



**Evaluation of the Better Access to Psychiatrists,
Psychologists and GPs through the Medicare Benefits
Schedule Initiative**

**Component A.2:
A study of consumers and their outcomes (focusing on
the occupational therapy and social work sectors)**

FINAL REPORT

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Table of contents

<i>Executive summary</i>	2
<i>Chapter 1: Background</i>	5
<i>Chapter 2: Method</i>	7
<i>Chapter 3: Study samples</i>	9
<i>Chapter 4: Experiences of consumers who have received care from social workers and occupational therapist through Better Access</i>	16
<i>Chapter 5: Experiences of social workers and occupational therapists who have provided care through Better Access</i>	28
<i>Chapter 6: Discussion and conclusions</i>	53
<i>Appendix 1: Survey/interview questions for social workers and occupational therapists</i>	57
<i>Appendix 2: Survey/interview questions for consumers recruited by social workers and occupational therapists</i>	59

Executive summary

Social workers and occupational therapists who are delivering care through Better Access initiative are making an important contribution to the success of the initiative. Consumers who receive care from these providers recognise them as skilled specialists with much to offer in terms of cognitive and behavioural therapies. These consumers commonly report that the treatment offered by these providers results in reduced symptomatology, decreased psychological distress and improved general wellbeing. The views of social workers and occupational therapists concur with those of consumers; these providers also perceive that Better Access is yielding positive outcomes for consumers. As providers, they are also appreciative of the opportunities that the initiative affords them.

Background

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) was introduced late 2006 and aims to improve outcomes for people with common mental disorders by encouraging a multi-disciplinary approach to their care. It takes the form of a series of new item numbers which have been added to the Medicare Benefits Schedule (MBS), supported by a range of education and training activities for relevant providers (GPs, psychiatrists and allied health professionals). Selected social workers and occupational therapists provide some of the services under the allied health professional item numbers.

In 2009, the Commonwealth Department of Health and Ageing (DoHA) commissioned an evaluation of the Better Access initiative with several components. The Centre for Health Policy, Programs and Economics (CHPPE) at the University of Melbourne was contracted to undertake several components, including Component A.2 which considers the experiences of consumers who have received Better Access care from social workers and occupational therapists, and the experiences of these providers in delivering this care. The current report describes the method by which Component A.2 was conducted and presents and discusses its key findings.

Method

We approached all social workers and occupational therapists who provided services under Better Access from 1 June 2009 to 31 May 2010 and invited them to participate. We asked those providers who agreed to participate to recruit 2-5 consumers who had completed treatment. We then invited participating consumers and providers to complete a survey or take part in a telephone interview. The surveys and interviews contained identical questions and explored consumers' and providers' experiences with Better Access. Recruitment and data collection for Component A.2 occurred over a three month period in 2010 (beginning in early August and ending in late October, with some leeway for the return of late surveys in the first two weeks of November).

Key findings

In total, 191 out of 852 invited social workers (22%) and 35 out of 216 invited occupational therapists (16%) participated. The social workers invited 1,203 consumers to participate and 458 (38%) did so. The occupational therapist extended an invitation to 215 consumers, 72 of whom (33%) took up the invitation.

Experiences of consumers

Participating consumers gave Better Access strong endorsement. Many had been unable to access mental health care in the past, usually for cost reasons, and they appreciated the fact that Better Access had removed such barriers. They had sought care from social workers or occupational therapists on this occasion for a variety of reasons, often because of a deterioration in their mental health or the occurrence of stressful life events. Sometimes a third party (e.g., a GP or a family member or friend) had suggested that such care might be beneficial. Many specifically commented on the attributes and skills of the provider, and on the usefulness of the advice, guidance and strategies that they received. The vast majority indicated that they had experienced significant improvements in terms of reduced symptomatology and increased coping ability, and many felt that this had had repercussions for their general wellbeing. Some also found that their life circumstances changed in positive ways. Most attributed these changes, wholly or in part, to the provider. The vast majority indicated that their needs were totally or partially met by Better Access. Most had found the process of dealing with Medicare relatively straightforward, and were extremely satisfied with the care they had received.

Most consumers reported that, from their perspective, there were no negative aspects of Better Access. Those who did identify negative points tended to focus on the restricted number of sessions or the time allocated for sessions, or on difficulties in meeting the “gap” payment. A small minority reported that there were sometimes practical issues associated with accessing care (e.g., travel time or waiting lists) and/or that they found the process of engaging in treatment confronting.

Experiences of providers

Participating social workers and occupational therapists were extremely positive about the Better Access initiative. Many commented that their services are now available not only to a greater number of people overall, but to proportionally more people with complex clinical and social needs and limited financial resources, many of whom would not have been able to access mental health care in the past. Many also mentioned that they are now in a better position to meet these consumers’ needs because they can provide timely, comprehensive and integrated care. They perceived this to have direct benefits for consumers in terms of improved access and affordability of care, and, consequentially, improvements in their mental health status, understanding of mental health symptoms and how to manage them, and relapse prevention. The increased access and improved affordability for consumers has had flow-on benefits for these providers in terms of professional satisfaction. They have appreciated the opportunity to collaborate with GPs and other mental health care providers, and had felt that being listed as approved Better Access providers has given them increased standing with these peers. In the main, their experiences with registering with and billing Medicare have been straightforward. Their charging policies have varied, with some bulk billing all or the majority of consumers, some bulk billing only a few or no consumers, and some introducing a sliding scale whereby the “gap” for consumers increases with their ability to pay.

Relatively speaking, the negative impacts of Better Access for providers have been minor. Although most participating social workers and occupational therapists have had good relationships with GPs, some have found GPs to dismiss them in favour of psychologists and/or to make inappropriate referrals, sometimes doing so via mental health treatment plans that contain insufficient information. Some have experienced administrative issues, such as difficulties with the interface between their own local systems and the Medicare system. Some questioned the level of reimbursement for their services, arguing that they should receive the same payments as psychologists and that they should be paid for the additional activities that are related to the provision of face-to-face care (e.g., record-keeping, communicating with other providers). While most were strongly of the view that Better Access has improved access to and

quality of care for many consumers, some expressed concerns about session limits, restrictions on the forms of therapy that they can provide, confidentiality, and motivation on the part of consumers.

Study limitations

Our study was limited by the time frame available to us, which may have precluded some consumers and providers from participating. Having said this, our data reached a point of “saturation”, suggesting that we successfully captured a comprehensive range of consumers’ and providers’ views about Better Access.

Our response rates were not as high as we might have hoped (22% for social workers and 38% for consumers recruited by them; 16% for social workers and 33% for consumers recruited by them), and our participants were self-selected. Nonetheless, our samples were reasonably representative of the groups from which they were selected, which engenders some confidence in the generalisability of the findings.

It is worth making a specific point about our decision to exclude consumers who did not speak English. This decision was made for resourcing reasons; we did not have the capacity to translate the surveys into other languages, or to make use of interpreters to conduct the interviews. We acknowledge, however, that the experiences of Better Access consumers from culturally and linguistically diverse backgrounds may be different from those of their English-speaking peers.

Like any survey- or interview-based study, the current study relied on self-report. As a result, participants may have given responses that they felt were socially desirable in some way. They may also have been some biases in their likelihood of recalling particular experiences. Ideally, we would have included some objective measures to validate particular responses – e.g., standardised instruments to measure outcomes of care, feedback from referring GPs – but this was beyond the capacity of the study.

Conclusions

Notwithstanding the above limitations, the current study suggests that consumers who receive Better Access care from social workers and occupational therapists are generally very positive about the initiative. They appreciate the increased access to high quality care from different professionals, and are reaping the benefits in terms of good mental health outcomes. Providers are also positive, finding the opportunity to provide care to consumers with a broader mix of needs professionally rewarding.

Chapter 1: Background

The Better Access initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative is one of 18 Australian Government initiatives introduced under the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011. It was introduced late 2006 in response to low treatment rates for common mental disorders, and its ultimate aim is to improve outcomes for people with such disorders by encouraging a multi-disciplinary approach to their mental health care.

Better Access takes the form of a series of new item numbers which have been added to the Medicare Benefits Schedule (MBS), supported by a range of education and training activities for relevant providers (GPs, psychiatrists and allied health professionals). Psychologists are the primary provider of services under the allied health professional item numbers, rendering about 95% of these services. Selected social workers and occupational therapists currently provide the remainder, although in the 2010/11 Federal Budget, an announcement was made that services delivered by these providers would no longer be covered under the Medicare arrangements from July 2010. This decision was subsequently reconsidered, and the date was revised to April 2011. More recently still, the decision has been rescinded and social workers and occupational therapists have been informed that they will continue to be listed as eligible providers under Better Access.

Evaluation of the Better Access initiative: Components A and A.2

In 2009, the Commonwealth Department of Health and Ageing (DoHA) commissioned an evaluation of the Better Access initiative with several components. The Centre for Health Policy, Programs and Economics (CHPPE) at the University of Melbourne was contracted to undertake Component A, which involved a study of consumers and their outcomes. Our team employed a novel methodology under which participating providers each recruited 5-10 consumers when they first presented for services provided via the item numbers. These consumers were followed during the course of their care, in order to explore their experiences (via interviews) and monitor their outcomes (as assessed by ratings on standardised outcome measures which are being collected via a minimum dataset).

Early in the evaluation, a decision was made to restrict Component A to GPs, psychiatrists and psychologists. This decision was made on the grounds that too few social workers and occupational therapists were providing services through the Better Access initiative to recruit sufficient numbers of consumers for meaningful analysis. Subsequent developments with respect to social workers and occupational therapists, however, highlighted the need to consider the experiences of the consumers who receive care from these providers and the experiences of these providers in delivering this care. This led to DoHA inviting us to conduct an additional component – Component A.2 – which extended Component A by including a focus on consumers who the social work and occupational therapy sectors.

To overcome the issue of the relatively small numbers of social workers and occupational therapists providing services through Better Access, Component A.2 used a methodology that represented a variation on that employed in Component A. We approached *all* social workers and occupational therapists who provided services under Better Access in the last year (rather than a random sample, as was the case with GPs, psychiatrists and psychologists). We asked those providers who agreed to participate to recruit 2-5 consumers who had completed treatment (rather than 5-10 consumers who were beginning treatment). All of our data

collection was based on surveys or interviews with consumers and providers (there was no opportunity to collect pre- and post-treatment outcome data for consumers).

The current report

Chapter 2 of the current report provides an overview of the methodological approach we used in Component A.2. Chapter 3 describes the study samples and considers their representativeness. Chapter 4 presents the findings for consumers who received care from these two groups of providers. Chapter 5 presents the findings from surveys and interviews with social workers and occupational therapists, describing their experiences with Better Access. Chapter 6 summarises, interprets and discusses these findings.

Chapter 2: Method

Recruitment of providers and consumers

DoHA's Medical Benefits Division acted as an intermediary in the recruitment of social workers and occupational therapists, identifying all of these providers who had provided services under the relevant Better Access item numbers in the 12 months from 1 June 2009. The Medical Benefits Division provided us with contact details for these providers, and we sent them letters of invitation, plain language statements and consent forms. Those who agreed to participate returned signed consent forms to our study team, and we enrolled them in the evaluation.

Participating social workers and occupational therapists acted as intermediaries in the recruitment of consumers. They approached up to 10 of their English-speaking consumers (aged 16+) who had most recently completed treatment and whose care was partially or fully funded through the MBS item numbers. The aim was for them to recruit 2-5 of these consumers. Consumers who agreed to be part of the evaluation were asked to sign a consent form and return it to us.

We offered social workers and occupational therapists gift vouchers as an incentive for participating; consumers were not offered an equivalent incentive. The rationale for this was that participation was more onerous for providers than it was for consumers, because of the burden imposed by the recruitment task; participating in a 15-minute interview or completing a brief survey was considerably less labour intensive.

Data collection

Data collection occurred in two ways: via standardised interview schedules or self-completion surveys. All interviews were conducted over the telephone by a trained member of our study team, and taped. Interviewers took comprehensive notes during the interviews, and the interviews were transcribed. The surveys were returned to the study team in reply-paid envelopes. The surveys contained the same questions as the interview schedules, and required respondents to complete check-box and free text responses (see Appendices 1 and 2).

We chose to run the two methods in tandem because of the short time-frame of the study. The interview methodology was much more labour intensive for the evaluation team (because of the time involved in setting up and conducting interviews); supplementing it with the survey methodology increased the manageable sample size. We were loath to drop the interview methodology all together, however, because we have used it successfully in the past, including in Component A. Different people prefer to provide information in different ways, so we felt that offering potential respondents two ways of providing the desired information might increase the overall response rate.

Content-wise, the interviews and surveys asked social worker and occupational therapists about delivering care through Better Access, the processes involved, and the perceived impacts for themselves and the consumers for whom they provided care. Basic demographic and professional information about these providers was made available by DoHA, in order that they could be compared with the broader groups of social workers and occupational therapists who are providing care via Better Access.

Consumers were asked about their experiences of accessing Better Access services, including whether the initiative had made care available to them which was previously inaccessible, whether they were satisfied with the care they received, and whether they believed that the care

was beneficial to them in terms of outcomes. They were also asked to provide some basic demographic information, again so they could be profiled against the broader groups of consumers who are receiving care through the social worker and occupational therapist item numbers.

For both consumers and providers, interview data were transcribed and responses to each question from both the interviews and the surveys were entered verbatim into an Excel spreadsheet.

Data analysis

Coding templates or 'code books' were developed to summarise and organise salient themes as they emerged from the data. Four separate code books were developed: one for social workers' responses; one for occupational therapists' responses; one for the responses of consumers who had seen social workers; and one for the responses of consumers who had seen occupational therapists. In each case, the process began with the identification of some broad, apriori themes. Responses to each question were read and re-read with these themes in mind, and segments of text were coded as belonging to these themes. During this process, additional broad themes were identified and portions of text were coded as being relevant to these new themes. Once the final set of broad themes was settled upon, the text relating to each theme was re-examined and narrower themes were identified and coded. The complete set of broad and narrow themes then formed the final code book that was applied across all relevant responses. This process was iterative, and each set of responses was read a number of times.

Wherever possible, an attempt was made to quantify the qualitative responses once they had been coded into broad and narrow themes. There is debate among qualitative researchers about whether such quantification is appropriate. Those who are opposed to this approach argue that it is contrary to the purpose of qualitative research, which is to elicit a range of views on a given issue rather than to gauge the representativeness of these views. Those who favour this approach argue that, in the right circumstances, quantifying qualitative responses can increase the objectivity and replicability of a given study, and can strengthen the potential for generalising its findings if the sampling strategy permits this. In the current evaluation, quantifying the qualitative responses was considered justified on the grounds that the thematic coding categories were systematically generated using the code books described above, and the sampling strategy did not involve purposive selection.

Study time frame

Recruitment and data collection for Component A.2 occurred over a three month period in 2010 (beginning in early August and ending in late October, with some leeway for the return of late surveys in the first two weeks of November).

Chapter 3: Study samples

Recruitment of providers and consumers

Providers

In total, 899 social workers were sent letters inviting them to participate in the evaluation. Forty seven of these were returned to CHPPE marked 'return to sender', bringing the denominator down to 852. Two hundred and twelve of these (25%) returned consent forms. Not all of these eventually participated for a variety of reasons – some only saw children, some were going on leave during the study period, and some had not seen any consumers through to the completion of their treatment. In total, 191 social workers participated by providing their views on Better Access to the evaluation and/or recruiting consumers, representing a response rate of 22%. Table 1 outlines the nature of their participation.

Table 1: Nature of participation in the evaluation by social workers (n=191)

	Recruited consumers	Did not recruit consumers	Total
Provided views via interview	57	15	72
Provided views via survey	73	9	82
Provided views via survey and interview	2	0	2
Did not provide views	35	0	35
Total	167	24	191

In the case of occupational therapists, 238 were sent invitation letters. Twenty two of these letters were 'returned to sender', reducing the available pool of occupational therapists to 216. Fifty one of these (21%) returned consent forms. Again, not all of these eventually participated (for similar reasons to the non-participating social workers). In total, 35 occupational therapists participated by offering their views, recruiting consumers or doing both. This represents a response rate of 16%. Table 2 describes the nature of their participation.

Table 2: Nature of participation in the evaluation by occupational therapists (n=35)

	Recruited consumers	Did not recruit consumers	Total
Provided views via interview	6	6	12
Provided views via survey	10	9	19
Provided views via survey and interview	1	0	1
Did not provide views	3	0	3
Total	20	15	35

Consumers

When providers returned their consent forms to CHPPE, they were asked to indicate how many consumers they thought they would be able to recruit. They were subsequently given a follow-up phone call to confirm their participation, confirm their details, confirm the numbers of consumers they would aim to recruit, and clarify any queries or concerns around consumer inclusion criteria. Using information from the consent form and the follow-up phone call, the study team sent each provider the requested number of consumer packs to distribute. In total, 1,209 consumer packs were sent to social workers (six of which were returned marked 'return to sender', bringing the denominator to 1,203). Two hundred and fifteen consumer packs were sent to occupational therapists.

Four hundred and fifty nine consumers who had seen social workers consented to providing information to the evaluation, and all of them ultimately did so (455 via the survey and four via interview). Seventy two consumers who had seen occupational therapists agreed to participate and all eventually did so (67 via the survey and five via interview). This amounts to response rates of 38% for consumers seen by social workers and 33% for consumers seen by occupational therapists.

Profile of providers and consumers

Providers

Tables 3 and 4 profile the participating social workers and occupational therapists in terms of the nature of their participation and their professional and demographic details. Wherever relevant, comparisons are made with the overall pool of providers from which these providers were recruited (i.e., all social workers and occupational therapists who provided services through Better Access between 1 June 2009 and 31 May 2010).^a

Four fifths of participating social workers were female. Two thirds of them fell into the 45-54 and 55-64 age ranges. Around half had qualified in 1980-1989 or 1990-1999. In these respects, they were similar in profile to all social workers providing services through Better Access from 1 June 2009 to 31 May 2010. On average, however, participating social workers had provided twice as many sessions and seen twice as many consumers during this period than the broader group of social workers.

Participating occupational therapists were relatively typical of the pool from which they were drawn in terms of their gender (with over 90% being female). However, they tended to be older (with two thirds falling into the 45-54 and 55-64 year old categories compared with closer to half) and to have qualified less recently (with only one tenth doing so in 2000-2009 compared with nearly one third). Participating occupational therapists had also provided three times as many sessions and seen three times as many consumers than the overall group of occupational therapists.

^a The comparison groups for providers and consumers were constituted in a slightly different way. Participating providers were compared with the total pool of providers who were invited to participate, and this group included all relevant providers (i.e., social workers or occupational therapists) who delivered services under Better Access between 1 June 2009 and 31 May 2010. This time period was selected because it was the most recent for which claims data were likely to be complete. Because consumers were invited to participate by providers, an equivalent pool of comparison consumers did not exist. For this reason, the comparison group of consumers was all those receiving Better Access services from the relevant provider (i.e., a social worker or an occupational therapist) during the calendar year 2009.

Consumers

Tables 5 and 6 provide a breakdown of the key socio-demographic and clinical characteristics of participating consumers seen by social workers and occupational therapists, respectively. Wherever possible, comparisons are made between participating consumers and the overall group of Better Access consumers seen by social workers and occupational therapists from 1 January 2009 to 31 December 2009.^a

Consumers recruited by social workers were broadly representative of the overall group of consumers who had used the services of social workers under Better Access. Females accounted for around three quarters of both the participants and the comparison group. There was a relatively even spread of ages across participants and the comparison group, although the former had a slight over-representation by those in the relatively younger age groupings. Two thirds of consumers in both groups lived in capital cities. Consumers from areas of relatively low socio-economic disadvantage dominated both groups.

For consumers recruited by occupational therapists, the picture was somewhat different. The comparison group was evenly split with respect to gender, whereas three quarters of participants were female. The two groups shared a similar age profile. Two thirds of the comparison group came from capital cities, whereas only one quarter of participants did. Over half of the comparison group lived in areas of relatively low socio-economic disadvantage (quintiles 4 and 5), whereas only one quarter of participants did.

Table 3: Profiles of (a) participating social workers and (b) all social workers providing care through Better Access from 1 June 2009 to 31 May 2010

		Participating social workers (n=191)		All social workers (n=899)	
		Freq	%	Freq	%
Gender	Male	40	21%	166	19%
	Female	151	79%	733	82%
Age	<25	3	2%	4	0%
	25-34	8	4%	57	6%
	35-44	39	20%	207	23%
	45-54	74	39%	317	35%
	55-64	57	30%	272	30%
	>64	10	5%	42	5%
Year of qualification	Pre-1960	0	0%	2	0%
	1960-1969	5	3%	18	2%
	1970-1979	31	16%	147	16%
	1980-1989	49	26%	202	23%
	1990-1999	70	37%	324	36%
	2000-2009	36	19%	206	23%
		Median	Range	Median	Range
No. of sessions of Better Access care provided from 1 Jun 2009 to 31 May 2010		206	2-1,188	95	1-2,537
No. of consumers seen via Better Access from 1 Jun 2009 to 31 May 2010		43	1-289	18	1-734

Table 4: Profiles of (a) participating occupational therapists and (b) all occupational therapists providing care through Better Access from 1 June 2009 to 31 May 2010

		Participating occupational therapists (n=35)		All occupational therapists (n=238)	
		Freq	%	Freq	%
Gender	Male	2	6%	19	8%
	Female	33	94%	219	92%
Age	<25	0	0%	3	1%
	25-34	2	6%	57	24%
	35-44	8	23%	70	29%
	45-54	14	40%	64	27%
	55-64	10	29%	37	16%
	>64	1	3%	7	3%
Year of qualification	Pre-1960	0	0%	0	0%
	1960-1969	2	6%	7	3%
	1970-1979	8	23%	32	13%
	1980-1989	13	37%	71	30%
	1990-1999	9	26%	59	25%
	2000-2009	3	9%	69	29%
		Median	Range	Median	Range
No. of sessions of Better Access care provided from 1 Jun 2009 to 31 May 2010		157	4-934	52	1-2,189
No. of consumers seen via Better Access from 1 Jun 2009 to 31 May 2010		33	2-207	11	1-352

Table 5: Profiles of (a) participating consumers seen by social workers and (b) all consumers seen by social workers through Better Access from 1 Jan 2009 to 31 Dec 2009

		Participating consumers (n=458) ¹		All consumers (n=28,276) ¹	
		Freq	%	Freq	%
Gender	Male	92	20%	8,806	31%
	Female	361	80%	19,470	69%
Age	<30	73	16%	5,372	19%
	30-39	113	25%	4,806	17%
	40-49	116	26%	5,089	18%
	50-59	92	20%	4,806	17%
	60-69	43	9%	4,524	16%
	>69	16	4%	3,676	13%
Region²	Capital cities	238	64%	17,514	62%
	Other metro	25	7%	1,913	7%
	Rural centres	54	15%	4,856	17%
	Other rural	45	12%	3,820	14%
	Remote areas	7	2%	173	1%
Socio-economic disadvantage³	Quintile 5 (Least)	137	37%	7,667	27%
	Quintile 4	80	22%	5,798	21%
	Quintile 3	72	20%	5,498	20%
	Quintile 2	49	13%	5,525	20%
	Quintile 1 (Most)	28	8%	3,470	12%

1. Cells do not always sum to the total n due to some missing data.
2. Region based on RRMA classification.
3. Socio-economic disadvantage based on IRSED classification.

Table 6: Profiles of (a) participating consumers seen by occupational therapists and (b) all consumers seen by occupational therapists through Better Access from 1 Jan 2009 to 31 Dec 2009

		Participating consumers (n=72) ¹		All consumers (n=5,103) ¹	
		Freq	%	Freq	%
Gender	Male	17	24%	2,437	49%
	Female	55	76%	2,666	52%
Age	<30	15	21%	1,174	23%
	30-39	15	21%	970	19%
	40-49	14	19%	970	19%
	50-59	15	21%	868	17%
	60-69	8	11%	612	12%
	>69	4	6%	510	10%
Region²	Capital cities	14	25%	3,491	68%
	Other metro	14	25%	549	11%
	Rural centres	8	14%	594	12%
	Other rural	17	30%	438	9%
	Remote areas	4	7%	31	1%
Socio-economic disadvantage³	Quintile 5 (Least)	18	25%	1,647	33%
	Quintile 4	6	8%	1,050	21%
	Quintile 3	16	22%	969	19%
	Quintile 2	13	18%	799	16%
	Quintile 1 (Most)	4	6%	595	12%

1. Cells do not always sum to the total n due to some missing data.
2. Region based on RRMA classification.
3. Socio-economic disadvantage based on IRSED classification.

Chapter 4: Experiences of consumers who have received care from social workers and occupational therapist through Better Access

As noted in Chapter 3, participating social workers recruited 458 consumers to the study and participating occupational therapists recruited 72. All of these consumers contributed their views via interview or survey.

Experiences of consumers who were recruited by social workers

Previous barriers to seeking mental health care

Consumers were asked whether cost had acted as a barrier to their seeking mental health care in the past. They were also asked to describe any other barriers that may have previously prevented their seeing a mental health care provider. Their responses fell into the categories listed in Table 7.

Table 7: Previous barriers to seeking care experienced by consumers who received Better Access services from social workers (n=458)*

	Freq	%
Costs	313	68%
Availability and difficulty accessing services	73	16%
Personal factors	66	14%
Lack of knowledge regarding services	26	6%
Stigma	14	3%
Previous experience contact with mental health services	13	4%
Not recognising that they needed support	11	2%

* Multiple responses permitted

Cost was by far the greatest barrier, with 313 consumers (68%) indicating that this had limited their help-seeking behaviour in the past. They typically made brief comments like:

“Mainly the cost.”

Difficulties with accessing services were also mentioned relatively frequently (by 73 consumers, or 16%). Some consumers commented on the lack of availability of services, and others talked about the lengthy waiting times associated with being seen by a mental health professional. The following two comments exemplify this:

“Many specialists are unavailable in my region. There is a lack of government funding in mental health services in many regional and remote areas. Travelling is a major barrier for people with mental/psychological conditions.”

“Very hard to get appointments because of waiting lists to see any of these professionals.”

Personal factors were another comparatively common obstacle. These factors, cited by 66 consumers (14%), included fears about “opening up” and the feeling that one should be able to cope on one’s own. These sentiments were exemplified in the following comments:

“My own idea that I should not have to talk to [someone] other than a GP as I should be able to deal with depression by myself.”

“Having the courage to attend [sessions] when you finally realise you can't do it yourself and need help. Realising that you need help. Fear of being judged.”

Another barrier which was mentioned by 26 consumers (6%) was a lack of knowledge about available services. These consumers made comments like:

“Not knowing who or where to go for help. When [I] finally started seeking [searching for a provider] there was a long waiting list. (Help would have been better during [the] crisis).”

“Didn't know exactly who or what type of help I needed or where to start looking.”

Other less commonly cited impediments included previous negative experiences with mental health services (mentioned by 13 consumers, or 3%), stigma (14, 3%) and a lack of recognition that help was required (11, 2%).

Reasons for seeking care from the social worker

Consumers were asked what had prompted them to seek care from their social worker on this occasion. Their responses were aggregated to the categories listed in Table 8.

Table 8: Reasons for seeking care from social worker on this occasion (n=458)*

	Freq	%
Mental health	206	45%
Stressful life events	171	37%
Referral by a GP or another health professional	135	29%
Perceived need for intervention	79	17%
Encouraged to seek care by friend or family member	41	9%
Health problems	17	4%
Addiction problems	8	2%

* Multiple responses permitted

Most commonly, consumers indicated that a deterioration in their mental health had acted as the catalyst for their seeing the social worker. Two hundred and six consumers (45%) responded in this way, making comments like:

“My chronic depression and feelings of worthlessness and hopelessness.”

“Increasing need due to worsening of anxiety and depression.”

Stressful life events were also frequently cited as reasons. One hundred and seventy one consumers (37%) mentioned experiences such a relationship break-up, the death of a loved one,

loss of employment and the birth of a child. Some of these are highlighted in the quotations below:

“Breakdown of marriage. Previous strong history of depression-wanted to prevent relapse.”

“I became a mother fairly quickly after being married. It was a big change of lifestyle and I needed support. I went to a psychologist for six months then to a relationship expert.”

“My family (husband and son) all suffered the loss of our new baby girl through a very sudden still birth.”

It was also relatively common for consumers to indicate that someone else had suggested that they might benefit from seeking care. One hundred and thirty five consumers (29%) said that their GP or another health professional had referred them to the social worker, and 41 (9%) mentioned that they had been encouraged to seek help by a family member or friend. Typical responses included:

“My GP suggested a social worker in conjunction with my medication for depression.”

“Referral from psychiatrist. I didn't know about services from a social worker until then.”

“A friend's prompting (when I lost too much weight).”

“My daughters advised me to seek help.”

Consumers also frequently reported that they visited the social worker because they had a need for intervention and advice. In total, 79 consumers (17%) responded in this way. Two such responses are provided below:

“Needed to talk to someone about thoughts I was having.”

“I needed to get some perspective on some issues.”

Other less frequent responses related to co-morbid conditions. Seventeen consumers (4%) said that they were prompted to see the social worker because of the psychological sequelae of physical conditions (e.g., cervical cancer). Eight consumers (2%) said that they saw the social worker for help with psychological aspects of addictions (e.g., alcoholism).

Sessions of care

The majority of consumers (259, or 59%) reported that they had attended the number of sessions that was recommended by the social worker. A further 101 (22%) were either unsure whether they had attended the recommended number of sessions or did not respond to this question.

Ninety eight (21%) indicated that they had not attended the recommended number of sessions, usually because they had noted improvements in their mental health (54, or 12%). Typically, they made comments like:

“Feeling better after resolving problems.”

Other reasons for not attending the recommended number of sessions included cost (14, 3%), time commitments (10, 2%) and running out of Medicare-subsidised sessions (eight, 2%). Twelve (3%) were still continuing treatment, and one had stopped attending because the treatment was not perceived as beneficial.

Process of receiving care through Medicare

Consumers were asked about their experiences of the process of receiving psychological services that were refundable by Medicare. Two hundred and sixty eight (59%) indicated that they found the process “good”, “easy” and “helpful”. One hundred and seven (23%) explicitly noted that Better Access had lowered costs and 31 (7%) commented that it had made care accessible. These sentiments are exemplified in the following quotations:

“Excellent – was a big help financially and was easy to process rebate.”

“It made it possible for us to attend.”

“Wouldn't have been able to afford it otherwise.”

“Medicare refund made service easier to obtain so the process was good in that it helped provide access to the service.”

A small number of consumers 22 (5%) reported that the process was “poor”. These consumers were critical of bureaucratic aspects of the process such as the referral requirements, the paperwork and the bulk billing process. They felt that these were unnecessarily cumbersome and time-consuming. The following responses summarise their concerns:

“Not easy and time consuming. It makes life harder and the process should and can be streamlined.”

“I felt that going to Medicare was unnecessary. Psychological services should be bulk billed on the premises.”

“Finding a time to fill out the necessary forms was quite difficult, as I work full time. And also I found that having to go through the same GP to receive another six sessions rather unnecessary.”

“It was annoying to have to go through the mental assessment at the GP just to be able to get the refund.”

“Okay, I guess. Medicare should help out more with people who seek psychological help because not everyone who has got psychological issues can pay so much for a session.”

Satisfaction with care received

The vast majority of consumers (440, or 96%) were satisfied with the care they received. In particular, 318 (69%) were satisfied with their social worker’s attributes and competency (i.e., the fact that he or she had specialised skills, developed a rapport with them, listened to them, and provided them with support, and were non-judgemental and kind). Typical responses included:

"I found my social worker to be extremely approachable, knowledgeable and allowed me to have the space I needed to express myself. We were able to develop a rapport. He also checks on me after the care which is fantastic."

"Excellent listener. We've developed ... a good relationship and rapport."

"Ongoing support, understanding, no judgement."

Two hundred and forty four consumers (53%) expressed satisfaction with the advice, strategies and guidance that they received from their social worker. They made comments like:

"She was fantastic! She used a variety of methods to get to the source of the issue and provided me with tools to address them and work through them."

"Professional advice, guidance, reassurance to help get me back on track and focused more positively on my life's goals."

Consumers were asked to rate the extent to which their treatment met their needs and expectations, using a Likert scale ranging from 1 ("not at all met") through 2 ("partially met") to 3 ("totally met"). The majority of consumers reported that their sessions with the social worker "totally met" (384, 84%) or "partially met" (62, 14%) their needs. Only two consumers felt that the therapy offered by the social worker did not meet their needs.

Negative aspects of care

Consumers were asked what aspects of care were unsatisfactory. Three hundred and forty seven (76%) either explicitly reported that there were no negative aspects of their care, or did not comment. Those who responded directly made statements like:

"Nothing. I looked forward to my appointments and I would come away with renewed optimism."

"None, the best thing I did was get a referral to her – honestly, I'd still be on the bottle."

Those who did identify negative aspects of care often focused on the restricted number of sessions or the time allocated for sessions (36, or 8%). The following responses exemplify their comments:

"Sometimes the time is too short. Half hour session is too short."

"Limited to 12 sessions under mental health care plan."

Twenty four consumers (5%) identified difficulties with payments and costs associated with accessing care as negative aspects of care. These difficulties included affordability of therapy, having to pay a co-payment and/or to pay up front, and having to pay a cancellation fee. These consumers made comments like:

"Still costly at \$45 per session after rebate."

"Having to pay for missing an appointment when I was sick."

Having to pay full [price] up-front and then having to wait for the Medicare rebate.

"Not being able to see her more often because I can't afford the sessions."

Twenty four consumers (5%) reported that there were sometimes practical issues associated with accessing care. In the main, these related to waitlists and accessing timely care:

“Limited time. Travel costs. Pressure to change.”

“Initial difficulties in accessing office.”

“Timelines. It was difficult waiting so long for an appointment.”

Thirteen consumers (3%) reported that they found the therapeutic process uncomfortable because it challenged them or because they had to discuss painful experiences. They recognised, however, that this was part of the recovery process. Their comments included:

“Having to take a long hard look at yourself! The care was always supportive – nothing bad.”

“Having to face/reface and live some horrible memories, to move on. I know that is part of the process, but very frightening.”

More isolated concerns related to the usefulness or value of therapy or the social worker’s techniques, a feeling of being ‘judged’ by the social worker, and having to access the social worker via the conduit of the GP.

Extent of change

Consumers were asked to rate the extent of change in their mental health and well being over the course of their psychological care on a Likert scale from 1 (“I felt a lot worse”) to 5 (“I felt a lot better”). The majority of consumers (376, or 82%) reported that they “felt a lot better” after treatment. A further 75 (16%) claimed that they “felt a bit better” after treatment. Only four consumers (1%) “felt a bit worse” or “felt a lot worse” after treatment.

Types of change

As well as rating their change, consumers were asked to describe the types of change they had experienced via a more open-ended question. Two hundred and forty eight consumers (54%) reported improvement in their mental health in terms of a reduction in severity of symptoms and improved coping strategies. Typical comments included:

“Less anxiety. Better able to see when and why I was getting anxious. Able to put in place strategies early when I noticed anxiety. Less teariness. Understanding myself and how others help me out.”

“My life has improved. Very little suicidal thinking, which I know how to deal with now. Definite improvements in relationships with my family and friends, socialising more, exercising regularly. Depression and anxiety have lessened.”

One hundred and seventy seven consumers (39%) reported making more general, all-round improvements in their confidence, self awareness and attitudes. The following comments exemplify these responses:

“Changes in attitudes, thoughts processes, value. Many changes!”

“More happy, more relaxed, peaceful, more energy, more positive. Better all round.”

Forty four consumers (10%) described noticeable changes in their physical health or sleeping patterns, as indicated in the following comments:

“Resolved severe emotional pain that I have had all my life. Slept much better. Changed negative thinking. Increased self-esteem. Loss of weight. Increased enjoyment of life – best I have ever been. More insight into myself. Healed skin rashes on both arms, feet, chest.”

“Many changes and all positive. Gained my health back and self esteem.”

Thirty two consumers (7%) reported that the care from their social worker helped them return to work, maintain their employment or cope better with their work situation. Their responses included the following:

“Less prescriptions of medication. Less anxiety and depression. Able to continue working full-time.”

“I got back to work and just felt a lot calmer.”

Thirteen consumers (3%) reported a reduction in their addictive behaviours (e.g., drug and alcohol use) as a consequence of their seeing the social worker:

“Reduced alcohol consumption. Better sleep patterns. Almost eliminated anxiety symptoms. Improving diet and exercise. Happier and less stressed out. Greater perspective on certain aspects of my life. Able to manage upsets better. More assertive. Reassured by having someone impartial to support me on things I did right.”

“Being able to face up to my current situation and deal with it in a calm manner as opposed to getting very angry and creating a huge drama. I am no longer a marijuana smoker ... I am communicating better with my family and they started to show me some respect as an adult.”

Attribution of change to the social worker

Consumers were asked to consider the extent to which they would attribute any changes they'd noticed to the social worker, and given the options of “not at all”, “partially” and “totally”. Two hundred and forty six consumers (54%) totally attributed their observed changes to the social worker, and 174 (38%) partially did so. A small number (24, or 5%) did not attribute changes to the social worker at all, and 14 (3%) did not respond to this question.

Experiences of consumers who were recruited by occupational therapists

Previous barriers to seeking mental health care

Consumers were asked whether cost had limited their seeking mental health care in the past. They were also asked to describe any other barriers that may have previously prevented their seeing a mental health care provider. Their responses fell into the categories listed in Table 9. Fifty three consumers (74%) recruited by occupational therapists found cost to be a barrier to seeking care.

Table 9: Previous barriers to seeking care experienced by consumers who received Better Access services from occupational therapists (n=72)*

	Freq	%
Cost	53	74%
Lack of knowledge regarding services and or not recognising that they needed mental health services	13	18%
Difficulty accessing services and service availability	10	14%
Personal factors	7	10%

* Multiple responses permitted

Thirteen consumers (18%) described how their previous likelihood of accessing care had been influenced by their lack of knowledge, either with respect to an understanding of their mental health problem or with regard to services that might be useful and/or available to assist. The following quotations exemplify this:

“Probably my own personal belief that depression was not a real illness – it was something people had to toughen up about and get over. (Of course, I no longer feel this way).”

“Knowing who was right for my situation.”

Difficulty accessing services and a lack of available services was the next most common barrier to seeking care, after cost. This barrier was cited by 10 consumers (14%). Consumers often commented that few services were available to them and, when they were, they often had to travel some distance to take advantage of them. The time commitment associated with travelling these distances was regarded as a limiting factor. Typical comments included:

“Distance to travel”

“... availability in my local area. Working full time does not leave much spare time to travel longer distances to an appointment – least of all regular appointments.”

Personal factors were the next most frequently cited barrier to seeking care. These factors, cited by seven consumers (10%), included stigma and loss of self esteem. They made comments along the lines of the following:

“Stigma attached to seeing these providers ...”

“A lack of feeling of self worth. If the rebate hadn’t been available I would have felt that I didn’t deserve to spend the cost of the consultation on myself.”

Reasons for seeking care from the occupational therapist

Consumers were asked what had prompted them to seek care from their occupational therapist on this occasion. Their responses varied and are listed in order of frequency under the categories in Table 10.

Table 10: Reasons for seeking care from the occupational therapist on this occasion (n=72)*

	Freq	%
Referral by a GP or another health professional	35	49%
Perceived need for intervention	16	22%
Mental health	9	12%
Encouragement from friends or family	6	8%
Stressful life events	4	6%

* Multiple responses permitted

The most commonly reported reason for seeking care was a referral from another professional, cited by 35 consumers (49%). In most cases this was a GP or other mental health professional, but in some cases it was another health professional. Typical responses included:

“After two years of taking a high dosage of antidepressants, I felt it was time to decrease the amount. My GP suggested I see the occupational therapist for CBT for extra help.”

“Referral from another specialist (a gastroenterologist), and acceptance that seeking care by the occupational therapist may be helpful. No other medical practitioners had suggested such help previously.”

Sixteen consumers (22%) indicated that their own recognition that they required professional help was the catalyst for their seeing the occupational therapist, and nine (12%) noted that their observation that their mental health was worsening was the trigger. These consumers made statements like:

“To help me learn to cope with problems in my life.”

“I was struggling with anxiety problems and panic attacks. This was causing an amount of depression”

Less common responses related to prompting by a family member or friend (mentioned by six consumers, or 8%) and stressful life events (mentioned by four consumers, or 6%).

Sessions of care

Forty five consumers (63%) indicated that they had attended the number of sessions recommended by the occupational therapist. A further twelve (17%) were unsure if they had attended the recommended number.

Ten consumers (14%) stated that they had not attended the recommended number of sessions. The main reasons for their discontinuing care related to improvements in their mental health. This is exemplified by the following quotations:

“My mental health had improved. I started a new job.”

“I was very happy with the results. The strategies I was taught made me feel confident that I could control my anxiety.”

Process of receiving care through Medicare

Consumers were asked about their experiences of the process of receiving psychological services that were refundable by Medicare. Sixty one (85%) were positive about the process, and 31 of these specifically indicated that reduced cost was a contributing factor. These consumers made comments like:

"I would not have been able to afford the help I required."

"It made it affordable."

Seven consumers (10%) described the process negatively, citing difficulties with confusion over the claiming process or disquiet with having to disclose mental health issues to staff at the Medicare office. For example, one of these consumers said the following:

"The occupational therapist sessions were extremely worthwhile. The process of going in to the Medicare office to claim for psychological services was slightly embarrassing. This is my problem though. I could have claimed another way."

Satisfaction with care received

All 72 consumers (100%) were satisfied with the care they received. Some suggested that the care had had a major impact on their health and wellbeing, making comments like:

"It changed my life. I only wish I had gone 20 years ago."

When they were asked about the aspects of care that they found good, they focussed on different things. Some were positive about what they gained from the sessions, others complimented the occupational therapist for his/her skills and attributes, and others focused on the holistic approach. Still others were sanguine about all aspects of their care. These different perspectives are exemplified in the quotations below:

"Skills to manage anxiety. Support to get back into the community."

"Approachable, communication was excellent – good teacher explains concept well. Not intimidating at all. "

"The occupational therapist's listening skills, advice, ability to get me to see a situation in a different way. "

"As an occupational therapist she had a focus on "whole body" health rather than just mental health."

"Communication between the occupational therapist and psychiatrist."

"All aspects."

Consumers were asked to rate the extent to which their treatment met their needs and expectations, using a Likert scale ranging from 1 ("not at all met") through 2 ("partially met") to 3 ("totally met"). The vast majority of consumers reported that their sessions with the occupational therapist "totally met" (60, 83%) or "partially met" (nine, 13%) their needs. Three consumer did not respond to this question.

Negative aspects of care

The majority of consumers (57, or 79%) specifically stated that there were no negative aspects with care, or made no comment at all. Their responses are summed up in the following comment:

"I cannot recall any bad moments. None."

Five consumers (7%) found the available appointment times problematic and that the appointments were too short. Another four consumers (6%) described being out of their comfort zone. Two consumers (3%) again cited cost as a negative aspect of the care. These sentiments are reflected in the following comments:

"Only worked during school hours, had to have time off school."

"I could have stayed longer, especially on 'bad' mornings."

"Nothing. Just at start felt out of comfort zone, not used to talking to anybody."

"Sometimes having to pay the gap fee, which left me short of money for food and petrol."

Extent of change

Consumers were asked to rate the extent of change in mental health and wellbeing over the course of their psychological care on a Likert scale from 1 ("I felt a lot worse") to 5 ("I felt a lot better"). The majority of consumers (61, or 85%) rated their extent of change in the highest category of "I felt a lot better". Nine consumers (13%) rated their change as "I felt a bit better".

Types of change

As well as rating the extent of any changes in their mental health, consumers were also asked to describe the types of change they had experienced. Forty three consumers (60%) described changes in terms of improvements in their mental health, relief of specific symptoms or learning specific strategies to manage their mental health problems, making comments like:

"Less anxiety, communication skills and ability to express my feelings improved a lot, learnt strategies and coping skills, provided a de-briefing forum for me while working through my depression, provided good reference material for further study."

"Am able to deal with my health problems easier."

Twenty five consumers (35%) made reference to a more general, all-round improvement, as exemplified in the following comments:

"Happier."

"Confidence, self-belief, understanding my feelings, growth."

"From ... couldn't take my head off the pillow to completely reinventing my life."

Eight consumers (11%) described a change in lifestyle, physical health or sleeping:

"I was achieving more balance in my life and feeling less guilty for taking time out. I developed time management strategies, which greatly improved my self esteem and moods."

"Getting out more. Doing things I wouldn't have done before. I feel happier and I am enjoying life again."

Seven consumers (10%) referred to the change as having improved aspects of their work, either in terms of helping them return to work or improvement in their current work situation. Typical comments were:

"Anticipation anxiety I was suffering days before going back to work disappeared."

"Support with specific goal development and to do with job career."

Attribution of change to the occupational therapist

Consumers were asked to consider the extent to which they would attribute any changed they'd noticed to the social worker, and given the options of "not at all", "partially" and "totally". Forty consumers (56%) totally attributed the change in their mental health and wellbeing to the occupational therapist, and 26 (36%) partially did so.

Chapter 5: Experiences of social workers and occupational therapists who have provided care through Better Access

As noted in Chapter 3, 188 social workers were recruited to the study and 156 of these provided their views via interview or survey or both. Thirty five occupational therapists were recruited to the study and 32 of these provided their views via interview or survey or both.

Experiences of social workers

Impact on consultations

Social workers were asked whether Better Access had had an impact on their consultations. Many (97, or 62%) reported that that Better Access had increased their caseload. Only nine (6%) reported that the initiative had had no impact on their caseload. Those who had noticed changes in their caseload typically made comments like:

“Yes! Only bulk billing service. Without Better Access I am unable to work as a private practitioner for [a New South Wales Division of General Practice].”

“My caseload has increased by 25%. There has been an increase in additional working hours to meet reporting requirements by three hours per week.”

“Caseload has increased as psychological services more accessible and affordable.”

Twenty nine social workers (19%) also reported that the mix of people comprising their caseload had altered. Typically, they indicated that they were now seeing more consumers with complex needs, both in terms of their mental health concerns and their personal circumstances. The following comments exemplify these responses:

“[I have] more consumers presenting with anxiety, depression, dual diagnosis, other mood disorders such as bipolar, drug induced psychosis etc.”

“A greater proportion of my caseload has become mental health work. The Medicare item numbers have allowed low income consumers to access counselling.”

Thirty three social workers (21%) indicated that Better Access had not led to changes in the way they conducted sessions, but 65 (42%) indicated that they had. Mostly, these changes related their being able to offer treatment more readily and earlier, and to offer an appropriate number of sessions. They said things like:

“Knowing that the client has at least six affordable sessions seems to take the pressure off both parties. I know that a client will not be terminating counselling for financial reasons. If their financial circumstances change during the period of counselling I reduce my fees accordingly.”

“Absolutely – 80% of consumers are Better Access, and this allows me to bulk bill consumers who urgently need treatment but are unable to pay.”

“Focus on early intervention with consumers suffering mental health issues.”

Thirty four social workers (22%) commented that Better Access provided them with structure and guidance and increased their efficiency. The flow-on effect was a change in the type of therapy they provided. Mostly, although not always, these impacts were seen as positive:

“So it means your work is more focused.”

“Shift from long-term psychotherapy to short-term work – more focused and structured.”

“The limited number of sessions has meant more efficient use of the say 12 sessions. I have given consumers more reading.”

“In terms of counselling, I work within a 12 session timeframe – it seems to focus therapy strategy and engage client in making the most of the time available.”

“The disappointing thing I think [is that] it's more limited and less creative.”

Ten social workers (6%) explicitly commented on the extent to which the Medicare item numbers adequately reimbursed them for their greater, more complex workload. Their views were divided. Six (4%) felt that they were not adequately reimbursed, whereas four (3%) felt that they were. These divergent views are highlighted in the quotations below:

“No it doesn't, but I guess in comment what I would say is that it means that I do unpaid work when I liaise with doctors and do any advocacy work. I just have to take that and hope that there is enough. That is a business plan about covering your expense. Unfortunately there is nothing under Medicare I can claim for all the liaison work that goes on. The item numbers I haven't had any problems with. I only bill really under one item number, possibly two, either it's a standard consultation or a short one. The item numbers aren't a particular problem in themselves [but] the rebate for the item numbers is a little bit sad.”

“At least now I can claim for services I would have offered free of charge to individual consumers, or maybe there are consumers would not have approached [me] for counselling.”

Communication with other mental health care providers

Social workers were asked about their experiences with communicating with other providers in the course of providing Better Access care. In the main, they discussed their communication with GPs.

Eighty five social workers (54%) reported that the referrals they received from the GP were appropriate. However, nine (6%) reported a contrary view. The following comments exemplify these responses:

“GPs refer consumers very readily to me. GP referrals are always relevant and appropriate.”

“GP referrals are 99.9% appropriate.”

“Absolutely atrocious. I've been sent consumers that, you know 'suffers anxiety levels and they've had ... problems, chronic suicidality' you know. The GPs in our area are money driven. You mention mental health [and] they just sort of freeze and handball it to somebody else ...”

Seventy social workers (45%) felt that the referral information provided by GP in the Mental Health Treatment Plan was adequate or comprehensive, but 34 (22%) indicated that it was more variable and often inadequate, too general and/or lacking in detail. Examples of these divergent responses are provided below:

“GP referrals mostly use a standardised format that gives a good range of information about the client. I go through this information with the client to ensure accuracy and to see if it is the same (better/worse) since the client consulted with the GP.”

“There is a range of information from GPs but I don't mind very brief referral information as I do my own assessment anyway.”

“Fine, adequate, all the information is there that I need.”

“The referral information in the GP mental health care plans varies enormously from highly detailed to scant. Most GPs write very little. Annoyingly, some have no practice address, no provider number and no dates on the sheet of paper the client is given.”

“At times it seems their assessment processes are not thorough and they don't always ensure [the] client has signed the mental health care plan.”

“It seems to vary a lot. Most GPs have provided very little info in the referral which is fine. Also, they never put their provider number on the referral and I have to ring up and get it.”

“... I've got a couple of GPs that do send me good information, but they're few and far between. No background, no history.”

A number of social workers discussed the kinds of additional referral information that would be useful from the outset. These included more information about the consumer's background, general health status, previous mental health history, previous treatment, current situation and current medication. A copy of the K-10 and detail on proximal and distal factors that may have precipitated their current mental health problem were also considered to be of value. Some of these are flagged in the comments below:

“Additional information that would be most helpful – previous letters and reports from specialist mental health services, mental health providers and additional history that they may have taken.”

“Information about their level of social support and previous counselling/therapy/treatment would be good.”

“It is most helpful to me when [the] GP lists symptoms and medications, then leaves choice of treatment to me.”

Beyond the referral process, social workers also discussed the nature of their more general communication with GPs. Twenty eight (18%) commented on having good communication channels, but 17 (11%) felt that communication with GPs (and other mental health professionals) was suboptimal because these providers lacked a comprehensive understanding of their role. These different opinions are highlighted in the following comments:

“I have found the process of communicating with the GPs who refer me [to be] extremely productive and appropriate.”

"The GP referrals are very appropriate as I have close contact with the GPs in my area that refer to me and we keep the lines of communication open."

"I find some of it is offensive and some of it is fine. So I get annoyed at the number of GPs, it might be decreasing, who put CBT strategies as a sort of a standard and I don't think it's for them to tell me how I work. I don't tell them how to work and of course there's that fallback sort of option which, as a psychotherapist, I don't use CBT strategies as a main tool. But for some of them, again it's variable, some GPs will say, 'Look I think this person needs ..., you know, these are the sort of issues ..., I think they'll need support in these areas ...' and that's fantastic."

"Most are not interested in getting information back, other than for paperwork purposes. Most GPs seem to have little understanding about counselling and see the main solution as prescribing medication for the patient's 'symptoms'."

One hundred and seventeen (75%) reported that their primary communication with GPs about individual consumers took the form of routine reports, usually after the initial consultation or after the 6th or 12th sessions. During this communication, social workers reported focussing on information relating to the consumer's current situation, their treatment response and any recommendations.

"My practice is to write detailed letters of two pages to GPs, psychiatrists or paediatricians. I ring directly if urgent."

"I report back to the GP after 1st, 6th and 12th session and at the end of therapy (whatever session number that is)."

Logistics of registering with and billing Medicare

The majority of social workers (92, or 59%) said that they did not experience difficulties registering with Medicare as an eligible mental health services provider and described the process as "straight forward" and "a good experience". A smaller number (32, or 20%) reported some difficulties, mostly related to the being paperwork time-consuming, confusing and complicated and the fact that they could not always get clarification from Medicare. These latter views are summed up in the following response by one social worker:

"The initial set up of use of Medicare was extremely difficult and frustrating. Frequently I would contact Medicare to seek advice and they would not be able to answer my questions."

Many social workers found the process of billing Medicare relatively easy. Seventy one (46%) reported having no problems with billing Medicare, finding the process straight forward and streamlined. However, 30 (19%) experienced some difficulties, mostly to do with absent or late payments, or finding the process cumbersome or time-consuming. The following quotations illustrate the range of views:

"Billing Medicare is a fairly straight forward system. I don't have any problems with this."

"[The] billing process was clear and manageable. [I've] always been paid on lodging claim forms and consumers receive rebates without any problems. Staff on the Medicare help-line have quickly resolved any problems I have had."

“Because I bulk bill, it just takes a bit of time and sometimes I don't put stuff on the letter and it gets declined so it's not bad but it just takes time.”

“I'm hoping that I can find a better way of doing it. The manual system is a bit onerous. I've got to set a day aside a month to actually do all the paperwork. So manually onerous, but I believe from other clinicians that I've spoken to that they've got some more online processes, so I'm sure they tell me that that's better. I just haven't had a lot of time to put into doing that just yet. I think when I become more online with that, it will be easier, but at the moment I'm manual and I find it quite ... it takes a day out to do it.

Charging policies

Social workers' charging policies varied. Thirty five social workers (22%) indicated that they bulk billed all or most of their consumers. The main reasons cited for this policy were working in bulk billing clinics, working with socio-economically disadvantaged groups, and a belief that charging consumers might cause them further distress. The comments below typify bulk billing social workers' responses:

“We bulk bill. That was one of the conditions that they wanted me to join their team. They said 'students are disadvantaged' and.... For me it's actually working with young people, and that was my primary role ...”

“As I work in an area with many people on low incomes, I have decided to bulk bill all consumers seen through Medicare, which is easy to do.”

“In 90% of cases I see on Medicare, I bulk bill. Often the reasons people are seeking support include financial difficulties as a component of their issues, stress, problems.”

Sixty two social workers (40%) indicated that they bulk billed some consumers but not others. They said that the decision for each individual consumer was based on whether he or she was a low income earner and/or on a pension or held a health care card. Standard responses from this group included:

“I bulk bill consumers on low incomes/pensions/under financial hardship. I write out the paperwork and they sign and date the session, so that all the details are filled in correctly.”

“I will bulk bill low income consumers occasionally (every second session). I always tell consumers to let me know if they cannot afford to attend a session and payment can be made at a later date (I bulk bill all meetings out of rooms).”

Thirty nine social workers (25%) indicated that they did not bulk bill at all. The reasons for not bulkbilling varied. Some felt that consumers valued the service more if they had to pay a small fee, others indicated that there were other avenues for referring consumers who could not afford to pay the gap, others stated that they could not afford to bulk bill consumers, and still others said that they did not work with financially disadvantaged consumers. Examples of these responses are provided below:

“I charge all consumers \$90 per session as I believe low income consumers value service more if they pay a small amount. I have not charged more than this as my social justice ethic has meant that I want help to be accessible.”

“If consumers don't have cash [to pay the full fee] up-front, we negotiate payment. I don't bulk bill as the social worker Medicare rebate is too low to manage to do this, but I may charge a lower rate for people struggling to pay.”

“Because I think that the relationship between the therapist and the patient is also about the money that is exchanged. There is a reality in that and I think it's useful for the patient to know what they are buying. If they're buying something for \$35, they'll feel differently about it than if they're buying something for \$105 which is what I charge. And I think that it's then their responsibility to engage with Medicare I don't have people who are struggling financially at all and, yeah, if I did I might reconsider.”

Some of the social workers who did not bulk bill (20, or 13%) indicated that they did employ a sliding scale whereby out-of-pocket costs were reduced for consumers on low incomes. They made statements like:

“I don't bulk bill but I do reduce my fee for people who may have financial constraints.”

“[I charge a] reduced fee for low income earners.”

Positive impacts for social workers

Social workers were asked whether Better Access had positive impacts for them, and 95% indicated that they had. Table 11 summarises the kinds of impacts that social workers perceived had accrued for them.

Table 11: Positive impacts for social workers (n=156)*

	Freq	%
Improving access	68	44%
Affordable care	58	37%
Financial rewards	57	37%
Professional recognition	26	17%
Integration of care	21	13%
Early Intervention	13	8%
Professional development	11	7%
Improving awareness	3	2%

* Multiple responses permitted

The most commonly reported positive impact was improved access and affordability for consumers, which social workers felt had flow-on benefits for them in terms of professional satisfaction. Sixty eight social workers (44%) commented on access and 58 (37%) made mention of affordability. Typical comments included:

“As a private practitioner, it has made this service far more accessible to the general population. It has increased choices for consumers and decreased waiting periods for service – extremely positive outcomes for both consumers and service providers.”

“With Medicare rebate access, consumers have been able to see me for more sessions than they would have otherwise which has meant that they are able to receive improved treatment and sustain their outcomes. This has been a better use of my specialist skills and gives improved job satisfaction.”

“Consumers who could not afford to access my services can be in contact. I find it very satisfactory because I feel I am being helpful and effective for those in most need.”

“More consumers can afford to attend treatment so my caseload has increased. [The] structure and process of Better Access provides accountability to [the] client and [the] GP. [I] feel more like a part of a team with the GP and others involved health/welfare services – [I’m] not so isolated. [The] greater diversity of issues and situations leads to more interesting and challenging work.”

Financial benefits were also frequently mentioned. Fifty seven social workers (37%) noted that this enhanced the viability of their private practice or allowed them to expand their practice. The following response was typical:

“It has boosted my practice, allowing me to only focus on private practice ...”

Another commonly-mentioned impact was increased professional recognition. Twenty six social workers (17%) commented the fact that they felt that an acknowledgement of the skills and therapeutic contributions of social workers had gone hand-in-hand with the Better Access initiative. They made comments like:

“It keeps me accountable and as well raises my 'status' and confidence to offer a service to mental health consumers.”

“Positive because I am recognised both professionally and monetarily for the amount of professional training and experience I have. The consumers know that they are receiving good ongoing quality care and have consequently received direct benefits of care.”

Some social workers also commented on the fact that Better Access had improved the nature and quality of care that they offered. Specifically, 21 (13%) mentioned that it had resulted in better co-ordination and integration of care and 13 (8%) noted that it had increased their ability to intervene early. The following comments illustrate these points:

“Medicare has helped doctors, consumers and I work as team around mental health problems.”

“... Medicare item numbers [have] meant new types of referral for consumers that have a range of mental health issues at a more 'early intervention' phase when consumers are still functioning well in daily life.”

Smaller numbers of social workers referred to the fact that Better Access provided them with professional development opportunities (11, or 7%) and reduced the stigma surrounding mental health issues (two, or 2%).

Negative impacts for social workers

Social workers were also asked whether Better Access had negative impacts for them. Sixty nine (44%) explicitly said that the scheme had no negative impacts for them, and seven (4%) did not comment. Eighty one social workers (52%) reported that Better Access had some negative impact for them, but often this was quite minor. Often when they mentioned small inconveniences associated with Better Access, they observed that the positive aspects of the initiative outweighed the negative. Table 12 lists the negative impacts in order of frequency of mention.

Table 12: Negative impacts for social workers (n=156)*

	Freq	%
Session limits	30	19%
Increased paperwork	29	19%
Increased demand	23	15%
Perceptions of role	16	10%
Financial viability	16	10%
Lower rebate than psychologists	11	7%
Uncertainty	10	6%
Supervision/guidance from professional bodies	2	1%

* Multiple responses permitted

The limited number of sessions and the limited number of therapies that can be provided under Better Access were seen as problematic by 30 social workers (19%). These social workers felt that the session limit meant that they could not meet the needs of some consumers, particularly as it was not always clear how to access additional sessions beyond the first six (or twelve). They were also concerned that the list of approved therapies was too restrictive. The comments below illustrate these concerns:

“Short-term nature can mean that some treatment is not complete.”

“The Medicare item numbers restrict/reduce my ability to be able to provide other interventions that are helpful in enhancing individuals' well-being, such as other forms of therapies besides CBT, family therapy, secondary consultation (speaking to school teachers, case managers, drug and alcohol workers etc about appropriate interventions for consumers, i.e. collaborative care).

Twenty nine social workers (19%) commented on the increased paperwork. Often these social workers were critical of the fact that they were not reimbursed for the administrative aspects of their work. These sentiments are expressed in the comments below:

“No negative impacts apart from the extra paperwork. Financial advantages to consumers and myself outweigh disadvantages.”

“The main negative has been the need to continually write back to the GP. This is time consuming and it can be hard to balance client privacy with the need to communicate something with content to the GP. If I am seeing a client on a weekly basis, six sessions are quickly used. Writing after six sessions is too frequent. I am okay if the GP wants to call the client back for a review after six sessions and requests information from me if required. I also find it a bit tedious having to always keep aware of the number of sessions used. 12-18 sessions is not enough for consumers with significant and long-standing mental health issues. I would welcome the availability of more sessions for certain consumers.”

“Some consumers are referred to be bulk billed, then on occasions have not attended resulting in loss of income for me. Phone calls, reports, letter writing, supervision, follow-up appointments, initial assessments are not covered by Medicare.”

Increased work demands were also relatively frequently mentioned as a negative impact. Twenty three social workers (15%) made comments along these lines, referring to time pressures and long working hours. Their comments are summarised in the one below:

“No negative impacts – except being a bit too busy. Need to consciously balance life to not become tired and worn out.”

Sixteen social workers (10%) reported that a lack of understanding of their role on the part of GPs had negative implications for their ability to deliver services. The following comment is typical:

“I think at times the way doctors interpret how mental health problems can be addressed (i.e., individual versus couple/family attending) has created some tension between myself and GPs, especially when I assess that issues for a person are linked to their relationships and better outcomes would be achieved by involving partners/family members. Some GPs are really against this type of use of mental health care plan and can result in consumers having to go elsewhere for couple or family work or they stop seeking assistance.”

An equivalent number of social workers (16, or 10%) were concerned about the financial viability of their practice. They felt that their payment did not adequately reflect their skills, and they indicated that they found it difficult to establish themselves. On a related note, eleven social workers (7%) voiced their discontent about the fact that they attracted a lower rebate than psychologists. The following comments sum up these concerns:

“Bitter, not paid enough. 1 hour session = \$70.20, and 20 minutes is not enough.”

“My husband keeps asking me when I'm going to make some money ... I've sunk about \$30,000 into [the practice] ... and I haven't made a cent out of it yet, but I keep on telling him 'these things take time'.”

“A uniform system would be useful using standardised language and protocols. There is a huge amount of administration involved. Other negative impacts include a lack of clarity from Medicare and other peak bodies (including the Australian Association of Social Workers and the Australian Psychological Society) about the ramifications/consequences for consumers around information held (and possibly disclosed) to third parties about the mental health status of consumers (e.g., to employers, for life insurance etc).”

“As a social worker I get lesser rebate than a psychologist. I find this discriminating and elitist thinking, particularly as I provide a comprehensive psychotherapeutic service and have all the associated costs as a psychologist would!”

“I find being paid less under Medicare than psychologists demeaning as we are all expected to provide similar treatments to consumers presenting with diverse issues. One local GP refuses to refer to me because I am not a psychologist.”

Other concerns for social workers related to supervision and the uncertainty associated with their ongoing coverage by Better Access.

Perceived positive impacts for consumers

Almost all of the participating social workers (155, or 99%) felt that being able to provide psychological services via Better Access had benefited consumers under their care. Table 13 provides a breakdown of the kinds of benefits that they discussed.

Table 13: Perceived positive impacts for consumers (n=156)*

	Freq	%
Access (general)	104	67%
Generalised benefits	59	38%
Increased treatment options	27	17%
Integration/co-ordination	21	13%
Early intervention	19	12%
Long-term care	12	8%
Reduced reliance on public sector mental health services	10	6%
Access (rural)	7	4%

* Multiple responses permitted

The main consumer benefit that social workers identified was that Better Access had improved access to psychological services by making care affordable. One hundred and four social workers (64%) mentioned this. Seven (4%) made particular reference to access for consumers in rural areas. The comments below illustrate these points:

“As previously stated, this is a great benefit for consumers who cannot afford counselling fees or at least the full fee. It can also provide anonymity if needed for consumers. One case in point this year has been the saving of a young marriage (with two children) as the young couple learnt how to negotiate their difficulties within specific pressures including pressures from both sets of in-laws.”

“Low income consumers benefit hugely.”

“Absolutely. Enables consumers to know about and access counselling when otherwise they wouldn't know about these services. Many low to middle income earners have accessed the service. Great referral rate for male consumers – more men come via a GP referral than self-refer. Can be a greater focus on preventative health, due to being referred by GP. Has given some consumers a 'taste' of counselling to then take up longer-term work.”

“Increased access to counselling services for rural/regional areas. Increased access/affordability for low income earners.”

“They get a service which otherwise would require between 3-4 hours of travel. It prevents exacerbation of their issues by providing early intervention ...”

Another recurring theme was the perception that Better Access had generalised benefits for consumers. These included reduced levels of symptomatology, enhanced coping strategies, and improved circumstances (e.g., relationships, work situations). Fifty nine social workers (38%) made comments of this sort:

“There are consumers I see whose lives have been saved from suicide, their marriages have been saved, children's behaviour problems ceased, cured from anorexia, intolerable grief and depression and anxiety healed, domestic violence difficulties assisted.”

“Most definitely. It has made counselling more broadly available/accessible and possible to complete blocks in order to complete goals and achieve outcomes. This has led to increased coping strategies, increased quality of life, reduced risks of harm to self and others, and reduced drain on other services from government and non-government sector who previously may have worked with these consumers.”

Twenty seven social workers (17%) suggested that Better Access offered a greater range of treatment options, particularly for consumers who might previously have been marginalised. The quotations below illustrate this point:

“... It's meant that I've been able to work with a high and complex need, hard to reach target population. In other words, young people who don't often access psychological services ... I've been able to offer them psychological services, whereas before they only had sort of outreach, drug and alcohol, now they've got mental health services in that school.”

“I see more low income consumers and they are more likely to complete treatment. Also, I have heard positive statements about the freedom to choose a non-psychologist.”

Twenty one social workers (13%) indicated that Better Access improved the integration and co-ordination of care, and encouraged accountability. They perceived that this had positive flow-on effects for consumers because it promoted a more multi-disciplinary, holistic approach. They made comments like:

“... I have been able to also link consumers into other services – more holistic care.”

“Consumers ... know that the GP knows and approves of my service and treatments. My consumers know that I'm working with the GP ... And also, there is a record of what services the consumers have accessed lodged with the GP (reports) and thus some two-way accountability.”

Nineteen social workers (12%) commented on the opportunities for early intervention and prevention. They felt that this had benefits for consumers in terms of averting crises and minimising the severity of an episode of mental illness. One social worker put it this way:

“Consumers are able to access counselling when issues have not yet compounded. My referrals have a primary focus on anxiety and depression in mostly well-functioning women. Drug and alcohol and sexual assault issues often co-exist. I have been able to provide services to ensure consumers have had an opportunity to access services prior to these issues increasing in complexity and severity.”

Other less commonly cited benefits were longer-term engagement with treatment (mentioned by 12, or 8%) and reduced reliance on public sector mental health services and (mentioned by 10, or 6%).

Perceived negative impacts for consumers

Eighty social workers (51%) perceived there to be no negative impacts of Better Access for consumers, and a further eight (5%) made no comment. Sixty eight (44%) articulated some negative impacts, and these are listed in Table 14.

Table 14: Perceived negative impacts for consumers (n=156)*

	Freq	%
Limited sessions	32	21%
Confidentiality	23	15%
Client factors	11	7%
Financial barriers	7	4%
Qualification of social worker	5	3%
Uncertainty	2	1%

* Multiple responses permitted

The most commonly-mentioned negative impact was the limited number of sessions available for consumers. The 32 social workers (21%) who expressed concern about this felt that consumers would benefit from more sessions and longer session times, and made comments like:

“Twelve sessions is limited for some adults who are parents and have severe mental health issues that are preventing them from having their child returned to their care. So, not having enough sessions and having to finish after the relationship is built, is not good.”

“For some clients, the restriction on the number of sessions is inappropriate – for example, where there have been multiple chronic medical conditions, coupled with grief issues. Occasionally clients experience difficulty accessing appointments with GPs in a timely fashion to obtain a re-referral.”

A number of social workers (23, or 15%) were worried about confidentiality issues as they might relate to consumers. In particular, these social workers felt that some consumers might feel compromised because the fact that they had received mental health care was recorded. They commented that some consumers were hesitant about their GP knowing this, and other consumers felt that their Medicare history might be sighted by other parties. These sentiments are summarised in the comments below:

“Some clients have reservations about information being provided back to their GP.”

“Yes, in one case only I made a mistake and reported some assessment detail that my client felt was inappropriate to be given to her GP. She terminated with me, after much apology [on my behalf]. So yes, the reports back to GPs are tricky with enough material to be useful, and not too much to be too disclosing and violate confidentiality. I now always show my clients the report before I send it to the GP.”

“No. Some clients have been concerned about being refused insurance or employment in the armed forces if they're identified as having a mental health concern.”

Eleven social workers (7%) commented that the Better Access initiative might impact negatively on consumers' motivation. Some referred to the fact that GPs might refer consumers who were

not likely to engage with mental health treatment. Others mentioned the fact that Better Access enabled consumers to access free or relatively inexpensive care might mean that they had insufficient investment in it to be motivated to follow through with therapy. These responses are exemplified by the comments below:

“Some clients are referred by well-meaning and concerned GPs but are not change-orientated. This is a small percentage though – most are well-prepared by GPs.”

“No, I don't think so, except maybe that – and again this only becomes a thing if you're talking about bulk billing because it kind of ties in a lot with what I said before – I think some people, if it's being subsidised fully by someone else, they don't, either consciously or unconsciously, the correct motivation is not there. You know if they had to pay anything out of their own pocket, but that's a question for the individual practitioner of course, whether they bulk bill or not. But the short answer would be no I don't think so, I think it only benefits.”

Seven social workers (4%) were concerned that cost barriers made it difficult for consumers to attend sessions. They made statements like:

“Low income clients find it difficult to find the full amount for sessions after they have had all their Medicare sessions. I reduce costs from \$90 to \$80 to make it affordable.”

Five social workers (3%) were concerned that a lack of recognition of their expertise on the part of GPs and other mental health professionals might have flow-on effects for consumers. They made comments like:

“There was one case where I suggested a new client I was seeing should talk to her GP to see if she was eligible for a GP mental health care plan. I did not know her GP. She rang me back to say that the GP did not want her to see me and that she would see a psychologist that he refers to.”

“Biases about social workers being able to make assessments and diagnosis due to limited understanding of knowledge and skills held can make arguing or advocating on behalf of a client with regards to treatment a challenge.”

A final, less commonly mentioned negative impact for consumers related to the uncertainty of the Better Access initiative. This was mentioned by two social workers (1%).

Additional comments

Social workers were given a chance to provide additional comments regarding Better Access. Mostly, they took the opportunity to expand on some of the issues that they had raised in response to earlier questions. In particular, they reiterated that Better Access was an extremely positive initiative, both for themselves as providers and for consumers. They made summary statements like:

“This is a valuable early intervention service that gives clients access to quality personalised service. It has the potential to reduce the development of more complex dysfunctional coping strategies.”

A number expressed a desire for their role to continue to be recognised under Better Access. Sixty social workers (38%) emphasised the value of their contribution to the mental health community and the importance of them remaining as an option for clients to access psychological services under the initiative.

“Please do not remove social workers or occupational therapists from the Better Access program. I believe this would be a discriminatory and [would] significantly change my ability to continue in private practice.”

“Let’s recognise that social workers have unique skills in engaging with marginalised groups in the community. Let’s recognise that this makes us different from but equal to our psychologist colleagues. We need to address the class issues inherent in the decision to remove social workers from the Better Access program. Those who will fall through the cracks are the poorer, more chaotic, less compliant clients who do not do well under a standard six sessions of CBT model. Better Access will become the reserve of the middle class, and the poor will be thrown back onto a highly inadequate public mental health service.”

“The Medicare item numbers for social worker to provide psychological services is a necessary service, particularly in rural and regional areas. Social workers have significant clinical skills and expertise in assessment, especially in locating the client in context of home and community. Psychological services provided by social workers are broadly focused on the client and their environment. Many other services are often provided to clients by social workers at no charge – e.g., advocacy, referral, education etc.”

Thirty eight social workers (24%) commented further on the discrepancy between their reimbursement rates and those of psychologists, making statements like:

“I would like to be financially valued as much as a psychologist, as I believe that my service to clients is as equally valuable and just as effective.”

“More money would be good ... I need to earn a living but I'm really not in it for the money ... I'm not complaining, I'm saying that probably, I mean for the service that I provide as a social worker, as against the services that are provided by a psychologist, there's a big disparity in income. We get \$70 a session and they get \$130 a session or something or other, that's bulk billed. My clients can't pick up a gap, I can't charge a \$50 gap because they don't have it and then they would be excluded from the service so I think for the work that we do, the social work, we probably should be more aligned with psychology rates of payment.”

A number of social workers (31, or 20%) suggested that there was scope for further expansion of the initiative. Specifically, they proposed that it could be broadened to include a wider range of treatment modalities (e.g., family and couple therapy), increased session numbers, and a wider array of treatment settings. The following comments illustrate these points:

“Yes – no option to do family or couple work even for once off psycho-education. Also, they take no account for the social work research, letter writing, referral processes which can take 30 minutes on top of the 50-60 minutes you spend with the client. GPs can put 3-5 clients in an hour, type case notes in front of the client and do not follow up but this is often not possible in a clinical or casework session. I also dislike GPs with no specialist knowledge in mental health care getting more than double what I get [paid], just to make a referral to me.”

“The item numbers should be broadened to include families – I often see clients with drug and alcohol problems and then go on to see the couple or in some case the family (where the patient is an adolescent).”

“I understand the political/historical reasoning behind the support for CBT etc as focused services but I cannot support these modalities as the best or most appropriate strategies for my clients all the time. I am not sure that Medicare should be identifying only specific treatment options, especially as there is excellent research to support, for example, family-based interventions, relationship counselling, psychotherapy etc.”

Experiences of occupational therapists

Impact on consultations

Occupational therapist providers were asked whether or not Better Access had had an impact on their consultations with consumers. Many (23, or 72%) reported that their caseload had increased (sometimes from a baseline of nothing) as a direct result of the introduction of Better Access. They made comments like:

“I am not able to see the majority of these people if we don't have the Medicare item numbers.”

“My whole process is based on the Medicare system.”

Fourteen occupational therapists (44%) also described an increase in particular groups of consumers, usually expressing this as consumers who would not otherwise have been able to afford occupational therapy services or would not typically have sought them out. The following comment sums this up:

“Sometimes it means that clients who previously wouldn't have engaged in mental health care are more open to engaging because it's supported by their GP and supported by Medicare.”

“... It does allow me to offer a complete service regarding the number [of sessions] that would be most beneficial which might otherwise not be something a client could afford.”

Twenty three occupational therapists (72%) reported that Better Access had had an impact on the way in which they consulted with consumers, particularly in terms of the treatment approaches they offered. Sometimes these changes were quite subtle; in other cases they were more dramatic. Sometimes they were associated with a shift to longer-term, more in-depth therapy; on other occasions the shift was in the opposite direction and led to more focused treatments. These different responses are highlighted in the comments below:

“The average length of treatment for my clients seems to have increased, with demonstrated therapeutic gain. This particularly applies to the sorts of clients who may previously have stayed for only a few sessions due to limited finance. They now remain in treatment for longer and consequently have a greater beneficial outcome.”

“Enabled more in-depth work, longer-term support and better results.”

“Medicare item numbers have enabled focused short-term work with clients, as opposed to long-term therapy in other areas of my practice.”

“Yes, as it is a time limited program, my treatment plan is very focused on changing behaviour and exploring self-support strategies rather than deeper therapeutic explorations.”

“Very little, perhaps a slight change for older clients requiring a more counselling/coaching approach.”

Some occupational therapists (6, or 19%) felt that Better Access had not influenced the quality of service they provided. A further five (16%) felt that it had improved their service quality by, for example, increasing their emphasis on reviewing consumers’ progress. These views are summarised in the comments listed below:

“I don't think it makes any difference in the quality of service that I deliver. It's the same quality whether I charge a Medicare fee or whether I charge a private fee.”

“If I see a Medicare client or whether I see a private client my approach, my quality of service my time I spend with that client is exactly the same.”

“It formalises the process of review and reporting so probably more, not that I wasn't overtly reviewing my work with clients prior to this, but certainly there is that requirement to send a report, so probably a little bit more transparently reviewing the clients, engaging them in that process and then them being required to review that with their GPs, so there is that level of transparency, takes it to another expectation.”

Only three occupational therapists (9%) explicitly stated that Better Access had limited the quality of care they could provide. They were concerned about the fact that Better Access restricted the strategies they could provide and set a limit on the number of sessions. They said that the former meant that they were not always able to use the approaches that they felt were most appropriate, and that the latter meant that they were asking consumers to do much more “homework” than would otherwise have been the case. The comments below illustrate these points:

“I am trained in a variety of other approaches, but I won't tend to use those approaches.”

“For some it would be the limits of what we can do, so work accordingly with really address that early on if that becomes evident, so sometimes you are well aware there would be potential for more work – there could be benefit from going on but it creates a limit that well you know if that person can't afford to do more well really to prioritise what is best.”

“... we would try and probably give more homework or more family homework if we feel like there should be more sessions and they just can't do it”

Communication with other mental health care providers

Occupational therapists were asked how they had found the process of communicating with other providers (particularly GPs) during the course of delivering services under Better Access. They were asked how appropriate they had found the GP referrals, and how adequate the referral information was. They were also asked to describe how they reported information back to the GP.

In general, occupational therapists tended to describe good communication processes. For example, eight (25%) talked about Better Access fostering a culture of collaboration or reinforcing strong networks of providers in their areas, making comments like:

"I have found the mandated communication (every six sessions) between myself and the GP to be very helpful. Clients generally appreciate and respond positively to this interdisciplinary approach to their treatment."

"I've got good relationships and knowledge I guess therefore of how to traverse the system because that's often the challenge for most people."

However, 11 occupational therapists (34%) commented on a lack of understanding among referring doctors of the role that occupational therapists can play in mental health care, noting that this hindered communication. The following comment exemplifies this point:

"GPs often don't know occupational therapists can provide services under Better Access if approved. Therefore many phone to ask how to refer as they think only psychologists [are approved providers]. We often need to send a letter."

Sixteen occupational therapists, (50%) found the referrals from GPs (and other relevant providers) to be appropriate and easy. By contrast, 11 (34%) found the referrals inappropriate, often attributing this to the above-mentioned lack of understanding of occupational therapy by the GPs and expressing it alongside a general frustration with the requirement for a referral. These divergent views are represented by the comments below:

"We live in a small community so I am the only provider and we have eight GPs in town ... [and] ... I know them all personally, I have known them for a long time. When I started out I went and saw all of them individually and I have had referrals from all of them."

"Very easy. Once GPs and psychiatrists were aware of the service they were able to refer appropriate clients."

"...the only time it happens is when I initiate a letter to the doctor and even then it can be like extracting teeth"

"The rebate paid to GPs for this token approach to mental health evaluations is therefore excessive and in my view contributes greatly to the unnecessary blow-out to the Better Access budget."

"I do question the GPs being gatekeepers to the practices of people who are very experienced mental health professionals."

When asked about the adequacy of the referral information presented in the mental health treatment plan, 14 occupational therapists (44%) indicated that it was inadequate and ten (30%) indicated that it was generally adequate (although this varied from GP to GP). Those who found it inadequate tended to complain that the GP did not provide sufficient detail or provided information that conflicted with the way in which the consumer presented. Those who found it adequate reported that it provided them with sufficient information upon which to begin their therapeutic relationship with the consumer. These differing views are summarised in the comments below:

"Scant. Often nothing, often 'would you just assist this person'."

"It's okay. A lot of the GP's don't often know how to refer, so they often don't know much about the plan, so I find that I am doing some education with them, but most of them are pretty good."

"That varies from GP to GP."

“Some GPs employ nurses who will gather the history and that goes into the GP care plan, so that can be quite comprehensive.”

“Because it comes from me I already know it. It's generated from your initiating.”

The majority of occupational therapists (25, or 78%) indicated that they reported back to the GP during and after treatment. In many cases, this appeared to be beyond the requirements of Better Access, and included a range of styles to match varying situations. This comment from one occupational therapist is fairly typical of the rest:

“My GPs get a letter after the first visit which is not part of the Medicare requirement but that's what I do.”

Logistics of registering with and billing Medicare

Participating occupational therapists were asked about their experiences with registering to provide services through Medicare. Many (16, or 50%) commented that they had found the process straight forward and easy. Only one occupational therapist (3%) mentioned having had problems, but even this provider accepted these problems as reasonable. The following comments are consistent with the majority:

“Very easy and straightforward – I was right at the beginning.”

“Process of registering with Medicare via Occupational Therapy Australia was comprehensive but not difficult.”

“The initial registration process was frustrating (as Medicare Australia took a long time to review my application), but it is good that there is stringent quality control so that only experienced practitioners can register.”

The majority of occupational therapists (21, or 66%) had no problem with billing Medicare and found the process easy. Some experienced minor issues initially, but once these were smoothed out, the process was described positively. They made comments like:

“No problems with the process after initial setup issues.”

“Drawn out – it was a bit fiddly and it was a bit unclear as to exactly what they wanted initially, it probably took a couple of months to actually get it done.”

“I found Medicare easy to deal with.”

By contrast, four occupational therapists (13%) noted that they had experienced problems (e.g., onerous administrative procedures, difficulties communicating with Medicare, lengthy waiting times). Some noted, however, that the problem was not with Medicare per se but rather with their own administrative procedures. Sometimes the difficulties had been significant enough to put the occupational therapist off billing Medicare, with the result that he or she adopted a policy of billing consumers directly, leaving the claim for reimbursement up to them. The following responses exemplify these concerns:

“That is just a horror at the moment, because our machine went down.”

“It is too difficult for us to manage as a small business with no secretary so we don't [bulk bill].”

“The only problems have arisen when clients haven't realised that another doctor has already prepares a mental health care plan for them – sometimes they can't identify who it was and lack paperwork so we have problems at our practice claiming for the work we've done in good faith. Due to privacy issues, Medicare is often unwilling to divulge who wrote the mental health care plan up and how many sessions the client may have had with another therapist.”

“I don't bill directly to Medicare I get clients to take the receipt into Medicare.”

“Billing (if bulk billing) can mean a lengthy wait for payments (I opted for cheque). I have asked clients for up-front payment and provided them with invoice/receipt which they then claim direct over the counter.”

Charging policies

Occupational therapists were asked about their charging policies. At the extremes, nine occupational therapists (28%) indicated that they bulk billed most of their clients and nine (28%) said that they did not bulk bill or rarely did so. In between these extremes, four providers (13%) described charging using a sliding scale with reduced fees for lower income earners, and two (6%) said that they bulk billed a few clients on low incomes. The remainder did not indicate that they had a particular charging policy. The following comments illustrate the range of charging policies outlined by occupational therapists:

“All my patients are low income or pensioners so they are all bulk billed”

“I bulk bill a certain percentage of clients in certain circumstances but I don't have an overall policy.”

“Billing in low income areas is insufficient to cover professional supervision - this is a big workforce issue.”

“I usually bulk bill clients on low incomes.”

Positive impacts for occupational therapists

Occupational therapists were asked whether or not they felt that Better Access had had any positive impacts for them themselves as providers. Table 15 provides a breakdown of their responses.

Table 15: Positive impacts for occupational therapists (n=32)*

	Freq	%
Meeting needs of consumers	23	72%
Financial benefits or enhancing viability of private practice	14	44%
Better coordination between providers / mental health services	6	19%
Better able to service low income groups	4	13%
Opportunities for further professional development and training	4	13%
Promoted early intervention	3	9%

* Multiple responses permitted

Most commonly, occupational therapists were sanguine about their increased capacity to meet the needs of consumers (both in terms of reaching more consumers and providing more sessions for individual consumers). Twenty three occupational therapists (72%) made mention of this. They spoke of servicing a broader range of consumers, with four (13%) explicitly mentioning that they could now provide care for people on low incomes. More generally, they spoke of being better able to meet the mental health needs of the community. Together, these impacts gave them considerable professional satisfaction. The comments below illustrate these points:

“Definitely clients are able to access more services or access our services and for longer.”

“A broader socio-economic group ... because there is a financial assistance for it.”

“I see a far greater range of issues.”

“So that gives me a great sense of satisfaction. I know that this service is making a difference, that what I am doing is making a difference in people's capacity to function and stay out of hospital.”

Fourteen occupational therapists (44%) commented that Better Access had financial benefits in that it made private practice a viable option for them as a professional group. The following comment from one occupational therapist typifies these responses:

“It's allowed me to start a private practice. I previously worked in public mental health but as an occupational therapist you have virtually no capacity to operate within a private situation without Better Access.”

Six occupational therapists (19%) felt that the opportunity to improve coordination between other service providers was a positive impact for them. They appreciated the opportunity to build relationships with and work with other providers in their local area, and made comments like:

“It means that I have developed more of a relationship with GPs.”

“Allows interaction between clinicians in management of client.”

Other less commonly-cited positive impacts for occupational therapists included opportunities for further professional development and training (mentioned by four occupational therapists, or 13%) and opportunities to be involved in early intervention (mentioned by three, or 9%).

Negative impacts for occupational therapists

Occupational therapists were also asked to identify any negative impacts that they had experienced as a result of Better Access. Table 16 shows the results.

Table 16: Negative impacts for occupational therapists (n=32)*

	Freq	%
Lack of common understanding about the contribution occupational therapists can make	10	31%
Increased paperwork and reporting	8	25%
Discontent with lower rebate amount for occupational therapists	5	16%
Increased demands	4	13%
Difficulties engaging clients	3	9%

* Multiple responses permitted

Most commonly, occupational therapists mentioned the lack of a common understanding about the contribution occupational therapists can make. Ten occupational therapists (31%) noted this, expressing it in a number of different ways. Some talked about the fact that other service providers were ignorant of the different therapeutic approaches occupational therapists could offer. Others discussed the fact that the structure of Better Access precluded their using some of their preferred practice paradigms. Still others discussed the fact that consumers did not always understand the treatment models offered by occupational therapy. The following two responses give a flavour of the range of issues covered under this theme:

"Maybe just getting GPs on board has been hard I feel sometimes I have to fight for my clients to be able to access it."

"Eighteen sessions a year is not enough for many with chronic mental health issues, trauma, eating disorders, PTSD, chronic depression, personality issues etc. These clients need more flexibility with sessions."

"The name 'mental health' is challenging for some parents of young children with psychological issues. It's hard providing social skills, communication, behavioural interventions, attention regulation, and relaxation strategies as 'mental health'."

Eight occupational therapists (25%) cited the increased administrative load associated with Better Access as a negative impact. They were particularly critical about the fact that they were not recompensed for this part of the process, making comments like:

"The unpaid hours doing long reports."

"The added workload of report writing is not remunerated."

Five occupational therapists (16%) specifically voiced discontent about the lack of parity between themselves and other providers, making statements like:

"It is unfair to preference psychologists over the occupational therapy and social work professions."

Four occupational therapists (13%) mentioned the increased demand on them as therapists. Mostly, they expressed this in terms of pressure to see a particular type of consumer:

"The more complex disabled people because they are usually not working and so they would have to be on the Better Access, and then you get a caseload or a client load of very complex distressed people and that would be wearing ..."

Three providers (9%) referred to challenges or difficulties keeping clients engaged in the treatment. These providers felt that because consumers were receiving free or relatively cheap services, they did not have the same commitment to therapy as they would have done had they been paying for it. This resulted in cancellations and “no shows” for which occupational therapists could not claim reimbursement. These points are summarised in the following two comments:

“I think sometimes I get more cancellations than I used to because the service is being funded.”

“Sub-optimal reimbursement due to inability to recover losses from 'failure to attends' in disadvantaged area.”

Perceived positive impacts for consumers

Occupational therapists were asked about whether they thought Better Access had had positive impacts for consumers under their care. Table 17 summarises their responses.

Table 17: Perceived positive impacts for consumers (n=32)*

	Freq	%
Offers to clients a choice in therapeutic options or providers	22	69%
Reduces financial strain and stress in seeking treatment for people with low income – ensures access to treatment	13	41%
Of general benefit to clients in undertaking their everyday lives	10	31%
Promotes opportunities for early intervention	6	19%
Reduces the burden on the public mental health system	4	13%
Improves coordination between services	1	3%
Promotes sustains longer term engagement with treatment	1	3%

* Multiple responses permitted

The most commonly cited positive impact for consumers was thought to be more choice in terms of their mental health care. Twenty two occupational therapists (69%) made comments in this regard. Some discussed the fact that consumers now had a broader range of options in terms of the types of providers from whom they could seek care, and others talked about the greater variety of treatment appropriate alternatives that were now available. They made comments like:

“They can access services, and they can access them for longer.”

Thirteen occupational therapists (41%) expressed the view that Better Access had been particularly beneficial for people on low incomes, because it reduced the financial strain associated with seeking help. They felt that this not only improved their initial level of access, but also allowed them to engage more significantly with treatment. These occupational therapists made comments like:

“Reduced financial stress for clients in low income category.”

*“I have seen **many** clients who have commented that without Medicare they would never have accessed help for financial reasons.”*

“I think that what it means is that some clients who previously could only afford to come for 2 or 3 sessions have been able to see through more of a course of treatments.”

Ten occupational therapists (31%) talked about more generalised benefits for consumers, noting that Better Access not only provided an avenue through which they could seek and receive mental health care but also acted as an acknowledgement of the value of such care. The following statement exemplifies this:

“It's legitimised their need for help.”

Six occupational therapists (19%) commented that Better Access had increased the likelihood that consumers would receive care early, before they reached a point of crisis or their mental health problems became entrenched. These occupational therapists made statements like:

“Help to 'nip in the bud'- [prevents] potential escalation of illness and the long-term consequences of this both to the person and financially to the burden on our health system.”

On a related note, four occupational therapists (13%) felt that Better Access may have helped to reduce the burden on public mental health services by, for example, averting hospital admissions. The following responses sum this up:

“There is no doubt you've prevented people having to access [public] mental health services if you view that as a positive.”

“It's meant that it's reduced the number of hospital admissions that they had had”

From the perspective of the occupational therapists, other less commonly cited positive impacts for consumers included improvements in coordination between services and longer term engagement with treatment.

Perceived negative impacts for consumers

Eighteen occupational therapists (56%) felt that the Better Access initiative did not have any negative impacts for consumers under their care. The remaining occupational therapists cited a variety of perceived negative impacts, and these are summarised in Table 18.

Table 18: Perceived negative impacts for consumers (n=32)*

	Freq	%
Number of sessions	7	22%
Issues related to confidentiality	5	16%
Lack of understanding of the aims of treatment	2	6%
Lack of understanding of the aims of Better Access	2	6%
Uncertainty about future for occupational therapists	2	6%
Costs	2	6%
Referral process	2	6%

* Multiple responses permitted

Seven occupational therapists (22%) felt that the limit on the number of sessions proved to be a negative impact for clients under their care.

"It's limited. We can't just see them every week for a year. [We] basically have to try and squeeze it in."

Five occupational therapists (16%) discussing matters relating to confidentiality. They felt that consumers were cautious about accessing care through Better Access because their GP would know (because of the referral requirement) and the services would be recorded in their Medicare history. They said that consumers were concerned that being labelled as having a mental health problem could jeopardise various opportunities for them, particularly if this information became available to unrelated parties. They made comments like:

"It does concern [consumers] that if it's on your Medicare history that it may jeopardise future employment opportunities."

"For some, 'stigma' of a 'mental health' label on their child."

"Confidentiality of sensitive information is compromised through auditing by non-health professionals."

"Sometimes people will come to me and I will say to them look there is this system you would be entitled to it, and they say 'no, they don't want to go through their GP'. I am currently seeing a woman who is separating from her partner and she's very worried ... because what happens with a mental health plan is that you get some sort of a diagnosis ... So if people are in situations ... say in a divorce or custody battle where people subpoena records and things like that ... if they've got a diagnosis, what that will mean for them? She has elected to go through her private health fund and she's just left her partner she's on her own so it's not financially that easy for her, but she's quite definite that she doesn't want to take the risk, so yes I think that for some people going through the GP has meant that it's not accessible for them."

Other less commonly cited negative impacts for consumers included a lack of understanding of the aims of treatment, a lack of understanding of the aims of Better Access, uncertainty around future funding for occupational therapists, costs, and the referral system that placed GPs in the role of gatekeeper. Each of these was mentioned by two occupational therapists (6%).

Additional comments

Occupational therapists were invited to add any additional comments about Better Access. In many cases, they took the opportunity to expand on issues they had already raised as being important to them.

Twenty occupational therapists (63%) made an appeal for occupational therapy services to remain an option under Better Access. They made summary statements like:

"I hope that it stays next year, and that occupational therapists and social workers don't lose it. That's been my big battle this year, because it is so important."

"It would be a mighty shame to take it away from us, just because I think it would limit people's options a lot."

“Removing occupational therapists and social workers removes choice for clients.”

“If they don't get service from my practice, 90% of people will get no service – 90% of what I see is depression and anxiety and it's early intervention.”

“Reinforce the point about the many positive arguments for having a range of allied health qualified practitioners registered under the system.”

“Very negative impacts in being taken away ... I think that the other part of it is that there is a huge reputational damage to our profession and despite what the government say there is no way that GPs are not going to be influenced in their perception that we are second rate or inferior providers.”

Eight occupational therapists (25%) spoke of the need to increase the rebate amount for occupational therapists and to provide reimbursement for a greater range of treatment options and for the administrative tasks associated with providing face-to-face care. The responses below provide a snapshot of these comments:

“It just doesn't pay enough.”

“I'd like the rebate for occupational therapists to be bigger. Item numbers need to be increased to allow for home visits, work site or school visits and consultations with GPs and reporting.”

One provider (3%) reiterated the fact that Better Access is prescriptive in terms of therapeutic approaches, and that this limits the options available to consumers. This provider said:

“The definitions in Better Access are technically, linguistically and evidentially flawed. Trying to squeeze highly trained professionals into 'focused psychological services' is professionally dishonest. All therapies are CBT. All therapeutic interactions are 'psychotherapy'. Let professionals practice using their full range of skills and monitor quality by good supervision.”

Chapter 6: Discussion and conclusions

Summary of findings

Experiences of consumers

Participating consumers gave Better Access strong endorsement. Many had been unable to access mental health care in the past, usually for cost reasons, and they appreciated the fact that Better Access had removed such barriers. They had sought care from social workers or occupational therapists on this occasion for a variety of reasons, often because of a deterioration in their mental health or the occurrence of stressful life events. Sometimes a third party (e.g., a GP or a family member or friend) had suggested that such care might be beneficial. Many specifically commented on the attributes and skills of the provider, and on the usefulness of the advice, guidance and strategies that they received. The vast majority indicated that they had experienced significant improvements in terms of reduced symptomatology and increased coping ability, and many felt that this had had repercussions for their general wellbeing. Some also found that their life circumstances changed in positive ways. Most attributed these changes, wholly or in part, to the provider. The vast majority indicated that their needs were totally or partially met by Better Access. Most had found the process of dealing with Medicare relatively straightforward, and were extremely satisfied with the care they had received.

Most consumers reported that, from their perspective, there were no negative aspects of Better Access. Those who did identify negative points tended to focus on the restricted number of sessions or the time allocated for sessions, or on difficulties in meeting the “gap” payment. A small minority reported that there were sometimes practical issues associated with accessing care (e.g., travel time or waiting lists) and/or that they found the process of engaging in treatment confronting.

Experiences of providers

Participating social workers and occupational therapists were extremely positive about the Better Access initiative. Many commented that their services are now available not only to a greater number of people overall, but to proportionally more people with complex clinical and social needs and limited financial resources, many of whom would not have been able to access mental health care in the past. Many also mentioned that they are now in a better position to meet these consumers’ needs because they can provide timely, comprehensive and integrated care. They perceived this to have direct benefits for consumers in terms of improved access and affordability of care, and, consequentially, improvements in their mental health status, understanding of mental health symptoms and how to manage them, and relapse prevention. The increased access and improved affordability for consumers has had flow-on benefits for these providers in terms of professional satisfaction. They have appreciated the opportunity to collaborate with GPs and other mental health care providers, and had felt that being listed as approved Better Access providers has given them increased standing with these peers. In the main, their experiences with registering with and billing Medicare have been straightforward. Their charging policies have varied, with some bulk billing all or the majority of consumers, some bulk billing only a few or no consumers, and some introducing a sliding scale whereby the “gap” for consumers increases with their ability to pay.

Relatively speaking, the negative impacts of Better Access for providers have been minor. Although most participating social workers and occupational therapists have had good relationships with GPs, some have found GPs to dismiss them in favour of psychologists and/or to make inappropriate referrals, sometimes doing so via mental health treatment plans that

contain insufficient information. Some have experienced administrative issues, such as difficulties with the interface between their own local systems and the Medicare system. Some questioned the level of reimbursement for their services, arguing that they should receive the same payments as psychologists and that they should be paid for the additional activities that are related to the provision of face-to-face care (e.g., record-keeping, communicating with other providers). While most were strongly of the view that Better Access has improved access to and quality of care for many consumers, some expressed concerns about session limits, restrictions on the forms of therapy that they can provide, confidentiality, and motivation on the part of consumers.

Implications of findings

The findings suggest that the social workers and occupational therapists who are providing therapy under Better Access are playing an important role in meeting the community's previously-unmet mental health care need. Although they constitute only a relatively small proportion of the total group of allied health professionals providing care under Better Access, they appear to be making a significant contribution in terms of facilitating access to care, and offering a quality of service that is yielding good consumer outcomes.

During our data collection period, there was still considerable uncertainty about the future of social workers and occupational therapists as providers of Better Access care. Many participating social workers and occupational therapists expressed concern about this uncertainty, noting that they were a pivotal part of the scheme. The current findings validate the recent decision to reinstate social workers and occupational therapists as approved providers.

Consideration might be given to whether the role played by social workers and occupational therapists under Better Access is identical to that played by psychologists, or whether there are some nuanced differences. There is clearly considerable overlap between consumers seen by these groups and consumers seen by psychologists, and many of the approaches to treatment are common. However, there are some indications that social workers and occupational therapists may be preferentially being referred consumers who have complex social needs and relationship issues and are suffering financial hardship. These sorts of factors may be compounding their mental health problems. There are also indications that social workers and occupational therapists favour a broader range of approaches than those which are currently listed under Better Access, and that some of these approaches may be particularly relevant for the groups in question. Deliberations about whether the respective roles of social workers, occupational therapists and psychologists are the same or different should also involve consideration of the relative levels of reimbursement for their services.

Any review of the roles of social workers and occupational therapists in Better Access should consider the evidence base for the kinds of therapies they can and might offer. This should include an examination of the evidence for such therapies being effective under different circumstances (e.g., if they are delivered within a given number of sessions). It should also include a consideration of how the delivery of approved, evidence-based therapies might be monitored.

Consideration might also be given to how best to ensure that Better Access fulfils its aim of encouraging a multi-disciplinary approach to consumers' mental health care. The current study suggests that there is variability in terms of how well GPs collaborate with social workers and occupational therapists in providing care for individual consumers. Where it works well, these providers show a mutual respect and understand each other's roles, and there is clear and relevant two-way communication at various stages in the care process. Where it doesn't work so well, these providers each have a limited understanding of how the other operates and what they can offer, and communication is minimal and lacking in detail. Improvements in

collaboration may occur naturally, as these providers continue to work together. However, there is also an argument that networking and training opportunities, such as those offered by the Mental Health Professionals Network, may help in this regard.

Study limitations

Our study was limited by the time-frame available to us. Anecdotally, we know that some consumers and providers were unable to participate within the study period, but would have done so had it been longer. Having said this, our survey and interview data reached a point of “saturation”, where participants were not adding any new responses. For this reason, we are reasonably confident that our participants articulated the range of views held by social workers and occupational therapists and the consumers who receive care from them.

Our response rates for participating social workers and occupational therapists were 22% and 16%, respectively. Higher response rates would obviously have been desirable, but the samples were broadly representative of the groups from which they were selected, which engenders some confidence in the generalisability of the findings. Where there was over-representation of particular sub-groups, it should not necessarily be viewed negatively. Participating social workers and occupational therapists tended to have provided more Better Access services to more consumers than the average, and may therefore have been better placed to comment on the scheme’s operation and impacts.

Our response rates for consumers who were recruited by social workers and occupational therapists were 38% and 33%, respectively. We deliberately used providers as intermediaries in our recruitment of consumers, because we had no other way of identifying consumers who had received services from these providers. An alternative might have been to issue a general call (e.g., via the *beyondblue* website) inviting anyone who had received such services to take part in the survey or interview, but this would have been likely to yield a fairly biased sample. In addition, our previous experience suggests that consumers do not always know the profession of the provider from whom they have received care, so it is likely we would have inadvertently recruited consumers who had seen other types of providers. Ultimately, our samples of consumers were fairly representative of the two groups from which they were drawn although participating consumers tended to be more disadvantaged than the overall pools of Better Access consumers, both in terms of being less likely to live in capital cities and more likely to live in areas of socio-economic disadvantage. They may therefore previously have had more limited access to mental health care. These characteristics may have meant they had particularly valuable insights about Better Access.

One further point to make about our samples of consumers is that those who did not speak English were “out of scope”. This decision was made for resourcing reasons; we did not have the capacity to translate the interviews/surveys into other languages, or to make use of interpreters. We acknowledge, however, that this strategy introduced a systematic bias. The characteristics of Better Access consumers from culturally and linguistically diverse backgrounds may be different from those of their English-speaking peers, as may their clinical outcomes. They may also have different experiences of receiving care through Better Access.

Like any survey- or interview-based study, the current study relied on self-report. It examined the experiences of consumers and providers, so there were no right or wrong answers, but participants may have given responses that they felt were socially desirable in some way. They may also have been some biases in their likelihood of recalling particular experiences. Ideally, we would have included some objective measures to validate particular responses – e.g., standardised instruments to measure outcomes of care, feedback from referring GPs – but this was beyond the scope of the study.

Conclusions

Notwithstanding the above limitations, the current study shows that consumers who receive Better Access care from social workers and occupational therapists are generally very positive about the initiative. They appreciate the increased access to high quality care from different professionals, and are reaping the benefits in terms of good mental health outcomes. Providers are also positive, finding the opportunity to provide care to consumers with a broader mix of needs professionally rewarding.

Appendix 1: Survey/interview questions for social workers and occupational therapists

1. **In the last year approximately how many clients have you seen whose treatment has been partially or fully funded via the Medicare item numbers for psychological services?**
2. **Have the Medicare item numbers for psychological services had an impact on your consultations with clients?** [For example: Have the Medicare item numbers had an impact on your overall caseload? Have you found the Medicare item numbers make any difference to the way in which you consult with individual clients?]
3. **How have you found the process of communicating with other mental health care providers?** [For example: How appropriate have you found the GP referrals? How have you found the referral information provided in the GP mental health care plan? What referral information from the GP would be most useful to you? How have you communicated information about the consumer back to the GP during and after treatment?]
4. **How have you found the logistics of billing Medicare for delivering psychological services?** [For example: What was your experience of registering with Medicare as eligible to provide services? How about the billing process itself? Have you adopted a particular charging policy (e.g., bulk-billing clients on low incomes)?]
5. **Have you found that being able to provide psychological services via the Medicare item numbers has had positive impacts for you? If so, what have these impacts been?**
6. **Have you found that being able to provide psychological services via the Medicare item numbers has had negative impacts for you? If so, what have these impacts been?**
7. **Would you say that your being able to provide psychological services via the Medicare item numbers has benefited clients under your care? If so, in what way?**
8. **Would you say that your being able to provide psychological services via the Medicare item numbers has had any negative impacts for clients under your care? If so, in what way?**
9. **Are there any additional comments you'd like to make about the Medicare item numbers for psychological services?**
10. **Sex (Tick response):**
[] Male
[] Female
11. **Age group (Tick response):**
[] ≤29
[] 30-39
[] 40-49
[] 50-59
[] 60-69
[] ≥70
12. **What year did you qualify as a social worker/ occupational therapist?**

- 13. What year were you first registered as a social worker/ occupational therapist in Australia?**
- 14. What year did you qualify as a specialist social worker/ occupational therapist, (if applicable)?**
- 15. What year were you first registered as a specialist social worker/ occupational therapist, in Australia? (if applicable)**
- 16. On average, how many hours per week do you currently spend working in a private practice setting where you see clients with mental health problems?**
- 17. On average, how many clients with mental health problems do you see in a private practice setting per week?**

Appendix 2: Survey/interview questions for consumers recruited by social workers and occupational therapists

1. **Had you seen a social worker (SW), psychiatrist, occupational therapist (OT), psychologist or GP for psychological services prior to 1 November 2006?**
SW Yes No Not sure
Psychiatrist Yes No Not sure
OT Yes No Not sure
Psychologist Yes No Not sure
GP Yes No Not sure

2. **Has cost been a barrier to your seeking care from a social worker, psychiatrist, occupational therapist, psychologist, or GP for psychological services in the past?**
SW Yes No Not sure
Psychiatrist Yes No Not sure
OT Yes No Not sure
Psychologist Yes No Not sure
GP Yes No Not sure

3. **Have there been other barriers to your seeking psychological care from any of these providers?**

4. **Thinking about your visits to the social worker who asked you to participate in the evaluation, can you describe what prompted you to seek care from him or her?**

5. **How many session of care did you receive from your social worker?**

- 6a. **Was this the number of recommended sessions by your referring GP or social worker?**
 Yes No Not sure

- 6b. **If you attended less than the recommended number of sessions can you please describe why?**

7. **How much were you required to pay for each session? Do not exclude the amount that was refunded to you by Medicare.**

8. **How did you find the process of receiving psychological services that were refundable by Medicare?**

9. **Were you satisfied with the care you received from the social worker?**
 Yes No Not sure

10. **What aspects of the care were good?**

11. **What aspects of the care were bad?**

12. Please rate the extent of any changes in your mental health and well-being over the course of your psychological care using the categories below?

I felt a lot worse	I felt a bit worse	I felt no different	I felt a bit better	I felt a lot better

13. What kind of changes did you notice?

14. To what extent would you attribute any changes to the care provided by your social worker?

Not at all	Partially	Totally

15. To what extent do you feel that your treatment matched your needs and expectations?

Not at all	Partially	Totally

16. Sex:

- Male
 Female

17. Age group:

- ≤29
 30-39
 40-49
 50-59
 60-69
 ≥70

18. What is your primary language spoken at home (please tick)? If other, please specify:

- English
 Italian
 Greek
 Cantonese
 Mandarin
 Vietnamese

Other _____

19. If your primary language spoken at home is not English, please select how well you speak English

- Very well
 Well
 Not well
 Not at all
 Unknown

- 20. Are you of Aboriginal or Torres Strait Islander origin? (For Persons of both Aboriginal and Torres Strait Islander origin mark both 'Yes' boxes).**
Aboriginal Yes No
Torres Strait Islander Yes No
- 21. What is your highest level of education successfully completed?**
 Primary and below
 Secondary: Year 7
 Secondary: Year 8
 Secondary: Year 9
 Secondary: Year 10
 Secondary: Year 11
 Secondary: Year 12
 Tertiary
Other _____
- 22. Do you live alone?**
 Yes No, with others.
- 23. Do you currently hold a valid health care card or are you on any other type of concession or pension?**
 Yes No
- 24. Have you been diagnosed with one of the following mental health conditions? (if applicable)**
 Alcohol and drug use
 Psychotic disorder
 Depression
 Anxiety disorder
 Unexplained somatic disorders
 Unknown
Other _____