



**Department of Human Services**

# South West Mental Health Mapping Project Summary Report

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## Abbreviations

BOIMHC	Better Outcomes in Mental Health Care program
DHS	Department of Human Services
EAP	Employee Assistance Program
EFT	Effective Full Time
GP	General Practitioner
LGA	Local Government Area
MBS	Medicare Benefits Schedule
ODGP	Otway Division of General Practice
PCP	Primary Care Partnership
SWHC PMHT	South West Health Care Primary Mental Health Team

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## Executive Summary

The Southwest Victoria Mental Health Mapping Project sets out to identify the level, accessibility and effectiveness of mental health services for high prevalence disorders amongst the adult population in the region. In response to this information possible actions are proposed that could improve outcomes for the community.

The study focuses on the high prevalence psychological disorders of depression and anxiety in adults aged 18-65 living in the five municipalities of Southwest Victoria, an area generally coinciding with the Otway Division of General Practice (ODGP).

**This report provides a summary of the main activities and findings of the project. For any further detail, please see the South West Victoria Mental Health Mapping Project Final Report.**

Within the project:

- Data have been collected on the number and location of relevant health professionals across the region.
- A substantial telephone survey of 1297 people selected randomly from the community of Southwest Victoria was undertaken to provide a social network analysis of primary contact points. This survey resulted in contact with 275 people with recent use of services for high prevalence mental health issues.
- In-depth qualitative interviews were conducted with 25 mental health services recipients.
- A survey of 37 health care professionals from relevant disciplines in the region was used to identify issues from the service provider perspective.
- The data collected were reviewed by a reference group of relevant health care providers and selected key informants to consider recommendations for possible future action.

The project reveals that there is a broad range and reasonable distribution of relevant services across the region but these are present in levels that are substantially below those in major cities.

The centrality of general practitioners (GPs) as the initial identifying, diagnosing and treatment agents is confirmed. This fact raises related concerns – whether, as time limited professionals, they have the capacity to respond appropriately, or the time to maintain their level of knowledge of mental health issues without systematic expansion of the teams around them including the Primary Mental Health Team (PMHT) of South West Health Care (SWHC).

The social network analysis arising from the consumer telephone survey also demonstrates the wide range of other agencies that become involved in supporting people with mental health issues. This correlates with the primary barriers identified by people requiring assistance – a lack of mental health education and knowledge of where to go for help. The lack of knowledge about available services appears to also extend to many of the service providers themselves.

There is a reasonable range of mental health professionals across the region, but recruitment and retention of appropriate people is considered to be a problem which contributes to the fragility,

and sometimes lack of continuity, of services. Federal initiatives need to be matched by State and locally funded services.

Overall there is some concern amongst consumers about the stigma of mental illness and access to services in the region within an acceptable timeframe and at manageable cost. The level of tolerance of delays in gaining access to services and a preparedness to travel within the region was higher than might have been expected.

The data indicate that there has been substantial uptake of the new Medicare Benefits Schedule (MBS) Better Access items. These data are not available by Local Government Area (LGA) level and do not show whether increased take up is due to increased levels of service provision or, at least in part, a displacement of services previously funded privately or through other MBS items.

Several recommendations are proposed:

- Mental health promotion leading to improved community awareness of symptoms of mental distress, actions that can be taken and that Medicare support is available.
- With the limitations on GP time, practices need to be encouraged to make greater use of practice nurses and/or mental health nurses to provide primary diagnoses and draft Mental Health Care Plans.
- Consistent with a growing body of evidence illustrating the benefits of collaborative multi-disciplinary care, GP clinics should be encouraged to consider co-location with other health care professionals from a range of disciplines including psychology, social work and mental health trained practice nurses, in their practices.
- An example of collaborative care and successful co-location of mental health practitioners in GP Clinics in South West Victoria exists with SWHC's PMHT and GPs. This example of collaboration and co-location is considered worthy of expansion.
- Given the acceptance and success of group therapy sessions, greater use should be made of these both as a component of treatment and in the form of peer support groups for on-going mental health maintenance.
- Given the importance of having GPs skilled in the detection and primary treatment of these high prevalence disorders, encouragement to undertake relevant professional development activity needs to be provided.
- Expansion of the services offered by the PMHT – or a similar model involving different agencies - and of community counselling services, would address availability and cost issues in accessing services.

## Project Objectives

The four objectives of the project are:

- Identify the capacity and structure of the current service system for depression and anxiety
- Assess the impact of the new MBS items for mental health care and other relevant MBS funded services

- Identify referral pathways, service gaps, barriers and enablers to service utilisation
- Put forward recommendations for improvements in service delivery

## **Objective 1. Identify the capacity and structure of the current service system for depression and anxiety**

### **Methodology**

Known service providers and project stakeholders were asked about their services, and acted as key informants. These primary discussions provided information about further possible service providers and about directories listing services which could be accessed.

Information from a paper-based Primary Care Partnership (PCP) directory was accessed (Southern Grampians and Glenelg PCP, 2003), together with a search of web based services directories. Services listed in these were cross checked against existing information and against each other. Professional body directories were also accessed. The web search included; DHS Victoria's on-line directory at Better Health Channel, directing people to services in their area; Australian Mental Health Services Reference Guide; [www.goodtherapy.com.au/location](http://www.goodtherapy.com.au/location) - online directory; Commonwealth Carelink Service Directory; and the Australian Psychological Society Find a Psychologist [www.psychology.org.au/FindaPsychologist](http://www.psychology.org.au/FindaPsychologist).

Additional scoping was done by looking up counselling and psychological services in the Telstra White and Yellow Pages. Those within the region were included. Individual service providers were contacted towards the end of the project period to check the current accuracy of information.

## Findings

Service providers were found in four categories: public sector, private sector, community sector and work place related.

Table 1 below shows the number of different service providers in each main town in the project region. The asterisk (\*) represents those services provided on a part time basis.

**Table 1 – Service Providers for Depression and Anxiety**

Town	GPs	Clinical Psychologist	Registered Counselling Psychologist	Community Service	Private Psychiatrist	Private Social Worker	SWHC PMHT	EAP	Private Counsellor
Camperdown	6	1*	1*					2+	
Mortlake	1			1*					
Terang	5			1*				1	
Timboon	3					1*		1	
Cobden	3								
Hamilton	16		1*					2+	1
Coleraine/ Casterton	5								
Penshurst	2								
Portland	10			5*				5+	1
Macarthur	1								
Heywood	2			1*					
Koroit	1*								
Port Fairy	5*							2+	
Warrnambool	40	2	12	11	1.5	2*	5.5	10+	1

The next figure represents the number of services found in each location throughout the project region. The asterisk (\*) refers to a part time service.

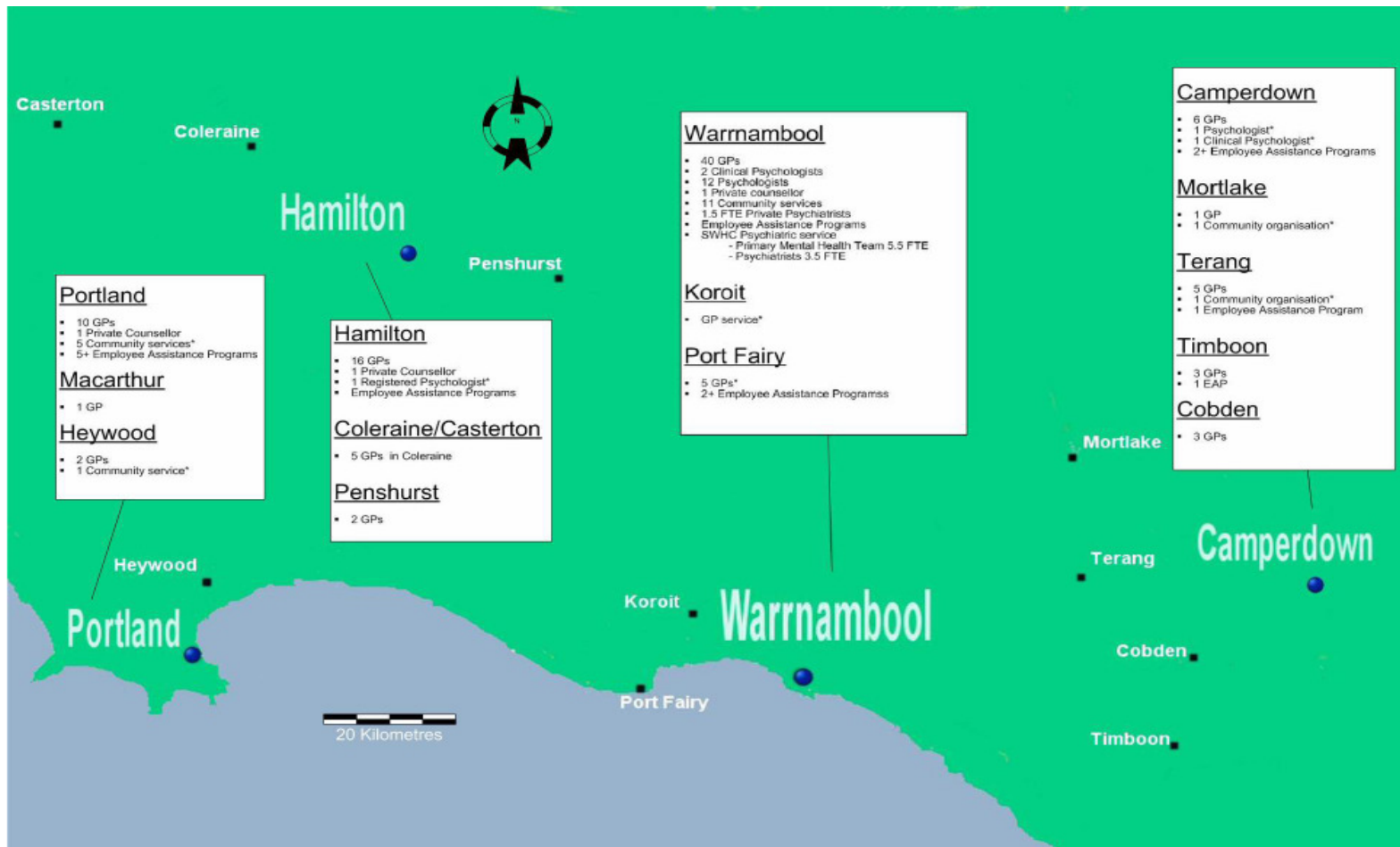


Figure 1 – Geographic distribution of services for depression and anxiety in the project region

In the project area there are approximately 100 General Practitioners (GPs) translating to approximately 1 GP per 1,410 people which is only slightly poorer coverage than the national average of 1 GP per 1403 people (PHIDU, 2005).

With psychologists, however, the picture is quite different. The Otway Division region accounts for 2.4% of the State's population and but has only 1.2% of psychologists registered in Victoria (APS, 2007 & ABS, 2006). This translates to one psychologist for each 5,852 of the population compared with 2,200 people per psychologist in the Melbourne metropolitan area.

A significant number of community based service providers, counsellors and social workers were identified, but there was no basis by which the level of these services could be compared with those available in other regions.

So while the region is relatively well serviced by GPs, in comparison to the Melbourne metropolitan area there are relatively fewer psychologists per capita. Some of this shortfall may be being compensated by other services.

## Discussion

The project region has a variety of services for depression and anxiety, some of which are available at no cost or at a subsidised cost. There is reasonably wide coverage throughout the area, however, most of the services are concentrated in the largest urban centre of Warrnambool. While it can be argued that the 'Warrnambool centric' nature of the service system in the Southwest may be justified because of the population base, in terms of access it does provide a barrier to those in outlying areas.

It is possible to access GP services at a wide range of locations and counselling services at a number of larger centres. However, outside of Warrnambool, the part time nature of many services and lack of specialist services can provide barriers to people accessing the service when they need it.

Several private service providers work in local health centres or GP clinics in order to provide a part time service to medium sized towns. Community health centres also provide a platform to offer counselling services in centres outside Warrnambool. South West Health Care's Primary Mental Health Team (PMHT) offer services both inside and outside of Warrnambool and at no cost, however they are limited to 5.5 EFT staff.

GPs are the largest group of providers. While they are distributed more widely through the Southwest than other types of providers, it needs to be understood that GPs do not have a uniform interest, or capacity, in the treatment of high prevalence psychological disorders. After GPs, private psychologists are the next biggest group of service providers. The relatively low availability of psychologists has an impact on waiting times and cost. Psychologists in the study region charge on average \$120 per session and even with Medicare subsidies, consumers can still be \$40 out of pocket per session.

While the overall number of psychologists in the region is relatively low, this shortfall is accentuated by the fact that there are only two clinical psychologists practising in the project area. Adding to the problem, there are 1.5 full time equivalent psychiatrists in private practice for the whole region. This highlights the lack of specialist clinical psychologist and psychiatrist services in the South West Victoria.

Another positive aspect of the service ‘system’ in the Southwest is that it is possible to access services which are of no cost to the consumer (for example, from the two private social workers that bulk bill) or which are priced according to the capacity of the consumer to pay (for example, at Centacare). Conversely some of the service providers charge fees that involve a significant gap payment.

The experience gained during this project in seeking to find current information regarding the availability of different services indicated that while there were many sources of information about what services are available, most of these were not completely up to date. One example of this was the GP practice profiles on the Otway Division of General Practice (ODGP) website, which supplied several out of date contact details. This has implications for consumers seeking information about where to access services as finding inaccurate information may discourage them in their search for a suitable service provider. It also has implications for service providers who may be looking for referral options for their consumers.

**The research shows there are a variety of services which are available for high prevalence psychological disorders, both in the public and private sector, and at a range of costs. GPs provide the most available services, but they are not evenly distributed throughout the region, which affects access by consumers. Counselling psychologists are available, but specialist services – clinical psychologists and psychiatrists in private practice – are extremely limited. This indicates a need for greater provision of services in the public and community sectors. Existing services in these sectors are prone to being overwhelmed. Many community services are part time, and may not specialise in high prevalence disorders. Recruitment and retention of suitably qualified and experienced staff are ongoing problems. (Please refer to the recommendations under Improved Service Provision in this report).**

## **Objective 2. Identify the Impact of the New Medicare Benefits Schedule Better Access Items and Other Relevant MBS Items on Mental Health Care**

### **Methodology**

Information about the new MBS Better Access program was obtained from several sources including the Department of Health and Ageing, the Australian General Practice Network and the ODGP. Information obtained from a community survey conducted in the region (see Objective 3, page 16) was also drawn upon in testing regional awareness and uptake of these Items.

Medicare statistics were accessed to highlight uptake of new MBS Better Access item numbers over the period November 2006 to March 2008. Unfortunately, access to statistics relating to geographic areas smaller than State level was not given, despite repeated requests to Medicare and the Commonwealth Department of Health and Ageing.

A study of the impact of Better Access in the first six months of the program was accessed, along with evaluations of several projects of the forerunner to Better Access, Better Outcomes In Mental Health Care (BOIMHC).

## Findings

For the purposes of this project we concentrated on the three most commonly accessed MBS item numbers for mental health. These are:

- Item 2710 – the GP Mental Health Care Plan consultation and preparation
- Item 80010 – 50+ minutes session with a Clinical Psychologist
- Item 80110 – 50+ minutes session for focussed psychological strategies with a Registered Psychologist

Uptake of these three items has been high Australia wide and Victoria has recorded the highest uptake per capita. Table 1 below shows the number of 2710 Medicare items processed in the period November 2006 – March 2008. (Please note, further graphs and tables showing uptake of items by State, by gender, by age, by State Medicare contribution, per capita, by Medicare contribution per capita and per month are contained in Appendix 9 of the Final Report.)

Women in the 25 – 44 year age group are the greatest beneficiaries of the new MBS items. In particular, women between the ages of 35 – 44 made up the group who were accessing the most services for all three items. This was followed for all three items by women in the 25 – 34 years category. Men have recorded significantly fewer consultations. Indeed, for items 2710, 80010 and 80110 use by women outnumbers men two to one.

While prevalence of depression and anxiety is generally higher in women than men, (National Health Survey 2004-5) the Mental Health Council notes that 75% of mental disorders appear before the age of 25, yet the data show that this group have not made significant use of these new items (Crosbie and Rosenberg, 2007). Men 24 years and under made up the groups with least uptake of these services. The extensive consumer survey conducted in this project generally supports these figures in both gender and age groups. The survey data shows that of the total number of respondents who sought assistance, 25.8% were men and 74.2% were women, though the data are not sufficient to allow closer analysis. (Please see Chapter 6 of the Final Report for more details of the consumer survey.)

Tables 2 and 3 below show the uptake of various item numbers Statewide and in the ODGP for the period November 2006 – December 2007. MBS statistics are not available by Local Government Area (LGA). Of the 155,036 Mental Health Care plans prepared in Victoria during the period November 2006 – December 2007, 2,579 (1.6%) were prepared by 102 GPs in the ODGP. Given that the region has 2.4% of the State's population this figure represents a lower than State average use of the Item. However, over the five quarters when figures were available for the ODGP, the number of Mental Health Care plans prepared by ODGP GPs grew steadily from 264 in Quarter 4 of 2006 (not a full quarter) to 634 in Quarter 4 of 2007. The number of GPs using the Item also doubled over this period with effectively all the region's GPs using the Item in the last quarter.

The consumer survey conducted in this project shows that of the 82% of respondents who sought assistance from a GP for depression or anxiety in the first instance, 14.9% reported being referred or directed on to a psychologist in private practice. The data do not show what proportion of these were MBS Better Access referrals, however it is inferred that most of these consumers were benefiting from subsidised sessions. A significant proportion (12.1%) of those presenting to GPs reported being referred or directed to either Psychiatric Services Primary Mental Health Team or to a Community Health service. (Please see figure 6 in Chapter 6 of the Final Report)

Table 2 Item Number 2710 – the GP Mental Health Care Plan

**Item 2710 – GP Mental Health Care Plan - Number of 2710 Medicare items processed from October 2006 to March 2008 by State**

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	Services	Services	Services	Services	Services	Services	Services	Services	Services
<b>2710</b>	227,753	189,971	115,590	39,819	56,779	14,147	9,468	2,469	655,996

Source: [https://www.medicareaustralia.gov.au/statistics/mbs\\_item.shtml](https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml) Accessed June 11, 2008

Table 3 – MBS Uptake Figures in the Otway Division of General Practice by Year and Quarter

		Services	\$ Benefit	Practitioners	
<b>2710</b>	<b>Preparation of a GP mental health care plan</b>	<b>2006Q4</b>	264	39,612	54
		<b>2007Q1</b>	511	76,662	73
		<b>2007Q2</b>	541	80,958	90
		<b>2007Q3</b>	629	94,350	96
		<b>2007Q4</b>	634	96,442	102
<b>2712</b>	<b>Review of a GP mental health care plan</b>	<b>2007Q1</b>	40	4,000	14
		<b>2007Q2</b>	111	11,100	41
		<b>2007Q3</b>	149	14,922	45
		<b>2007Q4</b>	214	21,760	53
<b>2713</b>	<b>Attendance in relation of a GP mental health care plan</b>	<b>2006Q4</b>	88	5,808	19
		<b>2007Q1</b>	218	14,399	23
		<b>2007Q2</b>	295	19,470	33
		<b>2007Q3</b>	387	25,542	40
		<b>2007Q4</b>	454	30,364	44
<b>2721</b>	<b>Surgery Consultation (Mental Health Care Initiative)</b>	<b>2006Q4</b>	*	*	*
		<b>2007Q1</b>	*	*	*
<b>2725</b>	<b>Surgery Consultation (Mental Health Care Initiative)</b>	<b>2006Q4</b>	*	*	*
		<b>2007Q1</b>	*	*	*

\* Indicates a figure suppressed for confidentiality reasons, and not included in totals.

Source: [http://www.medicareaustralia.gov.au/statistics/dyn\\_mbs/forms/mbsgtab4.shtml](http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbsgtab4.shtml). Accessed April 13, 2008

## Discussion

Overall, the MBS Better Access item number figures nationally, statewide and regionally, show there has been significant uptake of the new mental health item numbers, and therefore access to psychological services for high prevalence disorders has increased. In the project region there has been a relatively significant uptake of the Better Access item numbers relating to the preparation of the GP Mental Health Care plan (compared to other item numbers). These figures suggest that increased and increasing access to services for depression and anxiety has resulted from the uptake of the Better Access items.

The general data show that there is an imbalance between men and women in using the item numbers. Women are using the services made available through the item numbers in much greater numbers than men. This may reflect a higher prevalence rate among women and therefore, greater demand for depression and anxiety services. It may also reflect a tendency among men not to seek help for their problems.

The Mental Health Council of Australia report (Crosbie & Rosenberg 2007) argues that the initiative is only having a real impact in metropolitan areas. Given that most psychologists are located in metropolitan areas, most psychological services are delivered in the metropolitan areas (Dunbar, Hickie, Wakeman & Reddy, 2007). In the project region, the figures suggest that uptake, while growing, is still below the national and statewide averages. However the regional workforce of two clinical psychologists, 18 MBS registered psychologists and two MBS registered social workers limits the number of services that can be provided under the Better Access program. It is important to note this, as the assumption could be made that since regional and rural areas have a nominally increased access to mental health services under the Better Access program, although a lower uptake rate, the level of funding for community mental health services need not be continued at existing levels (Crosbie and Rosenberg, 2007). In fact the limitation of available referral services under the MBS program means that more people are seeking support from community health and other non-MBS funded sources.

Another possible impact being proposed of the Better Access program is that psychologists, social workers and occupational therapists will move from the public to private sector to take advantage of the increased access to their private services (Crosbie & Rosenberg, 2007, van Gool, 2007), thereby disadvantaging access through the public system. In fact in the project region, only one social worker has left Psychiatric Services at Southwest Healthcare and moved into private practice.

The issue of fees needs to be noted. While the involvement of private providers able to set their own fees beyond the MBS schedule (Van Gool, 2007), may encourage higher throughput of services, the issue of gap payments for sessions with psychologists may also become an issue for consumers. There is no way of knowing what uptake would have been had service fees remained lower.

According to the ODGP, at the introduction of the Better Access program in November 2006, the average gap payment was between \$10 - \$15. The average is now around \$45. For a 50+ minute consultation with a registered psychologist the Medicare subsidy is \$76.65. However, the average cost to the consumer in this region is \$120. Introduction of the MBS items therefore represents a significant reduction in the full cost of the service, but still leaves a significant cost to the consumer who may not be able to afford \$43 for each of several sessions. Clinical psychologists typically charge \$130 per 50+ minute session. The rebate for this is \$112, leaving the consumer \$18 out of pocket. There is no clear

information for either the consumer or the GP to clarify the difference in the services provided by a clinical psychologist and a registered psychologist. Also, consumers and GPs appear to be equally unaware of the difference in the cost of services provided by a clinical and registered psychologist. In the project region, some GPs have also voiced concern about their ability to prepare a mental health care and management plan. (See Service Provider Perspectives, Chapter 3, Final Report).

The new MBS items revert largely to individually provided service systems with a fee for service structure. Hickie & McGorry (2007) argue that this has resulted in high out of pocket expenses for consumers, and poor geographical and socioeconomic distribution of services. It has also been argued the new items encourage the proliferation of individual provider based treatment rather than collaborative care when the literature shows that collaborative care is superior to single-provider based treatment regimens (Hickie & McGorry 2007; Bambling et al 2007). There are no incentives in the MBS items for co-location of services, which is recognised internationally as one of the most important practical measure for promoting collaborative care (United States Institute of Medicine, 2006).

It is likely that these factors lie behind the inadequate levels of private psychologist and psychiatrist provision in the study region. Compensation for these factors requires the increased provision of salaried services and encouragement for co-location of medical services particularly in non-metropolitan settings such as the study region.

As Better Access was introduced, the restrictions on GPs using the Access To Allied Psychological Services (ATAPS) program, which operated under BOIMHC, were lifted. ATAPS targets those with lower income to provide access to Allied Health workers including psychologists. It was thought that the introduction of Better Access may cause ATAPs to become unnecessary. However, data in the project region mirrors a study by the University of Melbourne that found that an initial drop in the number of referrals through ATAPS with the introduction of Better Access, which has subsequently levelled off and in this region has started to rebuild. ATAPs continues to provide access to services for depression and anxiety for those in lower income groups (Bassilios, Fletcher, Pirkis, Kohn, Blashki, Burgess, 2008).

Overall it appears that there has been significant uptake of the new MBS items, both nationally and in the project region. This represents a significant increase in access to psychological services, predominantly for high prevalence disorders. However there are gaps in the data which prevent access being analysed more closely:

- There is insufficient analysis to know which payments are for new consumers using services for the first time and which are for consumers who were already using services and are now accessing the subsidy for them or using them more frequently.
- The inability to get regional data from the national data sources means there is also limited data on overall prevalence in the study region of mental health issues being treated through Better Access, nor on the effectiveness of these treatments. Therefore, we are unable to understand the health outcomes impact of increased access to psychological services.

While the availability of subsidised access to psychologists and mental health trained social workers and occupational therapists has increased in the project area, the uptake of the relevant item numbers has, through increasing gap payments and increasing waiting periods, been shown to outstrip the availability of these services. Hence, consumers in the project region will continue to look to other sources – to the Primary Mental Health Team of South West Health Care or to community counselling services – to access the care they need for depression and anxiety. Gap payments are of particular concern as an access and equity issue. It is important that public and community services continue to be available and affordable.

## **Objective 3. Identify Referral Pathways, Service Gaps, Barriers and Enablers to Service Utilisation**

### **Methodology**

For further details of the methodology employed for Objective 3 of the project, please see Chapter 3 of the Final Report.

#### **A. Service Providers' Perspectives**

Interviews were carried out with 12 local service providers who acted as key informants to identify gaps, barriers and enablers to service access. The interviews were unstructured, informal discussions about the services participants provided. Interview participants were invited to provide their perspectives of referral, gaps in service provision and any perceived barriers to providing adequate service.

A reference group was convened which comprised stakeholders of major service providers for depression and anxiety, and consumer representatives.

All identified service providers were invited to participate in a focus group in which identifying referral pathways, barriers, enablers and gaps was the main focus.

An on-line survey was conducted which was designed to look at referrals coming to the service provider and referrals which service providers then made. The survey also included open ended questions to further clarify some of the issues which service providers wanted to discuss about perceived issues in the provision of services for depression and anxiety. (A copy of the survey can be found at Appendix 7 of the Final Report.) A total of 38 service providers responded to the survey. Respondents were asked to classify themselves in one of the 'Type of Provider' categories shown in Table 4 below. For more details of questions and responses to the service provider survey, please see Chapter 6 (6.1.5) of the Final Report.

**Table 4: Service Provider Respondents according to Type of Providers**

Type of Provider	Frequency	Percent
GP	14	36.8
Psychologist in private practice	8	21.1
Counsellor with community organisation	7	18.4
Clinician with Psychiatric Services SWHC	5	13.2
Social worker in private practice	2	5.3
Psychiatrist in private practice	1	2.6
Psychotherapist in private practice	1	2.6
<b>Total</b>	<b>38</b>	<b>100</b>

Social network analysis was carried out on the data from the on-line service provider survey to identify referral pathways and relative prominence of different types of service providers.

## B. Consumers' Perspectives

Three consumer representatives took part in the initial reference group to act as key informants.

Twenty-five (25) semi-structured in depth one-to-one interviews were undertaken with local consumers who had used a service in the region for depression and/or anxiety within the last two years. These interviews explored qualitative responses to questions about finding a suitable service, satisfaction with the service, perceived barriers, enablers and gaps. The responses from these interviews informed the design of a larger telephone survey.

A telephone survey of 1297 consumers was conducted to expand on the responses elicited in the interviews and to provide a greater coverage of age and location in the responses. 275 participated in a longer survey. A script of the telephone survey can be found at Appendix 3 of the Final Report. Social network analysis was carried out on the data from all consumer interviews and surveys to identify services used and referral pathways taken.

## Findings

### A. Service Providers

The key informant interviews, reference group discussions and feedback, focus group discussions and survey of service providers provided the data to ascertain service gaps, barriers and enablers to service utilisation. The referral pathways were identified using social network analysis of the responses from the service provider survey.

#### Referral Pathways

Many service providers reported that knowing what other services were available for them to refer their consumer to, or which of these services would be most appropriate for their consumer, was an issue. For example, this comment came from within the ODGP: *There is*

*an increase in the need for mental health care and GPs have difficulty in where to refer patients, with some patients 'bouncing' because they don't fit in anywhere within the existing system.*

Others reported difficulty referring a consumer where a co-morbid condition existed along with the depression or anxiety, for example a drug or alcohol dependency. It was also noted that referrals may depend on an existing relationship between certain service providers rather than on how well they work together for the consumer.

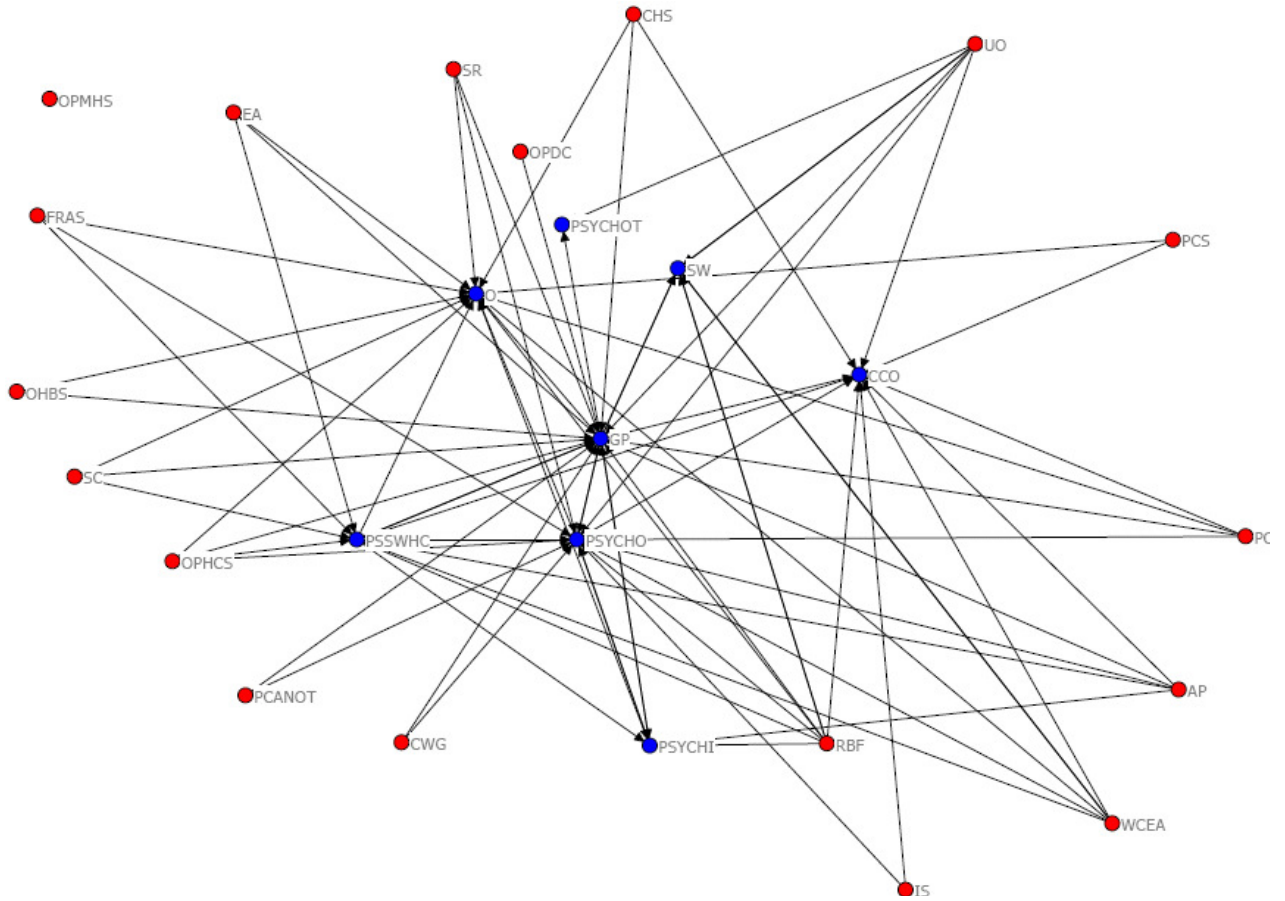
The introduction of the MBS Better Access item numbers has simplified the referral process to some extent. One psychologist noted: *Most referrals I get are through the Medicare 2710 plans.*

While referral can be difficult for some, other service providers had found pathways which worked for their consumers; *I always refer to Centacare when I get someone who is not in my area of expertise – some service providers claim they can do everything, but I don't do that and if I'm out of my depth I'm not going to take people's money and try and do something I can't. I refer them to specialist counselling.*

#### **Private service provider**

The following figures display the service provider referral information in network maps. In the following diagrams, the relative prominence of a type of service provider in the network is shown by the number of arrow heads that surround it. A list of abbreviations is provided at the end of this section on page 21.

Figure 2 displays the origins of consumers coming to various types of service providers. The service provider types who responded to the survey are displayed in blue. The distance between the nodes, and where a node is located in the diagram, is essentially arbitrary.



**Figure 2: Origins of consumer referrals**

Note: The diagram above displays the referral sources advised by service providers, but does not indicate the number or percentage of consumers being referred from any particular source. Care should be taken in interpreting this data, as equal weighting cannot be assumed.



## Abbreviations of Service Provider Types

AP	Already a patient, prior to consultation for anxiety or depression
CCO	Counsellor with community organisation
CHS	Community Health Centres (such as Portland District Health)
CWG	Church or welfare groups
EA	Emergency & Accident
FRAS	Financial planner, rural counsellor, accountant, solicitor
GP	General practitioner
Informal	Informal (friend, family member, coach, work colleague)
IS	Information sources (e.g. <i>beyondblue</i> website; yellow pages; internet search)
O	Other
OHBS	Other hospital based service
OPDC	Outpatients department or clinic
OPHCS	Other primary health care service
OPMHS	Other private mental health service
PC	Private Counsellor
PCANOT	Physiotherapist, chiropractor, acupuncturist, naturopath, occupational therapist
PCS	Phone counselling service or helpline (such as Lifeline)
PSSWHC	Psychiatric Services SWHC
PSYCHI	Psychiatrist
PSYCHO	Psychologist
PSYCHOT	Psychotherapist
RBF	Referred by (friend, family member, coach, work colleague)
RE	Referred elsewhere
SC	School Counsellors
SR	Self referral
SW	Social worker in private practice
UO	Unknown Origin
WCEA	Workplace counsellor / EAPs

## Service Gaps

The main service gaps identified by service providers were:

- **Lack of after hours counselling services** for people with depression and anxiety. Most services are only available during normal business hours, yet people need help after hours and on weekends.
- Obvious service gaps occur in **smaller towns** where there are **no local services** available. Many smaller towns do not have a full time GP or any other service located there.
- While there were different clinical services available to consumers, it was noted that there were few services which could offer support for those living daily with depression and anxiety. A private psychiatrist cited a **lack of outreach services** to provide follow up and support for his clients: *They simply do not exist.*

## Barriers

One of the main barriers from the service provision perspective is the **recruitment and retention** of suitably qualified and experienced staff. This issue affects service providers across the board, from GPs in their own practice to Psychiatric Services in their efforts to recruit clinicians.

Another acknowledged barrier to service access was **geography**. Most services are based in Warrnambool and this can make it difficult, time-consuming or expensive for people who live in outlying areas to get to a service provider. *Warrnambool is better resourced with GPs, for example, but it doesn't take long once you're out of Warrnambool for GP services to peter out.* **GP**

**Consumer knowledge** of what services exist and how to access them is an issue in the provision of services in the region. There needs to be a balance between discretion and promotion in order to be able to make people aware of services, but to minimise any stigma which may be connected with accessing services which are visibly for mental health issues.

**Service provider knowledge** of what is available is also seen as an issue. Some service providers thought it was difficult for GPs to keep abreast of all the other agencies which provide services. One GP felt she did not have a strong grasp of what services are out there. On another tack, one GP commented that people don't always know that they can even get mental health care from their GP. One GP noted: *Treating people with depression and anxiety is the most frustrating aspect of my practice. We can bulk bill patients which overcomes the cost barrier which is good, but as far as treatment I just have to chop and change antidepressants until we find something which works. But often the underlying issues are not being addressed.*

**The level of resources in the public health care system** was also noted as a barrier to accessing services for depression and anxiety. This summary came from a private service provider; *this region has significant deficits in overall provision of mental health care – the PMHT has tight eligibility in terms of who they can see and take on and people have to have a significantly diagnosable problem. I believe that 'soft' mental health problems are not really catered for.*

**Increased waiting lists** for services for depression and anxiety was another barrier identified and this was seen as a function of lack of resources in many cases. One GP mentioned that there are not enough psychiatrists available for access to appointments in the short term. A clinician with the PMHT spoke of the fact that s/he is only in clinics one day a week and this makes it difficult to see patients regularly as appointments get filled quickly,

meaning others have to wait. Another private service provider commented: *Demand on my time leads to longer waiting periods than desirable and at times difficulty with on-going sessions being at optimal intervals.*

Another barrier identified by service providers was the **stigma** associated with having a mental illness, especially in smaller towns where counselling may only be available part time. Culturally too, people in farming communities may be stoic about their difficulties and prefer not to seek help.

**Certain groups within the community experience distinctive barriers.** The indigenous community, for example, have needs which may not be being met in the mainstream system. *In the indigenous community, illness is identified by family and community members and escalates to a serious level before there is an intervention and then the community will utilise the Aboriginal service first. Discrimination can also be a barrier.* **Community service provider**

**Cost of services** was also considered to be a barrier. This was separate to the discussion of gap payments under the Medicare Better Access scheme. One private psychiatrist noted: *The Medicare Plus threshold of \$500+ for pensioners and health care card holders is still a barrier to many who wish for private care. Before the 80% rebate (the gap isn't covered by Medicare) they may still be out of pocket over \$50.*

Limited access to **after hours care** was also seen as a barrier. Apart from Lifeline, few services exist for high prevalence disorders after hours. Another barrier was access to rooms after business hours or on weekends; *I think I'm the only private service provider who can see people after hours because the clinic where I work allows this. I would love more access to rooms after business hours and weekends in other clinics, but for security reasons it is difficult. Particularly for people working casually – who lose money if they don't work – this would be helpful.* **Private service provider**

For those service providers in the community sector, the **difficulty in accessing secure ongoing funding** to provide their services was raised as a barrier to providing services for depression and anxiety. For example, Lifeline reported that while people are prepared to pay a small fee for stress management/managing depression type courses, it is hard to get consistent funding to run these regularly and to therefore have any real impact on a large number of people.

The **nature of a high prevalence** disorder itself was also identified as a barrier to accessing services. One counsellor with a community organisation expressed frustration that patients were sometimes unable to attend support groups as they were too anxious or depressed to attend. One GP spoke of patients' *'incompliance'* with their treatment program.

**Personal barriers** for the service providers were also mentioned – specifically the need to prevent his/her own burnout and difficulties accessing good, affordable, local professional development.

## **Enablers**

**Cooperation Among Service Providers** - Generally there was an acknowledgement that most services in the local service network exchanged a level of goodwill and willingness to work together with other services. There were some examples of collaboration which was extremely beneficial to those involved – for example, the program whereby PMHT clinicians are available in GP clinics works well for the service providers involved and for the consumers.

However, in some sectors of the service provision network, there appears to be less willingness to work together. One private service provider had this comment: *Locally, the private system tends to be competitive and service providers can be possessive.*

The role of GPs was acknowledged to be central to the treatment of many high prevalence service consumers. *It's almost assumed patients will stay in connection with the GP for follow up and monitoring. Some people have the GP and another source. It is assumed that there will be some GP monitoring and involvement as people often go on medication on the Medicare Mental Health plan.* **Private service provider**

**MBS Better Access Item Numbers** - The introduction of Better Access is seen as an enabler to greater access to services for depression and anxiety. For example, the following comment comes from a social worker in private practice who has a concern with equity of access and so, bulk bills consumers; *Some referrals I've had through Medicare have not accessed counselling in the past but have significant needs.* **Private service provider**

While it was agreed that access had increased due to Better Access, there were several issues raised to do with Better Access. One issue was that of service capacity. It was felt that the Better Access program may be creating demand which could not adequately be met by the existing number of psychologists and social workers in the region and that waiting lists were becoming too long.

The issue of gap payments which consumers have to pay over and above the Medicare subsidy was also raised by service providers. According to the Otway Division and after making several enquiries, it is clear these have increased. This coupled with the low numbers of available psychological services may mean that consumers from lower socio economic groups are being priced out of service access. It was acknowledged that gap payments can be significant for some consumers and a disincentive to accessing a service provider through the Better Access scheme. One GP said: *The new item numbers have just pushed up the amount the psychologists can get per session – like the first home buyers' grant pushed up the price of houses.*

The new item numbers are being used to good effect at St John of God Hospital where group programmes are run for depression, anxiety, grief and loss and trauma. It is cost effective to use one psychologist to run cognitive behaviour therapy in a group setting, and the other benefit is the support and shared experiences of the group.

## **B. Consumers**

The data gathered from the telephone survey were used to identify referral pathways for consumers. Qualitative information from the telephone surveys and the information from the consumer interviews provided the data to identify barriers and enablers to service utilisation. Consumers tended not to identify specific gaps in service provision as they do not all have uniform knowledge of what services are available and therefore where gaps might exist.

### **Referral Pathways**

The following diagram (Figure 4), from the telephone survey responses, displays the various pathways of consumers accessing services for a stress related disorder, anxiety or depression. The total number of consumers represented is 275 and of these respondents, 48.4% of



The diagram shows the important role of the GP in receiving referrals for, and referring on, consumers with stress, anxiety and depression problems. The diagram also shows the need for sufficient psychologists, as these are the providers to whom the GPs are referring the largest proportion of their anxiety and depression patients.

The GP was the first service provider seen for the majority of consumers who reported visiting the GP at some stage in their treatment (91.9% reported the GP as their first provider). Of consumers who reported seeing a GP 39% did not indicate any further provider. The next step in the pathway was a psychologist for 17.1% of consumers.

Most of the participants were referred by their GP to another service for additional specialist care for their depression or anxiety. One of the main services to which GPs referred consumers is SWHC's Psychiatric Services Division. Typically, it was the PMHT to whom these participants were referred. Others interviewed were subsequently encouraged to attend or referred to other services. These referrals may have been made by the GP, or may have been a 'secondary' referral by the service to whom the GP initially referred the consumer. Family and friends also played a role in directing consumers to other services.

## Enablers to accessing services

Several factors were identified by consumers as things that assist with seeking treatment:

- **Experience** with depression and anxiety and the ability to know early warning signs:

*I usually go because I recognise my early symptoms and I can go and say "I need my sleepers", so I don't fall in a hole. M. female 35 - 44*

- **Knowledge of services:** Having used services once and become more aware of what is available, some participants noted it would be easier next time for them.
- A **good relationship with the service provider** impacts positively on a participant's ability to successfully manage their illness
- **Medicare Better Access, Better Outcomes and the ATAPS programs** have provided financial accessibility. In talking to the interview participants, it was hard to separate these schemes out from one another. Some participants were vague about which scheme they had actually accessed and there was confusion about how many sessions they were entitled to.
- The **PMHT** also have a program whereby consumers of GPs can access sessions of counselling for no cost, within the GP clinic setting.
- The knowledge of **other community based services** provided an alternative to some people, when another service may not have been available, or when they felt that one service was just not making the difference they needed to get well.

*My GP urged me to go to Community Connections and talk to someone because when I came off the tablets it [my problem] would still be there. Q. female 25 – 34*

- From responses given to the telephone survey, the most common factors reported as helping respondents to access a provider are shown at table 5 below.

**Table 5: Factors helping respondent to access providers**

Factors that helped to access provider	Number of responses	Percent of respondents
Convenient location of service provider in local area	203	73.80%
Great service from one particular person	178	64.70%
Free or low cost service	154	56.00%
Prior experience of the provider	136	49.50%
Availability of information regarding a service	135	49.10%
Advice of a friend, relative or other close adviser	96	34.90%
None of the above	11	4.0%

## **Barriers**

**Stigma** - The issue of stigma came up repeatedly in the interview discussions. All interview participants agreed that there was a degree of stigma attached to having a mental health issue and therefore to seeking help for a mental health problem.

Many of the participants felt that while stigma still existed, it was something which was reducing in the community due to raised levels of awareness of high prevalence psychological disorders like depression and anxiety.

**Cost of services** - Cost was an issue mentioned by several of the participants as a consideration for them in deciding on what course of treatment to follow – this included the cost of the service and the cost of medication. Several commented that though there had been no cost to them in their treatment, that had there been a significant cost involved, it would have stopped them accessing the services they needed. Others said that they would have continued treatment if they had been able to afford it.

Gap payments associated with the Better Access program were an issue for some of the participants and the cost of medication as a treatment was also a consideration for one interview participant.

**Knowledge of services available** - Knowing where to go and what services are actually available can be difficult for consumers. Generally, they made their first point of contact with a service provider and relied on that service to educate them about, and direct them to, other services.

In the case of those interviewed, there was no distinction made between services which provide direct treatments for depression and anxiety (for example, a GP or a psychologist)

and those which provide support and coping strategies for those with depression and anxiety (for example, the stress management course of ASPIRE).

Mostly, people found out about a service from their initial service provider, in most cases the GP. However there is still a feeling that people are not aware of the services that are available to them. As most of those interviewed saw their GP in the first instance, the GP was the source of information regarding other possible services they might access.

*My GP didn't even know about them [Better Access] at the time, so I went to him and I said there's 10 free appointments....* **G. male 55 - 64**

**Satisfaction with services** - For some, dissatisfaction is a barrier towards accessing the help they need. Dissatisfaction may have been with the person providing the service or with some physical aspect of the service

Other comments related to continuity of care, usually arising from the relatively rapid turnover of professional staff in the larger practices.

**Nature of depression as a barrier to seeking help** - Another theme was that depression and anxiety could in themselves be factors affecting the consumer's ability to access an appropriate service. Low confidence and motivation, for example, were identified as part of the problem of depression and anxiety which also impacted on help seeking behaviour.

*It would be lovely to have the communication skills to be able to demand services for yourself. For example if I had have been in an extremely anxious state, it would have been nice to be able to say 'oh I feel like I need to see you sooner than that'.* **Female 25 - 34**

**Waiting for Services** - Several of the interview participants reported they waited what they felt was too long for their opportunity to see the service provider, or that the service provider was not prompt in contacting them.

**After Hours Availability** - While provision of after hours services is an obvious gap in care for low prevalence psychological disorders, it was not a major theme with consumers. However, for some it was an issue that they perceive as affecting their access to the services they need.

*Quite often you're in crisis, you know, on Friday night or Saturday something's gone pear shaped. It's not confined to business hours.* **Female 45 – 54**

**Location of Services** – there were two themes which emerged in regard to location of services, however, local availability itself was not a significant issue. Two participants deliberately chose to see a service provider outside the town where they live for its anonymity. Two other participants chose to access service providers in a more distant location, due to their perception that local service providers did not have the same expertise as those located elsewhere.

Table 6 below indicates the most common barriers identified by respondents to the telephone survey.

**Table 6: Barriers in seeking help**

Barriers in seeking help	Number of responses	Percent of respondents
Knowing what sorts of help were available to you	104	37.80%
Distance to travel to service provider	76	27.60%
Cost of the service	73	26.50%
Finding a service provider in your local area	64	23.30%
Knowing where to go for help	59	21.50%
Cost of transport	57	20.70%
Concerns about confidentiality/stigma	54	19.60%
Lack of transport	37	13.50%
Finding a service provider outside your local area	28	10.20%
Access for people with a disability	20	7.30%
None of the above	96	34.90%

## Discussion

It was evident from the consumer interviews, phone survey, service provider surveys and the social network mapping that GPs were very much the initial point of contact, which supports other findings in the literature. GPs are the first point of contact for about 75% of people seeking help for mental health problems (Andrews, Hall, Teesson 1999). This project suggests that there are several reasons for this.

GPs are generally more accessible than other services because of their number. GPs are spread throughout the region too, in terms of their location, which increases accessibility in comparison to other mental health care providers. GPs clinics are relatively stigma-free. A consumer walking into a GP's clinic could be presenting with any condition and it is not possible for others observing that consumer to know what condition may have brought them to the GP clinic.

Most of the consumers interviewed used more than one service when being treated for depression or anxiety, although most only accessed two different service providers.

In terms of referral pathways from a service provision perspective, several GPs were frustrated with the difficulty of getting their patients further help – from Psychiatric Services

or from a private psychiatrist. This is most likely a workforce issue, that is, there are just not enough resources to meet the demand from the GPs.

In Australia, research has revealed that stigma is associated with even simple forms of depression or anxiety (Bernard, McNaire, Hight, Hickie & Davenport 2002). This manifests itself in attitudes ranging from disbelief that depression is an illness - that it actually exists - to attitudes that depression is a result of personal inadequacy. The distinction has also been made between self stigma and perceived stigma (Barney, Griffiths, Jorm, Christensen 2006). Self stigma refers to a negative view of oneself as a consequence of internalising stigmatising views held by society generally. Those with self stigma may not seek help because they do not wish to appear weak, or do not want to admit to themselves that they need help. Perceived stigma is the belief that other people hold stigmatising ideas. This may impact help seeking behaviour if the consumer believes other people will act negatively to them if they seek help.

Self stigma and perceived stigma were evident among many of the participants. Almost all the interview participants agreed there was stigma attached to having a mental illness and, while many believed this was decreasing in society generally, most preferred to discuss their mental health issues only with close friends and confidantes. Several of the participants did not want to accept they were having mental health issues and put off seeking services because of this self stigma. With respect to perceived stigma, others made the comment that they didn't care what people thought about them, they just wanted to get help.

The issue of stigma is also couched in terms of confidentiality concerns, feeling embarrassed about their situation, feeling guilty about being unable to cope or being too proud to ask for help.

Many consumers had generally heard of references to Medicare rebate schemes through their service provider, through friends or family or from their own research, and several had been the recipients of related subsidised services. Most participants were vague as to the exact details of the scheme they had had access to. – whether it be the Better Access program, ATAPS, Better Outcomes or access to counselling through the Primary Mental Health Team. As consumers they were only interested in the fact that a service was available to them. Therefore, it is difficult to tell the impact that Better Access specifically has had on these consumers, although it did increase access to psychological services to some degree. What is clear, however, is that the BOIMHC program (with its ATAPs component) also proved an important tool in accessing services, as did the PMHT initiative in GP clinics.

The major issue with Better Access is that gap payments can be a barrier to access. Gap payments can be significant, whereas with ATAPs or the PMHT scheme the consumer had no out of pocket expenses.

Many service providers themselves acknowledged that they did not know what services were available, which may be of benefit to their consumers, or which may be the most appropriate. Access to and knowledge of other services impacted consumer outcomes and it was seen by the majority as a factor affecting access to treatment for depression and anxiety. One woman had episodes of depression for 12 years before one particular GP referred her for more specialist care through the PMHT. If she had access to this service 12 years earlier, her health may have been vastly different.

Ongoing mental health was also affected by consumers' knowledge about what services were available. This related mainly to different types of counselling services and services/agencies providing ongoing support for those living with depression and anxiety.

Most of the participants were satisfied with the service they received for their depression or anxiety and found that they could relate well with their service provider. For the majority of consumers, satisfaction with their service provider is an enabler to accessing the treatment and care they need. This is important as a poor relationship with the service provider can act as a barrier to them fully disclosing their emotional distress (Emslie, Ridge, Ziebland & Hunt 2007). The belief that a service provider can help or provide support is also an important enabler of help-seeking. (Bayer & Peay, 1997)

Free or low cost services were identified as an important enabler in accessing appropriate care for depression and anxiety. Conversely, high cost was seen as a barrier. While several participants said they placed such a high value on their mental health that budget was not an issue, for others this is not a practical response and they do have to be careful about the money that they spend. This is where the importance of schemes such as ATAPs, the PMHT/GP clinics collaboration and Better Access is highlighted.

For service providers, the recruitment and retention of qualified staff is a problem. From community health centres to GP clinics there are widely acknowledged difficulties in attracting and keeping staff in regional and rural areas. Workforce issues can represent a significant barrier to the provision of services as they can limit the availability of services, but other aspects of care (such as continuity, or the benefits of an experienced service provider) can also be affected by the inability to recruit and retain workers.

While distance was seen to be a barrier to access, it was interesting to note the distance factor was not limited to transport difficulties in getting to a specific service provider (and these can be considerable, especially where a consumer needs to travel between towns by public transport). Distance necessarily means that it will be time consuming to travel to the service provider and that the consumer must factor in their time away from their normal job or role when considering whether it is worth their while to access a certain service. However, distance did not seem to be too much of a barrier to accessing help, which was an unexpected attitude from consumers.

Waiting lists also did not seem to greatly concern most participants interviewed. Several expressed gratitude for the services they did receive, regardless of waiting time and most agreed that the waiting period was reasonable. While some speculated that if they had been in crisis the wait would have been too long, and several would have liked to wait less time, it did not appear to be a significant barrier to accessing the help they needed.

Drought was not mentioned by any of the participants either in the interviews or in the telephone survey.

While most consumers seek help firstly from their GP, the majority are referred to another service for counselling or other specialist care.

Among GPs there is variation in expertise in diagnosing and treating depression and anxiety, variation in interest in high prevalence disorders and variation in knowledge of what other services exist. Consumers identified their lack of knowledge of what services are appropriate and where they are available as a barrier. It is therefore important that any program of mental health promotion is aimed not only at consumers but also at GPs and other service providers.

The issue of stigma is prominent and needs to be taken into account when planning services for high prevalence mental health issues. People need to be able to access a service without worrying about what others will think. The issue of stigma also highlights the need for continued mental health education to break down the misconceptions about mental illness and to provide access to the help people need. It is also important for people to learn about high prevalence disorders so that they can recognise when they need help themselves.

Cost of services is another major barrier that needs to be taken into account, as is availability. While Better Access has increased access to psychologists in this region, for many consumers the gap payments make these services out of reach, and waiting lists for most services are long. The model of the Primary Mental Health Team working with GP clinics works well and should be expanded or replicated where possible to offer a viable alternative to those who need specialist counselling help but cannot afford it elsewhere. More counselling services need to be available at the community level to also increase access to services and to relieve waiting lists elsewhere.

## Objective 4. Recommendations

For the literature review related to formulation of recommendations, please see Chapter 8 of the Final Report.

### Community Information and Awareness

- Significant improvement in community awareness of depression has resulted from media campaigns such as those run by *beyondblue*. **This media activity needs to be reinforced at a regional level with additional information regarding local sources of mental health support including the fact that Medicare or ATAPS funding is available to assist people requiring treatments.**
- The role of a ‘significant other’ person identified frequently in the responses of consumers as being valuable in encouraging the seeking of diagnosis and providing support during treatment can be actively supported.

- The **expanded provision of Mental Health First Aid style courses in workplaces and the community** will increase the number of people able to recognise and support others with symptoms.
- The likelihood of people with a tendency towards depression/anxiety to have a clinical episode triggered by a second often non-medical issue, means that these non-medical service providers need to be aware of and alert to signs of mental stress conditions in their clients. Financial counsellors/accountants, relationship counsellors/solicitors, and those providing support regarding employment, accommodation, and other basic needs are all in this category. Therefore **a significant target for these Mental Health First Aid courses should be non-health counselling and other human and professional service providers.**

### Early Diagnosis and Preventative Treatment

Once a person self assesses or is recommended from a non-health source, confirmation of a condition, assessment of its severity and establishment of an effective MBS funded GP Mental Health Care Plan needs to be conveniently available.

- While the role of the typically time limited GP remains central to these processes, improved assistance can be provided.
  - **The addition to a general practice clinic of a Practice Nurse with knowledge of high prevalence mental health issues and access to screening and diagnostic tools** can assist with preparation of a draft Mental Health Care Plan. Recent MBS item numbers can support this role to be self funding within a practice. GGT UDRH is currently conducting training programs for practice nurses in management of depression funded by *beyondblue*.
  - Similarly, **the addition of a Mental Health Nurse to a practice** can provide an immediate referral point for diagnosis and preparation of a Mental Health Care Plan.
- Some prevention and early diagnosis can be achieved by people at risk enrolling directly, or by referral into, general ‘Stress Management’ or more directly targeted ‘Depression’ or ‘Anxiety Management’ courses. **These small group programs, either self funded or subsidised using MBS Better Access item numbers, need to be more generally available across the region.** At present they are offered by South West TAFE in conjunction with SWHC’s PMHT and by the Mental Health Team at St John of God Hospital, Warrnambool.
- Provision of out-of-hours support in the region for people with high prevalence mental health disorders is limited and depends largely on Lifeline telephone counselling. Several interviewees indicated dissatisfaction with this service due to its impersonal nature and inability to take any follow-up action. It is therefore recommended that **a follow-up face to face triage counselling service capable of direct referral to other support services needs to be made available in the region for out-of-hours and particularly weekend and public holiday use.**

## Improved Service Provision

If it is accepted that the number of mental health professionals will not change rapidly, then improved service provision will arise through optimising the effectiveness of current provision. This can be achieved by a combination of reducing the case load of professionals through use of other options wherever possible and by ensuring that skill levels of the relevant people are kept optimal.

- The strategies already described **using practice nurses or mental health nurses to streamline the workload of GPs and use of group programs** where these are adequate for the needs of the clients, assist with reducing the numbers needing more intensive treatment.
- Current workforce recruitment and retention efforts include the federally funded Rural Mental Health Academic program. **The DHS could augment the funding and encourage placements of probationary psychologists and nurse graduates trained in mental health.**
- Although social workers and occupational therapists can provide services under MBS Better Access item numbers, there are very few trained to do so in the region. **Incentives can be provided for social workers and occupational therapists in the region to take further education in mental health so they can be service providers.**
- Workforce pressures could also be reduced by use of the additional strategies proposed in the following section - 'Consumer Maintenance and Ongoing Support' - which would reduce the number of consumers returning for future treatments.
- The literature suggests that consumer outcomes and effective use of professional time can also be improved through the use of collaborative teams. **The development of teams involving a GP, mental health nurse and psychologist should therefore be encouraged through the offering of workshops.** These could be offered to encourage the development of such teams by highlighting the clinical, financial and time-saving advantages of coordinated consumer care.
- Specific amongst strategies to develop collaborative teams is the highly regarded work of the SWHC PMHT. This team, besides providing significant patient treatment in the relatively stigma free anonymity of the GP clinic, also provides a valuable professional development service for GPs and nursing staff at the clinic. **GP clinics should be encouraged to co-locate other health care professionals from a range of disciplines including psychology, social work and mental health trained practice nurses, in their practices. The capacity of the PMHT in this role needs to be significantly expanded.**
- Professional development to assist GPs to upgrade knowledge of mental health issues and to give them access to BOIMHC MBS Items is already available through the Division of General Practice. These activities are not proving to be attractive to doctors. **Further incentives to undertake professional development, in the form of subsidised travel and payment for the time**

**involved are worth trying** but may still not result in better uptakes. Therefore the options that allow GPs to work in expanded teams offering collaborative care are more likely to succeed.

- To ensure the optimal use of the services and people available to provide mental health care, a specific regional directory needs to be developed and resourced for maintenance, listing practitioners together with times available at various locations, services provided and gap fees charged. **Ongoing funding needs to be provided to an accountable regional organisation to establish and maintain this service directory.** This directory needs to be regularly maintained and distributed to all service providers. In addition to a directory, there may be opportunities for the funding to bring together the various service providers in the region to showcase their services.
- Many people with a predisposition towards depression or anxiety have episodes of ill health triggered by a non-medical issue. Personal crises involving finances, relationships, accommodation, and other basic needs can also result in the onset of anxiety or depression. Appropriate treatment of the mental health issue in these cases will be greatly enhanced if the parallel non medical issue is also addressed using a relevant agency. **Professional development and information needs to be available to GPs and community health services highlighting the importance of identifying and assisting the consumer in contacting relevant agencies dealing with these related non-medical issues.**

### Consumer Maintenance and Ongoing Support

Improved community mental health depends not only on treatment but also on continuing support and health maintenance for people with chronic or episodic mental health concerns.

People in these circumstances can often substantially self manage their condition if they have access to useful support mechanisms. Self management may reduce the load on health professionals who would otherwise be involved with episodic treatment.

- Self help peer groups meeting with a trained facilitator – who could well be a volunteer – is an established method of providing support for people with chronic conditions. **Assistance will be required with the establishment, training of facilitators, and convenient location of self help peer groups.** Organisations that have the capacity for providing such assistance could be funded by targeted grants.
- Individuals or groups would also be assisted by **development of mental health maintenance tools either for self administration or reference to a mental health nurse, practice nurse or qualified group leader.** Development of such tools may be the province of rural mental health academics teamed with mental health professionals in the region.
- Beyond these assisted self help processes, the previously listed **small group training programs** and **mental health management plans coordinated by a mental health nurse or practice nurse** and overseen by a GP, can provide ongoing support to people less capable of self management.

### Issues for Further Study

During the course of this study some related issues have arisen that were not included in the current objectives. Future work on these issues may be helpful for the development of regional mental health services. The issues include:

- **Difficulties with the recruitment and retention of professional staff.** Consumers are aware of difficulties arising due to lack of continuity of staffing in some areas of treatment. Other studies are currently being undertaken into this issue.
- Proposals for the development of **e-counselling services** will provide an additional option for treatment but further research is needed to identify the effectiveness and applicability of this style of service. It seems likely that there will be differences in uptake and effectiveness related to the age of consumers.
- Further exploration is needed into **the significance of non-medical triggers** as factors in the onset of episodes of anxiety or depression, and the impact of parallel treatment of these non-medical issues as a support to mental health treatment.
- The design of this project specifically excluded the complications of co-morbidity of depression and anxiety with other chronic conditions (eg., diabetes, heart disease, arthritis). We need to **learn how to promote communication in interprofessional teams** as it will be important in the management of depression and anxiety. There appears to be a need to improve education of medical professionals on mental health problems co-occurring with physical illness. At the same time, we need to improve education of non-medical professionals on how to manage mental health problems that co-exist with chronic conditions.
- A significant piece of information that was not captured in the design of this project was **to ascertain where people who have not had an experience of a high prevalence mental health disorder would go, in terms of a service provider, if the need arose and why.** This information would better inform the processes of mental health promotion amongst the wider community.

### Promoting Community Mental Health

The above recommendations attempt to outline an approach and set of processes that respond to the high prevalence and often chronic mental disorders in the adult community. They should provide a greater level of community understanding and acceptance, primary response, diagnostic and treatment services that optimise the use of and collaboration between the limited high level professional services and then provide for on-going, significantly self managed mental health maintenance.

We should also be creative in thinking of ways of linking DHS funded services with MBS funded services. Mixed funding models ought to be considered to extend existing services to meet community needs.

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