Addendum 1: Responding to the evaluation questions

This section of the report summarises the findings reported in section 4 in respect to each of the evaluation questions to be addressed by the consultation process.

1 To what extent has the Better Access initiative provided access to mental health services for people with mental health disorders? Across all Australia? Across all age groups?

With the exception of stakeholders providing mental health services to or living in remote communities, all stakeholder groups agreed that the Better Access initiative had improved access to mental health services. While reporting the success of the Better Access initiative stakeholders also noted that the improvements in access to services and referral pathways did not equally benefit all communities and population groups. All consumer groups and public mental health providers, nearly all GP and psychiatrists and most AHPs noted that some communities and populations benefited more than others and that many communities and population groups experienced barriers in access to service that included affordability of gap payments, service availability and appropriateness of the service model to their particular needs.

Groups identified by stakeholders as experiencing relatively poorer access included: people on low incomes, people living in socio disadvantage communities, children, youth, older people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities and people with complex care needs. The small number of stakeholders from very remote communities suggested that the Better Access initiative made it more difficult to access services because of reduced availability of AHPs to provide ‘fly in fly out’ services through ATAPS or industry supported health care programs.

A number of stakeholders suggested that some of the growth in services through the Better Access initiative reflected a shift in billing arrangements. It was argued that many AHPs were providing services prior to the Better Access initiative and for clients using these services, access had not improved although affordability had, with a cost shift to Medicare. The online survey of AHPs indicated that 21 per cent of providers had been in practice for less than two years, 29 per cent from two to five years and 50 per cent for six years or more.

A number of Divisions of General Practice indicated that more equitable access would be achieved if utilisation data was available at a Divisional level. This would assist the Divisions in identifying areas of relatively poor access as a basis for the developing and targeting education and awareness strategies, and prioritising mental health training within other areas of training and professional development.

2 To what extent has the Better Access initiative provided access to affordable care?

Overall, the MBS rebate has made mental health services more affordable for consumers as it provides a rebate for services, whereas previously the full cost of services was borne by the consumer. For some consumers it has provided access to care with minimal or no out of pocket expenses.

Most AHPs reported that the Better Access initiative allowed them to provide services to some individuals at low or no out of pocket cost to the consumer. This was achieved by charging full fees to those who could afford them. Generally, low or gap fees were provided to individuals whose financial situation had changed during the course of treatment. There were indications from metropolitan areas, that some 'bulk billing' practices had been established using a business model based on achieving high volumes of patient throughput and often using more junior psychologists. How widespread this is was not reported.

AHPs indicated that their fees were set within the recommended fee schedule of the respective professional body and that this had not changed significantly (allowing for CPI growth) following the introduction of the Better Access initiative. Although there were suggestions from some stakeholders that fees for individual providers had increased subsequent to the Better Access initiative, the availability of the MBS rebate meant that the consumer out of pocket expense was reduced. Paradoxically, the out of pocket expenses for the most expensive services (psychiatrists and clinical psychologists) was often less than general psychologists, social workers and occupational therapists, because services provided by psychiatrists and clinical psychologists attracted a higher level of rebate.

Stakeholders and interviewees providing mental health services to, or living in, remote communities reported that the cost of recruiting AHPs to provide 'fly in fly out' services had increased as a result of the Better Access initiative. As services were provided at low or no cost to consumers, this had not affected the cost to consumers but in some instances had reduced service availability. Consumers in remote communities reported that where service availability was reduced as a result of the Better Access initiative, they were either unable to access services or experienced increased travel costs to access services elsewhere.

For consumers with private health insurance it may have reduced out of pocket expenses as the Medicare rebate is higher than the rebate provided by most private health funds . The private health funds consulted indicated that they now paid the rebate to providers once the approved number of sessions through the Better Access initiative (up to 18 sessions per calendar year) was exhausted.

3 To what extent has the Better Access initiative provided equitable access to populations in need? (in particular people living in rural and remote areas, children and young people, older persons, Indigenous Australians, people from culturally and linguistically diverse backgrounds)

Improvements in access to mental health services have not been equitable across geographical areas and population groups.

In respect to geographical location the consultations suggest that:

- overall individuals living in metropolitan areas experienced the highest level of access. This was followed by individuals living in regional areas.
- although the number of providers establishing practices in regional and rural centres may be small, because of the few services existing in these areas the impact is relatively large. In some rural communities ,the AHP providing services through the Better Access initiative may be the only mental health service available.
- it likely that there has been little improvement in access to services for people living in remote communities and there is suggestions that the Better Access Initiative may have resulted in reduced access by this population group.
- within metropolitan areas, individuals living in higher socio-economic metropolitan areas enjoyed the highest level of access.
- there is the suggestion that there may be some distribution of services away from lower socio economic metropolitan areas to exploit the demand growth in higher income areas as a result of the Better Access initiative.

In respect to population characteristics:

- Individuals with anxiety and depression related disorders appear to be the group experiencing the most improvement in access to mental health services.
- Children were the group perceived to be receiving the second most benefit, due to the very few services previously available. However, it must be noted that barriers in access for children still remain in respect to gap payments and range of services that are available through Medicare.
- Young people also benefited because of the limited services previously available. Constraints were identified in respect to gap payments for young people and the appropriateness of a fee for service model of care for this population group. Innovations, such as Headspace, working in conjunction with Better Access appear to be contributing to improved models of care for disadvantaged young people with mental health problems.
- Although older people were reported as a high need group restricted capacity to provide services in the person’s home environment and engagement in multidisciplinary care reduced access by this population and the appropriateness of services that could be provided.

- Most stakeholders and interviewees did not know what difference, if any, the Better Access initiative made to access by Aboriginal and Torres Strait Islander people. Those who provided comment in relation to access by Aboriginal and Torres Strait Islander people, including stakeholders with a responsibility for provision of services to rural and remote communities and Aboriginal and Torres Strait Islander people, suggested that it made little if any difference. Based on perceptions of remote stakeholders, it is likely to have reduced access. Conversely, approvals by the Commonwealth to waive section 19(2) of the Health Insurance for Aboriginal Medical Services may have increased the funding for mental health services by allowing the MBS rebate for Aboriginal Medical Services. The lack of knowledge on access by Indigenous Australian is most likely to reflect the demographic base of the sample surveyed.

- Few stakeholders and interviewees reported improved access by individuals from culturally and linguistically diverse communities. Lack of interpreter services and recognition of extra time involved in providing services for this population group remains a major barrier in access for individuals whose primary language is other than English.

- Individuals with complex needs, requiring more intensive and/or coordinated and multidisciplinary treatment are experiencing poorer access to services through the Better Access initiative. This was as a result of the requirement for more treatment sessions and the MBS item numbers not reflecting the need for case conferencing, care planning and report preparation for this client group[78].

- AHPs generally perceived themselves as non-discriminatory in managing referrals. A number of AHPs argued that low referrals of special needs groups reflected a failure of GPs to identify, assess and refer individuals to AHPs.

- GPs identified gap payments for AHPS as a barrier in access to referrals and generally sought to understand the specific expertise and fees of the respective AHP prior to making a referral.

4 To what extent has the Better Access initiative provided evidence-based mental health care to people with mental health disorders?

Most GPs and AHPs perceived the Better Access initiative as providing evidence based care. GPs reported that they received feedback from their patients on the care received from AHPs and referred patients to AHPs they felt provided appropriate and effective care.

AHPs reported that they provided services consistent with principals of best practice and interventions known to work. As a group, psychologists were more likely to cite research and outcome studies to support the interventions employed.

[78] See note 12 on page **Error! Bookmark not defined.**

Most GPs and AHPs acknowledged that within any professional group there will be a minority of providers providing poor quality or inappropriate care. Generally, it was felt that this should be managed by the respective professional body and/or existing Medicare audit processes.

Approximately ten per cent of stakeholders, primarily psychiatrists and Divisions of General Practice, indicated that without outcome reporting it was difficult to know what services were being provided and questioned the evidence base and effectiveness of many services being provided. Within this group approximately half were highly critical of most aspects of the Better Access initiative.

5 To what extent has the Better Access initiative provided services that match client needs and expectations?

Most GPs, AHPs and consumers and carers reported that the Better Access initiative provided services that matched client needs and expectations. The principal area of concern was the restriction of the rebate to 18 sessions per individual per calendar year. This was perceived as inadequate for individuals with more complex and longstanding problems.

GPs reported that, through the assessment and Treatment Plan, they identified the individual patients' needs and used this to make the referral. Information on AHPs was based on information provided by local AHPs or their respective professional bodies and feedback from other patients.

Consumers interviewed generally had positive opinions in relation to their GP with very few (less than five per cent) reporting strongly negative perceptions"..

Overall though 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. (Attachment 1). AHPs also indicated that they undertook a comprehensive client assessment prior to commencing treatment.

Overall AHPs reported that the referrals from GPs were appropriate to the services that they provided.

6 To what extent has the Better Access initiative improved health outcomes for people with a mental health disorder?

Nearly all GPs, AHPs, and consumers and carers reported that the Better Access initiative improved health outcomes for individuals with a mental health disorder. As with access to evidence based care, a number of stakeholders raised the issue of how do you know of outcomes being achieved if outcomes are not being measured and reported. As a professional group, psychologists were more likely to report the use of standardised outcome measures as a component of the treatment provided. The APS has undertaken research demonstrating positive outcomes similar to the findings from the consultations and online survey.

It was noted that:

- A small number of psychiatrists expressed concern that the Better Access initiative was resulting in some patients receiving poor quality and/or inappropriate care and that referrals to a psychiatrist were being delayed. These delays meant that patients were not gaining the relief as early as they otherwise would.

- A very small number of GPs expressed concern that some patients were seeking referrals to AHPs unknown to the GP and that they received poor quality care not resulting in any improvement.

- A number of AHPs reported that, because of the Better Access initiative, individuals were able to access their services and were obtaining better outcomes than previously obtained through GPs, psychiatrists and what, at times, was a long period of engagement with the public mental health system.

- A few consumers and carers reported that services received from GPs, psychiatrists or AHPs had not helped or had made matters worse.

The perception of the evaluation is that approximately five per cent of respondents expressed no benefit or a deterioration in outcome because of services provided through the Better Access initiative. The number of respondents reporting no or poor outcomes was very small: these included comments in relation to psychiatrists (from consumers and AHPs), GPs (from AHPs and consumers) and AHPs (from psychiatrists, GPs and consumers). The low number of respondents expressing poor outcomes is similar to the results of the APS survey on client outcomes.

7 To what extent has the Better Access initiative impacted on the supply and distribution of the psychologist, social worker and occupational therapist workforce?

The perception of representatives (State and Area Directors) of public mental health providers interviewed was that the Better Access initiative had made it more difficult to attract and retain psychologists. The perceived extent varied across and within States and Territories, with larger states less likely to perceive it as a significant issue. There was only a marginal, if any, perceived impact on social workers or occupational therapists.

Several jurisdictions reported either considering or having implemented changed employment practices for clinical psychologists to facilitate recruitment and retention. These included supporting private practice opportunities.

Several public health representatives reported that they had filled clinical psychology positions with other allied health professionals.

When discussed in interview with clinical psychologists, most disagreed that the Better Access initiative was a reason for clinical psychologists moving from the public mental health system to private practice. They did note however, that the higher and more reliable income available through private practice provided the means to exit the public mental health system and was an incentive for many new practitioners. The principal reasons given by clinical psychologists for leaving the public mental health system to work in private practice included:

- Under resourcing of the public mental health system;
- A deskilling of profession specific skills through working within a generic mental health worker model; and
- A lack of recognition and devaluing of their skills and contribution.

8 How has the Better Access initiative interacted with other related programs / initiatives, including the Better Outcomes in Mental Health Program and the More Allied Health Services Program?

The interaction of the Better Access initiative with ATAPs and MAHS has varied across Divisions of General Practice.

Some Divisions reported no change to the operation of ATAPs and MAHS subsequent to the introduction of the Better Access initiative. GPs continued to determine referrals to these programs based on budget availability and the assessed need of patients (including an informal assessment of the patient's capacity to pay for services through the Better Access initiative)

Other Divisions reported that they had redirected ATAPs and MAHS funding to low income and special needs groups best served on a population basis, for example culturally and linguistically diverse communities, and Indigenous communities.

One Division reported using ATAPs funding to 'top up' or provide additional services after the 18 the Better Access initiative sessions had been exhausted[79].

9 To what extent has the Better Access initiative provided interdisciplinary primary mental health care for people with mental disorders?

Although most AHPs interviewed indicated that, when required, they would liaise with the GP, NGO or public mental health provider, it was generally agreed across stakeholder groups that the Better Access initiative did not provide well-coordinated interdisciplinary or multidisciplinary care.

Though generally positive in relation to quality of information provided in GP Mental Health Care Plans and reports from the AHP, both GPs and AHPs reported that a proportion of the information being exchanged (possibly up to 20 or 30 per

[79] This is an inappropriate use of ATAPS funding under MBS guidelines

cent)[80] was perceived as being of a poor quality, with each group being critical of reports being received from the other group. This critique of quality was likely to be a result of self-selection of respondents. GPs and AHPs responding comprised those with a commitment to mental health and a perception of the quality of the reports that they provided and were comparing these to the reports they received from a cross section of providers. As such this would include those who provide less than optimal reports. Further information reported in the consultations corroborating the comments of AHPs and GPs on the perceived quality of reports and documentation exchanged between GPs and AHPs, and some potential reasons for this include:

- A perception of a cross section of stakeholders was that 'point to point' referrals and lack of collaborative care planning did not encourage coordinated care. Though GP Mental Health Care Plans were being completed for the referral, stakeholders raising this issue questioned the degree to which joint planning was occurring. As with the concerns in respect to quality of information being exchanged this was only an issue for a minority of respondents.

- Many AHPs were unclear that the Better Access initiative was part of a multidisciplinary care team and cited privacy concerns as to the reason for not providing information to the GP.

- Many AHPs noted that the Better Access initiative does not provide MBS Item numbers to AHPs to prepare reports, participate in multidisciplinary care planning or provide secondary consultation services.

- During the consultations some GPs were unable to explain and/or indicated that they did not understand the expertise and service offerings of mental health social workers and occupational therapists. This limited their capacity to engage in effective interdisciplinary care.

- Some AHPs lacked an understanding of the roles and capabilities of general practitioners

10 Are professionals aware of how to access appropriate primary mental health care training?

This is a difficult question to comment on as at the time of evaluation, very little of the planned training had commenced. Interviewees provided isolated instances of the Better Access initiative training initiatives. As a group psychiatrists, GPs and AHPs were aware of what training was being provided and available through their respective professional bodies, but there was little awareness of training specific to the Better Access initiative.

[80] This is a best estimate from consultations with individuals and groups of GPs and AHPs. Note also all groups indicated that the quality of information being exchanged is improving

The MHPN had only just commenced and key peak organisations had endorsed CPE points for their members. At the time of evaluation the OTA had not been included.

Where the Better Access initiative training had occurred, cross professional training was highly valued as an opportunity for professional networking and information sharing.

The Divisions of General Practice play an important role in the provision of locally based training in primary care, including primary mental health care. There was variation across Divisions is the extent to which they invited other disciplines to participate in the training that they provide. Some Divisions encouraged AHPs to attend primary mental health training, while one only invited public mental health providers to attend.

Of the allied health professional bodies, the APS appeared to be the most organised in respect to clinical training for their members. The AASW also organised clinical training and in one state had arranged information sessions on working in private practice. This was well received and seen as an important step for AHPs transitioning from the public mental health system to private practice. The perception of many of the social workers and occupational therapists interviewed was that as mental health was only one component of the activity provided by their profession their respective representative bodies were not as proactive in supporting mental health training and advocating on their behalf as was the APS.

The relatively low impact of the Better Access initiative on clinical training was reflected in the online surveys. Forty per cent of GPs and 23 per cent of AHPs responding to the survey agreed with the statement that “the Better Access initiative had improved access to clinical training”.

In relation to developing local networking and training opportunities, a significant number of psychologists and social workers thought that the Divisions of General Practice were best placed to coordinate this process.

11 Are professionals accessing appropriate education and training (for example multidisciplinary or profession specific training)?

Professional bodies reported that their members are accessing the mental health training that they provide. The scope, frequency and relationship of training to continuing professional development (CPD) and continuing professional education (CPE) points varies across professions and jurisdictions. It would appear that most training is a core component of the function of the professional body and is not a result of the Better Access initiative. Most of the training reported by interviewees appeared to be profession specific and clinically based.

A concern noted by a number of GP and AHP providers is that those professionals whose practice may most benefit from training may be the least likely to access training.

A shared perception of GP representatives and a number of individual GPs was that approximately a third of GPs did not provide or only provided minimal mental health care. This proportion was perceived as higher in rural and remote areas where overall demand pressures are higher; competing demand from patients with acute and chronic physical conditions is higher; and there is a greater proportion of GPs who are overseas trained and may not have had the same exposure to mental health training as Australian trained colleagues and/or a different cultural based perception of mental health. A number of Level-2 trained GPs and a range of GP stakeholders noted that mental health training was not a prerequisite for accreditation with the RACGP[81] and that in training for accreditation, mental health training by overseas trained doctors may be assessed as a relatively low priority. These stakeholders and interviewees also commented that the Better Access initiative removed the financial incentive for GPs to undertake additional mental health training. There is now a requirement for all providers to access ongoing professional development to participate fully in this initiative.

AHPs discussed a similar issue in relation to the varying accreditation requirements across professional groups as to what constituted CPD and the level of CPD required to maintain professional registration and/or accreditation. A number of AHPs perceived an advantage in a common mandatory level of CPD for ongoing accreditation[82].

12 *What are the characteristics, including clinical characteristics, of consumers receiving Medicare rebateable Better Access mental health services?*

The view of most psychiatrists, GPs and AHPs was that the Better Access initiative client group primarily reflected the intended population of individuals with high prevalence mental health disorders. Ninety seven per cent of AHPs and 95 per cent of GPs agreed with the statement that “Better Access made services more accessible for individuals with anxiety and depression related mental health disorders”.

During consultations, it was noted that a significant and growing number of individuals with more complex problems are being treated and require more intensive and longer interventions. A number of AHPs reported an apparent expansion of the service into more complex and harder to reach client groups as the Better Access initiative has matured. This has included increasing numbers of middle aged men, older people and people with more complex problems. This was perceived as resulting from increased availability, greater awareness of mental health issues and less stigma associated with seeing an AHP compared to a psychiatrist.

Most AHPs indicated that their client group also included clients with complex and chronic care needs. For these clients the Better Access initiative, although not meeting all the sessions required, did help defray costs. AHPs noted that the

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[81] This comment will be checked with the RACGP for amendment and/or comment in the final report.
[82] The requirement for mandatory ongoing CDP was introduced in the last federal budget and is currently being developed.

differentiator between clients with complex care needs using the Better Access initiative and those using public mental health services was firstly capacity to pay and secondly the ability, or having a friend/family member who can assist them, to manage their own day to day affairs.

A concern expressed by a number of stakeholders was that the Better Access initiative may be, because of location of services and gap fees, primarily servicing more affluent consumers. This could not be ascertained from the self-selected sample of participants in consultations and on line surveys.

13 Are professionals, consumers and carers aware of the Better Access initiative?

All professional bodies and individual providers consulted were well aware of the Better Access initiative.

The RACGP and Divisions of General Practice indicated that significant training and education had been undertaken with the introduction of the Better Access initiative and that most, if not all GPs, would be aware of the initiative. It was noted that, as with other new initiatives, there is a period of phasing in as awareness grows and that this will be reflected in growth in service utilisation and quality of Mental Health Treatment Plans and Treatment Plan Reviews. This was seen as a natural maturing of the Better Access initiative.

By definition, all AHPs consulted were aware of the Better Access initiative as they had sought to become approved providers. As with GPs, the AHP representative bodies and individuals reported a phase-in period and maturing of the Better Access initiative as confusion about item numbers, claiming and reporting were clarified.

Although both GPs and AHPs expressed concern about the quality of information being provided in Mental Health Treatment Plans and reports, it was acknowledged that this was improving, and had improved significantly since the Better Access initiative has been implemented. AHPs expressed concern that the lack of referrals from some GPs suggested an awareness issue.

NGOs and consumers and carers expressed much more concern about the level of GP awareness and cited examples of cases presenting to GPs and not receiving help, being provided with only the option of medication or being refused a referral to an AHP. Action to increase GP awareness was a key recommendation from the consumer consultations.

Public mental health service providers indicated a high level of awareness of the Better Access initiative and perceived the Better Access initiative as complementing the public mental health system and providing referral options for patients. Sixty five per cent of public mental health service providers responding to

the online survey reported that workers in their organisation were aware of the Better Access initiative.

14 Has the Better Access initiative impacted on the use of medications prescribed for the treatment of mental disorders, in particular anti-depressants?

Psychiatrists indicated that, as a specialist service, they only received referrals for more complex patients and that the Better Access initiative had not influenced their prescribing practices. A small number of psychiatrists expressed concern that the Better Access initiative may have contributed to delays in patients receiving referral to a psychiatrist and effective treatment.

A number of GP representatives and individual GPs indicated that the influence of pharmaceutical marketing was the major driver of inappropriate prescribing practices and in the words of one GP:

> *"Until you get the drug reps out of GP surgeries you will not change inappropriate prescribing"*[83]

Responses from GPs indicated that the Better Access initiative impacted on prescribing practices in four main ways:

1. The provision of psychological interventions as an adjunct to medication was identified as consistent with the principles of best practice.
2. It provided the option to trial psychological options as an alternative to medication or adjunct to milder medication options (for example lower dose treatments or use of natural remedies).
3. For some patients who did not want medication, it provided a 'supervised and monitored' treatment option that could be reviewed by the GP and AHP.
4. Feedback from the AHP assisted the GP to review medication needs and adjust medications accordingly.

Most of the consumers indicated that the Better Access initiative provided better outcomes than previous medication-only treatments that they had received.

15 Has the introduction of the Better Access initiative changed how and where professionals practice? (e.g. movement to another location, change from public to private sector, or change in the mix of public and private sector work)

Psychiatrist and GP stakeholder groups indicated that it is unlikely the Better Access initiative has had any impact on where psychiatrists and GPs practice. One senior public mental health psychiatrist indicated two instances of psychiatrists

[83] GP stakeholder representative and GP educator in stakeholder interview

returning to part time public practice as a result of the Better Access initiative reducing referrals. This was not perceived as typical by other psychiatrists consulted subsequently.

The rate of increase in the number of psychiatric and GP services provided through the Better Access initiative may be partially explained by a recoding of activity already being undertaken but is suggestive of a change in how services are provided.

- Psychiatrists report the Better Access initiative has increased the number of assessments and reviews being undertaken for patients who continue to be managed by their local GP.
- The increase in GP Mental Health Treatment Plans and Treatment Plan review and referrals to AHPs is suggestive of a real increase in the number of mental health services being provided by GPs.

There is clear indication from public mental health providers and clinical psychologists that the Better Access initiative has corresponded with a shift in clinical psychologists from public to private practice, making it more difficult to recruit and retain clinical psychologists and provide professional supervision by clinical psychologists in the public mental health system. There is less evidence of a corresponding shift for general psychologists, social workers and occupational therapists. This is most likely due to the lower rebate paid for these professions.

The increased demand for AHPs as a result of the Better Access initiative and improved financial viability of private practice appears to have increased the pricing of AHP services through ATAPs and reduced the availability of AHPs to work in remote communities through ATAPs.

There were anecdotal reports that most new practices are establishing in higher socioeconomic areas and that there been some shift in practices from lower socioeconomic areas to more affluent areas to meet increased demand and due to the potential to realise higher 'gap' payments in these areas.

A number of AHPs noted that, in the longer term, the Better Access initiative will impact on training and supervision available in the public mental health system, the area where most practitioners have developed their clinical skills base. They identified the need to develop training and supervision opportunities that extended across the public mental health system and private practice so as to maintain the skills base of new professionals entering private practice.

16 Are there any unintended consequences for stakeholders due to the introduction of the Better Access initiative?

The principal unintended consequences to the Better Access initiative identified by stakeholders and interviewees include:

- A deterioration in access to mental health services in remote areas as a result of increased price competitiveness of providing practice in metropolitan and regional areas, and a reduction in the attractiveness of contracted services through ATAPs in remote areas.

- A number of AHPs and GPs suggesting a more simplified referrals process (a minority of respondents) suggested that there was the potential that the requirement for a GP Mental Health Treatment Plan, rather than a more simple MBS referral, not requiring a Treatment Plan, may 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 factors such as as time constraints, mental health awareness, culturally different perceptions of mental health) or in other cases patients not wishing to discuss mental health issues with their GP.

- The potential that the removal of the financial incentives to undertake GP Level Two mental health training is leading to a reduction in GP mental health skills.

- Reduction in supervision and training opportunities for psychologists should there be significant migration of clinical psychologists form the public mental health system to private practice.

- The exclusion of individuals from culturally and linguistically diverse communities from the Better Access initiative through the failure to provide access to the Commonwealth Interpreter Services for AHPs.

- The impediment to multidisciplinary care by not having case conferencing and secondary consultation MBS item numbers available to AHPs.

- The impediment to services to children by not having a secondary consultation MBS item numbers, allowing the AHP to meet with parents without the child present.