CHAPTER 6

BETTER ACCESS INITIATIVE

6.1 As well as initiatives aimed at assisting people with mental illness in their daily activities and participation in the community, the COAG Plan included initiatives focussed on improving access to clinical care within the community. Prime among these was the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule initiative. In this chapter the committee considers support for the initiative, the use of Better Access so far, barriers to access such as cost and geography and other concerns about the implementation of the initiative. The committee then looks at provider eligibility for Better Access before turning to the matter of evaluation.

The initiative

6.2 The aim of the Better Access initiative was to 'improve access to, and better teamwork between, psychiatrists, clinical psychologists and other allied health professionals'.[1] The initiative was the largest budget item in the COAG Plan, with $538.0 million allocated over five years. This amount was supplemented in February 2008, taking account of the strong early uptake of the program.[2]

6.3 The Better Access initiative provides Medicare rebates for certain GP provided mental health services and consultations with psychiatrists. It also provides Medicare rebates for consultations with specified privately practicing allied health professionals (psychologists, occupational therapists and social workers) where patients have been referred under a GP mental health care plan or by a psychiatrist or paediatrician.[3] The amount of the rebates for these services is set out in Table 1.

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1 COAG Plan, p. 9.

2 Funding for the Better Access initiative was supplemented to $773.8 million in February 2008, however was reduced by $29.7 million in the 2008–09 Budget. See Senate Community Affairs Committee, *Additional Budget Estimates*, February 2008, Tabled Document, 'Outcome 11 COAG Mental Health: Funding and Expenditure' and Budget Estimates *Committee Hansard*, 5 June 2008, p. 153.

3 DoHA, www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1, accessed 10 June 2008.

Table 1: Better Access Initiative, MBS rebates[4]

Service	Schedule fee	MBS rebate
Consultant Psychiatrist, Initial Consultation on a new patient	$235.05	$199.90
GP Mental Health Care Plan	$153.30	$153.30
GP Mental Health Care Consultation	$67.45	$67.45
Clinical Psychologist, Psychological Therapy long consultation	$132.25	$112.45
General Psychologist, Focussed Psychological Strategies long consultation	$90.15	$76.65
Occupational Therapist, Focussed Psychological Strategies long consultation	$79.40	$67.50
Social Worker, Focussed Psychological Strategies long consultation	$79.40	$67.50

6.4 Referrals to allied health professionals under the Better Access initiative are initially for up to six consultations. A further six consultations are also available following a review by the patient's GP. Under exceptional circumstances, where there is a clinical need and the GP advises Medicare, patients are able to claim a further six consultations, bringing the total available to eighteen.[5] In addition, patients are also able to receive a rebate for up to twelve group therapy sessions.[6]

6.5 Clinical psychologists are able to provide a range of psychological therapies under Better Access. Only certain therapies, labelled as 'Focussed Psychological Strategies' (FPS), conducted by other allied health professionals are eligible for a rebate. These therapies are:

- Psycho-education (including motivational interviewing)
- Cognitive-Behavioural Therapy (including behavioural interventions and cognitive interventions)
- Relaxation strategies (including progressive muscle relaxation and controlled breathing)

4 As at April 2008. Selected items only are shown in the table and refer to in room consultations. Department of Health and Ageing, *Utilisation of Mental Health Medicare Items.*

5 Mr Smyth, Assistant Secretary, DoHA, *Proof Committee Hansard*, 16 May 2008, p. 81.

6 *Better Access to Mental Health Care Questions and Answers*, http://www.health.gov.au/internet/main/publishing.nsf/Content/coag-mental-q&a.htm, accessed 28 July 2008.

- Skills training (including problem-solving skills and training, anger management, social skills training, communications training, stress management, and parent management)
- Interpersonal Therapy (especially for depression).[7]

Support for the initiative

6.6 Evidence to the committee's inquiry indicated widespread support for the Better Access initiative. Improved access to clinical services was viewed as a major achievement. Professors Hickie and McGorry have described the introduction of the Better Access rebates as a 'major step towards removing one of the most significant barriers to evidence-based care'. They commented that 'arguably, it is the most important and practical reform in Australian mental health care in the past 15 years'.[8]

6.7 Witnesses also hailed the subtle, structural change that Better Access is helping to facilitate. Government rebates for psychological and other allied health services have helped to effectively recognise the importance of 'talking therapies' in mental health care. For example, Ms McMahon, Chair of the Private Mental Health Consumer Carer Network commented, 'the better outcomes initiative has the capacity to shift the emphasis away from the traditional premise that medication is the only way to treat mental illness'.[9] She also commended the early intervention capacity in the program, as people are able to access psychologists early rather than having to 'wait until they end up in a mental health service'.[10]

6.8 The Australian Psychological Society also pointed to wider effects of the Better Access initiative, beyond individual treatment:

> The universal availability of psychological treatment through the nation's funded health system has possibly also contributed to a destigmatisation of help-seeking for mental health problems, which is an important development.[11]

6.9 The Mental Health Coalition of South Australia felt that by linking supports through GPs, Better Access assists people to self direct their own care. Mr Harris, Executive Director, commented that 'people can choose their GP. They might have a

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7 *Better Access to Mental Health Care Questions and Answers*, http://www.health.gov.au/internet/main/publishing.nsf/Content/coag-mental-q&a.htm, accessed 28 July 2008. Professor Jackson and Mr Rudd critiqued the appropriateness of this listing, *Submission 62*, p. 6.

8 Ian B Hickie and Patrick D McGorry, 'Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?', *Medical Journal of Australia*, Vol 187 No 2, 16 July 2007, p. 101.

9 *Proof Committee Hansard*, 8 May 2008, p. 48.

10 *Proof Committee Hansard*, 8 May 2008, p. 54.

11 Australian Psychological Society, *Submission 55*, p. 8.

family GP, or, if the first GP they go to is not very helpful, they can choose another one'.[12]

6.10 As such, while in many submissions and at hearings witnesses commended the Better Access initiative for the treatment it is making available to individuals, there was also recognition that it is playing a valuable part in addressing wider issues such as balancing the kinds of treatment available, destigmatising mental illness and contributing to consumers' ownership and control over their care.

Use of Better Access services

6.11 So far the Better Access rebates have primarily been used by GPs and psychologists. Fewer referrals have been made to other eligible allied health professionals such as occupational therapists and social workers.

6.12 Data on use of the Better Access Initiative from its commencement in November 2006 to 30 June 2008, show that in this period there were:

- 799,608 GP mental health care plans
- 730,495 GP mental health care consultations
- 1,545,290 focussed psychological strategy (FPS) long consultations with general psychologists
- 810,847 psychological therapy long consultations with clinical psychologists
- 119,253 initial consultations with a consultant psychiatrist for new patients
- 86,275 FPS long consultations with social workers
- 14,843 FPS long consultations with occupational therapists.[13]

6.13 Concerns were raised that there is limited understanding that allied professionals other than psychologists are eligible to provide services under Better Access.[14] Overall, services provided by occupational therapists and social workers accounted for only 2.5 per cent of all Better Access usage. While referrals to these allied health professionals have increased over time, so too has use of the other Better Access items.[15]

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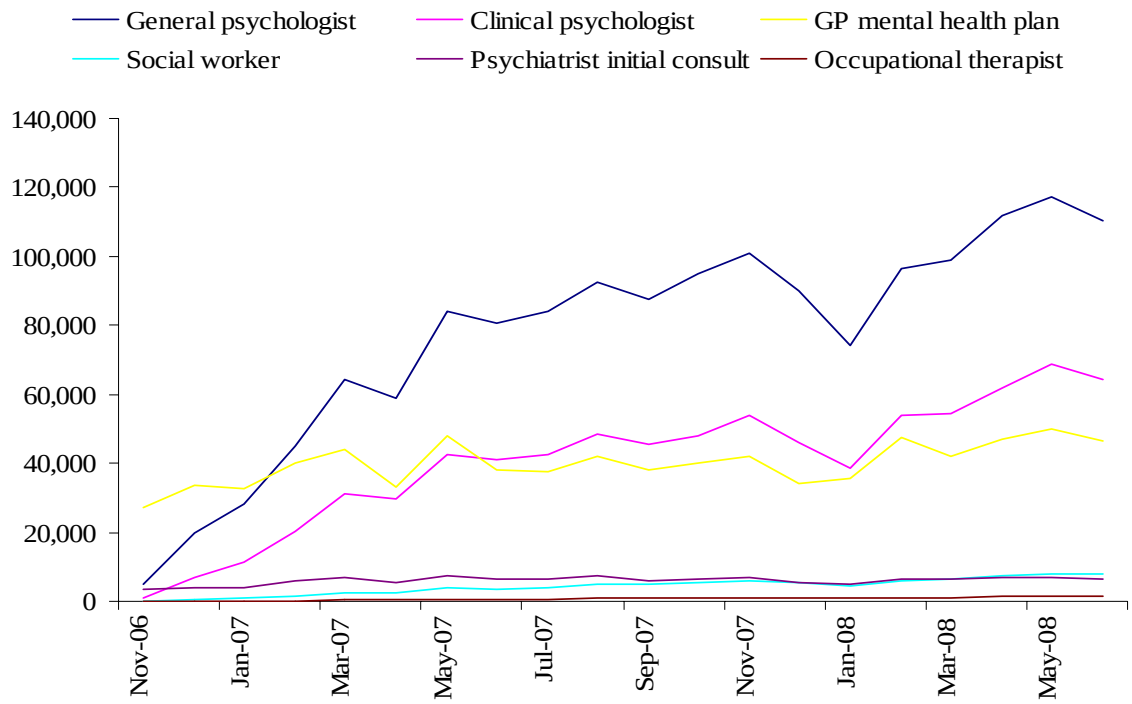
12 *Proof Committee Hansard*, 8 May 2008, p. 3.

13 Medicare Australia, www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 27 July 2008. Data refer to in-room consultations.

14 See for example SANE Australia *Proof Committee Hansard*, 1 April 2008, p. 1.

15 For a description of the increased use of Social Workers under the initiative see Australian Association of Social Workers, *Proof Committee Hansard*, 20 May 2008, p. 39.

Figure 1: Use of Better Access, selected items[16]



Diagnosis and treatments

6.14 Referrals can only be made under the Better Access initiative for eligible mental health conditions. This includes a range of conditions, for example psychotic disorders, phobic disorders, anxiety disorders and depression, post-traumatic stress disorders, sleep disorders, sexual disorders, eating disorders, alcohol and drug use disorders, panic disorders and obsessive compulsive disorder.[17]

6.15 An Australian Psychological Society (APS) survey of its members collected information about the diagnoses for people accessing psychological services under the Better Access initiative. The most frequent presentations were depression (18 per cent), co-occurring depression and anxiety (17 per cent), anxiety (13 per cent), post-traumatic stress (6 per cent), adjustment disorder (6 per cent), psychosis, schizophrenia and bipolar (6 per cent), and drug and alcohol use disorders (6 per cent).[18]

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16 Medicare Australia, www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 27 July 2008. Data for allied health professionals refer to Focussed Psychological Strategy in-room long consultations.

17 For a full list see *Better Access to Mental Health Care Questions and Answers*, http://www.health.gov.au/internet/main/publishing.nsf/Content/coag-mental-q&a.htm, accessed 28 July 2008.

18 Australian Psychological Society, *Submission 55*, p. 5.

6.16 While DoHA did not yet have a detailed breakdown on the use of Better Access services, Mr Smyth, Assistant Secretary, indicated that the average number of consultations per patient was around five.[19] The surveyed APS psychologists reported 38 per cent of Better Access clients required one to six sessions, 47 per cent required seven to twelve sessions and 15 per cent required thirteen to eighteen sessions for completion of their psychological treatment.[20]

Group therapies

6.17 The Western Australian Association for Mental Health (WAAMH) noted that there has been little use of the group activity items available under Medicare.[21] Indeed the large majority of services provided under the Better Access initiative have been for traditional in-room individual consultations. MBS items are available under Better Access for out-of-room services and group therapy sessions with Clinical Psychologists, General Psychologists, Occupational Therapists and Social Workers. However these kinds of treatment account for only 2 per cent of the Better Access services provided by allied health professionals.[22] Ms Hocking, from SANE Australia, suggested that there is little understanding that group activities and therapy are important.

6.18 Professor Calder, First Assistant Secretary DoHA, indicated that a planned post implementation review of Better Access would provide more information about the low use of the group therapy items, however it was possible that group therapy had previously been used more, because it was less costly than individual therapy.[23] With Better Access, presumably, comparatively more people are able to afford individual therapy.

6.19 The Mental Health Coordinating Council suggested that group therapy was not ideally placed within individual private practice:

> We note that the expanded options for access to mental health care under Medicare—such as group therapy, symptom management and psycho-education services outside of specialist consulting rooms and remote phone counselling—are almost negligible. We suggest that might be due to the fact that these options might be more appropriately placed within community services utilising a broad spectrum of mental health practitioners.[24]

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19 *Proof Committee Hansard,* 16 May 2008, p. 80.

20 Australian Psychological Society, *Submission 55*, p. 5.

21 See also Mental Health Community Coalition ACT, *Proof Committee Hansard,* 16 May 2008, p. 16.

22 Medicare Australia, www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 27 July 2008. Over the period November 2006 to June 2008.

23 *Proof Committee Hansard,* 16 May 2008, p. 82

24 *Proof Committee Hansard,* 27 March 2008, p. 44.

6.20 Similarly, the Australian General Practice Network (AGPN) pointed to some of the difficulties in referring patients for group therapy noting that 'in theory it is possible; in practice it is quite difficult to actually get the numbers in the groups and make it viable economically when you have limited resourcing to do it'. Dr Wells provided an example where group therapy is working well, noting that this involves a clinical coordinator to make bookings and coordinate the therapy. Dr Wells concluded that 'service coordination infrastructure is really important if we want to see group therapy become more widespread and be more systemically taken up'.[25]

6.21 It is clear that there has been a great take up of the Better Access initiative, with millions of mental health care consultations having been provided under the initiative. However, use of some types of providers and some types of services are more common than others. In evaluating the initiative it will be important to assess whether barriers are preventing access to the most appropriate type of care available.

Is Better Access providing 'new' services?

6.22 The committee received different views as to which groups of people and what kinds of needs the Better Access initiative is assisting. There was a concern that the Better Access initiative may not be providing new services, but rather more services to those already receiving some level of care. Some witnesses suggested that the initiative was meeting the needs of the 'worried well', rather than those with the most debilitating illnesses.

6.23 The Mental Health Council of Tasmania reported anecdotal accounts to this effect:

> Statements that are coming to us are that it is providing services for people who would be labelled middle class. So the people who would otherwise have accessed those services through government for free are no longer accessing them because they cannot get in to see anybody. I think it has had an adverse effect for a large part of our community.[26]

6.24 The Mental Health Coordinating Council reported:

> There was some feedback also from GPs that many of the clients using the MBS scheme represent those already accessing services privately, so we were concerned that this may be causing a shift from services for the seriously mentally unwell to those better able to access referrals and pay the gap.[27]

6.25 Dr Gurr, Comprehensive Area Service Psychiatrists Network of NSW (CASP) commented:

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25 *Proof Committee Hansard*, 16 May 2008, p. 10.

26 *Proof Committee Hansard*, 31 March 2008, p. 4.

27 *Proof Committee Hansard*, 27 March 2008, p. 43.

> It is interesting how few of the people who are going and getting a referral from their GP and having the expensive plan written actually go back for a review. If you look at the number of reviews, you see that they are very low by comparison. That says to me that either people have gotten better or it is the easier end of the spectrum that is being looked after in that process.[28]

6.26 However, preliminary results of a survey conducted by the Australian Psychological Society (APS) suggest that the initiative is reaching new clients and people who are very unwell. In the survey of its members, the APS found that 72 per cent of clients that were referred under the Better Access initiative had never seen a psychologist before. Nearly half (46 per cent) of clients presented with a moderate disorder and over a third (35 per cent) had severe disorders. A smaller number (19 per cent) had mild disorders.[29]

6.27 The Private Mental Health Consumer Carer Network, based on feedback through its committees and members, also believed that more people were accessing services through Better Access. Ms McMahon commented that 'a whole range of people are now accessing mental health who never would have'.[30]

6.28 The Queensland Alliance Mental Illness and Psychiatric Disability Groups provided a slightly different perspective. Witnesses noted that, even if Better Access is not providing services to the most unwell, it may at least have an early intervention effect and also relieve pressure on state run and NGO services, freeing them up to provide focused assistance to those with acute needs.[31]

6.29 It is difficult to reconcile different views about who is, and who is not, benefiting from the MBS items without further information. It is clear that the initiative is being taken up and the APS data suggests it is being used by people with moderate to complex needs, many of whom were not previously receiving this kind of treatment. However, many witnesses observed from their experience that for those with severe illness combined with other disadvantages, whether through social, economic or geographic circumstances, services remain out of reach. Some of these barriers to access are discussed later in the chapter.

6.30 The committee commends the APS for it efforts in collecting information about the use of the Better Access initiative. Discussion about whether the initiative is reaching new clients and those with greatest need in part relate to whether the initiative is providing value for money. Comprehensive information about the use of the program, and the outcomes it is achieving for people, is needed in order to assess

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28 *Proof Committee Hansard*, 27 March 2008, p. 74.

29 Australian Psychological Society, *Submission 55*, p. 5.

30 *Proof Committee Hansard*, 8 May 2008, p. 53.

31 Queensland Alliance Mental Illness and Psychiatric Disability Groups, *Committee Hansard*, 26 March 2008.

whether this is the best way to provide primary mental health care. The issue of information and evaluation is discussed further at the end of this chapter.

Barriers to access

6.31 While many witnesses commended successive governments for the Better Access initiative, concerns were raised that the initiative remains out of reach for some people including those with the most severe illnesses and in the most desperate circumstances. The following sections look at some of the barriers that need to be overcome to obtain the kinds of service offered through Better Access.

Costs

6.32 One concern in relation to the Better Access initiative is that services may remain unaffordable for some people with the greatest needs. People who are homeless or in other financial difficulty may not have contact with the private medical system, or, if they do consult a GP, be unable to afford the allied care. Unless a practitioner bulk bills, patients remain liable for the gap between the schedule fee and the MBS rebate, plus any charges made by the practitioner above the schedule fee.

6.33 The average gap payments for the most common services under Better Access between November 2006 and December 2007 are provided in Table 2. Bulk billing rates among psychologists and psychiatrists remain comparatively low and correspondingly, out-of-pocket expenses for these services are higher, particularly for psychiatric services.

Table 2: Better Access Initiative, costs to consumers[32]

Service	Bulk billing rate	Average co-payment
GP Mental Health Care Plan	92.5	$15.94
GP Mental Health Care Consultation	90.2	$18.58
Clinical Psychologist, Psychological Therapy Long Consultation	25.9	$27.97
General Psychologist, Focussed Psychological Strategies Long Consultation	30.4	$33.41
Consultant Psychiatrist, Initial Consultation on a new patient	29.9	$65.10

6.34 The different gap between the schedule fee and Medicare rebate for different providers, as set out in Table 1, is relevant when looking at bulk billing rates. Ms McMahon, Chair of the Private Mental Health Consumer Carer Network, pointed out

32 Department of Health and Ageing, *Utilisation of Mental Health Medicare Items*, 1 November 2006 to 31 December 2007.

that under Better Access, the Medicare benefit for GP provided mental health care is the same as the schedule fee with no 'gap'. As Ms McMahon commented 'one would assume that bulk-billing would be the way to go for GPs'.[33] Thus while GP bulk billing rates are high in comparison with the other service providers, it is perhaps surprising that they are not even higher.

6.35 In contrast, the Australian Association of Social Workers (AASW) pointed to the different level of rebate that social workers and occupational therapists receive, compared with other providers of psychological strategies. They said that this acts as a disincentive to bulk bill. Ms Sommerville, Mental Health Policy Officer, expanded:

> Social workers, with the underpinning values of social justice, have a natural inclination to do the best by our clients by addressing those in the most vulnerable positions. There is a natural inclination to want to bulk-bill, but to manage all the costs associated with private practice is quite difficult with the current rebates.[34]

6.36 Ms Debora Colvin, Head of the Council of Official Visitors in WA, commented that for the patients that Official Visitors see, there has been no change in access to psychologists, psychiatrists and GPs through the Better Access initiative. Official Visitors sees consumers who are involuntary patients, including those on community treatment orders, those who are accused of crime and are in authorised hospitals such as forensic units and those who live in licensed private psychiatric hostels.[35] Ms Colvin commented that these consumers are nearly always on disability benefits and are unable to pay gap fees. For those psychiatrists and psychologists that bulk bill, there are long waiting lists and many consumers have difficulty accessing GPs in the first place.[36]

6.37 Similarly Mr Quinlan, Catholic Social Services Executive Director, pointed out that for many clients any gap fee is going to put services out of reach:

> As one of our managers reflected, 'Due to the nature of our clients, it doesn't matter if the gap is $5 or $500; if they don't have it they can't afford it.' The cost of accessing external providers is a barrier for many of our disadvantaged clients because they just do not have the funds to resource a gap.[37]

6.38 The committee is concerned by evidence that suggests the Better Access initiative is not providing mental health services to those experiencing some of the greatest difficulties. While the Better Access initiative appears to have opened up access to previously underutilised service providers, the evidence to the committee

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33 *Proof Committee Hansard,* 8 May 2008, p. 48

34 *Proof Committee Hansard,* 20 May 2008, p. 40.

35 *Proof Committee Hansard,* 7 May 2008, p. 64.

36 *Proof Committee Hansard,* 7 May 2008, p. 65.

37 *Proof Committee Hansard,* 16 May 2008, p. 65.

reinforces the importance of maintaining well supported public mental health services. Even with government support, private care will remain unaffordable for some people most in need of mental health care.

6.39 The committee also notes that careful monitoring of gap payments over time is necessary to ensure that Better Access is making services more accessible and not simply more expensive.

Geography and workforce distribution

6.40 Submitters and witnesses questioned the equity of access to services provided through the Better Access initiative across different regions of Australia. Witnesses noted that provision of services under the initiative is driven not on the basis of population need, but by workforce supply. The Mental Health Coordinating Council said:

> …distribution of services across Australia is not uniform, with some states making much higher levels of claims for the new services on a per capita basis, and the distribution of claims appearing to broadly match the distribution of health professionals.[38]

6.41 Data from Medicare Australia's website indicate the different use of Better Access services across the States and Territories, as shown below in Table 3. Use of the Better Access services in the Northern Territory was well under half that of the national average. Other differences across the states and territories suggest differences in workforce distribution and health system structures. For example, consultations with clinical psychologists were the most used item in Western Australia, whereas consultations with general psychologists were most common in the other states and territories. Tasmania, Western Australia and South Australia had a higher uptake of the occupational therapist services than the other states, while Victoria and New South Wales were the greatest users of social worker consultations.

38 *Proof Committee Hansard,* 27 March 2008, p. 43.

Table 3: Use of Better Access per 100,000 population[39]

	NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT	Aust.
GP mental health plan	3969	4420	3377	3123	3274	3410	1447	3328	3782
Psychiatrist initial consult	560	613	560	680	462	385	240	506	564
Clinical psychologist	3740	4177	2027	3666	6965	5158	847	4014	3835
General psychologist	7258	10510	7216	3901	3186	6008	2136	6747	7309
Occupational therapist	71	78	45	84	88	131	0	22	70
Social worker	437	511	351	364	303	332	52	133	408

6.42 The ability of the Better Access initiative to improve service access beyond metropolitan areas was also questioned. For example, the dearth of psychiatrists and few psychologists in remote areas limits how much the initiative can help people with mental illness to access services in these areas.[40] AMSANT commented on the low numbers of clinical psychologists in rural and remote areas, and the heavy demand for their services. AMSANT suggested looking at options to upskill other existing health professionals already in these areas, particularly for the provision of Cognitive Behaviour Therapy:

> …there are a significant number of mental health professionals who are already in the Northern Territory who are not sufficiently qualified and are not eligible for the Medicare benefits. We think there needs to be an alternative pathway so that people like them could complete a very vigorous upskilling program.[41]

6.43 AMSANT also argued that in small jurisdictions like the NT and remote areas particularly, funding for allied health professionals is needed in the public sector:

> One thing that we do want to stress is that the public sector needs salaried psychologists and social workers who can access the items, not just the private sector, because the gap fees in the private sector are a very

39 Medicare Australia, www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 27 July 2008. Selected items only, for the period November 2006 to June 2008. Data for allied health professionals refer to Focussed Psychological Strategy in-room long consultations.

40 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 31; Government of Victoria, *Submission 41*, p. 8.

41 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 31.

> significant barrier to the very groups of people that the Senate [Select Committee] report said needed to be able to access CBT.

6.44 The AGPN also acknowledged the limitations of a fee-for-service model for people living in rural and regional Australia and for those who are economically disadvantaged. AGPN saw the need for a 'complementary funding model for allied mental health services' to improve access to care.[42]

6.45 The Australian Association of Social Workers noted that the distribution of social workers is better than the other allied health professionals included under Better Access, with over a third working in regional, rural and remote areas of Australia.[43] They considered that improvements could be made under Better Access to increase its use to people in rural and remote areas. For example, AASW suggested allowing longer consultation times for rural and remote social workers, given that consumers often have to travel a long way to access the service:

> They may come for their hour and then have to travel a long way back. If they had a longer consultation time then perhaps more could be achieved with less frequent sessions.[44]

6.46 Even within metropolitan areas, specialists are not evenly distributed. Dr Gurr, CASP, spoke about the situation in suburbs of Western Sydney:

> …these are areas where we do not get much benefit out of Medicare; the Commonwealth funding that is available just does not go to those areas. I am the only private practitioner in the City of Blacktown, which has a population of approximately 300,000 people, and I do three hours a month.[45]

6.47 Professor Calder, First Assistant Secretary DoHA, outlined some of the approaches that are being taken to improve access to psychological therapies in communities not well serviced by private Medicare eligible providers. For example, the Access to Allied Psychological Services (ATAPS) program is an initiative that enabled eligible GPs to refer patients to allied health professionals prior to the Better Access initiative. Funding for this initiative is distributed through the Divisions of General Practice. With Better Access now operating, Professor Calder outlined that ATAPS projects are being refocussed:

> The ATAPS refocusing and extension is to occur through a trial of telephone based therapy in rural and remote areas, the provision of better support and referral pathways for general practitioners managing patients at high risk of suicide and the provision of additional funds to rural and remote and outer metropolitan divisions of general practice that have unmet

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42 *Proof Committee Hansard*, 16 May 2008, p. 1

43 *Proof Committee Hansard*, 20 May 2008, p. 39.

44 *Proof Committee Hansard*, 20 May 2008, p. 40.

45 *Proof Committee Hansard*, 27 March 2008, p. 59.

> demand. It is anticipated that this will increase funding to over 50 per cent of rural and remote and outer metropolitan divisions. The government is also exploring models to target specific high-need groups, including homeless people and Indigenous populations.[46]

6.48 Mr Smyth, also from DoHA suggested that the current workforce distribution and gap payment barriers to allied health professional services are to some extent a reflection of the past full-fee system, with inequities expected to ameliorate over time. He said:

> …psychologists have generally been located in areas where people have been able to afford full-fee payment prior to the introduction of the Medicare items or they have had private health insurance arrangements for that. We really do expect over time that that will start to reduce as greater competition comes into the market and also as we see a greater distribution of psychologists in rural and regional Australia, as a number of the workforce measures…start to bite in the coming years.[47]

6.49 The committee discusses workforce shortages and issues of access to mental health care in rural and remote areas more generally in chapters 8 and 9. In relation to Better Access, the committee notes the different use of the program in different areas. Again, the committee suggests that this evidence emphasises the importance of well supported public sector mental health care. Better Access should not be viewed as the panacea to Australia's mental health care shortages.

Awareness

6.50 Lack of awareness about the Better Access initiative among providers and the public is another potential barrier to access. Ms Powell from the West Australian Mental Illness Awareness Council (WAMIAC) questioned how consumers find out about the initiative if they do not have a GP. This is particularly relevant for people with a mental illness who are homeless, or for other reasons are largely outside the existing health system.[48] Similarly WAAMH raised concerns that many people are not aware that the Better Access program exists, and that some GPs are not using the initiative.[49]

6.51 Ms Colvin, Head of the WA Council of Official Visitors, pointed to lack of awareness and interest in the initiative among some health professionals:

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46 *Proof Committee Hansard*, 16 May 2008, p. 77.

47 *Proof Committee Hansard*, 16 May 2008, p. 80.

48 *Committee Hansard*, 7 May 2008, p. 56.

49 *Committee Hansard*, 7 May 2008, p. 5.

> I personally have had an experience on behalf of a consumer where I met with the psychiatrist. He had no idea about the initiatives by the government in this area and little or no interest either.[50]

6.52 While it is concerning to hear accounts of health professionals who are not interested in the services potentially available to assist their clients, the committee also heard from professional groups about the efforts they undertake to increase awareness of the initiative. For example, the AGPN explained that the divisions of general practice have a role in helping GPs to understand and use the new referral pathways available under Better Access. Ms Wells noted that:

> A common practice for many divisions would be to facilitate local peer networking and local multidisciplinary training networks among providers, and to give GPs choice about the range of new referral pathways that are now available to them through COAG mental health. Divisions systematically and routinely put together service provider directories…[51]

6.53 The committee encourages all health professional groups to continue their endeavours in raising awareness and improving understanding of the Better Access initiative.

Concerns about the initiative

6.54 In addition to the specific barriers to access discussed above, submissions and witnesses raised some structural and implementation issues that are relevant in assessing whether the Better Access initiative is delivering the best possible mental health outcomes for the community. These are discussed below.

Distribution of resources across the states and territories

6.55 Some state governments were concerned about the fee-for-service basis of the Better Access initiative. Different amounts of funding go into the different states and territories not on the basis of population or need, but on the basis of service usage which is at least partly driven by the availability of professionals and allied health professionals in the different areas. For example, the Government of Western Australia argued that it does not receive its per capita share of MBS payments and that elements of the initiative should be 'cashed out' to provide equitable contribution to all the states and territories. Mr Thorn, from the WA Department of Premier and Cabinet conceded that WA had received more than a per capita share of some of the other Commonwealth COAG Plan initiatives, such as 'Mental Health Services in Rural and Remote Areas', of which WA received 25 per cent of the funding. However Mr Thorn assessed that this increase did not make up for the loss experienced through Medicare payments. The WA Government assessed that over the first 16 months of the COAG Plan, Western Australia had received 7.7 per cent of all mental health MBS funding,

50 *Proof Committee Hansard*, 7 May 2008, p. 65.

51 *Proof Committee Hansard*, 16 May 2008, p. 9.

whereas a population based share would be 9.9 per cent.[52] The Governments of South Australia and Northern Territory had similar concerns, given the lower number of psychologists and other allied health professionals in rural and remote areas and, in the case of the NT, the 'extremely small' private mental health sector, limited availability of GPs and lack of bulk-billing for services.[53]

6.56 The committee notes the different levels of use of Better Access items across the states and territories and the concerns expressed by some governments about inequity in the distribution of funds through the measure. In reviewing Better Access it will be important for the Australian Government to consider the funding to states and territories through the initiative along with additional funding through other measures, with a view to evaluating the equity of funding distribution.

Public sector capacity

6.57 Several state governments raised concerns that the Better Access initiative was drawing allied professionals out of the public sector workforce and therefore not necessarily increasing access to services, but rather reshuffling services to a more expensive part of the sector.[54] Other witnesses also presented this view. For example, Ms Swallow, from the Mental Health Council of Tasmania, commented:

> …a significant impact is psychologists exiting that system to set up in private practice because they can now access money through Medicare. It is having a significant flow-on effect.[55]

6.58 Although the committee did not receive any data on workforce movements, the professional associations reported their observations. Dr Freidin, from the Royal Australian and New Zealand College of Psychiatrists commented:

> There are certainly reasons for concern. There are a limited number of psychologists, particularly the most highly trained in the area—the clinical psychologists. Our experience currently is that psychologists who have been working full time in the public system are putting their toe in the water—they are cutting back from full time to three days a week, doing a day or two of private practice and seeing how it goes. Potentially, they may increase that if they find it to their interest or beneficial in other ways. Part of the difficulty is the disparity between the potential income through private practice and what they are paid as public employees, as well as the issue of there being a limited pool of highly trained mental health staff.[56]

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52 Department of Health, Government of Western Australia, Additional Information 9 June 2008.

53 *Proof Committee Hansard,* 8 May 2008, p. 88; *Proof Committee Hansard,* 1 May 2008, p. 49; see also ACT Government, *Submission 37,* p. 4.

54 See for example Tasmanian Government, *Submission 42,* p. 5; Victorian Government, *Submission 41*.

55 *Proof Committee Hansard,* 31 March 2008, p. 5.

56 *Proof Committee Hansard,* 1 April 2008, pp. 37–38.

6.59 The results of a survey of public sector psychologists in Melbourne in 2007 support Dr Freidin's assessment. The APS reported that a third of surveyed psychologists intended to reduce their working hours to take up some private practice over the next two years. Among the more senior psychologists, 41 per cent intended to reduce their public sector hours. Among the psychologists intending to leave the public sector, the main reasons were increased opportunities and remuneration, greater flexibility and autonomy. Improvements to public sector employment conditions that may lead them to change their plans included improved remuneration, increased specialist psychology work, promotion opportunities, increased study/conference leave, additional annual leave, professional development, increased provision of private practice rights and research opportunities.[57]

6.60 The Australian Association of Social Workers noted that when the Better Access initiative was introduced less than 250 mental health social workers were registered for the initiative and by May 2008 there were close to 800.[58] Ms Sommerville suggested the source of the increase as follows:

> Social workers have been working in private practice for many, many years so I think initially those were the social workers coming on board. But increasingly so it is some working in public mental health who are just perhaps reducing one or two days in public mental health or adding some extra private practice time on to their already full-time position in public mental health.[59]

6.61 In the context of workforce shortages, movement of mental health professionals and allied health professionals from the public sector to the private sector is a key indicator to monitor. For some people, including many of those experiencing the most severe illnesses, public sector services often remain the only option.

Promoting team work?

6.62 Although pleased to see money being allocated to primary mental health care, some witnesses questioned whether Medicare was the best way to use the available funds. Witnesses were concerned that the individual fee-for-service model underlying the Better Access initiative does not promote team work and integrated care. Mr Calleja, from Richmond Fellowship WA commented:

> The reality is that good recovery work is about integrated approaches to dealing with the whole person. If you have millions of dollars going into Medicare funded services that do not then have a connection to other aspects of a person's life, you have money siphoning off into a black hole.[60]

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57 Australian Psychological Society, *Submission 55,* p. 13.

58 *Proof Committee Hansard,* 20 May 2008, p. 39.

59 *Proof Committee Hansard,* 20 May 2008, p. 43.

60 *Proof Committee Hansard,* 7 May 2008, p. 47.

6.63 Similarly, Mr Crosbie, Chief Executive Officer of the Mental Health Council of Australia outlined:

> Collaborative care is always going to be better than individual care and every bit of research we know about mental health says that. In a sense, I am always concerned about models that privatise it down to an individual service practitioner level in any area of health, and then we rely on that individual service provider to in some way provide a service that they are being paid for without any sort of follow-up or any kind of review of how that is going in an ongoing way.[61]

6.64 Witnesses remarked that the current rebate system does not support an integrated approach among health professionals, let alone across clinical and non-clinical settings. Ms Oakley, NSW Consumer Advisory Council, said:

> …whilst people may be referred from their GP to the psychologist with a care plan in place, there is not always that consistent information sharing and updating, which is quite critical in managing the care of consumers.[62]

6.65 Dr Johnson, a member of the Royal Australian College of General Practitioners, gave the committee a sense of how collaboration occurs on the ground:

> Collaboration occurs in my own practice when I am able to set aside time. This might be to call another health professional to discuss the care of a person with mental health problems. One local psychiatrist that I work with will regularly send me a fax to notify me of medication changes to a mutual patient. Occasionally I can flag the psychologist who works in our practice for a brief discussion about the patients that we care for. These simple but extremely valuable interactions all occur alongside rather than within the current Medicare structure.[63]

6.66 The Medicare system does not fund collaborative efforts such as case conferencing or writing reports on joint clients.[64] Dr Gurr spelled out the business reality of the Better Access system:

> Medicare…if you are a psychiatrist, basically rewards you for doing things in an office for certain periods of time. You maximise your income by seeing people for 16 minutes exactly; for every minute that you go past that you start to lose money, comparatively. You do not get paid for liaison work. In discussing what is happening with a particular consumer and their relatives, you get paid less to talk to the relatives, you get paid nothing to talk to the GP and you get paid nothing to talk to another provider, whether it is a NGO, another discipline that is paid through Medicare or whatever. So there is no reward for properly communicating, yet the evidence in

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61 *Proof Committee Hansard,* 20 May 2008, p. 86.

62 *Proof Committee Hansard,* 27 March 2008, p. 51.

63 *Proof Committee Hansard,* 1 April 2008, p. 63.

64 Mr Calleja, *Proof Committee Hansard,* 7 May 2008, p. 48; Australian Psychological Society *Submission 55,* p. 11.

> mental health is that you get the most effect if you provide continuity of care and seamless transition of care.[65]

6.67 Professor Jackson and Mr Rudd were concerned about the diverse mix of education and skill levels that exist among the different allied health providers eligible for Better Access. They submitted that some of these groups do not have the specialist clinical skills to diagnose and treat mental illnesses. Professor Jackson and Mr Rudd considered that multidisciplinary teams, rather than individual fee-for-service providers, would allow for 'a more comprehensive and integrated case approach, and arguably better risk management, especially where complex presentations are concerned'.[66]

6.68 Beyond integrated clinical care, witnesses also pointed to the need for coordination with other supports and services that people with mental illness need in their recovery journey. These also are not encouraged by the individual fee-for-service system. Richmond Fellowship WA advocated connecting the Better Access strategy to the community sector, to promote a three-way relationship between GPs, allied health professionals and community agencies. Mr Calleja considered that this connected model has a 'much better chance of actually helping a person in their recovery process.'[67] Similarly, Ms Carmody from Ruah Community Services commented that it is important for clinical counselling services to be 'linked to an integrated coordinated support care approach'.[68]

6.69 Professors Hickie and McGorry have consistently raised concerns about the individual fee-for-service basis of the Medicare-rebate system and its ability to provide maximum mental health care to the population. Some of the concerns they have raised include:

- there are no requirements or incentives for collocation of services, recognised internationally as one of the most important measures for promoting collaboration;
- there are no requirements for geographic distribution of services;
- there are no incentives for treating patients in greatest need at low or no additional cost;
- there are no incentives for seeing younger people early in their illness;

65 *Proof Committee Hansard*, 27 March 2008, p. 60.

66 *Submission 62*, p. 5.

67 *Proof Committee Hansard*, 7 May 2008, p. 47.

68 *Proof Committee Hansard*, 7 May 2008, p. 48.

- services delivered under the scheme will remain highly concentrated in communities with the capacity to pay.[69]

6.70 While extensive use of the Medicare rebates under Better Access is clear, less evident to the committee is an increase in collaborative care. The Select Committee on Mental Health in its recommendations to government prioritised integrated care. It recommended 'a new set of Medicare mental health schedule fees and rebates for combinations of private consulting psychiatrists, GPs and psychologists who agree to work together or in conjunction with mental health centres under integrated, collaborative arrangements in the management of primary mental health services'.[70] Given the mechanism used by Government to provide Medicare rebatable psychological services, the committee considers it important that the review of the Better Access initiative look at options for improving collaboration between eligible providers.

GP plans and referrals

6.71 GPs are an important component of the mental health system as it currently functions in Australia. In 2006–07 one in ten consultations with GPs involved the management of a mental health related problem. This is equivalent to some 10.7 million GP consultations nationwide.[71] The Better Access system, by providing specific rebates for GP provided mental health services effectively recognised the role that GPs are providing in mental health care. The referral system under Better Access also aimed to help people with mental illness move through GPs to receive the specialist care that they need. However, the committee received different views as to how well GP Mental Health Plans are working. Ms McMahon considered that the GP Mental Health Plans were a progressive step:

> Whether they make it to a psychologist, an OT or a social worker, they are certainly being seen now in the GP sector…That is a formalised, structured plan now, whereas before there would have just been a long consult with a GP who would go through various issues. Now it is a formalised, structured plan…and one would assume it would have outcomes, goals and those sorts of things. [72]

6.72 The APS highlighted some issues with the GP Mental Health Plan process, based on the results of its survey of members. Surveyed psychologists reported that 27 per cent of GP Mental Health Care Plans did not reflect an accurate diagnosis and 33 per cent of psychologists believed that the GP's Mental Health Care Plan did not

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69 Ian B Hickie and Patrick D McGorry, 'Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?', *Medical Journal of Australia*, Vol 187 No 2, 16 July 2007, p. 101.

70 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 477.

71 AIHW, 2008, *Mental health services in Australia 2005–06,* p. xi.

72 *Proof Committee Hansard,* 8 May 2008, p. 53.

capture the most important features of a client's diagnosis and contributing issues. Psychologists needed to subsequently conduct their own full diagnostic assessment for 86 per cent of their Better Access clients.[73]

6.73 Dr Johnson, a member of the Royal Australian College of General Practitioners, saw the above statistics from a different view. She noted:

> …when people in psychological distress present in a primary care setting, it is not always apparent on the first or even the second or third visit what the diagnosis is, and it is also true that the diagnosis often evolves over time…You see someone who presents initially with depressive symptoms but, as you get to know them over time, it becomes clear that they may have, for example, bipolar disorder, or they may develop psychotic symptoms.[74]

6.74 Dr Johnson explained that some consumers do not want to divulge to their GP all the information that they might reveal to a mental health specialist. Given these kinds of considerations and that the minimum time to complete a Mental Health Plan is 30 minutes, Dr Johnson believed that it was positive that around two-thirds of GP plans were complete and captured the main issues.[75]

6.75 Similarly, Dr McAuliffe from the AGPN, did not see intrinsic problems with psychologists reviewing GP assessments:

> I think good clinical care means you always keep reviewing your diagnostic formulation and seeing whether you are providing the care that the individual needs, and that you are meeting the outcomes that are important to them and improving their health generally.[76]

6.76 However the APS considered that duplication in assessment and diagnosis wastes valuable resources that could be used for treatment services. The APS submitted that Better Access costs could be 'dramatically cut by reducing the role of the GPs in the assessment process and the requirement for them to write a Mental Health Care Plan', particularly given that as noted above the majority of psychologists will still undertake a full diagnostic assessment. The APS submitted:

> It is still suggested that GPs remain at the centre of patient care, and the 'gatekeepers' to treatment, by establishing that the patient has a mental health problem as part of a regular consultation and then referring the patient to a psychologist for a comprehensive assessment, diagnosis and treatment plan.[77]

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73 *Submission 55*; see also anecdotal evidence noted by Gippsland Advocates for Mental Health Inc about deficiencies in GP Mental Health Care Plans, *Submission 20*, p. 5.

74 *Proof Committee Hansard*, 1 April 2008, p. 66.

75 *Proof Committee Hansard*, 1 April 2008, p. 66.

76 *Proof Committee Hansard*, 16 May 2008, p. 11.

77 Australian Psychological Society, *Submission 55*, p. 11.

6.77 Diagnosis and care plans aside, some basic administrative processes in the Better Access initiative appear not to be working fully. Of concern, psychologists reported that 15 per cent of GPs did not activate the appropriate Medicare item number, with the result that clients could not claim a Medicare rebate. Nearly a quarter did not send a copy of the Mental Health Care Plan with the referral to the psychologist.[78] These occurrences certainly do not accord with the continuity of care and multidisciplinary approach that Better Access was intended to encourage.

6.78 Concerns were also raised about the amount of referral required back and forth through the GP. For example, if a patient is referred to a psychologist by their GP, but then assessed by the psychologist as requiring medication, the psychologist has to refer the patient back to the GP for them to refer onto a psychiatrist. Professor Littlefield, Executive Director of the APS, commented that it would be useful for psychologists to be able to refer directly to psychiatrists rather than back through the GP, noting:

> Any pathway that avoids a third step is not only useful but cost saving. Also, consumers tell you they do not want to tell their story multiple times.[79]

6.79 The committee agrees that provision for psychologists to refer Better Access patients directly to psychiatrists would simplify the care pathway for consumers. However, it is important that the GP be notified of any such referrals, to ensure that all providers involved in the person's care are aware of their current treatment.

6.80 Evidence from Professor Hickie and Professor Christensen suggests that referral pathways under Better Access are breaking down, with patient management and follow up needing to be prioritised:

> …something like 80 per cent of people who see a GP and need help, get a plan with their GP, if their GP is involved in the scheme, and those people are then referred. Sixty-six per cent of those people tend to turn up at the psychologist, say, for the program of CBT, and only 22 per cent actually get back to the GP. That is because nobody is there saying, 'Did they get to the psychologist?' The psychologist gets them and they do a very good job, then they refer them back, but the actual figures, from reading these unpublished reports, is that 22 per cent get back.[80]

6.81 The evidence to the committee suggests that the Better Access initiative itself has 'gaps' which consumers may fall through. Seeing a GP and setting up a Mental Health Care Plan is a first step in a treatment process, but of itself does not guarantee that consumers actually receive the planned treatment and support. Here, as in other areas of mental health care, connections between the different services and providers are paramount.

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78 Australian Psychological Society, *Submission 55*, p. 6.

79 *Proof Committee Hansard*, 1 April 2008, p. 50.

80 *Proof Committee Hansard*, 20 May 2008, p. 28.

Recommendation 13

6.82 The committee recommends that the post-implementation review of the Better Access initiative gives particular attention to the referral pathways in the Better Access initiative, whether consumers are effectively moving between the providers involved and whether any structural changes or additional funding are required to improve care management and coordination.

GP training

6.83 Some witnesses were concerned by what they saw as a 'watering down' of the training requirements for GPs under Better Access.[81] Prior to Better Access another program, Better Outcomes, provided an avenue through which GPs could refer patients to psychologists under Medicare. Under Better Outcomes, GPs who had completed level one training, a six hour course in managing mental health disorders, could refer patients to allied health professionals with a minimal out-of-pocket expense. GPs who had completed level two training, that is twenty hours of training in psychological treatment, could deliver focussed psychological strategies as claimable items under the MBS. As only one in five GPs had undertaken level one training, many consumers were not able to be referred under Medicare to a psychologist or allied health professional.[82]

6.84 Professor Littlefield, APS, commented on the Better Outcomes training:

> I believe in the Level 1 training that was there for Better Outcomes, which taught diagnosis. That was the three-step process that led to diagnosis and the development of a mental health plan. That was a very good training package. I think that would be very helpful to do.[83]

6.85 However, others noted that the kind of training that was provided under the Better Outcomes initiative did not necessarily actually lead to better outcomes for patients, as there was no evidence to show the training was then applied in practice. Dr Gurr, CASP, commented:

> I have done lots of training of GPs, I have been involved in all this Better Outcomes work and so on, I know that I can run any number of sessions, but they still will not actually apply the stuff because there is no supervision in practice. There is nobody to actually work with them in their practices on dealing with their difficult patients.[84]

6.86 Similarly, Dr Johnson, Royal Australian College of General Practitioners, commented:

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81 *Proof Committee Hansard*, 8 May 2008, p. 15.

82 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 145.

83 *Proof Committee Hansard*, 1 April 2008, p. 50.

84 *Proof Committee Hansard*, 27 March 2008, p. 71.

> …people outside of general practice often make the assumption that, if we run a training event—be it five hours, six hours or 20 hours—and GPs go to that, that will change behaviour. Yet the evidence is not very strong that it happens that way.[85]

6.87 More broadly, submitters commented on the need for medical practitioners to be able to bridge across medical based treatment and clinical perspectives to the community and psychosocial support needed to assist people with mental illness in their recovery. The Mental Health Coordinating Council commented:

> We support the concept of the GP as the most stable provider for clinical care, but the scheme fails to include a mechanism through which the GP can be upskilled to manage assessment and care plans and monitor consumer symptoms or work closely with the NGO sector to ensure the client's social, employment and other needs are met.[86]

6.88 Mr Senior, Acting President Mental Health Coalition of South Australia, observed that the 'GP model is still very much a medical, clinically driven model'. He saw room for further increasing the capacity of GPs to engage and assist individuals in the recovery journey in all areas of their life.[87]

Specific groups

6.89 The committee received evidence about weaknesses in the Better Access initiative for specific population groups. These issues are canvassed below. In chapter 9 the committee considers shortfalls in mental health services for these groups more generally.

Children

6.90 The APS raised a specific issue regarding the treatment of referred children. The APS explained that currently it is not possible under Better Access to claim a Medicare rebate for a session with the parent of a child who has been referred for treatment, unless the child is present. The APS submitted that:

> Provision of psychological services to the parents of a child who has been referred is an essential and often the most effective component of the treatment of the child. Unless the 'identified patient' (i.e. the child) is present, services provided to a parent or carer are not allowable under the Better Access initiative.[88]

6.91 The APS suggested that this limitation could be overcome by including appropriate words in the MBS notes to allow for parents and significant others to be

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85 *Proof Committee Hansard*, 1 April 2008, p. 65.

86 *Proof Committee Hansard*, 27 March 2008, p. 43.

87 *Proof Committee Hansard*, 8 May 2008, p. 15.

88 Australian Psychological Society, *Submission 55*, p. 12.

eligible for inclusion under specified items, in relation to the treatment of young children.[89] The APS survey of members showed that 10 per cent of psychologists' Better Access patients were children aged 12 years and under.[90]

Indigenous

6.92 The APS also reported outcomes from the first ever meeting of Indigenous psychologists in Australia. The following issues were raised in relation to the Better Access initiative for Indigenous consumers:

- The need for a referral from a GP to access treatment from a psychologist should be removed to allow referral from other professionals, self-referral and referrals from third parties (e.g., relatives).
- Longer time should be allocated to assess an Indigenous person and more valid forms of assessment are required as many assessment tools are culturally inappropriate.
- Indigenous clients need longer appointment times and will usually need more than 12 sessions.
- All Indigenous clients should be bulk billed and the bulk billing rebate for Indigenous clients should be increased.
- All psychologists should have Indigenous cultural competence as part of a requirement of registration, as is the case in New Zealand and the USA. Cultural competence should therefore be included in university training programs and ongoing professional development.[91]

Culturally and linguistically diverse communities

6.93 Multicultural Mental Health Australia (MMHA) submitted that there are limits as to how much the Better Access initiative can improve access to mental healthcare for people from culturally and linguistically diverse (CALD) backgrounds. Professor Malak, Executive Director, explained that for some consumers there are no accredited professionals who speak their language. The available professionals are also already busy and there are disincentives to taking on more CALD clients:

> …health professionals with different languages are somewhat overbusy. They do a lot of work and they are not really interested in doing more. If they have the energy, the psychologists offer help. In addition, if you are overworked you can get what you call an easy client. For people with different cultures, the only clients you get to see usually are the difficult ones. If you can do the easy ones as quickly as you can and get the same payment and you can do more clients in the day, you do that.[92]

89 Australian Psychological Society, *Submission 55,* p. 12.

90 Australian Psychological Society, *Submission 55,* p. 4.

91 Australian Psychological Society, *Submission 55,* p. 16.

92 *Proof Committee Hansard,* 27 March 2008, p. 29.

6.94 MMHA submitted that a range of mechanisms are needed to develop cultural competency and increase the number of bilingual and bicultural mental health staff.[93] They also submitted that direct funding to specialist services is required. Multicultural Mental Health Australia would like to be able to use its own clinicians to access Medicare funds, given the limited number of transculturally trained providers in private practice.[94]

Provider eligibility

6.95 There was discussion in the evidence to the committee about the eligibility of different providers to claim the Better Access Medicare items. Particular issues included the requirement for providers to be set up as private practitioners, and the inclusion of only certain allied health professionals. These issues are discussed below.

NGO providers

6.96 Currently the Better Access initiative is structured around a private practice, fee-for-service model. Several organisations suggested that access to psychologists and other allied health professionals could be improved, particularly for those outside the current medical system, by simplifying access to Medicare rebates for NGOs who employ allied health professionals directly. Mr Calleja from Richmond Fellowship WA commented that there is currently no mechanism through which non-government agencies can access the Medicare rebate funding, other than having their social workers and psychologists obtain individual Medicare provider numbers.

6.97 Ms Carmody, Ruah Community Services, felt that a strength of the NGO sector is reaching people that do not easily access mainstream services. Being able to access Medicare rebated services directly through NGOs would assist people who are currently not getting mental health care. Mr Calleja noted a further advantage of providing allied health services through NGOs:

> …the individual counselling work that is done can then be supplemented by the referral to employment, by support with education, by links with carers and family members and so on.[95]

6.98 Mr Calleja and Ms Carmody did not see a role for NGOs in replicating mainstream primary health care, but saw opportunities for NGOs to help expand the reach of Medicare funding. They provided examples of how their respective organisations could utilise Medicare funding. Mr Calleja outlined:

> If one of my staff members were an accredited Medicare person and they did three hours a week of counselling, we would simply be charging their salary against a different line.

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93 See for example *Submission 14*, p. 4, *Submission 13*, pp. 9–11.

94 *Proof Committee Hansard*, 27 March 2008, p. 29.

95 *Proof Committee Hansard*, 7 May 2008, p. 50.

6.99 Ms Carmody commented:

> We have 60 staff in mental health. I would make only one of our registered psychologists available for this function, and she or he would be available to provide counselling to clients who would not normally go to a GP or link in there easily because of special circumstances of anxiety.[96]

6.100 Catholic Social Services Australia reported that some of its agencies have 'managed access to the MBS items as part of their overall service delivery design'. While these agencies have had to overcome 'administrative and organisational hurdles' to make use of the new MBS items, they have been more successful in filling service gaps than those trying to use Better Access through external providers.[97] Mr Quinlan described the administrative arrangement necessary to enable NGOs to access the Medicare rebates:

> In order to make use of this scheme, the agency is required to set itself up in such a way that it can access those items as a Medicare provider and then often has to contract its own workers separately, in a sense as if they were in private practice, in order for them to have access to those funds. So what we are seeing is almost two agencies set up within one. The agencies that have managed to do that have reported some success in terms of that being a model that has actually allowed them to provide greater services to their clients, but it is quite an administrative twist to set up in that way.[98]

6.101 WAAMH was looking at whether arrangements could be made to link a Medicare provider number with the non-government organisation that employs mental health providers, rather than with the specific practitioner.[99] Mr Calleja saw the need for briefing and guidance to NGOs on how to go about using the Medicare structure to provide services through their agencies.[100]

6.102 Ms Morris, First Assistant Secretary DoHA explained that currently the Health Insurance Act details the rules around how a provider needs to be set up and the conditions that need to be met in order for a patient to be able to claim the Medicare rebate. She noted that DoHA understood the issues with respect to NGO providers and would consider these issues as part of the post-implementation review of the Better Access initiative.[101]

6.103 The committee sees merit in establishing mechanisms by which NGOs that employ psychologists and allied health professionals directly are able to access relevant MBS mental health care items. These organisations are a key pathway

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96 *Proof Committee Hansard*, 7 May 2008, p. 50.

97 *Proof Committee Hansard*, 16 May 2008, p. 65.

98 *Proof Committee Hansard*, 16 May 2008, p. 68.

99 *Proof Committee Hansard*, 7 May 2008, p. 13.

100 *Proof Committee Hansard*, 7 May 2008, p. 47.

101 *Proof Committee Hansard*, 16 May 2008, p. 83.

through which people who have been largely out of contact with the medical system can obtain clinical care.

Recommendation 14

6.104 The committee recommends that as part of the post-implementation review of Better Access a working group be established to simplify arrangements by which NGO employed psychologists and other eligible allied health professionals can use Better Access Medicare items.

6.105 The committee further recommends that the Australian Government fund a series of information workshops for relevant NGOs, explaining the outcomes of the working group and the available mechanisms for NGOs to make use of the Better Access Medicare items.

Should counsellors be included among the eligible allied health professionals?

6.106 The Better Access initiative established arrangements by which GPs, clinical psychologists, general psychologists, social workers and occupational therapists can deliver specific treatments as claimable items under the MBS. New items were also introduced for certain consultations with psychiatrists. The Mental Health Coordinating Council argued that by restricting access to these specified professionals and allied health professionals, Better Access has left further sources of mental health care underutilised.[102] The Australian Counselling Association (ACA) and the Psychotherapy and Counselling Federation of Australia (PACFA), the two peak bodies for counsellors and counselling organisations in Australia both argued that the Better Access Initiative should be extended to include counsellors. Professor Schofield, Director of Research PACFA, noted that counsellors have been integrated into primary health care in other western countries such as the UK and USA.[103]

6.107 Professor Schofield outlined a number of characteristics which set counsellors and psychotherapists apart from other providers such as psychologists and social workers. These included:

- a more consumer and client oriented model for working with people facing mental health crises, which aligns with recovery principles such as being person rather than problem centred and developing empowerment, hope, social skills and relationship skills;
- understanding problems as being largely interpersonal in nature, which can then create physical and mental symptoms;
- the importance of the client-therapist relationship as the key to resolving problems and effecting client change; and

102 *Proof Committee Hansard,* 27 March 2008, p. 43.

103 *Proof Committee Hansard,* 1 April 2008, p. 55.

- the capacity to work with client diversity and tailor responses to the specifics of particular clients and their circumstances.[104]

6.108 Mr Armstrong, Chief Executive Officer ACA presented the view that counselling services contribute strongly to prevention and early intervention, therefore extension of the MBS rebates to counsellors may be cost effective by helping to reduce the incidence of severe mental illness.[105] However, Mr Armstrong acknowledged that the existing research base presents mixed findings about the efficacy of counselling as a preventative measure.[106]

6.109 Mr Armstrong also observed that there are more counsellors available in rural and remote areas than psychologists and psychiatrists. He explained that 51 per cent of ACA members are outside general city areas. As such, the Australian Counselling Association argued that extending Medicare rebates to counsellors would help to fill current service gaps in these areas.

6.110 The Mental Health Council of Tasmania agreed that extending the initiative to counsellors was a way to address service shortages.[107] The Northern Territory Mental Health Council noted that, because of the lack of psychiatrists and psychologists in remote areas, people have to be taken out of their communities to access services, which is a traumatic experience.[108] They supported efforts to get more health professionals into remote communities, including counsellors.

Impact on counsellors

6.111 Mr Armstrong described the impact that exclusion from Better Access was having on counsellors due to a decline in referrals. In a survey of its members, the ACA found that of 330 respondents, 313 had experienced a decline in referrals since the introduction of Better Access, 255 had been told directly by their clients and GPs that they would no longer be used because of their inability to access Medicare rebates and 145 indicated that they would not be able to continue their practice for more than six months.[109] Similarly Professor Schofield commented:

> There has been a substantial negative impact on counsellors and psychotherapists who do not qualify for the Better Access initiative. We have had a consistent flood of distressed professionals who have found that their referrals have disappeared very rapidly following its introduction. We have had many stories of professionals who were in secure productive

104 *Proof Committee Hansard,* 1 April 2008, p. 56.

105 *Proof Committee Hansard,* 26 March 2008, pp. 40-41.

106 *Proof Committee Hansard,* 26 March 2008, p. 47.

107 *Proof Committee Hansard,* 31 March 2008, p. 5.

108 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 3.

109 *Proof Committee Hansard,* 26 March 2008, p. 41.

> relationships with seriously ill clients who were then referred to psychologists because that was cheaper for them.[110]

6.112 Professor Schofield also explained that employment outside private practice has become more difficult for counsellors:

> …many of the non-government organisations are moving to a different model, and even public sector mental health services are bringing in private Medicare funded services and favouring the employment of psychologists, social workers and so on because they can bring more money into the system.[111]

Standards of service

6.113 The Mental Health Council of Australia considered that any assessment about extending the Better Access initiative to counsellors should be based on the outcomes for consumers.[112] Improving access to mental health services is important, but so too is ensuring the standard of these services. One of the concerns about extending Medicare coverage to counsellors is the great variability in types of services that counsellors provide. Dr Freidin, Royal Australian New Zealand College of Psychiatrists said:

> Our concern is and has always been, preceding recent changes, that the word 'counsellor' can be used by anybody to do anything. There is no regulatory body and no standard of education, training, quality review or reporting. There is no oversight body like a medical board, so, although some counsellors have had various forms of training, anyone can use the word. We believe that in mental health, the same as in general health, patients in Australia should have access to fully trained, high-quality clinicians, who can be of many different sorts but have to be part of professional bodies. There has to be a degree of rigour in their education and training.[113]

6.114 Dr Freidin went on to say that the professional associations that the RANZCP work with 'generally have training programs of four to six years through universities and similar, followed by ongoing processes of supervision and training and accreditation by government recognised national bodies'.[114]

6.115 Similarly, the Australian Psychological Society said:

> The current push for counsellors to be included in the Better Access scheme is of grave concern. Counsellors are often minimally trained with few skills in the assessment and treatment of mental health disorders, are not required

110 *Proof Committee Hansard,* 1 April 2008, p. 55.

111 *Proof Committee Hansard,* 1 April 2008, p. 55.

112 *Proof Committee Hansard,* 20 May 2008, p. 88.

113 *Proof Committee Hansard,* 1 April 2008, p. 38.

114 *Proof Committee Hansard,* 1 April 2008, p. 38.

> to be registered to practice with a statutory authority, are not subject to disciplinary codes, and frequently do not engage in evidence-based treatment practices.[115]

6.116 Professor Schofield outlined that around 59 per cent of PACFA members have postgraduate qualifications in counselling and psychotherapy, with the majority of the rest having undergraduate qualifications.[116] She said:

> What we are arguing is that there is a large group of people out there who have often done significantly more training specifically in counselling and psychotherapy. Some of our practitioners have up to 13 years of training in psychotherapy. Many psychotherapies demand a very high level of training and ongoing professional development and supervision.[117]

6.117 The membership requirements for PACFA and the ACA are quite different. PACFA registration requires a minimum qualification of two years at postgraduate level or three years undergraduate training, plus 750 hours of supervised client contact and 75 hours of actual supervision.[118] PACFA indicated that currently 25 Australian universities offer mainly postgraduate and some undergraduate courses in counselling and psychotherapy, with a further 24 government accredited private training providers offering graduate and postgraduate courses.[119] In contrast, a diploma of counselling is currently the minimum requirement for membership of the Australian Counselling Association. Mr Armstrong acknowledged the breadth that currently exists in the types of training available for counsellors and explained that the Association has been working with the Industry Skills Council to develop a generic diploma of counselling. This is intended to provide a consistent minimum standard. This diploma would involve 800 to 1200 hours of training, which at best could be completed within a year.[120]

6.118 Professor Schofield noted that not all members of PACFA would currently meet the criterion to work as mental health professionals:

> Counsellors and psychotherapists would probably meet 90 per cent of the mental health training standards, but not all will have worked under supervision and so on. Not all will have the full diagnostic understanding of psychopathology.[121]

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115 Australian Psychological Society, *Submission 55,* p. 11.

116 *Proof Committee Hansard,* 1 April 2008, p. 55.

117 *Proof Committee Hansard,* 1 April 2008, p. 58.

118 *Proof Committee Hansard,* 1 April 2008, p. 58.

119 The Psychotherapy and Counselling Federation of Australia, *Submission 43, Additional Information*.

120 *Proof Committee Hansard,* 26 March 2008, p. 416.

121 *Proof Committee Hansard,* 1 April 2008, p. 60.

6.119 As such, PACFA is looking to provide pathways for those who want to complete their training to professional registration standards.

6.120 Counselling is currently not regulated by government. PACFA was established partly in response to the need for clear standards, monitoring and accountability and has been working over the past decade to improve self regulation. Professor Schofield indicated that the profession would welcome an externally regulated environment, however external regulation had not progressed:

> We would be very happy to be regulated by government if government wanted to do that, but they have said that they prefer the self-regulation route at this point. It is not that we are making that choice, in a sense. It is currently the only option that we are being given.[122]

6.121 Organisations which supported the extension of the Better Access initiative to counsellors were cognisant of the importance of ensuring service standards.[123] The Northern Territory Mental Health Council noted that, 'there would have to be a benchmark set as to what sort of training they have'.[124] The Mental Health Council of Tasmania saw the possibility for a national approach:

> …it may be about setting some national standards on what level of qualification or skills a person has to provide counselling.[125]

6.122 Professor Whiteford, Principal Medical Advisor DoHA, explained that while overall professional standards are critical, it is also important to understand that the Medicare rebates available through Better Access are not for general counselling services but for specific psychological therapies. He said:

> I think that the main thing to ensure, now that more people appear to be accessing mental health care, is the quality of care that is delivered. I think it is a misnomer to say that counselling is now on the MBS. What is on the MBS with this measure is evidence based psychological interventions, which are limited in number, for short-term, focused, evidence based therapies—cognitive behaviour therapy, psychoeducation, interpersonal therapy et cetera—and not general counselling. So we would want clinicians who are able to deliver evidence based interventions which we know work to treat common mental disorders. Even within the clinicians

122 *Proof Committee Hansard,* 1 April 2008, p. 58.

123 See for example Mental Health Coordinating Council, *Proof Committee Hansard,* 27 March 2008, p. 45.

124 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, pp. 3 and 8.

125 *Proof Committee Hansard,* 31 March 2008, p. 5.

> who are in the current group, we need to ensure that those evidence based therapies are being applied.[126]

6.123 It is clear that many counsellors and psychotherapists have extensive training and supervision and are a well qualified source of mental health care that is being underutilised in the current system. However, it is also clear that the label 'counsellor' currently covers a broad range of providers, with little consistency in the minimum standard of qualifications and experience. Providing access to quality, evidence-based care is an important principle for government funded health services. Therefore, until counsellors and psychotherapists are consistently, and preferably externally, regulated the committee does not support the extension of the Better Access initiative to these groups.

Evaluating the initiative

6.124 Numerous witnesses commented on the lack of publicly available data on the use of the Better Access initiative.[127] This means it is difficult to look at important aspects of the initiative such as uptake across different areas, the numbers of consultations that are used by patients and how many patients stay engaged with the process of referral between GPs and allied health professionals.

6.125 Further to this basic information, the absence of outcome measures was a primary concern in the evidence to the committee. Is the treatment provided assisting people in their recovery? Is the initiative making a difference to the lives of people with mental illness? Can changes be made to achieve better outcomes from the funding available?

6.126 Ms Henderson, Mental Health Coordinating Council, commented:

> A mechanism has not been established to obtain information from GPs as to whether mental health plans and initiatives are having an impact on mental health or providing effective early intervention. We feel that such outcomes need to be evaluated under the scheme. So, in view of the degree to which the MBS has been taken up, it would seem prudent to be able to measure its effectiveness.[128]

6.127 Mr Muller, President of the Queensland Alliance Mental Illness and Psychiatric Disability Groups commented:

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126 *Proof Committee Hansard*, 16 May 2008, pp. 82–83. Other submitters also raised the issue of ensuring standards among clinicians who are currently included in the Better Access scheme, particularly clinical psychologists. See Professor MacMillan, *Submission 59* and APS College of Clinical Psychologists Victorian Section, *Submission 60*. Also, the Australian College of Clinical Psychologists was concerned that APS eligibility criteria had excluded other experienced clinical psychologists from the Better Access initiative. See *Submission 40*.

127 See for example, Dr Gurr, *Proof Committee Hansard*, 27 March 2008, p. 73.

128 *Proof Committee Hansard*, 27 March 2008, p. 44.

> It pushed sideways a program called the Better Outcomes in Mental Health Care Initiative, which was a very measurable program. People were measured on entry and exit from the project and it was particularly styled for a certain category of people. In this one the categories are broader, but there does not seem to be any measurable outcomes. In mental health we do have outcome tools that could have been utilised. That has not happened.[129]

6.128 Dr Freidin, Royal Australian and New Zealand College of Psychiatry commented:

> The exact clinical outcomes…as with other Medicare changes that have affected psychiatrists, are very difficult to quantify, because there has not been a rigorous system of review and study of clinical outcomes…Anecdotally, we know from our fellows that it has been very helpful to be able to refer people to psychologists for specific cognitive behavioural therapy—and we also hear that from the general practitioners—so our overall impression is that this has been a useful initiative, but we would very much like to see properly-funded clinical research to study the outcomes of these new initiatives.[130]

6.129 Dr Johnson, Royal Australian College of General Practitioners, noted that there 'is really extremely limited information on the impact of the work that GPs are doing for patients with regard to mental health concerns'. She asked some pertinent questions: 'Are we targeting the people most in need of the services and do the current systems allow GPs to be effective gatekeepers? Is the initiative really encouraging GPs to take a larger interest in mental health care?'[131]

6.130 While the Department of Health and Ageing intends to undertake a post-implementation review of the initiative, Mr Crosbie, Chief Executive Officer, Mental Health Council of Australia was concerned that what was originally going to be an in-depth review has been 'scaled back':

> We were incredibly disappointed that there is to be no in-depth review of the impact of the MBS items. We had previously been led to believe that, at the end of 12 months, there would be an in-depth review and we would start looking at what was happening to people who were using these items—real consumers, their families and their providers.[132]

6.131 On the basis of correspondence with the department, Mr Crosbie concluded that the Better Access post-implementation review was focussed only on short-term affordable changes to the Medicare items. He said:

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129 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard*, 26 March 2008, p. 3.

130 *Proof Committee Hansard*, 1 April 2008, p. 37.

131 *Proof Committee Hansard*, 1 April 2008, p. 64.

132 *Proof Committee Hansard*, 20 May 2008, pp. 82 and 86.

> From my perspective, the kind of review that we are now doing in the MBS items is, at best, a review of what the professional groups think about the program that they are running rather than us actually asking consumers and, in some cases, carers, 'How has this worked or not worked for you?'

6.132 The committee is pleased that a post-implementation review will be conducted to assess the Better Access initiative so far. However it is also concerned about the scope of the review. An initiative which has been assessed as arguable the 'most important and practical reform in Australian mental health care in the past 15 years' with a budget in excess of $770 million should be soundly evaluated.[133] Evidence to this inquiry points to some particular areas for consideration, including:

- low uptake of referrals to social workers and occupational therapists;
- low uptake of group therapy items and out-of-room consultations;
- whether the initiative is filling gaps by providing services to those who were previously missing out on mental health care;
- different access across the states and territories and metropolitan, rural and remote areas;
- barriers to access including patient out-of-pocket expenses and how these are changing over time;
- the impact of the initiative on other service sectors;
- the kinds of illnesses for which people are receiving treatment under Better Access;
- whether the initiative can be better utilised to provide services to those with the most severe illnesses;
- whether the initiative can be better utilised to provide services to specific population groups;
- how well care is being coordinated among the different providers involved in the initiative and whether there is scope to improve collaboration; and most importantly,
- whether the initiative is improving mental health outcomes and advancing the recovery process for those that access eligible services.

Recommendation 15

6.133 The committee recommends that the post-implementation review of the Better Access initiative consider the concerns and issues about the initiative listed in this report (paragraph 6.132). In particular, the committee considers that assessment of the outcomes for consumers using the initiative is paramount. The committee further recommends that the findings of the post-implementation review be made publicly available.

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133 Ian B Hickie and Patrick D McGorry, 'Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?', *Medical Journal of Australia*, Vol 187 No 2, 16 July 2007, p. 101.