

Summary of consultation with stakeholders

Mental health in Australia

In 2007 a National Survey of Mental Health and Wellbeing found that one in five Australians aged 16 years and over had experienced symptoms of a mental disorder in the preceding 12 months, while an estimated 7.3 million Australians (45 per cent of the population aged between 16 and 85 years) had experienced a mental disorder at some time during their lives.¹

The 2007 survey also found that:²

- in the preceding 12 months, 14.4 per cent of people aged between 16 and 85 had experienced anxiety disorders, 6.2 per cent had experienced affective disorders and 5.1 per cent had experienced substance use disorders
- more than a quarter (26 per cent) of the youngest age group (16–24 years) had experienced symptoms of a mental disorder in the previous 12 months
- anxiety disorders were the most prevalent disorders in all age groups
- mental disorders were more common among people with chronic physical health conditions than among those with no such conditions (28 per cent compared to 18 per cent).

Mental health services in Australia

Services are offered through primary care and specialised mental health services. Primary care includes general practice, community nurses and allied health professionals. Specialised mental health services include private psychiatrists, public community-based mental health services, public and private acute and psychiatric hospitals, and specialised residential mental health care facilities.

The 2007 survey found that, for the estimated 3.2 million Australians aged between 16 and 85 having symptoms of a mental disorder in the preceding 12 months³:

- only 34.9 per cent had accessed services for their symptoms
- general practice was the most common service accessed (24.7 per cent)
- women, people aged 35 years and over, and people living in major cities were more likely to have accessed services
- people with affective disorders characterised by dramatic or extreme changes in mood were more likely to have accessed services (49.7 per cent) than those with anxiety disorders (22 per cent), despite the latter being more prevalent.

¹ Australian Institute of Health and Welfare. "Mental health services in Australia 2006-07". *Mental Health Series* Number 11, August 2009.

² Australian Bureau of Statistics *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*. October 2008.

³ Australian Bureau of Statistics, 2008, op.cit.

Even though people with mental disorders usually access general practice health services, there are numerous barriers to GPs providing quality mental health care services. These barriers include:

- the time required for Level Two trained GPs to perform appropriate assessments and deliver strategies, especially within the context of a busy fee-for-service practice
- inadequate education and training options
- poor access to specialist support.⁴

Better Access seeks to address these barriers, and thereby make mental health services for common mental disorders more accessible.

Better Access—summary

Better Access began in November 2006 to encourage general practitioners to work collaboratively with specialists and allied mental health professionals to improve patient outcomes in mental health. It:

- encourages more GPs to participate in providing mental health services—and streamlines access to appropriate primary care
- encourages private psychiatrists to see more new patients
- improves the availability and affordability of psychological services provided by psychologists, social workers and occupational therapists in private practice
- provides education and training to GPs and primary care service providers to better diagnose and treat mental illness.

Better Access is achieving these objectives through two key mechanisms:

- changes and additions to the Medicare Benefits Schedule (MBS)
- funding for education and training for the mental health workforce.

Changes to the MBS

GPs can provide early intervention, assessment and management of people with mental disorders, and refer them to community based mental health care providers, using the changed MBS items.

GPs are better remunerated for the time to effectively manage and provide quality mental health care to their patients. The new items are:

- the Preparation of a GP Mental Health Treatment Plan (item 2710)
- the Review of the GP Mental Health Treatment Plan (item 2712)
- the GP Mental Health Treatment Consultation (item 2713) which supports ongoing management of patients with mental disorders, through extended consultation

⁴ Australian General Practice Network 2007 *Better Access initiative Orientation Manual*, ACT, Australia.

provisions for patients with a primary diagnosis related to a mental disorder.

There were no mandated training requirements for GPs related to the use of these new items when the initiative was introduced.

Better consultation and liaison between GPs and psychiatrists is encouraged through:

- a new item for psychiatrist consultation with a new patient referred by a GP (item 296)
- expanded rebates for existing items for psychiatrists related to patient assessment and preparation or review of a treatment plan to be carried out by a GP (items 291 and 293).

There are new items for allied mental health services. These are available to allied health professionals who have registered with Medicare Australia, and satisfied specific eligibility criteria:

- psychological therapy and focused psychological strategies (FPS)⁵
 - provided by eligible clinical psychologists: items 80000, 80005, 80010, 80015 and 80020
 - provided by psychologists: items 80100, 80105, 80110, 80115 and 80120
 - provided by social workers: items 80150, 80155, 80160, 80165, 80170 and 81005
 - provided by occupational therapists: items 80125, 80130, 80135, 80140 and 80145.

These items are subject to referral from GPs, psychiatrists and paediatricians, in accordance with a GP Mental Health Treatment Plan or psychiatrist assessment and treatment plan. The services are capped at 12 per calendar year. Additional services are available to people for exceptional circumstances.

The 2009–10 Federal Budget announced two new measures under Better Access:

1. Continuing Professional Development (CPD).

From 1 July 2011 all general psychologists, social workers and occupational therapists must meet mandatory CPD requirements to be able to access the MBS items when providing FPS services under Better Access.

2. Improved targeting for the most in need and better quality of services.

This measure consists of three elements:

- changing the name of the 'GP Mental Health Care Plan' to 'GP Mental Health Treatment Plan' to better reflect what it does
- requiring GPs to include a diagnosis of a mental disorder in the plan
- introducing a new Medicare item for GPs who have not completed Mental Health Skills Training.

⁵ MBS item numbers

The mental disorders covered by the new MBS provisions are:⁶

- alcohol use disorders
- chronic psychotic disorders
- bipolar disorder
- phobic disorders
- generalised anxiety
- adjustment disorder
- unexplained somatic complaints
- eating disorders
- sexual disorders
- conduct disorder
- bereavement disorders
- drug use disorders
- acute psychotic disorders
- depression
- panic disorder
- mixed anxiety and depression
- dissociative (conversion) disorder
- neurasthenia
- sleep problems
- hyperkinetic (attention deficit) disorder
- enuresis
- mental disorder, not otherwise specified

Education and training

Better Access seeks to improve outcomes for people with mental health disorders by funding the education and training for the mental health workforce. This includes education and training activities to:

- increase awareness of MBS changes to improve access to mental health services
- provide multidisciplinary opportunities to develop referral networks and foster interdisciplinary care between health care providers
- improve the expertise of providers in working within multidisciplinary teams and promoting best practice.

Other programs

The Better Outcomes in Mental Health Care program (BOiMH) is an Australian Government program that improves community access to quality primary mental health care.

It has two components:

1. Access to Allied Psychological Services (ATAPS) which enables GPs to refer consumers to allied health professionals who deliver focused psychological strategies.
2. GP Psych Support which gives GPs access to patient management advice from psychiatrists.

⁶ *ibid.*

GPs cannot refer patients to allied health professionals through the Better Access initiative and ATAPs at the same time. However treatment can be provided through both programs within a single calendar year, if the total number of services provided under both does not exceed the maximum allowed.

GPs who provide focused psychological strategies themselves, rather than referring patients to allied health professionals, must undertake Level One and Level Two training accredited by the General Practice Mental Health Standards Collaboration.

Other national programs that provide primary mental health care include the Mental Health Nurse Incentive Program, the More Allied Health Services Program and the Mental Health Services in Rural and Remote Areas initiative.

Better Access complements these programs to make mental health services more widely accessible and affordable.

The evaluation

The Department of Health and Ageing (DoHA) engaged external consultants to assist with the evaluation of the Better Access initiative. The evaluation has assessed the accessibility, appropriateness and effectiveness of mental health care provided under Better Access. The six components of the evaluation are:

Table 1 – Components of the Evaluation of the Better Access initiative

Evaluation component/ domain		Access	Appropriateness	Effectiveness	Impact on health system	Skilled, knowledgeable, integrated workforce
A	A study of consumers & their outcomes	✓	✓✓	✓✓	✓	-
B	Analysis of MBS and PBS data	✓✓	✓	-	✓✓	-
C	Analysis of allied health workforce supply & distribution	✓✓	-	-	✓✓	-
D	Stakeholder consultation	✓✓	✓✓	✓	✓✓	✓✓
E	Evaluation of major education and training projects	-	✓	-	✓	✓✓
F	Analysis of Second National Survey of Mental Health and Wellbeing	✓✓	✓✓	-	-	-

KPMG carried out the evaluation of Component D—Stakeholder consultation. The objective was to understand:

- the perceived benefits and experiences of stakeholders about access, appropriateness and effectiveness of the services
- the impact of education and training undertaken as part of Better Access on the treatment of patients
- how Better Access interacts with other related programs.

The methodology

The project used a number of methods to consult with stakeholders, including:

- individual and small group interviews conducted either face-to-face or by teleconference
- workshops and focus groups
- online surveys.

These methods and the types of stakeholders are shown in the following table:

Table 2 – Stakeholder types consulted and mechanisms of consultation

Stakeholder type	Mechanism and approximate number of persons (N) consulted ⁷
National peak agencies (including non-approved providers)	Individual consultations— face-to-face/teleconferences, N = 53 2 submissions
State/territory peak agencies (including non-approved providers)	Individual consultations— face-to-face/teleconferences, N = 20
NGO mental health service providers	Specific NGO workshops (Brisbane, Darwin, Alice Springs, Perth) and interviews, N = 15 Small area workshops, N = 5 Online survey, N = 48
Public mental health service providers	Individual consultations with jurisdictional Health Department representatives—face to face/teleconference , N = 20 Small area workshops, N = 5 Online survey , N = 230 One submission
Private inpatient mental health services	Individual consultations— face-to-face/teleconferences, N = 15
Private health insurers	Contact with individual insurers lead to three written responses to the evaluation questions
Individual private providers (including psychiatrists and approved allied health providers)	Individual (or small group) consultations—face-to-face/ teleconferences, N = 17 Small area workshops, N = 26 Online survey, N = 418 2 submissions
General practitioners	Individual (or small group) consultations— face-to-face/ teleconferences (excluding national and state peak agencies), N = 15 Small area workshops, N = 12 Online survey , N = 193

⁷ Numbers are approximate and though individuals are only counted once they may have represented multiple organisations.

Stakeholder type	Mechanism and approximate number of persons (N) consulted ⁷
Consumers and carers	Carer and consumer small group workshops, interviews and teleconferences, N = 57 Small area workshops, N = 3 Online survey (specific surveys for consumers and carers), N = 155

The project received many unsolicited contacts and submissions from individual practitioners and representatives of smaller organisations such as individual approved and non-approved providers, sub-specialty groups such as grief and bereavement counsellors and private practice psychologists groups. These direct contacts were responded to by telephone interviews.

The consultation

Consultation was done at a national, state and, where relevant, regional and sub-regional level, ensuring a broad cross section of stakeholders. More than 1200 people were consulted: AHPs, GPs and psychiatrists, public mental health providers, NGO mental health providers, private mental health hospitals, health insurers, consumers and carers.

This report presents a summary of consultation undertaken to the end of August 2009.

Who was consulted?

Psychiatrists. A total of 31 psychiatrists took part:

- 24 psychiatrists: consulted (including representatives of RANZCP, the public mental health service and private practice/hospitals)
- 7 psychiatrists: online survey

Paediatricians:

- RACP: consulted
- 2 paediatricians: online survey

GPs. A total of 220 GPs or their representatives took part:

- 11 reps of GP peak bodies: face-to-face or telephone consultation
- 4 GPs: conversations
- 15 GPs or GP reps: consulted through small area consultation or in person (3 from rural areas)
- 193 GPs: online survey

NGOs:

- 15 NGO reps: face-to-face and teleconference and small area consultation
- 48 NGOs: online survey

Psychologists. A total of 307 psychologists took part:

- 30 psychologists or reps: face-to-face and telephone
- 17 psychologists: small area consultation or rural/remote teleconference
- 260: online survey (half were clinical psychologists)

Social workers. A total of 168 Social workers or their representatives took part:

- 2 reps of peak bodies: face-to-face
- 10: small area consultations or rural/remote teleconference
- 5: telephone
- 150: online survey

Occupational therapists:

- 10: telephone or face-to-face
- 1: online survey

Public mental health providers:

- 20 reps of state/territory mental health branches: teleconference or face-to-face
- 230: online survey
- 1: submission

Non-accredited mental health providers:

- 10 reps: consulted (some were also approved Medicare providers e.g. a psychologist who was a member of an association representing psychotherapists)
- 1 practitioner: telephone interview
- 2 organisations: submissions

Consumers and carers: A total of 215 consumers and carers or their representatives took part:

- 60: face-to-face, small groups and teleconferences
- 125 consumers: online survey
- 30 carers: online survey
- 3 consumer reps: small area workshops
- Consumers and carers at 19th National Mental Health Services conference: consulted by member of the evaluation team

Private hospitals and insurers:

- 3 private psychiatric hospitals: consulted (including 8 individuals in face-to-face)
- 3 private health insurers: consulted, each providing written response
- 1 peak body representing both groups: consulted

Evaluation criteria

DoHA identified 16 key evaluation questions to be explored through the consultations. These questions were grouped into six domains. These domains represent areas in which the Better Access initiative is expected to have an impact. The domains and the questions within each domain are:

1. Service accessibility

- To what extent has the Better Access initiative provided access to mental health services for people with mental health disorders? Across all of Australia? Across all age groups?
- To what extent has the Better Access initiative provided access to affordable care?
- 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, and people from culturally and linguistically diverse backgrounds)?

2. Service appropriateness

- To what extent has the Better Access initiative provided evidence-based mental health care to people with mental health disorders?
- To what extent has the Better Access initiative provided services that match client needs and expectations?

3. Service effectiveness

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

4. Mental health care system

- To what extent has the Better Access initiative affected the supply and distribution of the psychologist, social worker and occupational therapist workforce?
- How has the Better Access initiative interacted with other related programs and initiatives, including the Better Outcomes in Mental Health Program and the More Allied Health Services Program?

5. Skilled, knowledgeable, integrated workforce

- To what extent has the Better Access initiative provided interdisciplinary primary mental health care for people with mental disorders?
- Are professionals aware of how to access appropriate primary mental health care training?
- Are professionals accessing appropriate education and training (for example multidisciplinary or profession specific training)?

6. Informing the summative evaluation

The consultation process will also focus on the following additional questions:

- What are the characteristics, including clinical characteristics, of consumers receiving Medicare rebateable Better Access mental health services?
- Are professionals, consumers and carers aware of the Better Access initiative?
- Has the Better Access initiative affected the use of medications prescribed for the treatment of mental disorders, in particular anti-depressants?
- Has the introduction of the Better Access initiative changed how and where professionals practice (for example, movement to another location, change from public to private sector, or change in the mix of public and private sector work)?
- Are there any unintended consequences for stakeholders due to the introduction of the Better Access initiative?

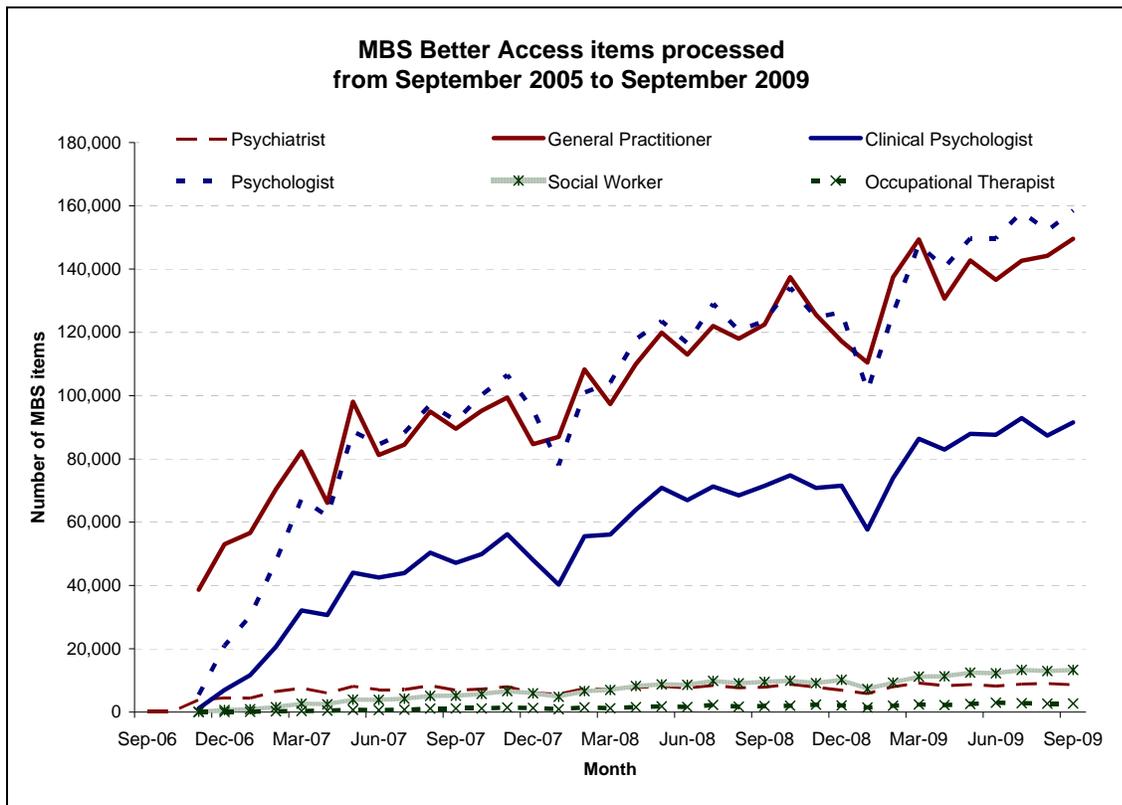
Reporting outcomes

The reporting outcomes are structured according to the six domains. The commentary is an objective representation of the opinions expressed and does not reflect those of either KPMG or DoHA. The evaluation attempts to weight the relative strength of each opinion by reporting the approximate number of participants who expressed it or the relative strength of the opinion.

1. Improved access

Almost all stakeholders and interviewees reported that Better Access has improved access to mental health services across all population groups. This is supported by Medicare data reporting the growth in the number of services funded through the Better Access initiative (see Figure 1 below).

Figure 1: Number of services funded through Better Access



- Services are more accessible.
- Services are more affordable.
- More GPs are providing services.
- More AHPs are providing services.

Ninety-six per cent of respondents agreed access had improved for individuals with anxiety and depression related disorders—a Better Access target group.

Access to services

Access to GPs

Fifty-two per cent of all Better Access providers (51% of GPs and psychiatrists, and 53% of AHPs) perceived an increase in GPs providing mental health services.

Medicare data for GPs also showed an increase with a 300 per cent rise in the number of mental health services funded between November 2006 and September 2009.

Why the increase?

better remuneration

Many GPs reported the new MBS items gave them better remuneration for the time spent providing mental health services and that they were now doing more mental health work than before.

partly due to artificial inflation

GPs acknowledged that the increase may partly reflect their using the new specific item number for mental health services, instead of the general item numbers—long consultation or Enhanced Primary Care item. GPs have been the main provider of mental health services in the community for many years.

confronting mental health problems

Some interviewees noted that all GP practices have a high proportion of patients with mental health problems, but before Better Access many of those patients would have received minimal treatment, or their GPs may have been reluctant to explore the mental health components.

One carer commented that previously GPs were reluctant to address mental health issues as it 'moved them out of their comfort zone'.⁸

But:

A few respondents thought some GPs may be claiming the provision of treatment plans due to the financial incentive of the MBS item, rather than reflecting the actual service being provided.

In one state, the Division of General Practice estimated 20–30 per cent of GPs provided minimal mental health care—a view subsequently endorsed by several psychiatrists and GP rep bodies—because:

- inadequate remuneration is provided for the time needed to assess and develop a treatment plan
- GPs' lack skills and confidence in mental health treatment
- some overseas-trained GPs (especially from non-English speaking countries) have a different cultural awareness of mental health and how it should be treated, a problem compounded by mental health training not being a core requirement for accreditation in Australia
- mental health is not a primary area of clinical interest to some GPs and they may therefore not recognise a mental illness underlying a somatic presentation.

Awareness of Better Access

⁸ Quote from rural carer participating in consumer and carer teleconferences in relation to problems in gaining services to treat depression experienced by their partner.

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.

Because GPs are the gatekeepers for access to psychiatrists and AHPs, changing their behaviour was seen as critical in improving access. GPs, GP stakeholder groups, psychiatrists, allied health providers, NGOs and consumers all reported a perception that GPs appeared to be more aware of mental health service options for their clients. Access to services had improved, with some noting that:

- Divisions of General Practice and GPs are aware of Better Access
- there are increasing referrals to psychiatrists and AHPs
- increasing numbers of patients are asking for referral to an AHP.

One GP reported:

This initiative is the single most important factor that has changed my working life in the past 5 years. Prior to this, dealing with mental health problems was nothing short of a titanic struggle for the average busy GP. Since referral to a psychologist with Medicare subsidy has been possible, GPs have not had to re-invent the wheel every time we saw a patient with high prevalence disorder (anxiety disorders or depression). I largely do not bother psychiatrists with these problems which are usually fairly straightforward for psychologists to deal with, often working with GPs as prescribers. Instead, psychiatrists are now used more appropriately to see people with mental illness that is more severe, or with psychotic disorders.⁹

But:

A small number of GPs reported that some of their colleagues were not well aware of Better Access, how to claim the item numbers or how to refer patients through Better Access.

Consumers and carers participating in the evaluation through the teleconference and online survey were more likely to report that GP awareness of Better Access remained an issue. Consumers did not generally perceive any changes in the behaviour of their GP as a result of Better Access.

Many consumers and carers reported that their GPs were still unsure of how to best work with people living with a mental illness, and expressed a desire for better education for GPs, both for Better Access itself and mental health generally. About a third reported that they initiated the referral to the AHP rather than the GP.

Access to psychiatrists

Only 13 per cent of respondents thought Better Access had contributed to psychiatrists being more accessible, with half of GPs and one-third of AHPs not perceiving psychiatrists as being more accessible as a result of Better Access.

⁹ Comment received in the online survey.

Some psychiatrists saw the new MBS items as effective in encouraging them to accept new referrals.

They supported Better Access because:

- the remuneration for the new MBS items was perceived to reflect the time required to assess a client and prepare a report
- psychiatrists were not expected to have ongoing management—the treatment plan is carried out by the referring GP
- due to the level of remuneration and ongoing patient management by the GP, they could set aside dedicated slots for new patients
- the tertiary assessment and referral focus of the new MBS items were professionally rewarding and an appropriate and cost effective use of their skills
- it met, in some way, the high level of demand in the community. Waiting times had reduced from up to six months to within six weeks.

But:

difficulties in accessing psychiatrists

Most GPs, AHPs and consumers also reported that it was still difficult to access psychiatrists, especially for patients who needed to be bulk billed or charged a reduced fee. This was perceived to be due to a shortage of psychiatrists, especially in rural and regional areas.

From the perspective of most public mental health providers, NGO providers, consumers, carers or allied health providers, there was little if any discernible improvement in access to psychiatrists.

high unaffordable up-front fee

Several consumers and carers reported the high, up-front fee as an unaffordable barrier. One GP noted that many psychiatrists work in small private practices and do not use online Medicare billing. This meant patients receiving a treatment plan may have to pay from \$355.50 (85% of scheduled fee) to \$418.20 + (scheduled fee) before receiving a Medicare rebate. This out of pocket expense was seen as a major deterrent.

inappropriate for complex patients

Some GPs were concerned that a treatment plan review by a psychiatrist once in a 12-month period was insufficient for more complex patients and therefore did not improve access for them.

One psychiatrist reported that psychiatrists within the region in which they worked had decided not to use the new MBS item because a single assessment did not provide quality care.

increased competition from AHPs

Some interviewees noted that the increased competition from AHPs may result in some psychiatrists reducing their number of psychotherapy patients.

One public health psychiatrist reported that two psychiatrists had returned to part-time public sector work because of increased competition from AHPs.

Access to allied health services

Almost 90 per cent of all Better Access providers (83% of GPs and psychiatrists, and 88% of AHPs) reported more allied health services in the community.

GPs and AHPs reported an increase in the number of people receiving allied health services. It was noted that some of the increase would comprise pre-existing clients of established AHPs now claiming the MBS rebate.

Most AHPs interviewed (mainly psychologists) perceived that growth was likely to continue because:

- there was a high level of unmet demand—fewer than half of the estimated one in five adults who experienced a mental disorder in the preceding 12 months received treatment
- GPs were increasingly aware of AHP services and referral networks were developing
- the budget for Better Access is not capped (unlike ATAPS).

Many AHPs reported that Better Access also increases the affordability of services in the private sector because:

- the streamlining of access to appropriate psychological care drives referrals to AHPs
- the availability of the MBS rebate and increased demand for services improves the viability of private practice, leading to more approved providers
- more providers make services easier to access, leading to more referrals
- as awareness grows, GPs are making more referrals.

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.

But:

Public providers reported increasing difficulty in recruiting and retaining clinical psychologists as a result of Better Access. Whereas most clinical psychologists thought that the shift to private practice was because the public system devalued skills and expertise—and that Better Access was a facilitator rather than a cause of the shift.

According to the online survey, GP referrals appeared to favour clinical psychologists.

Table 3: GP referrals to allied health professionals

GPs referring to	Number of GPs	Per cent of GPs
Psychiatrist	124	61%
Clinical psychologist	157	77%
Psychologists	120	59%
Social worker	40	20%
Occupational therapist	21	10%
Total respondents reporting nature of referrals	203	

Psychologists and clinical psychologists

Growth in services provided under Better Access is similar to that for GPs—see Figure 1, p. 11.

Social workers and occupational therapists

Before Better Access, Medicare funding for mental health services was not available to these occupations. Therefore, the relatively low growth in services may reflect the relatively small number of providers in private practice.

Some social workers reported that GPs did not understand their expertise and services, and appeared to prefer referring patients to psychologists.

Constraints

- A few AHPs reported no or very few referrals from local GPs.
- Most AHPs reported that the Medicare rebate was too low, failing to reimburse for reports and consultation with other service providers (especially for clients with more complex needs).
- The gap payment to meet the cost of service provision is a barrier for some people.
- Some general psychologists and social workers were concerned that the higher rebate paid for services by clinical psychologists allowed them to charge higher fees and a lower gap payment, resulting in a service that was more expensive to provide but cheaper for the client.

Access by consumers

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

Across all states and territories, all interviewees reported improved access to mental health services as a result of Better Access. People responding to the online survey varied in their views that Better Access had improved access to mental health services.

There was a perceived socio demographic inequity in service provision and access to services relating to:

- the disparity in rebate and recommended fee for AHPs, particularly general psychologists, social workers and occupational therapists, requiring gap payments
- no means testing of the rebate or level of rebate
- no financial incentive to bulk bill priority population groups. It was noted that the administrative delays of up to five weeks between the lodgment of the Medicare Item number and payment further discouraged bulk billing
- disadvantaged communities and higher need individuals often requiring a greater level of input and effort than that reflected in the Medicare items—e.g. case conferencing with other agencies, preparation of reports, secondary consultation and liaison and information sharing.

Inequalities were reported in accessibility across various groups:

Rural and remote consumers

Metropolitan areas seem to enjoy better access to services than rural and regional areas, although some NGOs reported that services were now available in areas where none had previously been. See section 4, Mental health system, for more on the distribution of the mental health workforce.

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 had not improved through Better Access. One consumer from a remote area reported service availability reducing and AHPs being less willing to provide 'fly in fly out' services.

Stakeholders reported the limited availability of psychologists and other allied health professionals, a factor also confirmed in the literature.^{10 11 12 13} The Australian Institute of Health and Welfare (AIHW) also reports poor access to allied mental health services provided by psychologists, social workers and occupational therapists in outer regional and remote areas (25 and 22 services per 1,000 population, respectively) compared to access in major cities and inner regional areas (33 and 34 services per 1,000 population, respectively).¹⁴

¹⁰ URBIS 'Environmental Scan Component of the Mental Health Professionals' Association Multidisciplinary Training Resource Program' Final Report January 2008.

¹¹ Rural Doctors Association of Australia "New mental health items 'out of reach' for rural patients" (2006) Accessed 19 March 2009 http://www.rdaa.com.au/uploaded_documents/New_per_cent20mental_per_cent20health_per_cent20items_per_cent20out_per_cent20of_per_cent20reach'_per_cent20for_per_cent20rural_per_cent20patients_per_cent20--_per_cent20October_per_cent202006.htm p1

¹² Eckert, K.A., Wilkinson, D., Taylor, A.W., Stewart, S, Tucker, G.R., 2006. "A population view of mental illness in South Australia: Broader issues than just location". Rural and Remote Health, 6, 541 p11.

¹³ Australian General Practice Network "Mental health Medicare measures welcome, but equity at risk" (2006) Accessed 19 March 2009

[http://www.agpn.com.au/site/index.cfm?module=MEDIA&PageMode=indiv&page_id=15740&leca=16_p1.](http://www.agpn.com.au/site/index.cfm?module=MEDIA&PageMode=indiv&page_id=15740&leca=16_p1)

¹⁴ Australian Institute of Health and Welfare "Mental health services in Australia 2005–06" (Canberra 2008)

Overall it was felt that, due to a small, dispersed and generally poorer population, the private practice model was limited in its application to small rural and remote communities.

— ATAPS

Higher revenue available to AHPs through Better Access has reduced the attractiveness of providing services through the ATAPS program and therefore has reduced the availability of services in rural and remote communities.

One rural and remote Division of General Practice reported that under ATAPS it recruited AHPs to provide a fly in fly out service at a cost of \$55 per session plus expenses two days a week. With the higher MBS rebate, providers raised their fee to \$125 per session, halving the number of services provided. DoHA then allowed the AHP to bulk bill patients on the second day of their visit, thereby doubling the cost to the Commonwealth. The Division felt this was unsustainable, especially given AHPs were increasingly reluctant to provide services in disadvantaged communities for less money than they could make from their urban or regional practice.

One consumer from a remote mining community confirmed that AHP services had ceased, other than those provided through the local Aboriginal Medical Service which was not available to mine employees and their families.

Some AHPs reported that because of there being fewer AHPs in rural and regional areas, waiting lists for Medicare approved practitioners are longer.

Proposed solutions:

- introducing items for secondary consultation to allow AHPs to support local workers to provide services in these communities (AHPs)
- providing online therapy by phone and/or VOIP and webcam (one psychology practice group)
- including mental health nurses within the approved range of providers (several public provider respondents)
- including Aboriginal Health workers within the approved range of providers (a couple of NGO respondents)
- expanding eligibility for MBS provider numbers to psychotherapists and counsellors (reps of psychotherapists and counsellors)
- allowing psychiatrists to refer directly to AHPs, given limited available of GPs in some areas (some psychiatrists in public practice).

Proposed solutions by some public providers and Divisions of General Practice (who thought private practice sessional-based services were not effective in servicing these areas):

- expanding the Division of General Practice budget to provide services on a contract or block grant basis (a view expressed by most Divisions of General Practice and many GPs)
- expanding funding to public mental health services to provide population based mental health services (a view expressed by most public providers)

- expanding funding to NGOs to provide population based mental health services (a less commonly expressed view of some NGOs).

In the Northern Territory, GPs generally operate out of Territory-funded facilities and their use of MBS items is low—therefore people are much less likely to be able to access mental health services through Better Access. Similar problems were reported in remote areas of Queensland.

Consumers perceived teleconferencing and VOIP-based therapy as less satisfactory than face-to-face 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
- individuals who, because of the size of the community and relations within the community, may not want to see the sole psychologist in town.

Less affluent consumers

Poorer communities were perceived as less able to access services because:

- fewer GPs and AHPs in these communities
- gap payments were prohibitive and very few AHPs offer bulk billing
- limited public transport, limiting access to services
- potentially a lower likelihood of individuals recognising and seeking help for a mental health problem.

Some respondents say there is a shift of AHP services to more affluent areas. But others say that eventually AHPs will relocate to areas of fewer services to capture demand.

Local consultations and consultations with some peak NGO organisations highlighted this issue, but it was not noted by peak GP and AHP bodies.

Different age groups

All groups and individuals reported improved access across all age groups.

— *children*

Most GPs, psychiatrists (combined 65%) and AHP (72%) respondents agreed that access had improved for children and young people.

Better Access has allowed a number of providers with expertise in child and adolescent mental health to enter the private system.

Some AHPs suggested that paediatric surgeons be allowed to refer to Better Access providers, given their referrals are currently coming via paediatricians.

A key barrier: there is no MBS item for providing family therapy or to see the parents or carers without the child present.

Many GPs, AHPs and NGOs noted that traditional providers and the Better Access model still did not provide adequate access by young people because:

- higher likelihood of cancellations, no shows and no payment for no shows, reducing the financial viability for providers
- limited capacity to pay gap fees
- longer periods of engagement needed to develop a therapeutic relationship than available through Better Access
- high likelihood of co-morbidities such as substance abuse
- often the need to engage with other services not funded through Better Access.

Some stakeholders suggested that services to youth were better provided as service specific funding, such as to youth services or Headspace.

— *older people*

Most GPs, psychiatrists (combined 65%) and AHP (71%) respondents agreed that access had improved for older people.

The difficulty of older people accessing mental health care can be considered in the context of a large population of older people have significant depressive symptoms, according to Beyond Blue and the AIHW.^{15 16}

A few providers reported that nursing home residents are excluded because they can't visit the AHP for treatment. GPs can manage their mental health problems but, according to the Australian General Practice Network, the five allowable MBS AHP per year are rarely used for referral to mental health professionals. The AGPN, and a few psychiatrists and GPs recommended that nursing home residents be eligible for GP mental health treatment plans.

Another group of psychologist practitioners suggested that access could be improved by allocating ATAPs funding for use in nursing homes and for therapists visiting clients, rather than requiring the client to attend a clinic.¹⁷ AHPs and GPS said there was strong evidence of need for outreach services to people's homes.

Other issues raised by a number of AHPs:

- extra cost of providing in-home visits to older people is not reflected in the MBS items
- high levels of networking and integration needed with local aged care teams, primary care services, home nursing and home and community care.

¹⁵ Beyond Blue "Depression in the Elderly" Synergy No 2, 2004

¹⁶ AIHW (2008)

¹⁷ It is recommended that Component B of the evaluation: Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) Administrative Data examine ATAPS and Better Outcome data to assess whether older people are accessing mental health service by alternative pathways.

Aboriginal and Torres Strait Islander people

Very few stakeholders or interviewees identified Aboriginal and Torres Strait Islander people as a priority group experiencing higher need or poorer access to services. However, the prevalence of mental illness in these communities is twice that of non-Indigenous people. According to AIHW, the more remote the greater the psychological distress.¹⁸

Their mental health service usage rates with GPs are similar to those of non-Indigenous people, therefore Aboriginal and Torres Strait Islander people are not accessing GPs for mental health issues at a rate comparable to their needs.

Stakeholders discussed the barriers:

- appropriateness with stakeholders noting that working within Aboriginal communities required acceptance into the community and an understanding of the Aboriginal perception of wellness
- issues of socioeconomic status
- geographic location
- MBS rebate inadequate to cover extra costs of providing outreach services into the community, and the time involved in working with the client's family and wider community (an AHP working closely with the local Aboriginal community)
- the need for face to face sessions rather than telephone-based services to receive the MBS rebate.

Several psychologists suggested funding client specific secondary consultation services to local Aboriginal health workers for less complex cases.

A widely held view was that these services may be better funded through other programs such as Better Outcomes or as part of Aboriginal and Torres Strait Islander health services.

CALD groups

Culturally and linguistically diverse (CALD) communities experienced difficulty in accessing mental health services through Better Access—raised by most public mental health representatives, one RACGP representative, two RANZCP representatives and several GPs in rural and remote areas.

Several other GP and AHP interviewees reported that they had not considered access issues for CALD communities, and were unaware of specific difficulties.

Major barriers:

- language—AHPs noted there is no interpreting service available for AHPs, whereas GPs can access the Australian Government's Translating and Interpreting Service (TIS) without charge

¹⁸ Australian Institute of Health and Welfare, "Aboriginal and Torres Strait Islander Health Performance Framework 2008 report: detailed analyses" (Canberra 2009)

- family or community members may be relied on to interpret, raising other difficulties
- extra time needed to work with an interpreter is not recognised—working through an interpreter more than halves the therapy time
- communities have different understanding and perceptions of mental health and treatments.

Solutions:

- more training and awareness campaigns (one opinion)
- services may be better funded through ATAPS and/or block funding to establish CALD-specific services.

A small number of AHPs said it was an issue for GPs who drive the referrals, and that AHPs could not readily influence improving access by CALD and other disadvantaged groups.

People with complex care needs

AHPs noted an increasing complexity in the profile of clients referred to AHPs as Better Access has evolved. This was largely perceived to be because:

- as relationships and trust develop between GPs, psychiatrists, AHPs and local support services, the complexity of those referred increased (AHPs)
- if the local public mental health systems were unavailable or overstretched, complex clients were more likely to be referred to an AHP through Better Access (local area consultations).

It was noted in the consultations that the number of sessions being required was increasing and up to 18 sessions was not unusual.¹⁹

Some NGO services reported that due to the specialisation of some AHPs, more services are available for special needs groups.

Concerns raised by a number of consumer organisations representing more complex patient groups:

- Better Access is not available to all clients with more complex needs who may benefit from those services
- the model of care and number of sessions was often not adequate for this client group who may require more intensive and longer term interventions
- given a perceived under resourcing for this client group, the allocation of an uncapped budget to a client group with lower acuity problems was perceived as poor prioritisation and inequitable allocation of resources.

People with a substance abuse disorder

¹⁹ Changes in the number of sessions per individual as Better Access has developed can be identified in Component B of the evaluation: Analysis of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) Administrative Data.

Sixty-two per cent of AHPs agreed that this group experienced improved access compared to 27 per cent of GPs and psychiatrists. In all, almost half of respondents agreed access to mental health services had improved for individuals with substance abuse disorders.

Improved affordability

This section focuses on the question: To what extent has the Better Access initiative provided access to affordable care?

Approximately half of the consumers responding to the online survey perceived AHP services as affordable, as did more than three-quarters of those participating in the consumer teleconferences.

But:

Despite the rebate, the gap payments and affordability was a real barrier for low socio economic groups, restricting their access, and for consumers with a longer history of mental health disorder.

General psychologists, social workers, occupational therapists and consumers questioned the higher rebate paid to clinical psychologists. The higher rebate may allow clinical psychologists to charge a lower gap payment, resulting in consumers using services that cost more to Medicare but less to the consumer.

2. Service appropriateness

This section responds to the question: To what extent has the Better Access initiative provided evidence-based mental health care to people with mental health disorders?

Nearly all interviewees across all stakeholder groups reported that Better Access had been successful in facilitating access to appropriate and evidence-based mental health care and achieving positive outcomes for clients.

Reaching the target

About 96 per cent of respondents reported that Better Access had improved access to mental health services for people with anxiety and depression related disorders.

Interviewees highlighted that before Better Access most people with a mental health problem were either untreated or received very limited treatment, usually through their GP.

But:

Some psychiatrists, GPs, AHPs, and state and territory health departments perceived that those experiencing the improved access were the 'worried well' and those who were traditionally good 'help-seekers'—they would have accessed mental health services anyway, either self-funding or using private health insurance to minimise out-of-pocket expenses.

A small number of psychiatrists, GPs and AHPs raised concerns about the types of clients receiving treatment through Better Access—for example, clients who needed counselling, yet did not necessarily need the services offered under Better Access.

A small proportion of psychologists said services should be targeted to clients with milder health issues, arguing that early effective intervention would lead to better outcomes for patients and the health system.

Meeting clients' needs

Nearly all AHPs reported that they provided evidence-based mental health care.

Concerns:

- A small number of interviewees questioned the evidence base of some of the interventions provided by AHPs (psychiatrists, Level Two-trained GPs, public mental health providers and a small number of AHPs with extensive private practice experience)
- without any outcome reporting, it was difficult to know the degree to which services were meeting the needs of clients and achieving improved outcomes for clients
- lack of outcome reporting might lead to a lessening of quality of care

Those concerned about the lack of outcome reporting—a small number of people engaged with the public health system or Divisions of General Practice—also had the following concerns:

- Better Access was not an effective means to prioritise and target services.
- Better Access did not lead to integrated and coordinated care, but supported an individualised service model.
- There was limited capacity to regulate quality.
- Uncapped funding for the Better Access initiative would limit available funds for services targeted to high need people.
- High need and special need people would have limited benefit from Better Access.

Some interviewees were concerned about the expansion of the provider base to include GPs without Level Two mental health training and general psychologists, social workers and occupational therapists.

A few clinical psychologists thought the MBS provider numbers should be restricted to clinical psychologists.

Another small group of GPs and psychiatrists strongly supported Better Access. They cited the incidence of untreated anxiety and depression in the community and the debilitating affect that this had on the individuals, their families and the wider community and economy. They thought:

- Better Access was effective in providing services to high prevalence mental disorders
- it was consistent with the overall Medicare approach and built on the core role of GPs as the key primary care provider
- as Better Access essentially expanded the same range of services and to the same client group as Better Outcomes, the findings of approved client outcomes for Better Outcomes were transferable to Better Access
- as the gatekeeper to service through the development and review of the Plan, the GP can ensure appropriateness of referrals and monitor and control quality
- professional bodies have mechanisms in place to ensure professional standards are met.

Matching clients' needs

The overriding opinion from all stakeholder groups and interviewees was that Better Access helped match services with clients' needs and expectations.

GPs reported that:

- as a result of Better Access, local resources had been developed (either by their local Division or local allied health providers) that provided information on AHPs and other mental health and support services in the local area—this helped them in the referral process

Psychiatrists reported that being able to access different professionals helped them match skills to clients' needs.

Social workers reported that because their expertise was not generally recognised by GPs, clients may receive fewer appropriate referrals.

A small number of psychologists reported a perception that some GPs referred only to psychologists with whom they had an established relationships, rather than on the basis of clients' needs.

Individuals with complex needs

Across stakeholder groups, it was noted these clients tend to require more intensive or different therapies to those covered through Better Access and therefore their needs could not be appropriately met.

AHPs, and subsequently other stakeholders, agreed that these clients often presented as having a more straightforward condition that could be treated through Better Access—therefore identification at the outset was difficult.

A number of psychiatrists expressed concern that people who have a physiological problem or require medication or medication reviews were either not being referred, or referral was delayed.

A social worker commented:

'The restrictions on number of sessions under Better Access means that allied health professions cannot provide longer term treatment to people who require this type of care. They are still forced to see psychiatrists in the public or private sector and this is often not the most appropriate form of care as it tends to rely more on psychopharmacology than other more effective interventions such as counselling and psychotherapy.'²⁰

Children

Most AHPs reported that the lack of Medicare items for seeing family members, providing family therapy or other secondary consultations was limiting the appropriateness of services that could be provided to children.

Aboriginal and Torres Strait Islander people

²⁰ Comment by social worker in online survey of allied health professionals.

As previously mentioned, a number of GPs and AHPs raised various issues that make providing appropriate services through Better Access difficult:

- acceptance into the community is essential
- an understanding of the Aboriginal perception of wellness is important
- issues are often complicated by other physical co-morbidity²¹

Some stakeholders suggested the following to improve the appropriateness of care:

- increasing training of Aboriginal and Torres Strait Islander people with local ties so that they could service their community directly
- psychologists and other mental health practitioners could work in a secondary consultation role with Aboriginal health workers

CALD groups

A number of GPs highlighted the difficulty in finding mental health professions with the necessary skills and experience to care for these consumers.

GPs and AHPs suggested a register that highlights professions with expertise in service provision for CALD communities.

3. Service effectiveness

Better client outcomes

Overall, stakeholders and interviewees believed that Better Access had resulted in improved outcomes for clients but because there had been no formal evaluation of client outcomes, that the quality and effectiveness of services were likely to vary across individual practitioners.

- 78 per cent of respondents to the online survey (81% of GPs and psychiatrists, and 75% of AHPs) agreed that Better Access had contributed to improved outcomes for people with anxiety or depression related disorders.
- 55 per cent agreed that improved outcomes are being achieved for older people (56% of GPs and psychiatrists, and 53% of AHPs), with only 5 per cent disagreeing.
- 53 per cent agreed that improved outcomes are being achieved for older people (52% of GPs and psychiatrists, and 54% of AHPs), with only 7 per cent disagreeing.
- 40 per cent agreed improved outcomes are being achieved for people with substance abuse disorders (35% of GPs and psychiatrists, and 46% of AHPs), with 13 per cent disagreeing.

All groups acknowledged their beliefs about service effectiveness were based on anecdotal evidence. Of the 118 consumers rating the helpfulness of the services they received from an AHP in the online survey:

- 47 per cent reported that the services had made them feel much better

²¹ Dr Jill Benson, "A Culturally Sensitive Consultation Model", Health in Human Diversity Unit, Discipline of General Practice, University of Adelaide, South Australia Migrant Health Service, Nunkuwarrin Yunti, and Parklands Medical Practice, Adelaide, South Australia Volume 5, Issue 2, 2006 ISSN: 1446-7984 Accessed 19 March 2009 <http://www.auseinet.com/journal/vol5iss2/benson.pdf>

- 48 per cent reported the services received made them feel somewhat better
- 17 per cent felt that the services did not make much difference
- 5 per cent reported that the services made them feel worse.

About 85 per cent of 118 respondents reported that, if a family member or friend were experiencing a mental health problem, they would most certainly (66 per cent) or possibly (17 per cent) recommend that they seek a referral to a therapist from their GP through Medicare.

A number of psychiatrists, GP stakeholders and public mental health providers suggested that outcome measures needed to be taken and reported to Medicare to determine effectiveness. The Better Access initiative was viewed as an unprecedented opportunity to inform, develop and strengthen the existing evidence-base for psychological treatments.²²

Two surveys by professional groups—APS and the Australian College of Clinical Psychologists (ACCP)—the vast majority of respondents in both surveys said the services provided under Better Access had resulted in improvement.

Worse client outcomes

In this evaluation, however, several stakeholders and consumers expressed the view that Better Access had not improved client outcomes.

- only 12 per cent agreed that improved outcomes are being achieved for Aboriginal and Torres Strait islander people or people living in remote communities (9% of GPs and psychiatrists, and 10% of AHPs—remote; 10% of GPs and 16% of AHPs—Indigenous)
- only 26 per cent agreed that improved outcomes are being achieved for people living in rural communities (23% of GPs and psychiatrists, and 28% of AHPs), although about half were unsure
- only 22 per cent agreed that improved outcomes are being achieved for people from culturally and linguistically diverse communities (18% of GPs and psychiatrists, and 25% of AHPs), although more than half were unsure.

Psychoanalysts raised concerns about:

- the types of therapies that could be delivered through Better Access, arguing that restricting the types of therapies allowed under the Better Access initiative was limiting the effectiveness of their treatments.
- the 12 session per year limit was inadequate, and that many patients required a longer course of therapy to meet their needs.

While they acknowledged that the Better Access-funded therapies such as cognitive behavioural therapy were useful, they argued that their usefulness and appropriateness was limited to certain patient populations.

²² Carey, Timothy A. Rickwood, Debra J. Baker, Keith. 'What does \$27,650,523.80 worth of evidence look like?' Centre for Allied Psychology, University of Canberra, (2009) p 17.

4. Mental health care system

Impact on public mental health workforce

Small shift of clinical psychologists

Throughout the consultation, providers, professional groups and health departments reported that they had expected a significant shift to the private sector of psychologists from the public mental health workforce following the introduction of Better Access. On the whole, these stakeholders held the view that little, if any, shift had in fact occurred, except clinical psychologists.

Psychology organisations and several state and territory health departments noted that any shift in workforce that had occurred appeared to be of senior clinicians moving towards a part time role. An APS survey undertaken in February 2008 of psychologist staff at Melbourne public hospitals indicated that, while only 12 per cent of P2 level psychologists were considering leaving the public sector, 41 per cent of P3 level psychologists were intending to reduce their hours of work for private practice in the next 12 months.

Impact on training

A number of psychologists and psychologist groups raised concerns about the consequences of the perceived shift by experienced practitioners to the private sector on the capacity of the public sector to provide adequate supervision for trainee psychologists. Many clients who attend private clinics are reluctant to allow students to either sit in on sessions or to accept therapy from a student. One group practice of psychologists suggested that Medicare could provide an enhanced rebate to clients who agree to receive therapy from a trainee or to have a student sit in on a session.

One psychologist group reported that a university, while not increasing the total number of psychologists in training, had increased the proportion of students in clinical psychology.

One university reported decreasing the supervised training hours for students because of the difficulty in attracting clients.

More social workers with provider numbers

A number of state and territory health departments and one psychologist professional body believed that there had been little shift from the public to private sector of the AHP workforce, even though the number of social workers with provider numbers increased from about 250 to 900. It is likely that, while social workers attained provider numbers, this may be the result of:

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

- AHPs, particularly psychologists, noted that the low level of MBS rebate encouraged a ‘cottage industry’ approach to service delivery, attracting providers with a supplementary income who worked from their own home.

Differences between jurisdictions

The smaller states reported that Better Access had had a significant impact on the public psychologist workforce, with practitioners either moving to private practice or reducing hours. One state health department reported that occupational therapists had been used to fill positions left vacant by psychologists.

Table 5: Impact of the Better Access initiative on public mental health workforce

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

States and territories, and their professional bodies, believe there has been little or no impact from Better Access on social worker and occupational therapist workforce because:

- they have had less experience in the private sector, making the move away from the public domain more challenging
- the lower MBS rebate for occupational therapists, general psychologists and social workers made the move less rewarding than for clinical psychologists. A social worker reported that it was ‘not worth the effort’ to see clients through Better Access.

Impact on location of AHP services

A number of public mental health providers, and GP, NGO and psychiatrist representative groups noted that there was no incentive in the current rebates to encourage the provision of services to disadvantaged communities or higher need individuals. In local consultations, all providers noted that AHPs tended to be located in the more affluent areas of the community.

There is also a perceived disproportionately higher number of AHPs in metropolitan areas compared to rural and remote regions. A small number of GPs, psychologists, social workers and public mental health providers reported through small area consultations and teleconferences that since the introduction of Better Access there had been a further shift of psychologists from rural and remote regions, to metropolitan areas.

Why?

These stakeholders believed that practitioners thought they would be better able to ‘cash in’ on the client base made available through Better Access. It was argued that, to do so, they needed good ties with a referral base, i.e. general practitioners. They contended that GPs were more concentrated in metropolitan areas. No similar trends were ascribed to either occupational therapists or social workers.

But:

A couple of AHP peak representative bodies noted that, as Better Access increased the financial viability of private practice, AHPs were not tied to working in areas where they could work part-time in public practice. This was reported as a positive factor in increasing the ability of AHPs to establish practices in areas where there were few public mental health services. One AHP representative suggested that, as a result of Better Access, the market would improve equitable access as practitioners established practices in areas to capture local demand and where there were previously few other services.

New model

State and territory health departments and providers themselves described new models emerging since the introduction of Better Access—such as psychologists starting group practices or psychologists and social workers attaching themselves to an existing GP practice.

Interaction with other programs

Most psychiatrists, GPs and some psychologists identified Better Access as complementing existing initiatives, such as ATAPS, and as having a positive influence on the level of engagement of GPs in the range of mental health options available. Some negative influences were also identified, such as the lower numbers of GPs reportedly seeking and retaining Level Two mental health accreditation.

Several GP stakeholders and interviewees reported a perceived flattening of demand for ATAPS following implementation of Better Access, but that demand for ATAPS was now increasing. A small number of Divisions and GPs also reported the use of ATAPS funds to provide additional therapy sessions to clients with complex care needs who had exhausted the 18 sessions provided through the Better Access initiative.²³

Most Divisions interviewed reported rethinking the targeting of ATAPS and how other services provided through Better Outcomes, MAHS and Better Access work together to improve access to mental health services.

Most sessions delivered through Better Access occurred in urban areas, while sessions through ATAPS were more equally distributed, indicating that these services may have a ‘relatively greater reach in rural areas’.²⁴

A number of GPs and GP representative groups noted that because GPs were more engaged in mental health issues, there had been increased interest in how the various components of the

²³ Note: This may be an inappropriate use of Better Access and ATAPS and in breach of MBS rules.

²⁴ Bassilios et al (2009)

system could be used together to maximise the benefit for the patient—e.g. using EPC items for case conferencing with other professionals (as no funding for this under Better Access).

But:

- A number of GPs were unclear about which programs should be used for which patients. GPs and AHPs reported being confused on how to use the MBS items, and found it difficult to get information and clarity from Medicare. As Better Access matured, their understanding was improving.
- A number of Level-2 trained GPs reported that, based on enquiries from colleagues, the mental health item numbers were the least understood.
- Since the introduction of Better Access fewer Level Two trained GPs had maintained their qualifications—it was suggested either because they were referring patients on to AHPs or, if providing focused psychological strategies themselves, were doing so using long consultation item numbers.
- One GP group identified that other initiatives implemented as part of the National Action Plan on Mental Health (e.g. the Mental Health Nurse Incentive Program or Personal Helpers and Mentors Program) had not been rolled out as far as initially expected. This stakeholder believed that clients who would have been supported through these other initiatives (i.e. those with more severe or complex illnesses) have instead relied more heavily on services available through Better Access. This has placed a degree of stress and expectation on the service provider through Better Access to do more than was originally intended.

5. Skilled, knowledgeable, integrated workforce

This section responds to the question: To what extent has the Better Access initiative provided interdisciplinary primary mental health care for people with mental disorders?

Overall, providers and professional bodies did not believe that Better Access had promoted interdisciplinary primary mental health care.

Barriers to coordinated care

Providers from AHP and medical professions identified a number of barriers to providing interdisciplinary care:

- no MBS item for case conferencing limiting information sharing, integrated care planning and coordinated care
- confusion among AHPs about the confidentiality of patient information and the need for greater clarification on exchanging information between AHPs and GPs—a health department reported that some allied health professionals believed that they could not report back to GPs about the client's treatment and progress without breaching client confidentiality
- lack of understanding of the professional roles and capabilities between professional groups—reported by AHPs and GPs. For example, some GPs reported that they were unclear about when to refer to a social worker or an occupational therapist versus a psychologist.

- geographic separation of medical practitioners and AHPs. Some AHPs reported that co-location fostered professional respect and facilitated effective discussions on patient care
- Limited contact between professions in patient management—possibly reflecting Better Access and the public mental health system working as complementary parts of the whole system and having different patient groups
- AHPs viewed the public mental health system as not geared to work proactively to manage clients to remain in the community. They were also concerned about the lack of contact from the public mental health service if a client was admitted to hospital and in discharge planning. Some GPs noted that the Division had attempted to address this issue through GP liaison programs but it needed further improvement
- Public mental health providers perceived the requests for engagement from AHPs as:
 - dumping of patients
 - placing more pressure on the public mental health system which was unable to allocate the resources requested.

A number of jurisdictions reported policies to better integrate Better Access—e.g. policies for notification on admission and discharge.

The online survey of public providers found:

- 63 per cent of respondents said that workers within their organisations were aware of services offered by Better Access
- 65 per cent said that services offered by Better Access complemented those of their organisation
- 63 per cent that Better Access increased referral options for people using their services
- 57 per cent that Better Access had improved the mental health system

Overlap between Better Access and the public system

Most AHPs noted an overlap in client group between Better Access and the public mental health system—also supported by the online survey of public providers.

Fifty-three per cent of respondents to the online survey of public mental health providers disagreed with the statement that ‘Better Access has no real impact on the client group my service works with’; 25 per cent of respondents disagreeing with the statement that ‘Better Access provides referral options for people they would not normally provide services to’; and 21 per cent reporting a perception that ‘Better Access has reduced demand for their public mental health services’.

Levels of skills

Treatment plans

A number of AHPs, particularly clinical psychologists, also argued that the information contained within the Mental Health Treatment Plan did not replace the need for them to conduct their own assessment and treatment plan (supported by a recent APS survey)

- 73% of respondents to the survey reported the information in the GP mental health care plan as good or fair
- 72% reported they had not received inappropriate referrals

The survey also noted the quality appeared to be improving.

Mental health assessment and referral

A small number of psychiatrists raised concerns about GP's skills in mental health assessment and referral—e.g. a patient was sent to a psychologist instead of a psychiatrist.

An AHP professional group also raised issues about GPs' patient assessment—e.g. misdiagnosing a heart related medical condition as an anxiety disorder.

Most AHPS reported examples of clients who self-referred rather than a referral by a GP.

AHP services

Some GPs raised concerns about AHP services.

Access to primary mental health care training

GPs, GP representative bodies, and state and territory health departments believed that GPs were not accessing primary mental health training at a level required to deliver high quality primary mental health care. At the time of the consultations very little of the training planned to be provided had commenced.

A significant number of AHPs and Level Two trained GPs raised concerns about the level of mental health skills by GPs who had not received mental health training—they held significant power in mental health care assessment and planning, but did not necessarily have the skills to undertake these tasks.

A number of professional groups argued that training of GPs in primary mental health care should be mandated.

All AHPs and GPs must take part in ongoing professional education in this area.

GP professional bodies general considered that most GPs knew what training was available or how to get information about training options.

At the time of the consultations, Better Access specific training through the Mental Health Professional Network (MHPN) had only recently begun. Therefore, the consultations did not identify any significant improvements in access to training for GPs and AHPs.

Impact of Better Access on training

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

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

Of the 417 allied health providers responding to the survey questions on training, 23 per cent reported that it had improved access to training. 9 per cent responded that Better Access did not improve access to clinical training.

6. Informing the summative evaluation

Characteristics of consumers of Better Access

Table 11 below highlights the more general client characteristics reported.

Table 7: 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

State and territory government health departments and public mental health providers thought a key limitation of Better Access was its lack of prioritization based on clinical need or capacity to pay.

But:

AHPs indicated that because referrals were generated by GPs, it was the GP who determined the profile of referrals.

Both AHPs and public mental health providers perceived the differences between clients receiving public mental health services and services through Better Access were that public clients:

- had a higher level of chronicity
- were more complex with more co-morbidities
- were less able to manage their own day-to-day affairs
- were more likely to need case management.

In areas where there were no public services, or they were unable to meet demand, Better Access provided therapy to this group, including clients with conditions such as bipolar disorder and chronic psychoses. AHPs treated these clients with the support of GPs and psychiatrists.

AHPs reported that initial Better Access referrals included 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 in their 50s and 60s, and accessing services for the first time
- more children being referred by paediatricians
- older people
- more complex clients who are referred as an alternative or adjunct to GP medication management of more complex disorders.

The increasing complexity of referrals is requiring more intensive and longer interventions, and treatment periods of 12–18 sessions are now becoming more common.

The change in the client profile is perceived to be a result of:

- a maturing of the practices of Better Access
- 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
- increased awareness that services are available and word of mouth referrals leading to client initiated referrals
- reduced stigma associated with seeking mental health care
- receiving treatment from a AHP carries less stigma than treatment by a psychiatrist
- increased awareness of service availability in the local community and sub groups in the community.

Awareness of Better Access

All stakeholders reported that Better Access was now well established, awareness among GPs was high and this would continue to improve as the initiative matured.

The degree of progress and implementation varied across GP Divisions but overall, GP representatives were pleased with the progress.

Private psychiatric hospitals were aware of Better Access, but had no direct contact with it. 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 which has developed in partnership with the Brisbane South Division coordinated access to psychiatrists under Better Access through General Practice Liaison and Assessment Service (GLAS). This innovative program recently won the 2009 Australian Private Hospital Association Award for Ambulatory Care.

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

But:

- 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 Better Access, but only being offered medication.
- One rural GP receiving the background information on the evaluation through the RACGP 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.
- All GPs reporting instances of receiving minimal information in documentation and reports from AHPs, again noting that the quality of reporting is improving.

Impact of Better Access on use of medications

Overall, psychiatrists, GPs and AHPs perceived that Better Access had had minimal, if any, impact on the level of medications prescribed for the treatment of mental disorders, in particular anti-depressants.

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 tested.

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 8: 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%

Concerns of AHPs

Differential rebates

The different rebates for clinical psychologists, general psychologists and occupational therapists and social workers were a highly contentious issue. Table provides examples of the range of rebates paid for focused psychological strategies lasting more than 50 minutes in consulting rooms and at a place other than consulting rooms.²⁵

Table 9: 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

²⁵ MBS online data accessed 7 July 2009. Link.

<http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=80160&qt=ItemID>

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 used the same range of interventions. 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. Some psychiatrists and social workers suggested 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 they offered.

Non-approved counsellors

Although supporting Better Access in principle and the improved access to services it offered, non-approved counsellors had three main concerns:

- Better Access does not provide scope for psychoanalysis and long-term psychotherapy for more severe psychological disorders
- their professional members who are not clinical psychologists, general psychologists, occupational therapists or social workers are not eligible to provide Better Access services
- Better Access 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 expanding Better Access to include their members would expand the available workforce and improve access to services.

Concerns of insurers

The evaluation contacted three major health insurers: MBF (BUPA), HCF and Medibank. In general, they supported improved access to focused psychological strategies 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.

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

Operational concerns

These issues were perceived as impeding the efficient operation of Better Access:

- a small number of Divisions of General Practice and individual GPs reported confusion about the Better Access MBS item numbers, needing more training and information from Medicare
- in small area consultations, GPs and AHPs reported they often received contradictory advice from Medicare

- several GPs reported that if, in the same day, they code an item 23 (professional attendance) and later on they code an item 2710 IGP Mental Health Treatment Plan), the MBS computer system only approves item 23. This causes stress and anxiety to the patient when Medicare advises they are not eligible for a rebate. Several AHPs also reported payment of rebates had not been approved even though the patient had a treatment plan.
- if a GP approves a further six sessions due to exceptional circumstances, on top of the 12 allowed in a calendar year, the MBS system defaults to not approving the referral.

Discussion

Potential bias within the evaluation findings

A major limitation of the stakeholder consultation process was relying on a self-selected sample of representatives of professional bodies, individual mental health service providers and consumers and carers.

Almost by definition, these representatives 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.

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

Achievement of objectives—overview

Better Access was set up to encourage general practitioners to work collaboratively with allied mental health professionals to improve patient outcomes in mental health. It:

1. encourages more GPs to participate in early intervention, assessment and management of patients with mental disorders—and streamlines access to appropriate primary care
2. encourages private psychiatrists to see more new patients
3. provides referral pathways for appropriate treatment of patients with mental disorders, including psychiatrists, GPs, clinical psychologists and other allied mental health professionals
4. provides education and training to GPs and primary care service providers to better diagnose and treat mental illness.

Across all stakeholder groups the overwhelming view was that Better Access achieved the first three objectives and that it was too early to tell about the fourth.

1. *Encourages more GPs to participate in early intervention, assessment and management of patients with mental disorders*

GPs are doing more mental health work than ever before: The new MBS items recognised the effort to assess people with mental health problems, and develop care and treatment plans. Being able to refer patients to an allied health professional encouraged GPs to manage more patients with mental health problems.

Psychiatrists noted that with the new and expanded items for psychiatrists to undertake patient assessments and care plans, GPs were more willing and capable of managing more patients and more complex patients than previously.

Public mental health providers noted an increased capacity to refer patients to their GPs for common mental health problems, and GPs' capacity to develop treatment options.

2. *Encourages private psychiatrists to see more patients*

All psychiatrists consulted indicated that the new MBS items encouraged psychiatrists to see more patients. They were more prepared to see new patients knowing that the GP would provide the patient's ongoing management and that alternative specialist mental health treatment options were available through AHPs.

However, a minority of respondents thought Better Access had contributed to psychiatrists being more accessible, with more than half of GPs and one-third of AHPs not perceiving psychiatrists as being more accessible. It is generally perceived as still difficult to gain access to a private psychiatrist, especially one with low fees or who bulk billed. GPs and consumers thought the difficulty in accessing psychiatrists was because there were too few.

A very small number of psychiatrists had concerns of patients being 'held onto' by GPs and not being referred to a psychiatrist and/or inappropriately referred to an AHP, when treatment by a psychiatrist would achieve a better outcome for the patient. Most thought this would be resolved through education and training rather than being an inherent problem with the initiative.

3. *Providing referral pathways for appropriate treatment of patients with mental disorders*

All stakeholder groups felt that Better Access had both developed treatment options and developed and improved existing referral pathways between GPs, psychiatrists and AHPs.

4. *Supporting GPs and primary care service providers through education and training to better diagnose and treat mental illness.*

At the time of consultations, very little of the planned training had begun. The one stakeholder who had participated identified the approach as positive.

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.