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Reddy, Prasuna and Morrison, Jane 2008, South West mental health mapping project final report, Greater Health - Greater Green Triangle, [Geelong, Vic.].

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South West Mental Health Mapping Project

Final Report

October 2008
Professor Prasuna Reddy
Jane Morrison
ACKNOWLEDGEMENTS

DHS Barwon South West Regional Office, Barrie Baker, Evaluation Solutions

Therese Gerber, Nicholas Place, Andrew Dilley, Margaret Skene, Graeme McDonald, Carmel Harris, Carmel Bateman, Julie Burch, John Dutton, Phil Hose, Cathy Culkin, Julene Cook, Dr. Phil Hall, Dr. Bill Bateman, Dr. Clare Mooney, Dr John Philpot, Imelda Purcell, Lee Town, John Parkinson, Bob Leahy, Rachel Boak, Tara McKenzie, Monique Lewis

The project team would like to thank all consumers who participated in the project, especially those who gave their time and shared their personal stories for the qualitative interviews.
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SOUTHWEST VICTORIA MENTAL HEALTH MAPPING PROJECT

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 psychological 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).

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 recent 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 an expert reference group of 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 health 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 about whether GPs, as time limited professionals, 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 using data from the consumer telephone survey also demonstrates the wide range of agencies that become involved in supporting people with mental health issues.
Primary barriers identified by people requiring assistance included lack of information about symptoms and where to go for help. The lack of knowledge about available health 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 clients about the stigma of mental illness and access to services within the region in an acceptable timeframe and at manageable cost. People who did use the services showed understanding and tolerance of delays in gaining access to services, and a preparedness to travel within the region.

The data indicate that there has been substantial uptake of the new 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.

**Recommendations**

- Improved community awareness is required not only of relevant symptoms of mental distress but also of appropriate actions that can be taken and that Medicare support is available. This can be achieved through use of Mental Health First Aid courses as well as general media.

- 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 of other health care professionals in their practices. These professionals may come from disciplines such as psychology, social work and nursing, and may practice within the public or private sectors.

- An example of collaborative care and successful co-location of mental health practitioners in GP Clinics in South West Victoria exists with SWHC’s Primary Mental Health Teams 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 mental health maintenance.

- Given the importance of having general practitioners 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 services similar to the PMHT model within GP clinics, and of community counselling services, would address availability and cost issues in accessing services.
• More research is needed regarding the role played by counsellors available to employees through Employee Assistance Programs (EAPs), and the numbers of employees accessing services for depression and anxiety through these programs. More research is needed on the impact this has on the use of services available to the general public.
1. Introduction

In February 2006, the Council of Australian Governments (COAG) acknowledged that mental health was an issue of national significance and that while governments had made significant investment in mental health, additional resources would be needed from all governments to address the issue. (COAG February 10, 2006)

One major outcome of the COAG emphasis on mental health care has been the introduction, in November 2006, of the Better Access to Mental Health Care Initiative. The preceding Better Outcomes in Mental Health Care (BOIMHC) program, which was introduced in 2001, continues concurrently. Through the Better Access initiative, the MBS provides subsidies for referral by GPs to allow consumers access to a range of mental health practitioners, including psychologists, psychiatrists, social workers and occupational therapists with appropriate mental health qualifications. The program specifically targets high prevalence psychological disorders, particularly depression and anxiety, which can be treated in primary care settings.

The Victorian government, subsequent to the COAG meeting in February 2006, engaged the Boston Consulting Group to produce the report ‘Improving Mental Health Outcomes in Victoria: The Next Wave of Reform’, (Boston Consulting Group, 2006). This review highlighted three key issues in the delivery of services by the mental health system in Victoria:

- insufficient access to clinical services;
- lack of connectedness between parts of the mental health system; and
- limited investment in prevention and early intervention.

In the context of the increased governmental focus on mental health, this project, the Southwest Mental Health Mapping Project, focuses on the provision of services for consumers with the high prevalence psychological disorders of depression and anxiety amongst adults aged 18-65 in the Glenelg sub-region of the DHS Barwon Southwest region of Victoria. The project takes a whole systems approach looking at services covered by State, Commonwealth, public and private providers and looks at the issues of access in provision of services for depression and anxiety, one of which is the impact of the Better Access program. The project sought to investigate delivery of, and access to, services from both a service provider and a consumer perspective.

1.1 Project Objectives

The objectives of the Southwest Mental Health Mapping project are:

- Objective 1: Identify the capacity and structure of the current service system for those with depression and anxiety.
- Objective 2: Assess the impact of the new MBS items for mental health care and other relevant MBS funded services.
- Objective 3: Determine patterns of service usage and identify service gaps, barriers and enablers to service utilisation.
- Objective 4: Make recommendations for improved service delivery.
1.2 Project Exclusions

The study has excluded psychological services which cater for co-morbidities – for example, drug and alcohol counselling services. The project also focused on services for adults between the ages of 18-65 years and therefore excluded child, adolescent and aged mental health services.

1.3 Ethics

Ethics approval for the project was obtained from the Flinders University Social & Behavioural Sciences Human Research Ethics Committee. All participants gave their consent prior to being interviewed. For consumers participating in the qualitative interviews, pseudonyms, gender and age group are used to attribute quotes. Consumers participating in the telephone survey were identified by a code number, age group and gender.

1.4 Project Area

1.4.1 Project Study Region

The project takes in the area of the following five Local Government Areas (LGAs): Glenelg Shire, Southern Grampians Shire, Moyne Shire, Warrnambool City and Corangamite Shire. The area covers Camperdown and Port Campbell in the East; Hamilton, Coleraine and Casterton in the North; and is bound by the South Australian border in the West.

This area is also covered by the Otway Division of General Practice (ODGP), classed as rural, although the Otway Division also extends further East along the coast. There is also an overlap with the West Vic Division of General Practice northwest of the project area (around Casterton and Coleraine in the Glenelg LGA). While the ODGP does not entirely fit the Mental Health Mapping project area, we have found it useful to use data which the Division has gathered within their area as indicative of the project area.

The total project area population, according to the 2006 Australian Bureau of Statistics (ABS) Census is 100,066 with most people living in the three largest towns of Warrnambool, Hamilton and Portland. The region extends over an area of South West Victoria which covers approximately 24,500 square kilometres (km).

Glenelg Shire

The Glenelg LGA covers the towns of Portland, Heywood, Nelson, Dartmoor, Merino and Casterton. It occupies an area of 7,210 square km and has a population of 19,759.
Southern Grampians Shire
Southern Grampians takes in Hamilton, Coleraine, Cavendish and Dunkeld with a population of 16,638. It occupies an area of 6,837 square km.

Moyne Shire
Moyne takes in Port Fairy, Bushfield, Macarthur, Koroit and Allansford and has a population of 15,453 people. Its area covers approximately 6,010 square km.

Warrnambool City
Warrnambool is the largest town in the project region. It has a population of 31,600 and is one of the fastest growing areas in the State. The 103 square km which make up the city are rapidly developing.

Corangamite Shire
Corangamite covers 4,357 square km and incorporates the towns of Camperdown, Mortlake, Cobden, Port Campbell and Terang. The population of the Shire is approximately 16,616.

Population: 2006 Census ABS

Figure 1: Population by Local Government Area as Proportion of Region


1.4.2 Regional Information

Historically, the region is made up of rich, grazing farmlands. Dairying is still a major farming activity, with dairy processing factories in the Shires of Moyne, Corangamite and the City of Warrnambool. Economic activity in the region is still predominantly primary industry, including fine wool growing, forestry, cropping and fishing. Other large industry includes the aluminium smelter and port at Portland, the Iluka Mines Mineral Separation Plant near Hamilton and the growing blue gum plantation industry in the West of the region. Tourism continues to be a growth industry for the area, along with developments in wind farming. Warrnambool is the largest city in the region and is the service centre for surrounding districts.

1.4.3 Demographics

The Index of Relative Socio-economic Disadvantage (IRSD) is an index derived from the ABS Census. It reflects disadvantage such as low income, low education levels, unemployment and proportion of the workforce in unskilled labour. The score is standardised across Australia at 1000. Scores lower than 1000 therefore reflect relative disadvantage. Geographic location is not taken into account in the IRSD.

The IRSD score for Warrnambool city is 1005.1. For Corangamite shire the score is 1025. Southern Grampians has an IRSD score of 1029, Glenelg Shire’s score is 981 and for Moyne Shire it is 1031. By way of comparison, the highest IRSD score in Victoria is in Booroondara.
City with a score of 1122. The Victorian LGA with the lowest score is Greater Dandenong with a score of 876.9. The IRSD scores in the project region show there is variation in the relative socio-economic disadvantage of residents in the different shires of the project region, with Glenelg showing the most relative disadvantage (Public Health Information Development Unit [PHIDU] 2005).

The number of GP services per population in the Division is 1,410 people to each full time equivalent GP service. This is slightly higher than the rest of Australia as a whole which has 1,403 people to each full time equivalent GP service (PHIDU, 2005). GPs are not evenly distributed across the project region. The following table shows the GP services per capita for each of the LGAs in the project area.

**Table 1: General Practitioners per capita by LGA**

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>General Practitioners per 1,000 population</th>
<th>Rank among Victorian LGAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warrnambool</td>
<td>1.27</td>
<td>17</td>
</tr>
<tr>
<td>Southern Grampians</td>
<td>1.05</td>
<td>36</td>
</tr>
<tr>
<td>Glenelg</td>
<td>1.02</td>
<td>41</td>
</tr>
<tr>
<td>Moyne</td>
<td>0.50</td>
<td>76</td>
</tr>
<tr>
<td>Corangamite</td>
<td>0.47</td>
<td>78</td>
</tr>
</tbody>
</table>

*(DHS 2008)*

Most of this project area is classified ‘accessible’ under the Accessibility/Remoteness Index of Australia (ARIA) and Warrnambool is classified as ‘highly accessible’.

### 1.4.4 Transport

The major transport routes for the South West sub-region originate from Geelong. The major roads – the Princes and Hamilton Highways – run east-west through the area with smaller north-south connecting links. The passenger rail service provides daily trains or coaches to Melbourne, from Portland, Heywood, Warrnambool, Terang and Camperdown. There are also regular (although not frequent) intercity bus services within the region – including:

- between Warrnambool and Mortlake,
- between Warrnambool, Port Fairy, Portland, Heywood and Dartmoor,
- Warrnambool, Hamilton, Coleraine and Casterton,
- Warrnambool, Peterborough and Port Campbell.

Generally there is little public transport outside the main towns and travel by public transport from outlying areas is infrequent and time-consuming.

Even among the main towns, regular, frequent public bus services exist only in Warrnambool, with most areas of the city served. Hamilton has a community bus service. Taxi services also exist in Warrnambool, Portland, Hamilton, Port Fairy, Koroit, Camperdown, Timboon and Terang. In other areas it is not always commercially viable to run a service. While there are discounts available to people with a severe mental disability, normal prices apply to the rest of the population and taxis remain a relatively expensive form of transport.
2. Background

2.1 Definitions

2.1.1 High Prevalence Psychological Disorders

For the purposes of this project, high prevalence psychological disorders refer to depression and generalised anxiety disorder. Their high prevalence differentiates them from more severe or acute psychological disorders, such as bipolar affective disorder or psychoses, which occur less frequently. There is a wide spectrum of severity within the high prevalence disorders and their episodic nature can mean that someone with depression or anxiety can be quite well and functioning normally for much of the time. With a mild episode of depression or anxiety, a person may still be able to socialise, work and go about life although with difficulty.

Given the episodic nature of these disorders, early intervention is important in helping people to deal with their depression or anxiety, and to halt the possible development of a more severe problem which may require hospitalisation or long term specialist treatment.

Data from the Australian National Survey of Mental Health and Wellbeing (NSMHW, 1997), showed that of the total burden of mental disorders in Australia, anxiety and depression account for more than half (Andrews, Sanderson, Slade & Issakidis, 2000). While there are effective treatments for both disorders, 40% of those surveyed who had current disorders did not seek treatment in the previous year. The study concluded that with respect to high prevalence disorders, too many people do not seek treatment and, when they do, effective treatments are not always provided.

2.1.2 Depression

Clinical depression is a generic term for a number of conditions where the most common symptoms are persistent feelings of sadness, hopelessness, and lack of interest in usual pleasurable activities. Depression can be episodic and can vary in its severity.

The following definition, summarised from the World Health Organisation (WHO) International Classification of Diseases (ICD-10) (WHO 2007b) highlights a range of emotional, cognitive, physical and behavioural symptoms. A combination of these typically makes up the diagnosis of clinical depression, which is classified as an affective mood disorder:

- the state where a patient suffers from lowering of mood, reduction of energy and a decrease in activity. Capacity for enjoyment and concentration is reduced and persistent feelings of sadness, hopelessness and lack of interest pervade. Marked tiredness even after minimum effort is common. Other symptoms can be sleep disturbances, appetite changes, reduction in self-esteem and self-confidence, problems with memory or concentration and feelings of guilt. Depression tends to be episodic and of varying severity.

The number and combination of symptoms needed to make a diagnosis are operationally defined in ICD-10 and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (APA, 2000).
Depressive disorder is the most common psychological disorder among patients attending primary care worldwide. In a study of over 25,000 patients attending primary care conducted by the WHO, the estimated prevalence of depressive disorder was 10.4% (Unstun & Sartorius 1995).

2.1.3 Anxiety

Anxiety disorders, which can be chronic or recurrent, are a group of high prevalence psychological disorders which typically include the following symptoms summarised from the ICD-10:

- persistent and excessive sense of apprehension with dominant physical symptoms such as sweating, palpitations, chest pain, choking sensations, general unreality and feelings of stress.
- there is often a secondary fear of dying, losing control or going mad. Panic attacks, which can occur with different anxiety disorders, often lead to a persistent fear of having another attack.

Some of the main types of anxiety disorders include:

- generalised anxiety disorder,
- panic disorder,
- agoraphobia,
- post traumatic stress disorder,
- obsessive compulsive disorder,
- social phobia, and
- specific phobia.

As with depression, the number and combination of symptoms for a clinical diagnosis are defined in the ICD-10 and DSM-IV-TR.

Anxiety disorders are almost as common as affective disorders, and are often under detected and under treated. A recent US study of 1,000 patients in primary care clinics found that of those with anxiety disorders, 41% reported no current treatment (Kroenke, Spitzer, Williams, Monahan & Lowe, 2007).
2.2 National Prevalence

The NSMHW was undertaken in 1997 by the ABS and is the most recent survey of its kind. Adults aged between 18 and 99 years were surveyed in a sample representative of the adult Australian population. An hour long survey with participants was undertaken and covered the most common mental health disorders defined by the ICD-10. The survey found that for all males the prevalence of any depressive disorder was 4.2%, and for any anxiety disorder 7.1%. For females, the figures were 7.4% for any depressive disorder and 12.0% for any anxiety disorder. The total figures for all persons were 5.8% and 9.7% for depression and anxiety respectively (McLennan, 1997).

*Figure 2. Prevalence of Anxiety Disorder and Depressive Disorder in Adult Australian Population*

![Prevalence of Anxiety Disorder and Depressive Disorder in Adult Australian Population](image)

The NSMHW found that the prevalence of any mental disorder was highest in the 18-24 year age group (including substance use disorder) and this decreased steadily for each subsequent age group. For women prevalence was highest in the 45-54 age group (16%), and for men in the 18-24 age group (9%). The prevalence of depressive disorders was highest among females 18-24 years (11%) and males 35-44 years (8.5%). The survey also showed that rates of common mental disorders were similar across the capital cities and the rest of each State or Territory (McLennan, 1997).

The National Health Survey (NHS) conducted by the ABS in 2004-5 provides more recent data about mental wellbeing in the adult population. Personal interviews were conducted with a random sample of 19,500 adults and included questions relating to long term mental and behavioural problems. The most commonly reported problems were anxiety related and mood
(affective). Each was reported by approximately 4% of males and 6% of females; respondents were not asked whether they had been diagnosed by a health professional (ABS 2006). In the same survey, 5.2% of adults reported using antidepressant medication and 19% of adults reported using some medication for mental health problems — including pharmaceutical medication, vitamins, minerals and/or herbal treatments.

2.2.1 Burden of Disease

Depression and anxiety make up Australia’s most debilitating diseases. Depression accounts for 8% of all years lived with a disability and over $3 billion annually in direct and indirect costs (Hickie, 2004). The Australian burden of disease figures show that mental disorders account for 22% of all Disability Adjusted Life Years (DALYs) lost (McLennan, 1997).

Disability data collected in the NSMHW suggest that depression and anxiety disorders have a considerable impact in terms of burden of disease. For the purposes of comparison, people who had none of the mental disorders analysed for the survey reported that in the past month they had, on average, one day in the past month when they had not been able to carry out their usual duties. People with anxiety had, on average, 2.1 days per month out of role — a total of 2.7 million person days out of role per month among Australian adults. Depressive disorders accounted for 2.1 million person days out of role per month among adults in Australia (Andrews, Hall, Teessen & Henderson, 1999).

2.2.2 Health Services Utilisation

The NSMHW showed that 40% of people with a depressive disorder had consulted their GP within the past year. However, only 28% of people with an anxiety disorder sought any treatment from any health service during the same period. While the literature is not clear on the effectiveness of the treatment provided by GPs for high prevalence psychological disorders, they do seem to be the first port of call. This is reinforced by the figures showing that only 8.4% of those with a depressive illness visited a psychiatrist and 6.2% a psychologist (Andrews et al., 1999).

Women are generally more likely than men to have sought help from a health service provider. However, 62% of people with a mental disorder did not seek any professional help for their problem.
2.3 Victorian Prevalence

The Victorian Population Health Survey (VPHS) 2006 was conducted using a representative Statewide sample of adults from randomly selected households. From self-reported answers to questions about specific health conditions, 22.4% of females under 65 years of age reported that they had been diagnosed with either depression or anxiety. The figure for men of the same age group was 13.7%. The VPHS also provides data on rates of psychological distress, using the Kessler Psychological Distress Scale (K10) scale as a measure (DHS, 2006).

The Victorian survey found that almost 3% of all people aged over 18 had K10 scores greater than 30 indicating very high levels of psychological distress. The percentage of adults with a K10 score indicating high to very high psychological distress levels was 10.7%. In all age categories except the 55-64 age group, females had higher K10 scores than males. Psychological distress tended to be higher for females in the younger age groups, declining steadily as age increased. For males, the highest rates of psychological distress were noted in the 25-34 age group (DHS, 2006).

While the VPHS made no geographical analysis of its data, the previously cited NSMHW broke down the prevalence of psychological disorders for each State between the capital city and the rest of the state. In Victoria, the prevalence of anxiety disorders in the capital city Melbourne is 9.4%, while for the rest of the State it is 8.8%. For affective disorders, the figures are the same in Melbourne as for the rest of the State at 5.3%. 
2.3.1 Health Services Utilisation

When it came to seeking help for mental health related problems, the VPHS found that almost 12% of adult females and 7% of adult males had done so and that most people (54.3%) sought help from a GP. Twenty-four per cent sought help from a counselling service or psychologist and 18.6% from a private psychiatrist (DHS, 2006).

2.4 Prevalence in the Project Region

A recent population based study was carried out by the Greater Green Triangle University Department of Rural Health Flinders and Deakin Universities (GGT UDRH), investigating risk factors for chronic disease within the GGT region. The K-10 scale was used to measure psychological distress in the Limestone Coast Shire in Southeast South Australia and Corangamite Shire in the project region. The study also used the Hospital Anxiety and Depression Scale (HADS) to assess anxiety and depression (Kilkkinen, Kao-Philpot, O'Neil, Philpot, Reddy, Bunker, et al., 2007).
The results showed that in the Corangamite shire, the reported level of psychological distress was 31% for both men and women with two-thirds reporting moderate and one-third reporting high levels of psychological distress. The highest rate of psychological distress, anxiety and depression occurred in the 45-54 year age group (Kilkkinen et al., 2007).

It is difficult to accurately assess the prevalence of depression and anxiety in the project area. Prevalence data are not available at the LGA level. We do know that there is no substantial difference between rural and urban areas in the prevalence of mental illness (Eckert, Taylor, Wilkinson & Tucker, 2004; Judd, Jackson & Komiti, 2002). The PHIDU profile (PHIDU, 2005) also shows that in comparison with the rest of Australia, marginally fewer people over 18 years of age in the Otway Division have very high psychological distress levels as measured by the K-10. Mental health related chronic disease estimates are similar to the national average with 98.8 per 1,000 people self-reporting as having mental health and behavioural disorders.
3. **Methodology**

The methodology for each objective of the project is outlined below. In following chapters, a brief summary of methodology is given.

3.1 **Objective 1: Identify the capacity and structure of the current service system for depression and anxiety**

Eighteen known service providers and project stakeholders were asked about their knowledge of available services in the region. These primary discussions provided information about further possible service providers and about directories listing services which could be accessed. A list of people interviewed in initial inquiries about the local service network can be found at Appendix 1.

Information from a paper-based Primary Care Partnership (PCP) directory was also accessed (Southern Grampians and Glenelg PCP, 2003).

A search of web based service directories was undertaken. Any services listed in these were cross checked against existing information and against each other to ascertain any inconsistencies which were further investigated. Directories of professional bodies were also accessed. Service providers were contacted to clarify their service and what they actually provided. The web search included:

- DHS Victoria’s Mental Health Services on-line directory, directing people to services in their area,
- Australian Mental Health Services Reference Guide,
- Infoxchange Service Seeker – online directory,
- Moyne Shire Council directory of services,
- Warrnambool City Shire directory of services,
- Aussiweb Local Search – online directory,
- Commonwealth Carelink Service Directory,
- Glenelg Shire Council directory,
- Corangamite Shire directory,
- Mpower South West Directory of Services,
- Australian Medical Association – Doctor Search.

Additional scoping involved listings of 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 for current accuracy of information.

3.2 Objective 2: Assess the impact of the new Medicare Benefits Schedule Better Access items for Mental Health Care

Information about the new MBS Better Access program was accessed through several sources including the Department of Health and Ageing, the Australian General Practice Network and the Otway Division of General Practice.

Medicare statistics were obtained to highlight uptake of new MBS Better Access item numbers over the period November 2006 to March 2008. Access to statistics relating to geographic areas smaller than State level was requested from the Department but not provided.

A study of the impact of Better Access in the first six months of the program was accessed, along with several evaluations of BOIMHC projects.

3.3 Objective 3: Determine patterns of service usage, and identify service gaps, barriers and enablers to service utilisation

Information from both a consumer and service provider perspective was analysed.

3.3.1 Service Providers’ Perspectives

Key Informant Interviews

Interviews were held with 12 individual service providers from a range of services to gather more information about the services they provide and about the state of service provision for depression and anxiety generally. A list of key informants can be found at Appendix 4.

Reference Group

A reference group was convened comprising major stakeholders and participants in service delivery. To provide balance, there were also three consumer representatives on the reference group. The purpose of the reference group was to gather information and perceptions of participants about services provided in the region and the structure of a ‘service system’. Given their knowledge of the region, it was also a chance to ‘pick their brains’ and to have their input into the project. Reference group members also provided feedback regarding the project report and recommendations. The reference group met twice formally, but individual reference group members have been contacted throughout the project. A list of reference group participants can be found at Appendix 5.
At the initial reference group, participants were asked to come up with positive and negative aspects of the current service system. A presentation of the ‘mapping’ exercise carried out to date was presented and questions about the following were asked:

- Are all the current services covered?
- Are there any omissions?
- Structure and capacity of service providers
- Relationships between different agencies, how do they work together? Issues, shortcomings, things that work well?
- Are there typical pathways through the system?
- What changes have the Better Access item numbers made?

At the second group, the draft recommendations of the project were presented. The group discussed the draft recommendations and provided feedback.

**Focus Group**

A focus group was held to broaden the range of input into the project from service providers. Letters of invitation were sent to all identified providers of services specifically for depression and anxiety. Most were sent by email, in preference to fax or mail. On advice from the ODGP, all GPs received a letter of invitation via a mail out through the Otway Division. This meant that all GPs were able to be contacted and satisfied any privacy concerns that the Division had in handing over GPs’ contact details. We had planned to conduct several focus groups in different towns in the region; however the response was such that we only held one. A list of focus group participants can be found at Appendix 6.

The main activities of the focus group were to discuss the following:

- A network analysis exercise was carried out to identify group perception and understanding of the service system currently available and the links between different services.

  - Who are the players?
  - What are the relationships?
  - Prominence of specific types of services?
  - Directional relationships?
  - Quality of relationships?

- The group was then asked to discuss their perception of barriers and enablers to access to services and to give examples.

- The group discussed benefits and drawbacks of the Better Access initiative and the new MBS item numbers.

- An exploration of a future perfect scenario - for example, if things were perfect, what would the system look like.
Service Provider Survey

Social network analysis techniques guided the development of a survey of mental health service providers in the region, with the aim of describing the flow of consumers between the various types of providers. The aim of the analysis was to be able to represent the links between different services, if any, and the relative prominence of particular service providers in the network overall.

For the purposes of the analysis, it was necessary to ‘bound’ the network, that is, to be specific as to which providers were included and which would be excluded. Service providers who provided some form of treatment for depression and anxiety were included. This included GPs, private psychologists, counsellors, psychiatrists, clinical staff from SWHC’s PMHT and counselling staff from various community health centres and non-government organisations (NGO’s). All providers were treated as individual providers, regardless of whether they operated in sole practice or as part of a bigger service provider.

Although all known service providers in the region were invited to participate, low response rates to previous surveys suggested it was unlikely that a highly favourable response would be received. Consequently, the decision was taken to measure the relative percentages of referrals between different types of providers, rather than between specific named providers.

The survey asked each provider to indicate the number of consumers seen in the last three months for issues of anxiety or depression. Respondents were asked to identify the sources from which consumers came, and to indicate the percentage of consumers coming from each source, with percentages totalling to 100% of all consumers seen for anxiety or depression. Options included primary health care services, hospital based services, allied health services, private mental health services, school, work or business counselling services, community services, and self-referral.

The survey then asked each provider to indicate the percentage of those consumers seen for anxiety or depression in the last three months who were referred on to another provider or service. Respondents were asked to identify the types of providers and services to which they referred consumers, and to specify what percentage of those referred on were referred to each type of provider or service.

The resulting data set enabled an assessment of the relative numbers of referrals between the different types of providers completing the survey and listed in the survey. These connections were then represented visually using Netdraw software.

The Service Provider survey also sought to identify any constraints or access issues present in the system, by asking respondents to rate the various types of providers and services in terms of accessibility. Respondents were asked to indicate whether access/availability is always an issue, sometimes an issue or occasionally an issue. Respondents could also indicate that they are able to access services, that they have no use of services, or that they are unaware of the services. This enabled both the demand for services and constraints on services to be identified.

Open-ended comments collected in the survey enabled further explanation of the origins and destinations of consumers, and the barriers to providing services and accessing services.

A copy of the survey can be found at Appendix 7.
3.3.2 Consumers’ perspectives

Qualitative Interviews

Semi-structured interviews were conducted with 25 consumers of health services for depression and anxiety. All consumers interviewed had depression or anxiety in the previous two years and had sought treatment from a service provider within the project region.

Interview participants were recruited through notices placed in GP clinics, psychologist waiting rooms, community health centres and with the Primary Mental Health Team. Participants in the TAFE Stress Management Course were also contacted and invited to participate.

Interviews were mainly conducted face to face, although five were conducted over the phone to overcome the barrier of distance. Interviews were taped and generally lasted between 20 minutes and one hour.

The structure of the interview was designed to elicit information about the first place at where people sought help for their mental health problem. Subsequent referrals to a different service provider were explored. Interviewees were also asked about their perceptions of the quality of the care they received and about barriers or enablers to accessing appropriate treatment.

Interviews were recorded and transcribed. Two researchers listened to the recordings to identify themes. The interviewers also took notes of responses to questions during the interviews.

A copy of the interview schedule can be found at Appendix 2.

Telephone Survey

In order to gain a broader understanding of the issues facing consumers of services for depression and anxiety, a telephone survey was undertaken. The issues brought up and explored qualitatively in the consumer interviews were used in the design of the quantitative telephone survey of consumer perspectives.

The telephone survey was also designed to enable social network analysis of the data, with the aim of identifying the pathways taken by consumers accessing services for a stress related disorder, anxiety or depression.

Telephone Survey Sample Design: The telephone-based survey aimed to secure a response from approximately 210 residents from the Glenelg, Southern Grampians, Warrnambool, Moyne and Corangamite LGAs who had sought treatment for a range of stress related illnesses in the last two years. Respondents had to be aged between 18 and 64 years old to qualify for an interview.

The sample base for the survey was the electronic White Pages. This sample is known to be sub optimal, as the churn of telephone numbers due to people moving and new numbers being added as dwellings are occupied, affects about 12% to 15% of possible numbers. Further, from previous research we know that the proportion of silent numbers is increasing and can be as high as 25-30% in some areas. To deal with these issues, a technique was used that starts with the population of numbers listed in the telephone book and adds new and unlisted numbers using the ‘half open’ method. In this method, all numbers were incremented by five to create new numbers in the ‘gaps’ between the listed numbers. The resultant universe of numbers was then de-duplicated to remove any numbers that may be repeated. This process was replicated three
times to create a new theoretical universe of telephone numbers. This provided the opportunity for all potential numbers to be selected in the sample. This equal and known opportunity for selection is the first criterion of good random sampling.

Once the potential universe of numbers had been generated, a computer program was used to randomise the database. The sample was geographically stratified based on the distribution of households with phone numbers within the region. This process gave a very even distribution of potential numbers across the whole survey area and within the three survey sub areas. Every phone number therefore had an equal and known chance of selection and every part of the survey area received a proportional representation in the final sample of phone numbers selected for dialling.

**Telephone Survey Data Collection:** During the survey process, a person from the selected household who was between 18 and 64 years of age was interviewed. The respondent was asked if they had sought treatment for a range of mental illnesses in the last two years. If they had, they completed the full interview. Otherwise they completed an abridged survey and were then asked if any other member of the household had sought treatment for any of these conditions. If the affected person was not at home, callbacks were scheduled for a later time or day. Unanswered numbers were retried six times throughout the period of the survey. These procedures ensure a good sampling process from the sample frame used. Interviews were conducted on weekday evenings between 4.30 p.m. and 8.30 p.m.

Non-private numbers and faxes reached during the selection process were excluded from the sample. Continuous interviewer monitoring was used and post interview validations were conducted within five days of the close of the survey.

The survey was conducted using an Interview Quality Control Australia (IQCA) accredited Computer Aided telephone interviewing (CATI) facility, which operates under AMRSA standards for ethical behaviour. This organisation is a member of the Australian Market and Social Research Organisation (AMRSO) which allows the application of the Market and Social Research Privacy Principles.

**Social Network Analysis:** During the survey, consumers were asked to indicate which service providers they had accessed, and how many. These data enabled an assessment of the number of steps typically seen in a consumer pathway, as well as the variety of pathways consumers may take. The most prominent start point (first service provider accessed) and end point were also identified.

The range of pathways was graphically represented using a proprietary reporting tool. Further, the sources and destinations of consumers coming to each type of provider were analysed and provider centric diagrams, to visually represent the relative weighting of providers on either side of a particular provider node, were produced.

A script of the telephone survey can be found at Appendix 3.
3.3 Objective 4: Identify models and make recommendations for improved service delivery

A review of published and available ‘grey’ literature was undertaken regarding topics which may be utilised in the project region to optimise the use and knowledge of current services, and new areas of service provision which may be utilised.

Using the Ebscohost data base system, we were able to search the following databases:

- Academic Search Premier
- AMED (Alternative Medicine)
- Applied Science & Technology Abstracts
- CINAHL
- Clinical Reference Systems
- EJS E-Journals
- Health Business Full text Elite
- Global Health
- Health Source
- Information Science and Technology Abstracts
- MEDLINE
- Mental Measurements Yearbook
- PsycARTICLES
- PsyINFO
- Psychology and Behavioural Sciences Collection

We searched the literature using a ‘silo’ model looking for the problem, context and intervention using key words.

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<thead>
<tr>
<th>Problem 1</th>
<th>Problem 2</th>
<th>Key Words</th>
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</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Rural mental health services</td>
<td>Co-location</td>
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<tr>
<td>Anxiety</td>
<td>Workforce</td>
<td>Collaborative Care</td>
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<tr>
<td>Psychological Distress</td>
<td>Workforce shortage</td>
<td>Telehealth</td>
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<tr>
<td>High prevalence psychological disorders</td>
<td>Barriers to access</td>
<td>Web-based counselling</td>
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<td>Regional mental health</td>
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<td>Outreach Models</td>
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Abstracts found to be relevant were read and full papers were obtained from their original sources. The reference lists of relevant articles were also screened to obtain further literature. The main areas which emerged were: outreach models which maximise the use of specialist services in rural areas, studies regarding the co-location of psychological services within a GP practice; recruitment, retention and development of the regional mental health workforce; mental health literacy of both consumers and service providers; and possibilities for expanding collaborative care.

All articles and presentations accessed are contained in the list of references at the end of this report.
4. **Objective 1: Identify the capacity and structure of the current service system for depression and anxiety**

This section includes a list of services for consumers with high prevalence psychological disorders. It is based on the information which was available at the time of this project report, but may be incomplete as personnel changes occur with service providers.

### 4.1 Summary of Methodology

Consultations were held with eighteen stakeholders in provision of services for people with depression and anxiety as to services provided, location and personnel involved. These people acted as key informants in providing information about service provision locally.

A search of web based services directories was undertaken. These were cross checked to ascertain any inconsistencies which were then investigated further. The Telstra White and Yellow Pages were used to check for services.

Individual service providers were contacted towards the end of the project period to check for current accuracy.

(For more detail on the methodology, please see Chapter 3 of this report.)

### 4.2 State and National Service Provision

The Boston Consulting Group overview of the Victorian mental health system, (Boston Consulting Group 2006), delineates between State, Commonwealth and private funding for mental health services. It also differentiates services between high and low prevalence psychological disorders.

State funding accounts for the majority of mental health care beds in Victoria, for inpatient acute care, extended care, prevention and recovery care, and specialist care. The State system also provides 13 Child and Adolescent (CAMHS) teams, 21 Adult Mental Health (AMHS) teams and 17 aged teams, along with psychiatric disability rehabilitation support services throughout the state. These teams include service delivery across a range of mental health aspects including Primary Care and Early Intervention, Clinical Continuing Care, mother/baby care and early psychosis.

In Victoria and Australia wide it is possible for consumers to access GPs, psychologists and psychiatrists through the federally funded MBS Better Access to Mental Health Care Initiative. The Commonwealth also shares some funding with the Victorian government in the area of services for mental health care for the aged.

Private hospitals provide approximately 100 inpatient beds for mental health patients across Victoria.
4.3 Services for Depression and Anxiety in the Project Region

When exploring direct services for anxiety and depression in the South West, four main categories were identified: public, private, community and workplace related. See Appendix 8 for a list of identified providers for services.

4.3.1 Public Sector

These are services funded by Department of Human Services Victoria through Psychiatric Services under the auspices of SWHC in Warrnambool and Western District Health Care in Hamilton.

Psychiatric Services, Southwest Health Care

SWHC Psychiatric Services provide a 24-hour-a-day, seven-day-a-week specialist psychiatric care service. Teams provide early detection, assessment and treatment of mental illness across the spectrum of mental health problems.

Within Psychiatric Services, the PMHT provides clinical services for consumers with high prevalence psychological disorders. The team currently comprises 5.5 full time equivalent (FTE) staff.

The PMHT team provides clinical services at their main location at Bohan Place in Lava Street, Warrnambool. In addition, they provide counselling services co-located with GPs in five clinics across the region. This service allows GPs to refer consumers to a PMHT clinician for subsidised counselling sessions. Sessions are conducted within the GP clinic, so there is no need for the consumer to attend a new location and any stigma attached to attending the Psychiatric Services offices is bypassed. The PMHT have also run stress management courses in conjunction with South West TAFE.

Clinical services are also provided by the PMHT, through education, to primary care providers within the region. They act as advisers – for example, the community health nurse can telephone PMHT staff for advice and help in dealing with particular consumers.

Self-referral to the PMHT or referral from a doctor or other service provider is accepted. There is no cost to the consumer.

Other services of SWHC Psychiatric Services are:

- 3.5 EFT Psychiatrists
- Area Adult Mental Health Team which provides mobile support and treatment throughout the region. The regional AMHS teams also provide some service for depression and anxiety when necessary – although it is usually only in terms of assessment and referral to an appropriate service.
- Crisis Assessment and Treatment Team
- Child and Adolescent Team
- Acute Inpatient services – 15 beds
• State-wide specialist services support

4.3.2 Private Sector

In this category are GPs, clinical psychologists, registered psychologists, psychiatrists, and private counsellors in the region who operate under a user pays system, although there is some MBS funding under the Better Access Initiative.

There is also a new mental health unit at St John of God private hospital which has inpatient beds and will provide services for those with high prevalence disorders through outpatient workshops for people referred by GPs, psychologists and psychiatrists.

General Practitioners

GPs provide an important service for depression and anxiety, given that the majority of people seeking help for these disorders first present to their GP (McLennan, 1997).

Across the project region there are approximately 100 GPs. Information from the ODGP and from individual clinics has been used to make this estimate. The Otway Division has 111 GPs registered, not including short term registrars, but extends beyond the project boundaries. In terms of full time equivalent (FTE) GP positions, the number in the Otway Division is 93. The estimated number of female GPs practising in the Otway Division is 27 out of 111, approximately 23% (PHCRIS, 2006).

The rates of population per FTE GP in Otway DGP vary little from the rates for Victoria and Australia, indicating a similar level of provision of GP services in the Division (PHIDU 2005). However, GPs are not spread evenly throughout the project region.

GPs are able to provide assessment of the patient and to prescribe medication. Under the Better Access program of the MBS they can draft a Mental Health Care Plan and refer patients to subsidised counselling services with psychologists, social workers, occupational therapists or psychiatrists. GPs are also able to access psychologists through the BOIMHC Access to Allied Psychological Services (ATAPS) program administered through the Otway Division.

While some services are Warrnambool based, there is a spread of GPs throughout the project region. Consumers are able to self refer to GPs and the cost of consultations is subsidised through the MBS, with medication available through the Pharmaceutical Benefits Scheme (PBS) where appropriate.

Psychiatrists

One private psychiatrist is based in Warrnambool and another, also based in Warrnambool, works part time. There is a cost to the consumer for these services and some subsidies are available through the Better Access program.

Consumers need to be referred by their GP or another medical specialist in order to be eligible for any Medicare subsidy. There are waiting lists of at least two months for these services.

Psychologists

Psychologists are in practice in Warrnambool, Portland, Camperdown and Hamilton and visit other centres on a part time basis. Throughout the region, there are 18 psychologists and two clinical psychologists practising privately. All local psychologists are registered to practise with the Psychologists Registration Board of Victoria.
Consumers can self refer or can be referred by their GP or another service. Costs vary from service to service, however consumers can be eligible to a subsidy under the Better Access MBS scheme.

In Victoria in 2004-05 there were 6,096 registered psychologists (Australian Institute of Health and Welfare (AIHW, 2006) which represents one psychologist per 809 people in Victoria using the most current census population figure for Victoria of 4,932,422 (ABS, 2006). The proportion of these psychologists who are metropolitan based is 98.3% (AIHW, 2006). The project region, with an approximate population of 101,000 (ABS, 2006) therefore has one psychologist per 5,050 people.

Social Workers
Within the region, there are three social workers in private practice providing services for consumers with high prevalence disorders. Two of these are registered to provide services under the Better Access program, and are known to bulk bill some of their consumers. All three are based in Warrnambool.

Private Counsellors
There are two counsellors in private practice in the project area. Counsellors do not have the formal qualifications of psychologists and consumers can self refer. Costs vary and there is no subsidy available for these services through Medicare.

4.3.3 Community Sector
This includes counselling services run through NGOs such as Lifeline, community health centres, churches, former bush nursing hospitals, Koori Cooperatives, and charities. Funding may include some State Government grants, bequests and public fundraising. Services in the community sector generally provide part time counselling for depression and anxiety and they do not specialise in high prevalence disorders exclusively (for example, Lifeline also provide financial counselling). Many of these groups provide support and information to consumers and, as such, do not provide a direct ‘treatment’ service. Below is a cross section of community organisations:

Frances Hewitt Community Centre, Hamilton
The centre, part of the Western District Health Service (WDHS), provides a broad range of primary health care services including access to counselling for high prevalence disorders at no cost to the consumer.

Heywood Rural Health
Heywood Rural Health services the town of Heywood and the surrounding district. Among other services, counselling for depression and anxiety is available on a part time basis. There is no cost to the consumer.

Portland District Health
The Portland District Health service provides health education, general counselling and support for those with depression and anxiety. A community mental health worker is available three days per week. There is no cost for services.

Western District Health Service
The Western District Health Service also provides some counselling made available through small primary community health centres in Balmoral, Casterton, Coleraine and Penshurst.
Lifeline
Lifeline provides a 24 hour telephone crisis counselling and information service, providing an immediate response to consumers. Lifeline has, at times and dependent on funding, provided the Strengthening Women course which equips women living with anxiety or depression with strategies to cope with their illness. The LARC centre (Lifeline Access Resource Centre) also provides short term counselling for a range of issues, including depression and anxiety. Services are provided at no cost and are provided by more than 40 active volunteers.

Centacare
Centacare is a community non-government organisation which provides counselling for depression and anxiety among a range of other issues such as family mediation, grief and loss and anger management. The cost of these services is negotiable and is based on the consumer’s income.

Community Connections
Community Connections is a not-for-profit non-government organisation which provides a range of services in the project region. Counselling is offered as one of many support services they provide. Counselling is available to those with a mental illness as part of the general public.

ASPIRE
ASPIRE is a community organisation providing psychiatric disability rehabilitation and support services to people with a mental illness and their carers. While they focus on providing services for those with a disability resulting from mental illness, they provide support groups and health promotion programs (such as Mental Health First Aid) which can be accessed by people with depression and anxiety.

Aboriginal Health and Support Services
The Kirrae Health Service (Framlingham), the Gunditjmarra Aboriginal Coop (Warrnambool) and Winda Mara Aboriginal Corporation at Portland also provide support and referral for local aboriginal individuals who require help. Each service liaises with other regional support services and aboriginal services state wide and nationally. There are also aboriginal liaison officers at Warrnambool and Portland hospitals.

4.3.4 Services through the Workplace

Workplace counselling is provided by many companies through Employee Assistance Programs (EAPs). Generally, these are larger employers and the EAP provides access to confidential counselling for employees including for depression or anxiety. Examples of companies who provide EAPs in the region include banks, councils, Wannon Water, Alcoa, Fonterra and Deakin University.

Figure 4 below outlines the geographical distribution of services throughout the project region. An asterisk (*) denotes that the service is provided part-time. The SWHC PMHT, while based in Warrnambool, also provides services in Camperdown, Hamilton and Portland. EAPs were found to be common among larger employers, but difficulty was encountered in accessing more information due to employers’ reluctance to discuss details of the services on ‘privacy’ grounds. More research needs to be done into the role of EAPs.
Figure 4: Geographical Distribution of Services for Depression and Anxiety
5. Objective 2: Assess the impact of the new Medicare Benefits Schedule Better Access Items for Mental Health Care

5.1 Summary of Methodology

Several evaluations of the BOIMHC initiative were studied to highlight differences between Better Outcomes and Better Access.

Information about the new MBS Better Access program was accessed through several sources including the Department of Health and Ageing, the Australian General Practice Network (AGPN) and the ODGP.

Medicare statistics were accessed to highlight uptake of new MBS Better Access item numbers over the period November 2006 to March 2008. Access to statistics relating to geographic areas smaller than State level was requested but not given.

(For more detail on the methodology, please see Chapter 3 of this report.)

5.2 Introduction

One of the main features of provision of mental health care services, where high prevalence disorders are concerned, has been the initiative by COAG, funded by the Commonwealth Government, to provide greater access to psychologists and mental health trained occupational therapists and social workers under the Better Access program.

5.3 Better Outcomes in Mental Health Care

The forerunner to the Better Access initiative was the BOIMHC program, introduced in the 2001-2002 Federal Budget. BOIMHC provided several strategies for delivery of mental health care in the general practice setting. One of these strategies, the 3 Step Mental Health Process items required GPs to complete at least 6 hours of mental health training in order to use them. This strategy was phased out from May 1, 2007. However, the GP Psych Support Service – whereby GPs have phone, fax or web based access to patient management advice from psychiatrists - and the ATAPS components of BOIMHC continue to be funded. ATAPS is administered through General Practice Divisions and specifically targets low income consumers who have difficulty accessing psychological services. The ODGP uses a voucher system in their ongoing ATAPS program, which continues to provide another referral option for local GPs.

Several evaluations of BOIMHC – and General Practice Division projects under the scheme – have been undertaken. One evaluation of the first three years of the BOIMHC program concluded that ‘the high level of uptake of the main components of the BOIMHC initiative have resulted in an expanded national capacity to respond to those with common mental disorders, such as depression and anxiety.’ (Hickie, Pirkis, Blashki, Groom & Davenport, 2004)

The Centre for Health Policy, Programs and Economics, School of Population Health, The University of Melbourne conducted an evaluation of the ATAPS component of the BOIMHC in 2007. They found that collectively the ATAPS projects had been used by over 6,000 GPs, over
2,000 allied health professionals (mainly psychologists) and over 63,000 consumers (Bassilios, Fletcher, Pirkis, Kohn & Blashki, 2008) The evaluation also found that overall the projects reached the target group – those with a low income and with no previous history of mental health disorders. Typically, these consumers were women around the age of 40 with depression or anxiety disorders.

The evaluation of the Southern Highlands and Illawarra Divisions of General Practice ATAPS programs found that anxiety and depression were easily the most common reasons for GP referral and that the programs provided increased access to psychological services for those with high prevalence disorders (Vagholkar, Hare, Hasan, Zwar & Perkins, 2006).

In our project region, defined by the ODGP, only 10 of the approximately 115 GPs in the area undertook the Mental Health training required to be able to use the ATAPS program. This limited the impact of the program. Indeed, there is anecdotal evidence that the GPs with this training did not want to be known as ‘mental health GPs’ and were therefore reluctant to let people know that they had done the training and were eligible to use the item numbers. This was a barrier to the BOIMHC program being more effective in the region. So while the BOIMHC did allow for increased access to psychological services, the small number of GPs willing to undertake the training in order to be eligible to use the program limited its potential impact in providing services for consumers with depression and anxiety.

### 5.4 Better Access Initiative

From November 1, 2006, new mental health care item numbers became available through the MBS under the Better Access program. The aim was to expand affordable access to mental health care by providing for GPs to undertake assessment and management of patients with mental health issues and provide a referral pathway to clinical psychologists or allied mental health service providers. Unlike the preceding BOIMHC, the Better Access program is open to any GP which immediately broadens the access for consumers.

Table 2 below sets out the main item numbers relating to services for adults with depression and anxiety.
### Table 2 Description of Item Numbers in the Better Access Program

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Item</th>
<th>Schedule Fee</th>
<th>Rebate Nov 06</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GP Mental Health Care Items (New)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Preparation of a GP Mental Health Care Plan | - Assessment of patient and preparation of GP Mental Health Care Plan.  
- Enables referral of patients to clinical psychologists and other allied mental health professionals.                                             | 2710   | $150.00      | $150.00       |
| Review of a GP Mental Health Care Plan    | - Review of the patient’s progress against the goals in the GP Mental Health Care Plan.  
- May also be used by a GP to review a referred psychiatrist assessment and management plan.                                                  | 2712   | $100.00      | $100.00       |
| GP Mental Health Care Consultation        | - Extended consultation (20 mins +) where the primary treating problem is related to a mental disorder.  
- May be used for ongoing management of a patient with a mental disorder, including for a patient being managed under a GP Mental Health Care Plan | 2713   | $66.00       | 66.00         |
| **Focussed Psychological Strategies and Psychological Therapy Items (following GP, psychiatrist or paediatrician referral)**                                                                                       |        |              |               |
| GP - Focussed Psychological Strategies items | Increased fees for existing items provided by medical practitioners registered with Medicare Australia as having the required mental health skills training. | 2721   | 30-40 mins $80.35  
2725   | 40+ mins $115.00                                    | 30-40 mins $80.35  
2725   | 40+ mins $115.00                                    |
| Clinical Psychologist – Psychological Therapy | - Clinical Psychologists eligible for membership of the Australian Psychological Society’s College of Clinical Psychologists.                          | 80000  | 30-50 mins $88.20  
80010  | 50+ mins $129.40                                    | 30-50 mins $75.00  
80010  | 50+ mins $110.00                                    |
| Psychologist – Focussed Psychological Strategies | - Psychologists registered with the Psychologists Registration Board in the State or Territory in which they are practising.                              | 80100  | 20-50 mins $62.50  
80110  | 50+ mins $88.20                                    | 20-50 mins $53.15  
80110  | 50+ mins $75.00                                    |
| Social Worker and Occupational Therapists - Focussed Psychological | - OTs with full or part-time membership of OT AUSTRALIA with a minimum of two years experience in mental health who                                    | 80125  | 20-50 mins $55.05  
80135  | 20-50 mins $46.80                                    | 20-50 mins $53.15  
80135  | 20-50 mins $75.00                                    |
Strategies abide by The Australian Competency Standards for Occupational Therapists in Mental Health.
- Social workers with membership of the Australian Association of Social Workers (AASW), including certification by the AASW as meeting the standards for mental health set out in the AASW’s ‘Standards for Mental Health Social Workers 1999’

<table>
<thead>
<tr>
<th>Group Psychological Therapy or Focussed Psychological Strategies Services</th>
<th>80020</th>
<th>80120</th>
<th>80145</th>
<th>80170</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical Psychologists</td>
<td>$32.90</td>
<td>$22.45</td>
<td>$19.75</td>
</tr>
<tr>
<td></td>
<td>Psychologists</td>
<td>$28.00</td>
<td>$19.10</td>
<td>$16.80</td>
</tr>
<tr>
<td></td>
<td>OTs and Social Workers as above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For 6-10 patients and minimum of 60 minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Graphs showing uptake figures by state, per capita, per quarter and by age and gender can be found at Appendix 9. All these statistics were accessed from: http://www.medicareaustralia.gov.au/statistics.

This site enables access to reports which relate to uptake of item number in total, by state, by demographic, by usage per month, per quarter and, for items relating to GPs, by Division of General Practice.

What we have not been able to access, despite several requests over a six month period to both Medicare and to the Department of Health and Ageing, are any uptake figures on a LGA level. We were also unable to access some figures for psychological services items at the GP Division level for privacy reasons. (This is where the uptake of a particular item number is less than 5 for that period.) The website did not allow the same access to Otway Division Statistics which were accessed on April 13. Therefore, we only have Otway Division uptake figures to the end of Quarter 4, 2007.

Other research bodies experienced similar difficulties. The Mental Health Council of Australia (MHCA) in its report of July 2007 reports that “despite phone and written requests to the responsible authorities, the MHCA has not yet been able to obtain a breakdown identifying MBS services provided by region, or even a simple rural/metropolitan analysis” (Crosbie & Rosenberg, 2007, p.10)

### 5.5 Uptake of Better Access Item Numbers

The report of the Mental Health Council of Australia (Crosbie & Rosenberg, 2007) concentrated on the uptake rates of what they categorise as the three major item numbers in the Better Access program:

- 2710 - the GP Mental Health Care Plan,
- 80010 - 50+ minutes session with a clinical psychologist, and
- 80110 - 50+ minutes for psychological focussed strategies with a registered psychologist.

As part of this project, statistics for the same three item numbers were accessed. Nationwide in the period November 06 to March 08, 655,996 Mental Health Care plans had been prepared by GPs (item 2710). Of these, 189,971 - 28.9% - were in Victoria. This is second only to NSW and represents the highest per capita uptake for this item with 3,632 services per 100,000 of population. NSW had 227,753 Mental Health Care plans prepared during the same period which is 3,269 services per 100,000 population. The Northern Territory had the least number of Mental Health Care plans prepared during the period – 2,469. This also represented the fewest services per capita with 1,181 services accessed per 100,000 of population. (Please see tables 1 and 2 in Appendix 9).

In Victoria, the Medicare contribution to the 2710 item numbers accessed was $28,668,206 for the period November 2006 to March 2008. Uptake rose sharply in the first few months after the introduction of the Better Access program. The months in which the greatest number of GP Mental Health Care plans were accessed were May 2007 and February 2008 with approximately 48,000 each. (See Table 3 and Graph 1 in Appendix 9.)
Across all States, women in the age group 35-44 years have recorded the highest uptake of the 2710 item number, followed by the 25-34 years age group. Men have recorded fewer consultations (230,193) compared with the total number of consultations which women have accessed (425,803). Boys under 14 years accessed the fewest Mental Health Care plans of any age group or gender. (See Table 5 and Graph 2 of Appendix 9.)

Of the 155,036 Mental Health Care plans prepared in Victoria during the period November 2006 to March 2008, 1.6% (2,579) were accessed by GPs in the ODGP. These were provided in Quarter 4 of 2007 by 102 GPs (see Table 3 below).
### Table 3 Uptake Figures in the Otway Division of General Practice

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

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

For item 80010 (consultation with a clinical psychologist over 50 minutes long), 615,815 services were accessed Australia wide (see Table 6 in Appendix 9). Of these, 168,391 were in Victoria which is 27.3% of the total. Per capita, Victoria had the highest use of this service with 3,220 consultations per 100,000 population. By contrast, South Australia had 2,678 consultations per 100,000 population (see Table 7 in Appendix 9). The Medicare contribution towards item 80010 in this period was $19,021,876 in Victoria and $2,159,875 in Tasmania for the same period (see Table 8 in Appendix 9).

For consultations with a clinical psychologist, Western Australia recorded the highest levels per capita with 5,428 consultations per 100,000 population. The Medicare contribution per capita for these services in WA was $618,879 per 100,000 population. For Victoria this figure was $363,691 per 100,000 population.

The peak months for access to the 80010 item number in the period November 2006 to March 2008 have been November 2007, February 2008 and March 2008 with around 50,000 consultations accessed in each of these months (please see Graph 3 in Appendix 9).

Women in the 35 to 44 years age bracket accessed the greatest number of services at 101,242. The next largest was the 25-34 years age group of women. Boys in the 4-15 years age brackets accessed the fewest services (see Table 10 and Graph 4 in Appendix 9).

For MBS item 80110, consultation with a psychologist for focussed psychological strategies over 50 minutes, the total number accessed for the period November 2006 to March 2008 was 1,205,900. In Victoria the figure was 427,932 which is 35.5% of the total. Victoria had the highest level of access per capita with 8,182 services per 100,000 population. Queensland recorded 236,335 services in total which is 5,670 services per 100,000 population. (See Tables 11 and 12 in Appendix 9).

The Medicare contribution to these consultations in Victoria was $33,450,498. This is $639,561 per 100,000 population. For NSW the Medicare contribution for item 80110 totalled $31,264,395 or $448,727 per 100,000 population. The peak month for these services Australia-wide was November 2007 when almost 100,000 consultations were accessed (see Tables 13 and 14 of Appendix 9).

As with the items 2710 and 80010, for item 80110 the group accessing the greatest number of services was women aged 35-44 years, followed by women aged 25-34 years. Women 35-44 years accessed 204,711 services. By contrast men in the same 35-44 years age group accessed 91,498 which was the highest level of access of all the male age groups (see Graphs 5 and 6, and Table 14 of Appendix 9).

The uptake of items relating to services provided by social workers, occupational therapists and mental health nurses is negligible across Australia. In the South West Mental Health Mapping project region, there are two social workers and no occupational therapists or mental health nurses making use of the items. The uptake of items relating to group therapy, services outside consulting rooms and remote phone counselling is also negligible.
6. Objective 3: Determine patterns of service usage, and identify service gaps, barriers and enablers to service utilisation

6.1 Service Provider Perspectives

This section of the report provides the perspective about provision of services for depression and anxiety from the service providers who have been identified in the region.

6.1.1 Summary of Methodology

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 provided. Interview participants were invited to provide their perspectives about referral, gaps in service provision and any perceived barriers to providing adequate service.

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

All service providers were invited to participate in a focus group in which identification of 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.

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.

(For more detail on the methodology, see Chapter 3 of this report.)
6.1.2 Reference Group meeting

Issues and strengths of the service provision network were discussed and are summarised below:

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good range of services offered across a range of agencies and areas.</td>
<td>Low level of consumer awareness regarding what services exist and how to access them.</td>
</tr>
<tr>
<td>New MBS items have increased access to psychological counselling.</td>
<td>Accessibility due to geography</td>
</tr>
<tr>
<td>Placement of Primary Mental Health Care Team in GP clinics is working well.</td>
<td>Capacity of services in terms of demands placed upon them.</td>
</tr>
<tr>
<td>Synergy and goodwill exist between some service providers.</td>
<td>Need active coordination to shore up appropriate referrals – could be cleverer at collaborating.</td>
</tr>
<tr>
<td></td>
<td>Workforce recruitment, retention and experience issues.</td>
</tr>
<tr>
<td></td>
<td>No registered mental health nurses outside SWHC Psychiatric Services is a disadvantage.</td>
</tr>
</tbody>
</table>

6.1.3 Focus Group

The focus group consisted of nine service providers ranging from GPs, private counsellors, EAP counsellors, clinical psychologists and registered psychologists.

As part of the group exercise, participants were asked to list all the services (formal and informal) which they thought consumers would seek help for depression and anxiety from. The group identified these categories and headings:

- **Medical Practitioners – GPs**
- **Nurse/Medical/Hospital** – SWHC Psychiatric Services, Emergency & Accident
- **Informals** – including friends, family, sporting club coaches, barman, hairdresser, chat room etc. This group includes any of the people you might speak to informally about how you’re really feeling
- **Small Business Services** – included in here are financial planners, rural counsellors, accountants and solicitors. These are people who are not running a mental health service as such, but would provide advice for people in various stressful situations
- **Community Services** – includes community health clinics and non-government agencies who provide a counselling service (may be part time and may not be a dedicated service for depression and anxiety only). Examples included Lifeline, Centacare and Portland District Health
- **Private Counsellors** – includes psychiatrists, clinical and registered psychologists, psychodynamic psychotherapist, other private counsellors with various qualifications in private practice
- **Work Force Services** – relates to counselling provided by EAPs
- **Schools** – school counsellors, chaplains, teachers and their role in providing a service. (Note: school services are not included in our project, but were included here by the focus group).
• **Information Sources** – where people can go to get information about mental health services. The group included the internet (eg, beyondblue website, Australian Psychologists Society referral list) and the Yellow Pages.

### 6.1.4 Themes Identified by Service Providers

#### Workforce

One theme which emerged strongly from the different sources of service provider information is the perception there are not enough qualified staff to provide the number of services needed. Demand outweighs supply for services in both the private and public sectors. This is the case even where the project region is relatively well serviced, for example in the case of GPs. GPs reported that recruitment is difficult in rural and regional areas and that vacancies in clinics remain open for long periods of time.

Psychiatric Services, SWHC, noted that while recruitment of qualified staff can be problematic, the real difficulty lies in retention of these staff beyond the period where they are being supervised and ‘getting up to speed’. Since it is difficult to recruit suitably qualified staff, Psychiatric Services often recruits young, probationary psychologists whose aim is to finish their probation and return to Melbourne. Turnover of staff is an ongoing issue.

Limited staff means that the services provided are also limited. For Psychiatric Services, this means that the PMHT need to limit their presence in GP clinics or that other Psychiatric Services teams are unable to take on the full demand for their clinical services. This can lead to frustration in other service providers.

> Psych Services expect an overwhelming amount of information. They’re the specialists; they should elicit that type of information. If I do ring them they always ask if the patient is at risk of immediate harm. In my opinion, it’s always my assessment that I think they need priority. **GP 1**

One of the effects of the workforce shortage is that waiting lists can be long. A small workforce, coupled with the introduction of Better Access leading to an increase in demand for psychological services, has meant that waiting lists of over two weeks are not unusual. One service provider of a private service noted that

> Generally there are not enough services - I have waiting lists of 3 or 4 weeks, it’s a bug bear for me. It’s a real worry that we’re only in the start of June, the start of winter and it’s already blown out, because in winter it’s generally very busy. **Private service provider 1**

Another local private practitioner pointed out,

> Demands on my time lead to longer waiting periods than desirable and at times difficulty with ongoing sessions being at optimal intervals. **Private psychologist 1**

Continuity of care for consumers is also affected by the difficulty in recruiting and retaining suitable staff, especially in the public sector. The recruitment of overseas trained psychiatrists at Psychiatric Services was also noted as a workforce issue. Locally trained psychiatrists are unwilling to take a posting in a regional area, so mostly psychiatrists from India have been recruited in the past seven years. Recruitment, resettlement for doctors and their families and ongoing professional training and supervision are all factors which make recruitment difficult and costly. Other issues have been identified in connection with overseas trained psychiatrists, including communication difficulties, cultural differences and the perception that once they are
able to obtain citizenship and join the Royal Australian & New Zealand College of Psychiatrists, they will leave the region to pursue other opportunities.

One GP noted that in the field of psychiatry, the prevalence of international medical staff presented a problem because of the importance of the consumer being able to communicate effectively with the service provider. This GP felt that the cultural and language differences between rural Australians and overseas psychiatrists presented a problem.

_The feedback from patients on the overseas trained psychiatrists is that this is one specialty where people really need to be able to speak to the doctor. The feedback is not all good._  **GP 1**

The fact that there are no psychiatric nurses outside of Psychiatric Services or the private hospital (St John of God) in the region was identified and noted as another workforce issue and led to limited services for high prevalence disorders. If there were more psychiatric nurses able to use the Medicare Mental Health Nurse Incentive Program, more work could be done following up and evaluating consumers seen by GPs or psychiatrists, along with early intervention.

The fact that the region is under serviced by private psychiatrists was also raised. The waiting list for a private psychiatrist is generally accepted to be over 2 months.

_There are not enough psychiatrists available for access to appointments in the short term._  **GP 2**

Not only are psychiatrists hard to access due to waiting lists, they are also perceived as an expensive option for consumers. One GP noted;

_I find that 95% of my patients are either unwilling or unable to pay for their care, so I only refer to a private psychiatrist when they can afford it._  **GP 1**

In this case, a subjective decision had to be made on the part of the GP as to whether he or she perceived that the patient was able to pay for private psychiatric care.

One suggestions raised by service providers was the possibility of opening up the MBS eligibility to drug and alcohol counsellors to cover greater need. This could be especially useful in rural areas where there are not enough psychologists or allied health workers to cover demand.

Several of the service providers mentioned that their workload and the nature of their work meant that looking after oneself is important. One comment was:

_My own health and the need to prevent burnout [is important]._  **Private Psychologist 1**

Another workforce issue which related to retention of staff was;

_Difficulties in accessing good, affordable, local professional development._  **Private Psychologist 1**

This psychologist felt there was little understanding of how far our region is from Melbourne which is where most professional development opportunities take place.

**Knowledge of Services**

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.
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.

Several service providers spoke about the Regional Alliance for Mental Health Promotion (RAMHP) which is a network of local agencies which focus on mental health promotion and raising awareness of services. RAMHP focuses on the mental health literacy of both service providers and consumers. Other agencies were mentioned with regard to enhancing mental health literacy – for example, ASPIRE provides mental health promotion in schools and also provides community education. *Beyondblue* is also providing awareness of mental health problems and of what services are available for those with mental health issues. The comment was made also that while *beyondblue* has raised awareness of seeking help, it may also have increased demand for services which are already stretched.

Mental health promotion literature was discussed in the focus group. One clinical psychologist talked about Good Mood Guide (www.goodmoodguide.org), a public mental health promotion booklet, which was found to be helpful for educating consumers and keeping GPs up to date.

The PCPs, initiated by DHS, were also mentioned as sources of information about what services are available for consumers with high prevalence mental health issues.

**Pathways for referral**

This is an area which is difficult for service providers. Many consumers with depression and anxiety benefit from accessing more than one service provider, but which services are appropriate depends on the specific consumer presentation. The question of to whom to refer consumers, in terms of competency, speciality and availability, can pose problems for service providers.

> There is an increase in need in 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. **ODGP**

One of the difficulties that was mentioned by service providers and which related to referral pathways was accessing Psychiatric Services. These comments were typical from private providers:

> [Psych services] have a lengthy intake process (eg, initial contact then the need for cases to be reviewed by a team before the client is considered for/able to access treatment) and they have apparently restrictive service guidelines which cause problems for clients in accessing public psychiatric services. **Private psychologist 2**

> Public psychiatric services do not provide support for these patients and have to discharge them from their care very rapidly and this can be confronting for some patients. **GP 3**

> I don’t refer to the Psych Services system if I really don’t have to. **GP 1**

However, others had positive experiences of referring to Psychiatric Services.

> Primary Mental Health workers are a great resource, very helpful. **Community Counsellor 1**

> One enabler is the funded availability of the primary mental health care workers in the clinic. **GP 4**
Referral can be problematic when there are co-morbidities involved. While this project has deliberately excluded services that are for co-morbidities such as drug and alcohol dependency, or long term chronic illness, it is virtually impossible to eliminate co-morbid conditions with depression. Therefore, the difficulty in accessing services for those with co-morbidities is important to note.

As noted when discussing collaboration, referral pathways may depend on the existing relationship between service providers. One GP noted:

*With 20 years experience the patient pathways are pretty clear. GPs know what works well for their patients and know which services to refer them to.*  
**GP 5**

However relationships built between service providers based on how well they work together may not necessarily be the best referral pathway for the consumer.

The introduction of the Better Access program had simplified the referral process for some service providers.

*In the last 3 months, I have not referred clients elsewhere other than the GP and most referrals I get are through the Medicare 2710 plans.*  
**Private Psychologist 2**

The variation in GP expertise and interest in mental health was also brought up. This comment highlights that the effectiveness of referrals can very much depend on the individual service provider and that it is not possible to homogenise a service provision group, such as the GPs, by referring to them as a whole.

*Some GPs are very supportive and accessible. Others are very difficult. One GP recently told a client that the government spends too much money on counselling and people are just wasting government money. This patient felt very powerless and chastised and felt they had to beg and show gratitude to get a referral.*  
**Private service provider 2**

*GPs have different skill sets, different areas of interest, different levels of awareness… it is not a uniform service.*  
**GP 5**

Several of the service providers mentioned that community organisations which were not set up solely to deal with depression and anxiety were extremely useful. This again points to the difficulty in separating out high prevalence disorders as a stand alone condition. Many consumers have other stressors and difficulties in their lives which need to be addressed along with the depression or anxiety they may also be experiencing.

*Most of the clients I see have depression related to depression…. Those that I referred to CASA (Centre Against Sexual Assault) were happy that I made the contact with CASA.*  
**Community counsellor 2**

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 1**
However, the mention of referral pathways did bring out some cynicism from some service providers. They believe that a lot of ‘navel gazing’ has been done about services, different directories had been produced and not kept current and that nothing really ever changes.

*I don’t want to sound cynical, but we’ve done this so many times. Please don’t be put off when you develop this further by peoples’ lack of enthusiasm – people are pathwayed out!*  

Private service provider 1

Collaboration and Cooperation between Service Providers

Collaboration is important to patient outcomes (see literature review, Chapter 8) and was discussed in meetings with service providers. Some collaboration is based on relationships that naturally develop between certain service providers. Other collaboration is more deliberate or planned. One example of a collaboration which is working well is the program whereby PMHT clinicians are available within GP clinics. This is seen as facilitating increased access to psychological counselling services while reducing the stigma associated with attending a mental health facility.

One comment was that there needs to be some sort of active coordination to facilitate appropriate referrals being made. This indicates that there is a need for some sort of ‘system-wide’ monitoring of consumer movements but presents logistical difficulties. Many of the service providers considered that collaboration was important, but that it was difficult to work out in practice given existing resource constraints.

Who to include in ‘collaboration’ also generated discussion. It was felt that there was a need to support the support networks of people with depression and anxiety. For example, sports clubs can provide a real support for their members but a down side is the culture of alcohol abuse in many sporting clubs.

Service providers also disagreed in some areas on the issue of collaboration. For example, one group suggested that good GP/psychologist feedback seemed to exist, but another GP said that getting any feedback from psychologists was a difficulty. This suggests that collaboration may depend on the relationship which exists between individual service providers, rather than being deliberate across the whole ‘system’. It was clear, in general, that goodwill does exist between different types of service providers and that there is at least willingness to collaborate in order to provide more effective consumer outcomes.

But there was also this comment from one provider;

*Locally, the private system tends to be competitive and service providers can be possessive.*  

Private service provider 1

Another example of collaboration was how Lifeline are available as an after hours stop gap for people in need of counselling help. It was also noted that Lifeline spend a lot of their time coaching their callers in how to discuss and express their mental health problems with their GPs.

Other examples of collaboration highlighted the importance of the relationship between service providers.

*I refer my patients to [the private psychiatrist]. There is usually a two month wait but he will speak to me on the phone promptly and advise me that way. But the patient would need to be suicidal to get a quick appointment.*  

GP 1
The role of GPs was acknowledged to be central to the treatment of many high prevalence service consumers. While consumers may be referred from the GP for counselling, there needs to be some collaboration for follow up;

*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 2

Unhelpful dealings with the police was a theme that came out of the focus group.

**Service System**

It was noted that there does seem to be a wide range of services offered across different agencies with different areas of expertise, and across the region more generally. The question was asked

*Do we need to concentrate resources and just do one or two things really well?*  

SWHC Psychiatric Services 1

One specific gap in the system of services was noted by several service providers – that of after hours care. Apart from Lifeline or crisis care, there was little service provision for weekends and nights. Lifeline have carried out a feasibility study and are piloting a general community counselling service which takes a ‘no wrong door’ approach. Consumers can walk into the service, be assessed and referred to an appropriate provider. Counselling will also be available from duty staff. The service will be available after hours.

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. There are courses in Stress Management offered through the TAFE and group work courses for depression and anxiety through St. John of God. The intake for these is limited and the number of courses run per year is also limited.

One participant noted that from his perspective;

*The mental health system in this region is a mess. There is increased need and GPs don’t know where to refer. Some patients don’t seem to fit in anywhere.*  

ODGP 1

And this from another GP, relating to services beyond what GPs can provide;

*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.*  

GP 1

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.*  

Private service provider 1
A private psychiatrist cited a lack of outreach services to provide follow up and support for his clients:

They simply do not exist. **Private psychiatrist**

The Warrnambool-centric nature of services was also identified in discussions about the service system in the region as a whole.

*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 5**

It was felt that it may be difficult to access a suitable GP in rural areas, that consumers may be forced further afield to find one with whom they could relate and were happy to discuss their mental health issues with. It was acknowledged that can be difficult for people to adequately articulate their mental health issues within the timeframe of a standard GP consultation.

Hotlines, web based information and other technological services are seen as helpful, but not ideal. They do not provide any local knowledge, they cannot provide referral to a more suitable service provider, and they do not have any capacity to follow up a consumer.

The PMHT team focus on GPs because they believe they are a good use of scarce resources and that GPs are the first port of call for high prevalence disorders. It was also noted that at times the regional Adult teams of SWHC Psychiatric Services had consumers presenting to them with high prevalence psychological problems. The Adult teams are set up to deal with low prevalence disorders, so in these cases they try to refer the consumer to a community health service counsellor in their town. This is one of the difficulties of most of the services being based in Warrnambool.

While there are several counsellors in business in the region, offering an alternative to more formal services, one GP said;

*I don’t know enough about private counsellors so I am reluctant to refer to them. They’re an unknown entity; I don’t know what they offer.* **GP 1**

The reference group discussed EAPs and the growing, more formal role they play in providing access to counselling in the work place. Another comment was, however, that very few employers in the region provided these programs so that EAPs would have little effect on access to services for high prevalence disorders.

**Medicare Benefits Schedule – Better Access Scheme**

Service providers agreed that these have appreciably increased access to psychological services and have given the GPs another option for referral. More of the GPs use the Better Access program than used the BOIMHC schemes so in that sense it is an improvement from the previous model.

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 [consumers] wouldn’t seek counselling if it was not available at no cost as they couldn’t make the initial commitment to spend money on counselling. Some would. Some referrals I’ve had through Medicare have not accessed counselling in the past but have significant needs.* **Private service provider 2**
While it was agreed that access had increased, 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.

Some service providers commented that the

*economics of the program [Better Access] is a bit upside down* GP 2

For example, it was felt that the money paid to the GP for Mental Health Care Plan and for the follow up consultation could better be spent if it were injected into providing for the care of the mental health service consumer.

Yeah, I mean, I need to refer someone to see a cardiologist, I can just write them a referral and off they go and then the cardiologist writes me a letter back and tells me all about it and that's fair enough, but, if I want someone to see a psychologist, I've got to fill out this mumbo jumbo and get them the ticket to go, and then after six visits they have to come back to get the thing that you're complaining about [updated Mental Health Care Plan], the ticket to get the next six, I mean, and that all costs time and money from my point of view, and also the government is paying for it. Why isn't that money going into the care of the patient? GP 2

It was also discussed that the patient goes to a GP for an initial consultation which is rarely long enough to discuss mental health issues. Another appointment has to be made for another consultation – like ‘double dipping’ for the same problem.

Another concern centred around the equity of the program with some at the reference group questioning whether the new items were not just making psychological services easier to access for those who could already afford those services. The general feeling was that it should be providing equitable access.

Similarly there was discussion about the gap payments which consumers have to pay over and above the Medicare subsidy. According to the Otway Division and to several direct enquiries made, these are increasing. 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 access 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.* GP 5

Other service providers, however, disagreed that there had been any increase in the cost of psychological services since the introduction of Better Access.

The Otway Division also voiced concern about inappropriate referrals. Examples of this may be where people are having 12 sessions when they do not really need that many or of people going to psychologists when they really need to access acute care from Psychiatric Services. GPs also noted that some consumers are accessing their GP after already visiting the psychologist. The psychologist sends them to the GP to get a referral under Better Access – thus the assessment has already been done by the psychologist and the GP is just going through the motions as far as writing up the Mental Health Care Plan is concerned.
GPs reported that there was a lot of paperwork generated by the Mental Health Care Plan and they felt that this was unwieldy and time consuming. It was felt that there is a lot of bureaucracy around the Better Access program and the administration was seen as ‘tedious’ with the potential to interrupt the treatment of a consumer.

The requirement to go back to the GP for the Care Plan follow up and further referral after the initial 6 [psychologist] visits can interrupt the flow of the treatment. After session number six, you cannot schedule another one until [the consumer] has seen a doctor. And that is where some people and some clients just don’t know what to do. Private psychologist 3

One GP felt he was untrained in how to appropriately and effectively write a Mental Health Care Plan;

I feel the psychologist – who is really the treating professional – should be the one paid to do the care plan. GP 2

One GP commented that it was not a truly collaborative program;

The GP provides the Mental Health Care Plan to the psychologist which is an improvement on a one line referral – however, there is no feedback coming back from the psychologists. GP 6

One psychologist believed that the increase in access to consumers could be increased if the referral mechanism was not just available to GPs.

GP are a good enabler, but this is primarily to get a Mental Health Care plan. Other practitioners not being able to make similar referrals could be a barrier. Private Psychologist 4

According to service providers there was no evidence that the new MBS items were having an impact on public sector staffing. It has been suggested that public sector clinicians would leave the public system in order to take advantage of the increased demand for private services, however only one clinician in this region has moved into private practice and this cannot be solely attributed to the introduction of the Better Access scheme.

Two private service providers had noted that their businesses had basically dried up since the introduction of the scheme. Their services were not eligible under the MBS item numbers, therefore no GPs were referring consumers to them.

I only have one client [currently]. People now go to Psychologists as they can claim the visit on Medicare. Private service provider 3

The new item numbers are being used to good effect at St John of God Hospital where group programs 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.

Other Barriers to Access

Service providers were asked their perceptions about what may constitute a barrier to consumers accessing an appropriate service. Geography was considered a barrier to access in terms of cost of travel, public transport limitations from outlying areas, time taken in travelling and the ‘Warrnambool centric’ focus of services. It was also perceived that in some smaller towns, people would prefer to leave and seek treatment elsewhere. Even in Warrnambool, it was noted that the service provider could be someone the consumer knew (an example was where the
consumer and the psychologist had children in the same class at school) and that this stigma and
the need for anonymity was a barrier to accessing services in the region.

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.

Other service providers considered the consumer’s personal circumstances when speaking about
other barriers to accessing services. One private psychologist said:

Negative influence and no understanding of the condition from close family members and/or friends is, at
times, a substantial barrier. Private psychologist 5.

Other life issues, for example a family member in crisis and wider family attitudes. Transport, funding
(e.g., to undertake stress management course or see private services) and waiting lists for other services like
CASA or ASPIRE [can all be barriers]. Private service provider 2

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 3

Other barriers noted included patients who denied that they had a problem, and patient non-
compliance with service providers’ treatment. The relationship between service provider and
consumer may also prove to be a barrier to access. For example if there is only one GP available
in a small town, a problem may arise if a consumer just does not like that particular GP.

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. Private psychiatrist 1

It was also discussed that the length of GP visits was a barrier to adequate mental health care.
The standard consultation is not long enough to adequately explore issues of mental health,
especially where consumers may have difficulty in talking about these issues. While the new MBS
items provide for a longer consultation to prepare the GP Mental Health Care Plan, the brevity
of the initial contact a patient may have with the GP was seen as delaying access to treatment.

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 1
Other Issues in Service Provision

The reference group noted that the issue of suicide was not being adequately addressed. While the group agreed it was outside the brief of this project, it was suggested that suicide be named as an issue.

Similarly the problem of substance abuse was flagged as an issue to be addressed. Many consumers make their way into the service for depression and anxiety with existing drug and alcohol problems. Or they may seek services for depression and anxiety when they need services for substance abuse. It is very difficult to separate these out.

It was also suggested that the impact of the drought, if any, should be raised. Another suggestion was that the scope of other organisations, such as the Country Fire Authority and Brophy be investigated as a way of increasing the number of options for the treatment of depression and anxiety.

For those service providers in the community sector, the difficulty in accessing secure ongoing funding to provide their services was raised. 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 service providers who participated were keen to see some outcomes from this project. As one service provider put it;

_Everyone is happy for this work to be done, for integration and quality of services to be improved – but how will it be sustained?_ Public sector service provider 1

6.1.5 Service Provider Online Survey

Thirty-eight 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. Respondents could also self-nominate an ‘Other’ type of provider. However in order to group the service providers meaningfully for further analysis, the five respondents who specified ‘other’ types have been included in the category ‘Counsellor with community organisation’. This includes service providers who identified themselves as follows: Mental Health Nurse Incentive Program, R P N 3/ A O D clinician, relationship counsellor and educator, Mental Health Nurse and Lifeline Manager.

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>14</td>
<td>36.8</td>
</tr>
<tr>
<td>Psychologist in private practice</td>
<td>8</td>
<td>21.1</td>
</tr>
<tr>
<td>Counsellor with community organisation</td>
<td>7</td>
<td>18.4</td>
</tr>
<tr>
<td>Clinician with Psychiatric Services SWHC</td>
<td>5</td>
<td>13.2</td>
</tr>
<tr>
<td>Social worker in private practice</td>
<td>2</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Table 4 Respondents according to Type of Providers
Service provider locations have been grouped into larger towns, according to the provider’s proximity to these towns. Table 5 gives the resulting distribution of service providers in the sample:

### Table 5: Respondents according to location

<table>
<thead>
<tr>
<th>Larger Town</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warrnambool (includes Port Fairy)</td>
<td>22</td>
<td>59</td>
</tr>
<tr>
<td>Multiple towns</td>
<td>6</td>
<td>15.4</td>
</tr>
<tr>
<td>Camperdown (includes Cobden and Terang)</td>
<td>4</td>
<td>10.3</td>
</tr>
<tr>
<td>Hamilton (includes Penshurst)</td>
<td>3</td>
<td>7.7</td>
</tr>
<tr>
<td>Portland (includes Heywood)</td>
<td>2</td>
<td>5.1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Most of the respondents (59%) were in the Warrnambool area, reflecting the larger number of service providers who are practicing in this area as compared to the other larger town areas. Six providers reported practising in more than one town. Five of these included Warrnambool. One provider reported his/her location to be Lake Bolac, and this is shown under ‘Other’ in Table 5.

#### 6.1.5.1 Number of consumers seen and referred

Table 6 provides summary information about the number of consumers seen by the different types of providers in the last three months for issues relating to anxiety or depression.

### Table 6: Mean and median number of consumers seen for issues relating to anxiety or depression, by type of service provider

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Number of providers</th>
<th>Consumers seen for anxiety or depression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total number</td>
</tr>
<tr>
<td>Psychiatrist in private practice</td>
<td>1</td>
<td>200</td>
</tr>
<tr>
<td>Psychotherapist in private practice</td>
<td>1</td>
<td>120</td>
</tr>
<tr>
<td>GP</td>
<td>14</td>
<td>1385</td>
</tr>
<tr>
<td>Social worker in private practice</td>
<td>2</td>
<td>145</td>
</tr>
<tr>
<td>Psychologist in private practice</td>
<td>7</td>
<td>320</td>
</tr>
<tr>
<td>Clinician with Psychiatric Services SWHC</td>
<td>5</td>
<td>120</td>
</tr>
<tr>
<td>Counsellor with community organization</td>
<td>7</td>
<td>377</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
<td><strong>2667</strong></td>
</tr>
</tbody>
</table>

One service provider did not provide this information.
General practitioners reported the highest number of consumers seen in the last three months for issues relating to anxiety and depression (1385 in total), but this ranged from five consumers for one GP to 250 for another.

The median number of consumers per service provider was highest for the psychiatrist in private practice who responded to the survey, reporting that s/he had seen 200 patients in the last three months for issues relating to anxiety and depression.

Service providers were also asked “Of the consumers you have seen in the last three months for issues relating to anxiety or depression, approximately what proportion did you refer on to other service providers for further treatment?”
Table 7 shows summary information for consumers referred on by the different types of providers:

**Table 7: Percentage of consumers referred on, by type of provider**

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Number of providers</th>
<th>Proportion referred on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Min. %</td>
</tr>
<tr>
<td>Psychiatrist in private practice</td>
<td>1</td>
<td>55</td>
</tr>
<tr>
<td>GP</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Social worker in private practice</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Clinician with Psychiatric Services SWHC</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Psychologist in private practice</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Counsellor with community organisation</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Psychotherapist in private practice</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Summary</strong></td>
<td><strong>37</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

One service provider did not provide this information.

The psychiatrist had the highest median percentage of consumers referred on (55%), followed by general practitioners (50%). It should be noted that the range was once again large for GPs, ranging from 20% of the consumers seen to 95% of consumers seen.

It is interesting that service providers in private practice reported referring up to 90% of the consumers they had seen in the last three months.

### 6.1.5.2 Origin of patients

Table 8 indicates the origins of consumers that Service Providers have seen in the last three months for issues relating to depression and anxiety. Service providers have been grouped into four categories – GPs, Clinicians with Psychiatric Services (SWHC), Counsellors with Community Organisations, and Private Providers (including the categories Psychiatrist in private practice, Psychologist in private practice, Psychotherapist in private practice, and Social Worker in private practice).
Table 8: Origin of consumers seen in the last three months for issues relating to depression and anxiety, by type of provider.

<table>
<thead>
<tr>
<th>Service providers of types listed on the right indicated that consumers came to them from the following sources:</th>
<th>GP (n = 14)</th>
<th>Clinician with Psychiatric Services SWHC (n = 5)</th>
<th>Counsellor with community organisation (n = 6)</th>
<th>Private Providers (n = 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>244 18%</td>
<td>102 85%</td>
<td>11 11%</td>
<td>547 70%</td>
</tr>
<tr>
<td>Other primary health care service</td>
<td>2 0%</td>
<td>3 3%</td>
<td>10 10%</td>
<td>2.7 0%</td>
</tr>
<tr>
<td>Emergency &amp; Accident</td>
<td>18 1%</td>
<td>5.3 4%</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Psychiatric Services SWHC</td>
<td>17 1%</td>
<td>0 0%</td>
<td>9 10%</td>
<td>105 13%</td>
</tr>
<tr>
<td>Outpatients department or clinic</td>
<td>24 2%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Other hospital based service</td>
<td>50 4%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Physiotherapist, chiropractor, acupuncturist, naturopath, occupational therapist</td>
<td>2 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0.002 0%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>12 1%</td>
<td>0.3 0%</td>
<td>13 13%</td>
<td>4.4 1%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>24 2%</td>
<td>0.3 0%</td>
<td>1.3 1%</td>
<td>2 0%</td>
</tr>
<tr>
<td>Private Counsellor</td>
<td>22 2%</td>
<td>0.3 0%</td>
<td>1.3 1%</td>
<td>2.4 0%</td>
</tr>
<tr>
<td>Other private mental health service</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Financial planner, Rural counsellor, Accountant, Solicitor</td>
<td>0 0%</td>
<td>1 1%</td>
<td>0 0%</td>
<td>25 3%</td>
</tr>
<tr>
<td>Workplace counsellor / EAPs</td>
<td>0 0%</td>
<td>0.4 0%</td>
<td>3.3 3%</td>
<td>28 4%</td>
</tr>
<tr>
<td>School Counsellors</td>
<td>25 2%</td>
<td>1 1%</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Community Health Centres (such as Portland District Health)</td>
<td>7 0%</td>
<td>0 0%</td>
<td>1.3 1%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Phone counselling service or helpline (such as Lifeline)</td>
<td>0 0%</td>
<td>0 0%</td>
<td>3.5 4%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Church or welfare groups</td>
<td>1 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0.002 0%</td>
</tr>
<tr>
<td>Information sources (e.g. beyondblue website; yellow pages; internet search)</td>
<td>0 0%</td>
<td>0 0%</td>
<td>3.6 4%</td>
<td>10 1%</td>
</tr>
<tr>
<td>Self referral</td>
<td>673 49%</td>
<td>1.5 1%</td>
<td>14 15%</td>
<td>11.5 1%</td>
</tr>
<tr>
<td>Referred by (friend, family member, coach, work colleague)</td>
<td>35 2%</td>
<td>2.3 2%</td>
<td>24 24%</td>
<td>24.0 3%</td>
</tr>
<tr>
<td>Already a patient, prior to consultation for anxiety or depression</td>
<td>236 17%</td>
<td>1.6 1%</td>
<td>1.3 1%</td>
<td>10 1%</td>
</tr>
<tr>
<td>Unknown Origin</td>
<td>12.5 1%</td>
<td>0 0%</td>
<td>1.2 1%</td>
<td>13.3 2%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1385 100%</td>
<td>120 100%</td>
<td>97 100%</td>
<td>785 100%</td>
</tr>
</tbody>
</table>
Approximately half of the consumers seen by GPs came through self referral (49%). A further 18% were referred by another GP, and 17% were already a patient prior to consultation for anxiety or depression.

The majority of consumers seen by Clinicians with Psychiatric Services SWHC came through referrals from GPs (85%), with a small number coming through Emergency and Accident (4%).

A quarter of the consumers seen by Counsellors with Community Organisations were referred by a friend, family member, coach or work colleague. A further 15% self-referred, 13% were referred by a Psychiatrist, 11% by a GP, 10% by Psychiatric Services SWHC, and another 10% by other primary health care services.

The majority of consumers seen by Private Providers were referred by GPs (70%), with a further 13% being referred by Psychiatric Services SWHC.

Service providers were asked, after the questions about the sources through which patients came to them: “Are there any further comments you would like to make regarding the origins of patients you have seen for anxiety or depression?”

Two clinicians with Psychiatric Services SWHC and one service provider in private practice commented that all their referrals (or in one case, private referrals) were from GPs. The service provider in private practice stated that GPs can refer their patients through the Better Access program or through ATAPs, and mentioned that he/she had ATAPs registration through the Otway Division. Referrals from inpatients were mentioned by one counsellor with a community organisation, and referrals from maternal and child health nurses at Community Health Centres were mentioned by a GP. Another service provider in private practice commented that “Most referrals are through Medicare 2710 plans. Otherwise people can’t afford to pay.” A GP said that “Some patients are referred to us by psychologists just so we can refer them back under the Better Access.”

Four respondents (a clinician with Psychiatric Services SWHC, a GP and two service providers in private practice) mentioned that some clients self-refer, or are encouraged to attend by family or friends.

One service provider in private practice spoke of the diversity amongst patients:

“Some referrals wouldn't have sought help from an unknown counselling service, but will begin discussions at a workplace or in their home. Some wouldn't seek counselling if it was not available at no cost as they wouldn't make the initial commitment to spend money on counselling. Some would. Some referrals I've had through Medicare have not accessed counselling in the past but have significant needs.”  **Private service provider 2**

Two GPs stated that they were the only women in their practice and therefore see a high proportion of female patients. One specified that 50% of her anxiety/depression patients were antenatal or postnatal patients. The other speculated that male GPs probably see more 'pathology' relative to her patients, “since women are more likely to present with and talk about depression”.
6.1.5.3 Referring on

Service providers were asked to indicate the number of consumers they saw in the last three months for issues relating to depression and anxiety, and also the percentage of those consumers who were referred on to other services. This enabled a calculation of the number of consumers referred on.

Table 9 indicates the different types of services that those consumers were referred to for issues relating to depression and anxiety. This table includes only those consumers who were referred on.

In this following table, service providers have been grouped into four categories – GPs, Clinicians with Psychiatric Services (SWHC), Counsellors with Community Organisations and Private Providers (including the categories Psychiatrist in private practice, Psychologist in private practice, Psychotherapist in private practice, and Social Worker in private practice).
Table 9: Types of services that consumers were referred to for issues relating to depression and anxiety, by type of provider making the referral

<table>
<thead>
<tr>
<th>Service providers of types listed on the right indicated that they referred consumers to the following sources:</th>
<th>GP n = 14</th>
<th>Clinician with Psychiatric Services SWHC n = 5</th>
<th>Counsellor with community organisation n = 6</th>
<th>Private Providers n = 12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of providers (n)</strong></td>
<td>Participating GPs referred on 54.6% of consumers seen, (756 consumers referred on)</td>
<td>Participating Clinicians referred on 22.5% of consumers seen, (27 consumers referred on)</td>
<td>Participating Counsellors referred on 11.3% of consumers seen, (11 consumers referred on)</td>
<td>Participating Private Providers referred on 25.4% of consumers seen, (199 consumers referred on)</td>
</tr>
<tr>
<td>General practitioner</td>
<td>0 0%</td>
<td>15 54%</td>
<td>3.1 29%</td>
<td>56 28%</td>
</tr>
<tr>
<td>Other primary health care service</td>
<td>19 2%</td>
<td>0.8 3%</td>
<td>0 0%</td>
<td>0.8 0%</td>
</tr>
<tr>
<td>Emergency &amp; Accident</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>3.3 2%</td>
</tr>
<tr>
<td>Psychiatric Services SWHC</td>
<td>80 11%</td>
<td>0.01 0%</td>
<td>0.8 7%</td>
<td>4.3 2%</td>
</tr>
<tr>
<td>Outpatients department or clinic</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>2.2 1%</td>
</tr>
<tr>
<td>Other hospital based service</td>
<td>60 8%</td>
<td>0.17 1%</td>
<td>0 0%</td>
<td>60 30%</td>
</tr>
<tr>
<td>Physiotherapist, chiropractor, acupuncturist, naturopath, occupational therapist</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0.80 0%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>39 5%</td>
<td>0.9 3%</td>
<td>0.65 6%</td>
<td>3.2 2%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>468 62%</td>
<td>4 15%</td>
<td>0.4 4%</td>
<td>5.5 3%</td>
</tr>
<tr>
<td>Private Counsellor</td>
<td>40 5%</td>
<td>0 0%</td>
<td>0.4 4%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Other private mental health service</td>
<td>1.8 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Financial planner, Rural counsellor, Accountant, Solicitor</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>2.4 1%</td>
</tr>
<tr>
<td>Workplace counsellor / EAPs</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>2.5 1%</td>
</tr>
<tr>
<td>School Counsellors</td>
<td>5 1%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Community Health Centres (such as Portland District Health)</td>
<td>0 0%</td>
<td>4.8 18%</td>
<td>0 0%</td>
<td>12 6%</td>
</tr>
<tr>
<td>Phone counselling service or helpline (such as Lifeline)</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0.0 0%</td>
</tr>
<tr>
<td>Church or welfare groups</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>5.5 3%</td>
</tr>
<tr>
<td>Information sources (e.g. beyondblue website; yellow pages; internet search)</td>
<td>12 2%</td>
<td>0.6 2%</td>
<td>0 0%</td>
<td>14.4 7%</td>
</tr>
<tr>
<td>Informal (friend, family member, coach, work colleague)</td>
<td>0 0%</td>
<td>0.6 2%</td>
<td>0 0%</td>
<td>16.5 8%</td>
</tr>
<tr>
<td>Referred elsewhere</td>
<td>0 0%</td>
<td>0 0%</td>
<td>0.27 3%</td>
<td>2 1%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>32 4%</td>
<td>0.38 1%</td>
<td>5.0 47%</td>
<td>7.6 4%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>756 100%</td>
<td>27 99%</td>
<td>11 100%</td>
<td>199 100%</td>
</tr>
</tbody>
</table>
Slightly over half (54.6%) of the consumers reported in this survey who were seen by GPs were referred on to another service. Of those, 62% were referred to a psychologist, 11% were referred to Psychiatric Services SWHC, and 5% to a Psychiatrist.

Of the consumers who were seen by Clinicians with Psychiatric Services SWHC, 22.5% were referred on to another service. Of those, 54% were referred to a GP, 18% were referred to a Community Health Centre, and 15% were referred to a psychologist.

For consumers who were seen by Counsellors with Community Organisations, 11.3% were referred on to another service, however the service type was not specified for around half (47%). The number referred to a GP was 29%.

A quarter (25.4%) of the consumers who were seen by Private Providers were referred on to another service. Of those, 30% were referred to a hospital-based service, and 28% were referred to a GP. The remainder of referrals were spread across many types of services: 8% were referred informally to a friend, family member, coach or work colleague; 7% were referred to information sources such as the beyondblue website; 6% were referred to Community Health Centres; 3% to a Psychologist and 2% to a Psychiatrist.

After the questions about where they referred patients, service providers were asked whether they had any further comments.

Some service providers gave information on alternative providers to whom they refer, for example to ATAPs (mentioned by a GP), to a personal fitness coach (mentioned by a clinician with psychiatric services) or to Centacare (mentioned by a service provider in private practice). The latter service provider talked about referring to Centacare for specialist counselling “when I’m out of my depth”, for example for marriage or relationship counselling.

A GP spoke of costs for patients:

I find that 95% are either unwilling or unable to pay for their care, so I only refer to a private psychiatrist when they can afford it. GP 1

Two service providers in private practice commented on the role of the GP in the referral process:

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 there will be some GP monitoring and involvement as people often go on medication if on the Medicare mental health plan. Private service provider 2

Some clients [are] referred back to doctor following six sessions, others also to treating Psychiatrist. Private psychologist 5

One GP spoke of his/her frustration with psychiatric services:

Psych Services expect an overwhelming amount of information. They’re the specialists; they should elicit that type of information. If I do ring them they always ask if the patient is at risk of immediate harm. In my opinion, it’s always my assessment that I think they need priority - but then Psych Services will say ‘well the team meeting isn’t until Tuesday’. If you don’t want to go through their system if you really don’t have to…The feedback from patients on the overseas trained psychiatrists is that this is one specialty where people really should be able to speak to the doctor. The feedback is not all good. GP 1
6.1.5.4 Barriers to accessing services for consumers with anxiety or depression

Service providers were asked to indicate whether they had experienced difficulties regarding access to/availability of services for their patients. Table 10 summarises the response for the service providers who indicated that they had need of each of these services.

<table>
<thead>
<tr>
<th>Access/availability of these services is...</th>
<th>Always an issue</th>
<th>Sometimes an issue</th>
<th>Occasionally an issue</th>
<th>Able to access services</th>
<th>Total Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information sources (e.g. beyondblue website; yellow pages; internet search)</td>
<td>0 0.00</td>
<td>0 0.00</td>
<td>1 5.56</td>
<td>17 94.4</td>
<td>4 18</td>
</tr>
<tr>
<td>Phone counselling service or helpline (such as Lifeline)</td>
<td>0 0.00</td>
<td>0 0.00</td>
<td>1 6.25</td>
<td>15 93.7</td>
<td>5 16</td>
</tr>
<tr>
<td>Community Health Centres (such as Portland District Health)</td>
<td>0 0.00</td>
<td>1 5.88</td>
<td>3 17.65</td>
<td>13 76.4</td>
<td>7 17</td>
</tr>
<tr>
<td>Church or welfare groups</td>
<td>0 0.00</td>
<td>2 15.38</td>
<td>2 15.38</td>
<td>9 69.2</td>
<td>3 13</td>
</tr>
<tr>
<td>Workplace counsellor / EAPs</td>
<td>1 6.25</td>
<td>2 12.50</td>
<td>3 18.75</td>
<td>10 62.5</td>
<td>0 16</td>
</tr>
<tr>
<td>Informal (friend, family member, coach, work colleague)</td>
<td>0 0.00</td>
<td>4 19.05</td>
<td>4 19.05</td>
<td>13 61.9</td>
<td>0 21</td>
</tr>
<tr>
<td>Emergency &amp; Accident</td>
<td>0 0.00</td>
<td>2 11.11</td>
<td>5 27.78</td>
<td>11 61.1</td>
<td>1 18</td>
</tr>
<tr>
<td>Private Counsellor</td>
<td>0 0.00</td>
<td>4 28.57</td>
<td>2 14.29</td>
<td>8 57.1</td>
<td>4 14</td>
</tr>
<tr>
<td>Psychiatric Services SWHC</td>
<td>2 7.14</td>
<td>8 28.57</td>
<td>4 14.29</td>
<td>14 50.0</td>
<td>0 28</td>
</tr>
<tr>
<td>Physiotherapist, chiropractor, acupuncturist, naturopath, occupational therapist</td>
<td>1 6.25</td>
<td>2 12.50</td>
<td>5 31.25</td>
<td>8 50.0</td>
<td>0 16</td>
</tr>
<tr>
<td>School Counsellors</td>
<td>1 5.56</td>
<td>2 11.11</td>
<td>6 33.33</td>
<td>9 50.0</td>
<td>0 18</td>
</tr>
<tr>
<td>Outpatients department or clinic</td>
<td>2 16.67</td>
<td>3 25.00</td>
<td>2 16.67</td>
<td>5 41.6</td>
<td>7 12</td>
</tr>
<tr>
<td>Financial planner, Rural counsellor, Accountant, Solicitor</td>
<td>0 0.00</td>
<td>4 26.67</td>
<td>5 33.33</td>
<td>6 40.0</td>
<td>0 15</td>
</tr>
<tr>
<td>General practitioner</td>
<td>1 4.17</td>
<td>6 25.00</td>
<td>9 37.50</td>
<td>8 33.3</td>
<td>3 24</td>
</tr>
<tr>
<td>Psychologist</td>
<td>0 0.00</td>
<td>10 41.67</td>
<td>6 25.00</td>
<td>8 33.3</td>
<td>3 24</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>8 27.59</td>
<td>9 31.03</td>
<td>6 20.69</td>
<td>6 20.6</td>
<td>9 29</td>
</tr>
</tbody>
</table>
Almost none of the service providers surveyed reported having problems accessing information sources and telephone counselling services/helplines. The greatest access/availability issues were reported to be with general practitioners, psychologists and psychiatrists (reported to be an issue at least some of the time by 66.7%, 66.7% and 79.3% of respondents respectively). Interestingly, 28% of the respondents reported that access to psychiatrists was always a problem.

One service provider in private practice clarified the response to the question reported in Table 10 above:

*I would prefer to say that access to psychiatric services SWHC is OFTEN/VERY OFTEN an issue rather than just “sometimes”, as it is more frequent than that, and “always” is too prescriptive.* Private service provider

Table 10 shows the views only of those service providers who indicated that they had need of the listed services. Some respondents indicated that they had no need of particular services for their patients.

- One service provider in private practice had no need for Workplace counsellors / EAPs
- One clinician with Psychiatric Services SWHC and one service provider in private practice had no need for Community Health Centres
- One GP and one service provider in private practice had no need for phone counselling services or helplines
- One counsellor with a community organisation, two GPs and two service providers in private practice had no need for church or welfare groups
- Two service providers in private practice had no need for information sources such as the beyondblue website, yellow pages and internet searches
- One GP and two service providers in private practice had no need for informal services (e.g. friend, family member, coach, work colleague)

Some respondents indicated that they were not aware of the various services (in the context of using these services in the treatment of consumers with anxiety and depression):

- Two clinicians with Psychiatric Services SWHC and one GP were not aware of Outpatients Departments or clinics
- One GP was not aware of financial planners, rural counsellors, accountants, solicitors
- Two GPs reported were not aware of workplace counsellors/EAPs
- One clinician with Psychiatric Services SWHC was not aware of School Counsellors
- One GP and one service provider in private practice were not aware of church or welfare groups
- Two GPs were not aware of information sources (e.g. beyondblue website; yellow pages; internet search)

Service providers were asked “In your treatment of consumers with depression or anxiety, is there anything else you have experienced which may have been a barrier or enabler to their optimal treatment?”

Enablers included:

- Primary health care workers are helpful (Counsellor with community organisation)
- There is funding for primary health care workers at clinics (GP)
- CASA (Counsellor with community organisation)
- GPs, primarily to get a Mental Health Care Plan (Service provider in private practice)

Barriers included:

- Availability of self and other service providers: A service provider in private practice said: “Demand on my time leads to longer waiting periods than desirable and at times difficulty with on-going sessions being at optimal intervals.”
- A GP mentioned that there are not enough psychiatrists available for access to appointments in the short term. A clinician with Psychiatric Services SWHC 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.
- Another service provider in private practice mentioned the waiting list for services like CASA and ASPIRE.
- A clinician with Psychiatric Service SWHC mentioned difficulty accessing alcohol and drug detoxification services.
- Lengthy intake processes: A service provider in private practice spoke of the intake process for public psychiatric services. Case reviews are needed before a client is considered for treatment, and service guidelines restrict access to these services.
- Cost: Service providers in private practice mentioned the cost of the gap on the Medicare scheme, an inadequate Medicare threshold for pensioners and the cost of private services. The latter was also mentioned by a GP.
- Funding is relatively short term: A service provider in private practice spoke of the relatively short term funding for counselling through schemes like MAHS, BOIMHC and Enhanced Primary Care (EPC). Another service provider in private practice mentioned that 12 Medicare funded sessions is not enough for some clients.
- Ongoing support: A GP mentioned that patients are discharged rapidly from public psychiatric services, and the psychiatric services do not provide support for the patients.
- Time: A GP spoke of ‘time in consultation’ being a barrier.
- Discrimination (not further specified) was mentioned by a counsellor with a community organisation
- Transport (as a barrier for patients) was mentioned by a service provider in private practice
- Patients themselves: A 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, or because of other commitments. One GP spoke of patients’ ‘incompliance’ with their treatment program, another of denial and a third said simply (in response to the question about other enablers and barriers) ‘the person themselves’.
- Lack of understanding from family and friends: Two service providers in private practice mentioned attitudes of close friends and family. A GP mentioned “stigma”
- Lack of outreach services: A GP said that these “simply do not exist”
- The fact that only GPs can prepare a Mental Health Care Plan was mentioned by a service provider in private practice
• Premises: A service provider in private practice said that s/he would like to be able to offer patients more appointments after hours and on weekends, but access to rooms is a barrier.

• Personal barriers for the service providers: A service provider in private practice mentioned the need to prevent his/her own burnout and difficulties accessing good, affordable, local professional development

Service providers were also asked ‘Are there any further comments you would like to make in relation to this study?’ The responses varied.

• Support for the survey: “Thanks for the opportunity” (service provider in private practice);

• Needed assistance with the survey: “Would have been helpful to be assisted in filling out the questionnaire re: definitions, overlaps, etc to give more accurate and meaningful responses.” (service provider in private practice)

• Survey difficult to complete in the case of telephone helpline: “It's difficult to complete surveys on data from once-off telephone counselling calls even though a very high percentage of our callers suffer from depression and anxiety.” (counsellor with a community organisation)
6.1.6 Social Network Analysis – Service Providers

6.1.6.1 Where Consumers come from (Random Configuration)

This section displays the service provider information in network maps. (For further information on social network analysis, see Chapter 3 Methodology.) A list of abbreviations is provided at the end of this section on page 74. The information in these network maps comes from the responses of service providers in the on-line survey (discussed above).

The following diagram 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.

![Social Network of service providers.](image)

*Figure 5: Social Network of service providers.*

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.
6.1.6.2 Where Consumers come from (Circle Graph)

The following diagram displays the origins of consumers coming to various types of service providers. The circle graph is provided to visualise which nodes are most highly connected. In this diagram, this indicates the service providers with the highest numbers of sources.

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 6: Social network of service providers (circle graph).](image)

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.
6.1.6.3 Where Consumers go to (Random Configuration)

The following diagram displays the destinations of consumers referred by 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 7: Where consumers go.

Note: The diagram above displays the referral destinations advised by service providers, but does not indicate the number or percentage of consumers being referred to any particular source. Care should be taken in interpreting this data, as equal weighting cannot be assumed.
6.1.6.4 Where Consumers go to (Circle Graph)

The following diagram displays the destinations of consumers referred by various types of service providers. The circle graph is provided to visualise which nodes are most highly connected. In this diagram, this indicates the service providers who refer to the highest numbers of different services.

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 8: Where consumers go (circle graph).

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

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. beyondblue 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
6.2 Consumer Perspectives

6.2.1 Summary of Methodology

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. The number who participated in a longer survey was 275.

Social network analysis was carried out on the data from all consumer interviews and surveys to identify services used and referral pathways taken.
6.2.2 Qualitative Consumer Interviews

The following table contains summary data of the interview participants.

Table 11. Summary Characteristics of Interview Participants (n=25) [n,(%)]

<table>
<thead>
<tr>
<th>Gender</th>
<th>Location of Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5 (20)</td>
</tr>
<tr>
<td>Female</td>
<td>20 (80)</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
</tr>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>Corangamite</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Glenelg</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Moyne</td>
<td>4 (16)</td>
</tr>
<tr>
<td>Southern Grampians</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Warrnambool</td>
<td>17 (68)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age - Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 24</td>
<td>1 (5)</td>
</tr>
<tr>
<td>25 – 34 years</td>
<td>7 (35)</td>
</tr>
<tr>
<td>35 – 44 years</td>
<td>3 (15)</td>
</tr>
<tr>
<td>45 – 54 years</td>
<td>4 (20)</td>
</tr>
<tr>
<td>55 – 64 years</td>
<td>4 (20)</td>
</tr>
<tr>
<td>65 – 74</td>
<td>0</td>
</tr>
<tr>
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6.2.2.1 Further Information on Participants

Duration of Depression and Anxiety

Most had experienced different episodes of depression and/or anxiety over a long period. Five participants had experienced depression or anxiety only in the past two years – most had experienced depression or anxiety in the past two years and had some previous occurrence. Most participants reported several episodes in their history - periods of depression and anxiety over many years but also other periods when they had been well.

Experiences of Depression and Anxiety

While all of the participants had experienced depression and/or anxiety in the past two years, some had different mental health issues in their history. Two of the participants had psychotic episodes. One of these participants had ongoing periods of depression and anxiety with only one
known psychotic episode. The other participant had had more than one episode of psychosis, had been hospitalised involuntarily with psychosis and had experienced ongoing depression as well.

Two of the women had experienced post natal depression, but had also experienced depression independent of the post natal period. One of the men experienced difficulty with a gambling addiction for which he sought specialist treatment independent of his treatment for depression and anxiety. He also accessed a service for victims of sexual assault.

Several participants had experienced events in their lives which may have contributed to the development of their depression or anxiety. Two of the participants had been victims of crime. For one, this experience had exacerbated the mental health issues he already experienced. The other said that being a victim of crime led to depression and the subsequent need for treatment.

Relationship breakdown featured as a stressor or catalyst for depression and anxiety. One participant was newly single after his marriage had broken up and he found himself living alone for the first time in his life. He is experiencing loneliness and isolation which appears to be heightened by the lack of social motivation which is part of his depression. At the same time, he feels the depression is exacerbated by his feelings of isolation and loneliness.

Four of the women were single mothers. They talked about the difficulties of being a single mum – of managing children, work and finances – along with dealing with the breakdown of the relationship with their former partners.

**Types of Treatment**

Of those participating, 20 were treated with a combination of medication – either anti-depressant or anti-anxiety - and “talking therapies”. Three participants received counselling only as treatment for their depression and anxiety. One participant was treated with medication only and one participant was referred by her GP to a stress management course to provide her with the skills and strategies needed to manage her anxiety and depression. The stress management course was run by South West TAFE in conjunction with the SWHC PMHT.

**Family History**

Of interest was the number of interview participants who had family members with a mental illness. Ten people reported that other family members had also experienced some form of mental illness, although this was not a discrete question in the interview schedule. These experiences included living with the mental illness of a parent as a carer to not discovering other family members had mental health issues until the participant ‘came out’ with depression or anxiety themselves.

**Where They Were Referred**

Of the 25 interviewed, the following is a breakdown of how many were referred and where:

- 2 to a GP for medication (from a private psychologist)
- 8 to SWHC’s PMHT (from a GP)
- 7 to a private psychologist (from a GP)
- 1 to SWHC’s Counselling and Support as a medical inpatient
• 4 not referred elsewhere; of these, 3 saw their GP and one sought help from her workplace EAP
• 1 saw a GP first, but then sought help elsewhere themselves
• 1 was referred directly by a GP to the South West TAFE stress management course
• 1 was referred from a Community Health Centre to South West TAFE stress management course.

**List of Services and Support Agencies accessed:**

• GP
• PMHT, SWHC
• Private Psychologist
• EAP, workplace counsellor
• Centacare
• Centre Against Sexual Assault (CASA)
• Workcover
• Victims of Crime Assistance Tribunal
• ASPIRE
• TAFE Stress Management Course
• Lifeline
• Lifeline Strengthening Women Course
• Community Health Centres
• Commonwealth Rehabilitation Services (CRS)

**Living With Their Depression and Anxiety Now**

Most of the participants recognised that their depression and anxiety is something which is cyclical in nature and which may well return. Many have already experienced at least one episode. Ongoing treatment and management is therefore important.

Some of the participants, who had experienced the episodic nature of depression or anxiety, reported that they now know how to recognise early warning signs and mitigate against the problem escalating to a severe illness.

*I know what I'm doing now, I've had it that many times – you recognise the signs, it's obvious that's what's going on. If I find myself lying on the couch I say, come on you know, get up...[laughs].*  
**R. female 35 - 44**

*I need to work on it all the time just to make sure I don't go down hill. I manage my stress, do nice things for myself, positive self talk – I know I need to do these kinds of things to keep myself healthy.**  
**O. male 35 - 44**
Sleep difficulty is one area which participants reported as an early warning of their depression or anxiety returning or escalating.

I usually go because I recognize my early symptoms and I can go and say “I need my sleepers” because if I can get my sleep right...As I've got older I get on top of it really quickly, so I don't fall in a hole. So if I'm not sleeping I need to get on top of it quickly. **M. female 35 - 44**

I've got a pretty good level of insight into my own condition and my early warning signs. And if I notice that my, you know, my sleep patterns become disturbed and my mood patterns are swinging a bit, then I always go to my GP and discuss having an increase in my medication. **Y. female 45 - 54**

Several of the participants had different complementary treatments – such as nutritional health or naturopathy - or stress management strategies they employed in their ongoing management of depression and anxiety. Some make exercise, such as walking or Tai Chi, an important part of their management regime.

**Meditation is very good and for me writing is good.** **N. female 25 - 34**

When I know that mentally I'm not doing well, I make a conscious effort to do all the healthy living things, you know...exercise, relaxation, meditation. All those things are really helpful. I concentrate on eating well, getting my sleep, exercise, not isolating myself, making sure I have people I can go and talk to in my circle of friends. **Y. female 45 - 54**

One participant explained the strategies she used which included practising positive thinking and talking to friends, but then went on to say;

I'm not on medication – but I'm very fragile at the moment. Every day I have a cry because of my circumstances. Had two good cries today and it happens very, very regularly... I'm a little bit raw. **S. female 55 - 64**

The reluctance to take or continue taking medication was evident in some participants.

I used [antidepressants] as my crutch and when I didn't need it I went off it. I'm taking herbal things now. **P. female 55 - 64**

For others, medication is an important part of their ongoing treatment.

I wouldn't ever stop taking my medication – I'd adjust the dose accordingly, but you know, I'd like to be finding out more about alternative stuff that might help me...My treatment includes medication now, but it's definitely not just the tablets, you need to push yourself as well. You gotta think positive, you gotta watch yourself, you've gotta lift your game. I've been on the tablets and I've been negative and I've been crap. **R. female 35 - 44**

But having used services once and becoming more aware of what is available, some participants noted it would be easier next time for them.

Now I've had the experience, I know it's there and I know if and when I get unwell I can get help. **K. female 25 - 34**

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Southwest Victoria Mental Health Mapping Project – Chapter 6. Service Usage, Gaps, Enablers & Barriers
Awareness of Depression and Anxiety Beforehand and Once Diagnosed

Several of the subject interviews observed that their attitude to mental health issues had changed due to their own experience and that, for several, their awareness of the extent of the problem had increased. Several noticed that once they opened up about their illness, that others felt able to share their own mental illness too.

Suddenly I had two quite good friends that were suffering the same thing. I knew that one closer friend, she had been having physical problems. She was calling it hormonal and I didn’t make that connection. **V. female 45 - 54**

Goodness me, it’s amazing how many people have things they’ve got to deal with. Not many people open up until they identify a similar problem and then they say well actually, I’m taking antidepressants too. It’s such a common [thing]…which is scary in itself, to think there are so many people out there who need help. **S. female 55 - 64**

We’re seeing more depression now, see more of it — but that could be just one of those little filters because like before…you don’t…like it is around there but it isn’t relating to you, you don’t really take much notice of it. **O. male 35 - 44**

I’m a lot more sympathetic now to people with a mental illnesses. **N. female 25 – 34**

Difficulty with co-morbid presentations

While the project specifically tried to exclude co-morbid presentations with high prevalence mental health disorders, it is clear that there are almost always overlapping issues which consumers have to deal with. For one of the participants, it was a gambling problem and a history of sexual abuse. For another, managing her ongoing epilepsy and her depression posed a challenge.

6.2.2.2 Who Did Consumers go to First?

Most of those interviewed initially sought help for depression or anxiety from their GPs. Five of the participants initially sought help from a service other than their GP. Some presented to their GP on the advice of their family or friends, as general advice that the GP was a good place to start. Others presented without knowing what exactly was wrong, but knowing that they were somehow unwell and that the GP would be the best person to approach.

Four years ago I went to a GP because I didn’t realise what I was suffering from — that’s one of the symptoms I guess — and it was my GP who diagnosed me straight away, which was good. I thought no that’s not what it is, but he gave me all the reading material and … it was. He was onto it straight away. **V. female 45 - 54**

I went to the GP with physical symptoms, I was unaware that I had symptoms of depression. **D. Male 45 - 54**

It was a routine visit to the GP and the GP made the judgement that I needed help. **B. Female 55 - 64**

My perception was that the GP was the only place to go for assistance. **E. Female 35 - 44**

I went to see the doctor for a back injury initially…. I had a prolapsed disc at work and was in bed for six weeks. He initially made the observation that I was depressed and gave me medication. **R. female 35 - 44**
One participant went to the GP because she was unaware of any other services for high prevalence mental health disorders.

*I went to the doctor – he’s the only one [service] I know.*  
**J. female 75 - 84**

Others went to the GP with encouragement from, or on the advice of, friends and family. While they may not have seen a need to consult any service provider, their loved ones were able to see that some help was needed.

*A friend first recognised I was struggling, was depressed, and recommended I see my GP.*  
**E. Female 35 - 44**

*I talked it over with my mum and my partner. My mum suggested I see the GP – I was thinking I was fine.*  
**A. female 25 - 34**

*After talking it over with a friend, I felt the GP was the only place to go for assistance.*  
**E. Female 35 - 44**

For others it was clear that the GP was someone knowledgeable, who would be likely to assist them with their health problem or direct them to someone else who could.

*It’s important to have a trusted GP and to be guided in the right path when it comes to your health.*  
**T. male 25 - 34**

One participant who did not present initially to the GP decided to access counselling through her local Community Health service. Another went directly to a private counselling psychologist.

*I was aware of the counselling program because I had used other programs at the same community service.*  
**F. female 25 - 34**

Two participants accessed counselling through the EAPs at their workplace as the initial service provider.

*I sought help once I decided I needed help… The first part was a confidential phone call to [workplace counselling provider] and they arranged a counsellor.*  
**L. female 25 - 34**

*I didn’t discuss things with a GP first – in fact it was the other way round. The counsellor I saw asked if I could actually speak to my GP.*  
**N. female 25 - 34**

Several of the participants sought help from a GP and another service provider simultaneously as their first option for getting treatment for depression or anxiety. Once they had decided to seek help, they were prepared to look at several options, rather than wait for any formal referral or direction.

*My first contact was with my family doctor. I also sought out some complementary treatments at the same time…Tai Chi, seeing a naturopath and nutritional medicine.*  
**H. female 25 - 34**

*We spoke about it and that was how I got into the course that was going on at Lifeline at the time – Strengthening Women, something like that.*  
**V. female 45 - 54**

Other community groups, such as Lifeline, ASPIRE, Brophy Family & Youth Services or Centacare, also provided a first option for those seeking help for depression and anxiety.
I also went to Brophy – but that counsellor was adding to my problem. That didn’t work.  W. male 35 - 44

I can remember ringing Lifeline and stuff like that. Just talking to someone… can break that negative kind of track that you’ve got yourself on.  M. female 35 - 44

6.2.2.3 Seeking out the initial service provider

How did the interview participants find out about the provider they first sought help from? The majority of participants went to their GP as the first service they tried. Most referred to the GP as ‘their’ doctor indicating that they did not need to seek out the GP, that the GP was already known to them, was accessible and was someone with whom they felt comfortable.

I can see them [GP] when I feel I need to.  E. female 35 - 44

I have a good, long term GP who I trust.  U. female 55 - 64

My probably, usually, my main source of medical help is my GP.  Y. female 45 - 54

My GP is fantastic… he has been there forever and a day. It’s like going to see a friend.  Q. female 25 - 34

For the few other services which were the first port of call for interview participants, these were made known to the consumer through word of mouth from friends and family, or through the EAP at their workplace. One participant learnt about the counselling service he used through the phone book.

[I saw] a formal service – a private counsellor. I found out about them by reputation.  N. female 25 - 34

Being a teacher, I knew the DEECD makes counselling options available.  D. male 45 - 54

Alternatively, they may have been already using the service in a different capacity.

So I went to see my counsellor again, because he tried marital counselling with us and after that I saw him privately for myself and when the marriage split up he started to see me with…. chronic depression.  P. female 55 - 64

6.2.2.4 What Happened Next?

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. Psychiatric Services provides case management for individual consumers and also provides a service whereby consumers can call and speak to a duty clinician should they need to.

One initiative of the PMHT is a scheme where consumers are able to access 6 sessions with a PMHT clinician who is located within a GP clinic on a part time basis.

My GP recommended I see a psychologist through the…medical clinic and referred me.  V. female 45 - 54
The GP clinic had a counsellor that they used, from SWHC. I think she was from the PMHT. X. female 18 - 24

At the GP clinic apparently they can refer a number of people to a psychologist for six sessions and I happened to be one of these people. S. female 55 - 64

The GP referred me to a counsellor through the doctors. Q. female 25 - 34

Others interviewed were recommended or referred subsequently to other services for depression and anxiety. 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.

Several interview respondents were directed to the South West TAFE Stress Management course or other courses in the management of stress or symptoms of depression and anxiety such as the “Strengthening Women” course which was run by Lifeline on an ad hoc basis.

My case manager at Psych Services put me in touch with ASPIRE and through them I have done several courses… the mental health first aid. U. female 55 - 64

I did go to Psych Services and they did the initial assessment…decided that Centacare would be best, that I needed more specialist counselling. T. male 25 - 34

I was additionally referred by my counsellor to the Stress Management course which was being conducted here in Portland. F. female 25 - 34

One participant was subsequently admitted to Southwest Healthcare as an inpatient due to physical ailments after seeing his GP for depression and anxiety. While an inpatient, he received support from a Southwest Healthcare Counselling and Support Services social worker.

Given the long history some participants had with their GP, and given that they experienced depression or anxiety cyclically, some participants chose to stay with the GP rather than be referred on.

He didn’t talk about referral probably because I’ve stuck with the same GP for years and he probably tends to be guided by what I need. M. female 35 - 44

For others, the referral pathway was not so straightforward. After seeing her GP for depression following a back injury sustained at work, one participant started back at her job on reduced duties. Subsequent workplace bullying added to her distress and when she approached her boss,

He said, oh, you can go here [private psychologist]. I said I wish I’d known about that before. It was a Workcover claim, part of something [employer] provided for workers. It didn’t have to be about work, it could be personal and they provided this counselling service. R. female 35 - 44

After seeing the initial service provider, one participant referred himself elsewhere.

The counsellor was only working part time and I was studying part time…so it was hard to mesh with the counsellor. The days I wanted, the counsellor seemed to be booked. So that’s when I also saw a student counsellor. O. male 35 - 44

Another participant was referred to more specialist counselling to address his gambling addiction which was a complication in his treatment for depression.
Psychiatric services was okay, but I found that I really needed the specialist counselling. That's when they directed me to Centacare. T. male 25 - 34

GPs also referred consumers to private psychologists through a number of different schemes to increase access to these services. The Medicare rebated Better Access program, whereby consumers access sessions with a psychologist or social worker (in this region) was one of these. Others included schemes funded by the Commonwealth and administered through the ODGP. (Refer to Chapter 5 on the impact of Better Access MBS items – page 36.) While consumers were not always sure of the scheme which they had been referred under, many nonetheless received psychological counselling via this pathway.

First they managed it with antidepressants, then wrote a referral for a psychologist. The GP gave me the names and numbers of psychologists that did this program where you get the subsidies or the free things, but there were only so many who were local. W. male 35 - 44

I went to see my GP – because I try to think logically, I'm not really a stupid person – and I told him which psychologist I wanted to see....this is when they brought in those 10 free appointments. My GP didn’t even know about them at the time, so I went to him and I said there’s 10 free appointments, I want to go, I need to go and this is the man I want to see and I went to those 10 appointments. G. male 55 - 64

[I was referred to] the MAHS – more allied health services, I think I had eight sessions. H. female 25 - 34

6.2.2.5 Factors Affecting Access to Services

Stigma

The issue of stigma came up repeatedly in the interview discussions. All 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.

There is, there is [stigma attached to mental health issues]. I find that a lot of people won’t stand up and say it, or seek help because they’re afraid of what other people might, you know, might say…Q. female 25 - 34

Stigma hasn’t really affected me because I understand it and people can think what they like. But that said, I don’t usually tell people that I’ve had an appointment or I’m on medication and that sort of thing. It’s just ignorance. People are afraid of what they don’t understand. It does make it more difficult seeking help. K. female 25 - 34

There are some people you’d say, oh yeah I’m on medication and I’m seeing someone. Others you’d just say, yeah I’m having a bit of a difficult time of it if they notice you feeling a bit down. O. male 35 - 44

Well, that’s how I grew up I suppose, thinking that there was stigma and nobody talked about that sort of thing. The stigma is just enormous. I think [my husband] thought I was being weak and I should have sorted it out myself. J. female 75 - 84

Stigma did affect some of the participants’ acceptance of their own mental health problems and did affect their help seeking behaviour.
Oh yeah, a lot of people don’t understand how many people suffer from depression. It didn’t affect me seeking help, it was just me conceding that I needed help. **W. male 35 - 44**

Yes, there is a stigma. You don’t even want to admit it to yourself, that you have a mental health issue.….. **A. female 25 - 34**

I did hold off a bit longer [from going to the GP to discuss depression]. It’s, yeah, sort of a bit of a case of just saying it is normal and you know sometimes your body needs, you know, something, a little something to help you through, to get over the hard times. **Q. female 25 - 34**

I think there definitely is a stigma and that needs to be broken down so that people will, or so that they’re aware of what might be wrong with them to start with because I had no idea what might have been wrong with me. It wasn’t something that jumped to my mind whereas if it’s in people’s minds they’re going to be able to identify that if they do have a problem and you know do something before it’s too late. **H. female 25 - 34**

There still is stigma and it took me a long time to understand that depression is not a weakness. **I. female 45 - 54**

I didn’t want to be a burden. I didn’t want to admit I had depression. The appearance I gave to others [of coping] I felt I had to maintain. **F. female 25 - 34**

Several of the interview participants detailed modifications in their behaviour because of perceptions of stigma.

Didn’t bother me, it wouldn’t bother me where I had to go to get treatment. I didn’t mind coming here [Psychiatric Services for the interview]….. Even though I say I wouldn’t mind coming here, it’s not something I talk about freely to people – only my close family and friends know. Certainly my work colleagues or anybody like that I didn’t discuss it with. So, I don’t know, obviously there is still a stigma to it. Yeah, it’s not easy to come out and say I have got a mental health problem **H. female 25 - 34**

I didn’t want people to see my car at Psych Services.” **A. female 25 - 34**

When I moved to Psych Services here I didn’t like to park my car out the front – I liked to park out the back. It just that people know… the lady that works across the road is best friends with my boss. I’d prefer to not have to answer those questions should they arise. **K. female 25 - 34**

To walk into a mental health place would have been something I probably wouldn’t have gone ahead with if I had to do that. So meeting her there [psychologist at the GP clinic] was just fantastic. At that time and at that frame of mind I was in, walking in…. I just wouldn’t have come [to psych services]. **Q. female 25 - 34**

But while most agreed that stigma was an issue with other people, they preferred to think that they did not let this affect them greatly and certainly not to affect them to the extent that it would jeopardise their mental health by causing them to discontinue treatment. In most cases the stigma or perceptions of stigma did not greatly impact the services the consumer sought out.

I didn’t feel that [stigma]. I knew I had to have help because of my daughter, there was really no other choice. I don’t know how other people felt. But at that stage I was too busy wallowing in self pity to worry what other people thought. **P. female 55 - 64**

For others, though, it did impact on where they sought help.
I went to the psychologist in Warrnambool, I wouldn’t have done it in [local town].  G. male 55 - 64

Some respondents spoke about poor treatment they or others had received by people who didn’t understand mental illness. These examples had made them wary of being open about their own problems.

[But there is a stigma for other people] I found that out when I joined croquet and I liked it a real lot but I found there was, like, heaps of people were really good and the other people weren’t and I just got that feeling that they didn’t want to get close because I was like that…. So I stopped going because I just felt uncomfortable.  U. female 55 - 64

Personally, I’m not interested in stigma, but I know it’s out there. In my workplace, someone applied for a job and it was known that they had had depression, they were not given a chance in the workplace and that just comes back to another person’s judgement on whether they can deal with a person with a mental health issue and a lot of people just can’t handle it.  S. female 55 - 64

Several of the respondents found that, despite the stigma attached to having a mental health problem, that their sharing of their experience enabled others to be open about their own experiences. The feeling is that perceptions of mental health – and associated stigmas – are changing with an increased openness and awareness of common mental illnesses.

When I went to the [Strengthening Women] course, I thought who’s gonna see me here but then I thought they’re all here for the same reason, so…People are starting to talk about it now, with that beyondblue in the last few years and it’s getting it out there. People are aware of it, they’re starting to talk about it and it’s becoming more ‘normal’ I suppose because it’s something that happens to a lot of people.  V. female 45 - 54

It come out after I had depression it come out that my brother had suffered from it and my sister had suffered from it. My mother also suffered from it – she had come from a city girl to living in the bush in Panmure. So there was some family history of depression there but it was only when I admitted I had it to my family that they admitted that they had had it. It was a relief that I wasn’t the only one in the family that had suffered from it. W. male 35 - 44

Yes [there is stigma]. It doesn’t bother me what other people think, that I’ve got mental health. To me it’s just an everyday sickness and you know other people, I’m meeting a lot of other people with it and you’re not the only one. When I first got depressed years ago you kind of didn’t, you didn’t want anyone to know, but now, as I said, it doesn’t bother me if other people know.  U. female 55 - 64

I’m pretty open about depression now and I’m always on the alert for it, particularly in other people.  I. female 45 - 54

But I think stigma too, but it’s also those kinds of internal negative things that want to keep you from getting help, it’s a part of the feeling of those negative thoughts…it’s part of those thoughts, ‘no one will understand, I’ll be right’, you have to say to yourself, ‘no, I do need help’. M. female 35 - 44

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.

It’s getting lower, but there is still a stigma attached.  O. male 35 - 44
Maybe there's a little [stigma] but I think it's lessening. If someone asked me if I had sought help, I would be okay with saying that I had. I don't think it would make my family or friends view me any differently, like I was loopy just because I had to go and seek some help with things. N. female 25 - 34

It's good now like they have all the ads, and everything like that. It's more acceptable, you don't feel so bad about having depression… You know, you're not the only one, there's a big part of the community that have it, you're not isolated. R. female 35 - 44

I think there is definitely stigma and that needs to be broken down so that people will, or so that they're aware of what might be wrong with them to start with because I had no idea what might have been wrong with me. It wasn't something that jumped to mind whereas if it's in people's minds they're going to be able to identify that if they do have a problem and, you know, do something before it's too late…. People are starting to talk about it now, with the beyondblue in the last few years and it's getting it out there. People are aware of it, they're starting to talk about it and it's becoming more 'normal' I suppose because it's something that happens to a lot of people. I. female 45 - 54

The need for confidentiality was a theme with several of the participants. Given that they understood the stigma of having a mental illness, it was very important to them that their service provider maintained their anonymity and confidentiality.

I did say to my GP that I wanted the file to be private. I didn't want the girls at the desk to be able to read it because [town] is a small town. His automatic reaction was, 'oh they're not allowed to talk about it and it's private ya, ya, ya…. But hey, I'm 63. I know what happens, I've been through it, they do talk about it and it's a small town. So I just make that observation. G. male 55 - 64

Some thought that notions of stigma would be more prevalent in smaller towns.

I feel there's more of a stigma in a country town as far as what you say, how you say it, who you say it to. In terms of being in the city, one can be a little bit more anonymous in terms of what services they use and where they are at in their life. I notice in a country town people talk…but with mental health, living in the country it can be very isolating…for fear of other people knowing. I am very, very careful about what I tell them. I don't go around talking about my life to every Tom, Dick and Harry. T. male 25 - 34

Stigma also extended to the type of treatment that interview subjects agreed to participate in. Some felt that they should be able to deal with the problem themselves and resisted medication.

The whole stigma of being dependent on something or addicted to something, I just didn't want to take them [antidepressant medications]. R. female 35 – 44

**Better Access, Better Outcomes and the Primary Mental Health Team**

The MBS Better Access program, whereby consumers can access up to 12 sessions with a psychologist, occupational therapist or social worker, has been in place since November 2006.

Prior to that the BOIMHC program provided access to similar services but on a much smaller scale and through schemes administered at General Practice Division level. This is ongoing.

The PMHT also have a program whereby consumers of GPs can access sessions of counselling for no cost, within the GP clinic setting.

Under BOIMHC (which incorporates the ATAPS program) consumers pay no gap. Under Better Access, consumers do have a gap payment to make up the difference between the MBS scheduled fee and the fee actually charged by the service provider. The recent nature of the
Better Access program also means that there is no facility for consumers to pay just the gap payment to their service provider – they need to provide full payment for the service at the point of service delivery and claim the MBS rebate later.

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.

I don’t know what it’s called… that ‘gap’ one where you get 5 visits at a reduced rate? I don’t know what it’s called – Rural Mental Access or something like that…. Supposed to be 5 free consultations but it actually turned out to be I think: it’s $30 a visit because they [Medicare] pay so much and it’s never as much as the consultation, so… W. male 35 - 44

So I went to see my counsellor again… he started to see me with, um, chronic depression. The doctor referred me to see him so I could claim it through.. can’t remember what it is now.. BOIMHC, something like that. So I was under that for some time and then after that it was claimed through Medicare. P. female 55 - 64

I think with the way it is at the moment, the GP has given approval for me to have 12 sessions, I think it’s 12 sessions within a six month period. Y. female 45 - 54

Others were very clear as to the scheme they had accessed.

The Commonwealth government offers 6 free sessions after an assessment by your doctor. If after the six sessions, you still require further sessions, more sessions will be made available to you. I make the $120 initial payment and it only ends up costing me $6, but I have to make the initial $120 payment up front. But it is only a $6 gap, so it’s really quite good. More than reasonable, I’d be happy to pay 20 or even 50 per session, so long as I’m getting the help that I need. I’ve had 3 sessions so far. I. female 45 - 54

MAHS – more allied health services, I think I had 8 sessions. After the 8 we weren’t able to continue and I needed more. But this year, I’ve accessed more sessions through MAHS again. H. female 25 - 34

They [GP clinic] had a counsellor that they used, I think she was from SWHC, from the PMHT. X. female 18 - 24

Gap payments associated with the Better Access program were an issue for some of the participants.

It’s a fairly big gap when you’re a single mum. I think after 6 visits I had $400 odd to pay and that just took me ages to pay back. I was aware that there would be a gap, but I was not aware of how much. When they said Medicare rebate or Medicare would handle it I thought well everything is covered. I thought it might be about $20 but it was about four times that. So cost is a factor, yes. P. female 55 - 64

I was aware of it [Better Access] through a friend. She was going to a psychologist and it cost her about $130 and she was getting a rebate of around $70 – so even though she and her partner had two incomes, she still had to stop if you know, she found it hard to continue. Q. female 25 - 34

These schemes provided access to counselling services for people who may not necessarily have been able to afford a private psychologist. Some spoke of their gratefulness.

Six sessions was enough, at that time I didn’t require any further help. It wasn’t a life or death situation and I very much appreciated the help I was given. S. female 55 - 64
There was no cost involved and it was very straightforward. All the paperwork was done at the [GP] clinic. S. female 55 - 64

I accessed six counselling sessions provided through BOIMHC which meant I had nothing to pay. B. female 55 - 64

I try to follow it a little bit, I didn’t know that was the name, but I did know about the rebates. K. female 25 - 34

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. 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.

I only work one day a week, so cost is a factor. I also have a disability pension, and I had to pay $120 up front and I don’t have $120 to pay up front. I mean, fair enough, you can go down to Medicare and get most of it rebated, but the initial outlay of that amount of money…not when you’re living from day to day. And part of the depression and stress, part of mine is financial as well. I’m happy to pay, I just don’t have large sums of money and that to me is a large sum of money, I don’t have that just lying around. I. female 45 - 54

I had used [community organisation] in the past for counselling. At the time I wasn’t working and there was a small fee, and I managed to pay that but I know there have been times I wanted to go back there and I haven’t. I hesitate because of the cost. It was about $50 per session. Q. female 25 - 34

Cost was not much of a consideration because it was covered through work. If I had to pay though, I think it would have made me think... when I used to see them [psychologist] before it was $70 and when I went back, it was $130 and I wouldn’t have been able to cough that up. R. female 35 - 44

I had used Centacare in the past for counselling. At the time I wasn’t working and there was a small fee, but I know there have been times I wanted to go back there and I haven’t... because of the cost. It was about $50 per session. Being a single mum, with four kids, paying off a house and working... Q. female 25 - 34

So I was under that for some time and then after that it was claimed through Medicare. So I was seeing him until it got to the stage where I had to pay the balance and I stopped after that because I couldn’t afford it. I couldn’t afford the difference – although I would still be seeing him if I could. P. female 55 - 64

I saw the psychologist about 5 times, you know five times are free and I saw him 2 or 3 times after that I paid for myself and because I was unemployed he gave me a reduced rate. It would have been helpful if more subsidised sessions were available. W. male 35 - 44

Oh yeah, [cost has been a concern for me] because I’m a single mum and I’m only working part time… I probably have thought at times it would be good to go and have a little chat to someone and I’ve probably thought, no. I’ve just really managed with my GP. M. female 35 - 44

I accessed him [the psychologist] for the 10 visits, but I needed him for 30 visits. But I couldn’t afford the $80 per week. G. male 55 - 64
I discontinued because of the cost of seeing [service provider]. I was off work, then working reduced hours and I just didn’t have the money to be going back to see him. And he is not that generous in allowing people to be bulk billed. Y. female 45 - 54

Others, however, placed such a priority on their mental health that they did not let cost affect the type of services they accessed.

Sanity is paramount to me so for me cost would not be a factor. I would restructure my budget so I could get those services. T. male 25 - 34

Cost wasn’t an issue. It was important enough that cost wasn’t really relevant. N. female 25 - 34

Money’s well… everyone can do with more but we’ve got plenty. J. female 75 - 84

Knowledge of services available

Knowing where to go and what services are actually available can be difficult for consumers. In some cases, participants found out about a particular service only once they had been directed there – that is, they did not generally have prior knowledge of a service and then subsequently use this knowledge to access the service once the need arose. Rather 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 or ASPIRE).

People mainly 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 what services are available to them.
All I ever really hear about mental health in Warrnambool is Ward [9]. I have walked past here [Psychiatric Services offices] and never knew what was behind these glass doors. W. male 35 - 44

Some of those interviewed who did come into contact with a community group took the opportunity to access further ways to get further help and support.

At the Strengthening Women [course, to which she had been referred] – that’s where I got to see all these other services that were available. V. female 45 - 54

The case worker at Psych Services put me in touch with ASPIRE…. I did several courses with ASPIRE, the mental health first aid, and then the Stress Management course. U. female 55 - 64

Finding out about services came about in different ways. One participant found out about a community service by coincidence.

I found out about [community organisation] because we did some of their printing at work and I read their stuff. P. female 55 - 64

Another talked about how she came to find a good support.

And then I heard about the stress management course, it was advertised actually, at TAFE. S. female 55 - 64

But others were happy with their knowledge of what they would need.

I would know where to go if I needed help again. I would go back to the GP. X. female 18 - 24

Word of mouth from family and friends was another way in which the participants found out about different services. Some commented on being assisted by friends who had knowledge about depression and where to seek help regarding this.

It is slightly confusing for people who need assistance. You don’t know services are there until you need them. E. female 35 - 44

One closer friend she had been having physical problems as well and she was calling it hormonal and whatever….but we spoke about it a few months later and that was how I got into a course that was going on at Lifeline at the time. V. female 45 - 54

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. For one woman, the lack of knowledge by successive GPs was a source of frustration once she realised there were other services she could have been accessing. This shows that the knowledge of the service system by service providers is also important.

I would be regularly unwell, occasionally see a doctor, sometimes not, be on and off different medications and for that whole period of time – so 12 years – I didn’t know there was a place called Psych Services. I didn’t know that it existed, I didn’t know that there was help available. I guess I assumed that if there was somewhere I could get help, somebody would have told me. So when, at 28, the locum GP said he was going to send me to Psych Services and on learning it existed, I thought there might be other things out there as well. Then I started looking just off my own bat and I made phone calls and that’s when I found places like ASPIRE, CRS, Lifeline… And I wouldn’t have thought I was stupid.. I had friends with post natal and that sort of thing and I knew that there were agencies and services available but I just didn’t know the system. K. female 25 - 34
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

Other participants mentioned that ‘knowing the system’ helped them to seek help as they already had knowledge of which service might be useful to them.

I was in a fortunate position to have knowledge of agencies who provide the service and knowledge of helping systems and how they work. D. male 45 - 54

EAPs were available to several of the participants and they clearly knew about them and accessed them as either the employee of the company concerned, or as a member of the immediate family of the employee. Several highly motivated participants actively sought out different services and agencies which they felt would be of help to them.

I was going to Tai Chi and I joined the walking group and I was doing exercises at Archie Graham [community centre] and walking the dog…it wasn’t as if I was just sitting at home, moping. J. female 75 - 84

The knowledge of other services provided an alternative to some people, when another service may not have been available, or when they felt the one service was just not making the difference they needed to get well.

The days I wanted, the counsellor seemed to be booked. So that’s when I also saw a student counsellor at uni. O. male 35 - 44

I also sought out help from ASPIRE. I needed a lot more feedback and help than what I was actually getting because I was just that low and I saw one of the ladies from ASPIRE and she was wonderful. P. female 55 - 64

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

Some participants made suggestions about support services they would like to have access to.

At the moment I am not at a stage where I really need to go and see the counsellor regularly but I feel that it would be good to have a chat sometimes…. It would be nice to have some sort of support group that I could go along to every couple of weeks, like a peer group and that would just help me be honest and say oh yes, there are things that I need to do for my mental health. O. male 35 - 44

I think there should be friendship groups, so people have a peer group not just around depression – and not so people can hook up and jump into bed with each other – but just to be there for each other and be friends. G. male 55 - 64

**Satisfaction with services**

Satisfaction with their service provider varied among the participants and the 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.

There was a time where .. I was booked in to see a psychiatrist and I don’t know what it was, I don’t know if it was his personality or if it was what… but he just made me really uncomfortable and because I felt like that I was not inclined to tell him anything really. Like, for me having someone I felt comfortable with was
a big factor because if you’re not comfortable, you’re not really going to be able to tell them anything, are you? N. female 25 - 34

The GP was accessible, but not particularly useful. That’s just a personality really. I just don’t feel as comfortable with the GP but it’s really hit and miss for GPs or counsellors. K. female 25 - 34

My initial appointments [at service provider] were always made after hours… and that was a little uncomfortable just arriving somewhere in the dark, and I didn’t know where I was going or what was happening and I was on my own and just the fact that it was dark somehow made it weirder, daunting. K. female 25 - 34

My experience with [organisation] was pretty poor actually – it was more the [clinician]. I don’t think they gave me any recognition to the fact that I actually knew and was fairly knowledgeable about my own illness and what worked for me…Once I had the money to see a private psychiatrist, he basically agreed with me and he wrote back to the [clinician], the medication was changed and my health improved almost immediately. Y. female 45 – 54

I felt like it was just the normal channels. The GP palmed me off to her [Psych Services case worker] and then she did her pre-recorded routine. Had I been anyone, I would have just got the same treatment. It was such a structured experience. You feel more isolated, more alone, if the people in that service can’t make you feel comfortable. A. female 25 - 34

For this participant her experience was part of her decision to discontinue treatment. Others said they were able to make the change to a different service provider if they were not satisfied. One participant was dissatisfied with her medication due to associated weight gain, but found her GP dismissive of her concern. She subsequently found a new GP who is very supportive. One participant needed to go to her GP to prepare a back to work plan as part of her Workcover claim but was disappointed with that service so she went to another. There were also others.

I’m a bit angry with my old GP that he didn’t direct me to places. I don’t know if they just get sick of people or what, but it didn’t help me. R. female 35 - 44

One woman was disappointed with her local service provider and subsequently sought a service provider in Melbourne.

It [sourcing another provider] reflected me taking control of the support I received. C. female 45 - 54

Another participant also travelled to Melbourne to seek a suitable service provider. This was an option for him as part of his EAP. For the other consumer (mentioned above) it was a direct response to the lack of suitable service provider locally. They also both reported a perception of greater expertise amongst Melbourne based providers, and also a perception of lack of expertise by possible local providers of counselling.

However, if there is a good relationship with the service provider, this impacts positively on the participant’s ability to successfully manage their illness.

I’ve stuck with the same GP for years and he probably tends to be guided by what I need. I usually go because I recognise my early symptoms and I can go and say “I need my sleepers” because if I can get my sleep right… He is pretty supportive as to how to change my medication. M. female 35 - 44

My GP is fantastic. He has been there forever and a day. It’s like going to see a friend. I’m just happy with the way that everybody that I’ve come in contact with has helped me. I’m really grateful for that. And
that I haven’t had to pay a fortune to do so, as I said I’d hate to think where I would be if I had had to pay because I wouldn’t have been able to do that. Q. female 25 - 34

At first it was a bit daunting [going to counselling], it was a stranger and I was very emotional. So it was really, really hard at first. But she was fantastic, she made me feel as though, you know, I was normal and that I had every right to feel what I was feeling. I was comfortable with her, she was fantastic. Q. female 25 - 34

I’m lucky I’ve got a very good GP who knows a lot about different services. I. female 45 - 54

Other comments related to continuity of care, for example:

I didn’t like that when I had [an] appointment I was seeing registrars and those registrars were changing all the time. Y. female 45 - 54

**Nature of depression as a barrier to seeking help**

Another theme which emerged from the interviews was that depression and anxiety could in themselves be factors affecting the consumer’s ability to access an appropriate service.

Within the range of symptoms which can indicate depression in particular, lack of motivation and interest in one’s own wellbeing figures highly. Thus some participants spoke of being easily discouraged or of not having the confidence and wherewithal to organise and keep appointments, chase up other potential services and follow up on any recommendations.

I wasn’t aware of this but the GP talked about having 6 sessions. I rang the psychologist but they didn’t ring back. People need things on a plate with mental illness because they can’t cope with anything, do you know what I mean? A. female 25 - 34

One thing I’ve found...it’s hard to find...you don’t know where to really look to find information about seeking help unless you’ve been thinking straight enough to go to your own doctor. W. male 35 - 44

When you’re depressed it’s very hard to drag yourself out of that deep hole, you know, to say to yourself 'you need to do some deep breathing'. I’m suicidal, but I don’t want to suffer pain while I’m doing it...I’ve got nothing to live for. If I could press a button and just go 'poof' I would probably consider it on a weekly basis. G. male 55 - 64

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'. H. female 25 - 34

Others discussed that negative thoughts associated with depression could impact decisions made to access services.

But it’s also those kinds of internal negative things that want to keep you from getting help, it’s a part of the feeling of those negative thoughts...it’s part of those thoughts, ‘noone will understand, I’ll be right’... You have to say to yourself, ‘no, I need help’. M. female 35 - 44

**Waiting for Services**

Several of the survey 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.
I waited over a month for an appointment – yes, it was too long… One to two weeks at the most would have been a timely wait. **H. female 25 - 34**

I went in [to regional Psychiatric Unit] on the Saturday and Mr [psychiatrist] said someone from psychiatric services would come, but it was Tuesday, Wednesday before they came. He was very annoyed. **U. female 55 - 64**

Well with this most recent episode, because my surgery is [xxx clinic], it was going to be a long wait to get in to see [counsellor] and I thought you know I’m too much at risk so I actually rang the [counsellor’s clinic] and I was able to get in much quicker there. The waiting period was a little over seven days…but it was going to be over a six week wait if I’d made the appointment through the GP clinic, not directly with the counselor. **Y. female 45 - 54**

Two participants reported that they felt rebuffed by an unreturned or late phone call from the agency from which they were seeking help.

I rang the psychologist but they didn’t ring back. **A. female 25 - 34**

[The service] was okay.. but not timely, which didn’t bother me too much and I understand they were under resourced, etc, but if you say to a client you are going to ring them, then you have to ring them. But it was explained to me that it was a resource issue. **T. male 25 - 34**

Some participants were more explicit about the effect on them of waiting to see a service provider.

I probably waited too long. From the time I made contact with the counsellor until the time of the appointment it felt like the anxiety heightened…It seems like forever. **N. female 25 - 34**

If I had been in a crisis, it would have been too long. **I. female 45 - 54**

Even to see a doctor, you’ve got to make an appointment two weeks in advance. If I really felt like killing myself now here today, you ring up a psychologist and you make an appointment for two weeks time. I mean, how ridiculous is that? **G. male 55 - 64**

Others were simply thankful for the opportunity to get help and understood that they may have to wait.

I felt very lucky that I could actually see somebody. I would have liked it sooner, but I know there’s a lot of people out there who don’t get the help. I don’t know why. I know that they seek it but they don’t get it, they don’t seem to push hard enough to get it. So I’m happy that I was seen to in around seven days. **Q. female 25 - 34**

The waiting period was between two and seven days and I didn’t feel it was too long. I very much appreciated the help that was there for me. **S. female 55 - 64**

**After Hours Availability**

While after hours services is an obvious gap in care for low prevalence psychological disorders, it was not a major theme in the interviews with high prevalence 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. **I. female 45 - 54**
If you want to see a psychiatrist, psychologist or anyone… you go in and see them on Tuesday at 2pm. But you might really need help at 5pm [after hours] on a Thursday… G. male 55 - 64

**Location of Services**

There were two themes which emerged about location of services, but location did not greatly affect how people accessed services. Two participants reported that they deliberately chose to see a service provider outside the town where they lived. In both cases this was because of stigma related issues such as not wanting to be seen to access the service in the town where they lived. One also noted that he had trouble accepting that his treatment would remain confidential within his small town.

Two other participants chose to access service providers in a location which was not local to them. This was due to their perception that local service providers did not have the same expertise as those located elsewhere.

**6.2.3 Consumer Telephone Surveys**

**6.2.3.1 Survey Part A: All Respondents Who Were Contacted By Telephone**

Of the 1297 people contacted by telephone, about two thirds (66.3%) were female.

*Table 12: Gender – All Respondents*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>435</td>
<td>33.5</td>
</tr>
<tr>
<td>Female</td>
<td>860</td>
<td>66.3</td>
</tr>
<tr>
<td>Refused</td>
<td>2</td>
<td>.2</td>
</tr>
<tr>
<td>Total</td>
<td>1297</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Just over 41% of all respondents were in each of the age categories 35 to 49 and 50 to 64 years. Approximately 17% were in the age category 18 to 34 years.

*Table 13: Age Categories – All Respondents*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 34</td>
<td>218</td>
<td>16.8</td>
</tr>
<tr>
<td>35 – 49</td>
<td>535</td>
<td>41.2</td>
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<tr>
<td>50 – 64</td>
<td>539</td>
<td>41.6</td>
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<tr>
<td>Refused</td>
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<td>.4</td>
</tr>
<tr>
<td>Total</td>
<td>1297</td>
<td>99.6</td>
</tr>
</tbody>
</table>

Table 14 shows the distribution of the whole sample into LGA groups; participants were about equally distributed among the LGA groups.
Table 14: Local Government Areas – All Respondents

<table>
<thead>
<tr>
<th>Location</th>
<th>Frequency</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Southern Grampians</td>
<td>408</td>
<td>31.5</td>
</tr>
<tr>
<td>Glenelg</td>
<td>482</td>
<td>37.2</td>
</tr>
<tr>
<td>Warrnambool, Moyne and Corangamite</td>
<td>391</td>
<td>30.1</td>
</tr>
<tr>
<td>Not known</td>
<td>16</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1297</strong></td>
<td><strong>98.8</strong></td>
</tr>
</tbody>
</table>

Respondents were asked whether they had experienced a stress related problem, anxiety, depression and/or any other mental health problem in the last two years. Respondents could select more than one condition.

Approximately 73% reported that they had not experienced any of the conditions in the last two years. 21% reported that they had experienced a stress related problem in the last two years, 17% anxiety and 17% depression.

Table 15: Condition(s) Experienced in Last Two Years – All Respondents

<table>
<thead>
<tr>
<th>Condition experienced</th>
<th>Number of responses</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Stress Related Problem</td>
<td>275</td>
<td>21.2%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>224</td>
<td>17.3%</td>
</tr>
<tr>
<td>Depression</td>
<td>219</td>
<td>16.9%</td>
</tr>
<tr>
<td>Any Other Mental Health Problem</td>
<td>47</td>
<td>3.6%</td>
</tr>
<tr>
<td>None</td>
<td>941</td>
<td>72.6%</td>
</tr>
</tbody>
</table>

Of the 1297 respondents, 275 (approximately 21%) reported that they had sought assistance or received help for a stress related problem, anxiety or depression from a doctor or other service provider.

Table 16: Respondents Who Sought Assistance or Received Help – All Respondents

<table>
<thead>
<tr>
<th>Yes</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>275</td>
<td>21.2</td>
</tr>
<tr>
<td>No</td>
<td>1022</td>
<td>78.8</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>1297</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

These 275 respondents who reported seeking assistance or receiving help were invited to participate in a more detailed survey, and the results from the detailed survey are reported in Part B.
6.2.3.2 Survey Part B: Respondents Who Sought Assistance or Received Help (Detailed Survey)

Demographics

Of the 275 respondents who sought help, approximately 74% were female.

Table 17: Gender – Detailed Survey Respondents

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>71</td>
<td>25.8</td>
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<tr>
<td>Female</td>
<td>204</td>
<td>74.2</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Of the respondents who sought help, 44% were in the age category 35 to 49, 39% were in the age category 50 to 64 and 17% were in the age category 18 to 34.

Table 18: Age categories – Detailed Survey Respondents

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
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<td>17.1</td>
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<tr>
<td>35 – 49</td>
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<td>44.4</td>
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<tr>
<td>50 – 64</td>
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<td>38.5</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Approximately 41% of the respondents who sought help were from Glenelg, 30% from Warrnambool, Moyne and Corangamite, and 29% from Southern Grampians.

Table 19: Local Government Areas – Detailed Survey Respondents

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Grampians</td>
<td>80</td>
<td>29.1</td>
</tr>
<tr>
<td>Glenelg</td>
<td>112</td>
<td>40.7</td>
</tr>
<tr>
<td>Warrnambool, Moyne and Corangamite</td>
<td>83</td>
<td>30.2</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Of the respondents who sought help, 78% reported experiencing a stress related problem in the last 2 years, 63% reported experiencing anxiety, and 65% depression. Respondents could select more than one condition.
Table 20: Condition(s) experienced – Detailed Survey Respondents

<table>
<thead>
<tr>
<th>Condition experienced</th>
<th>Number of responses</th>
<th>Percent of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Stress Related Problem</td>
<td>214</td>
<td>77.8%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>172</td>
<td>62.5%</td>
</tr>
<tr>
<td>Depression</td>
<td>179</td>
<td>65.1%</td>
</tr>
<tr>
<td>Any Other Mental Health Problem</td>
<td>24</td>
<td>8.7%</td>
</tr>
<tr>
<td>None</td>
<td>10</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Issues, Barriers and Enablers

In response to a question about respondents’ overall satisfaction with the care they received, approximately 52% reported that they were very satisfied, and 29% that they were satisfied.

Table 21: Overall Satisfaction With Care Received

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very dissatisfied</td>
<td>9</td>
<td>3.3</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>15</td>
<td>5.5</td>
</tr>
<tr>
<td>Neither satisfied nor dissatisfied</td>
<td>27</td>
<td>9.8</td>
</tr>
<tr>
<td>Satisfied</td>
<td>80</td>
<td>29.1</td>
</tr>
<tr>
<td>Very Satisfied</td>
<td>144</td>
<td>52.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>275</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Approximately 92% of respondents reported that they would prefer to seek assistance from a service provider in the region rather than outside the region.

Table 22: Preference for Service Providers In or Outside the Region

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this region</td>
<td>252</td>
<td>91.6</td>
</tr>
<tr>
<td>Outside of the region</td>
<td>23</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>275</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The most common factors reported as helping respondents to access a provider were (in order from highest percentage of respondents): convenient location of service provider in local area (74% of respondents), great service from one particular person (65% of respondents) and free, or low cost, services (56% of respondents). Respondents could select more than one factor.
Table 23: Factors Helping Respondent to Access Providers

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

Respondents who chose ‘great service from one particular person’ were asked to specify from whom the great service was received. GPs were specified by 118 respondents, 11 psychologists and nine counsellors. Thirteen respondents specified a combination of GPs and other service providers (psychologists, counsellors, psychiatrists, nurses, welfare agencies and midwives). The remainder of respondents who selected this option mentioned mothercraft nurses, social workers, community health services, colleagues, naturopaths, yoga teachers, psychiatric services workers, psychiatrists and other medical specialists.

There were 122 responses to the question ‘Was there any other factor or person who was useful in getting you the help you needed?’ Many respondents mentioned family members (16 partners, 3 parents, 1 grandparent, 1 mother-in-law, 4 children, 1 daughter-in-law, 1 niece, 11 ‘family’ as a whole and 5 unspecified ‘family member’ or ‘relative’) who provided support and/or information, ‘identified the problem’, suggested getting help, drove the respondent to the appointment and/or attended the initial appointment with the respondent. 18 respondents mentioned friends (some of whom were also doctors, nurses or naturopaths) who encouraged them, guided them, talked and listened or advised them to see a GP. One respondent mentioned a young parents’ group who helped with transport, while another mentioned church volunteers who came to sit with and support the respondent.

One respondent simply said ‘God’.

Four respondents mentioned employers who had been supportive or helpful, who had ‘identified the problem’ or who had passed on information. Three other respondents mentioned colleagues, one mentioned a professional network who ‘listened’, and one mentioned a work physician who ‘made a recommendation’.

Sixteen respondents mentioned doctors who referred them and/or listened to them. Six respondents mentioned the local community health (or mental health) centre or nurse, who were helpful, listened and followed up. Other respondents spoke about an assessment centre, a case worker, a chemist (who provided drugs), a ‘herbal provider’, a psychotherapist, a psychiatrist, a district nurse and other nurses (who ‘directed in the right direction’).

Two respondents mentioned ASPIRE (where they could ‘plan activities, socialise with others in the same situation’). Two people mentioned beyondblue. One had a friend who recommended beyondblue, while the other referred to an interview about beyondblue on television. Another
respondent mentioned advertising in the local media and two others mentioned pamphlets that they had seen, one for the local advisory service.

Two respondents did not specify the person involved but said that they had ‘insisted’ that the respondent sought help. Nine respondents said that they sought help on their own initiative. One respondent named ‘confidentiality’ as a factor that was useful in getting them the help they needed.

The most common barriers in seeking help were (in order from highest percentage of respondents): knowing what sorts of help were available to them (reported by 38% of respondents), distance to travel to the service provider (reported by 28% of respondents), and cost of the service (reported by 27% of respondents).

Table 24: Barriers in Seeking Help

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

There were 73 responses to the question ‘Did you experience any other barriers that prevented or made it difficult to access help?’ Some respondents reiterated the barriers listed in the table above: three respondents (one with a disability) mentioned lack of suitable transport; one mentioned the cost of transport; four mentioned knowing where to go for help; and six mentioned concerns about confidentiality or stigma, for example ‘being in the local community: too many people know me’, ‘small town gossip’ and ‘worried about friends knowing’. One respondent said ‘hard to find the right person for the situation in small area’.

Twenty responses referred to a lack of available appointments – not enough service providers available, doctors too busy, doctors available for limited (and inflexible) hours, and long waiting lists. Four respondents referred to lack of child care, and another four to busy schedules of work or other responsibilities. One mentioned family resistance. Three mentioned financial issues (one of these was ‘ongoing costs of medicines’).

Six people reported not being satisfied with their service provider, giving the following reasons: ‘didn’t feel listened to by first GP – frustration’; ‘lack of understanding from service providers’; ‘maybe not good advice from GP’; ‘original GP did not recognise the problem’; ‘professionals wouldn’t help at all’ and ‘GP would not give medication until further help was sought’.
Thirteen people referred to personal barriers, for example ‘only myself’, ‘anxious about going in the first place’, ‘embarrassment’, ‘feeling guilty about being unable to cope’, ‘too proud to ask for help’, ‘admitting self had a problem’, ‘generally putting on a brave face to seek help’ and ‘being depressed and then recognising you actually need help’.

Other responses were unique and/or difficult to classify, for example ‘alcoholism’, ‘depression with empty nest syndrome’, ‘not a lot of people who can understand’, ‘not well - very hard to communicate with reception staff’ and ‘government agencies refusing benefits: admin incompetence’.

**The Medicare Benefits Schedule Better Access Scheme**

Only 32% of the respondents reported awareness of the MBS Better Access scheme, and of these approximately 60% said that although they were aware, they had never used the scheme. 68% of the respondents reported that they were not aware of the scheme.

**Table 25: Awareness of the MBS Better Access Scheme**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, not aware</td>
<td>187</td>
</tr>
<tr>
<td>Yes aware, but never used</td>
<td>53</td>
</tr>
<tr>
<td>Yes, have made use of this</td>
<td>35</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>275</strong></td>
</tr>
</tbody>
</table>

In response to the question ‘To what extent does this (Better Access scheme) influence your decision to seek assistance for anxiety or depression?’, 39% of the respondents said it ‘strongly encouraged’ them to seek assistance, and 26% said it ‘mildly encouraged’ them.

**Table 26: Influence of MBS Better Access Scheme on Decision to Seek Assistance**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>96</td>
</tr>
<tr>
<td>Mildly encourage</td>
<td>72</td>
</tr>
<tr>
<td>Strongly encourage</td>
<td>107</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>275</strong></td>
</tr>
</tbody>
</table>

Some of the respondents would have been responding to this question (“To what extent does this (the MBS scheme) influence your decision to seek assistance for anxiety or depression?”) hypothetically, having reported in the previous question that they were not aware of the scheme. Others, who reported that they were aware, would have (in reality) taken the availability of subsidised visits to the psychologists into account when they did seek assistance.

Table 27 shows the percentage of respondents who reported that the availability of such subsidised visits influenced their decision to seek assistance, separately for respondents who reported awareness of the MBS scheme and those who did not:
Table 27: Crosstabulation - Influence of MBS Better Access Scheme on Decision to Seek Assistance by Awareness of the MBS Better Access Scheme

<table>
<thead>
<tr>
<th>Influenced your decision to seek assistance</th>
<th>Count</th>
<th>No, not aware</th>
<th>Yes aware, but never used</th>
<th>Yes, have made use of this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td></td>
<td>61</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>32.6%</td>
<td>45.3%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Mildly encourage</td>
<td></td>
<td>55</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>29.4%</td>
<td>18.9%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Strongly encourage</td>
<td></td>
<td>71</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>38.0%</td>
<td>35.8%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>187</td>
<td>53</td>
<td>35</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Of respondents who reported that they were aware of the MBS scheme and had made use of it, 69% reported that it ‘mildly’ or ‘strongly’ encouraged them to seek assistance. For those who reported that they were aware of the scheme but had never used it, reported that it ‘mildly’ or ‘strongly’ encouraged them to seek assistance. Further, 67% of respondents who reported that they were not aware of the scheme, reported that it would ‘mildly’ or ‘strongly’ encourage them to seek assistance.

In response to the question ‘Are there any barriers to using these subsidised services?’, 19% of respondents selected cost and 19% availability of appointments. Respondents could select more than one option.

Table 28: Barriers to Using Subsidised Services

<table>
<thead>
<tr>
<th>Number of Responses</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (possible gap payments)</td>
<td>52</td>
</tr>
<tr>
<td>Availability of appointments</td>
<td>52</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>49</td>
</tr>
<tr>
<td>None</td>
<td>171</td>
</tr>
</tbody>
</table>

Other barriers were specified by 49 respondents (18%), while 16 respondents mentioned travel or distance. A few specified distance to the service provider (one example was the ‘closest [Medicare provider] is 48km away’). Seven people referred to transport-related issues, two of which were related to cost of transport. Two people mentioned lack of available child care.

Two respondents mentioned the red tape or the amount of paperwork required (‘red tape makes it so hard to access: you become despondent’) as a barrier to using subsidised services. One specified ‘lack of qualified practitioners’, and another said there was a need for psychiatrist services. One respondent said ‘only one choice: if unsuitable makes it difficult’ and another said ‘finding someone I can trust’. Four responses referred to problems with service providers:
‘previous experience with psychologist’, ‘my GP won’t refer me to psychologist: doesn’t believe in it’, ‘quality of service’ and ‘doctor’s recognition of the service’. One respondent mentioned ‘lack of spiritual aspects in mental health treatment’. Two respondents mentioned lack of awareness of the subsidies.

Three respondents referred to confidentiality or stigma (‘confidentiality in the local region’, ‘worried about being known’, ‘working in the health system’). A few others referred to personal factors such as emotional obstacles (‘hard for people to talk to strangers’, ‘embarrassment’, ‘fear of taking the first step’), a medical condition (‘having diabetes, having to work around that also’) or simply ‘self’.

Some responses were difficult to classify or interpret in the light of this question, for example ‘cost of medications’, ‘lack of computer skills’, or ‘only 12’ (subsidised sessions).

### 6.2.4 Consumer Pathways & Social Network Analysis

#### 6.2.4.1 Individual Consumer Pathways

The following diagram displays the various pathways of consumers accessing services for a stress related disorder, anxiety or depression. The total number of consumers represented is 275. As indicated in Table 29 (below), 48.4% of consumers had two steps in their pathway, and 40.7% had just one step. One consumer reported six steps in his/her service provider pathway.
Figure 9: Linear Representation of Consumer Pathways
6.2.4.2 How long was the pathway for each respondent?

The following table indicates the number of steps in the pathway, as indicated by respondents completing the detailed Consumer Phone Survey:

*Table 29: Number of Steps in the Service Provider Pathway for Each Respondent*

<table>
<thead>
<tr>
<th>Number of Steps Reported</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>112</td>
<td>40.7</td>
</tr>
<tr>
<td>2</td>
<td>133</td>
<td>48.4</td>
</tr>
<tr>
<td>3</td>
<td>22</td>
<td>8.0</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>1.8</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>.7</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Whilst 112 consumers reported seeing only one provider when seeking services for a stress related disorder, anxiety or depression, 134 consumers had two steps in their pathway; 22 had three steps; 5 had four steps; 2 had five steps and one consumer had six steps in his/her pathway.

6.2.4.3 Service providers seen last in pathways

The following table indicates the type of provider seen last by respondents completing the detailed Consumer Phone Survey. For some respondents, this service provider will represent the end of their treatment journey; however, given the ongoing nature of treatment, it cannot be assumed that this is always the case.
Table 30: Type of Service Provider Seen Last by Respondents

<table>
<thead>
<tr>
<th>Provider Type Seen Last</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP / local doctor</td>
<td>96</td>
<td>34.9</td>
</tr>
<tr>
<td>Psychiatric Services SWHC</td>
<td>17</td>
<td>6.2</td>
</tr>
<tr>
<td>Community Health Centre</td>
<td>17</td>
<td>6.2</td>
</tr>
<tr>
<td>Psychiatrist (private)</td>
<td>27</td>
<td>9.8</td>
</tr>
<tr>
<td>Psychologist (private)</td>
<td>45</td>
<td>16.4</td>
</tr>
<tr>
<td>Counsellor (private)</td>
<td>34</td>
<td>12.4</td>
</tr>
<tr>
<td>Workplace counsellor (EAP)</td>
<td>9</td>
<td>3.3</td>
</tr>
<tr>
<td>Phone counselling service (such as Lifeline)</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>10.5</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>100.0</td>
</tr>
</tbody>
</table>
6.2.4.4 Consumer Pathways through Service Provider Network

The following diagram displays the consumer pathways through the mental health service network reported by consumers who participated in the Consumer Phone Survey. The distance between the nodes, and where a node is located in the diagram, are essentially arbitrary. The weight of the connecting lines indicates the relative number of consumers in each link.

![Diagram of consumer pathways through service provider network](image)

**Figure 10 Consumer Pathway (Random Configuration), based on data given by consumers (n = 275)**

Figure 9 shows a random configuration social network which essentially represents the same pathways as Figure 8. However, in this case the pathways are not shown in a linear way and the start and end points of the individual pathways are not shown. The random configuration social network shows the relations among the types of service providers. The thickness of each arrow in Figure 9 indicates the frequency of referrals in the direction indicated by the arrow.

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 following section focuses on some of the most connected nodes shown in Figure 9, and shows the distribution of service provider types which consumers reported that they saw immediately before and after the service provider type represented by these nodes. Percentages have been calculated with reference to the total number of occurrences of that particular service
provider type in the pathways. Note that a service provider type can appear at different stages of a treatment pathway, and can appear more than once for a single consumer.

6.2.4.5  **GP as central node**

The following diagram displays the types of providers seen by consumers in the step before and after seeing a GP for a stress related disorder, anxiety or depression:

![Distribution of service provider types seen before and after GPs (total number of occurrences = 246)](image)

**Figure 11: Distribution of service provider types seen before and after GPs (total number of occurrences = 246)**

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, a counsellor for 10.6%, a psychiatrist for 10.5%, and Psychiatric Services SWHC for 8.1%.
6.2.4.6 Private Psychologist as central node

The following diagram displays the types of providers seen by consumers in the step before and after seeing a private psychologist for a stress related disorder, anxiety or depression:

![Distribution of service provider types seen before and after private psychologists (total number of occurrences = 56)](image)

Figure 12: Distribution of service provider types seen before and after private psychologists (total number of occurrences = 56)

Three quarters (75%) of consumers who reported visiting a psychologist at some stage in their treatment had seen a GP in their previous step. While 12.5% did not report any previous provider; 7.1% reported seeing a psychologist in the prior step.

80.4% of consumers who reported seeing a psychologist did not indicate any further provider. The next step in the pathway was a counsellor for 7.1% of consumers, and a psychiatrist for 5.4%.
6.2.4.7 Private Psychiatrist as central node

The following diagram displays the types of providers seen by consumers in the step before and after seeing a private psychiatrist for a stress related disorder, anxiety or depression:

![Figure 13: Distribution of service provider types seen before and after a private psychiatrist (total number of occurrences = 37)](image)

Of the consumers who reported visiting a psychiatrist at some stage in their treatment, 70.3% had seen a GP in their previous step, 8.1% reported seeing a psychologist in the prior step, and 8.1% reported visiting Psychiatric Services SWHC.

Among consumers who reported seeing a psychiatrist, 73% did not indicate any further provider. The next step in the pathway was a psychologist for 10.8% of consumers, a psychiatrist for 5.4%, and a counsellor for a further 5.4%.
6.2.4.8 **Private Counsellor as central node:**

The following diagram displays the types of providers seen by consumers in the step before and after seeing a private counsellor for a stress related disorder, anxiety or depression:

![Diagram showing distribution of service provider types seen before and after private counsellor (total number of occurrences = 40)](image)

*Figure 14: Distribution of service provider types seen before and after private counsellor (total number of occurrences = 40)*

Of consumers who reported visiting a private counsellor at some stage in their treatment 65% had seen a GP in their previous step, while 17.5% did not indicate any previous provider, 10% reported seeing a psychologist in the prior step, and 5% reported seeing a psychiatrist.

For consumers who reported seeing a private counsellor 85% did not indicate any further provider. The next step in the pathway was a GP for 7.5% of consumers, a psychiatrist for 5%, and 2.5% reported visiting another counsellor.
6.2.4.9 **South West Health Care Psychiatric Services as central node:**

The following diagram displays the types of providers seen by consumers in the step before and after seeing Psychiatric Services SWHC for a stress related disorder, anxiety or depression:

![Distribution of service provider types seen before and after Psychiatric Services SWHC](Image)

*Figure 15: Distribution of service provider types seen before and after Psychiatric Services SWHC (total number of occurrences = 28)*

Of consumers who reported seeing Psychiatric Services SWHC at some stage in their treatment 71.4% had seen a GP in their previous step. In terms of using a previous provider, 14.3% did not indicate any, 10.7% reported visiting Emergency & Accident at the local hospital prior to Psychiatric Services SWHC, and 3.6% reported a previous visit to Psychiatric Services SWHC.

For consumers who reported seeing Psychiatric Services SWHC, 60.7% did not indicate any further provider. A GP was the next step in the pathway for 10.7% of respondents, a further 10.7% indicated they saw a psychiatrist, 7.1% saw a psychologist and 7.1% a Community Health Centre next.
6.2.4.10 **Community Health Centre as central node:**

The following diagram displays the types of providers seen by consumers in the step before and after visiting a Community Health Centre for a stress related disorder, anxiety or depression:

![Distribution of referrals to and from a Community Health Centre](image)

**Figure 16: Distribution of referrals to and from a Community Health Centre (total number of occurrences = 20)**

Of consumers who reported visiting a Community Health Centre at some stage in their treatment, 60% had seen a GP in their previous step. While 20% did not indicate any previous provider, 10% reported seeing Psychiatric Services SWHC, 5% reported seeing a psychologist and 5% another unspecified provider.

While 85% of consumers who reported visiting a Community Health Centre did not indicate any further provider, 10% went on to see a GP in the next step, and 5% a psychologist.
### 6.2.4.11 Number of Consumers who saw each type of Service Provider

The following table indicates the number of times that different types of service providers appear in the consumer pathways:

**Table 31: Number of times that different types of service providers appear in consumer pathways**

<table>
<thead>
<tr>
<th>Number of times reported in pathway:</th>
<th>GP / Local Doctor</th>
<th>Emergency &amp; Accident</th>
<th>Psychiatric Services SWHC</th>
<th>Community Health Centre</th>
<th>Psychiatrist (private)</th>
<th>Psychologist (private)</th>
<th>Counsellor (private)</th>
<th>Workplace Counsellor EAP</th>
<th>Phone Counselling service</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>f</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>f</td>
<td>%</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>34</td>
<td>12.4%</td>
<td>272</td>
<td>98.9%</td>
<td>248</td>
<td>90.2%</td>
<td>255</td>
<td>92.7%</td>
<td>240</td>
<td>87.3%</td>
</tr>
<tr>
<td>1</td>
<td>236</td>
<td>85.8%</td>
<td>3</td>
<td>1.1%</td>
<td>26</td>
<td>9.5%</td>
<td>20</td>
<td>7.3%</td>
<td>33</td>
<td>12.0%</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>1.8%</td>
<td>.0%</td>
<td>.0%</td>
<td>1</td>
<td>.4%</td>
<td>.0%</td>
<td>.0%</td>
<td>2</td>
<td>.7%</td>
</tr>
<tr>
<td>3</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
</tr>
<tr>
<td>Total consumers visiting provider type</td>
<td>241</td>
<td>3</td>
<td>27</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>35</td>
<td>0</td>
<td>56</td>
<td>0</td>
</tr>
<tr>
<td>Total occurrences</td>
<td>246</td>
<td>3</td>
<td>28</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>37</td>
<td>0</td>
<td>56</td>
<td>0</td>
</tr>
</tbody>
</table>
### 6.2.4.12 Number of Repeat Visits by Consumers

For each type of service provider that consumers visited, they were asked to specify how many times they contacted that provider. The following table indicates the number of times that consumers saw each type of provider:

**Table 32: Number of times that consumers visited each service provider type**

<table>
<thead>
<tr>
<th>How many times each consumer contacted provider</th>
<th>GP / Local Doctor</th>
<th>Emergency &amp; Accident</th>
<th>Psychiatric Services SWHC</th>
<th>Community Health Centre</th>
<th>Psychiatrist (private)</th>
<th>Psychologist (private)</th>
<th>Counsellor (private)</th>
<th>Workplace Counsellor EAP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Just Once</td>
<td>47</td>
<td>1</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>%</td>
<td>20.1</td>
<td>33.3</td>
<td>22.2</td>
<td>25.0</td>
<td>15.6</td>
<td>10.7</td>
<td>10.8</td>
<td>22.2</td>
<td>17.6</td>
</tr>
<tr>
<td>2 to 4 times</td>
<td>85</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>14</td>
<td>12</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>%</td>
<td>36.3</td>
<td>66.7</td>
<td>29.6</td>
<td>50.0</td>
<td>18.8</td>
<td>25.0</td>
<td>32.4</td>
<td>55.6</td>
<td>26.5</td>
</tr>
<tr>
<td>5 to 10 times</td>
<td>39</td>
<td>.0%</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>3.1%</td>
<td>19</td>
<td>32.4</td>
<td>.0%</td>
</tr>
<tr>
<td>%</td>
<td>16.7</td>
<td>.0%</td>
<td>14.8</td>
<td>5.0%</td>
<td>3.1%</td>
<td>33.9</td>
<td>32.4</td>
<td>20.6%</td>
<td></td>
</tr>
<tr>
<td>More than 10 times</td>
<td>63</td>
<td>.0%</td>
<td>9</td>
<td>3.3%</td>
<td>20.0</td>
<td>62.5</td>
<td>17</td>
<td>24.3</td>
<td>2</td>
</tr>
<tr>
<td>%</td>
<td>26.9</td>
<td>.0%</td>
<td>33.3</td>
<td>20.0</td>
<td>62.5</td>
<td>30.4</td>
<td>9</td>
<td>35.3%</td>
<td></td>
</tr>
<tr>
<td>TOTAL Consumers</td>
<td>234</td>
<td>100.0</td>
<td>27</td>
<td>100.0</td>
<td>20</td>
<td>100.0</td>
<td>32</td>
<td>100.0</td>
<td>9</td>
</tr>
<tr>
<td>%</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0%</td>
<td>34</td>
</tr>
</tbody>
</table>

A single step in a consumer’s pathway may consist of one or more interactions with the same service provider. Consumers reported the most repeat visits for the private psychiatrist and private psychologists:
- 62.5% of consumers using the private psychiatrist saw him/her more than 10 times
- 33.9% of consumers using a private psychologist saw them five to 10 times, and 30.4% saw them more than 10 times

Consumers reported the least number of visits for Emergency & Accident, workplace counsellors and Community Health Centres:
- One of the three consumers using Emergency & Accident saw them once, and the remaining two saw them two to four times
- Two of the nine (22.2%) consumers using workplace counsellors saw them once, and five of the nine (55.6%) saw them two to four times
- 25% of consumers visiting a community health centre saw them once, and 50% saw them two to four times

Consumers seeing GPs and private counsellors at some point in their treatment pathways were more evenly spread in terms of how many times they saw them:
- 20.1% of consumers using private counselors saw them once, 36.3% saw them two to four times 16.7% saw them five to 10 times and 26.9% saw them more than 10 times
- 10.8% of consumers using private counselors saw them once, 32.4% saw them two to four times 32.4% saw them five to 10 times and 24.3% saw them more than 10 times

### 6.2.4.13 How consumers came to use each type of provider

For each type of service provider that consumers visited, they were asked to specify how they came to use that provider. The following table summarises this information:

**Table 33: How consumers came to use each service provider type**

<table>
<thead>
<tr>
<th>How consumers came to use each type of provider</th>
<th>GP / Local Doctor</th>
<th>Emergency &amp; Accident</th>
<th>SWHC Psychiatric Services</th>
<th>Community Health Centre</th>
<th>Psychiatrist (private)</th>
<th>Psychologist (private)</th>
<th>Counsellor (private)</th>
<th>Workplace Counsellor</th>
<th>EAP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>Already a patient</td>
<td>192</td>
<td>82.1</td>
<td>0.0</td>
<td>1.3</td>
<td>1</td>
<td>5.0</td>
<td>2</td>
<td>6.3</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Referred by a medical practitioner</td>
<td>6</td>
<td>2.6</td>
<td>15</td>
<td>55.6</td>
<td>10</td>
<td>50.0</td>
<td>27</td>
<td>84.4</td>
<td>38</td>
<td>67.9</td>
</tr>
<tr>
<td>Referred by another health professional</td>
<td>5</td>
<td>2.1</td>
<td>0.0</td>
<td>0.0</td>
<td>2</td>
<td>10.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>Referred by community centre</td>
<td>0.0</td>
<td>0.0</td>
<td>1</td>
<td>3.7</td>
<td>2</td>
<td>10.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>Information sources</td>
<td>0.0</td>
<td>0.0</td>
<td>1</td>
<td>3.7</td>
<td>1</td>
<td>5.0</td>
<td>0.0</td>
<td>2.36</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Suggested by a friend or relative</td>
<td>11</td>
<td>4.7</td>
<td>2</td>
<td>7.4</td>
<td>2</td>
<td>10.0</td>
<td>0.0</td>
<td>2.36</td>
<td>4</td>
<td>10.8</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>8.5</td>
<td>3</td>
<td>100.0</td>
<td>7</td>
<td>25.9</td>
<td>2</td>
<td>10.0</td>
<td>3</td>
<td>9.4</td>
</tr>
<tr>
<td>TOTAL Consumers</td>
<td>234</td>
<td>100.0</td>
<td>3</td>
<td>100.0</td>
<td>27</td>
<td>100.0</td>
<td>20</td>
<td>100.0</td>
<td>56</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Consumers using GPs at some point in their treatment pathways were mostly already a patient (82.1%).

Consumers using a private psychiatrist at some point in their treatment pathways were mostly referred by medical practitioners (84.4%). The same was true of consumers using counsellors (75.7% referred by a medical practitioner), private psychologists (67.9%), Psychiatric Services SWHC (55.6%) and Community Health organisations (50%).

Consumers were also referred to Community Health Centres by other health professionals (10%), community centres (10%) and friends or relatives (10%).

Suggestions of friends and relatives also accounted for 10.8% of consumers coming to use private counsellors.
7.0 Discussion

Objective 1: Identify the capacity and structure of the current service system for those with depression and anxiety

The project region has a variety of services and a reasonably wide coverage throughout the area. Most of the services are concentrated in the largest urban centre of Warrnambool. It is possible to access GP and counselling services in a range of areas, although these are often only available on a part time basis so some waiting period is involved. Several private service providers work in local health centres or GP clinics in order to provide a part time service to smaller towns. Community health centres often provide a platform to offer counselling services in centres outside 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. So too, the part time nature of many services and lack of specialist services outside of Warrnambool can provide barriers to people accessing the service when they need it.

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 flagged that GPs do not have a uniform interest or capacity in the treatment of high prevalence psychological disorders. When accessing a GP a consumer is not assured of a specific type of treatment or level of expertise in dealing with depression or anxiety, as might be reasonably expected when accessing a psychologist or other specific mental health clinician.

In the project area there are approximately 100 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 has 1.2% of psychologists registered in Victoria practising there (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. This factor affects access to the services they provide.

After GPs, private psychologists are the next biggest group of service providers. The relatively lower 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. Of the private psychologists, two are clinical psychologists.

Another aspect of the service ‘system’ in the Southwest is that it is still also possible to access services which are of no cost to the consumer (for example, from the couple of social workers that bulk bill or at a community health centre) or which are priced according to the capacity of the consumer to pay (for example, at Centacare).

There are 1.5 full time equivalent psychiatrists in private practice for the whole region which means that consumers have a long wait to access a psychiatrist privately.
For the purposes of this project, we collated the details of services for depression and anxiety in the region, however, such data are of little use if they are not kept continuously up to date. The same applies to formal service directories. Unfortunately the experience gained during this project indicated that while there were many sources of information about what services are available, most of these were not completely accurate. One example of this was the GP practice profiles on the ODGP website, which supplied several out of date contact details. This has implications for consumers seeking information about where to access services as they may come across inaccurate information which may discourage them in their search for a suitable service provider. It may be necessary to implement a large directory encompassing a range of services which is resourced such that it is possible to keep it up to date. An example of this is the directory of South Australian services which is administered and managed by the not-for-profit organisation Community Information Strategies Australia. The South Australian directory can be found at: http://www.cisa.asn.au/cgi-bin/wf.pl. A valuable hard copy local directory is currently compiled by MPower but it is subject to uncertain funding.

**Objective 2: Assess the impact of the new Medicare Benefits Schedule items for mental health care**

Overall, the MBS Better Access item number figures 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. The figures accessed show that items are being used in great numbers Australian wide, with Victoria having the highest per capita uptake of major item numbers.

In the project region there has been a particularly significant uptake of the Better Access item numbers relating to the preparation of the GP Mental Health Care plan. These figures suggest that increased access to services for depression and anxiety has resulted from the uptake of the Better Access items.

However, 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 occur in the metropolitan areas and this is where the Better Access initiative is having the most impact (Dunbar, Hickie, Wakerman & Reddy, 2007). In the project region, the workforce of two clinical psychologists, 18 MBS registered psychologists and two MBS registered social workers limits the number of services that can be provided.

In the Melbourne metropolitan area, there are 2,200 people to each psychologist. In combined rural areas there are on average 6,707 people to each psychologists (APS 2007 & ABS 2006). For Victoria as a whole, 23% of the population reside in regional and rural areas, however only 2.3% of psychologists registered in Victoria live there. Within our area of interest there are only 20 psychologists, including 2 clinical psychologists. This is 5,852 people per psychology service.

There are concerns that governments may make the assumption that regional and rural areas have increased access to mental health services under the Better Access program and therefore may not see the need to continue funding for community mental health services as a result.

In the project region, there is evidence that the Better Access program may be taking some pressure off the public mental health system. According to the SWHC PMHT, GPs can now refer those who can not afford the gap fees with a private psychologist to the PMHT and also use the PMHT to deal with consumers with more complex needs.
As Better Access was introduced, the restrictions on GPs using the ATAPs program were lifted. ATAPs targets those with lower income to provide access to Allied Health workers including psychologists. There was concern that the introduction of Better Access may cause ATAPs to become unnecessary. However, a study by the University of Melbourne has found that while there was an initial drop in the number of referrals through ATAPs since the introduction of Better Access, this has levelled off and ATAPs continues to provide access to services for depression and anxiety for those in lower income groups (Bassilios, Fletcher, Pirkis, Kohn, et.al., 2008).

Another possible impact of the Better Access program was the movement of psychologists, social workers and occupational therapists from the public to private sector to take advantage of the increased access to their private services (Crosbie & Rosenberg, 2007, van Gool, 2007). The concern was that the overall supply of psychologists is reasonably fixed and that services subsidised through Medicare may attract new psychologists at the expense of public sector services. In the project region, only one social worker has left Psychiatric Services at Southwest Healthcare and has moved into private practice.

There has also been the argument that with the combination of psychologists moving into private practice and setting their own fees beyond the MBS schedule (making their services more expensive to the consumer), and the movement out of the public health sector (as public clinicians set up in private practice to take advantage of the MBS rebates) that there is potential that access will not have been greatly improved overall (Crosbie & Rosenberg, 2007). Similarly, it has been suggested that it is not an economically efficient means of funding services, since private providers can set their own fees. (Van Gool, 2007) It was noted, though, that fee-for-service may encourage higher through put of services and, to the extent that the uptake figures represent better access, there is significant improvement in access. There is no way of knowing what uptake would have been had service fees remained lower.

The issue of gap payments for sessions with psychologists can be confusing for consumers. According to the ODGP, at the introduction of the Better Access program in November 2006, the average gap payment was between $10 - $15 but 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. This represents a reduction in the full cost of the service, but is still a significant cost to the consumer who may not be able to afford $43 for each of several sessions.

The clinical psychologists (of which there are only 2 in the project region) typically charge $130 per 50+ minute session. The rebate for this is $112, leaving the consumer $18 out of pocket. However, there is no clear information, which the consumer can access, to clarify the difference in the services provided by a clinical psychologist and a registered psychologist – neither does the average consumer understand the difference in the cost of services provided by a clinical and registered psychologist respectively. Indeed, some referring service providers do not understand these differences.

For access to items 2710, 80010 and 80110 women outnumber men two to one. 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. This was followed for all three items by women in the 25 – 34 years category.

Men 24 years and under made up the groups with least access to these services. While prevalence of depression and anxiety is generally higher in women than men, (NHS 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 had significant access to services using these new items. The extensive consumer survey conducted in this project generally supports these figures in both gender and age groups, however the data is not sufficient to allow closer analysis.

The Australian Medical Association (AMA), while generally supportive of the Better Access reforms, has made reference to the undervaluing of GP services – that is, the MBS rebate is lower for GPs than for other health professionals (Metherell 2006 & van Gool 2007). In the project region however, GP concerns centre on their ability to prepare a mental health care plan and patient management. They have concerns about their capacities to fulfil these functions well.

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 evidence 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).

Another issue to consider is the limit on the number of sessions provided to a consumer through the Better Access program. Several of the consumers interviewed in this project commented that they were able to access a given number of sessions with a psychologist through the MBS items, but after that they either had to pay the full cost of the session or to discontinue seeing the psychologist.

It is apparent 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 closer:

- 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. Therefore it is difficult to work out the actual increase in access.

- There is also limited data on overall prevalence of mental health issues being treated in the services provided by Better Access, nor on the effectiveness of these treatments – therefore, we are unable to understand the impact of increased access to psychological services on the improvement of mental health generally (Crosbie & Rosenberg, 2007).

**Objective 3: Determine patterns of service usage and identify service gaps, barriers and enablers to service utilisation**

**Service Provision ‘Network’**

One of the issues in looking at service providers’ perspectives in this discussion is the tendency to treat them as a homogeneous group. This is problematic. Service providers may be private business people, such as private psychologists or GPs. They may work for another organisation,
such as SWHC or be employed by a community organisation such as Centacare. These differences impact on people’s perspectives of service provision. It colours their beliefs about other service providers and about what the priorities in service provision should be. It is important to acknowledge these differences and to take them into account when looking at the whole ‘system’.

Understandably, each service provider brought their own subjective views about ‘the system’ and about other service providers’ roles. Sometimes they were not favourable and service providers were quite candid in some of their comments. This could also reflect their lack of knowledge of other services or the constraints under which other service providers are operating.

There were areas where information from certain service providers conflicted with that already reported by another - for example, the issue of feedback from psychologists to GPs. Some reported that this was done well, others reported that it was non-existent.

**First Port of Call**

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. In the project region, for example, there are some 100 GPs, whereas there are only 18 counselling psychologists. GP visits are well subsidised by Medicare and some GPs will bulk bill. This contrasts with the general feeling that private therapy is costly.

GPs are spread throughout the region too, in terms of their location, which increases accessibility in comparison to other mental health care providers. Even many smaller towns have some access to local GPs. In Heywood, a town with a population of 2,000 there is one full time GP clinic. However, in Heywood, counselling is available on a part time basis only as part of the Glenelg Rural Health Service outreach.

Geographical distance is not the most important determinant of the choice of GP of rural people (Humphreys, Mathews-Cowey & Weinand 1997). While there are several factors which affect a GP’s acceptability to a consumer, most people were able to find a GP they felt comfortable with. Factors including information, communication, concern, respect, personal attention to the patient’s condition and skill were most important. An acceptable GP is often a trusted person whom the consumer has seen before. For several of the participants, a long term relationship existed with their GP. Most of the GPs surveyed estimated that the majority of their patients who came to see them for depression or anxiety did so as existing patients.

GPs clinics are relatively stigma-free. A consumer walking into a GP’s clinic could be presenting with any condition. It is not possible for others observing that consumer to know what the problem is that a consumer has come to see their GP about. There is a perception of greater stigma involved in entering a psychologist’s rooms or the Psychiatric Services building.

Many of the participants had talked their condition over with friends and family and for those who had someone to talk to, this was very important. Often it was a friend or family member who encouraged a participant to actually go and seek formal help and most often they suggested the GP.
Others sought help where they already had a contact or had had a previous positive experience – for example, one woman had used her community health centre prior to seeking counselling there for depression. Of the consumers surveyed by phone, the next most important service provider was the psychologist, although we do not know if these providers were accessed privately or through the GP using ATAPs or Better Access. We also do not know if consumers accessed psychologists because they were actively perceived as a good choice of service provider or, given psychologists represented the second largest group of service providers, whether they were simply the next most available service.

Referrals

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. Sometimes this came about by referral, at other times consumers sought out a secondary service by themselves. This suggests a certain level of knowledge of services available on both the part of local service providers and of the consumers themselves. Other consumers voiced frustration that they did not know what other services were available and had to rely on the knowledge of their initial service provider to appropriately direct them to other services.

Several of the consumers, once they had sought treatment, went on to actively seek out other organisations or agencies which could provide them extra or longer term support. ASPIRE seemed to fulfil this role for several of those interviewed.

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. However, it may also be interesting to hold a discussion between the GPs and other clinicians regarding the substance and appropriateness of the referrals. One WA study (Lockhart 2006) found that it was vital for definitions of professional roles and of mental health conditions to be understood uniformly among service providers. This way, GPs would understand exactly when they should refer to Psychiatric Services or a psychiatrist and know how these service providers are likely to respond.

Stigma

A recent study in Scotland found that mental health problems were stigmatised. Limited availability of mental health services along with a high level of visibility of these services had its own detrimental impact on people’s mental health and their ability to seek care (Parr, Philo & Burns 2004). In the Australian setting, it was noted that stigma was 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.

Personal stigma was also found to be higher among men than women, higher among those with less education and among those born overseas. Remoteness of residence was not associated with either types of stigma (Griffiths, Christensen & Jorm 2008).
However where consumers seek help for a psychological problem from their GP – as is the case in the majority of consumers we interviewed and surveyed – perceived stigma does not necessarily influence help-seeking behaviour (Komiti, Judd & Jackson 2006).

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.

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.

**The Medicare Better Access Program**

The Better Access scheme is designed to increase consumer access to psychological services, however it is not the only means of accessing subsidised or free services.

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. Given the timeframe of illness experienced by those interviewed – for most this extended back prior to the introduction of Better Access – and given that there were several different schemes available, it was difficult to determine the impact of the current program on seeking help.

Consequently while many of the consumers had accessed some form of subsidised psychological service for their depression or anxiety, few were clear as to which ‘scheme’ they had accessed. 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. It is clear however that the BOIMHC program (with it’s 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. Other ‘schemes’ available through which consumers could access psychological services included EAPs and workplace counsellors, and subsidies provided under Workcover and Victims of Crime. The impact of the scheme on individual consumers’ mental health outcomes depended on the relationship with the psychologist to a large extent.

Several of the service providers suggested that the Medicare item numbers for mental health could be opened up for other service providers to release some of the workforce pressures on the
formal ‘mental health’ system. Other human service providers – such as drug and alcohol counsellors, non-psychologist counsellors or rural financial counsellors for example – could provide care as they are accessible and there is less of a stigma involved with accessing them (Fuller et al, 2004). This may present many challenges to the provision of a high quality of care, including the need for specialist mental health knowledge on the part of human service providers, along with an adequate referral pathway for when a consumer’s needs were too complex.

**Knowledge of Services**

Almost all participants went to their GP in the first instance and those who didn’t had specific reasons for attending another service provider – for example, a workplace counsellor was readily available to them. Consumers made their first point of contact with a service provider and generally relied on that service to educate them about and direct them to other services. This depends on service providers themselves having adequate knowledge of what’s available and this is where some of the interview subjects felt disappointed. 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. Several of the interview participants found that once they accessed one service, they found out about others. For example, one woman found that she required some extra support other than her GP and Psychiatric Services SWHC. She accessed ASPIRE and then learned about several courses which she undertook to learn strategies to cope with her illness.

Several participants felt they wanted to ‘give something back’ and subsequently became a volunteer with an agency which had been helpful to them.

**Satisfaction**

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).

It was also notable that most of those who felt uncomfortable with their service provider changed providers. This indicates that the participants recognised the importance of having a service provider they felt comfortable with and that, despite their depression or anxiety, they had the capacity to search out a different, more appropriate service provider when needed.

Research has shown that generally people are suspicious of medication in the treatment of mental illness (Jorm, Korten, Jacomb, et al., 1997). Among the interview participants, 22 (88%) had
received treatment in the form of medication and it did not feature as a problem for most participants. While one woman had decided to go off her antidepressant medication in favour of ‘herbal things’, several commented that they knew their medication was important and that they would seek out their service provider to adjust their medication if they recognised that their health was deteriorating.

However, there were many other ways that participants used to improve their mental health and to maintain it. These included relaxation and meditation, journaling, exercise, socialising, Tai Chi and positive thinking. Rather than use these means to avoid medication, we found the participants used them to augment other more formal treatment. While there is not a large evidence base for the effectiveness of such activities, exercise and relaxation have been shown to be effective in the treatment of depression (Jorm, Christensen, Griffiths, & Rodgers 2002).

**Cost of Treatment**

The cost of services can be a significant barrier to consumers seeking help for depression and anxiety. 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 are important.

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.

**Workforce**

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, (See Literature Review in Chapter 8 of this report).

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.

**Distance**

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. Several consumers mentioned a lack of child care as a barrier to accessing help. It is clearly important to have privacy and be able to discuss mental health concerns confidentially with a service provider and this can be compromised if the consumer is accompanied by children at an appointment.

**Unexpected Responses**

One unexpected outcome of the interviews was in the attitudes towards and use of Lifeline. While Lifeline provides consumers with someone to speak to immediately while they wait for an appointment with a formal service provider, few of the participants had called Lifeline or even considered them as a viable option. Grievances from the qualitative interviews included 'you
have to give them too much information’ but others were vague such as ‘Lifeline are useless’. Given that Lifeline is one of very few counselling services available after hours, our expectation was that more of the interview participants would have used Lifeline and had a helpful experience.

Another unexpected response was that distance did not seem to be too much of a barrier to accessing help. Two participants chose to access a service provider in another town but this was more to do with stigma or confidentiality issues than with availability of the service provider.

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. It could be argued that this region has not been widely devastated by the drought, although it has impacted on farmers. It could also be argued that given rural farming cultural traits like stoicism and the stigma involved in expressing mental health concerns that those most likely to be affected by the drought may be those least likely to participate in a project dealing with depression and anxiety. While prolonged drought is acknowledged as a serious stressor (Sartore, Kelly, Stain 2007) more research targeted more specifically at farmers in this region would need to be done to ascertain the impact of this drought on them.

Limitations

In order to recruit the 25 interview participants we advertised in various places for volunteers to participate in the interviews. We found that the majority of those who were interviewed were recruited through a mail out to all past participants in the TAFE Stress Management Course.

One reason for this may be the personal letter which they received, whereas others just saw a generic notice asking for volunteers. Another reason may be that those who have completed this course are highly motivated to stay well and to help others by using their own experiences to share some of the issues in high prevalence mental health disorders.

Most of the those interviewed were from Warrnambool and Moyne Shires and, as such, were not geographically far from where services are concentrated (that is, in Warrnambool). This may have impacted on our ability to assess whether geographic location influences access to services.

The majority of consumer participants in both the interviews and phone surveys were women and it was to be expected that women were more likely to be willing to speak about their experiences (Emslie, Ridge, Ziebland, & Hunt 2007). While several studies have found that women are more likely to seek help for mental health problems compared with men (Bergeron et al, 2005, & Parslow and Jorm 2000) and while women experience higher prevalence in depression and anxiety disorders, it would have been useful to have greater participation from men to better understand consumer issues related to seeking help for depression and anxiety.

Another difficulty encountered in the project was encouraging the participation of service providers, especially GPs. The majority of service providers – GPs and psychologists in private practice – are private business people, and as such, their focus is on their main business activity. Of the approximately 100 GPs in the region, we had the involvement of approximately 17 (this figure is not clear as some service providers participated in the online survey anonymously and
therefore we do not know if they were the same ones who participated in the reference group or focus group). In a 2003 study, the barriers to GP participation in research were found to be primarily a lack of time and a lack of financial remuneration from research activities (McCall, Cockram, Judd et al., 2003). Other research has found that GPs view research as lacking intrinsic clinical or professional value and that they lacked the time to participate in research (Salmon, Peters, Rogers, et al., 2007 & Veitch, Hollins, et al., 2001).

Through the consumer phone survey we surveyed 1297 people who responded that they had experienced depression, anxiety or stress related problems within the last two years. However, of these, only 275 people had sought out a service provider for treatment of some kind. Consequently, we do not know why the majority did not seek a service for depression or anxiety, what knowledge they had of potential services and where they may have gone if they did need help. More research needs to be done in this area.

One of the difficulties of this project is that we do not have accurate data on the prevalence of depression and anxiety in the region. The VPHS data are not available by region, and the self-report measures which are used in most public health surveys do not adequately measure depression and anxiety. For example, most use the K-10 scale which measures psychological distress rather than depression or anxiety. It could be that when people are asked about depression and anxiety, they interpret these terms in different ways – some may view any kind of stress as depression and anxiety; others may view only severe mental illness as depression and anxiety. So it is difficult to accurately answer the question of whether there are sufficient resources in the region to meet the needs of consumers, when the need is difficult to accurately quantify.
8.0 Literature Review and Recommendations

8.1 Summary of Methodology

Using the Ebscohost data base system, we were able to search the following databases;

Academic Search Premier; AMED (Alternative Medicine); Applied Science & Technology Abstracts; CINAHL; Clinical Reference Systems; EJS E-Journals; Health Business Fulltext Elite; Global Health; Health Source; Information Science and Technology Abstracts; MEDLINE; Mental Measurements Yearbook; PsycARTICLES; PsyINFO; and Psychology and Behavioural Sciences Collection

We searched the literature using a ‘silo’ model looking for the problem, context and intervention using key words. Abstracts found to be relevant were read and full papers were obtained from their original sources. The reference lists of relevant articles were also screened to obtain further literature.

Several topics emerged which we have expanded below.

Recommendations were drafted after assessing the outcomes of the project. Reference group members were invited to provide input and feedback about the recommendations presented in this report.

8.2 Literature Review

The aim of the literature review in this report was to search for projects and research which could be potentially applicable in the project region and which could help to contribute to recommendations for local improvements to current service delivery. Emphasis was placed on literature which concerned the Australian rural context.

There is a lack of clarity in the literature regarding the classification of non-metropolitan areas in Australia. Most of this project area (Glenelg, Southern Grampians, Moyne and Corangamite) is classified ‘accessible’ under the Accessibility/Remoteness Index of Australia (ARIA) and Warrnambool is classified as ‘highly accessible’. While most of the project area is classified as rural or regional in terms of the RRMA classification, much of the literature relates to isolated rural and remote areas where distances and accessibility are greater issues and cultures of self-reliance in local communities are more evident.

8.2.1 Integrated Specialist Care

Among the literature were two projects in remote or rural areas of Australia which experimented with integrating specialist care into areas where specialists were scarce. The Far West Mental Health Integration Project in NSW was one example. The key to this model is that local mental health teams, GPs and other service providers are supported by visiting psychiatrists who visit outlying areas regularly and provide case management and staff development support. The project (Perkins, Russell, Tuana & Rosen, 2006) showed that the visiting specialists became core to the provision of services
by local community mental health teams but also core to the support and professional development of local staff.

The other project sought to identify a working model between rural mental health services and GPs and was based in the project region. Psychiatric Services SWHC, based in Warrnambool, commenced a ‘GP liaison project’ in 1998 which facilitated communication between psychiatric services and GPs through regular meetings supplemented by video conferencing. Psychiatrists from Psychiatric Services would visit outlying community mental health centres three times a week and be based in the Warrnambool centre two days per week. An evaluation showed significant increase in access to psychiatric services by the GPs (Samy, Hall, Rounsevell & Carr 2007).

8.2.2 Mental Health Literacy of Consumers and Service Providers: Increased Knowledge of Disorders, Services and Treatments

The project region is relatively well serviced in terms of GP distribution. The area also has a PMHT and a small group of private providers of psychological services. In order to increase the impact of these existing services on the treatment of depression and anxiety in the project region, service providers and consumers alike need to have sufficient mental health literacy in order to recognise when a consumer needs help, what the problem is and therefore, which help is most appropriate.

What is meant by ‘mental health literacy’? Jorm, Korten, Jacomb, Christensen, Rodgers and Pollitt (1997) define mental health literacy as the ability to gain access to, understand and use information in ways which promote and maintain good mental health. In the case of this project, mental health literacy relates to recognising the symptoms of common mental illness and knowing what effective treatments are available to the consumer.

The lifetime risk of developing a mental disorder is nearly 50% (Kessler et al., 1994) therefore almost the whole population will have direct experience of a mental illness, either in themselves or in someone close to them. A high level of mental health literacy in the population would enhance early recognition and intervention for many people and ensure that they are aware of what services and treatments are available to them (Jorm et al., 1997).

Consumer Perspective

It has been demonstrated that the majority of people with a high prevalence psychological disorder do not seek or receive an evidence-based treatment (Hickie, Davenport, Naismith, Scott, Hadzi-Pavlovich & Koschera, 2001; Andrews, Sanderson, Slade & Issakidis, 2000). While prevalence of anxiety and depression is similar in rural and metropolitan areas (Eckert, Taylor, Wilkinson & Tucker, 2004), there are fewer services per capita generally available in the regional areas. In addition, Caldwell, Jorm and Dear reported that an underlying factor relating to the increased suicide in young men in rural and regional areas is lower use of services in rural areas generally, rather than higher rates of mental disorder (Caldwell, Jorm & Dear 2004).

An issue may be that people just do not know where to go. One study of mental health literacy in rural Queensland found that only 40% of respondents in a rural population were aware of where they could receive help for a mental health problem (Bartlett,
Travers, Cartwright, Smith, 2006). This highlights the importance of not only having services available, but of consumers knowing about and using these services (Hickie 2004).

Another problem to be overcome is the difference between public and professional beliefs about treatment (Jorm, Christensen, Griffiths & Rodgers, 2006). The respondents in one study (Jorm, et al., 1997) varied widely on their perceptions of the efficacy of treatment of mental disorders. While 42% of respondents thought that antidepressant medication was harmful and 13% thought that psychotherapy was harmful, treatments such as vitamins, minerals and special diets were considered more helpful. The treatments which rated most highly were non-standard in nature. The study shows that public perceptions often diverge from those of mental health professionals and may lead to unwillingness to accept help from a mental health professional or to lack of adherence to their advice.

Improved mental health literacy and understanding of evidence-based treatments would raise the level of adherence to treatment regimens and would therefore produce better consumer outcomes. There is evidence from a meta-analysis of randomised controlled trials that for mild and moderate depression that there is little difference in the effectiveness of treatments (evidence-based pharmacological, talk therapies or a combination of both) but that ongoing treatment is more important than the type of treatment (Ellis & Smith, 2002). This suggests that consumers need to be educated on the importance of continuing their treatment and of continuing their relationship with their treatment provider.

In the study of a representative sample of Australian adults (Jorm et al., 1997), recognition of a mental disorder was high, although the correct psychiatric label was only applied in the minority of cases. GPs rated very highly as the person most helpful in the case of depression and this may suggest that public perceptions of seeking help from mental health professionals such as psychologists and psychiatrists needs to change (Jorm et al 1997).

Another Australian study (Jorm, MacKinnon, Christensen & Griffiths, 2005) found that these beliefs reflect not specific knowledge, but the application of broad classes of treatment irrespective of the mental health disorder. Any mental health literacy program needs to take into account pre-existing beliefs about mental health and tailor evidence based versions of these belief systems to overcome this.

There is also evidence that stigma and other beliefs affect public perceptions and acceptance of people with common mental disorders and their treatment. In a rural Australian study in Bendigo (Judd, Jackson, Komiti, Murray, et.al., 2006) it was found that farmers do not generally use the term ‘depression’ or report symptoms of depression, but they discuss these issues in terms of ‘stress’ in broad terms such as the drought or relationships. This has implications for those who deal with these disorders in farming communities especially and shows that efforts to improve help-seeking by rural residents for mental health problems need to focus on understanding and addressing such attitudes – that is, that rural populations need to be educated in accepting that they would actually benefit from seeking professional help. The support of people with a mental health problem is important in the recognition and treatment of such problems and therefore it is important to reduce the stigma and other beliefs associated with mental illness through improved mental health literacy (Jorm 2000).
Gender has been suggested as an important risk factor in psychological distress, however data supporting this might also reflect the greater tendency for women to seek mental health services rather than a significant difference in incidence (Emslie, Ridge, Ziebland & Hunt, 2007). It is hypothesised that women may also be over-diagnosed with depression because of the way they express emotional distress, whereas men’s lack of articulacy may mean their depression is ‘hidden’ (Brownhill, Wilhelm, Barclay & Schmied, 2005). Mental health literacy needs to be targeted properly to be effective for both male and female audiences.

**Service Provider Perspective**

The need for improved mental health literacy also applies to service providers. This Mental Health Mapping project has found that service providers are not always aware of other services which may be of benefit to those with depression and anxiety.

The mental health literacy of service providers is not just limited to the knowledge of services. While most people who do seek help for depression and anxiety do so from their GP (Andrews, Hall, Teesson & Henderson, 1999) there is concern that GPs may not have the level of mental health literacy needed to provide the best outcomes to the consumer. One study found that many GPs failed to recognise depression for a variety of reasons (Hickie, Davenport, Naismith, Scott, Hadzi-Pavlovich, & Koschera, 2001) and there is no real evidence to indicate that GPs are the best at providing that care, in terms of patient outcomes.

Training has been suggested as a way of increasing GPs’ knowledge of depression and anxiety, detection and treatment, however different studies have shown that this does not appear to translate into health gains for consumers (McCall, Clarke & Rowley, 2004; Gask, Dowrick, Dixon, Sutton, Perry, Torgerson & Usherwood 2004; Meredith, Mendel, Pearson, Wu, Joyce, Straus, Ryan, Keeler & Unitzer, 2006; Clarke, Smith, Peake, Trauer, McCall, Blashki & Piterman, 2006). GP knowledge of alternative services that consumers may be eligible to access, may prove to be helpful.

GPs themselves have identified training not only in knowledge and detection of mental health issues, but in providing brief mental health interventions in their general practice setting, as important (Bambling, Kavanaugh, Lewis, King, King, Sturk, et al., 2007). Some research has indicated that training GPs in structured psychosocial interventions – such as problem solving techniques – may have merit (Huibers, Buerskens, Bleijenberg, & van Schayck, 2003) and that highly motivated GPs can improve their competency in cognitive behaviour strategies but whether this translates into improved patient outcomes needs further research (Blashki, Piterman, Meadows, Clarke, Prabaharan, Gunn & Judd, 2008).

The mental health literacy of the population needs to be raised. While there have been considerable moves towards treatment of mental health disorders in primary care this needs to be conveyed more strongly to service providers and consumers of such services so that they understand when they need help and where they can go to get help.
8.2.3 Collaborative Care

Collaborative care is structured care which involves a greater role of allied health specialists to augment primary care (Gilbody, Bower, Fletcher, Richards, Sutton, 2006). The evidence is clear that individualised medical care – that is, isolated, disorganised and episodic - is less effective than well planned, integrated and multidisciplinary collaborative care. Collaborative care is superior to single-provider based treatment regimens in primary mental health care (Gilbody at al 2006; Katon, Russo & von Korff, 2002; Hickie & McGorry 2007). Coordination of effort and collaboration between key stakeholders is required to better meet the needs of Australians in remote and rural areas (Judd and Humphreys 2001).

There are different models of collaborative care. In some rural areas, for example, the state can provide only specialist mental health care and is unable to concurrently provide adequate community treatment (Habibis, Hazelton, Schneider, Bowling, 2003). In cases such as this, it may be best to target and collaborate with community services, and accept what is achievable, rather than developing community services at the expense of the existing tertiary mental health care. Providing a forum for different service providers to get together to determine the issues affecting their efficacy proved useful in rural Southern Queensland and there were collaborative spin offs as a result of different service providers meeting and forming alliances in that setting (Eley & Baker, 2007).

Another model makes use of a broad range of helpers – such as church ministers and rural financial counsellors – to address some of the issues which underlie psychological distress and could help prevent escalation of some mental health disorders (Fuller, Edwards, Martinez, Edwards & Reid, 2004). A study of the definition of mental health problems (Fuller, Edwards, Procter, Moss, 2008) found that many mental health workers believe that mental health problems are often a response to life circumstances (such as relationship breakdown or financial stress). It is possible then, that some of the care for high prevalence psychological disorders could be supported by generalist health and other human service workers – with collaborative support from specialist mental health workers. Where mental health resources are limited, as in much of rural Australia, it is important to be pragmatic and creative. Since most community mental health teams are set up to provide specialist care for those with the most disabling mental health disorders, those with less disabling problems could be best serviced by GPs and others in collaboration with specialist mental health care providers (Fuller et al., 2004). Barwon Health piloted a model of collaborative care around the management of their Clozapine program whereby public, primary and private health care providers cooperated with the result that there were decreased relapses and readmissions for consumers with schizophrenia (Kularis, 2007). A central Clozapine coordinator worked with each sector to provide support and education, and to monitor for duplication or omissions. The program demonstrated that linking GPs, public mental health and private psychiatrists can work in practice.

Elsewhere the literature focuses on the need to try new ways in which evidence-based treatment can be provided in regions where there are few clinical psychologists or psychiatrists available. Hodgins, Murray, Donoghue, Judd and Petts (2004) explored capacity building in all clinicians in an Area Mental Health Service to enable them to better detect anxiety and depression, to identify those who would benefit from focussed psychological therapies and to participate in that treatment with supervision and support from skilled therapists. It is argued that local capacity building is an important
component in providing access to evidence-based psychological treatments in rural Australia.

Co-location is one of the most effective ways of providing mental health services in a primary practice setting. It reduces the perception of stigma which a consumer might have attending a private psychologist or mental health service (Rajkumar & Hoolahan, 2004). It also enhances the prospect of better communication between the GP and the mental health service provider (United States Institute of Medicine 2006). In the project area, the co-location of PMHT clinician in GP clinics across the region has been a successful strategy. Given the importance of GPs in service provision, greater intersectoral collaboration between GPs and other primary health care workers would improve mental health care.

However, collaborative care models need to pay careful attention to the relationships between the service providers. Negativity between GPs and mental health workers can adversely affect collaborative care and by definition, patient outcomes. Rural Australian research (Lockhart 2006) showed GPs did not have enough knowledge of the services which state Mental Health Workers provided and there was a perception that GPs made little effort to become more familiar. For their part, GPs, who are in private business, cited lack of time as the major reason for lack of collaboration.

The model of collaboration itself needs to be distinctly defined, so that all parties are clear of operational processes and responsibilities. Superficial agreements and lack of clarity over referral processes can lead to tensions between different types of service providers and ultimately impact the consumer outcomes (Chew-Graham, Slade, Montana, Stewart & Gask, 2007).

Other problems with collaborative care include the pay structures of GPs compared with those of those in the State funded mental health system. GPs are private business people and can have different approaches to those in the public system. Another problem is turnover of staff which can be high with some mental health services – this is a negative outcome for consumers but also for collaborative relationships (Fuller et al 2004). One study in rural Queensland showed that there is considerable misunderstanding between GPs, community mental health and non government providers and there are considerable challenges to a shared care arrangement. Each sector has its own imperatives and drivers. Mental health services generally operate in a model which gives priority to severe disorders and makes it difficult for them to be available to GPs’ requests for assistance with ‘milder’ problems (Bambling, etal., 2007).

Greater communication and improved intersectoral collaboration between GPs, the community and NGO sector is critical to an effective solution for mental health care needs.

### 8.2.4 Web-Based Interventions for Depression and Anxiety

There are a growing number of websites which are dedicated to disseminating information about depression and anxiety, such as beyondblue (http://www.beyondblue.org), or the Black Dog Institute (http://www.blackdoginstitute.org.au). These types of sites provide information about how people might feel when they have depression and anxiety and provide information about where people may go to seek help.
However, there is enormous scope for the internet to not just provide health promotion information to consumers, but as a potential provider of web-based interventions for high prevalence psychological disorders. An example of a web-based program is MOODgym (http://moodgym.anu.edu.au). Some of the different interventions include:

- **Peer support**
  - For consumers via chat rooms
  - For service providers who can access expert advice online
- **Counselling**
  - Live via text or web cam
- **Clinical Treatment**
  - Self-directed where a patient runs themselves through an online program

The advantages of web based interventions include avoiding stigma, avoiding costs associated with travel and distance, the possibility of anonymity even with the therapist and from a public health perspective, some burden is taken off the conventional health services system. Web-based programs can usually be accessed 24 hours a day, seven days per week providing an option after hours (Austin, 2008).

Disadvantages may include a large attrition rate, especially in self-directed programs. For self-directed programs, there is no direct monitoring for a participant and motivation can be an issue, especially with depression where one symptom may be lack of motivation. Therapist assistance programs have shown the lowest drop out rates in comparison to consumer-directed courses (Richards, Klein and Carlbring 2003).

Several studies were identified on the outcomes for consumers using web-based treatment. One study in 2002 (Clarke, Reid, Eubanks, O’Connor, Debar, Kelleher, et al., 2002) found no differences between the experimental group – who used a web-based intervention for treatment of depression – and the control group. A systematic review of computerised cognitive behaviour therapy for depression and anxiety conducted in 2002 found there was not enough evidence to assert that computer based cognitive behaviour therapy programs were more effective than therapist based treatments or other treatments as usual. The review did conclude that some of the programs they looked at were effective at reducing the symptoms of depression and anxiety (Kaltenthaler, Shackley, Stevens, Beverley, Parry & Chilcott, 2002).

A systematic review of outcomes of internet-based treatment for anxiety disorders found that while internet based treatment was found to be effective, there was consistent evidence that the web-based intervention should be accompanied by some therapist input to maximise the effectiveness and minimise drop-out rates (Richards, et al., 2003).

The more of the intervention the consumer completes, the better the psychological outcomes (Christensen, Griffiths, Groves and Korten, 2006).

For depression, one Australian study compared the efficacy of two internet interventions. The first of these was BluePages which provides psychoeducation and information about depression. The second was an interactive cognitive behaviour therapy website – MoodGYM (Christensen, Griffiths & Jorm, 2004). The study found that both cognitive behaviour therapy and psychoeducation delivered via the internet led to a reduction in depression symptoms. An unexpected outcome of this study was that the
psychoeducation was as effective as the interactive cognitive behaviour therapy in reducing the symptoms of depression.

Universal internet access is a problem, especially in many remote areas, and broadband is still relatively expensive. Existing programs which are text based require some level of literacy. However, a general summary seems to be that these are useful tools - especially in very remote areas - but that not a lot of studies have yet been done to assess their efficacy. It has been demonstrated that rural GPs’ greatest need is access to cognitive behaviour therapy and patient education about depression. Stigma is identified as a barrier to seeking help or information. Web based counselling offers a way around these. It can also be very cost effective for the service delivered (Griffiths & Christensen 2007).

Limited therapist assistance seems to be most effective in patient outcomes and in consumer compliance and completion of the course. The issue of consumer follow up to ascertain the sustainability of any improvements needs to be investigated (Christensen, et al., 2004). One innovative web-based program was trialled in Western Australia which sought to address the issue of following up consumers who had been treated for depression. In this study, consumers were referred to a web-based program called ‘RecoveryRoad’ which was used to augment clinician based treatment and facilitate self-management of depression. Adherence rates were higher than for previously reported internet based interventions and there was a large reduction in depression severity for those who completed the eight sessions of the program (Robertson, Smith, Castle, Tannenbaum, 2006).

Clarke et al., (2002) referred to internet based psychological interventions as a ‘burgeoning field’ and, as research continues and issues of internet access and effectiveness of programs are refined, it appears that the internet has the capacity to be a considerable resource in the provision of services for people with depression and anxiety, especially in regional and rural areas.

8.2.5 Workforce Issues

Recruitment and retention of rural mental health workers is a problem which is widely documented in Australia and internationally. Workforce shortages are common in rural areas. This can lead to long waiting lists, discontinuity of care and a focus on more acute psychological illnesses (at the expense of higher prevalence but less acute consumers).

Several studies have identified the factors which affect how long a rural health worker will stay in his or her job. Belcher, Kealey, Jones and Humphreys (2005) reported that in rural and regional Victoria, personal factors – family, health and wellbeing, spouse and lifestyle – were important in considering work in rural areas. In the far West of New South Wales, a far more remote region, the main attractors to a rural mental health role were the rural lifestyle and environment. The most often stated reason for leaving was to pursue better career opportunities (Perkins, Larson, Lyle and Burns, 2007).

A study in the South West of Victoria (Stagnitti, Schoo, Reid and Dunbar, 2005) found that age was linked to length of stay and tenure. Younger recruits were less likely to stay for longer periods of time. Other reasons for not staying in a rural position were found to be the management structure of the employer, lack of career path, lack of professional support, and social isolation. Factors which encouraged people to stay included a good lifestyle, extended family ties and career.
Extending from this study in South West Victoria, a model for recruitment and retention of allied health staff was developed looking at three domains – the personal, the organisational and the community (Schoo, Stagnitti, Mercer & Dunbar 2005). Community factors, such as an ageing population combined with projected growth in coastal communities such as South West Victoria, need to be taken into account when planning workforce policy, along with personal needs – lifestyle issues, career path potential, etc – and the organisational imperatives of providing an effective and efficient service.

The importance of targeting rural health workers at the undergraduate level and offering attractive placements for students during their training, is also acknowledged (Schoo, et al. 2005; Kilpatrick, Johns, Millar, Lee & Routley, 2007).

Difficulties in recruiting staff to rural areas of Australia has led to the increase of overseas trained doctors (known as International Medical Graduates) and other overseas trained health staff being employed. In the project area, there are now many GPs who are overseas trained and the full-time psychiatrists employed at SWHC are all from India and are Indian-trained. One recommendation to maximise the effectiveness of these staff, and to prolong their tenure in regional areas, is the continued training in cultural and communication awareness for these staff which helps to increase the impact their care can have in the local setting (Duncan and Gilbey, 2007).

A study of international medical graduates in Gippsland (Wilks, Oakley Brown & Jenner, 2008) found that to improve retention rates for rural psychiatrists certain circumstances need to be in place: there needs to be rapport building with the new psychiatrist; an extensive orientation program; and the needs of the individual and their family professionally and in the wider personal context need to be met. Professionally, the opportunity to work in both inpatient and community settings, and the provision of ongoing educational support, was important.

GP's are a very important part of the primary mental health workforce in the project region. GPs are relied on more heavily in rural areas because of a lack of other health care providers (Caldwell 2004). However, the same study found that the rates at which GPs are managing mental health problems is sparse in non-metropolitan areas compared to city rates which indicates that GPs are a resource which could be providing more services for mental health and, as such, are an important part of the mental health workforce in rural areas.

We have also seen through the consumer perspectives in this project that the relationship with their GP is important. It has also been found that incentive programs designed to recruit and retain more GPs must acknowledge the importance of attracting doctors with whom consumers will feel comfortable – that is they need suitable clinical and communication skills to meet the needs of their consumers in a rural setting (Humphreys, Mathews-Cowey and Weinand, 1997).

Factors affecting the retention of doctors in the New England area of NSW included access to hospitals, reasonable work load, and opportunities for procedural work. Also important were social and cultural facilities, work opportunities for their partner and educational opportunities for their children (Alexander 1998).

Key factors in building up the rural health workforce include: shared responsibility for addressing the workforce shortage between employers, government and education and
training bodies; training should be complemented by a focus on retention through improvement of career opportunities and increasing job satisfaction (for example, through flexibility in working hours) and; targeting groups which may not have otherwise considered a career in health – over 45s, students, sea change seekers and culturally and linguistically diverse (CALD) workers (Kilpatrick, et al., 2007).

An innovative model of resourcing to address a workforce shortage was described in a study of a capacity building project in Western Australia (Aoun & Johnson, 2002). To overcome mental health workforce shortages, general health staff participated in a distance education program in mental health. The outcomes showed marked improvement of the skills of health workers in knowledge of mental health treatments, assessment and clinical practice. It also led to a greatly improved relationship with the existing mental health team. This study did not evaluate patient outcomes, however the greater coverage of mental health conditions by the augmented mental health workforce suggests that more patients had the opportunity for treatment.

### 8.3 Recommendations for Future Action

Whilst this report has been prepared for the Victorian Department of Human Services which has the capacity to influence some areas of mental health service provision more than others, the following recommendations provide a general response regarding possible future actions that are suggested by this study. Individually and collectively the recommendations will improve community mental health in a region such as Southwest Victoria.

With high prevalence mental health disorders being such all pervasive community issues, responses need to cover the full range of prevention, detection/diagnosis, treatment and ongoing mental health maintenance.

The recommendations presume and accept that:

- Psychologist and psychiatrist numbers in the region, (and to some extent the availability of GPs), while insufficient against metropolitan population ratio levels, will be unlikely to change significantly in the foreseeable future.

- GPs and related health professionals are also small business operators with concerns about effective time use and financial management.

- GPs, as the primary reference point for general community health concerns, are and will continue to be the first contact for diagnosis and treatment of depression and anxiety.

The project has shown that people have found benefit from referral to mental health service providers through the new MBS item numbers. The problems are gap payments, limited number of providers and getting referrals from GPs. As a consequence, most of the recommendations seek to extend the range of supporting services, enhance the skills of and provide efficiency improving tools to the current workforce, and enhance consumers’ capacity to self manage their conditions.

**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 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 counselling under MBS 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 their knowledge of mental health issues 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.**

**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, drug or alcohol dependency). 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.

• More research is needed regarding the role played by counsellors available to employees through Employee Assistance Programs (EAPs), and the numbers of employees accessing services for depression and anxiety through these programs. More research is needed on the impact this has on the use of services available to the general public.

**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.
REFERENCES


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APPENDIX 1

Key Informant Interviews for Service System

- Director, Psychiatric Services, Southwest Health Care (SWHC)
- Acting Manager, Community Adult Mental Health, SWHC
- Coordinator Adult Teams, Psychiatric Services, SWHC
- Program Officer, Primary Mental Health Team, SWHC
- Mental Health Program Officer, Otway Division of General Practice
- Manager Telephone Counselling Service, Lifeline Southwest
- Executive, Lifeline Southwest
- Consultant & Project Manager, Lifeline
- Chaplain, Brauer College
- CEO, ASPIRE
- Support Services Manager, ASPIRE
- Private Psychologist
- Clinical Psychologist
- 4 GPs
- Social Worker in private practice
APPENDIX 2

Mental Health Mapping Project
CONSUMER INTERVIEW

Name:
Gender:
Age:
Location:
Consent:
Interview medium:

4. Have you felt flat, depressed or anxious within the last two years, AND have you sought help?
   Yes  ☐ 1
   No  ☐ 2

5. If yes, did you find a suitable service for help with depression and/or anxiety?
   Yes  ☐ 1
   No  ☐ 2 Please give details ..............................................

6. If yes, from whom did you seek help in the first instance?
   Informal source
   Family member  ☐ 1
   Friend  ☐ 2
   Pastor/minister/priest  ☐ 3
   Work colleague  ☐ 4
   Other  ☐ 5 Please specify..........................................

   Formal service
   GP  ☐ 1
   Lifeline  ☐ 2
   Southwest Healthcare Psychiatric Services  ☐ 3
   Private psychologist  ☐ 4
   Workplace counsellor  ☐ 5
   Community service  ☐ 6
   Private Counsellor  ☐ 7
   Private Psychiatrist  ☐ 8
   Other  ☐ 9 Please specify.........................

7. If you went to a formal service, how did find out about this service?
   Used service before  ☐ 1
   Phone book  ☐ 2
   Advertising material  ☐ 3 Please specify .........................
   Other  ☐ 4 Please specify.................................
8. Did the first person/service from whom you sought help direct you to another service?
   Yes □ 1
   No □ 2

9. Which one?
   □ 1 GP
   □ 2 Lifeline
   □ 3 Southwest Healthcare Psychiatric Services
   □ 4 Private psychologist
   □ 5 Workplace counsellor
   □ 6 Community service
   □ 7 Private Counsellor
   □ 8 Private Psychiatrist
   □ 9 Other Please specify

10. Did you subsequently try another service?
    Yes □ 1
    No □ 2

11. If yes, please specify why.
    □ 1 Referred or directed by previous service
    □ 2 Did not relate well to service provider
    □ 3 Travel times/distance
    □ 4 Cost
    □ 5 Waiting times
    □ 6 Other Please specify

12. Do you believe there is a stigma attached to seeking help for depression or anxiety?
    Yes □ 1
    No □ 2
    Not sure □ 3

13. Did this affect which service provider you used?
    Yes □ 1
    No □ 2
    Not sure □ 3

14. How long did you wait for an appointment with the service provider.
    (first provider) □ 1
    □ 2
    □ 3
    (second provider) □ 1
    □ 2
    □ 3

15. Did you feel you waited too long?
    (first provider) □ 1
    □ 2
    □ 3
    (second provider)
16. **Did you feel comfortable with the service provider?**
   (first provider) (second provider)
   Yes □ 1 □ 1
   No □ 2 □ 2
   Not sure □ 3 □ 3

17. **Was the service provider located in your town?**
   (first provider) (second provider)
   Yes □ 1 □ 1
   No □ 2 □ 2

18. **If a service was available, but you chose not to use it, can you talk about why you travelled further afield?**

19. **From your perspective, was the cost of the treatment a factor in the type of treatment you received?**
   Affordable □ 1
   Too expensive □ 2
   Treatment became too expansive after initially affordable □ 3
   Other □ 4 Please specify ....

20. **Have you had contact with your service provider within the last six months?**
   a. Yes □ 1
   b. No □ 2
   c. Please give details ...........................................

21. **When was the last time you had contact with any service for depression/anxiety?**

22. **What constituted your treatment?**
   a. Medication only □ 1
   b. Talking type treatments only □ 2
   c. Combination of both above noted treatments □ 3

23. **Did your GP refer you to sessions with a psychologist which were subsidised through Medicare?**
   a. Yes □ 1
   b. No □ 2
   c. Not sure □ 3
24. Is there anything about your experience of seeking help that I’ve not asked you about?
APPENDIX 3

Mental Health Mapping Project – Consumer Phone Survey SCRIPT

Hello, my name is ________ from IRIS Research, and we are conducting a short survey on behalf of the Department of Human Services about health services in your region. I would like to speak to a person in this household, aged between 18 and 64 years? Is that you? Just to give you some background, we are conducting a survey to see what health services local people are using, and any issues people are having in getting access to services. The information provided by respondents will remain completely confidential. The survey will take about 5 to 10 minutes, can we do it now? [IF NOT ARRANGE A CALL BACK] Before we start I need to inform you that my supervisor may monitor this call for quality control and training purposes.

Could you please tell me the name of the town you live in or that is closest to you?

[IF TOWN NOT IN LIST PLEASE THANK RESPONDENT AND TERMINATE]

PART A: Screening Questions

As the survey relates to certain groups of people only, could you please tell me whether, in the last 2 years, you have been told by a doctor that you have any of the following conditions?

(Read options. Multiple responses allowed)

- A stress related problem
- Anxiety
- Depression
- Any other mental health problem
- None
- Declined to answer

In the last 2 years, have you sought or received help for a stress related problem, anxiety, or depression from a doctor or other service provider?

- Yes (Go to Part B)
- No (Go to part D)
- Declined to answer (Go to part D)

PART B – Service Provider Journey

I’d now like to ask you some questions about the service providers you have used. Thinking back, could you tell me which type of provider you first saw when seeking assistance for a stress related problem, anxiety or depression?

- GP / local doctor
- Emergency & Accident (at local hospital)
- Psychiatric Services SWHC (at local hospital)
- Community Health (at local hospital)
- Psychiatrist (private)
- Psychologist (private)
- Counsellor (private)
○ Workplace counsellor (employee assistance program)
○ Phone counselling service (such as Lifeline)
○ Other

Did you see any other type of provider after that? (Record the second, third, fourth provider, etc)

I would just like to ask you a few questions about your contact with [first service provider].

i. Was the provider in this region or elsewhere?

(The region covered by this survey extends from the SA border, up to Casterton/Coleraine, and includes Portland, Hamilton, Warrnambool and Camperdown.
○ In region
○ Out of region

ii. Were you still living in the region at the time?
○ Yes
○ No

iii. And how long ago did you first see [this provider] for a stress related problem, anxiety or depression?
○ Days
○ Weeks
○ Less than 6 months
○ 6 – 12 months
○ 1 – 2 years ago
○ More than 2 years ago (Please specify number of years)

iv. How did you come to use that provider?
○ Already a patient
○ Referred by a medical practitioner (please specify)
○ Referred by another health professional (e.g. nurse, counsellor) (please specify)
○ Referred by community centre (include pamphlet/poster in community centre)
○ Information sources (e.g. beyondblue website; yellow pages; internet search)
○ Suggested by a friend/relative
○ Other (please specify)

v. And how many times did you contact that provider for a stress related problem, anxiety or depression?
○ Just once
○ 2-4 times
○ 5-10 times
○ More than 10 times

vi. And over what period of time was that?
○ Few days
○ Weeks
○ 1-2 Months
○ 3-6 months
PART C - Issues, Barriers and Enablers

I’d now like to ask you about your experiences in getting to see a service provider for a stress related problem, anxiety or depression.

Overall, how satisfied were you with the care you received?
- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very Satisfied

Would you prefer to seek assistance from a service provider
- In this region
- Outside of the region

Did any of the following factors help you to access a provider?
- Convenient location of service provider in local area
- Great service from one particular person (please specify e.g. GP ____)
- Availability of information regarding a service
- Free or low cost of service
- Prior experience of the provider
- Advice of a friend, relative or other close adviser
- None of the above

Can you think of any other factor or person who useful in getting you the help you needed? (What did they do that was useful?) ______________________

Did you experience difficulties with any of the following?
- Knowing where to go for help
- Knowing what sorts of help were available to you
- Finding a service provider in your local area
- Finding a service provider outside your local area
- Concerns about confidentiality
- Cost of the service
- Lack of transport
- Cost of transport
- Distance to travel to service provider
- Access for people with a disability
- None of the above

Did you experience any other barriers that prevented or made it difficult to access help?
- Other barriers____________________

What would have made it easier for you to access services? ______________________
Are you aware of the new Medicare Benefits System (MBS) item numbers that enable up to 12 subsidised visits to a psychologist when referred by a GP?
   - No, not aware
   - Yes, aware, but never used
   - Yes, have made use of this
   - Don’t know

(If further information is requested about the program which enables better access to mental health professionals through Medicare, consumers may:
   - speak with their GP
   - visit the Department of Health and Ageing website [www.health.gov.au/mentalhealth](http://www.health.gov.au/mentalhealth) and click on “Mental health programs”
   - phone Medicare on 132 011)

To what extent does this influence your decision to seek assistance for anxiety or depression?
   - Not at all
   - Mildly encourage
   - Strongly encourage

Are there any barriers to using these subsidised services?
   - Cost (possible gap payment)
   - Availability of appointments
   - Other (please specify)____________________
   - None

**PART D - Demographics**

Now to finish off with some general questions about you…

What was your age at your last birthday?
   - 18 – 24
   - 25 – 29
   - 30 – 34
   - 35 – 39
   - 40 – 44
   - 45 – 49
   - 50 – 54
   - 55 – 59
   - 60 – 64
   - Refused

I assume from your voice you are?
   - Male
   - Female
   - Refused

What is the postcode of the house? ______________
Is there any other town you visit regularly where you would find it convenient to access health services (e.g. where you work, shop, study, do volunteer work)?

- Locations ____________________

You said earlier that you had not sought help for any stress related problem, anxiety, or depression in the last 2 years.

Is there another member of your household who has sought help for any of these conditions in the last 2 years that I could talk to?

- Yes
- No

[IF ANYONE ELSE SUITABLE…COMPLETE THE SURVEY, CHOOSE ANON, ASK TO SPEAK TO SECOND RESPONDENT, COMPLETE DETAILS WITH EITHER FIRST OR SECOND RESPONDENT AND INTERVIEW OR RECORD CALLBACK]

Finally may I ask your first name as my supervisor audits one in ten of my calls as part of the quality control process?

First Name_______________

That completes our interview. As this is social research, it is carried out in compliance with the federal privacy act. The information you provided is confidential and only used for research purposes.

Again my name is _______ and my supervisor’s name is Judy. If you have any questions about the survey, you can call us on 02 4229 4777 between 9am and 5pm weekdays.

Thank you for your time.

**End of Survey**
APPENDIX 4

Key informant interviews for service provider perspectives

- Director, Psychiatric Services, Southwest Health Care (SWHC)
- Manager, Community Adult Mental Health, SWHC
- Coordinator Adult Teams, Psychiatric Services, SWHC
- Program Officer, Primary Mental Health Team, SWHC
- Mental Health Program Officer, Otway Division of General Practice
- Manager Telephone Counselling Service, Lifeline Southwest
- Consultant & Project Manager, Lifeline
- Chaplain, Brauer College
- CEO, ASPIRE
- Support Services Manager, ASPIRE
- Social Worker in private practice
- Manager, Mental Health Unit, St John of God
APPENDIX 5

Reference Group Members

- Executive, Lifeline Southwest
- GP
- GP
- DHS – BSW
- Director, Psychiatric Services, Southwest Health Care (SWHC)
- Manager, Community Adult Mental Health, SWHC
- Program Officer, Primary Mental Health Team, SWHC
- Mental Health Program Officer, Otway Division of General Practice
- Consultant & Project Manager, Lifeline
- Support Services Manager, ASPIRE
- Consumer Representative
- Consumer Representative
APPENDIX 6

Focus Group Participants

- Private Psychologist
- Clinical Psychologist
- GP
- GP
- Private Psychologist
- Employee Assistance Program Counsellor, Commonwealth Rehabilitation Services
- Clinical Psychologist
- Private Counsellor
- Executive, Lifeline Southwest
APPENDIX 7 Service Provider Online Survey

Greater Health Mental Health Mapping Project

This survey is for the Greater Health Mental Health Mapping project, and is for those service providers who deal with depression and anxiety. Please visit the Greater Health website if you would like further information about the project. Go to www.greaterhealth.org/research/ and click on BSW Mental Health Mapping Project.

We thank you for participating in the survey. The responses you give will help us to analyse referral pathways and to look at some of the barriers consumers may experience when seeking treatment for depression and anxiety. We also welcome your extra comments at the end of the survey about any aspect of the delivery of your service.

Any information you give us through the survey will be confidential. However, in order to identify and verify the different types of service providers and get a full picture of the service provision network, we need to ask some information about you and your organisation. On the following page, you will therefore be asked to provide your name and organisation’s name, the type of service you provide, and your location. This will also assist us to manage the survey and send reminders only where necessary.

If two or more categories of provider on the following page apply to you, please select only one option and complete the survey in relation to the services you provide in that role. You may complete the survey multiple times if you practice in more than one capacity.

This survey may also be completed online at www.e-value-it.com/survey/greaterhealth/mentalhealth/
Please enter your details before beginning the survey.

Name: ____________________________________________

Organisation: ______________________________________

Type of Provider:
- Clinical psychologist in private practice
- Clinician with psychiatric services SWHC
- Counsellor in private practice
- Counsellor with community health centre
- Counsellor with community organisation
- GP
- Psychiatrist in private practice
- Psychologist in private practice
- Psychotherapist in private practice
- Social worker in private practice
- Other (please specify)

If Other Type of Provider, please specify: ____________________________

Location:
- Camperdown
- Casterton
- Cobden
- Colerain
- Koroi
- Hamilton
- Heywood
- Macarthur
- Port Fairy
- Portland
- Terang
- Timboon
- Warnambool
- Other

If Other Location, please specify: ________________________________
PART A: Where consumers come from

1. How many consumers have you seen in the last three months for issues relating to anxiety or depression?
   
   ________________ individuals

2. Thinking about those consumers, out of 100, what percentage came to you through the following sources?
   (Percentages should add up to 100%)

<table>
<thead>
<tr>
<th>% of consumers with anxiety or depression from this source in last 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health care services</td>
</tr>
<tr>
<td>General practitioner</td>
</tr>
<tr>
<td>Other primary health care service (please specify below)</td>
</tr>
<tr>
<td>Hospital based services</td>
</tr>
<tr>
<td>Emergency &amp; Accident</td>
</tr>
<tr>
<td>Psychiatric Services SWHC</td>
</tr>
<tr>
<td>Outpatients department or clinic</td>
</tr>
<tr>
<td>Other hospital based service (please specify below)</td>
</tr>
<tr>
<td>Allied health service</td>
</tr>
<tr>
<td>Physiotherapist, chiropractor, acupuncturist, naturopath, occupational therapist</td>
</tr>
<tr>
<td>Private mental health service</td>
</tr>
<tr>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Psychologist</td>
</tr>
<tr>
<td>Private Counsellor</td>
</tr>
<tr>
<td>Other private mental health service (please specify below)</td>
</tr>
<tr>
<td>School, Work or Business services</td>
</tr>
<tr>
<td>Financial planner, Rural counsellor, Accountant, Solicitor</td>
</tr>
<tr>
<td>Workplace counsellor / Employee Assistance Programs</td>
</tr>
<tr>
<td>School Counsellors</td>
</tr>
<tr>
<td>Community Services</td>
</tr>
<tr>
<td>Community Health Centres (such as Portland District Health)</td>
</tr>
<tr>
<td>Phone counselling service or helpline (such as Lifeline)</td>
</tr>
<tr>
<td>Church or welfare groups</td>
</tr>
<tr>
<td>Information sources (e.g. beyondblue website; yellow pages; internet search)</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Self referral</td>
</tr>
<tr>
<td>Informal (friend, family member, coach, work colleague)</td>
</tr>
<tr>
<td>Already a patient, prior to consultation for anxiety or depression</td>
</tr>
<tr>
<td>Unknown Origin</td>
</tr>
</tbody>
</table>

   TOTAL 100%

If you included a percentage against the following options, please specify the type of provider below:

   Other primary health care service
   Other hospital based service
   Other private mental health service

3. Are there any further comments you would like to make regarding the origins of patients you have seen for anxiety or depression?
### PART B: Where consumers go to

4. Of the consumers you have seen in the last three months for issues relating to anxiety or depression, approximately what proportion did you refer on to other service providers for further treatment?

(Please include all consumers who you directed to other services, whether or not you also continued to provide treatment)

<table>
<thead>
<tr>
<th>% of individuals referred to another provider</th>
</tr>
</thead>
</table>

5. Now, thinking only about the consumers you referred to other service providers for treatment, what percentage did you refer to the following services?

(Percentages should add up to 100%)

<table>
<thead>
<tr>
<th>% of referrals directed to the following services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary health care services</strong></td>
</tr>
<tr>
<td>General practitioner</td>
</tr>
<tr>
<td>Other primary health care service (please specify below)</td>
</tr>
<tr>
<td><strong>Hospital based services</strong></td>
</tr>
<tr>
<td>Emergency &amp; Accident</td>
</tr>
<tr>
<td>Psychiatric Services SWHC</td>
</tr>
<tr>
<td>Outpatients department or clinic</td>
</tr>
<tr>
<td>Other hospital based service (please specify below)</td>
</tr>
<tr>
<td><strong>Allied health service</strong></td>
</tr>
<tr>
<td>Physiotherapist, chiropractor, acupuncturist, naturopath, occupational therapist</td>
</tr>
<tr>
<td><strong>Private mental health service</strong></td>
</tr>
<tr>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Psychologist</td>
</tr>
<tr>
<td>Private Counsellor</td>
</tr>
<tr>
<td>Other private mental health service (please specify below)</td>
</tr>
<tr>
<td><strong>School, Work or Business services</strong></td>
</tr>
<tr>
<td>Financial planner, Rural counsellor, Accountant, Solicitor</td>
</tr>
<tr>
<td>Workforce counsellor / Employee Assistance Programs</td>
</tr>
<tr>
<td>School Counsellors</td>
</tr>
<tr>
<td><strong>Community Services</strong></td>
</tr>
<tr>
<td>Community Health Centres (such as Portland District Health)</td>
</tr>
<tr>
<td>Phone counselling service or helpline (such as Lifeline)</td>
</tr>
<tr>
<td>Church or welfare groups</td>
</tr>
<tr>
<td>Information sources (e.g. beyondblue website; yellow pages; internet search)</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>Informal (friend, family member, coach, work colleague)</td>
</tr>
<tr>
<td>Referred elsewhere (please specify below)</td>
</tr>
</tbody>
</table>

If you included a percentage against the following options, please specify the type of provider below:

- Other primary health care service
- Other hospital based service
- Other private mental health service
- Referred elsewhere

6. Are there any further comments you would like to make regarding the information provided above?
**PART C: Access Issues / Barriers**

7. Please indicate whether you have experienced difficulties in getting access to any of the following services for your patients:

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Access / availability is always an issue</th>
<th>Access / availability is sometimes an issue</th>
<th>Access / availability is occasionally an issue</th>
<th>No, I am able to access services for my patients</th>
<th>No, I have no need of these services for my patients</th>
<th>I'm not aware of these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary health care services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Other primary health care service</td>
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<td>☐</td>
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<tr>
<td><strong>Hospital based services</strong></td>
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<tr>
<td>Emergency &amp; Accident</td>
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<td>☐</td>
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<tr>
<td>Psychiatric Services SWHC</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Outpatients department or clinic</td>
<td>☐</td>
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<tr>
<td><strong>Allied health service</strong></td>
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<tr>
<td>Physiotherapist, chiropractor,</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>acupunctureist, osteopath,</td>
<td></td>
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<tr>
<td>occupational therapist</td>
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<tr>
<td><strong>Private mental health service</strong></td>
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</tr>
<tr>
<td>Psychiatrist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Psychologist</td>
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<tr>
<td>Private Counsellor</td>
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<tr>
<td>Other private mental health service</td>
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<td><strong>School, Work or Business services</strong></td>
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<tr>
<td>Financial planner, Rural counselor,</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Accountant, Solicitor</td>
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<tr>
<td>Workplace counsellor / Employee</td>
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<tr>
<td>Assistance Programs</td>
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<tr>
<td>School Counsellors</td>
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<tr>
<td><strong>Community Services</strong></td>
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</tr>
<tr>
<td>Community Health Centre(s) (such as Portland District Health)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Phone counselling service or helpline</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>(such as Lifeline)</td>
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</tr>
<tr>
<td>Church or welfare groups</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Information sources (e.g. beyondblue</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>website, yellow pages, internet search)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Informal (friend, family member, coach,</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>work colleague)</td>
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</tr>
</tbody>
</table>

If you included an answer against the following options, please specify the type of provider below:

| Other primary health care service        |   |   |   |   |   |   |
| Other hospital based service             |   |   |   |   |   |   |
| Other private mental health service      |   |   |   |   |   |   |

8. In your treatment of consumers with depression or anxiety, is there anything else you have experienced which may have been a barrier or enabler to their optimal treatment?

9. Are there any further comments you would like to make in relation to this study?
### APPENDIX 8 Service Providers in the Project Region

<table>
<thead>
<tr>
<th>Location</th>
<th>Name</th>
<th>Contact</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychologists/ Counsellors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access Psychology</td>
<td>5562 0239</td>
<td>depression/anxiety</td>
<td></td>
</tr>
<tr>
<td>Ms. Bente Schjeflo</td>
<td>2 Fitzroy Road, W'bool 3280</td>
<td>MAPS</td>
<td></td>
</tr>
<tr>
<td>Hopewell Clinic</td>
<td>5561 1488</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amanda Beames</td>
<td>69 Mortlake Rd, W'bool</td>
<td>Janine Bounds</td>
<td>MAPS</td>
</tr>
<tr>
<td>SouthWest Counselling Services</td>
<td>55651 2796</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bill Radley</td>
<td>903 Ragland Pde, W'bool</td>
<td>Bill Radley</td>
<td>MAPS</td>
</tr>
<tr>
<td>Andy Alt</td>
<td>5237 7473 / 0425 224 726</td>
<td>Andy Alt</td>
<td>MAPS</td>
</tr>
<tr>
<td>Kelli Garrison</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patricia Hennig</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Susan Hook</td>
<td></td>
<td></td>
<td>Clinical Psych</td>
</tr>
<tr>
<td>Michael Harris</td>
<td></td>
<td></td>
<td>Social Worker - not registered for MBS items</td>
</tr>
<tr>
<td>Dr John Clarke</td>
<td>5562 3005</td>
<td>MAPS PhD</td>
<td></td>
</tr>
<tr>
<td>Su Clift</td>
<td>5561 5809/5561 6883</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Camperdown Clinic</td>
<td>5593 1222/0416 141 232</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Melissa Ferrier-Lynn</td>
<td>56 Scott St</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genesis Consulting Psychologists</td>
<td>18 Kerr St W'bool</td>
<td>Denis Shackell</td>
<td>MAPS</td>
</tr>
<tr>
<td>Murray S. Kingsley</td>
<td></td>
<td></td>
<td>MAPS</td>
</tr>
<tr>
<td>Warmambool</td>
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<td></td>
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<tr>
<td>Hamilton</td>
<td>Lauren Campbell</td>
<td>5572 5258</td>
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<tr>
<td>Location</td>
<td>Service</td>
<td>Contact Details</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
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<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td>Portland</td>
<td>Tess Howells - Portland Complementary Health Group</td>
<td>5523 7488 - 81 Hurd St Warrnambool</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>registered psychologist</td>
<td></td>
</tr>
<tr>
<td>Camperdown</td>
<td>Camperdown Resilience Centre</td>
<td>194 Manifold St C'down</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Julene Cook</td>
<td>0425 224 726 Clinical Psych</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Alan Woodward</td>
<td>0409 167 101</td>
<td></td>
</tr>
<tr>
<td>W'bool, Portland, Ham</td>
<td>Hopkins Counselling</td>
<td>5561 1601</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Andrew Gray</td>
<td>MAPS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kathy Culkin</td>
<td>MAPS</td>
<td></td>
</tr>
<tr>
<td>Hamilton</td>
<td>New Direction Counselling - John Lamb</td>
<td>0409 138 638 counselling - general</td>
<td></td>
</tr>
<tr>
<td>Portland</td>
<td>Ms Gillian Yee</td>
<td>5523 5289</td>
<td></td>
</tr>
<tr>
<td>Psychotherapists</td>
<td>Dr Elizabeth Arthur</td>
<td>5572 2851 psychodynamic psychotherapist</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>35 Carmichael St Hamilton 3300</td>
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<tr>
<td>Psychiatrists</td>
<td></td>
<td></td>
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<tr>
<td>W'bool</td>
<td>Mark Ivers</td>
<td>5561 1038</td>
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<td></td>
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<td></td>
<td>Graham Ridley</td>
<td>5561 2803</td>
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<td>GPs Camperdown</td>
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<tr>
<td></td>
<td>Camperdown Clinic</td>
<td>5593 1222</td>
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</tr>
<tr>
<td></td>
<td>Dr Eldon Lyon</td>
<td>56 scott st c'down 3260</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Anthony Brown</td>
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<td></td>
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<td></td>
<td>Dr Ruth Stewart</td>
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<tr>
<td>Location</td>
<td>Name</td>
<td>Contact</td>
<td>Specialty</td>
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<tr>
<td>---------------</td>
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<tr>
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<tr>
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<td>Dr Jojy Thomas</td>
<td>Robinson St</td>
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<tr>
<td></td>
<td>Dr Brendan Condon</td>
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**Phone Support**

- beyondblue 1300 22 4636 incl farmers’
- SANE 1800 187 263
- Vietnam Veterans Hamilton 1800 011 046 24 hour hotline
- LifeLine - contact Carmel Harris 5561 3758

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<td>Iby Neerakal</td>
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<td>55619100 or 5564 6000</td>
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<td>Regional Teams</td>
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<td>Hamilton - Jan Austin</td>
<td>5551 8418</td>
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<tr>
<td></td>
<td>Portland - Fred Nittsjo</td>
<td>5522 1000</td>
</tr>
<tr>
<td></td>
<td>Kate Schlicht</td>
<td>5593 6000</td>
</tr>
<tr>
<td>Consumer Consultant</td>
<td>Barry Ladlow</td>
<td>5561 9174</td>
</tr>
<tr>
<td>Warrnambool Adult Team</td>
<td>Tim Reading</td>
<td></td>
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APPENDIX 9 – MBS Better Access Uptake Statistics

Table 1 Item 2710 – GP Mental Health Care Plan - Number of 2710 Medicare items processed from October 2006 to March 2008 by State

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<thead>
<tr>
<th>State</th>
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<tr>
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<tr>
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<td>39,819</td>
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</tr>
<tr>
<td>TAS</td>
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<td></td>
</tr>
<tr>
<td>ACT</td>
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<tr>
<td>NT</td>
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<td>655,996</td>
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Table 2 Item 2710 – GP Mental Health Care Plan – Number of 2710 Medicare items processed from October 2006 to March 2008 per capita

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Table 3  Item 2710 – GP Mental Health Care Plan - Medicare items processed from October 2006 to March 2008 by Medicare Contribution

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Table 4  Item 2710 – GP Mental Health Care Plan - Medicare items processed from October 2006 to March 2008 by Medicare Contribution per capita

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<th>SA</th>
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<th>TAS</th>
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Graph 1 Item 2170, GP Mental Health Plan – Services Per Month October 2006 to March 2008

Table 5 Item 2710 – GP Mental Health Plan - processed from October 2006 to March 2008 by patient demographics and State

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<th>Total Services</th>
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<td>35-44</td>
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<td>55-64</td>
<td>65-74</td>
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<td>Total</td>
<td>227,753</td>
<td>189,971</td>
<td>115,590</td>
<td>39,819</td>
<td>56,779</td>
<td>14,147</td>
<td>9,468</td>
<td>2,469</td>
<td>655,996</td>
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</table>

Graph 2 Item 2710 processed from October 2006 to March 2008

**Patient Demographics**

Table 6 Item 80010 – Consultation 50+ minutes with Clinical Psychologist
Medicare items processed from October 2006 to March 2008 by State

<table>
<thead>
<tr>
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<th>NSW</th>
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<th>QLD</th>
<th>SA</th>
<th>WA</th>
<th>TAS</th>
<th>ACT</th>
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<th>Total</th>
</tr>
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<tbody>
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Table 7 Item 80010 – Consultation 50+ minutes with Clinical Psychologist
Medicare items processed from October 2006 to March 2008 per capita

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<th>TAS</th>
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### Table 8 Item 80010 – Consultation 50+ minutes with Clinical Psychologist
Medicare items processed from October 2006 to March 2008 by Medicare Contribution

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<th>State</th>
<th>NSW $Benefit</th>
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<th>SA $Benefit</th>
<th>WA $Benefit</th>
<th>TAS $Benefit</th>
<th>ACT $Benefit</th>
<th>NT $Benefit</th>
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### Table 9 Item 80010 – Consultation 50+ minutes with a Clinical Psychologist
Medicare items processed from October 2006 to March 2008 by Medicare Contribution per capita

<table>
<thead>
<tr>
<th>State</th>
<th>NSW $Benefit per 100,000 population</th>
<th>VIC $Benefit per 100,000 population</th>
<th>QLD $Benefit per 100,000 population</th>
<th>SA $Benefit per 100,000 population</th>
<th>WA $Benefit per 100,000 population</th>
<th>TAS $Benefit per 100,000 Population</th>
<th>ACT $Benefit per 100,000 Population</th>
<th>NT $Benefit per 100,000 Population</th>
<th>Total $Benefit per 100,000 population</th>
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Graph 3 Item 80010 – Consultation 50+ with Clinical Psychologist – Services from October 2006 to March 2008

**Table 10** Item 80010 - Consultation 50+ Minutes with Clinical Psychologist processed from October 2006 to March 2008 by State and demographics

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</thead>
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<td>NSW</td>
<td>VIC</td>
<td>QLD</td>
<td>SA</td>
<td>WA</td>
<td>TAS</td>
<td>ACT</td>
<td>NT</td>
<td>Total</td>
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Total: 197,330

Graph 4 Item 80010 processed from October 2006 to March 2008

Patient Demographics

**Table 11** Item 80110 – Consultation with Psychologist 50+ minutes
Medicare items processed from October 2006 to March 2008 by State

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**Table 12** Item 80110 – Consultation with Psychologist 50+ minutes
Medicare items processed from October 2006 to March 2008 per capita

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Table 13 Item 80110 – Consultation with Psychologist 50+ minutes
Items processed from October 2006 to March 2008 by Medicare contribution

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Table 14 Item 80110 – Consultation with Psychologist 50+ minutes
Medicare items processed from October 2006 to March 2008 by Medicare contribution per capita

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Graph 5 Item 80110 – Consultation with Psychologist 50+ minutes
Services per Month October 2006 to March 2008

Table 15 Item 80110 – Consultation with Psychologist 50 + minutes processed from October 2006 to March 2008 by patient demographics and State

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Graph 6 Item 80110 processed from October 2006 to March 2008

Patient Demographics