

SOCIAL WORKERS AND OCCUPATIONAL THERAPISTS FORUM – 24 JUNE 2010

Record of small group discussions (agenda item 5) - Better Access and fee for service arrangements and Better Access evaluation

At the agreement of the vast majority of participants, all small groups focused on the following questions:

1. What works well under the fee for service arrangements under the Better Access initiative?
2. What lessons/constraints/issues arising from the Better Access experience could be considered in the future arrangements? Do fee for service arrangements have limitations for some people with mental illness?
3. How can the experiences of social workers and occupational therapists contribute to inform the evaluation of the Better Access initiative?
4. What further information can be provided to the Department in addition to the current quantitative and qualitative work underway to inform the evaluation?
 - What has Better Access enabled you/your service to offer?
 - What improvements in the mental health profile of clients have you seen?
 - Does your practice using Better Access or ATAPS dovetail with any other funding from government/non-government sources?

TABLE 1

What Works Well

- An established 'brand'
- Flexibility and accessible
- Allows for better collaboration between GP and mental health provider – without going through 3rd party
- Immediacy – can happen quickly particularly if relationship exists – encourages innovation
- Some advantage to co-location but some GP practices take 30% - encourages early intervention
- Some disadvantages – captured by practice - some experience stigma through GP practice
- Innovation – linked to immediacy and accessibility
- Allow programs to give access to specific populations. Headspace and bulk billing gives access to those who could not otherwise afford it
- Diverse range of population can access services
- Populations that previously had no familiarity with self care – mental health issues can get some support and assistance
- Beyond 'worried well'

What Doesn't Work

- Some providers over service - reduction in quality, capped number of days – anecdotal
- Group work – impractical. The process excludes its use, not viable with 6 – 10 on treatment plan
- Can't access family therapy
- Doesn't pay for diagnosis and assessment
- Doesn't pay for narrative therapy for non indigenous
- Just providing 'Focussed Psychological Strategies' service is not adequate for what our clients need – not allow for range of model required to meet our clients mental health needs. ie: family therapy / group work / family assess liaison and case meetings
- Screening tools are just one part of comprehensive psychosocial assessment often inadequate K10 and DASS
- Not paid for 'additional services of liaison'. Case conference, advocacy, letters, DSS housing, consultation with GP

TABLE 2

What Works Well

- Flexibility
- Access for everyone that is equitable – hours of delivery, place of delivery
- Easy process
- Gives consumers a choice – profession and needs matched
- Multidisciplinary care and contribution
- Connected care – liaison with GPs
- Improved outcomes for clients
- Professional accountability – assess, review, closure
- Not long waiting lists
- Bulk billing ability
- Youth sector included due to bulk billing
- Providing early intervention – preventing acuity
- Measured, clear credentialing of social workers and occupational therapists ensuring quality which is ongoing and includes professional supervision and CPD.
- Culturally sensitive and safe – community controlled populations have input
- Empowers client group
- Ability to have anonymity – not stigmatised, not state mental health

What Doesn't Work

- Pathways – GPs?
- Travel – no recognition or remuneration
- Report writing

- Liaison of care – schools, carers/parents, community
- Red tape attached – MBS - procedures, process – often not in the most disadvantaged areas because of this
- Distribution of resources – training, support, allowances – like rural GPs
- Inequitable payment schedule
- No GP education – process, referral etc
- No clear accountability – not monitored, not audited, no clear guidelines, some unethical practice
- Evaluation after it began. Unable to capture outcomes and disengaged consumers
- Group items don't work

TABLE 3

What Works Well

- Ease of referral (GP access)
- Choice by consumer therefore reduction in monopolies and therefore increase in skills levels
- Ease of patient access
- Monopolies drive costs up
- Flexibility (appointment times, weekends, service delivery settings)
- Facilitates person and environment fit
- Protection provided by anonymity
- Stigma
- Increase access in environment of workforce shortages
- Good population – based program
- Occupational therapists, social workers and psychologists deliver FPS using their unique perspectives
- Tailored
- Facilitates choice of practitioner
- Allows 'holistic' approach to be delivered in private sector

What are the lessons from the Better Access experience?

- Costs are rising therefore restructure Better Access Mental Health Services eg: means testing, adjust Medicare schedules
- Should the 'gateway' (GP health plan) be reconsidered to free up funds into the delivery of allied health services (overhaul GP plan). Use funds for it's purpose. Eg: lower rebate for GP Mental Health Plan (GPs refer – allied health assess and review)
- Limitations of fee for service
- Limited if bulk billing does not occur
- Better Access Mental Health Service has capacity to develop workforce and career pathways by giving more options (both private and public)
- Better Access allows preventive intervention to avoid hospitalisation, chronicity

- Flexibility in environments of service delivery

How can Occupational Therapist and Social Workers experience Contribute to Inform the Evaluation of Better Access

- Ask about clinical outcomes
- Needs process evaluation
- Can then use clinical outcomes to inform the planning agenda
- Employ Chief Allied Health officer within DoHA

TABLE 4

- More guidance to GP on how to make appropriate referrals to programs and services
- Direct referrals work well – reduced cost, reduced time, increases confidentiality, increases access
- More ease of access to on-line referral forms that cater for age and different diagnoses, with standard and simple form
- Education for GPs on mild, moderate and severe and different health professionals' roles
- It has enhanced relationships between GPs and counsellors
- CHOICE is good
- Do GPs want the role of Mental Health Care Plan and referrals?
- More flexibility on number of sessions
- Getting admin cost of our services for free
- Rebate for service – not discipline: same rebate for all disciplines
- Psychologists need experience in mental health before eligible – equality of service. Review provider eligibility
- It provides a career path for mental health workers in the public system. This enhances the workforce in public system
- It fills a gap in mental health service network
- Contract is with the client not the mental health service – this gives more scope for therapy and self motivation
- Occupational Therapist and Social Workers are more likely to work with marginalised and disadvantaged
- Mental Health Care Plan on medical record can be a disadvantage for client

TABLE 5

What Works Well

- Equity of access by 3 allied health professionals – maintains equal playing field
- Quickly accessible and easily understood by client / GPs to referrers, to clients, to practitioners – across ages, across locations, equity across diagnoses
- Access to multidisciplinary care

- Reasonably and flexibly affordable – decisions can be made collaboratively, client gets input and choice. Re: practitioner, payment approach, location of service
- Availability of diverse practitioner, ie: skills. Re: CALD, bilingual workers
- What service provided clear in plans
- Continuity of care possible
- Access through GP – integration with other health care and less stigma

What Works

- Allows for:
 - Early intervention
 - Mental Health promotion
 - Education – consumer, other providers (GP)
 - Range of models
 - Making links with other providers – MHPN, maternal child health nurses
 - Identifying gaps and tailor approaches to address them in particular communities. eg: home visits, indigenous
- No additional admin ‘layers’ – efficient and less admin costs

Lessons / Constraints / Issues

- Balance of money – assessment and treatment ineffective cost
- Mental Health Treatment Plan overpriced, not informative and has to be repeated
- People don’t/can’t go to GP (or prefer not to) to access care – GP as gatekeeper
- Enabled access to relapse prevention for short-term (eg: come 5 sessions and then back a year later as relationship in place)
- Improvements in clients being able to access service in own language and being understood
- Broader scope to use strategies flexibly
- Public / private partnerships where public pays gap – broader range of non-traditional organisations involved (eg: schools, employment agencies, NGO)
- Provision of free service (to client)
- Improved outcome measures in only a few sessions (K10, DASS etc)

TABLE 6

Social Workers and Occupational Therapists Unique Contribution to Mental Health

- Psychosocial assessments
- Holistic and contextual approaches
- Person in context of their environment
- Relational focus (rather than individualistic)
- Focus on therapeutic alliance in recovery
- Flexible and adaptive client-centred focus

- Outcome focussed rather than treating symptoms
- Unique clinical skills – strong mental health experiences
- Commitment to professional supervision and development
- Capacity for family and group interventions
- De-pathologising approach
- Best practice by multidisciplinary professionals
- Some social workers are clinical

Better Access Positives

- Accessible (immediately)
- Early intervention
- Entitlement
- Choice availability
- Broad skills across different professionals
- Preventative mental health care
- Cheaper than public mental health systems
- Broad spectrum
- Increased community awareness re depression and supports
- Specialised expertise
- Broad definition of mental health
- Impact on mental health promotion (less stigma)
- Long term unmet needs now being met
- Increased access to previously excluded groups
- Inter-generational attachment issues addressed
- Reduced medications

Better Access Negatives

- Gap fees still disadvantage low income clients
- Cost of Mental Health Treatment Plan by GP too costly (\$150)
- Lack of awareness of social worker clinical expertise
- Refusal of health insurers for professional indemnity and life insurance (depression)
- GPs don't typically work collaboratively (too over-loaded and not enough GPs and not skilled in assessments)
- Inequity of rebates across all the allied health professionals
- Confidentiality is compromised in the auditing process (compromises detail in reporting)
- Exclusion of some important therapeutic approaches (narrowness of prescribed techniques)
- Assumption of evidence. Re: good practice – other approaches also evidence based
- Limitation of session numbers (especially for serious mental health problems)

Better Access

- Direct money, higher rebates to disadvantaged clients (rather than higher rates for some professions)
- Only pays for interventions and not other time (reports, travel, referrals etc)
- Social Workers and Occupational Therapists need to have more input to assessment and intervention and outcome tools
- All professions must be represented on the Evaluation Review Steering Committee
- Need tools to measure unique social worker and occupational therapist contributions
- Need better professional promotion
- Need standards across all professions mental health standards (eg: minimum mental health experience) – how is a new psychologist graduate more skilled than experienced social workers