

Better Access or better barriers? An evaluation of the Better Access initiative

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Declaration

I declare that this thesis does not incorporate without acknowledgement any material previously submitted for a degree in any university or another educational institution and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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Abstract

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (BAI) initiative is the most expensive of all the programs outlined in the National Action Plan on Mental Health 2006-2011. Over the five-year period, the Federal Government committed \$753.8 million to this scheme alone. Its intention: to increase access to mental health services for all Australians. Since then, costs have ballooned. The initiative is expected to cost nearly three times the initial commitment. It is important, therefore, that an evaluation is undertaken to ensure it is working effectively and efficiently.

This evaluation has been the primary aim of this study. Three issues were of particular concern: firstly, whether the 2009 changes regarding eligibility requirements to access the scheme negatively affected uptake; secondly, whether the central role of General Practitioners in the scheme amounts to 'best practice'; and thirdly, whether there was any evidence that the program had been successful in targeting vulnerable groups, with a previously low engagement with mental health services.

Contrary to predictions, changes to eligibility requirements in 2009 have not negatively impacted on the accessibility of services. Results of data from Medicare Australia and the Commonwealth Department of Health and Ageing indicate that there has been an overwhelming overall uptake rate of services under the initiative. Nonetheless, there are several areas of concern. While GPs are invaluable to mental

health, their central role as 'gatekeepers' to services may be inhibiting the efficiency of the initiative. Consistently lower access among key groups, including adolescent males; indicate a general failure to assist particularly vulnerable groups. These findings indicate that further research is required to ensure that the BAI initiative can continue to provide access to affordable mental health care beyond the 2011 end of funding commitments.

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Abbreviations

Action Plan	National Action Plan on Mental Health 2006-2011
AMA	Australian Medical Association
APS	Australian Psychological Society
ATAPS	Access to Allied Psychological Services
BAI	Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative
BOiMHC	Better Outcomes in Mental Health Care
COAG	Council of Australian Governments
DHA	Commonwealth Department of Health and Ageing
GP	General Practitioner
GPMHTP	General Practitioner Mental Health Treatment Plan
MBS	Medicare Benefits Schedule
MHCA	Mental Health Council of Australia
NMHS	National Mental Health Strategy
PIR	Post Implementation Review of the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS Initiative
Statement of Rights	National Mental Health Statement of Rights and Responsibilities

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Chapter 1

Introduction

Few other policy areas elicit the passionate opinions and ongoing debate that health policy does. Taking up almost 20 per cent of the Federal Government's budget, and appearing in almost every electoral campaign, health policy is considered to be 'the most social of all social policy' (Barraclough & Gardner 2008, p.3). It affects every member of society, often when they are at their most vulnerable. Despite the high importance of the health portfolio, mental health is one area of healthcare that has, until recently, been sorely neglected. Yet mental illness should be of greater concern in Australia. In any one year, more than three million Australians are affected by mental illness, costing approximately \$20 billion annually (Council of Australian Governments (COAG) 2006, p.1). Around 14 per cent of Australia's total health burden is from mental disorders and suicide (Mental Health Council of Australia (MHCA) n.d.-b). It is estimated that unipolar depression alone will be the second biggest disease burden worldwide by 2020 (Raphael 2000, p.2). Of more concern than the financial cost is the plight of the individuals and their carers. The Mental Health Council of Australia (MHCA) reports that one-third of young people have experienced mental illness before the age of 25, and in any 12-month period approximately two-thirds of all sufferers of mental illness do not receive treatment (MHCA n.d.-b). With statistics such as these, it is not surprising that there has been a large push for change.

In recent years policy makers have recognised the need to increase resource allocation to mental health care in Australia. This has resulted in a National Action Plan on Mental Health 2006-2011 (COAG 2006), which has allocated an additional \$4 billion dollars of new resources to mental health at both state and federal levels over a five-year period. The largest amount of funding has gone towards one of the most significant policy developments in recent history: the Better Access Initiative (BAI).

With Commonwealth funding commitments due to expire in 2011 it is important that an evaluation of the efficacy of the initiative be undertaken. Furthermore, the cost of the initiative is already well over the amount that was committed. In light of this, the initiative should be examined to ensure that it is operating efficiently. The primary aim of this thesis is to evaluate the BAI to determine whether it has been successful in achieving its goals. For this purpose, 'success' is measured against Outcome Three of the National Action Plan on Mental Health 2006-2011 due to its parallels with the purpose of the BAI.

Outcome Three of the National Action Plan on Mental Health 2006-2011

The National Action Plan on Mental Health 2006-2011 (COAG 2006) (National Action Plan) has four key 'outcomes', or goals. Of particular interest to the current research is Outcome Three, which aims at:

Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care... at the right time, with a particular focus on early intervention. (COAG 2006, p.1)

This outcome closely aligns with the aim and purpose of the BAI:

[to] improve access to...psychiatrists, psychologists, General Practitioners and other allied health professionals. Reforms will...encourage early assessment and management of these people...(COAG 2006, p.9-10).

The aims of both the Action Plan and the BAI emphasise two related strategies: early intervention and improved accessibility. While the focus on early intervention in the BAI is implicit rather than overt (that is, it falls outside the category of strategies that are designed to specifically target promotion, prevention and early intervention (COAG 2006, p.6), its emphasis on improved accessibility provides its *raison d'être*.¹The general purpose of the BAI is the provision of accessible mental health care. It does this primarily through improving affordability of services by making mental health treatment available under Medicare. It is this aspect that is of most interest. Whether the initiative has improved accessibility is the primary aim

¹ Other prevention and early intervention strategies include public information and education activities; expanding mental health research; and investing in age-specific support groups (COAG 2006, p.3). While implicit, the BAI is ideally placed within the health system to be able to, if not prevent, certainly intervene in mental health problems at an early stage. Nonetheless, early intervention is outside of the purview of this research. There are two reasons for this. The first is that focussing on early intervention impacts the accessibility of services so focussing on whether people are able to access services should capture those who are receiving early intervention strategies. The second reason that early intervention is not being specifically reviewed is due to the difficulty in accessing information about those who have symptoms but are yet to be clinically diagnosed with a mental illness.

of this study. In order to examine this, the efficacy and efficiency of the BAI are considered.

The Efficacy of the Better Access initiative

In evaluating whether the initiative has been effective in providing mental health services, the current thesis will address two questions:

1. Who is accessing mental health services under the Better Access Initiative?

In addressing this question, this research is primarily interested in whether young people and low-income earners are statistically represented. This can be ascertained by looking at both access demographics and the number of services provided. These two groups were chosen as they represent both an area of need and, prior to the initiative, confronted financial barriers in accessing mental health services. An increase in their overall access to these services would suggest that the initiative is efficacious.

The second question relates to a structural process embedded in the Initiative. It asks:

2. Does the requirement for diagnosis of a mental disorder reduce accessibility of services?

In July 2009, a new eligibility criterion was introduced so that a clinical diagnosis of mental disorder became required in order to access services under Medicare.

Arguably, this restricts the number of people who can access mental health services under the initiative and reduces the ability of clinicians to provide early intervention strategies to those who do not meet criteria for clinical diagnosis. If the access statistics show a decrease in rates of participation this suggests that the requirement for diagnosis has created a barrier to access. If, however, the rates of participation in the scheme do not show a corresponding decrease then we can assume that the diagnosis requirement is having little or no impact on the scheme.

Efficiency of the Better Access initiative

The efficiency of the BAI will be explored by examining the role of General Practitioners (GPs). Under the initiative, GPs hold the critical role of reviewing and diagnosing virtually all patients who are using BAI services, regardless of the provider. As such, it is important to determine whether this is the best use of resources, especially in light of the escalating costs. The efficiency of this process will be analysed against the evidence generated in examining the first two questions. The research will ask:

3. Does the central role of General Practitioners in the scheme amount to 'best practice'?

Evaluating this question was less tangible in that there is no quantitative data available to analyse. The question was explored in terms of the results of the first two questions. Several areas were revealed that indicated how the role of GPs may

be overly dominant within the framework of the multidisciplinary involvement that the Initiative encourages. Exploring the question with reference to the medicalisation of mental health helps to position the potential problems within a theoretical context and provides some historical insight.

Thesis outline

First, it is necessary to explore the context in which the BAI was implemented and to provide a broad overview of federal intervention in mental health. It is to these developments that the following two chapters will turn. Subsequently the literature will be reviewed exploring the diverse areas of mental health research that is encapsulated in the initiative, with a particular focus on the context of the medicalisation of mental health. The findings of the research will then be discussed with particular focus on answering the first two research questions but also examining the role of GPs within the research findings. Finally, the findings will be examined in the context of the medicalisation of mental health to give some background as to why the program operates in this way but also to identify how these challenges might be overcome.

Chapter 2

How the Better Access Initiative came about

The National Action Plan on Mental Health 2006-2011 (Action Plan) (COAG 2006) is arguably the biggest and most comprehensive policy document on mental health in Australia's recent history. The Council of Australian Governments (COAG)² released it on 14 July 2006 after the Mental Health Council of Australia (MHCA) published a damning report on the state of the nation's mental healthcare system. Entitled *Not For Service: Experiences of Injustice and Despair in Mental Health in Australia*, the report was compiled using evidence gathered from 19 public forums, 351 submissions and over 1,000 personal stories (Mental Block on Australia's Mental Health 2005; MHCA 2005, p.853-860). These submissions, from sufferers, carers and clinicians, highlight the distressing plight of the individuals suffering from mental illness, and that of their family and carers. The recurring theme of the inadequacy of the mental health system was underscored in one mother's submission: on the day her son committed suicide he had contacted mental health services three times (MHCA 2005, p.19).

It is no surprise then that the report found that 'any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialized or

² COAG describes itself as 'the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA).' Their website can be found at: <http://www.coag.gov.au/>

neglected' (MHCA 2005, p.14). *Not For Service* (MHCA 2005, p.15-16) made many recommendations, including the need for integrated governance arrangements between all levels of government and non-government organisations; an increase in mental health expenditure to 12 per cent of health care funding by 2010; the formation of programs to increase the number and quality of mental health care workers and perhaps most importantly: creating policies so that there is 'a fundamental shift from a preoccupation with process and statutory relationships to providing services' (MHCA 2005, p.15). COAG responded to the report with the 'Action Plan', which took up the majority of the recommendations made and was officially accepted by COAG at their 18th meeting on 14 July 2006. Under the plan, the mental health system is improved at both state and national levels by promoting integrated funding and policies so that more care and services can be provided through government, private and non-government organisations in a seamless way.

The National Action Plan aims to achieve four general goals: the reduction of the prevalence and severity of mental illness; the reduction of the risk factors associated with mental illness; the increase of access to appropriate mental health care; and, the increase of the ability of individuals suffering from mental illness to actively participate in the community (Van Gool 2006, p.7). Individual implementation plans for each of the federal, state and territory governments aim to achieve the defined outcomes using five areas for action with specific policy directions: promotion, prevention and early intervention; integrating and improving the care system;

participation in community and employment, including accommodation; coordinating care; and increasing workforce capacity (COAG 2006, p.2-6).

The largest portion of the Federal Government's funding for the Action Plan has been allocated to 'Integrating and Improving the Care System'. Sixty-four per cent of funding or \$1,196.9 million worth of resources has been dedicated to policies aimed at increasing the provision and quality of mental health care services and increasing the number of people who can access them (COAG 2006, p.9). The biggest and most significant of the initiatives under this policy direction is the 'Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule' (BAI). This provides Medicare rebates for individuals seeking help from allied mental health professionals.

Both the Action Plan and the BAI received widespread support, albeit with important caveats. The MHCA criticised the five-year evaluation of the plan and suggested instead a system of ongoing monitoring and assessment. Additionally, they argued that the level of funding was inadequate and would not reach the level recommended in their report (Van Gool 2006, p.4). The Australian Medical Association (AMA) also raised concerns that the Medicare rebates would undervalue the role of GPs in the provision of mental health care and argued that the Government was making it difficult for GPs to access the mental health items due to additional training requirements (Van Gool 2007, p.2). In responding to these criticisms amendments were made so that additional training and education of GPs in mental health became a recommended guideline, but importantly, it did not make this training compulsory for

GPs to access the mental health items on Medicare. In addition, part of the Action Plan includes \$103.5 million in funding for additional education places, scholarships and clinical training in mental health with the expectation of increasing the quantity and quality of the workforce in this area by 1,400 mental health nurses and 700 clinical psychologists by 2011 (Department of Health and Ageing (DHA) 2008a, p.1).

The Australian Psychological Society (APS) was very supportive of both the Action Plan and specifically the BAI stating that it put Australia 'at the international cutting edge' (Gleeson & Brewer 2008, p.12) of mental health care. Gleeson and Brewer's (2008) study raised concerns that the availability of psychological services on the Medicare Benefits Scheme would make private practice more appealing to psychologists at the cost of non-government, and not-for-profit community, organisations. Despite this, their research found that only one-third of psychologists were actively planning for private practice and that incentives remained a viable way to retain psychologists in the public system.

Better Access

Prior to the BAI, Gray identified cost as a major deterrent for individuals considering access to mental health care professionals (2004, p.42). The inclusion of mental health care under the Medicare Benefits Scheme (MBS) in the BAI was specifically designed to benefit individuals in the community who have a high prevalence, low-grade mental illness to obtain early assessment and treatment. Under the new system treatment

could be sought from a GP, or by a GP referral to specialist treatment with a psychologist, psychiatrist or other qualified allied mental health professional (DHA 2008a, p.2). By increasing the affordability of these services through the Medicare rebate, it was believed that more individuals would be able to access timely and appropriate treatment: early intervention, assessment and management of illness. The BAI scheme was remarkable in that it continued to expand the benefits covered by Medicare beyond medical practitioners. The cornerstone of the BAI is the 'GP Mental Health Treatment Plan'.³ This became available on the Medicare Benefits Schedule on 1 November 2006 and addressed the Action Plan goals of early intervention and the integration and improvement of the mental health care system. Under the GP Mental Health Treatment Plan (GPMHTP), patients could receive three consultations with a General Practitioner (at least one of which would be an extended consult of at least 20 minutes); 12 individual sessions, and 12 group sessions, with a psychologist or other allied mental health professional in any one calendar year (DHA 2007a, p.1). The GP consultations receive a Medicare rebate of 100 per cent of the scheduled fee, while the rebate for the psychology or allied mental health consultation is 85 per cent of the scheduled fee (Medicare Australia 2010b, p.155-157). As Van Gool (2007, p.5) points out, these rebates do not necessarily guarantee better access to these services as providers are able, and often need, to increase their fees beyond the Medicare Scheduled fee. This leaves a 'gap payment' or 'co-contribution' that a patient may not

³ Previously called 'GP Mental Health Care Plan' until 1 July 2009 when the name was changed to better reflect its purpose (DHA 2010a, p.5).

be able to afford. This is a significant point. While the extension of Medicare rebates for mental health treatment rightly draws in government funding, this may not, in and of itself, be providing *greater* access to services that existed prior to the introduction of BAI.

The introduction of Medicare rebates for mental health services was aimed at reducing financial affordability as a barrier to accessing care (Gray 2004, p.42). It is important, therefore, to assess whether the initiative has succeeded. On the surface it would seem that it has indeed been a success. Recent surveys have found that 73-96 per cent of patients could not have accessed psychological services if the BAI had not been in place (Giese, Lindner, Forsyth et al. 2008a, p.33; Giese, Littlefield & Mathews 2008b, p.36). These findings suggest that the scheme is reaching the right people. Bulk-billing rates for psychologists are also relatively high with 48 per cent of psychologists and 62 per cent of clinical psychologists providing bulk billing to their clients (Lindner & Stokes 2007, p.30). Despite these findings, there remains a continuing concern that the majority of people benefitting from this initiative are those who were already accessing these services, and therefore already able to afford treatment (Russell 2008, p.24). Affordability of services is not just related to low-income earners but a range of people in the community. Adolescents have found the cost of care prohibitive to seeking help (Quine, Bernard, Booth et al. 2003, p.6). Young people aged 16-24 are more likely to develop a mental illness (Media Release- One in Five Australians have a Mental Illness; ABS 2008) and yet young men have among the smallest uptake rate (MHCA n.d.-a). These contradictory findings suggest that more research needs to be done to evaluate

the efficacy of the Medicare rebate in removing the financial barriers in mental health care.

The progress of the implementation and operation of the Action Plan will continue to be reported annually to COAG using the four agreed outcomes and 12 progress measures, and an independent evaluation and review of the plan will be carried out at the end of the five years (2011) as outlined in the Action Plan (COAG 2006, p.7). While there are some who are sceptical of the feasibility of tracking progress using the measurements outlined in the report (Van Gool 2007, p.7), the Australian Senate has announced that it will be setting up a watchdog to ensure that the National Action Plan on Mental Health 2006-2011 delivers on its promise to make the desperately needed improvements to mental health care in Australia. Current data shows that in the first four months after inception, the Government had spent \$42 million on mental health care items (Van Gool 2007, p.3) and as of 31 December 2009, over 11 million mental health services had been subsidised by Medicare under the BAI to over 1.9 million Australians. There are currently 24,000 GPs using the Medicare items and 16,400 allied health workers registered with Medicare (DHA 2010, p.5). These figures indicate the importance of this policy and the massive impact it has had. While these large numbers do show that a significant number of people are accessing mental health care under the initiative, they do not necessarily translate to success. In Australia, with 16,400 allied health care workers registered in a population of over 22 million people, it seems reasonable that we should be concerned not simply with better access to health care, but with questions of provision.

The role of the General Practitioner

While the BAI has been implemented in order to increase accessibility of mental health services, some of the requirements of the Medicare rebated services may actually be hindrances themselves. GPs perform a vital role in the identification and management of both physical and mental health and illness. Previous research has found that general practice is the most common service sought for mental health issues in Australia (Minas, Klimidis & Kokanovic 2005, p.112) with up to 75 per cent of a patient's mental health care provided by their GP (Australian Division of General Practice 2010). This highlights the important function that GPs have in ensuring timely and appropriate access to mental health care. Management of mental illnesses, especially administering psychological strategies, can take longer than the average consultation time for physical disorders, due to their complexity and interactional nature.

Recent research has found that since the introduction of the Better Outcomes in Mental Health Care (BOiMHC) initiative in 2002, the precursor of the BAI, GPs have reported significantly higher levels of referrals to allied mental health professionals for psychological treatments, and that the main reason for referral is a shortage of time (McGarry, Hegarty, Johnson et al. 2009, p.75-78). This shortage of time impacts not just the service they are able to provide their patients, but the service provided by the referred psychological specialist. Under the BAI, psychological services are only rebated if a GP Mental Health Treatment Plan has been completed, and a diagnosis of clinical disorder has been made (McGarry et al. 2009, p.76; Medicare Australia 2010b, p.70).

However, a survey conducted by the APS (Giese et al. 2008b, p.37) found that despite a GP assessment and diagnosis, psychologists had to conduct their own full assessment in 87 per cent of BAI clients. This means that the client must repeat their situation to their psychologist due to the inadequacy of information garnered for the GP Mental Health Treatment Plan. The lack of time and significantly reduced specialist mental health training that GPs have, compared to psychologists, begs the question of why patients are required to first see a GP in order to obtain psychological strategies from a field that the AMA has historically classed as non-medical (Palmer & Short 2010, p.182).

Better Access or Better Business?

With funding only committed until 2011 it is pertinent that a review of the BAI be conducted to ensure that it is contributing to the achievements of the outcomes set out in the National Action Plan. The current research will not only quantitatively analyse the services being utilised, but will also examine how the structure of the initiative may be contradictory to the goal of increasing accessibility of mental health care and how this may be overcome. This requires examining the role of GPs, the medical profession and the Australian Medical Association in mental health care and policy and the historical division between 'medical' and 'non-medical' treatments. There is little, if any, evidence to suggest that the BAI has been so ineffective that funding should not continue; nonetheless, results to date have pointed to contradictions in the efficacy of the plan. With the estimated cost to Commonwealth

Government at \$2 billion over five years (MHCA n.d.-a) it is imperative that the initiative be closely examined to ensure that these funds are being spent in the most effective way.

This study aims to examine some of these contradictory findings. Firstly, the study will determine whether we can evaluate the efficacy of the Medicare rebate in removing the financial barriers in mental health care. In doing so it will examine who is accessing the psychological services under the BAI, and the type of services they are using to determine whether this scheme has assisted in achieving the four outcomes of the Action Plan. Secondly, the study will examine whether the way in which the BAI is set up acts as a barrier in and of itself, that is, whether the requirement to obtain a GP Mental Health Treatment Plan creates a barrier to accessing mental health care. The research raises the question of whether a more successful approach might be for patients to access rebated psychological services directly. The professional demarcation lines in the provision of service, as with those relating to the provision of funding, are grounded within a long historical practice. Understanding these may help to reveal structural impediments in the supply of mental health care in Australia. These historical legacies are addressed the next chapter.

Chapter 3

Federal Policy and Mental Health

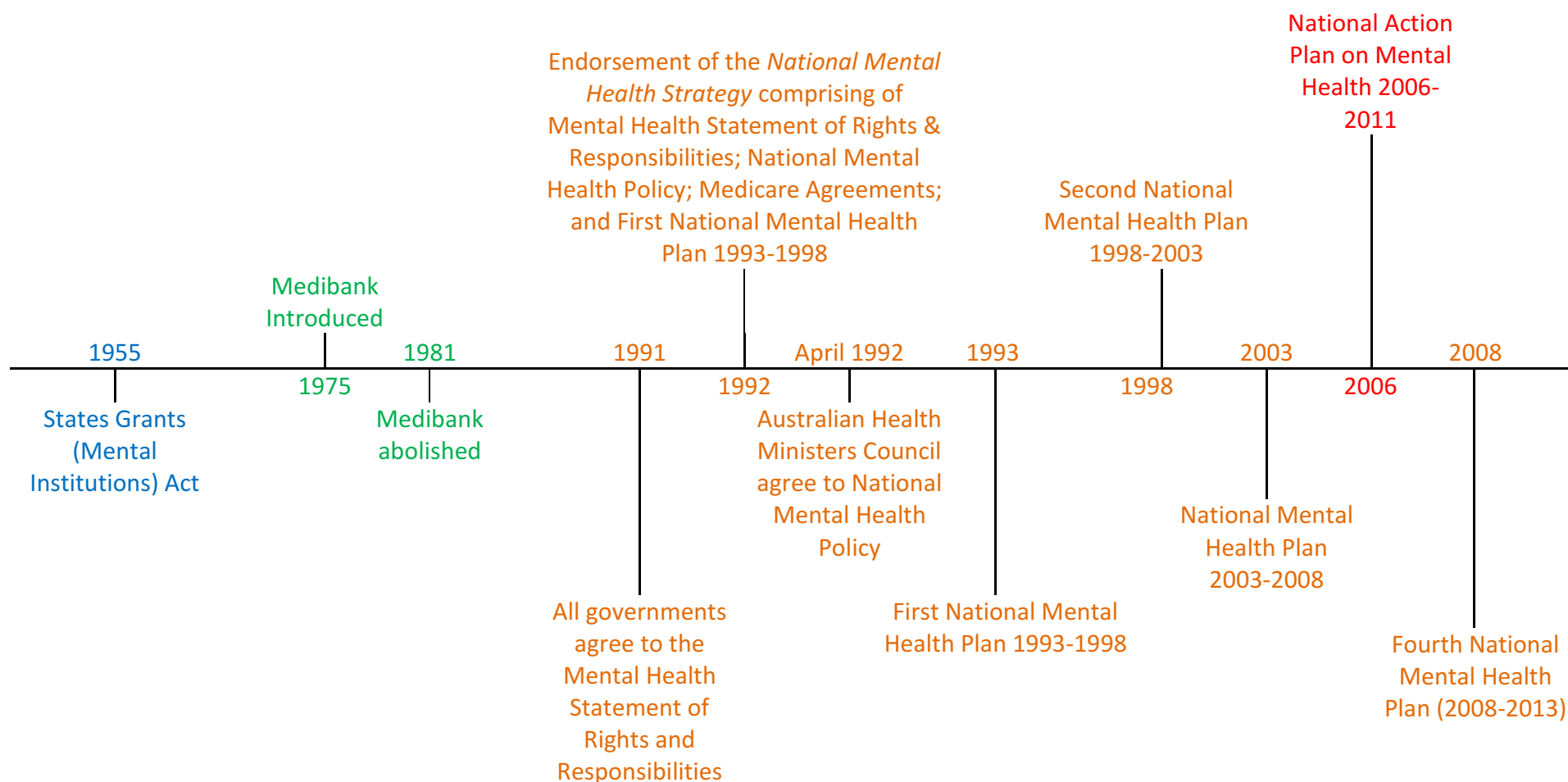
The legacy of past mental health policies has shaped current practice (Meadows, Singh, Grigg et al. 2007b, p.63-98). As such, it is important to understand current mental health care in Australia, in terms of both possibilities and limitations, in its historical context. Three key developments stand out, which together lay the foundation for how governments operate in this important area of healthcare. The first significant development, the States Grants (Mental Institutions) Act of 1955 institutionalised unprecedented funding from the Commonwealth government (Singh 2007b, p.68) and started an ongoing partnership between state, territory and federal governments to improve conditions in, the then much criticised, mental hospitals. The second key development occurred with the Whitlam Labor Government's 1975 introduction of Medibank. Important in this was the equal significance given to mental and physical health. As part of this emphasis unlimited, government funded psychiatry sessions, were provided through Medibank.⁴ The third key development in this area occurred in the early 1990s with the introduction of the National Mental Health Strategy (NMHS). This was a collaborative initiative across state, territory and federal governments which

⁴ The only amendment to the initial Medibank arrangement has been the limit of 50 sessions per year that the Howard government introduced in 1997 (Singh 2007b, p.69).

aimed to improve the mental health of all Australians. It was through the NMHS that many initiatives came into being, including the BOiMHC initiative which was the precursor to the BAI discussed in the previous chapter. Combined, these three developments: federal funding to states and territories for mental health infrastructure, federal funding of psychiatry sessions, and a collaborative foundation for policy and strategy, form the basis upon which mental health policy operates (see Figure 3.1).

Each of these three events in federal policy can be seen as turning points because they changed the way that governments managed mental health and illness. The States Grants (Mental Institution) Act shifted responsibility from state to federal government; the introduction of Medibank saw the government officially acknowledge mental illness as a medical condition; and the National Mental Health Strategy recognised the need for integration between state and federal operation of mental health programs. These changes have had a significant impact on the way that mental health and illness is treated in terms the operational structure of programs such as the BAI. This chapter will examine each of these events to show how changes to federal mental health policy during the 20th century have left their legacy.

Figure 3.1: Timeline of National Mental Health Policies



States Grants (Mental Institutions) Act 1955

The 1950s were a time of emerging changes in the area of mental health. Not only was the groundwork being laid for the process of deinstitutionalisation (Robson 2008) but the responsibility for funding mental health was beginning to shift from the state governments to the Commonwealth. The States Grants (Mental Institutions) Act 1955 signalled the first time it was recognised that a partnership between state and federal governments in the area of mental health was needed. It is this first step toward integrated management of mental health and illness that allowed the BAI and the National Action Plan to come to fruition. The following section briefly outlines how the States Grants (Mental Institutions) Act 1955 came about.

Mental Illness under State Control

Until the 1950s, each state was primarily responsible for funding mental health themselves (Lewis 1988, p.33). Every state had their own policies to manage the asylums, which were the most common form of management of people with mental illness. However, almost as soon as they were opened, 'lunatic asylums', as they have historically been known, across Australia came under scrutiny (Singh 2007a, p.66). Inquiries consistently found shortcomings and inadequacies, commonly surrounding staff shortages, overcrowding and substandard conditions (Cummins 2003, p.104; Dax 1961, p.20). In Victoria alone, the 1940s saw scathing press reports and increasing public concern over the state of the facilities, and, as a result, the Mental Hospital

Enquiry Committee was formed (Dax 1961, p.15). Following their unfavourable report in January 1948, the Victorian Holloway government asked British psychiatrist, Professor Alexander Kennedy, to investigate the claims. His report in 1950, dubbed the Kennedy Report, found the condition of the seven operating mental hospitals in Victoria appalling. The hospitals lacked essential services and urgent attention was required for everything from water supply to the kitchens (Dax 1961, p.19). It was found that chamber pots were still being used frequently and were often stored in the same place as food; toilets were without seats, frequently broken and of insufficient number; and significant overcrowding in the region of about 1,500 residents resulted in many people sleeping on the floor (Dax 1961, p.20). Newspapers reported Professor Kennedy's descriptions of mental hospitals as 'inhumane and unclean' (Mental Homes 'Inhumane and Backward' 1950, p.1). The Mental Hygiene Authority was formed, under psychiatrist Eric Cunningham Dax, in response to the Kennedy Report's recommendation of a new administrative system (Dax 1961, p.17-18). Dax described the situation when he took over in 1952 as being 'in a state of utter neglect and far below the standard of the oldest and most backward hospitals...in Great Britain or those seen in Europe' (Dax 1961, p.3).

The Commonwealth Takes Control of Health

The 20th century was dominated by debate surrounding universal health care provision (Palmer 1983, p.19). Health care operated on a fee-for-service basis. Those who could afford it could take out insurance, while charities and very limited government funding

provided health care for the economically disadvantaged (Browning 2000, p.4; Palmer 1983, p.19). Labor governments largely led the drive for compulsory universal health insurance. During and after World War II, the attempts by the Curtin and Chifley Labor Governments failed to achieve a national health scheme but Labor did succeed in amassing Commonwealth power to intervene in health matters.⁵ These included the provision of health services, quarantine powers and payments to States for specified purposes (Browning 2000, p.4). As a result, the federal government was able to influence state policies, effectively forcing the state and federal governments to work collaboratively to solve the problems within the health system, including mental health and illness.

When the Menzies Liberal Government came into power in 1949 the focus shifted away from nationalising the health system. Menzies' Government was a proponent of voluntary health insurance, while also recognising the Commonwealth's responsibility in providing targeted support to those in need. In 1953, they took advantage of the increased Commonwealth health powers to introduce the Medical Benefits Scheme (Browning 2000, p.5). This was based on the concept of voluntary health insurance whereby doctors operated on a fee-for-service basis and patients made payments to their choice of insurance fund. The insurance companies then paid the appropriate Commonwealth benefit on behalf of the Government (Browning 2000, p.5).

⁵ These powers were gained by the Commonwealth government under Section 51 (xxiiiA), Section 51 (ix) and Section 96 of the Constitution following a constitutional referendum. (Browning 2000)

The Stoller Report and the States Grants (Mental Institutions) Act 1955

The new health powers granted to the Commonwealth were also being used to improve health services in the states through specific payments. In order to provide funds to the states to improve mental health services, the federal government commissioned a national report into the conditions of mental health facilities and their future requirements (Cummins 2003, p.115). Undertaken in 1954 by Dr A. Stoller and Mr K. Arscott, the *Report on Mental Health Facilities and Needs of Australia*, known as the Stoller Report, found that Australia had lower standards of psychiatric services than the United Kingdom, Canada or the USA in relation to overcrowding, understaffing and research (Singh 2007b, p.68; Smark & Deo 2006, p.3). As a result, the States Grants (Mental Institutions) Act 1955 was initiated which provided states⁶ with significant funding for capital works (Singh 2007b, p.68). It operated on a dual funding basis where for every £1 that States spent on capital works, such as renovations to mental hospitals or new facilities, the Commonwealth government would provide 10/- (Cummins 2003, p.113). While the payoff was less funding for maintenance costs, the new arrangement institutionalised co-payment funding from the Commonwealth and represented a major commitment to mental health. The importance of the Stoller Report and the subsequent introduction of the States Grants (Mental Institutions) Act 1955 is that it signalled the first time the Commonwealth government accepted responsibility for providing the states with the financial assistance needed to provide modern psychiatric

⁶ At that time there were no mental hospitals operating in the ACT or Northern Territory (Cummins 2003, p.115).

facilities (Cummins 2003, p.115). Furthermore, the 1950s saw the birth of a relationship of integration and shared responsibility between state, territory and federal governments which continues today (Singh 2007b, p.68) and underpins the current National Action Plan on Mental Health 2006-2011.

The introduction of Medibank and the reinforcement of the medical model

While the reforms of the Menzies Government were adequate for a time, they fell short of providing full coverage (Scotton 2000). One of the greatest victories in mental health occurred through the introduction of Medibank in 1975 by the Whitlam Labor Government. This allowed universal, unrestricted access to specialist psychiatric services (Singh 2007b, p.68-69). Medibank, the precursor to the current Medicare, was the first compulsory national health insurance scheme in Australia (De Voe & Short 2003, p.350). Importantly, the inclusion of psychiatry meant that mental health was equated to physical health, not just from a theoretical perspective, but in practice as well. This meant that for the first time every Australian could receive psychiatric treatment in the community with no limit on the number or type of service. These services created affordable treatment options for mental illness outside of hospital. They also allowed for early intervention in mental illness and even prevention by providing patients the chance to seek help before the issue started having a severe impact on their life. This echoed a significant shift in emphasis in healthcare, evidenced by the Whitlam Labor Government's earlier strategies on reforming the health care

system which witnessed a shift from curative to preventative health care (Browning 2000, p.7). The introduction of Medibank also increased public awareness and acceptability of mental health and illness in society and improved the standing of the psychiatry profession (Singh 2007b, p.69). The inclusion of psychiatry and mental health under Medibank put Australia in the forefront of mental health care as the Medibank scheme was the most generous of its kind worldwide (Singh 2007b, p.69). Medibank enabled equal, universal, access to mental health treatment and has had a marked impact on today's mental health policies.

The Fall of Medibank

Just six months after Medibank became operational the Whitlam Government lost the federal election. Despite the new Fraser Liberal Government's election promise to keep Medibank intact, the scheme began to be dismantled (Scotton 2000). In the years that followed, Medibank underwent significant changes due, at least in part, to budgetary constraints and economic concerns (Palmer 1983, p.19). The rebate amount for medical services under Medibank was reduced from 85% of the scheduled fee to 75%, then to 40%, before being replaced by a fixed amount of the difference between the scheduled fee and \$20 (Scotton 2000). By 1981 Medibank and the idea of universal health insurance had been abolished, with medical benefits restricted to eligible pensioners or very low-income earners.

However, the cancellation of Medibank did not mark the not the end of a universal health scheme. The Hawke Labor government re-introduced Medibank with

only minor changes in October 1984 under the name Medicare (De Voe & Short 2003, p.344; Palmer 1983, p.20; Scotton 2000).

Medicalisation of Mental Health

With the replacement of Medibank by Medicare, there have been few overall changes to psychiatric service provision in the last 35 years. The main change occurred in 1997 when the Howard government limited the number of psychiatric services under Medicare to 50 sessions per year (Singh 2007b, p.69). The influence of Medibank is still apparent, as the rebated psychiatric sessions are similar to the model used for rebated psychological sessions now being offered under the BAI.

However, having government funded psychiatry services has not been without its drawbacks. These arrangements cemented the idea that psychiatrists, as medical professionals, are the only people adequately equipped to manage mental illness. This professional demarcation has had interesting consequences. Other health professionals, such as psychologists and social workers, were not covered by Medibank, and later, Medicare. This medical dominance over mental illness continues in the current arena. A hierarchy of care is still evident today with psychiatrists treating more complex mental illness cases while psychologists handle less complex mental health issues (APS 2010; Shorter 1997, p.295). Other professions, most notably psychology, but also social work and occupational therapy, are challenging the medical model of mental illness (Mackinnon & Coleborne 2003, p.6). Government funded psychiatry shows how entrenched the medical model has become and highlights an interesting

professional progression. Psychiatrists have gone from being at the bottom of the medical hierarchy during the early 20th century (Lewis 1988, p.99) to now being the elite of mental illness; practitioners who treat those whose mental illness is most severe (Hickie, Davenport, Luscombe et al. 2006, p.8).

Having psychiatrists included under the Medibank arrangements has excluded other professions from legitimacy in mental health care and it further cemented mental illness within a medical domain. Admittedly, psychology was not as strong a field in the mid-twentieth century as psychiatry but it nonetheless existed as a viable alternative to treatment (Dax 1961, p.33-34; Lewis 1988, p.109; Shorter 1997, p.293). It is not the initial exclusion of psychology that causes problems today but the political acceptance of the medical model of mental illness when Medibank was first introduced. As a result of this, federal health policy has failed to recognise alternative mental health practices whose prominence and role have continued to rise. An 'us' and 'them' culture has emerged whereby health professionals are divided between medical and non-medical (Mackinnon & Coleborne 2003, p.6). This historical legacy has particular relevance to the BAI.

Part of this legacy is the significant political power wielded by the Australian Medical Association (AMA), which has further cemented medical dominance in this field (see Browning 2000; De Voe & Short 2003). De Voe and Short (2003, p. 346) describe the relationship between the government and the AMA as a 'corporate partnership' based on mutual dependence which gives the AMA the power to veto

undesirable health policies. As mentioned previously, the AMA successfully negotiated that mental health skills training for General Practitioners as a requirement to provide BAI services be optional rather than compulsory.

The partnership between government and the AMA has been beneficial for the enhancement of medical professionals, particularly GPs, in mental health. The Howard government further cemented the role of GPs in mental health when they restricted referrals so that only GPs could make referrals to specialists that are valid for more than three months (Singh 2007b, p.69). The forced involvement of GPs in virtually all aspects of health care is a legacy which the BAI is still trying to work under today. Despite being non-medical mental health workers, a referral from a medical professional (i.e.: a GP, paediatrician or psychiatrist) is required in order for psychologists to provide services under Medicare. It was a curious omission at a time when the biomedical model of mental illness faced its greatest challenge. Politically, the major challenge to medical dominance of mental health came with the policies of deinstitutionalisation that formed part of the National Mental Health Strategy.

The National Mental Health Strategy

The establishment of the National Mental Health Strategy in the 1990s signalled a major commitment to mental health in Australia and reignited the idea of an integrated approach to mental health first seen in the 1950s. Following a stream of negative reports on the state of Australia's mental health system, including *Out of Sight, Out of*

Mind (Groom, Hickie & Davenport 2003), the *Richmond Report* (Richmond 1983), and the *Burdekin Report* (Burdekin, Guilfoyle & Hall 1993), governments officially recognised deinstitutionalisation⁷ and launched an agenda of national mental health reform (Meadows, Singh & Grigg 2007a, p.69). In 1991 all governments agreed to the Mental Health Statement of Rights and Responsibilities (the Statement of Rights) which aimed to make mental health the goal of society and to improve social justice, equity and access (Mental Health Consumer Outcomes Taskforce 1991, p.iv). This document clearly outlines the rights of people with mental illness, such as the right to have a say in the direction of their treatment; and the right of access to timely and quality care. It states ‘the diagnosis of mental health problems or mental disorder is not an excuse for inappropriately limiting [patients’] rights’ (Mental Health Consumer Outcomes Taskforce 1991, p.ix). The statement also outlines the rights of carers, service providers and the community, marking the rise of the role and emphasis placed on the community health sector.

The following year the Australian Health Ministers Council agreed to the National Mental Health Policy (DHA 2007b, p.12). This policy defined the aims and objectives of the mental health care reforms. Importantly, it recognised that mental illness was the result of psychological and social factors in addition to biological causes (Australian Health Ministers 1992, p.7). This was a major breakthrough in challenging medical dominance and the biomedical model of mental health. Furthermore, the

⁷ Deinstitutionalisation had been occurring since the 1950s in various states across Australia but did not become official policy until much later. In Victoria this occurred with the Mental Health Act 1986 (Vic) (Robson 2008a).

policy expressed that the first priority in mental health policy and service delivery was a positive outcome for consumers⁸ (Meadows et al. 2007a, p.70). The Statement of Rights and the National Mental Health Policy formed the basis of the National Mental Health Strategy developed in 1992 under which Australian commonwealth, state and territory governments agreed to work together to improve outcomes in mental health (DHA 2007b, p.12).

The establishment of the National Mental Health Strategy saw successive five-year inter-governmental plans specifically targeting the aims and objectives of the National Mental Health Policy. The First National Mental Health Plan 1993-1998 focussed on prevention and promotion of mental illness; ensuring the rights of people with mental illness; and reduction of the impact of mental illness. It also committed to deinstitutionalisation by mainstreaming psychiatric services into general health services and integrating hospital and community components of mental health care (Meadows et al. 2007a, p.70). The two successive National Mental Health Plans, running from 1998-2003 and 2003-2008, were fairly similar in their approach. Both focussed on promotion of mental health, prevention or early intervention, and service delivery. One of the major achievements was the introduction of allied health workers under Medicare agreements.

The Better Outcomes in Mental Health in Mental Health Care (BOiMHC) program was launched in July 2001 with \$120 million of Commonwealth funding over

⁸ In this context, the term consumer refers to anyone who has a mental illness, as well as anyone who is currently using or has previously used mental health services (Lammers & Happell 2004, p.264).

four years (Pirkis, Stokes, Morley et al. 2006, p.152). It was groundbreaking in that it finally funded non-medical professionals to treat people with mental illness. One component of the BOiMHC program was that of Access to Allied Psychological Services (ATAPS) which allowed GPs to refer patients to allied health professionals for focussed psychological strategies (evidence based strategies such as cognitive behavioural therapy, psychoeducation and therapy). This landmark decision set the stage for the BAI and went further in providing consumers with the choice of treatment given under the Statement of Rights. However, despite the recognition that consumers have the right to choose their own course of treatment and that mental illness is not just biologically determined, BOiMHC still required that a GP referral be obtained before a consumer could access psychological treatment. This reinforced the concept that, in direct contradiction to the National Mental Health Strategy, mental illness is the domain of medicine. The status of gatekeepers conferred on General Practitioners was maintained.

While some positive changes were being made, by the time the Third National Mental Health Plan (2003-2008) was launched there was no associated Commonwealth Government funding (Meadows et al. 2007a, p.72). Once again national inquiries, such as the 2005 *Not For Service* report (MHCA 2005) into mental health found services to be inadequate and it became generally accepted that the National Mental Health Strategy had been, at best, only partially successful (Richmond & Savy 2005, p.216). The result of this was the National Action Plan on Mental Health 2006-2011, which runs

concurrently with the National Mental Health Plans and aims to overcome the failings of the previous plans.⁹

Conclusion

There have been three main developments in federal policy and mental health in the 20th Century that has left a legacy on the current system. These developments have had many positive benefits, such as the additional involvement of the federal government in mental health matters in the 1950s, which enabled the breakthrough of psychiatric services being included in Medibank. The renewed commitment to mental health and the integrated approach to rectifying the inadequacies of the system through the National Mental Health Strategy has revitalised the push for improvement. However, these changes have not been without pitfalls that have impacted on the current system. The legacy of past policies has also cemented negative practices that the system still struggles to overcome. What we are left with is a system that is still weighed down by medical dominance and the medicalisation of mental health and illness, which perpetuates the role of the GPs as gatekeepers, prevents accessibility of services and hinders true measures of prevention and early intervention. The following chapter examines how the medicalisation of mental illness is still apparent in many aspects of mental health care related to the BAI, in particular, the role of the GPs.

⁹ See Chapter 1 for further information on the *Not for Service* report and the National Action Plan on Mental Health 2006-2011.

Chapter 4

Literature Review

In a curious contradiction, the BAI still privileges a 'medical model' of mental illness. On the one hand the BAI has succeeded in challenging the medical emphasis by engaging allied health professionals in the mental health treatment system. On the other, their involvement is only possible on referral from a General Practitioner. This suggests that the medicalisation of mental health is still predominant.

Medicalisation is described as 'a science- medicine- going beyond its boundaries' so that 'medicine is vested with an all-solving power' (Colucci 2006, p.1). Mental illness is a prime example of this. Colucci points out that the domain of medicine has always been the physical body, and diagnosis and treatment were based on physical symptoms and organic causes. By contrast, mental illness lacks an anatomical body over which medicine can claim knowledge (Colucci 2006, p.1) and yet is still regarded as the primary authority. Medicalisation of mental health and illness has attracted much scrutiny over recent decades. While the concept of medicalisation

is being challenged, most notably by the process of deinstitutionalisation,¹⁰ but also by the BAI, several areas are still evident today.

Part of medicalisation, as touched on by Colucci, involves significant power over the profession. The Australian Medical Association (AMA) has been particularly successful in crossing from a professional body into a political powerhouse. De Voe and Short explain that during the second half of the 20th century the medical profession, through the AMA, had gone from being a simple lobby group to a 'corporate partner' of the government; a mutually dependent relationship which provided the AMA with significant veto power against undesirable health policies (2003, p.345-346). It is this political influence that is relevant to the BAI. Initially, there was a clause in the BAI stipulating that all GPs must undertake additional mental health skills training. However, the AMA fought against this, and the program was altered so that the additional training became optional (Van Gool 2007, p.2). In this way it becomes clear that the interests of the members of the AMA, that is medical practitioners, are at the forefront of their decisions over government collaboration. This, in and of itself, is not necessarily a bad thing; certainly it is advantageous to medical clinicians. However, as Martin points out, the inclusion of psychologists under Medicare can benefit the community through increased consumer choice as well as increased competition (2003, p.5). Martin has pointed out that one of the barriers to gaining rebates for

¹⁰ Deinstitutionalisation has been one the biggest challenges to medical dominance and is reported to have started as early as the 1950s (Dax 1961). This thesis will not touch on this process as an entire thesis could be dedicated to it and much has been written on the subject (eg: Dax 1961; Mackinnon & Coleborne 2003; Robson 2008).

psychologists was the anticipated opposition from the AMA: the organisation which viewed the move as threatening the 'special status' of medicine (p.5). Scott, an opponent of medicalisation concurs that this model denies consumers any choice in service provision (2010, p. 27). It is on this matter of choice that some of the issues around professional divisions come into play.

Part of the problem of medicalisation, as implied by Martin, is the exclusion of other professionals from mental health care provision (2003, p.5). A division exists between medical and non-medical or allied health professionals, where traditionally allied health staff work as subordinates to medical clinicians (Palmer & Short 2010, p.182). Allowing psychologists, social workers and occupational therapists to provide services under Medicare partially overcomes this professional demarcation; however, it is not complete. By keeping GPs at the centre of the scheme, the BAI still privileges their role. In particular the GP Mental Health Treatment Plan (GPMHTP) forces all service users to consult a medical practitioner thereby reducing choice of who to seek help from. Carey, Rickwood and Baker question the role, and thus the value, of the GPMHTP itself. They note that there is no evidence to suggest that detailed diagnosis enhances treatment outcomes (2009, p.14). However, there is nothing to suggest that the diagnosis provided by a GP would be more detailed. On the contrary, Littlefield, Giese and Matthews reported that psychologists found the information provided by GPs in the GPMHTP to be inadequate. In these cases, psychologists were required to conduct their own assessment and diagnosis in 86 per cent of cases (Giese et al. 2008b, p.37). The question of who should be responsible for assessment and diagnosis is a

complex, but extremely important one. On the one hand, when there is a limit on the number of sessions it is important that these not be unduly taken up with assessment (Carey, Rickwood & Baker 2009, p.14). On the other hand, GPs are notoriously time poor, often mentioning time constraints and work pressure as a barrier to treating psychological illnesses (Chew-Graham, Mullin, May et al. 2002, p.633; McGarry et al. 2009, p.77; Younes, Gasquet, Gaudebout et al. 2005, p.20). Research has found that significantly more GPs are referring patients to specialists since the inception of the BOiMHC initiative, the precursor to BAI (McGarry et al. 2009, p.78). McGarry and colleagues found that lack of time was the most influential factor in deciding to refer patients on for psychological treatment, and availability of Medicare funded psychology services was significant (p. 80). This indicates that GPs are open to the prospect of being less involved in mental health care. Younes and colleagues study supports this as nearly two thirds of surveyed GPs were dissatisfied with the number of patients with mental health problems they had (2005, p.20).

Of equal importance when examining the role of GPs in mental health is recognising where people go when seeking help. It is well established that the majority of people contact their GP for mental health issues (Australian Division of General Practice 2010; Fletcher, Pirkis, Bassilios et al. 2009, p.244; Minas et al. 2005, p.112) and as such GPs are in a prime position for providing mental health care. However, what has not been established is whether this is by choice, or necessity. A study by Angermeyer and colleagues examining where people choose to seek mental health care revealed that physicians were the fourth most endorsed source of help, behind

confidants, psychiatrists and psychotherapists (1999, p.204). Furthermore, their study showed that only one quarter of participants gave the family physician as their first choice of help (p.204). These findings are similar to Australian research conducted by Jorm, Wright and Morgan which showed that General Practitioners were not the primary source for seeking help among young people (2007, p.557). Interestingly, this was not the case among the young people's parents ,who did nominate GPs as the primary source of help (p.558). Earlier research found that GPs were most commonly mentioned as sources of help in both 1995 and 2003-2004, however, in all but one vignette less than 40 per cent of respondents nominated GPs (Jorm, Christensen & Griffiths 2006, p.38). These findings indicate that while GPs may be the most common point of contact they are not necessarily the most preferred.

Given the uncertainty over whether GPs are the first choice for mental health care and the documented time and work pressures faced by GPs, the current thesis will examine whether the central role played by GPs in the BAI represents best practice or is simply part of the legacy of medicalisation that the current system is attempting to overcome.

There is a vast amount of research into mental health. This includes the different aspects of mental healthcare, including evaluation of programs and policies such as BAI or BOiMHC in Mental Health Care (i.e.: Littlefield & Giese 2008; Hickie & Groom 2002); the examination of perceived needs and barriers to mental health care (i.e.: Prins, Meadows, Bobevski et al. 2009); issues around professional divisions (i.e.:

Carey, Rickwood & Baker 2009); or more generally, the medicalisation of mental health (i.e.: De Voe & Short 2003). In examining the BAI in context, this thesis draws from this research to determine the effectiveness and efficiency of the program.

Chapter 5

Methods

The evaluation of the BAI is a mixed methods research project examining the effectiveness and the efficiency of the program. The current study aims to evaluate the BAI against the third outcome of the National Action Plan to determine whether it is achieving its goal of improving access to mental health services. This is undertaken by answering three questions:

1. Who is accessing the services?
2. Does the requirement for diagnosis of mental disorder reduce accessibility of services?
3. Does the central role of GPs in the scheme amount to 'best practice'?

A mixed method approach encompassing data and analysis was used. As Fisher points out, multi-method approaches are useful in strengthening research as the combination can counter balance the flaws of any single approach (2007, p.125).

Policy documents and report analysis

Poole describes 'texts as artefacts which both reflect and create contemporary social, cultural and political realities' (2010, p.138). Analysis of documents and reports has been used elsewhere when researching health policy (see De Voe & Short 2003; Pirkis et al. 2006) and is considered appropriate.

For this study, documents relating to service access (including bulk billing and co-payments) were obtained from the Department of Health and Ageing. Education and training information was sourced using the Monash University 2011 Course Handbook and was reviewed in conjunction with information from the Royal Australian College of General Practitioners and the Australian Psychological Society. All documents used for this research are publicly available from the organisation websites. Where possible, the most up to date information was used. The limitation of utilising public source materials is that more recent data was not always available. For example, the most recent data regarding bulk billing and co-payments was only available for the period 1 November 2006 to 31 December 2007.

Data Analysis

Data was obtained from Medicare Australia and is available to the public through the organisation website. Data pertaining to the number of services provided, the demographic breakdown, and the benefit paid by Medicare for each item were reviewed. Separate data sets containing demographic information; benefit paid; and numbers of services provided were available for each of the 29 items numbers and had to be individually downloaded. Each data set had the data broken down by state/territory and financial year or by month. A total of 25 data sets were downloaded from Medicare Australia; of these 18 data sets related to the four most commonly accessed services under the initiative. An additional six data sets were

reviewed. Data sets were cleaned and elements combined to perform calculations and analysis.

Limitations of the data

The data sets provided by Medicare contained frequency tables rather than individual cases. As such, statistical analyses were not performed. Whiteford, Doessel and Sheridan note that the length of a year is non-uniform due to leap years; however they observed that the measurement error resulting from this is insignificant (2008, p.51).¹¹

The results from the data and document analysis were combined and are presented in the following chapter.

¹¹ Current data relating to bulk billing rates were requested from the Department of Human Services, Medicare Financing and Analysis Branch; and Medicare Australia. Medicare Australia advised they were unable to provide the data. The Department of Health and Ageing advised that they would not release the information. As the original data relating to bulk billing, co-payments and ATAPS uptake rates could not be accessed these findings have been reported from the documents mentioned above with no further analysis.

Chapter 6

Findings

Examination of the data obtained from Medicare and the Department of Health and Ageing (DHA), coupled with the document analysis of reports from DHA yielded mixed results. While there have been a very large number of services provided through BAI the findings revealed that there are several areas that warrant further examination. Of particular note are the gender differences apparent in the access of services, particularly in relation to young men. It was also found that bulk billing rates and out of pocket costs among psychologists are of concern and may be placing services out of financial reach for low income earners. It should be noted that further explanation of the findings extrapolated from the data by DHA is required¹². The findings from both the data and document analysis are described and discussed in the following sections drawing out the key areas of concern in relation to the BAI. The following chapter will then review the role of GP in light of these findings to determine whether having GPs in a central role is best practice or medical dominance.

¹² It is not possible, at this stage, to identify the magnitude of growth in the provision of mental health services, as the statistical monitoring of this data begins in 2006 with the BAI.

General Information

Since its inception on 1 November 2006 through to 31 December 2009, over 1.9 million people had accessed services under the BAI (DHA 2010, p.5). The data reveals that as of 30 June 2010, a total of 13,770,678 services have been provided under the BAI at a cost of \$1,401,306,549. This shows that there is a clear need for the services provided under the initiative. Descriptive statistics of Medicare data revealed that the four most commonly claimed items numbers are: Preparation of a GPMHTP (item 2710); GP Mental Health Consultation (item 2713); Extended Psychological Therapy Service provided in rooms by a Clinical Psychologist (item 80010); and Extended Focussed Psychological Strategy Service provided by a registered psychologist (item 80110). The descriptive statistics also revealed that these four items numbers account for 85 per cent of all services provided.

These results indicate that an overwhelming number of mental health services have been provided to the Australian public. The Department of Health and Ageing (DHA) consider these results to prove that the Initiative has increased accessibility to mental health care (2009, p.8). However, as Carey, Rickwood and Baker (2009, p.10) explain, this justifies the Initiative but does not prove whether it is efficient. By examining whether the services available under the BAI are reaching the right people; that is, those who are most in need of affordable mental health services, we are better placed to assess its effectiveness. A demographic breakdown of access to services points to an area of concern: the different access rates among men and women. An assessment of the policy in practice reveals another concern: namely, whether differences in gap payments create a barrier to access. A starting

point to examine these issues is the General Practitioner Mental Health Treatment Plan (GPMHTP)

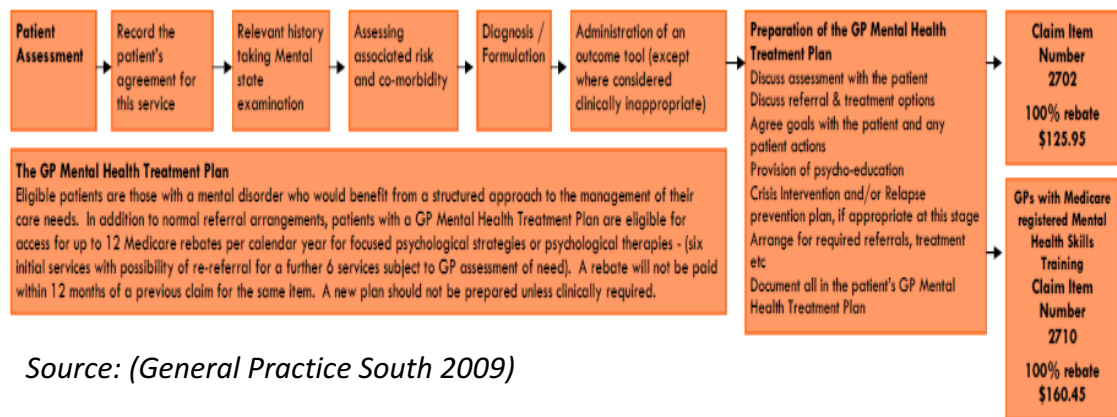
Who is accessing services?

The General Practitioner Mental Health Treatment Plan – items 2702 and 2710

The GPMHTP is a consultation with a General Practitioner (GP) that receives a 100 per cent rebate from Medicare, for the Medicare Scheduled Fee under item numbers 2702 and 2710 of the Medicare Benefits Schedule (MBS) (Medicare Australia 2010b)¹³. During the consultation, which is not required to be an extended consult, the GP must evaluate the patient to determine whether they are eligible for mental health care under BAI, who they should be treated by and, since 1 July 2009, provide a clinical diagnosis of mental disorder. Either during or following the consultation a treatment plan is completed. While there is no set form for the treatment plan, suggested templates are offered by the Commonwealth Department of Health and Ageing and various Divisions of General Practice (part of the Australian General Practice Network). Examples of templates available from various organisations are provided in Appendix A. Figure 6.1 below, from the Southern Division of General Practice, shows the process of the completion of a GPMHTP.

¹³ The two different item numbers relate to whether the GP has undertaken the optional Mental Health Skills training; item 2710 reflects that this additional training has been completed, while item 2702 is for GPs who have not completed this training.

Figure 6.1: Process of the GP Mental Health Treatment Plan

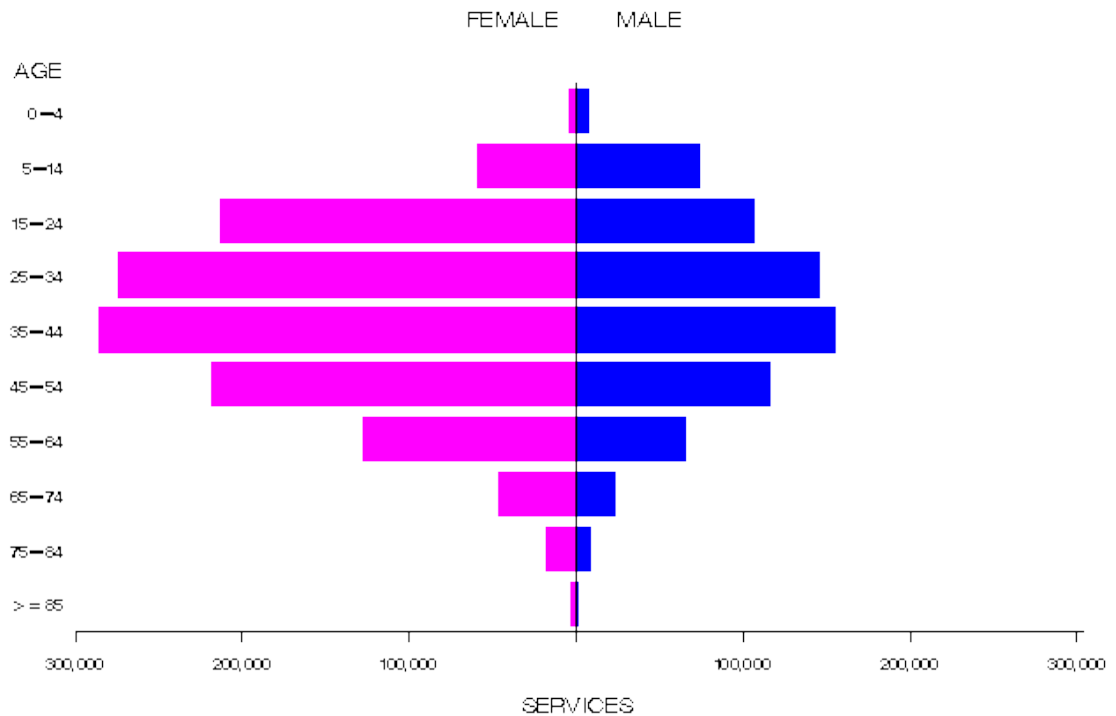


Source: (General Practice South 2009)

Between 1 November 2006 and 31 July 2010, there have been 2,077,723 GPMHTPs prepared under MBS Items 2710 and 2702 at a cost of \$318,062,594. As the majority of patients accessing mental health care under this initiative receive a GPMHTP, this data has been used to demonstrate demographic information. Given that DHA use data relating to GPMHTPs as representative of the uptake of services in their Post-Implementation Review (PIR), use of this data to examine demographic information is considered appropriate (2009, p.14). The graph from the Medicare website, shown in Figure 6.2 below, shows the demographic information of patients using MBS Item 2710, preparation of a GP Mental Health Treatment Plan.¹⁴

¹⁴ Preparation of a GP Mental Health Treatment Plan (item 2710) has been used as this item was created in 2006 for the BAI. In January 2010 a second item number (2702) was introduced for GPMHTP. This second item was designed for use by GPs who have not undertaken specified mental health training. For the purpose of this thesis, evidence is based on item 2710 as it has been in use since the inception of the BAI. Where applicable, items 2702 and 2702 have been combined.

Figure 6.2: Patient Demographics for GPMHTP items processed Australia wide from November 2006 to June 2010



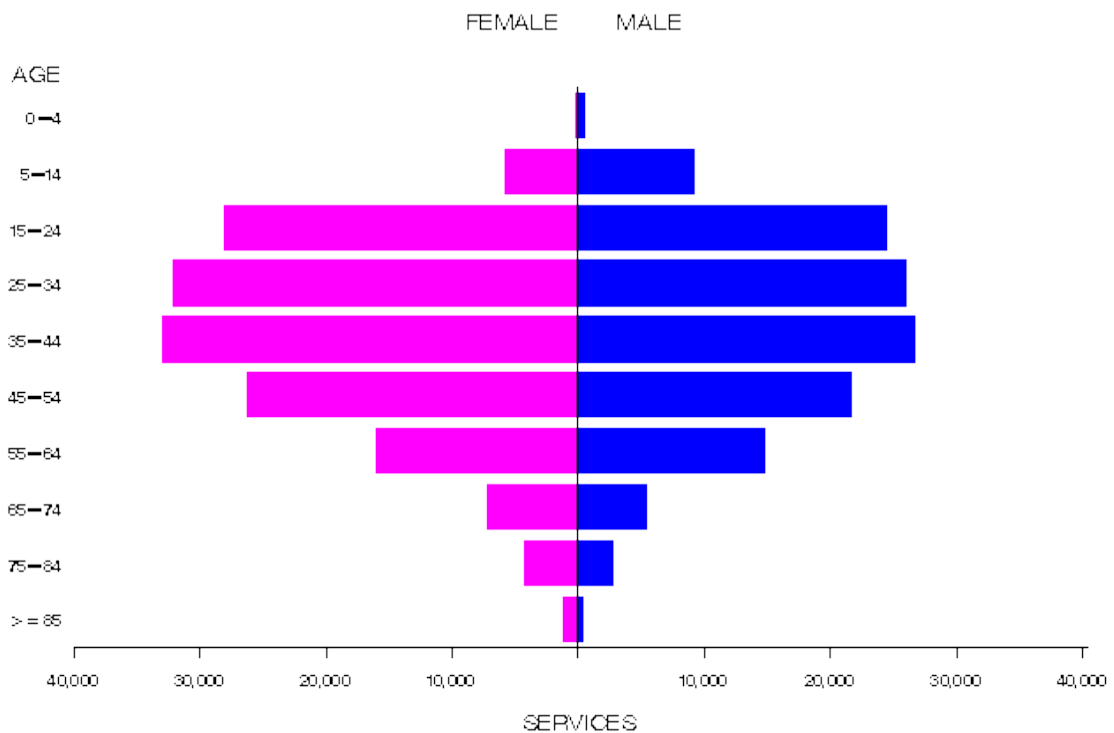
Source: Medicare Australia 2010

As can be seen from figure 6.2, more women have accessed this service than men, with most services provided to women in the 35-44 year bracket, followed closely by those aged 25-34. Women account for 64 per cent of the total number of GPMHTP preparation services provided Australia-wide over the past four years. In Victoria, women account for 64.4 per cent of these services. Of particular interest in this data is that only 5.5 per cent of these services were provided to young men aged 15-24, despite this age group being at high risk for developing mental illness (Australian Bureau of Statistics 2007, p.9). This indicates that mental health services under this initiative may not be effectively targeting those most in need.

Services pertaining to provision of treatment

Among all the types of treatment services provided, again, the substantial majority of services were provided to women rather than men, with one exception. Men accounted for 46.1 per cent of all services provided by psychiatrists in rooms (item 299). Figure 6.3, from the Medicare website, shows the demographic information for services provided by a psychiatrist from November 2006 to June 2010. The majority of services were provided to those between 15 and 54 years of age.

Figure 6.3: Patient Demographics for in-rooms consultation by a psychiatrist November 2006 to June 2010



Source: Medicare Australian 2010

Given that the prevalence of mental disorder in females in the general adult population is 22 per cent compared to 18 per cent for males (ABS 2007, p.8), the numbers of men receiving services should be only marginally lower than women. The figures, however, tell us that the ratio of women to men accessing services is 64

and 36 per cent respectively. This discrepancy is most pronounced among young men. The PIR compared gender differences in access to various services provided under Medicare to demonstrate that gender differences do not exist within BAI (DHA 2009, p.20). However, comparing gender differences against services for physical ailments does not satisfactorily explain why comparatively fewer men access mental health services than women. Why this discrepancy might be the case is examined in the following section.

Men and Mental Health

The data shows that, overall, fewer services are provided to males than females. This is partly expected as males are generally less likely to access any form health care than females (Leong & Zachar 1999, p.124). However, the discrepancy is substantially larger than one would expect given the prevalence of mental disorder among males is only marginally lower than for females in the general adult population (ABS 2007, p.8). Furthermore, men accounted for over three quarters of all suicides in 2008 (ABS 2010a, p.48). Given the high correlation between mental illness and suicide attempts (see Soukas, Suominen, Heila et al. 2010), rates of suicide among Australian males demonstrates the need to attempt to understand why so few men are accessing services. This can be done by examining help seeking behaviour of males and their perceived barriers to accessing mental health care.

Two particular age groups will be examined in terms of help seeking behaviour, and perceived barriers, to show how services need to be better targeted and improvements made to increase the proportion of men who access services.

Firstly, adolescent and young men, particularly those aged 16-24 years will be addressed due to the comparatively high rates of suicide among this demographic (Soukas et al. 2010, p.2). In fact, nearly one quarter of all deaths of males aged 15-24 are due to suicide (ABS 2010a, p.48). The other group that will be looked at is that of men over 65 years of age. The data shows that the proportion of men in this age group accessing services is far lower than women of the same age. Yet research from the Australian Bureau of Statistics shows that suicide rates increase in men after the age of 60 (2010a, p.49). While the outcome of individual cases utilising services cannot be ascertained, these data nonetheless suggest a real need for mental health services to be specifically targeted to males, especially in these age groups.

Young Men and Mental Health

Suicide rates are indicative of both current and future mental health problems. Research has found that attempts at suicide during adolescence is an indicator of future susceptibility to mental illness (Fergusson, Horwood, Ridder et al. 2005, p.989). The impact of untreated mental illness among young men can be devastating, not just for the sufferers themselves but also those around them. Research has indicated that the onset of mental illness early in life can predict violence towards an intimate partner (see Kessler, Molnar, Feurer et al. 2001, p.498; Lipsky, Caetano & Roy-Byrne 2010, p.1-2). An Australian study found that among adolescent males, depression was a major health concern and yet many respondents reported difficulties in seeking help (Quine et al. 2003, p.4). These

findings highlight the importance of ensuring that young men are accessing services and indicates that the current BAI needs to be more effective in targeting this group. This begs the question: why are young men not accessing services?

Why men don't seek help

Previous research has found that the attitudes and opinions held by individuals will affect both the success of a service and the extent to which it is utilised (Leong & Zachar 1999, p.123). Understanding the reason why so few males access mental health services can help to better target this group. Several categories of barriers to accessing mental health care have been identified. These include: stigma-related barriers, structural barriers, and mistrust of treatment (Jorm, Wright & Morgan 2007, p.557). It is to these barriers that this chapter will now turn.

Australia has been identified as being a country that is particularly 'masculine'; meaning that gender roles are more prominent and men are supposed to be tougher, more assertive and more focussed on success than women (Prins, Meadows, Bobevski et al. 2010, p.10). It has also been found that those who take on these stereotypically masculine roles are generally less willing to seek help (Leong & Zachar 1999, p.124). In a study comparing the perceived need of, and barriers to, seeking mental health care among Australian and Dutch populations, the most commonly reported reason for not seeking help was the desire to solve the problem themselves (Prins et al. 2010, p.8). This idea of being self-reliant ties into the concept of masculinity and the need to be seen as resilient. Quine *et al's* Australian study confirms this. In one example from their study, a young male

responded, when talking about depression that 'It's the macho thing...to say there is a problem would be weak' (Quine et al. 2003, p.4). This can be further extended when the role of stigma is considered.

Australians have been found to be significantly more likely to experience stigma than other populations; and stigma, shame and pessimism have all been linked to the male role (Prins et al. 2010, p.9-10). These feelings lead to defensiveness about counselling and the belief that there is something wrong with individuals who require it (Leong & Zachar 1999, p.129). Among adolescent males in Australia there is a strong feeling of stigma associated with mental illness (Quine et al. 2003, p.4-5). As a result, people who feel this way are less likely to seek help when they need it themselves (Lipsky et al. 2010, p.4; Quine et al. 2003, p.9).

Older men and mental health

It is worth noting that the number of older men accessing mental health services under the BAI is disproportionate to the rise in the suicide rates amongst this age group. Research has found that in this age group suicidal manifestations amongst people with no mental dysfunction are extremely rare (Leo, Hickey, Neulinger et al. 2001, p.45). This is an interesting, yet not fully examined, finding. Several risk factors of suicidal behaviour have been uncovered for older populations. These include physical illness, psychiatric disorder and various types of loss, including retirement and loss of a spouse (Leo et al. 2001, p.44). To examine these stressors is outside the scope of this thesis, nonetheless it is important to draw attention to this disparity and the need for future research to be conducted in this area.

Where do people prefer to seek help?

Given that not all demographic groups are accessing services equally, an understanding of whether people may prefer to seek help elsewhere is relevant in determining whether the role of GPs constitutes best practice. Under the BAI GPs are given a very prominent role as being the gatekeepers to mental health services (Prins, Meadows, Bobevski et al. 2010, p.2). That is, access to psychological services under Medicare is only available with a GPMHTP. It is undisputed that GPs are well placed to provide mental health interventions (Fletcher et al. 2009, p.244). While having the one point of entry as GPs does make sense when considering that they are the primary source of mental health care (Caldwell, Jorm, Knox et al. 2004, p.775; McGarry et al. 2009, p.76), there is one issue which causes this facet of the initiative to be called into question. The appropriateness of requiring all services to come through a GP becomes questionable when one considers that one quarter of people seeking mental health help do not contact their GP first (Australian Division of General Practice 2010). Furthermore, several studies have found that GPs are not always the preferred point of contact for mental health concerns (see Angermeyer et al. 1999; Jorm et al. 2007). In light of this, it is important that consideration be given to alternative entry points to services when accessibility of the right services at the right time is a goal.

Young people, in particular, are less likely to seek help from their GP (Jorm et al. 2007, p.559; Wright, Harris, Wiggers et al. 2005, p.20). As discussed in chapter four, research on the preferences for mental health treatment among both adults

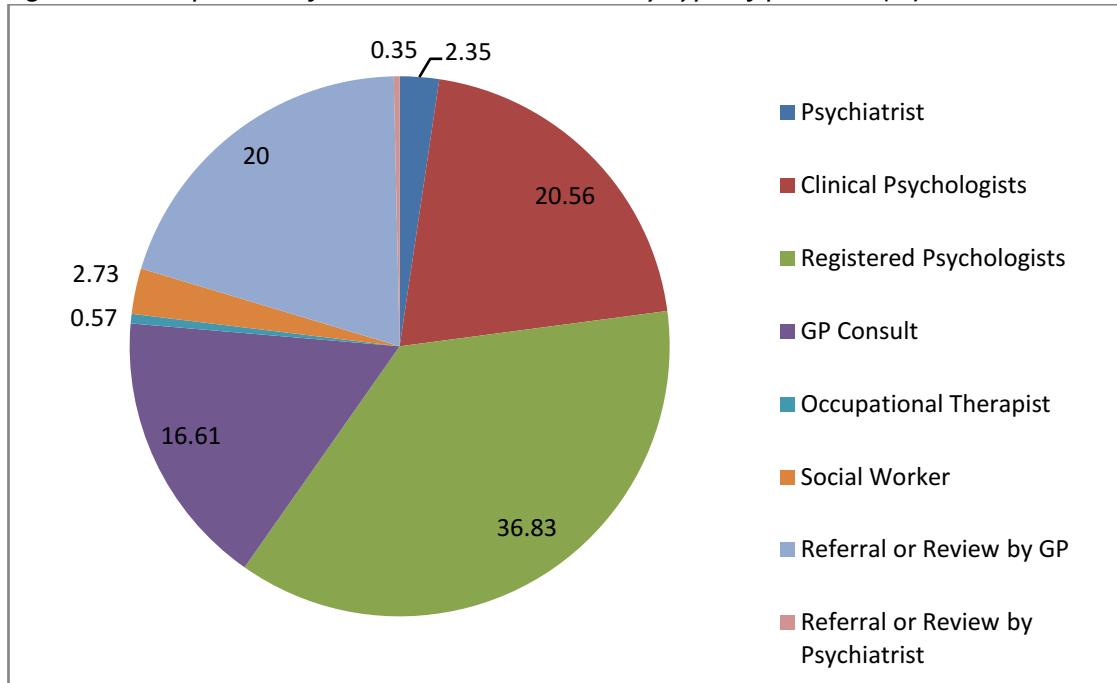
and youth shows that family and mental health professionals (psychologists, psychiatrists, counsellors etc) were mentioned as being the source people would go to seek help (Angermeyer et al. 1999, p.204-205; Jorm et al. 2007, p.557). Given these findings it is worth considering whether alternative entry points should be available, particularly to adolescents and young adults who are most vulnerable to mental disorder (Wright et al. 2005, p.18) and have been found to have the lowest uptake rates.

The Role of the General Practitioner

Post referral, registered psychologists (36.83 per cent) and clinical psychologists (20.56 per cent) provided the majority of therapeutic services. Social workers (2.73 per cent) provided slightly more services than did psychiatrists (2.35 per cent).

General Practitioners provided 16.61 per cent of therapeutic services. Non-therapeutic services accounted for 20.35 per cent of all services. Non-therapeutic services include preparation or review of GPMHTPs by GPs (20 per cent), and referral or review by psychiatrists (0.35 per cent). Data from the Medicare data sets was compiled to show the proportion of all services accounted for by each type of provider (see Figure 6.4 below).

Figure 6.4: Proportion of all services undertaken by type of provider (%)



General Practitioners play a vital role in mental health. The Australian Division of General Practice estimates that 75 per cent of people with mental health problems will seek help from their GP (Australian Division of General Practice 2010), though as Figure 6.4 shows they are not the largest provider of services. With the vast majority of people seeking help from their GP, it is unsurprising that GPs have been assigned a 'gate-keeping' role under the BAI. While it might be unsurprising, it may not necessarily represent best practice. What is being explored here is not whether GPs play a valuable role in mental health, but whether their position at the core of the BAI is appropriate and effective. GPs are notoriously 'time-poor' and this has been consistently found to be a barrier to providing mental health care, as has inadequate mental health training (Hickie 1999, p.171; Ollerenshaw 2009, p.3).

Having already seen that GPs are not necessarily the preferred contact for help, the effectiveness of this central role will be examined from a different

perspective. That is, comparative training of GPs compared with non-medical mental health specialists, primarily psychologists, to determine whether GPs hold this position because they are the best source of assessment and diagnosis.

Mental Health Training and Education

GPs report that they lack the training in mental health to be confident in providing mental health care (Ollerenshaw 2009, p.3). This is pertinent because it is the GPs who must make an assessment and diagnosis of mental illness and ascertain the best course of treatment. With such a pivotal role in the BAI it is reasonable to determine whether GPs are the most suitably qualified mental health diagnosticians. For ease and equivalency of comparison, information regarding course content was obtained from Monash University for both psychology and medicine courses.

Psychology Training Pathways

There are currently two training pathways for eligibility to practice as a psychologist in Australia. Table 6.1 from the APS (Examination of the Current Dual Pathways of Psychology Training 2009, p.12) shows the differences and similarities between these pathways. All psychologists are required to undertake a four-year accredited undergraduate degree in psychology. The fourth year can be an Honours year or a Post-graduate diploma. At this undergraduate level, education is focussed around core discipline knowledge and the international consensus is that professional

training at this level is not practical (Examination of the Current Dual Pathways of Psychology 2009, p.11-12).

Figure 6.5: Comparison of current professional training pathways for registration as a psychologist

	Pathway 1: Workplace supervised practice	Pathway 2: University-based professional course
Entry requirements	<ul style="list-style-type: none"> Accredited Bachelors degree plus accredited 4th year course Character referees Interview conducted by employing agency 	<ul style="list-style-type: none"> Accredited Bachelors degree plus accredited 4th year course with Honours IIA or equivalent results Academic and character referees Interview
Professional training	<ul style="list-style-type: none"> Two-years equivalent Personally selected supervisor approved by the Board in some States Assessment by supervisor Limited specification of required training Professional development required as part of the supervised training program 	<ul style="list-style-type: none"> Two-years equivalent accredited training University supervision Formal assessment processes with quality control Fields of training specified by accrediting body Emphasis on evidence-based training within university course
Coursework	<ul style="list-style-type: none"> Optional 	<ul style="list-style-type: none"> Mandatory
Research training	<ul style="list-style-type: none"> Optional 	<ul style="list-style-type: none"> Research project on applied topic
Minimum duration of training	<ul style="list-style-type: none"> Six years 	<ul style="list-style-type: none"> Six years

Upon completion of the undergraduate degree there is then the option to undertake supervised workplace training or to continue with higher education, which comprises a combination of practical workplace training, practical skills development and research (Examination of the Current Dual Pathways of Psychology Training 2009).

The most comparable pathway in psychology to that of medicine is to undertake the Doctor of Psychology degree. The Doctor of Psychology is four-years full time and includes 1,500 hours (or 188 days) of practical supervised training. In addition, 15 units of mental health specific coursework is undertaken, each unit runs for 13 weeks (Monash University 2011a).

GP Training Pathway

The training pathways for GPs is somewhat more complicated than for psychologists, the entire curriculum will not be reviewed, only the proportion spent on specific mental health training. In the first two years of study, medical students undertake one unit entitled 'Human Behaviour' as part of 15 general units of study. From third year, students are predominately undertaking clinical placements in a variety of settings. One placement is to be undertaken in 'general practice and psychological medicine' (Monash University 2011b). The training and clinical experience undertaken between the second and fourth years of medical school has been shown to increase the ability to recognise mental illness (Hickie, Davenport, Luscombe et al. 2007).

Upon completion of the undergraduate degree junior doctors commence internships or residency, usually within a hospital with a new option of doing a term in general practice. This is followed by three years of specialisation in general practice, with an emphasis on practical experience (Royal Australian College of General Practitioners 2007). The 1999 RACGP Training Program Curriculum outlines 12 priority areas that all registrars must complete, of which mental health is one (Royal Australian College of General Practitioners 2006).

Comparing education and training

Due the vastly different training programs undertaken in order to practice as a General Practitioner or psychologist, real evaluation of the course content is difficult. What is clear is that General Practitioners undertake a greater amount of

overall training, especially in terms of practical experience. However, as would be expected, GPs spend a significantly lower amount of time focussing on mental health and illness. It is clear that GPs have a broader knowledge of health and illness in general, but whether they have received adequate training to be able to provide accurate diagnosis of mental illness is debatable, especially in light of the propensity for inadequate and inaccurate diagnosis (Giese et al. 2008a, p.37).

What is encouraging is the promotion of additional training. A new item number was introduced on 1 January 2010 for those GPs who have not completed accredited Mental Health Skills training (DHA 2010, p.5). The item number (2702) carries with it a lower scheduled fee than for those who have undertaken the mental health training (Medicare Australia 2010b, p.78). The Medicare Benefits Schedule Book 'strongly recommended that GPs providing mental health treatment have appropriate mental health training. GP organisations support the value of appropriate mental health training for GPs using these items' (Medicare 2010b, p.78). There is an implied understanding in this statement that the education completed when becoming a GP may not be sufficient or 'appropriate'¹⁵.

One way to ensure that service users are receiving an appropriate assessment, diagnosis, and treatment plan is to allow psychologists to undertake their own comprehensive assessment and diagnosis. Currently this is only possible in the first session, and only in order to guide treatment provision (Littlefield &

¹⁵ As discussed in chapter 4, GPs were originally required to undertake additional Mental Health Skills Training before being eligible to provide services under BAI but the AMA successfully lobbied to have this made optional.

Giese 2008, p.44). However, it has been noted that there is no evidence to suggest that treatment outcomes improve with greater assessment detail (Carey et al. 2009, p.14). Nor has training been clearly related to improved outcomes in mental health treatment (Carey et al. 2009, p.12). Given the cost of enforcing the GPMHTP as the source of diagnosis, assessment, and treatment under the BAI, it is worth examining whether it is necessary or beneficial to clients. Research has found a significant increase in the number of referrals to mental health specialists since 2001-2002 (McGarry et al. 2009, p.78). This may indicate that GPs want to have less involvement in mental health interventions. This is especially relevant when considering where people seek help. As previously mentioned, 75 per cent of people see their GP for mental health concerns; however, this leaves 25 per cent seeking help from other places. It is important to understand where people seek help, and why they choose that source, in order to understand the role the GP plays in mental health care.

Affordability

The BAI was designed to increase access to mental health care by making services more affordable. Affordability has been examined using bulk billing rates and out-of-pocket costs as this information is particularly relevant when considering low-income earners. This information was obtained from the Utilisation Tables collated by DHA and relates to the period 1 November 2006 to 31 December 2007 (DHA

2008b).¹⁶ The number of services provided to December 2007, the percentage of those services bulk-billed, and the average gap payment were compiled and are shown in Table 6.1 for each of the four most claimed item numbers.

Table 6.1: Bulk billing rates and average out of pocket costs by type of service

Type of Service (item number)	Total No. of Services	Bulk Billing Rate (%)	Average Out-of- Pocket Cost (\$)
GPMHTP (2710)	530, 713	92.5	15.94
GP Mental Health Care Consultation (2713)	452, 937	90.2	18.58
Clinical Psychologist Session (80010)	468, 800	25.9	27.97
Registered Psychologist Session (80110)	935, 983	30.4	33.41

Table one shows that bulk billing rates were highest among GPs who also had the lowest co-payment amount. Psychologists were considerably less likely to bulk bill their patients and the average out of pocket cost was nearly double that of GPs. It should be noted that the GP mental health consultation is only required to be 20 minutes or more. In addition, all services provided by GPs under the BAI receive a Medicare rebate of 100% of the Medicare Scheduled Fee. By contrast, consultations provided by psychologists under these item numbers are required to be in excess of 50 minutes and attract a Medicare rebate of only 85% of the scheduled fee. This may account for some of the disparity in the average out-of-pocket costs.

¹⁶ While data up to May 2009 became available during the course of this research, it was grouped by provider rather than service (item number). As such, it was decided that the older data be used to provide a more reliable picture of the bulk billing rates for the four most commonly accessed services.

There is a strong correlation between socioeconomic status and mental illness, with the risk of mental illness increasing as socioeconomic disadvantage increases (ABS 2010b, p.3). Cost has been repeatedly identified as a barrier to accessing mental health care (Lipsky et al. 2010, p.7; Prins et al. 2010, p.9-10; Quine et al. 2003, p.6). The research undertaken for the PIR also found that stakeholders felt that financial barriers to care still exist under the Initiative due to out-of-pocket costs and low bulk billing rates (DHA 2009, p.21 & 59). While current data relating to bulk billing rates and proportion of health care card (HCC) holders (low income earners) accessing services could not be obtained, we can draw tentative conclusions from older data. There are two ways the data can be examined in terms of affordability: bulk billing rates and out of pocket costs.

Bulk billing rates

Bulk billing rates are important as they measure the proportion of services being provided with little or no charge to the client. In instances of bulk billing, the service provider will bill Medicare directly for the rebate amount, usually 85 or 100 per cent of the scheduled fee (Elliott 2002). For obvious reasons, bulk billing is particularly important for low-income earners and pensioners. Bulk billing represents the most affordable provision of health care due to there being no upfront payment required by the patient and therefore can be used to examine the ability of low-income earners to access services.

There have been discrepancies in the research as to whether the BAI has been effective in reaching low-income earners. These relate specifically to the rates

of bulk billing. A survey by the Australian Psychological Society (APS) found that 62 per cent of clinical psychologists and 48 per cent of registered psychologists surveyed provided bulk billing to their clients (Lindner & Stokes 2007, p.30). However, the data from the Department of Health and Ageing (DHA) shows that an average of only 28.15 per cent of services provided by psychologists were bulk billed (DHA 2008b). Given that DHA use population data obtained from services claimed through Medicare, rather than a sample of psychologists, it is likely that this data more accurately reflects the incidence of bulk billing than the APS findings. It is essential to identify accurate bulk billing rates. Research conducted on Australian adolescents found that the lack of bulk billing in rural areas made seeking health care unaffordable (Quine et al. 2003, p.6). Given the need to encourage this age group to engage mental health services it is important to promote increasing in bulk billing rates among psychologists; however, this is only half the equation, the need to reduce, or eliminate, gap payments is the other.

Out of pocket costs

Out of pocket costs, or co-payments, refer to the amount of money that a client has paid after the rebate from Medicare has been received. In many cases, practitioners charge above the Medicare scheduled fee. Out of pocket costs are therefore not always related to bulk billing rates; research has found that the Northern Territory had both the highest bulk billing rate and the highest out of pocket costs (Elliott

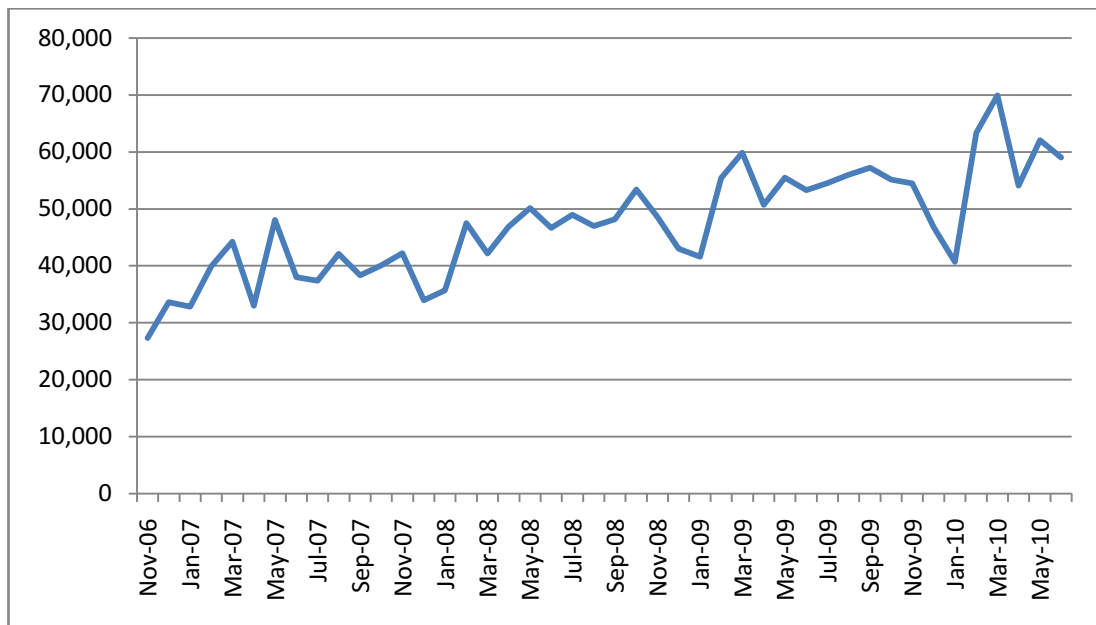
2002).¹⁷ DHA data shows that the average co-payment for mental health care consultations by GPs is \$18.58, while for clinical and registered psychologists it is \$27.97, and \$33.41, respectively. It is important to reiterate that the GP mental health consultations are only required to be at least 20 minutes duration, while the psychologist consultations being used for this analysis are required to be 50 minutes or more. However, the advantages of the 'therapeutic hour' have not been established (Carey et al. 2009, p.13). Carey *et al's* research demonstrates that duration of therapy is not axiomatic of benefit. The other important note on comparing this data is that of the rebate amount. As previously mentioned, GP mental health consultations receive a rebate of 100 per cent of the scheduled fee while the psychologist provided sessions are entitled to a Medicare rebate of only 85 per cent of the scheduled fee (Medicare Australia 2010b). However, this is not to say that this information is not valuable in considering the affordability of these services. For those who have limited funds the co-payment is of great consequence. While there is currently no data for HCC holders, the PIR did reveal that young people (under 25 years) are incurring higher out of pocket costs, on average, than their older counterparts for the same services. This is a concerning trend that DHA has stated will be examined in the full program evaluation (DHA 2009, p.21).

¹⁷ Gap payments refer to the difference between the rebate paid by Medicare and the scheduled fee while the out of pocket cost refers to the difference between the scheduled fee and the amount the practitioner actually charges you (Medicare Australia 2010).

Addition of diagnostic eligibility requirement

When the BAI first came into effect there was no specified restriction on who could receive services under the initiative. However, changes made from 1 July 2009 restricted eligibility criteria. The restriction revolves around the stipulation that GPs must make a clinical diagnosis of mental disorder before a patient can access mental health services. While the reasoning for this has not been stipulated, one can assume that this measure was put in place in an attempt to reduce the escalating costs of the initiative; therefore it seemed plausible that there was a potential to significantly reduce the number of people who would become eligible to receive services. In order to address this question the uptake rates for both GPMHTP items (MBS items 2710 and 2702) were combined. As figure 6.6 shows, contrary to expectation, uptake rates continued to increase after July 2009. In fact, the total number of GPMHTPs provided rose by over 11 per cent from the 2008/09 to 2009/10 financial years. This indicates that the introduction of diagnostic requirement did not impact the accessibility of services.

Figure 6.6: Total number of GPMHTP items provided by month, from November 2006- May 2010¹⁸



Despite the data indicating little or no effect on the provision of services, the impact of this addition should continue to be monitored. The change means that those who are 'sub-threshold', meaning those whose symptoms do not meet the diagnostic criteria, are not eligible to receive treatment under Medicare. This appears to be in contradiction to the third outcome of the Action Plan. Not only does it have the potential to act as a barrier to mental health care, it also takes the focus away from early intervention. People whose symptoms are below the clinical threshold for diagnosis of a mental disorder can still find their symptoms disabling (Issakidis & Andrews 2002, p.154). It is important to ensure that these people are still able to

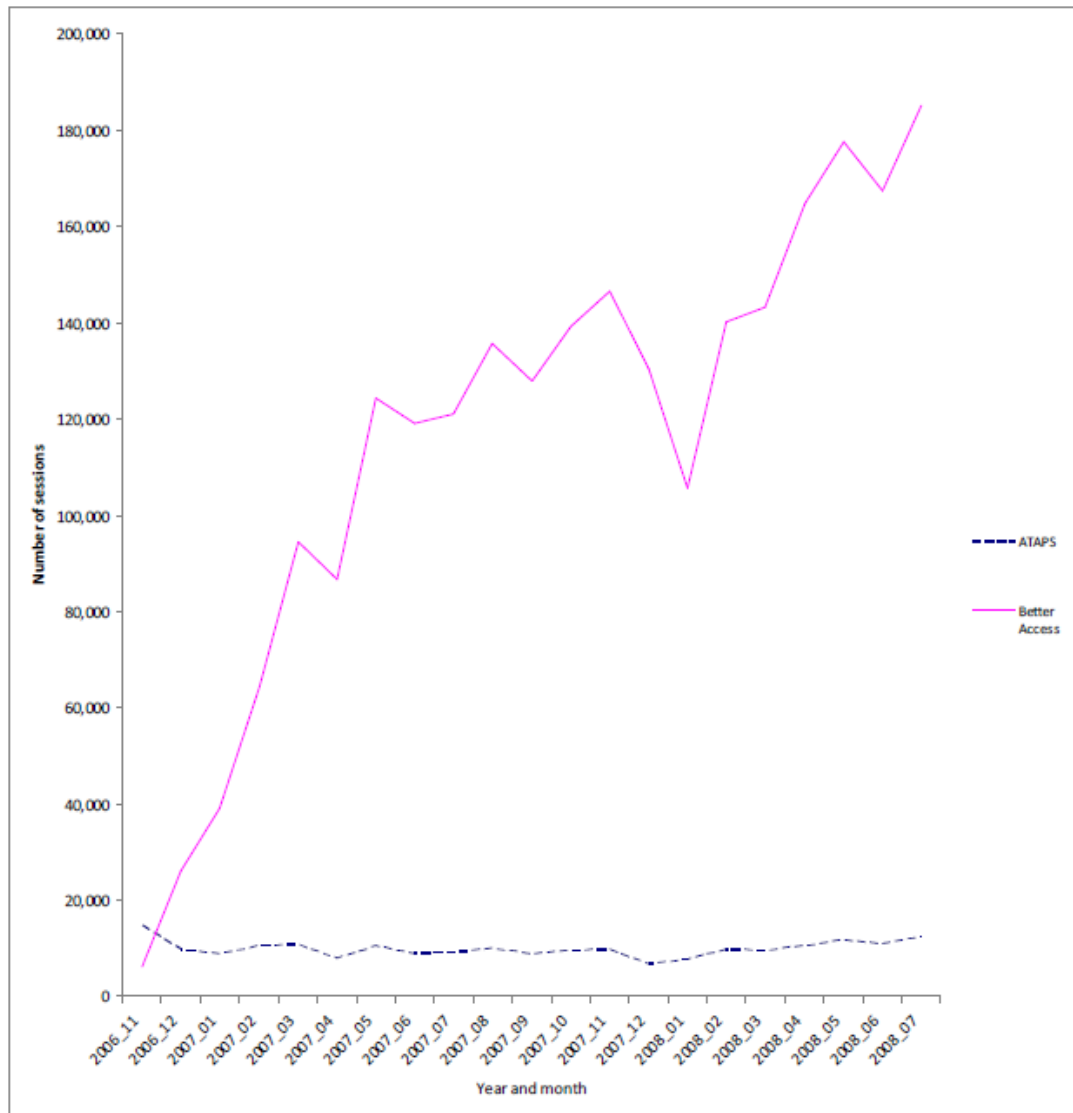
¹⁸ There was a steep decline in the number of services provided in December 2009 and January 2010. However, previous research (Whiteford et al. 2008, p.52) has noted that this corresponds to the traditional summer holiday period and the reduction of services is evident at this time every year.

receive help before their symptoms turn into clinical diagnosis. Research should be undertaken to determine whether an increased number of people suffering sub-threshold symptoms are being excluded from Medicare services on the basis of the diagnostic criteria.

Increasing Access?

Evaluations of Access to Allied Psychological Services (ATAPS), part of the Better Outcomes in Mental Health Care initiative (BOiMHC), have found that in the period from 1 July 2003 to 13 March 2009 a total of 602,405 sessions were provided to 153,922 consumers. This figure has remained relatively stable both before, and after, the introduction of the BAI (Bassilios, Fletcher, Pirkis et al. 2009, p.3, & 11). The number of services provided under the BAI is substantially more than this. Figure 6.7 from the 13th ATAPS Evaluation (Bassilios et al. 2009, p.8) below, shows the number of services provided under each of the BAI and ATAPS initiatives. This table demonstrates that provision of mental health services under government initiatives has increased since the inception of the BAI.

Figure 6.7: Uptake Rates for BAI and ATAPS initiatives



Source: (Bassilios et al. 2009, p.8)

DHA consider this data to be evidence of improved accessibility of mental health care. A survey conducted by the APS found that psychologists believed up to 76 per cent of their clients could not have accessed psychological services without the Medicare rebate (Giese et al. 2008a, p.36)¹⁹.

¹⁹ In evaluating the reliability of this data it should be noted that an increase in demand of this size and rate would have a significant impact on the, particularly psychology, workforce. Assessing the extent to which the workforce has been able to keep up with demand could provide a way to triangulate the data and improve its reliability.

Conclusion

While it is clear that the BAI is enabling the provision of much needed services, it is important that the program is operating effectively. This means ensuring that the groups most at need are specifically targeted. The results identified two groups that may not be receiving appropriate mental health care. As discussed in this chapter, these groups included males, particularly adolescent and young men; as well low-income earners. It is important that further research be conducted to determine how best to reach these groups. Careful and ongoing monitoring is needed to ensure that the requirement of a clinical diagnosis does not jeopardise the ability of those suffering from disabling, yet sub-threshold, symptoms to access early intervention or preventative treatment. This may include further changes to the MBS or expanding the type of providers able to prepare and review Mental Health Treatment Plans. The following chapter will discuss some of the issues raised here in the context of the medicalisation of mental health, and will look specifically at the limitations and implications of this research and suggest possible future directions.

Chapter 7

Medicalisation, Limitations and Future Directions

The previous chapter has shown that the BAI has been successful in providing access to mental health care and the eligibility requirement have not had a negative impact on the number of services being provided. However, certain areas of concern are nonetheless apparent. This chapter will discuss these concerns within the broader perspective of the medicalisation of mental health. After identifying the study's limitations to suggest areas for further research, the evaluations and future directions of the BAI will be reviewed.

Medicalisation of Mental Health

While the Medicare Benefits Schedule has been extended to embrace allied health professionals, including psychologists, social workers and occupational therapists; the centrality of the GP in the process demonstrates that medical model of mental illness still predominates. Only medical professionals can refer a patient to the BAI. As such, mental health remains firmly in the domain of medicine.

All services under the BAI first come through the GP Mental Health Treatment Plan (GPMHTP). Carey and colleagues have questioned the function of the treatment plan on the grounds of whether it requires a complete diagnosis and assessment, or simply a referral (Carey et al. 2009, p.14). The GPMHTP is the core

aspect of the operation of the BAI (COAG 2006). As such, Carey *et al.* argue that the GPMHTP actually reinforces the problem of stigmatisation of mental illness, as it requires that a diagnostic label be placed on all those who wish to receive help (2009, p.14). The problem of stigma, discussed in chapter 6, is that it acts as both a deterrent to seeking mental health care, as well as being potentially damaging to clients (Scott 2010, p.27). It is not just public perceptions of mental health and illness that need to be attended to through the awareness campaigns being run under the Action Plan. Chapter 6 showed how cultural expectations of masculinity in Australia prevent men from seek help. This highlights that equal, if not greater importance, should be placed on targeting any cultural perceptions of what it means to be male. By challenging these perceptions the barriers to accessing mental health care among men can be diminished. Further research should be conducted to determine the best way to overcome these barriers.

Additionally, while the GPMHTP privileges GPs diagnostic abilities, the evidence does not support this faith. The concept of the medical profession being more highly skilled was examined through training and education requirements for GPs and psychologists. It was found that, as expected, while GPs had a significantly broader knowledge base and far more extensive practical training, the amount of mental health specific training was substantially less than psychologists. Even Medicare recognise the benefits of additional mental health skills training for GPs. Were it not for the intervention of the AMA, this additional training would be compulsory for all GPs wanting to provide BAI services. This seemingly confirms the notion of medical dominance. Through the GPMHTP GP are afforded a level of

authority despite research that suggests that the majority of GPMHTPs contain incorrect or inadequate diagnostic information (Giese et al. 2008b, p.37). It seems reasonable then to propose that restrictions on the preparation and review of mental health treatment should be lifted.

The third related way in which BAI contributes to the medical dominance of mental health relates to the way that the scheduled fees and rebate amounts have been set up through Medicare. The results show comparatively lower rates of bulk billing and higher out of pocket costs among psychologists compared with GPs. GPs consultations, both for the initial GPMHTP and any subsequent mental health consultation are entitled to a rebate through Medicare of 100 per cent of the scheduled fee. By comparison, psychological services are entitled to a rebate of only 85 per cent of the scheduled fee (Medicare Australia 2010b, p.155-157). This discrepancy is also apparent when the scheduled fees for the four most commonly accessed services: GP Mental Health Care Consultation (item 2713); Extended Psychological Therapy Service by a Clinical Psychologist (item 80010); Extended Focussed Psychological Strategies Service by a Registered Psychologist (item 80110); and the GPMHTP (item 2710) are reviewed. As the required duration for each type of service is different (psychology sessions being 50 minutes or longer, while GP Mental Health consultations being just 20 minutes or more) the cost has been calculated on a per minute basis. There is no required duration for the GPMHTP so it has been based on a 20 minute consultation. If it is assumed that the amount payable on a per minute basis reflects the value placed on the services provided then GPs are well ahead. For a mental health consultation they receive \$3.53 per

minute based on the scheduled fee. By contrast, clinical psychologists receive \$2.77 per minute and registered psychologists just \$1.89 per minute. The most surprising allocation of funds is for the GPMHTP for which GPs receive \$8.02 per minute, based on a 20 minute consultation (Medicare Australia 2010b, p.155-157). While these fees do not include any time for post-consultation administration, it is nonetheless a stark comparison.

The differences in scheduled fee is even more compelling, especially for the GPMHTP, when research by the Australian Psychological Society (APS) is considered. Their research found that 27 per cent of GPMHTPs contained an inaccurate diagnosis; and 33 per cent of psychologists felt the GPMHTP was missing crucial information. A full re-assessment and diagnosis was required for 86 per cent of cases referred under the BAI (Giese et al. 2008b, p.37). The validity of the GPMHTP should therefore be questioned as it appears not to be fulfilling its, admittedly ill-defined, purpose.

This is not to say that the BAI has not made great strides in challenging the medical dominance of mental health. On the contrary, the recognition of no less than four categories of non-medical mental health specialists (Whiteford et al. 2008, p.51) demonstrates the extent to which the medical model is being challenged and broken down. However, the construction of the initiative around the GPMHTP can be seen to be reinforcing the idea that medicine is the dominant and most suitable profession for handling mental illness. Recent research by Dempsey and Donaghue found that GP criticisms of the Medicare changes were related to 'the bureaucracy of the GP mental health care plans' with the major issue being 'GP

workloads and increased burden of paperwork' (2009, p.288). It seems an unsatisfactory process all round.

A note on method and limitations

Several limitations of the study must be identified. It is difficult to say with certainty that more people are accessing mental health services under the BAI than were previously. Prior to the BAI there were no distinct MBS item numbers used for referrals to allied health items. Patients were referred under normal GP consultation items (Bassilios et al. 2009, p.14). In addition, it was, and still is, possible to go directly to a psychologist without a referral; however, this means that the services are not eligible for the Medicare rebate. As such, the only relevant data available is that from the ATAPs program. This shows that services under ATAPS have remained steady, while the BAI scheme has increased. While tempting to accept this in combination with the magnitude of the number of people accessing services, as definitive proof that mental health care has become more accessible, it would be inaccurate. The use of incomparable data sets has been identified elsewhere as requiring caution when extrapolating from results (Jorm & Butterworth 2006, p.47-48). In addition, the large sample sizes can produce false positive results requiring caution when interpreting the data comparisons (Bassilios et al. 2009, p.11).

As previously discussed, uptake rates are widely used in the literature and are accepted as reflecting an increase in services. However, there is a distinct lack of

literature regarding the demand problems that the psychology profession must surely be facing if the number of patients they see has increased to the same or similar degree as uptake rates. A survey conducted by the APS states that 72 per cent of clients seen by psychologists under the initiative had never been to a psychologist before (Giese et al. 2008b, p.36). Yet there is relatively little research on whether the existing workforce is coping with this rapid rate of growth, although some concerns have been raised with DHA (2009, p.36). This may indicate the increase in service users is not quite as dramatic as the numbers alone imply.

Conclusion

The comparatively higher out of pocket costs, and lower bulk billing rates for psychological services suggests that the BAI, while privileging General Practice on the one hand, may actually be doing them a general disservice on the other. Research tells us that cost can reduce the type of treatment options available.²⁰ As such, the financial barriers to mental health care have not been fully addressed by the BAI. One possible outcome is a greater reliance on General Practitioners for mental health care. Several ways to increase bulk billing rates have been suggested, including increasing the rebate available to psychologists to 100 per cent of the scheduled fee; increasing the scheduled fee; and providing financial incentives for bulk billing (Littlefield & Giese 2008, p.47).

²⁰ This appears to contradict the Mental Health Statement of Rights and Responsibilities, which states that patients need to have choice in their treatment (Mental Health Consumer Outcomes Taskforce 1991)

The BAI was examined through the role of the General Practitioner (GP) to determine whether it was set up in a way that amounts to best practice. Exploration of their role has shown that while they are undoubtedly an integral part of mental health services, it may be beneficial to decrease their role as sole point of entry. The legacy of medical dominance over mental health can be seen in the requirement that a GP conduct a mental health treatment plan. This is potentially restricting the efficiency of the initiative and limiting the choices available to patients about the types of treatment available by making GP consultations more financially attractive. It is worth considering whether enabling psychologists to receive rebate rates of 100 per cent of the scheduled fee or provide services without a GPMHTP would relieve the pressure on GPs and potentially reduce the cost of the initiative. In order for the BAI to claim success it must ensure that the most vulnerable to both mental illness and financial barriers have not just the ability to access services but actually utilise those provided. Without reaching these vulnerable groups, like low income earners and young men, the BAI should not claim to be achieving its goals.

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Appendix A

GP Mental Health Treatment Plan Template from Monash Division of General Practice

GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710 / 2712) PATIENT ASSESSMENT			
Patient's Name	<<Patient Demographics: Full Name>>	Date of Birth	<<Patient Demographics: DOB>>
Address	<<Patient Demographics: Full Address>>	Phone	<<Patient Demographics: Phone (Home)>>
Carer details and/or emergency contact	<<Carer and/or emergency contact>>	Other care plan e.g. GPMP / TCA	<<Other care plan eg GPMP/TCA>>
GP Name / Practice	<<Doctor: Name>> / <<Practice: Name>>		
AHP or nurse currently involved in patient care	<<AHP or nurse involved in patient care>>	Medical Records No.	<<Patient Demographics: Record Number>>
PATIENT CONSENT Patient has agreed to GP Mental Health Care Plan service	<<Patient agrees to GP MHCP service>>		
PRESENTING ISSUE(S) What are the patient's current mental health issues?			
PATIENT HISTORY Record relevant biological developmental history psychological and social history including any family history of mental disorders &/or substance use substance use history (incl drugs & alc) physical health problems	Clinical History: Family History: <<Clinical Details:Family History>> Social History: <<Clinical Details:Social History>>		
MEDICATIONS (attach information if required) <<Clinical Details:Medication List>>			
ALLERGIES			
ANY OTHER RELEVANT INFORMATION			

RESULTS OF MENTAL STATE EXAMINATION			
Record after patient has been examined			
	General Appearance and Behaviour		
	Speech (rate, volume, tone, quality)		
	Mood (depressed/ labile)		
	Affect (flat/ blunted)		
	Thought (content/ rate/ disturbance/ stream/ possession)		
	Perception (hallucinations, illusions etc)		
	Cognition (level of consciousness/ delirium /intelligence)		
	Attention/Concentration		
	Memory (short and long term)		
	Orientation (time / place / person)		
	Insight (understanding of their illness)		
	Judgment (ability to make rational decisions)		
RISKS AND CO-MORBIDITIES			
Note any associated risks and co-morbidities including suicidal tendencies and risks to others			
	Associated Risk		
	• suicide ideation		
	• suicide intent		
	• current plan		
	• access to means		
	• risk to others - neglect - violence / aggression etc		
	Assess co-morbidity		
Outcome Tool Used:		Results:	
DIAGNOSIS			

GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710 / 2712)					
PATIENT PLAN					
PATIENT NEEDS / MAIN ISSUES	GOALS Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take.	TREATMENTS Treatments, actions and support services to achieve patient goals.		REFERRALS Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.	
CRISIS / RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention.					
APPROPRIATE PSYCHO-EDUCATION PROVIDED	<<Appropriate Psycho-education provided>>	PLAN ADDED TO THE PATIENT'S RECORDS	<<Plan added to patient's records>>	COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS	<<Copy of plan offered to other providers>>
COMPLETING THE PLAN On completion of the plan, the GP is to record that s/he has discussed with the patient: -the assessment; -all aspects of the plan and the agreed date for review; and -offered a copy of the plan to the patient and/or their carer (if agreed by patient)			<<Assessment discussed>> <<All aspects of plan and review date discussed>> <<Copy of plan offered to patient and/or carer>>		
DATE PLAN COMPLETED: <<Date plan completed>>			REVIEW DATE: <<Review date (initial review in 4 weeks to 6 months)>> (initial review 4 weeks to 6 months after completion of plan)		
REVIEW - MBS ITEM 2712 Note: If required, a separate form may be used for the Review. PATIENT CONSENT Patient has agreed to GP Mental Health Care Plan Review service			OUTCOME TOOL RESULTS ON REVIEW		
REVIEW COMMENTS (Progress on actions and tasks)					

Source: (Monash Division of General Practice 2006)

GP Mental Health Treatment Plan template from Sutherland Division of General Practice

SUTHERLAND MENTAL HEALTH ASSESSMENT			
Patient Name		Date of Birth	
Address			
Post Code	Phone	Gender	
Aboriginal or Torres Strait Islander origin	No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Unknown <input type="checkbox"/>		
GP		Practice P'code	
Date of Assessment	Outcome Tool	Result	
Description of Presenting Complaint / Problem			
Mental Health History / Treatment		Family History of Mental Illness	
Social History (including substance, or other, abuse) including Current Relationships, Job			
Is the person a low income earner? (A judgement by GP): Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			
Current Medications		Relevant Medical Conditions / Investigations / Allergies	
Mental Status Examination (Please indicate relevant details)			
Appearance and Behaviour		Mood	
Thinking		Affect	
Perception		Sleep	
Anhedonia		Appetite	
Attention / Concentration		Motivation / Energy	
Memory		Judgement / Insight	
Orientation		Speech	
Risk Assessment (if answer is Yes to plan, intent or risk to others refer to ACCESS Team, TSH, on 9540 7474)			
Suicidal thoughts		Suicidal intent	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Current plan		Risk to Others	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	
ICD – 10 Provisional Diagnosis		Patient is suitable for:	
F1 Alcohol & Drug Use disorder <input type="checkbox"/>		Depression group <input type="checkbox"/>	
F2 Psychotic Disorder <input type="checkbox"/>		Panic and avoidance group <input type="checkbox"/>	
F3 Depression <input type="checkbox"/>		Co-morbidity group <input type="checkbox"/>	
F4 Anxiety Disorder <input type="checkbox"/>		Individual therapy <input type="checkbox"/>	
F5 Unexplained Somatic Disorder <input type="checkbox"/>			
Other / Unknown:			
Has the patient signed consent for GP and psychologist to share clinical information?			Yes <input type="checkbox"/> No <input type="checkbox"/>

Source: (Sutherland Division of General Practice 2006)

GP Mental Health Treatment Plan from Department of Health and Ageing

GP MENTAL HEALTH CARE PLAN (MBS ITEM NUMBER 2710) PATIENT ASSESSMENT			
Patient's Name		Date of Birth	
Address		Phone	
Carer details and/or emergency contact(s)		Other care plan	YES <input type="checkbox"/>
GP Name / Practice		Eg GPMP / TCA	NO <input type="checkbox"/>
AHP or nurse currently involved in patient care		Medical Records No.	
PRESENTING ISSUE(S) What are the patient's current mental health issues			
PATIENT HISTORY Record relevant biological psychological and social history including any family history of mental disorders and any relevant substance abuse or physical health problems			
MEDICATIONS (attach information if required)			
ALLERGIES			
ANY OTHER RELEVANT INFORMATION			
RESULTS OF MENTAL STATE EXAMINATION Record after patient has been examined			
RISKS AND CO-MORBIDITIES Note any associated risks and co-morbidities including risks of self harm &/or harm to others			
OUTCOME TOOL USED	RESULTS		
DIAGNOSIS			

GP MENTAL HEALTH CARE PLAN (MBS ITEM Number 2710)			
PATIENT PLAN			
PATIENT NEEDS / MAIN ISSUES	GOALS Record the mental health goals agreed to by the patient and GP and any actions the patient will need to take	TREATMENTS Treatments, actions and support services to achieve patient goals	REFERRALS Note: Referrals to be provided by GP, as required, in up to two groups of six sessions. The need for the second group of sessions to be reviewed after the initial six sessions.
CRISIS / RELAPSE If required, note the arrangements for crisis intervention and/or relapse prevention			
APPROPRIATE PSYCHO-EDUCATION PROVIDED YES <input type="checkbox"/>	PLAN ADDED TO THE PATIENT'S RECORDS	YES <input type="checkbox"/> NO <input type="checkbox"/>	COPY (OR PARTS) OF THE PLAN OFFERED TO OTHER PROVIDERS
NO <input type="checkbox"/>			
COMPLETING THE PLAN On completion of the plan, the GP is to record that s/he has discussed with the patient: the assessment; all aspects of the plan and the agreed date for review; and offered a copy of the plan to the patient and/or their carer (if agreed by patient)			
DATE PLAN COMPLETED	REVIEW DATE (initial review 4 weeks to 6 months after completion of plan)		
REVIEW COMMENTS (Progress on actions and tasks) Note: If required, a separate form may be used for the Review.		OUTCOME TOOL RESULTS ON REVIEW	