Strait Islander people and engagement with the community and wider family network is a prerequisite to working in these communities. Challenges in working in these communities is often compounded by the remoteness of the community and need to communicate in the local community language. Services funded on a 'fly in fly out' sessional payment basis are often not appropriate and do not account for the time taken to engage with the community and more systems model of intervention.

- *Culturally and linguistically diverse communities:* Additional to the cultural sensitivities required to work within these communities, there may be language barriers. Currently interpreter fees and time required to work through interpreters are not reflected in the MBS items and rebate.

- *Older people:* The current MBS items do not account for the additional cost of providing services to older people in residential care or their home environment. Nor do they recognise the requirement for multidisciplinary care planning and management required for older people.

- *Children:* The key restriction of the current model is the exclusion of secondary consultation services. There is no MBS item for sessions with the child's family or carers without the child being present, or group work with the child's family or carers.

- *Youth:* Affordability of services for youth was also reported by GPs, NGO mental health providers, AHPS working with youth and consumers. It was also noted by AHPs that while youth had less capacity to pay a gap payment the cost of working with youth can be higher due to more time being required to engage with young adults, higher likelihood of comorbidities (such as drugs) and/or social welfare problems (e.g accommodation, income, employment) requiring engagement with other agencies and professionals and missed appointments.

- *People with complex care needs:* A key issue raised by many stakeholders is that 18 sessions is inadequate for people with long standing and complex care needs and the need for multidisciplinary care planning and secondary consultation to effectively work with this client group.

Issues of access for some of these groups (for example individuals with low prevalence disorders, Aboriginal and Torres Strait Islander people) are compounded by jurisdictional issues relating to which funding body has primary responsibility for service provision to these groups (including OATSIH, DOHA, state and territory health departments).

The consultation process identified a range of potential options to improve access for these groups including:

- managing the allocation of provider numbers on a regional or area basis to ensure service provision in disadvantaged areas;

- increasing the rebate and means testing eligibility to drive supply to lower socio economic areas;

- introducing outcome reporting to monitor and drive effective practice;

- introducing provider audits to ensure services are being provided to the eligible population and requirements of service are complied with;

- holding the rebate constant for existing items and increasing the rebate for services eligible only to selected population groups;

- funding and targeting ATAPS and MAHS to priority population groups;

- introducing secondary consultation MBS items for targeted population groups;

- introducing MBS items for telephone, internet and VOIP services to residents of rural and remote communities or special need groups requiring particular language skills or cultural sensitivities;

- introducing additional items for specific conditions and/or population groups.

How these options relate to the specific population groups are identified in Table 19 below.

Table 19: Options to improve effectiveness and equity in access

Strategy	Low income earners	Remote areas	Aboriginal and Torres Strait Islander people	CALD communities	Older people	Children	Chronic and complex needs
Managing geographic allocation of provider numbers to enhance equity	✓	✓	✓	✓			
Increasing rebate and means testing eligibility	✓						
Introducing outcome reporting to monitor effectiveness	✓	✓	✓	✓	✓	✓	✓
Holding rebate constant on existing MBS items and introducing new MBS items for selected population groups	✓	✓	✓	✓	✓	✓	✓
Enhance funding and target ATAPs and MAHS to priority population groups	✓	✓	✓	✓	✓	✓	✓
Introducing secondary consultation MBS items for targeted population groups		✓	✓	✓	✓	✓	✓
Introducing MBS items for remote telephone, internet and VOIP services to rural and remote areas and special needs groups		✓	✓	✓			

5.4 Appropriateness, effectiveness and evidence based care

Although GPs and AHPs report providing appropriate and effective evidence based care, the lack of outcome reporting and concerns identified in the consultations as to the adequacy of documentation exchanged between providers is suggestive that in some cases the intent and guidelines for the Better Access initiative are not being complied with. As such there may be benefit in a more stringent appraisal of the effectiveness of services being provided. It is expected that this will be undertaken through the random recruitment of providers and consumers into Component A of the evaluation. A greater understanding of clients receiving services and outcomes being achieved, relative to the mix and intensity of services being provided, will better inform the appraisal of options to improve equity in access and target services to maximise outcomes.

The operation of the Better Access initiative in relation to the interface between GPs and psychiatrists appears to be working well and is effective in providing secondary consultation to support and improve the skills and confidence of GPs in managing patients with a mental health disorder.

However, the interface of GPs and AHPs appears to operate primarily on a point-to-point referrals with scope to improve the exchange of information between the GP and treating AHPs. Where clients with more complex problems require coordinated care planning with the GP and or other services (such as PHAMS, HACC, public mental health services, NGOs), there is no MBS item to support this process. This is particularly an issue for providers other than clinical psychologists, where the MBS rebate (and thus average fees that can be charged and capacity to absorb this into general costs) are much lower. The identified need for additional MBS items to foster coordinated care management is discussed in the preceding section.

A theme from the consultations was that where a GP Mental Health Treatment Plan is being undertaken solely as a prerequisite to referral to a AHP and the GP has little ongoing involvement with the patient, or management of the patient's mental health problem, it may be adding an unnecessary cost burden to the Better Access initiative

The intent of the GP Mental Health Treatment Plan was to recognise and renumerate the additional time required to undertake a comprehensive mental health assessment and develop a Treatment Plan. The increase in the number of services provided through this MBS item number has been dramatic, although this increase is subject to artefact given the majority of those with mental health problems in the community have in the past received care from their GP, and a significant proportion of the increase reflects changes in the item numbers rather than an increase in services. Despite this there is an increase in mental health services provided by GPs indicating that one of the objectives of this initiative has been achieved. Further, consumers surveyed generally had positive opinions in relation to their GP with very few (less than five per cent) reporting strongly negative perceptions".

Some GPs also expressed concern about the Plan as a prerequisite for referral and questioned its value when it was being produced to meet the requirements of the referral process, rather than as a tool for assessment and care planning. When its primary purpose was to secure the referral to the AHPs, GPs perceived little value in the Plan and many indicated a simpler referral would be more appropriate.

A number of AHPs and GPs suggested a more simplified referral process (a minority of respondents) and that there was the potential that the requirement for a GP Mental Health Treatment Plan, may itself act as a deterrent in access to mental health services due to a reticence of GPs to prepare a Treatment Plan. It was suggested that this may be as a result of such factors as time constraints, awareness of mental health issues, culturally different perceptions of mental health and/or in other cases patients not wishing to discuss mental health issues with their GP.

Many AHPs proposed that they should be able to receive referrals directly and that the assessment function and ensuring compliance with eligibility criteria transfer from the GP to them. Compliance with guidelines would be regulated in the same way it would be for GPs. Under this proposal, clients may present direct to an AHP or be referred through a GP with or without a Plan. Although improving and streamlining access, this approach may fragment patient care and does not contribute to service integration and coordination, and, most importantly, would remove the current gate keeping role of GPs. It is also most likely to accelerate demand growth and budgetary pressures. Within the context of the National Health and Hospitals Reform Commission's recommendations for a greater reliance on evidence-based outcomes to prioritise resource allocation and the importance of coordinated primary care based on general practice, this may not be a preferred solution.

There would appear to be an argument by some, especially AHPs, to remove the requirement for a GP Mental Health Treatment Plan as a prerequisite to referral to an AHP. A simpler referral, as occurs with other specialist referrals, might lead to some cost savings, but may reduce coordinated and integrated service provision, and remove a key plank of the Better Access Initiative to improve access to GPs for those with mental health problems. Within this model, the GP Mental Health Treatment Plan could be retained as an MBS Item number and the GP may choose to utilise this where they feel the extended consultation and Treatment Plan is a requirement of effective management of the individual presenting patient. Claiming against this MBS item could be monitored in the same way that Medicare monitors and acts to regulate other areas of potential over servicing.

A random audit of GP Mental Health Treatment Plans and AHP reports for comprehensiveness and compliance with guidelines would provide a benchmark measure of the potential savings through a change in the referral requirements and comparator for monitoring claim rates against this item.

A paradox of the Better Access initiative is that clinical psychologists can provide focussed psychological strategies in any setting and attract the same rebate for doing so, unless it is an outreach service in which a marginally higher rebate is payable. Level-2 trained GPs can only receive the higher rebate for provision of approved focussed psychological strategies when these are provided in an accredited GP

practice. This regulation is a legacy of the pre Better Access service model where limiting funding to accredited GP practices served as a proxy indicator of service quality. The result now is that Level-2 trained GPs attract a lower rebate if they provide a mental health service in what may be a more suitable mental health environment that is not an accredited GP practice. It does for example act as a financial barrier to Level-2 trained GPs working within a youth specific Headspace service where they would attract a lower rebate than working in an accredited non-youth and non-mental health specific GP practice. Removing this restriction on Level-2 trained GPs may improve access without a significant impact on cost.

5.5 Workforce education and training

At the time of consultation there had been limited roll-out of the Better Access initiative training to psychiatrists, GPs and AHPs. Professionals were well aware of training opportunities available through their respective professional bodies and how to access them. Professional bodies reported that providers were accessing training.

Where multidisciplinary training was provided, this was welcomed as an opportunity to network, develop referral pathways and importantly share information on the clinical strengths that different professionals bring to mental health care.

A number of psychologists expressed concern that some of the training provided by the APS was too academic and intervention specific, and failed to capture the complexities of managing real patients. Within this context vignette based training was seen as a valuable means to provide new practitioners with the practical skills and referral networks required to develop their practice. For social workers, training in how to develop and operate a private practice was perceived as valuable for a workforce transitioning from employment in the public mental health system to private practice.

Although nearly all providers acknowledged the value of multidisciplinary training, the degree to which this was being implemented at a local level varied. The perception of the evaluation was that, as training was primarily being arranged by the professional bodies, it tended to be profession specific and failed to actively include other professions. Through the MHPN, key peak organisations have endorsed CPE points for their members. It is noted that OTA had not been included at the time of the evaluation.

There was a general recognition of the central role of the Divisions of General Practice in developing primary practice at the local level, and most AHPs agreed with the concept that the Divisions were well placed to facilitate multidisciplinary mental health training at a local level to complement profession specific training developed by the respective professional bodies. A challenge for social workers and occupational therapists was that, as with GPs, mental health was only a small component of activity provided by this professional group. As such a number of social workers did not feel that the AASW and OTA was as proactive in supporting mental health training for their members and advocating on their behalf as was the APS for its members.

- Public mental health providers and a number of psychologists in private practice questioned what impact the reduction of clinical psychologists within the public sector would have on the supervision and training of psychologists in the future. They questioned where the supervision and exposure to a broad range of clients and working within multidisciplinary teams would come from the Better Access initiative appeared also to be impacting on clinical training in universities. It was reported that one university had reduced its supervised training hours requirement because referrals to the university clinic had reduced as a result of the Better Access initiative. A suggestion by several psychologists in private practice was that the development of funded rotational placements across public and private practices would be an important contributor to maintaining training opportunities. Similar issues are likely to affect mental health training for social workers and occupational therapists, if there is a migration of more experienced practitioners to private practice.