Delivering mental health care in General Practice: Implications for practice and policy

Research Findings

Survey commissioned by the General Practice Mental Health Standards Collaboration (GPMHSC)

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The Navigators

Table of Contents

Table of Figures

Introduction and Research Approach

Introduction

The Australian Institute of Health and Welfare estimates that nearly 1 in 2 Australians aged 16-85 have experienced a mental disorder during their lifetime and that one in five Australians reported they had a mental or behavioural condition in the period between July 2017 and June 2018.[1]

The report for the Productivity Commission inquiry into the economic impacts of mental ill-health (June 2020) found that many do not receive the treatment and support they need and as a result too many people experience preventable physical and mental distress, disruptions in education and employment, relationship breakdown, stigma, and loss of life satisfaction and opportunities. The Inquiry has reported that reform of the mental health system would produce large benefits, mainly improvements in people's quality of life. These benefits were valued at up to $18 billion annually with an additional benefit of up to $1.3 billion due to increased economic participation.[2]

The Productivity Commission Inquiry Report lists improving the competency of mainstream health services in mental healthcare amongst its recommendations. The report states that "… GPs would likely remain a dominant provider of mental healthcare services. All GPs need to be competent in treating people with mental illness. In any given year, at least 5 million Australians see their GP for assistance with their mental health, including treatment of a mental illness. … Despite their central role in providing primary mental healthcare services and prescribing medications, most GPs receive minimal training in mental healthcare when qualifying as a GP (although some subsequently gain specialist mental health skills)."[3]

The General Practice Mental Health Standards Collaboration (GPMHSC) reports that 90% of GPs in Australia have completed their Level 1 mental health training (Mental Health skills training) and 3.5% have undertaken Level 2 training (Focussed Phycological Strategies skills training) and registered as Focussed Psychological Strategies (FPS) providers.

It is hypothesised that the use of Medical Benefits Schedule (MBS) mental health item numbers by GPs understates the volume of mental health presentations to which GPs attend, but there is little data to support this hypothesis. The use of FPS by GPs who have undertaken the FPS skills training is not well understood and it is unclear whether the MBS item numbers allocated to FPS are an accurate reflection of how this skills training is being applied.

The purpose of this research is to provide insights that will support the work of the GPMHSC and a base of evidence for formulating policy and practice relating to mental health and the upskilling of GPs in mental health. The GPMHSC commissioned The Navigators Community Pty Ltd to undertake both qualitative and quantitative research amongst GPs in Australia who had completed either Level 1 Mental Health Skills Training or Level 2 Focussed Psychological Strategies Skills Training, the findings of which are summarised in this report.

1 https://www.aihw.gov.au/reports/australias-health/mental-health

2 https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf

3 https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf (page 34)

Research Approach

Research objectives

The primary objective of this research is to understand the unique challenges and barriers associated with GPs upskilling in mental health.

Secondary objectives include understanding:

- the use of mental health MBS item numbers among GPs and the key factors impacting how these are used (including the use of FPS item numbers)
- the dynamics driving or limiting uptake of FPS skills training specifically
- the use of FPS skills in general practice amongst those who have undertaken the training

Methodology

Details of the methodology are appended.

The research was comprised of a qualitative research stage followed by a quantitative survey of a robust stratified random sample of actively practicing Level 1 GPs and all Level 2 (FPS) trained GPs.

The purpose of the preliminary qualitative research stage was to identify insights about the experiences, behaviours, challenges, barriers and motivations for Level 1 and Level 2 (FPS) trained GPs to guide the development of the survey questionnaire. Additionally, the qualitative research provided the researchers with important contextual knowledge to aid in the analysis and interpretation of the survey findings and as a source of complementary information to assist readers of this report in bringing to life the analysis.

33 semi-structured in-depth telephone interviews were conducted for the qualitative stage.

The purpose of the quantitative stage of the research was to provide a comprehensive and robust, statistical characterisation of the experiences, behaviours, attitudes and needs of GPs regarding training in mental health, providing support to patients with mental health conditions, utilising FPS skills training in their practice and billing using the MBS mental health item numbers.

An online survey was emailed to GPs for the quantitative phase, with 846 GPs completing the survey, comprised of 626 Level 1 trained GPs and 220 Level 2 trained GPs.

In the body of this report, verbatim quotes from the 35 semi-structured qualitative interviews and responses to open-ended questions in the quantitative survey have been used to illustrate findings from the survey.

"Quotes from the qualitative interviews and verbatim comments from the survey are presented in this way throughout the report."

Key Findings and Recommendations

Key Findings

These conclusions are drawn from a survey that was distributed to a randomly selected list of GPs from the GPMHSC database of GPs with Level 1 mental health skills training and all GPs with Level 2 (FPS) skills training. 846 GPs active in clinical general practice completed the survey, 626 of whom have completed Level 1 mental health skills training and 220 of whom have completed FPS (Level 2) skills training.

The quantum of mental health addressed by GPs is vast and substantially underestimated by MBS billing data

Attending to mental health forms a significant portion of GPs' caseloads, with an estimated 38% of consults in a typical week attending to an element of mental health. 13% of consults attend to mental health alone and 25% attend to mental health and other items in combination.

The use of MBS item numbers substantially underestimates the volume of mental health care attended to by GPs (84% of GPs claim it underestimates their volume). Estimates of the number of consults in a typical week that address mental health versus the number billed using MBS mental health item numbers suggests that 36% of mental health consults are billed as such – for every 1 consult billed as a mental health consult, another 1.8 are not. A key contributing factor is that the MBS item numbers are not structured to accommodate co-billing and in practice GPs are attending to mental health alongside other items in 25% of consults.

Even where consults attend to mental health alone, approximately 45% are not being billed using the MBS mental health item numbers.

Mental health consults place pressure on GPs on many fronts, making it a particularly challenging area of their practice

The majority of GPs report mental health to be a challenging area of their practice. It is not only emotionally taxing for many, but places pressure on running their practice on multiple fronts.

72% agree that they find mental health work tiring and emotionally draining. 72% agree that mental health consults take long, creating problems in their practice. 67% agree that dealing with mental health puts pressure on their ability to meet the needs of other patients. 83% agree that there is a great deal of unpaid time coordinating care and follow-up for patients with mental health conditions.

While many GPs find it rewarding work and recognise the need for it in their community, it places a high degree of pressure on the GP and their practice environment, resulting in little appetite to grow this area of their practice or to be known as a 'go to' GP for mental health by colleagues and patients, unless this is an area of health they have a particular interest in.

GPs differ in their disposition toward and interest in engaging in mental health

There are four distinct segments of GPs with different attitudinal characteristics regarding mental health.

The segment that is most engaged with mental health, defined as 'Interested, Engaged & Resilient', make up 22% of GPs. These doctors do no report finding it tiring or emotionally draining, they are interested in the subject and find it rewarding. None treat mental health reluctantly; they describe themselves as naturally good at mental health and it is a good fit for them. This segment is most open to further training, but have already completed more training than others and will benefit from training that adds to their existing knowledge and experience.

32% of GPs are in the 'Interested, Engaged but Draining' segment, the largest segment. They are interested, find mental health rewarding and feel it is a good fit for them, but find it tiring or emotionally draining. Compared with the previous segment who do not find it tiring or emotionally draining, they are more likely to report that mental health takes a long time, creates problems in their practice and puts pressure on their ability to meet the needs of other patients. None treat mental health reluctantly. They are open to training, but the struggle to balance mental health with the rest of the practice and the impact on their own well-being is unlikely to make it an appealing option to dedicate time and money to further develop their skills – there is little incentive to do further training.

The 'Low Interest & Reluctant' segment accounts for 29% of GPs. Interest levels are lower than the previous two groups, few find it rewarding, most finding it emotionally tiring and draining and are more likely to do it reluctantly than the previous two groups. This group is less likely than the previous two to say that the set-up and nature of their practice is suitable for patients with mental health conditions. This cohort is less likely to make the time for, or incur the cost of, further training in mental health compared with the previous two groups.

The last segment accounts for 17% of GPs and is described as 'Out of Comfort Zone'. Members of this cohort do not feel they are naturally good at mental health, that patients feel comfortable with them or that the work is a good fit for them. They are not interested in the subject, and they do not find mental health consults rewarding. Almost all find it emotionally draining and many do it reluctantly. This cohort has the least interest in further training.

The return on investment of mental health consults is a disincentive for most GPs to advance this area of their practice

Only 9% of GPs report that they can earn a suitable financial return on their time for treating patients with mental health conditions. Even amongst the cohort who are most positive about mental health, the 'Interested, Engaged & Resilient' group, only 20% believe they can earn a suitable financial return, indicating that this is a widespread problem.

There are several variables that contribute to this finding. 83% report that there is a great deal of unpaid time required for coordinating care and follow-up for patients with mental health conditions. Since most mental health consults are long, the number of patients the GP can attend to is reduced thereby having a negative impact on their income.

There is also a fear of triggering an audit by billing too many long consults. 45% of GPs agree that they sometimes claim a shorter consult than was done to avoid being a statistical outlier based on the number of long consults billed, further compromising the economic viability of mental health consults.

Furthermore, the MBS mental health item number 2713 pays (marginally) less than a standard consult (36) of the same length, signalling to GPs that their time spent on mental health is not valued.

Consequently, the appetite for further training in this area of medicine is compromised. While many GPs are motivated to do further training to better serve the needs of their community, the most frequently mentioned factor that would motivate GPs to do further training is improving the economic return for treating mental health, taking into consideration that it is considered less economical than other forms of medicine and many describe it as the most demanding part of their job.

The broader system and environment in which GPs deliver mental health is not supportive

While the paucity of resources motivates many GPs to do further training to support their community better, it also contributes to the difficulty of delivering mental health support to patients and detracts from the motivation to make this a greater focus in their practice. Only 13% agree that there is sufficient access to other mental health services in their area.

Furthermore, 63% disagree that the design and structure of the MBS item schedule is suitable for treating mental health as a GP and 37% are concerned about triggering an audit. 55% agree that the administrative requirements for mental health consults are onerous. 25% of weekly consults address mental health in combination with other issues, yet the system for billing does not recognise this.

The system in which GPs operate is not optimised to encourage the delivery of mental health services.

Mental health consults account for a larger proportion of female GPs' workloads

While male GPs do 49% of all consults involving mental health, it only accounts for 32% of their weekly consults, whereas it accounts for 47% of female GPs' weekly consults. Female GPs therefore have the potential to feel the pressure on their time, income, and emotional wellbeing more acutely. The greater share of mental health consults that females undertake is not accounted for by having a greater interest in mental health, suggesting that while some may choose to take this on, other factors drive the mental health work in their direction.

The skills learnt through FPS (Level 2) training offer benefits beyond the delivery of FPS but do not solve the problems of delivering mental health services

Being trained (or registered) in FPS skills does not necessarily lead to GPs delivering FPS. In situations where FPS is considered appropriate for patients, 43% of FPS trained GPs tend to deliver it themselves whereas 46% tend to outsource it.

The challenges with FPS are similar to the challenges with mental health consults more broadly. 70% of those who outsource it agree that FPS is not financially viable in their practice and 70% agree that it is not well suited to a conventional General Practice business model. Even amongst those who mostly deliver FPS themselves, 62% agree that it is not financially viable in their practice. This is not sustainable for the profession.

Even though many FPS trained GPs outsource FPS treatment, 81% found it valuable as a tool to enable them to provide FPS consultations to patients. However, even more value was placed on the skills gained in FPS training

as a useful tool across a wide range of consults. FPS trained GPs estimate that in 47% of the consults in which mental health alone is addressed, they use the skills they learnt in the training, but not in a way that would qualify them to bill it as an FPS item. In comparison, only 39% of mental health only consults use the skills in a way that would qualify.

The MBS billing data substantially underestimates the quantum of FPS being delivered

GPs who are registered FPS providers estimate they do an average of 6.4 consults per week that are stand-alone mental health consults and qualify to be billed as an FPS item, yet only 2.5 consults are billed as FPS item numbers.

Although unlikely to be compliant with Medicare billing requirements, FPS trained GPs estimate they attend to 11.8 mental health consults per week that qualify as FPS items, whether stand-alone consults or in combination with other issues being addressed. For these consults only 3.4 are billed as FPS item numbers.

The limit to the number of MBS items available to a patient for psychological services impacts GPs' treatment and use of item numbers

79% of FPS trained GPs who are outsourcing FPS treatment say that they would do more FPS if it did not take away from the number of MBS billable sessions available for a psychologist.

This also impacts billing patterns. 23% of all GPs say they use a non-mental health item number because they are reluctant to use a patient's allowance for a set number of mental health consults per year.

GPs are open to further training in mental health, but the barriers are substantive

GPs are open to further training to better meet the needs of their communities and deliver a better outcome for patients.

However, the emotional, economic, and practical viability of delivering mental health services create reluctance amongst GPs to invest resources in further training in mental health. Structural barriers like time to do the training, the cost of the training and access to training are present, and there is insufficient motivation amongst the broader GP population to overcome these barriers. The majority of GPs feel that they are adequately equipped to meet the needs of their patients.

If the GPMHSC wants to leverage the openness to further training, both the structural barriers of access, time and cost as well as the underlying problems with the delivery of mental health, including but not limited to financial viability, need to be addressed.

Recommendations Arising from this Research Study

These recommendations are based on the survey data presented in this report. The authors acknowledge that this is only one data source and that this should add to the total body of knowledge that guides policy and practice decisions. Although this is only one data source, the findings suggest that the issues highlighted in this report require urgent and serious attention.

Address the factors that are contributing to economic inequality between mental health and other presentations so that there is no financial disadvantage for GPs to attend to the significant and growing volume of mental health consults.

This includes, but is not limited to, the recommendations listed below.

- Recognise that mental health consults require more time and there is an opportunity cost for GPs doing long consults compared with the income that would be earned doing multiple shorter consults. Structure remuneration to ensure that all time worked is economically equitable for GPs.
- Identify and reduce factors that discourage accurate billing of long consults for fear of triggering an audit.
- Remove the disparity between mental health and other consults in the value of MBS item numbers.
- Identify the factors contributing to and address the underlying causes (where possible) of the unpaid time required for coordinating care and follow-up for patients with mental health conditions.
- Change the remuneration to reflect the additional time required to coordinate care.

Align the MBS with the needs of patients and their care providers with regard to mental health to ensure that the MBS structure supports GPs in their provision of mental health services.

This includes, but is not limited to, the recommendations listed below.

- Recognise that consults involving both mental and physical health are considered necessary and are commonplace in patient centred care and adapt the MBS to improve alignment with the billing structure and what is happening in practice.
- Make the administrative time and effort required to bill a mental health item commensurate with that of any other item.
- Reduce the risk to GPs of payment claims being rejected resulting from a patient exhausting their MBS allocation through other providers.

Address the factors that are contributing to GPs not using the MBS mental health item numbers in order to improve the accuracy of MBS data and provide better evidence for the development of policies and practice around mental health.

Attending to the recommendations listed above is likely to contribute to greater accuracy in the use of MBS item numbers for mental health. More specifically:

- Reduce factors that intimidate GPs and influence their behaviour around accurately billing for long consults.
- Remove the remuneration inequity between mental health and other consults.
- Remove the need for greater administrative effort required to bill an MBS mental health item number.

Ensure that GPs' own mental and emotional wellbeing are supported so that the mental health component of their role does not take an undue toll on their ability to serve their profession and communities well and sustainably.

This includes, but is not limited to, the recommendations listed below.

- Addressing some of the aforementioned recommendations will signal support for GPs and create a more viable model for sustainable delivery of high volumes of mental health consults.
- Putting in place opportunities for GPs to seek support for their own mental well-being that results from their attending to mental health presentations and encouraging them to do so without fear of being identified and reported.

Address the paucity of resources to give greater access to mental health services and reduce the demands on GPs to prevent mental health from eroding their ability to meet the needs of all patients and attend to all presentations.

This includes, but is not limited to, the recommendation listed below.

- Recognise that some GPs are more interested in and engaged with the delivery of mental health and many GPs find mental health consults difficult to accommodate within the constraints of a conventional general practice. Explore alternative service models that encourage this cohort to expand their capacity to undertake more mental health work or models that facilitate the delivery of mental health services without eroding the ability of GPs to meet other needs.

Attend to the gender inequality in the delivery of mental health services and ensure that female GPs are not disproportionately disadvantaged by undertaking a relatively higher proportion of mental health consults.

By addressing the previous recommendations and ensuring that mental health is suitably remunerated and well supported, there should be no disadvantage to those GPs who do a greater proportion of this work.

With respect to training, the following recommendations are proposed:

- Given the volume of mental health that GPs address and the lack of time for further training once they are practicing, GPs should be appropriately equipped to deal with mental health consults as part of the Australian General Practice Training (AGPT).
- In addition, offer intermediate training (between Level 1 and FPS skills training) that is not designed around the delivery of therapy but extends the knowledge and confidence of GPs in diagnosing and supporting patients with mental health conditions. This could take the form of specific training on common presentations (e.g. addiction, trauma, anxiety and depression) that is patient centric rather than treatment centric. This training would not be limited in appeal to only those who show a strong interest in mental health but could be offered in a way that overcomes the time and cost barriers to training.
- For those who are FPS trained, active in the delivery of FPS or particularly interested or skilled in the delivery of mental health services, offer additional training that builds on their already extensive knowledge for Continuing Professional Development (CPD), ensuring that the training adds value to these GPs. Note though that this is likely to be relevant to a small proportion of GPs.

The Context: Mental Health in General Practice

The Contribution of GPs to the Management of Mental Health in Australia

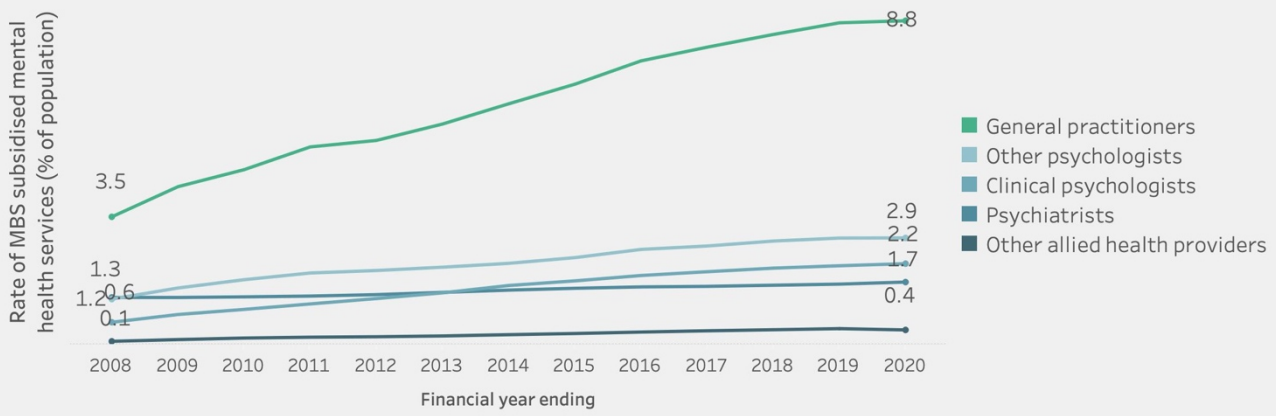
Based on MBS data, more than 10% of the population received MBS-supported mental health care in 2019-2020, almost doubling the rate from 10 years prior.[4] The same source indicates how this has increased further because of the COVID-19 pandemic, with the number of MBS-subsidised mental health-related services processed in the 4 weeks to 27 June 2021 being 4.1% and 13.9% higher than the same periods in 2020 and 2019, respectively.

The proportion of the population receiving mental health care based on MBS item numbers is a conservative estimate, with 84% of GPs stating that their use of the MBS mental health item numbers underestimates the volume of mental health consults they attend to (Figure 17).

The majority of the MBS-supported mental health care services (82%) were provided by GPs.[5] Aligned with this, four out of five GPs (81%) reported having patients with mental health conditions that are mostly managed within general practice in the Health of the Nation study.[6]

These findings highlight not only the growth in mental health presentations over the last 10 years, but also the increased role played by GPs in the management of mental health and how critical their role is, even before the onset of COVID-19.

Figure 1. Percentage of population attended to for MBS-subsidised mental health care by provider



Source: Australian Institute of Health and Welfare 2021. Mental health services in Australia. Canberra: AIHW. Viewed 26 November 2021

4 Australian Institute of Health and Welfare. Mental health services in Australia. Canberra: AIHW, 2021

5 Australian Institute of Health and Welfare. Mental health services in Australia. Canberra: AIHW, 2021

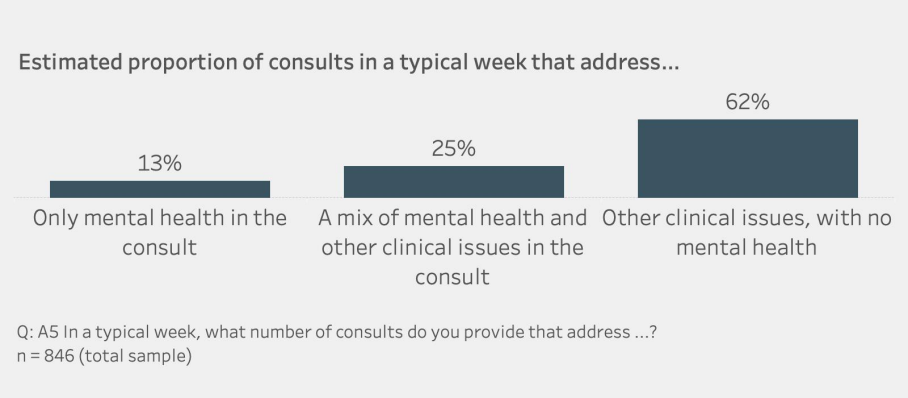
6 EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021

Quantum of Mental Health Consults

In the 2021 Health of the Nation study of RACGP Fellows, psychological conditions were the most reported reasons for patient presentations. The overall number of GPs who selected mental health in their top three reasons for patient presentations has risen steadily from 61% in 2017 to over 70% in 2021. In the same study almost two-thirds of GPs (63%) reported that most of their patients have physical and mental health conditions that they treat concurrently.[7]

The GPMHSC survey found that 38% of GP consults in a typical week address a component of mental health. This is comprised of 25% of consults addressing a mix of mental health *and* other clinical issues and 13% of consults addressing mental health as the only condition.

Figure 2. Estimated proportion of weekly consults with a mental health component



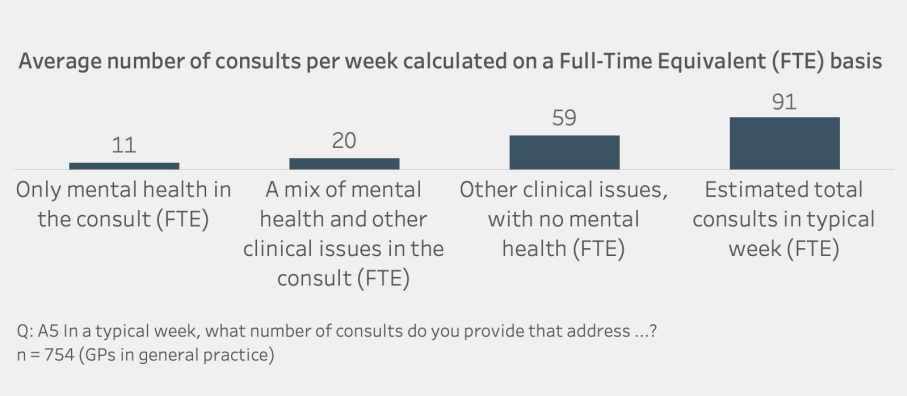
38% of all consults address a mental health component.

25% address a mix of mental health and other clinical issues.

The GPMHSC survey asked GPs to estimate the number of consults they did in a typical week that addressed mental health only, that addressed a mix of mental health and other clinical issues, and addressed other clinical issues, with no mental health. Since there is variation in how many hours per week GPs work in general practice (see Figure 54), the average number of consults of each type shown in Figure 3 has been calculated on the basis of a GP working full time in general practice. On a full-time equivalent (FTE) basis, the estimated number of consults in a typical week is 91, of which 31 address mental health.

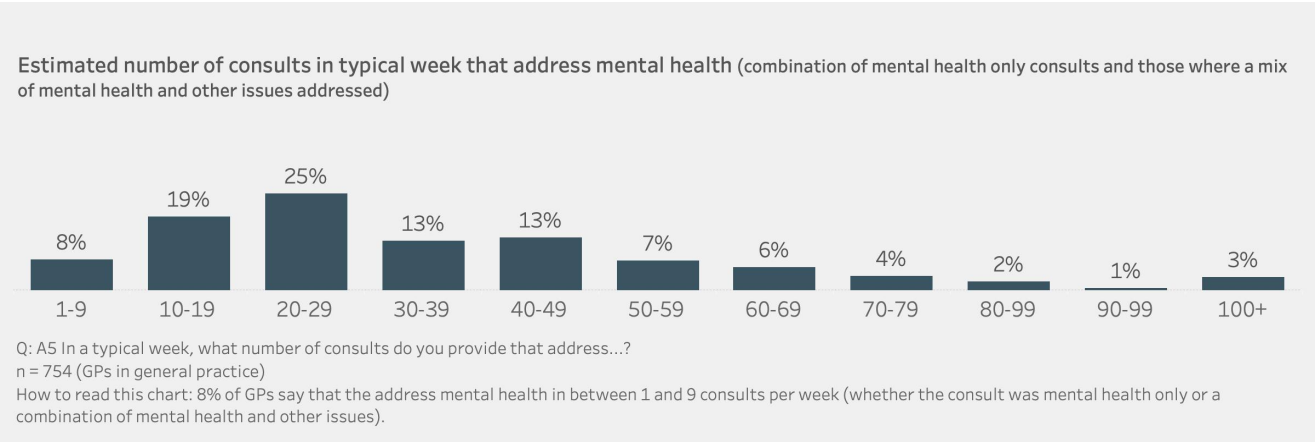
7 EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021

Figure 3. Estimated number of consults in general practice



There are, however, a high proportion of GPs that are dealing with many more than the 31-consult average. 36% of GPs estimate they address mental health in more than 40 consults in a typical week, whether they be stand alone, or in combination with other clinical issues.

Figure 4. Frequency count of estimated number of mental health consults in a typical week



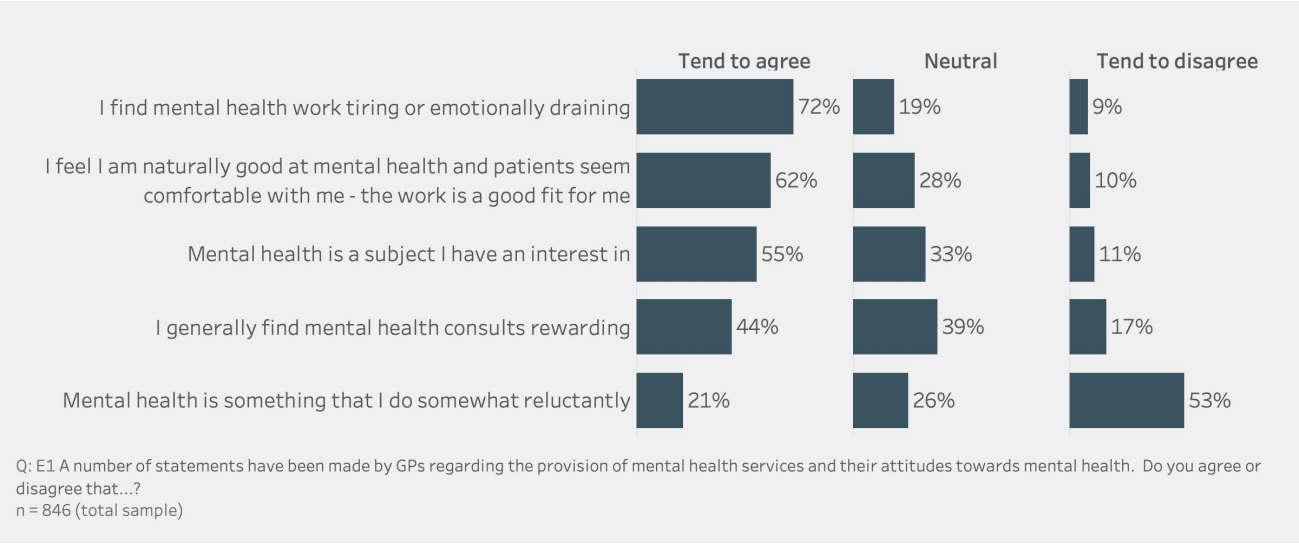
Orientation of GPs Toward Mental Health

The response to the GPMHSC survey indicates a tension in the orientation of GPs toward dealing with mental health conditions in their practice. While the vast majority say they find mental health work tiring and draining, many of these people also believe they are naturally good at supporting people who present with mental health conditions and have an interest in the area. A minority say they deal with mental health conditions reluctantly.

72% agree that they find mental health work tiring or emotionally draining, indicating that supporting patients with mental health conditions is also demanding on their own mental wellbeing. This is likely to be a consequence of both the large share of mental health in their weekly caseload and the challenges associated with providing support which are discussed later in this report.

Although 1 in 5 GPs do mental health consults somewhat reluctantly, more than half disagree that this is the case. 62% agree that they feel they are naturally good at mental health, and it is a good fit for them, 55% agree it is a subject they are interested in and 44% find it rewarding.

Figure 5. Attitudes toward mental health



Q: E1 A number of statements have been made by GPs regarding the provision of mental health services and their attitudes towards mental health. Do you agree or disagree that...?
n = 846 (total sample)

To provide a clearer understanding of how GPs engage with the challenges of treating people with mental health conditions, we have further analysed the responses to the statements in Figure 5. A statistical method called Cluster Analysis has been used to classify GPs into four distinct segments with similar patterns of response and therefore have a "natural" similarity in their orientation toward mental health.[†] These segments describe their attitude to and interest in mental health. The size and composition of the segments are contained in Figure 6.

Segment 1: Interested, Engaged & Resilient

22% of GPs are in the segment described as 'Interested Engaged & Resilient'. They tend to agree that it is a good fit for them, they are interested in the subject and find it rewarding. None agree that they find it tiring or emotionally draining, and none agree that they do this work reluctantly.

"Personally, I think it's very rewarding. Personally, I think, it makes a huge difference to a person's life to get their mental health right"

Segment 2: Interested, Engaged but Draining

This group accounts for 32% of GPs. Like the previous segment, they are interested in the subject and believe it is a good fit for them, but everyone in this segment agrees that they find it tiring or emotionally draining.

"Some of the consultations are really challenging, really draining. In my first practice for example I had two patients that committed suicide. Not my regular patients but ones that I've seen, when the regular GP was away. And, yeah, that's kind of affected me. Yeah, I learned to take care of my own mental health."

"A problem if it becomes too much of your clinical load because it is quite exhausting."

[†] See appendix for details on calculation of segments.

Segment 3: Low Interest & Reluctant

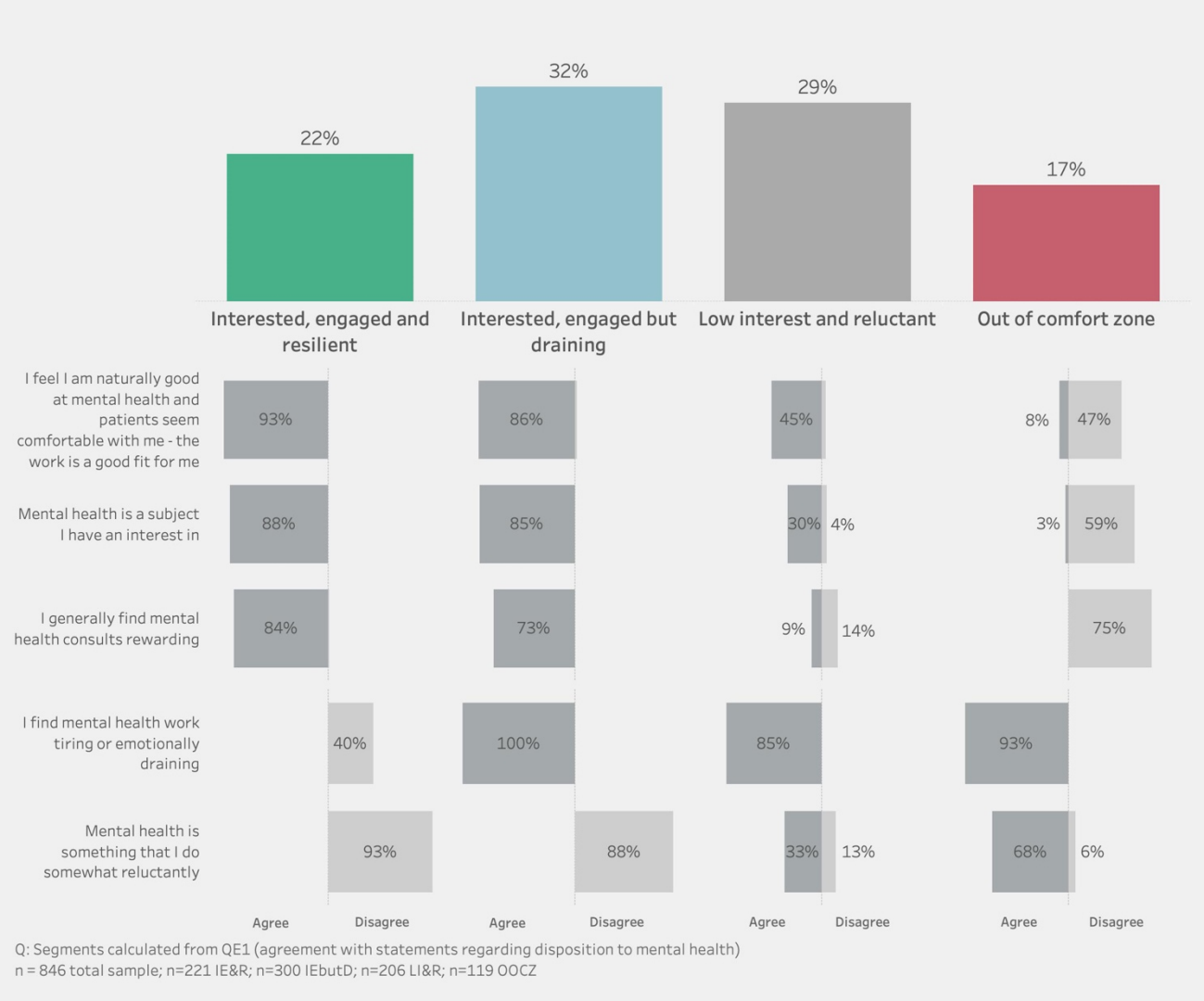
This group is not strongly opposed to mental health consults, but have little interest, don't find it rewarding and find it tiring and emotionally draining. This group accounts for 29% of GPs.

Segment 4: Out of Comfort Zone

17% of GPs are in the segment described as 'Out of Comfort Zone'. Many in this segment do this work reluctantly. They do not find it rewarding, it has the largest number who feel the work is not a good fit for them and they disagree that it is something they are interested in.

"I don't think I'm particularly skilled or gifted in mental health counselling, I understand CBT and I understand different techniques. But I don't think I'm particularly gifted in implementing them."

Figure 6. Segmentation of GPs by disposition to mental health

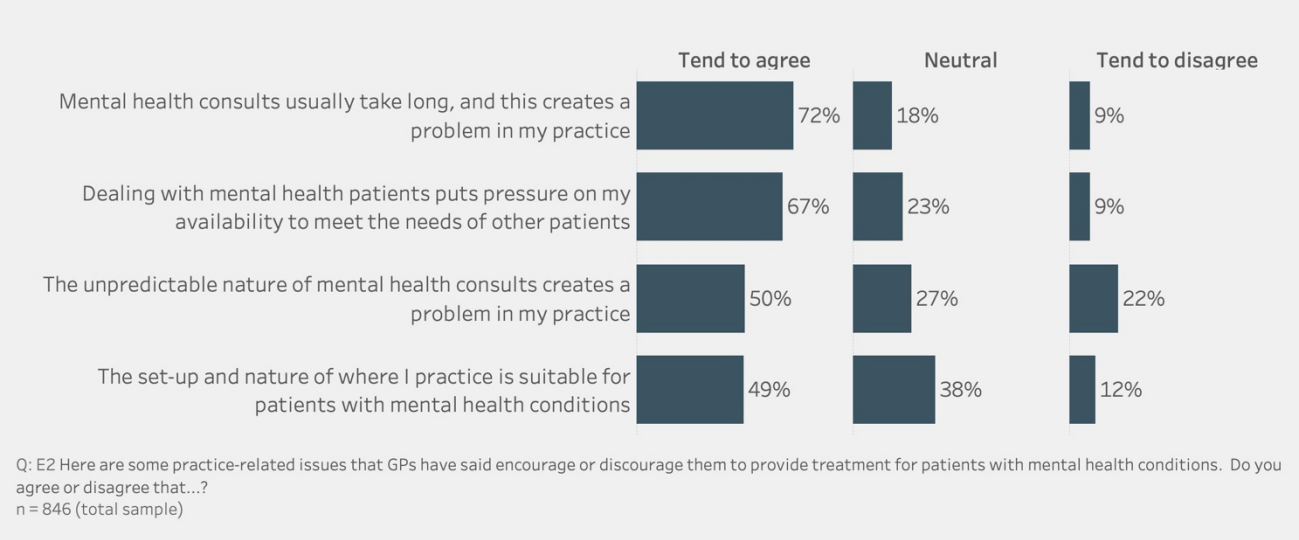


Challenges of Accommodating Mental Health in the Practice

Many GPs report practical difficulties with the delivery of mental health consults. 72% agree that these consults take a long time, creating a problem in their practice and 67% agree that dealing with mental health patients puts pressure on their availability to meet the needs of other patients. The unpredictable nature of mental health consults adds to the complexity of delivering this service.

72% of GPs agree that mental health consults usually take a long time, and this creates a problem in their practice.

Figure 7. Experience with mental health in the practice



"We do have a large pressure of patients all the time. So it's very difficult when you have a three hour clinic to spend an hour of that three hours with one person."

"When you survey the waiting room there is that tight chest feeling because you know that this consult is going to set you back, make you late for the rest of the day."

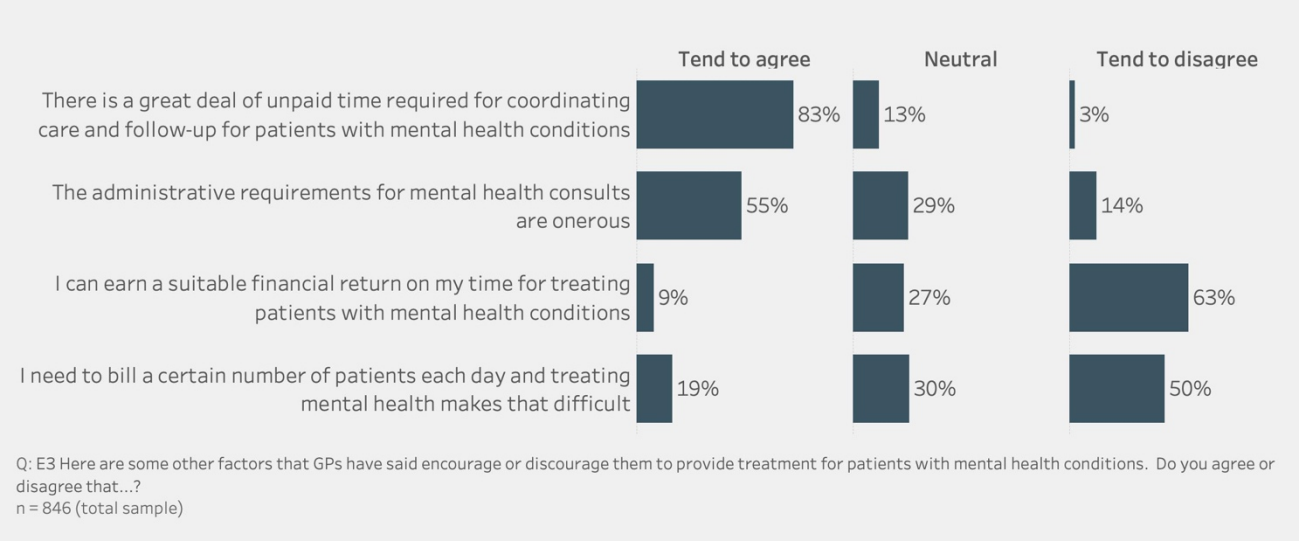
In addition to the challenge of managing lengthy consults, the survey also revealed many GPs find the time required to coordinate care and provide support outside of the consultation to be a significant challenge. Over 80% of GPs agree that there is a great deal of unpaid time required for coordinating care and follow-up for patients with mental health conditions. Over one in two agree that the administrative requirements for mental health consults are onerous.

Only 9% of GPs agree they can earn a suitable financial return on their time for treating patients with mental health conditions.

The additional time burdens described by GPs manifest in a widely held view that the economic return from treating mental health is significantly poorer than treating other conditions. Only 9% of GPs agree they can earn a suitable financial return on their time for treating patients with mental health conditions.

"MBS reimbursements are frankly ridiculous – this is a major barrier for clinicians and patients. A GP who sees six straightforward patients an hour might do 5 x 23s and a management plan – billing almost $500 on Medicare with the most basic qualifications required for our profession. That same GP could choose to see one long complex mental health patient and, with the highest qualification available to them, having spent their own time and money to do two levels of mental health skills training, and will bill less than half this amount."

Figure 8. Commercial and economic impacts of mental health consults



Q: E3 Here are some other factors that GPs have said encourage or discourage them to provide treatment for patients with mental health conditions. Do you agree or disagree that...?
n = 846 (total sample)

"The very fact that a 2713 pays less than a 36 speaks volumes."†

"It's clear that there are lots of GPs that feel that our time is not valued financially. So doing a mental health consult, spending 30 minutes with a patient, to earn the same amount of money as an eight-minute consult for a sore knee. It's just not viable financially."

"It's just not financially worthwhile. If you did it regularly, cost would be an issue"

"That's kind of why it takes so much time, accessing the additional services, particularly in the acute cases. If anyone ever needs to go to hospital, it really is a bit of a nightmare both communicating with the team and also getting adequate support as an outpatient, even with, you know, complex mental health, social workers and nurses and things like that, it still is very fragmented. It's really hard. Putting all of that together to make sure this person is actually getting the support they need. That's where I'm getting lost myself."

"I feel good from a patient care perspective, but I felt very negative about it from a billing perspective, because it, you know it lengthens your consult. It is much more complicated and to me it's much harder work, than clinical medicine, and we're a bulk billing practice so it's just, yeah, I think that the MBS doesn't recognise it at all. So it's a bit unfair in that respect."

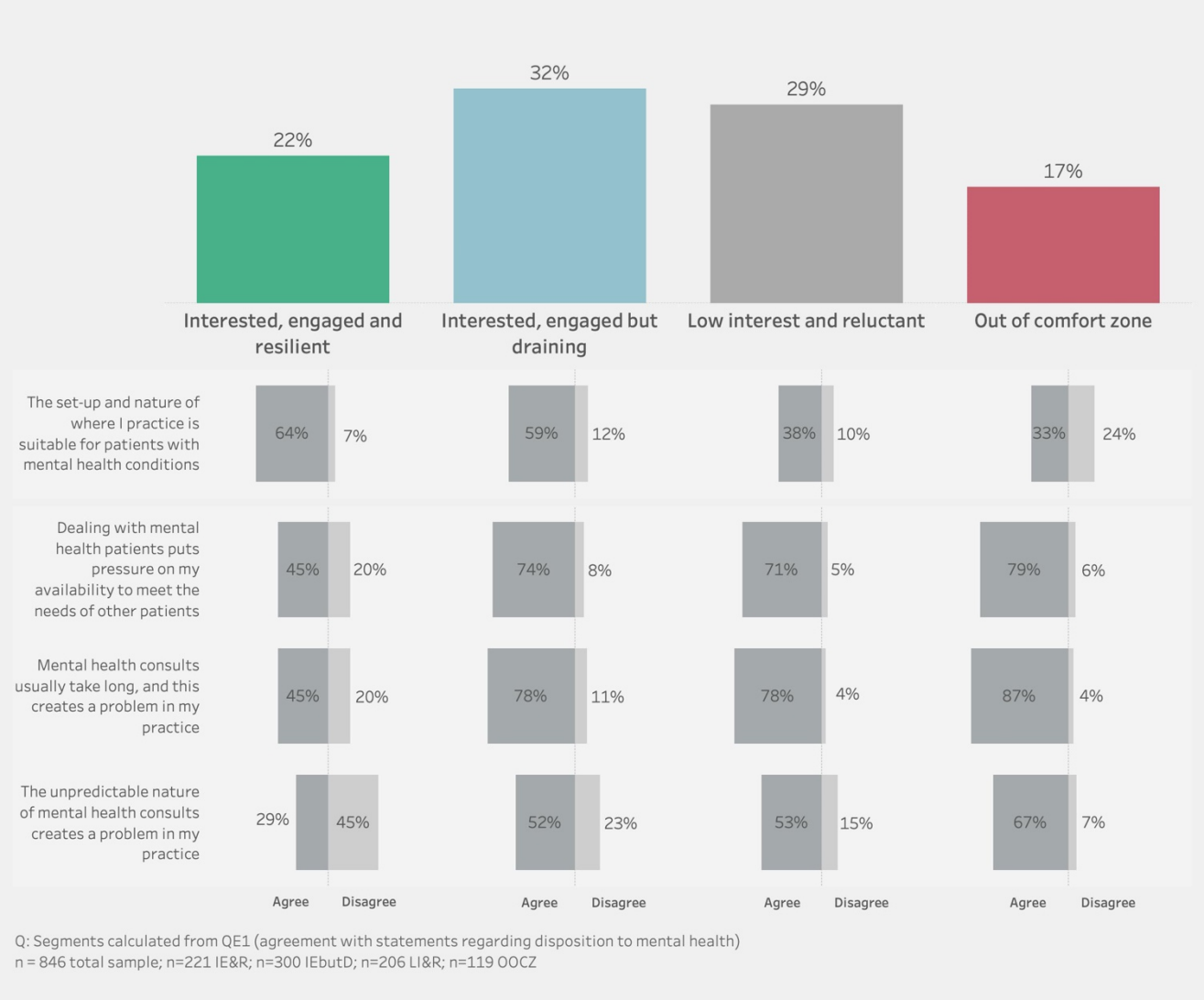
† Respondent is referring to 2713 MBS item number, Fee $74.60: Professional attendance by a GP in relation to a mental disorder and of at least 20 minutes in duration. 36 MBS item number, Fee $75.75; Professional attendance by a GP at consulting rooms (other than a service to which another item applies) lasting at least 20 minutes

The economic and practical impacts of mental health consults and the challenges they present in a practice are present regardless of GP attitudes and orientation toward mental health.

Even amongst the most positive segment, the 'Interested Engaged & Resilient' group, only 20% agree they can earn a suitable financial return on their time for treating patients with mental health conditions and 81% agree there is a great deal of unpaid time required for coordinating care and follow up for patients with mental health conditions.

The most notable difference between the two groups who are engaged with mental health is those finding it tiring and emotionally draining are more likely to agree it presents problems in their practice, by putting pressure on their availability to meet the needs of other patients, the unpredictable nature of consults and in particular, the length of consults. 45% of those who are 'Interested, Engaged & Resilient' say mental health consults usually take a long time and this creates a problem in their practice, compared with 78% of those who are in the 'Interested, Engaged but Draining' segment agreeing with this.

Figure 9. Segmentation of GPs by experience with mental health in their practice

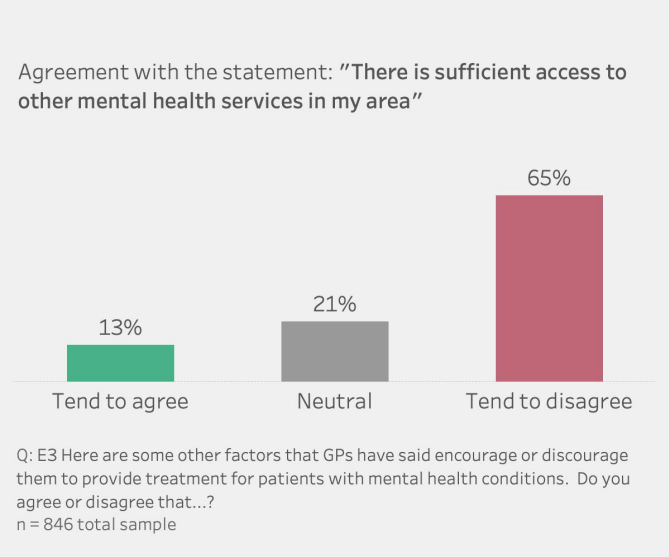


Q: Segments calculated from QE1 (agreement with statements regarding disposition to mental health)
n = 846 total sample; n=221 IE&R; n=300 IEbutD; n=206 LI&R; n=119 OOCZ

Perceived Access to Mental Health Services in the Area

Adding to the challenges facing GPs in delivering mental health is the lack of access to other mental health services in the area. Only 13% of GPs agree there is sufficient access to other mental health services in their area.

Figure 10. Perceived access to mental health services in area



Only 13% of GPs agree there is sufficient access to other mental health services in their area

"Finding a psychologist. It's very, it's very difficult in our area. Most of the psychologists are booked out for months, and some even years, so it's impossible to get like immediate help for the patient."

"It's the hardest part of my clinical practice like liaising with other specialties, like even getting a hold of a psychiatrist, is really difficult. So even just, you know the difference between managing say type two diabetes which would have potentially, as many or more stakeholders in it, is so much easier than managing mental health because of the paucity of resources, and the complexity of getting in touch with the patient and the responsibility for our patients. For example, one just hung up now I can't get on to them and am I concerned about suicide? How much responsibility am I prepared to take on in this area?"

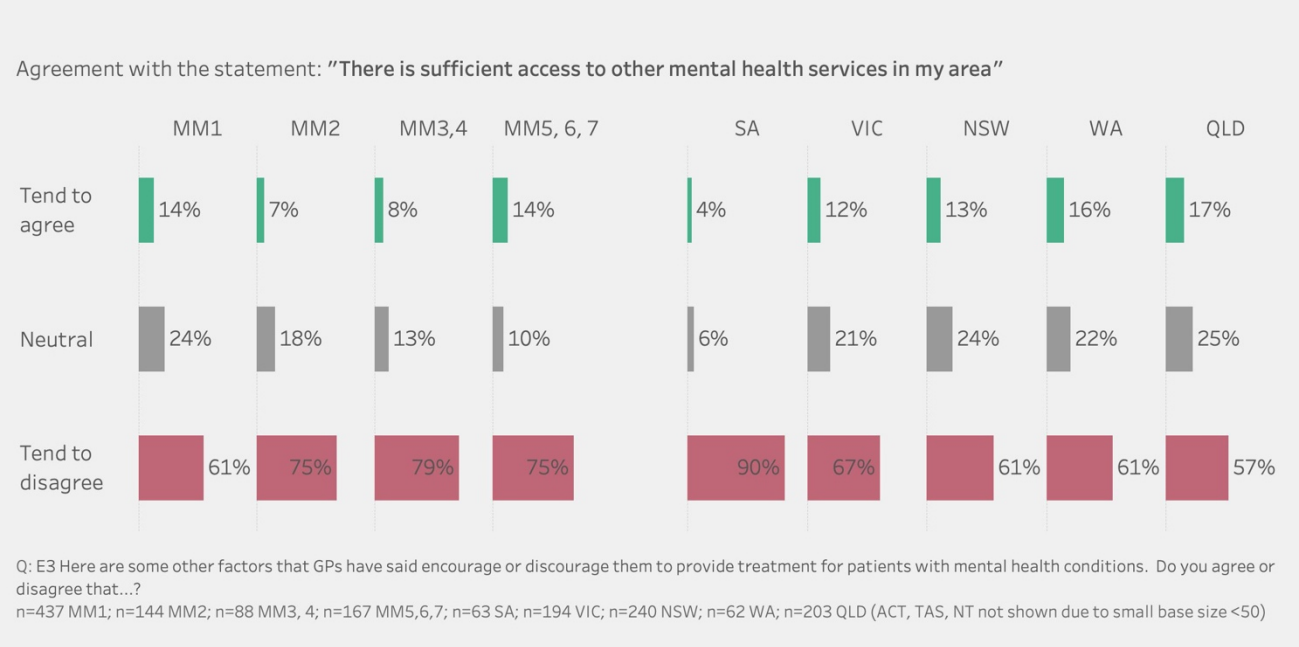
"I do this work; I am skilled and trained in it, but it is emotionally exhausting and the distinct lack of good-fit referral pathways to professional counselling and challenges getting unwell patients properly accepted and managed by our CAMHS and AMHS is an additional impediment to this work."

The view that there is inadequate access to other mental health services is widespread amongst GPs, from metropolitan through to rural and remote settings. Of GPs in MM2 areas through to MM7 areas, over 75% disagree that there is sufficient access to other mental health services. In areas classified as MM1 (major cities) a lower, yet considerable proportion of GPs (61%) disagree there is sufficient access to other mental health services.†

† The Australian Government Department of health uses the Modified Monash Model (MMM) to define whether a location is a city, rural, remote, or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) category MM1 to MM7, where MM1 is a major city and MM7 is very remote.

While a considerable proportion of GPs in all states believe there is insufficient access to mental health services in their area, this concern is most prominent in South Australia, where 90% disagree there is sufficient access in their area (significantly higher than any other state at the 95% level of confidence).

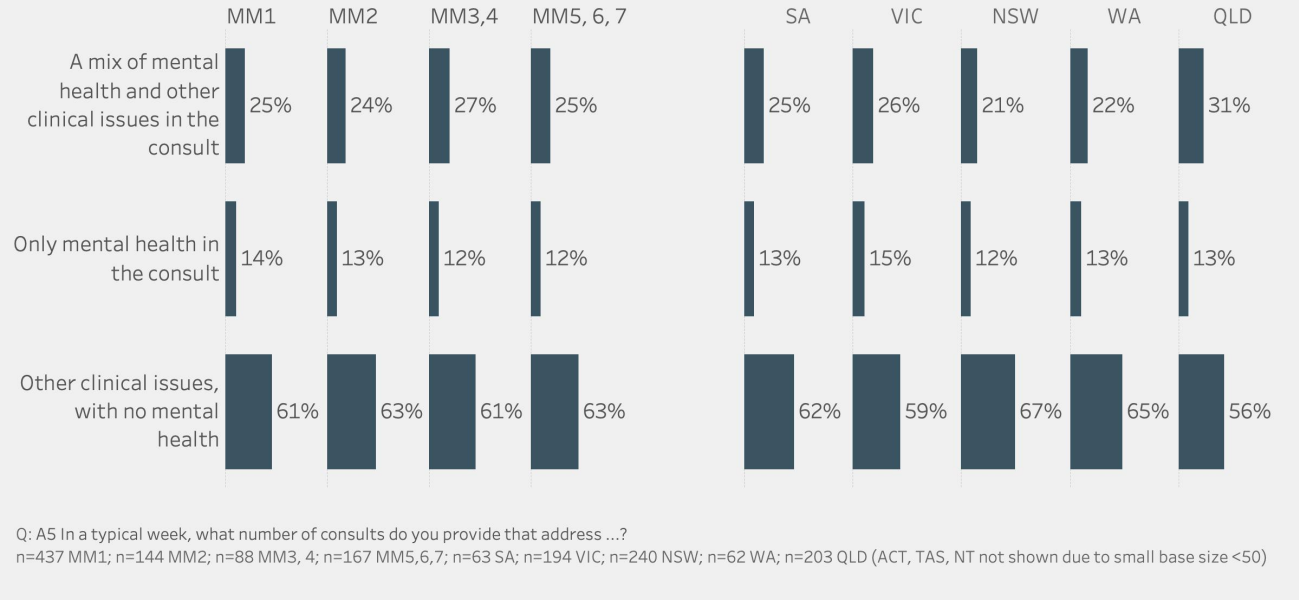
Figure 11. Perceived access to mental health services by MMM and state



Q: E3 Here are some other factors that GPs have said encourage or discourage them to provide treatment for patients with mental health conditions. Do you agree or disagree that...?
n=437 MM1; n=144 MM2; n=88 MM3, 4; n=167 MM5,6,7; n=63 SA; n=194 VIC; n=240 NSW; n=62 WA; n=203 QLD (ACT, TAS, NT not shown due to small base size <50)

The estimated proportion of weekly consults that address mental health is consistent from cities to remote areas (based on the Modified Monash Model). GPs in Queensland estimate a higher proportion of consults have a mental health component than other states (statistically significant at 95% level of confidence compared with NSW.)

Figure 12.Estimated proportion of weekly consults with a mental health component by MMM and State

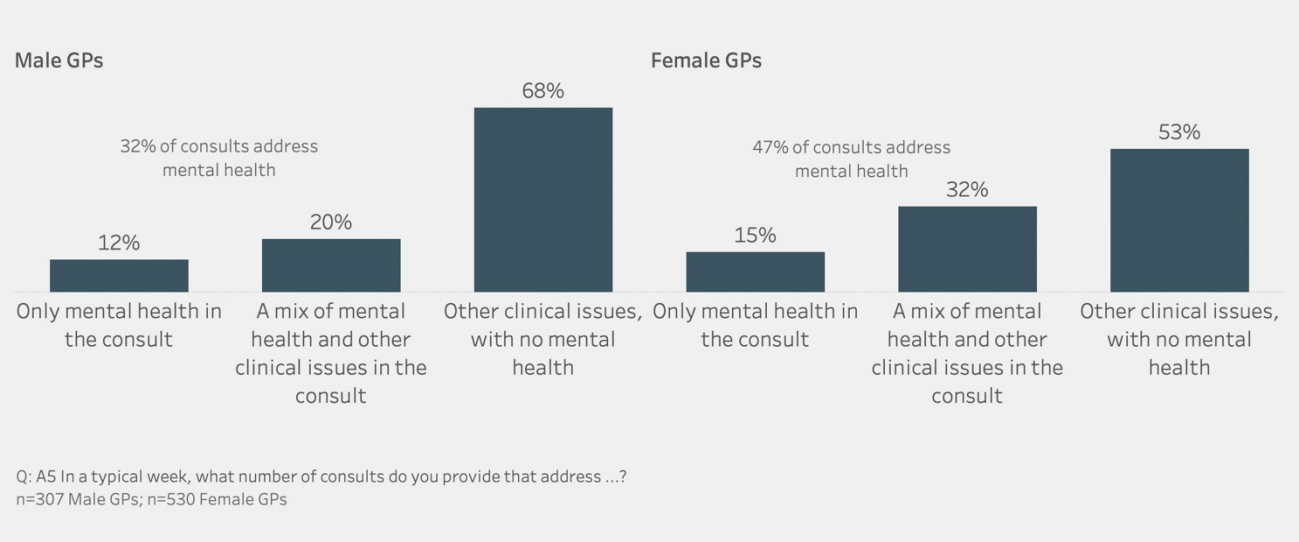


Q: A5 In a typical week, what number of consults do you provide that address ...?
n=437 MM1; n=144 MM2; n=88 MM3, 4; n=167 MM5,6,7; n=63 SA; n=194 VIC; n=240 NSW; n=62 WA; n=203 QLD (ACT, TAS, NT not shown due to small base size <50)

Quantum of and Attitudes to Mental Health by Gender

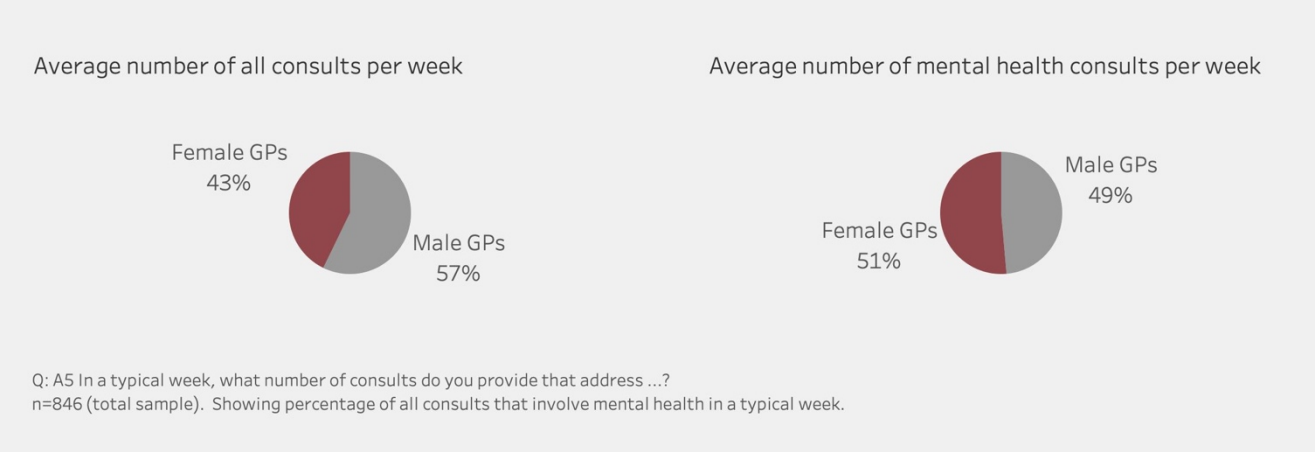
The GPMHSC survey has confirmed a distortion in the mental health patient loads carried by GPs of different genders. Female GPs estimate that 47% of their consults include a mental health component, as compared to only 32% for male GPs. The disproportionate quantum of mental health attended to by female GPs was also evident in the 2021 Health of the Nation survey, with 76% of female GPs reporting psychological issues as one of the three most common presentations they see, compared with 61% amongst male GPs.[8]

Figure 13. Estimated proportion of weekly consults with a mental health component by GP's gender



Whilst female GPs report a heavier mental health caseload as a proportion of their weekly consults, the total quantum of mental health consults administered is almost evenly shared with male GPs. This is a function of male GPs typically working a larger number of hours per week in general practice (Figure 54). Male GPs attend to 49% of estimated mental health consults in a typical week with 51% attended to by female GPs.

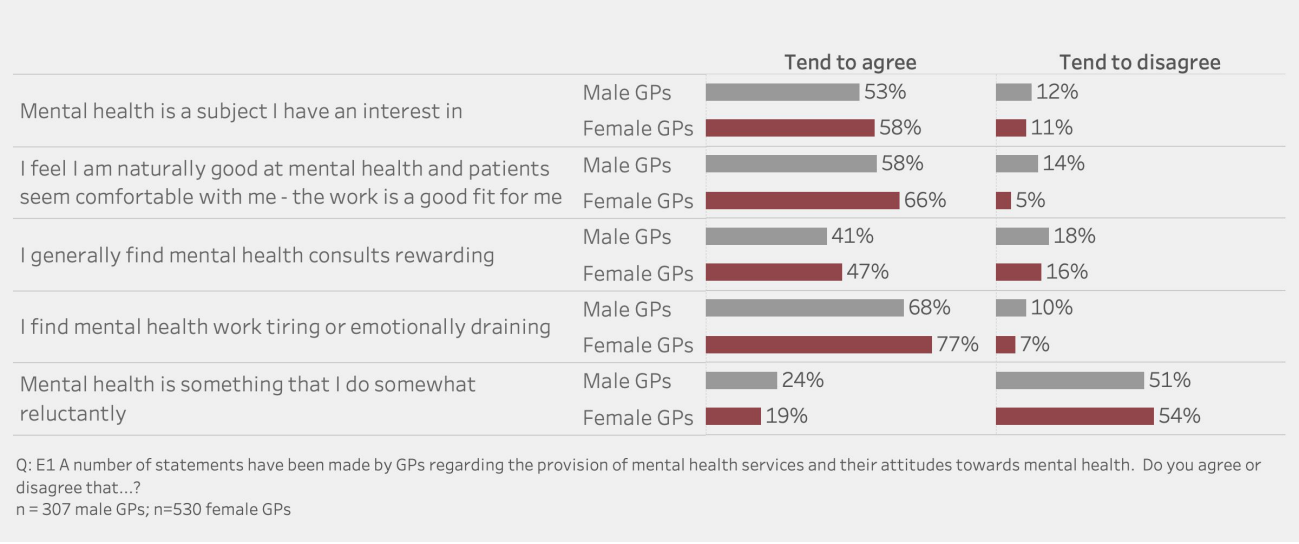
Figure 14. Proportion of all versus mental health consults by gender



8 EY Sweeney. RACGP GP Fellow Survey. Melbourne: EY Sweeney, 2021.

As indicated previously, 47% of the weekly consults attended to by female GPs address mental health, compared with 32% for male GPs. While slightly more female GPs are interested in and feel mental health is a good fit for them, the difference in GP attitudes to mental health indicated in the chart below does not explain the disproportionate incidence of mental health consults attended to by female GPs. This finding suggests it is not the female GPs themselves that are seeking out this work, but perhaps patient choice or practice related factors that channel this work in their direction.

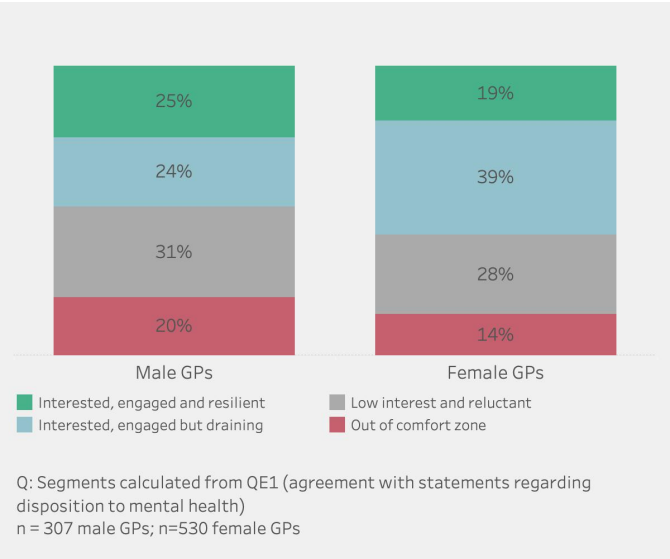
Figure 15. Disposition to mental health by gender of GP



Q: E1 A number of statements have been made by GPs regarding the provision of mental health services and their attitudes towards mental health. Do you agree or disagree that...?
n = 307 male GPs; n=530 female GPs

The segmentation of GPs by their attitudes toward treating mental health reinforces the skew toward higher ratios of mental health consults among female GPs. Female GPs are not over-represented in the group that are 'Interested, Engaged & Resilient'. They are overrepresented in the group described as 'Interested, Engaged but Draining'. 39% of Female GPs are classified as members of this segment, compared to only 24% of male GPs, a statistically significant difference at the 95% level of confidence.

Figure 16. Segmentation of GPs by disposition to mental health, gender profile



Q: Segments calculated from QE1 (agreement with statements regarding disposition to mental health)
n = 307 male GPs; n=530 female GPs

"I do a lot of mental health at my practice compared to others as a young friendly female GP who is a good listener. It is poorly remunerated and emotionally draining compared to other GP work, especially procedural work such as skin cancer excisions."

"Mental health consultations financially disadvantage female health care workers. This contributes to the economic gender gap and contributes to clinician burnout for female doctors."

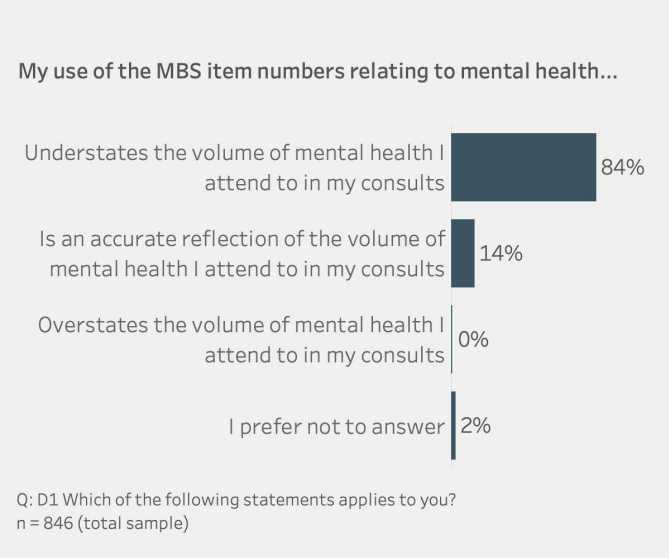
Use of and Attitudes Toward MBS Mental Health Item Numbers

MBS Mental Health Item Number Utilisation

There is a hypothesis that the MBS Mental Health item numbers underestimate the volume of mental health consults attended to by GPs. This hypothesis is described in a Parliamentary Library Research Paper: "According to the Bettering the Evaluation and Care of Health (BEACH) survey of GPs. The BEACH survey found 12.4 per cent of GP encounters (or 17.7 million separate encounters) in 2015-16 involved the management of psychological problems, such as depression, anxiety and sleep disturbance. This is much higher than the 3.2 million GP mental health-specific Medicare Benefits Schedule (MBS) items (MBS Group A20) that were billed by GPs in 2015-16, indicating that GPs likely billed many of these encounters as general MBS items."[9]

In the GPMHSC survey, GPs were asked whether their use of the MBS mental health item numbers understated, overstated, or accurately reflected the volume of mental health attended to in their consults. Most GPs (84%) indicate that their use of the MBS item numbers for mental health understates the volume of mental health they attend to in their consults.

Figure 17. MBS item numbers as a reflection of volume of mental health attended to in consults



84% of GPs claim their use of MBS item numbers understates the volume of mental health they attend to in their consults.

GPs estimate 37% of their consults that address mental health are claimed as mental health MBS item numbers.

GPs were asked to estimate† how many consults they did in a typical week that addressed mental health only, mental health and other issues and consults in which no mental health issues were addressed. Based on these numbers, GPs were asked to estimate what proportion of consults involving mental health were billed as MBS mental health item numbers.

It is estimated that for every 1 consult using an MBS mental health item number, 1.8 consults use other item numbers, even though mental health was addressed in the consult. GPs estimate only 36% of their consults which address mental health are claimed as a mental health item number.

9 Cook, L. Mental health in Australia: a quick guide. Canberra: Parliamentary Library, 2019 [Accessed 15 November 2021]

† The data is not based on verified numbers, it is based on a GP's estimate of the number of consults they attend to in a typical week and their view of what to count as addressing a mental health issue in the consult.

When GPs *only* address mental health in the consult, they estimate 55% of these consults are claimed as a mental health item number.

Figure 18. Use of MBS items for consults involving mental health

Average number of mental health consults in a typical week (estimated) allocated to each MBS item number. Based on all consults that address mental health alone in the consult.

	Level 1	Level 2	Total	Level 1	Level 2	Total
MBS GP Mental Health item (2713)	2.9	4.3	3.0	24%	26%	24%
MBS GP MH Treatment Plan items (272 to 282 for non-VR or 2700, 2712, 2715 and 2717 for VR GPs)	3.6	3.4	3.6	29%	21%	29%
MBS Item numbers for the provision of Focussed Psychological Strategies (2721 to 2731)	0.1	2.4	0.2	1%	14%	2%
MBS 23/36/44 (Level B, C or D)	5.2	5.9	5.2	42%	36%	41%
MBS Other item numbers	0.6	0.3	0.6	5%	2%	4%
Total Mental Health only consults per week	12.3	16.3	12.5	100%	100%	100%

Average number of mental health consults in a typical week (estimated) allocated to each MBS item number. Based on all mental health consults, whether mental health only or in combination with other issue.

	Level 1	Level 2	Total	Level 1	Level 2	Total
MBS GP Mental Health item (2713) - All	5.6	9.7	5.7	16%	19%	17%
MBS GP MH Treatment Plan items (272 to 282 for non-VR or 2700, 2712, 2715 and 2717 for VR GPs) - All	6.2	6.1	6.2	18%	14%	18%
MBS Item numbers for the provision of Focussed Psychological Strategies (2721 to 2731) - All	0.1	3.2	0.3	0%	4%	1%
MBS 23/36/44 (Level B, C or D) - All	20.2	20.9	20.2	59%	59%	59%
MBS Other item numbers - All	2.0	2.5	2.1	6%	4%	6%
Total Mental Health only consults per week - All	34.2	42.4	34.5	100%	100%	100%

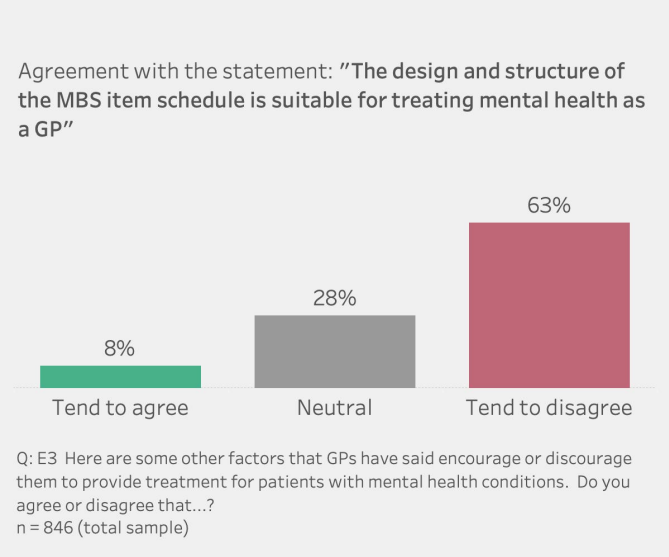
Q: A5 In a typical week, what number of consults do you provide that...1) address only mental health in the consult 2) address a mix of mental health and other clinical issues in the consult?
Q: D2/D3 Thinking about consults that address XXX, what proportion of these consults do you bill each of the following MBS item numbers in a typical week?
n = 626 Level 1; n=220 Level 2

Factors Contributing to the Inaccurate Use of Mental Health MBS Item Numbers

The structure and requirements of the MBS with respect to mental health consults is the most significant contributing factor to the difference in mental health presentations to GPs and the use of MBS items specific to the treatment of mental health.

A substantial majority of GPs (63%) disagree that the design and structure of the MBS item schedule is suitable for treating mental health as a GP. This view is widespread, regardless of the GP's orientation to mental health, with 56% of the 'Interested, Engaged & Resilient' GP segment disagreeing that the MBS design and structure is suitable, and 63% of the 'Low Interest & Reluctant' GPs disagreeing that it is suitable.

Figure 19. Perceived suitability of design and structure of MBS item schedule for treating mental health



Only 8% of GPs agree that the design and structure of the MBS item schedule is suitable for treating mental health as a GP.

In conducting the initial qualitative interviews with a wide range of GPs, two themes emerged that explain why GPs disagree that the MBS item schedule is suitable for treating mental health and why the use of MBS item numbers understates the actual treatment of mental health in general practice.

The first theme is a disconnect between what happens at the coalface in general practice and the structure of the item numbers. The nature of general practice requires that GPs focus on understanding the health of the whole person whereas the MBS structure enforces a separation of mental health from other conditions.

Another theme that contributes to the disconnect is the constraints imposed by the limited number of consults for mental health item numbers per patient. This constraint leads some GPs to ration their use of some item numbers for a patient to preserve them for consultations the patient may have with other mental health practitioners.

Lastly, a perceived elevated risk to their practice of an audit and potential repayment for consults also weighs on the mind of GPs when considering which MBS item to use for mental health consults.

Inability to co-bill mental health and other clinical issues

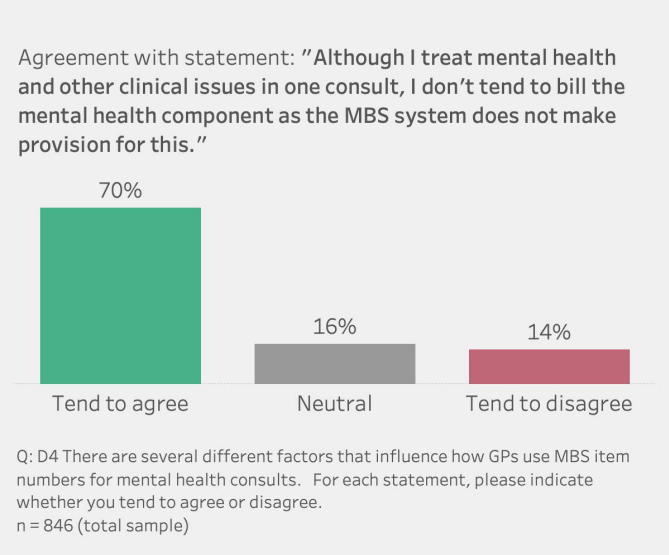
GPs estimate that, in a typical week, 1 in 4 consults address a mix of mental health and other clinical issues (see Figure 2). 70% of GPs agree that although they treat mental health and other clinical issues in one consult, they don't tend to bill the mental health component as the MBS structure does not allow for this.

In the qualitative interviews GPs expressed the opinion that having separate consults did not reflect the real world in which they practiced, where patients often needed both addressed and it was unrealistic, impractical and expensive for the patient to be asked to return for a second consult, as well as difficult to deliver given the high demand on the GP's time.

"Mental health isn't a pigeonhole. People don't present with a mental health issue or a physical health issue. Often, it's a combination of things. And that's what the government thinks – you can have a separate mental health consult and again that's taking up extra time as a general practitioner, it also takes up extra time for the patient and potentially extra money for the patient."

"Patients should not have their problems divided into mental health or not. GPs treat the whole person. The billing system should reflect this."

Figure 20. Dual consults and the impact on MBS billing of mental health



"The very fact that most mental health consults include non-mental health and the government PSR [Professional Services Review] frowns on co-billing is extremely disheartening."

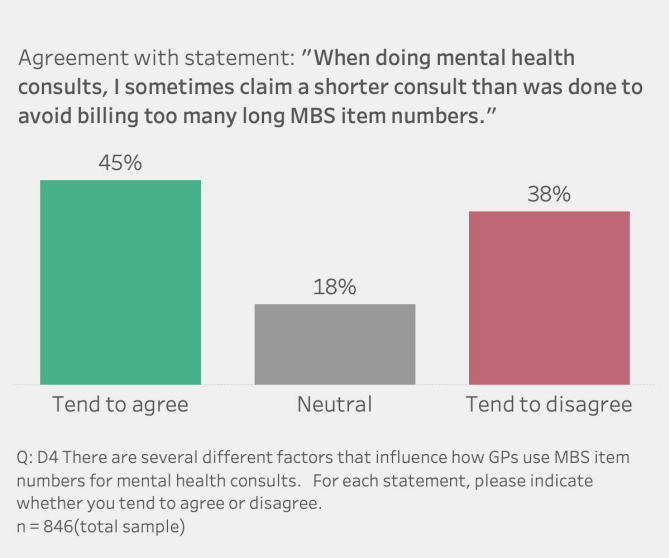
"It is unsatisfactory to not be able to bill mental health items and physical health items together unless in extenuating circumstances. It is not how people arrive and getting the documentation correct for billing both is a deterrent to billing appropriately for the work done."

Feeling pressured not to bill too many long consults

The vast majority of GPs (72%) agree that mental health consults usually take a long time, which creates other problems in their practice (see Figure 7). While the qualitative interviews suggested that the problems leading from the long consult are widespread, a recurring theme was that billing many long consults creates risk for the GP as it may make them a statistical outlier and trigger a Medicare audit.

A substantial proportion of GPs (45%) agree that when doing mental health consults, they will sometimes claim a shorter consult to avoid billing too many long item numbers. When taking into consideration that only 9% of GPs agree that they can earn a suitable financial return treating patients with mental health, feeling under pressure to bill shorter consults is likely to exacerbate this problem.

Figure 21. Concern with claiming too many long consults

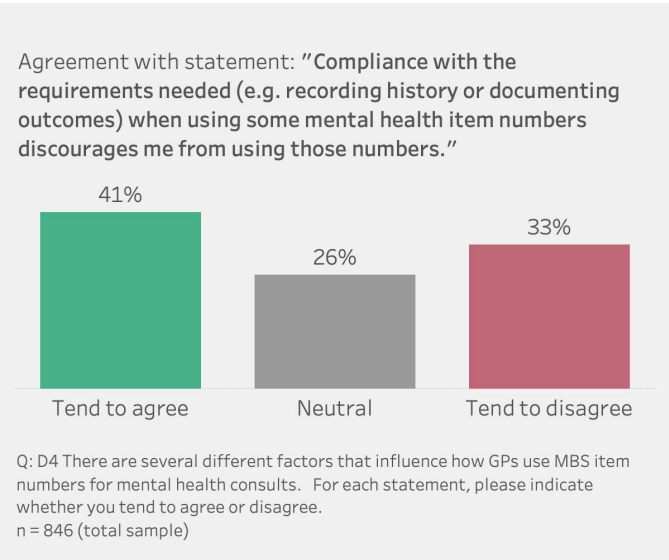


"Yet another long consult, yet another mental health consult, I'm sure I'm going to trigger off something terrible you know. 'Beware, your standard deviation's out of the door.' So there's that pressure, that pressure." [Respondent is referring to risk of being a statistical outlier on Medicare billing data.]

Administrative requirements deter GPs from using MBS item numbers

Most GPs (55%) agree that the administrative requirements for mental health consults are onerous (see Figure 8). A substantial proportion (41%) also say the need for compliance with requirements such as recording history or documenting outcomes when using some mental health items discourages them from using those numbers.

Figure 22. Compliance with requirements a deterrent for using mental health item numbers

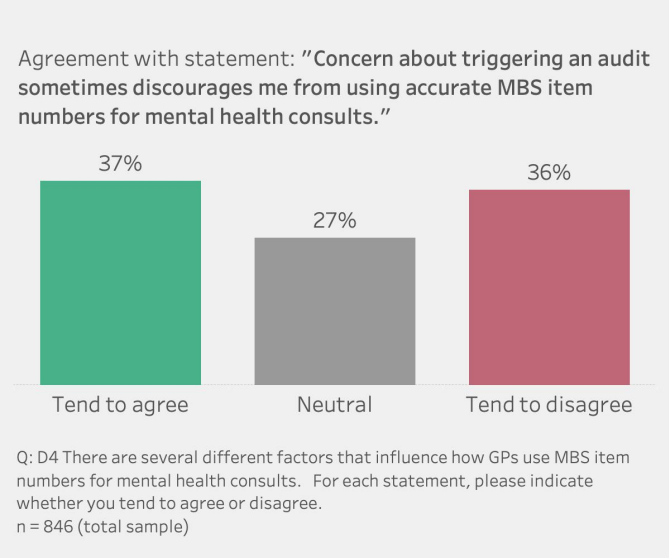


"If it is not written down it wasn't done' is a real issue when trying to audit-proof notes and Medicare item descriptors are pedantically analysed. Mental health is important, but my GP training is being required in other fields that the psychologists can't provide."

Concern regarding triggering an audit

When it comes to Medicare audits, 37% of GPs say their concern with triggering an audit sometimes discourages them from using accurate MBS item numbers for mental health consults. In the qualitative interviews GPs expressed the concern that the number of long consults billed, co-billing of mental health item numbers and failing to meet the administrative requirements increased the chance of triggering an audit. In addition, a number of GPs indicated they or peers had received a letter from the Department of Health that heightened their concern for being identified as a statistical outlier in the Medicare billing data. This concern was linked to triggering, rather than failing, an audit. Consequently, some GPs use the least risky (and potentially financially disadvantageous to the GP) approach to billing.

Figure 23. Concern regarding triggering audit



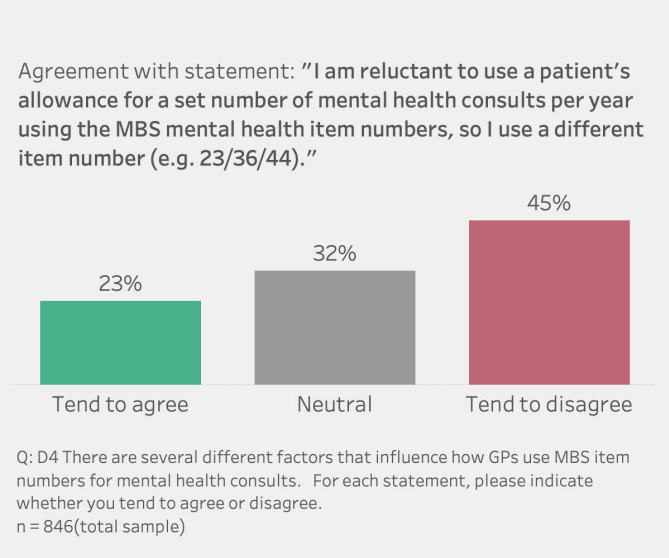
"The practice manager doesn't want to have an audit; they don't like to charge two item numbers like a 36 for ECG and a 2713 for the panic disorder so I just leave it as time based. I prefer to fly under the radar."

"And so, it's very clear on a graph, if you do a lot of long consultations, you would presumably show up on those graphs easily and I've actually heard of other GPs who were approached and audited because they did a lot of long consultations."

Avoiding using the annual patient allowance for MBS mental health item numbers

The GPMHSC survey has identified that a substantial proportion of GPs (23%) are reluctant to use a patient's allowance for mental health consults per year for MBS mental health item numbers, so they will bill consults using a different item number. This behaviour is even more pronounced among FPS skills trained GPs with 48% saying they choose to use different MBS items to preserve a patient's annual allowance for mental health consults.

Figure 24. Reluctance to use patient's item number allowance



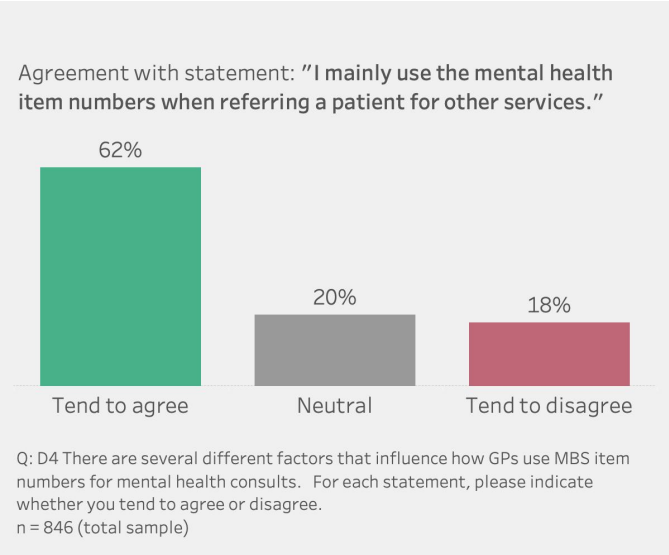
"Each item I use means one less for the patient with a psychologist."

"Unfortunately, I don't use the FPS items, although we deserve to because we are using the skill, but because we also send the patient to psychologists. If you use it, they cannot."

Use of MBS mental health item numbers for referrals

62% of GPs tend to agree that they mainly use the mental health MBS item numbers when referring a patient for other services.

Figure 25. Use of mental health item numbers when referring patients



"Mostly I'd be using a 23 or 36 because often it is a blend of things, and then if the appointment is needed as a Mental Health plan review to get a referral to a psychologist, I'd use the mental health item number."

"I use the MBS numbers when I'm intending to refer people to psychologists so that they can get a rebate, but otherwise tend to just use 23 and 36. It's just easier, I'm not certain what the actual differences are, the amounts are very similar."

Use of standard MBS item numbers for mental health

Approximately one in two GPs say they use the standard 23/36/44 item numbers for mental health consults because these items are more familiar to them and the process to do so is less complex. There is also some concern that there is a risk associated with using mental health item numbers (for example, being rejected because a patient has used their allocation for the period) and using the standard item numbers eliminates that risk.

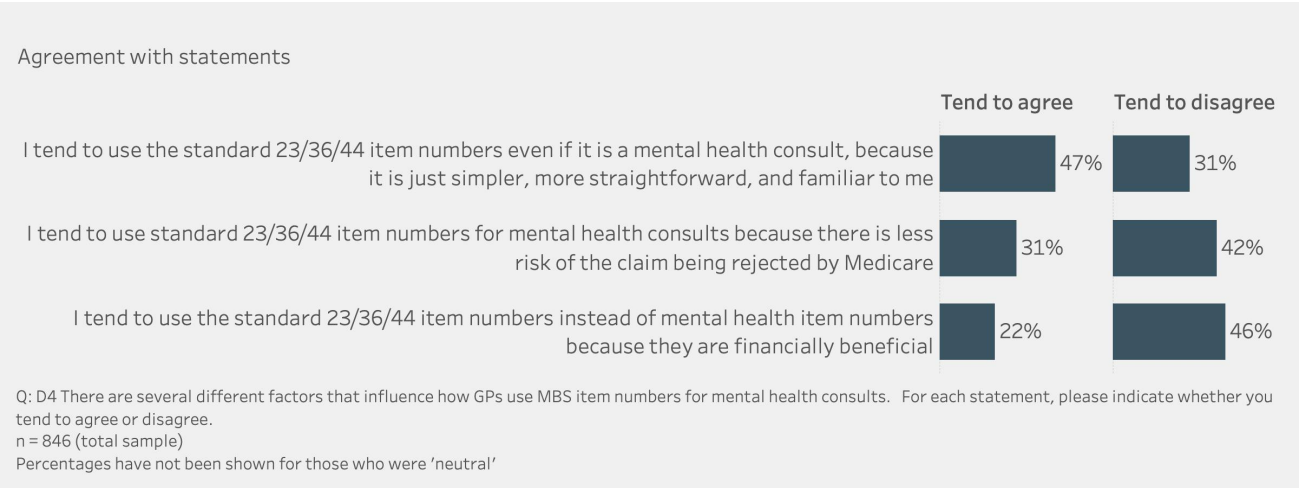
The qualitative interviews with GPs revealed many were frustrated with the fact that a mental health item number paid less than the equivalent length standard consult.

"I think it is appalling that seeing someone for a mental health consult for 30 minutes is now paid less than a 36."

"Why would you ever charge 2713 when item 36 has a higher rebate for the same time?"

In practice, 46% of GPs disagree that they use the standard items because they are financially beneficial and 22% agree that is the case.

Figure 26. Use of standard 23/36/44 items



Insights into the FPS Trained (Level 2) Cohort of GPs

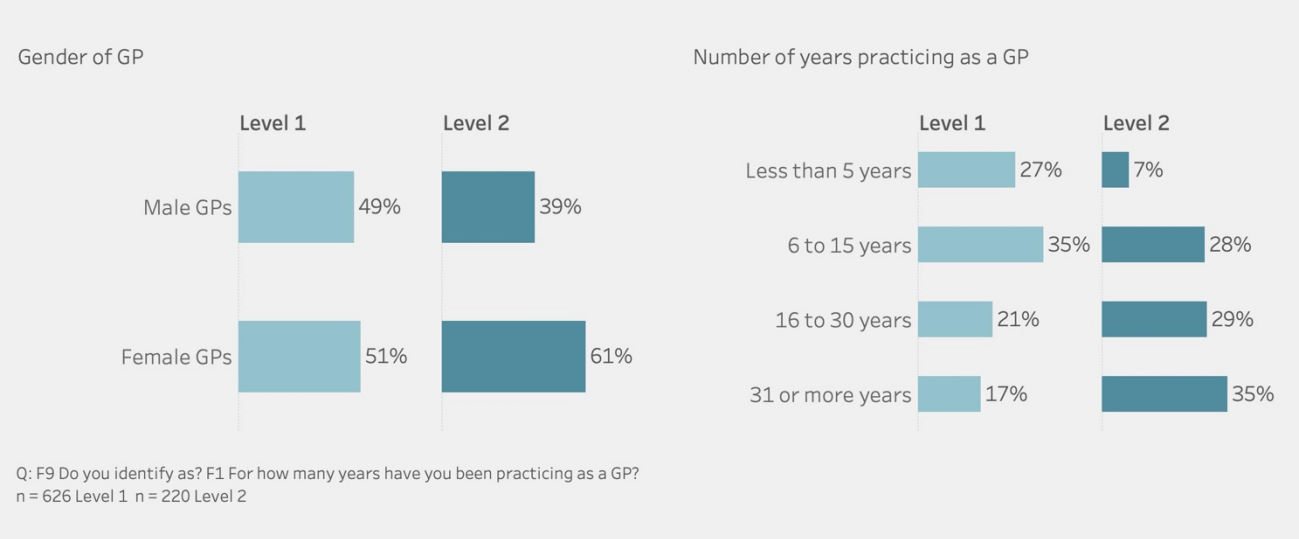
Profile of GPs Who Have Completed FPS Skills Training

The GPMHSC reports that approximately 1,440 GPs have completed the FPS skills training, and 1,300 of these are registered with Services Australia as FPS providers. The number of registered FPS providers account for approximately 3.5% of GPs in Australia.

The sample profile of the FPS skills (Level 2) trained GPs suggests that they have been practicing for a considerably longer time than others. More than a third of those who are Level 2 trained have practiced as a GP for more than 30 years, compared to only 17% of Level 1 trained GPs. The ageing profile of FPS trained GPs suggests there may be a need to reinvigorate training amongst a younger generation of GPs.

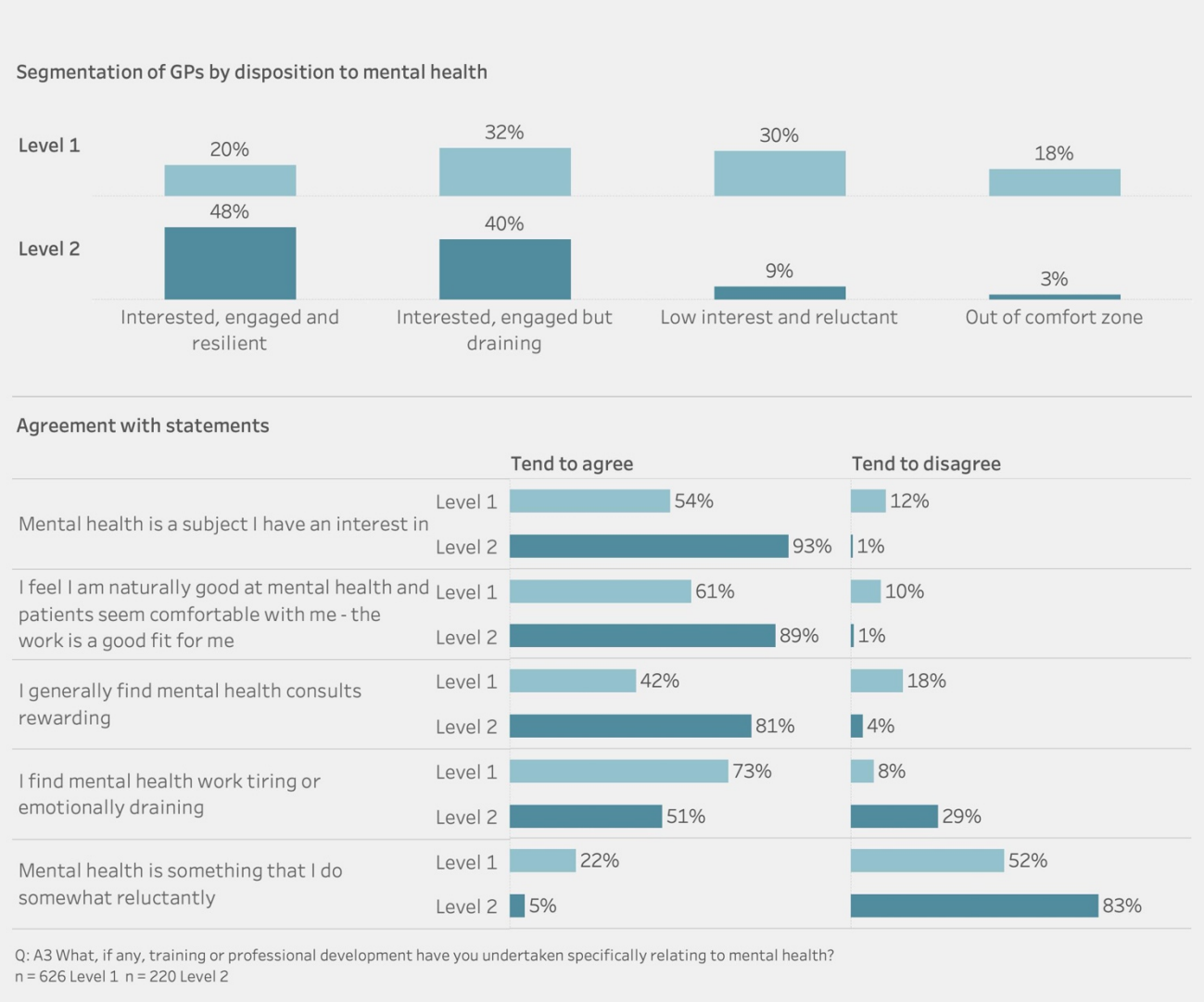
FPS trained GPs are significantly more likely to be female than male (statistically significant at 95% level of confidence).

Figure 27. Profile of GPs with Level 2 training



The profile of Level 2 trained GPs indicates they have a more positive disposition towards mental health, with almost 9 in 10 Level 2 trained GPs falling into the two 'Interested & Engaged' segments (see Figure 6 for further details on the segments). Among Level 2 trained GPs, 48% are classified as being part of the 'Interested, Engaged & Resilient' segment. In comparison, only 20% of Level 1 trained GPs are in this segment.

Figure 28. Disposition of GPs to mental health by level of training



The characteristics of the environment in which Level 2 trained GPs practice, compared with Level 1 trained GPs, is appended in Figure 55.

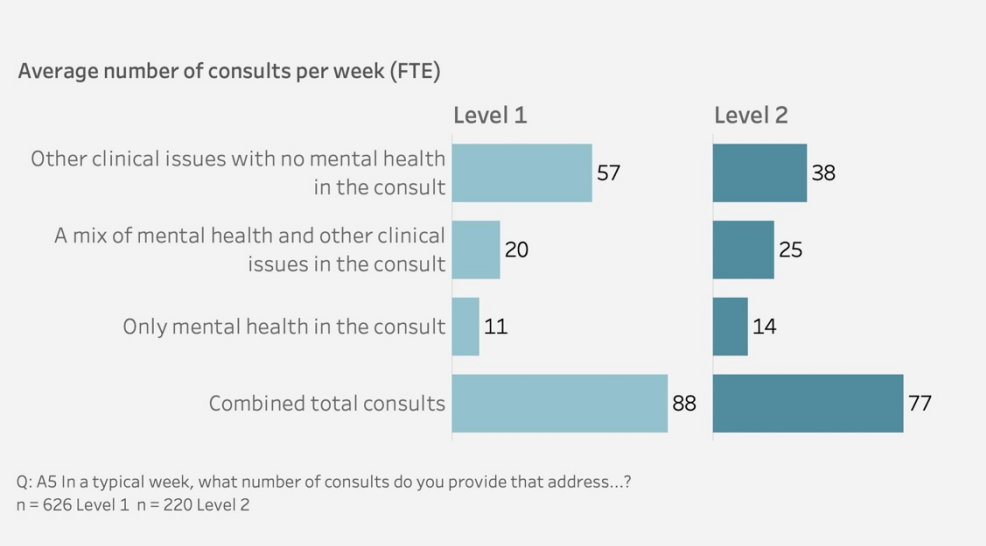
Quantum of Mental Health Consults amongst FPS Trained GPs

The figure below compares Level 1 and Level 2 trained GPs by the average number of consults undertaken in a typical week and the nature of the consult. To remove the influence of gender on these estimates (due to there being more females amongst Level 2 trained GPs, working fewer hours), the averages below are based on full time equivalent (FTE) hours. Level 2 GPs average 77 consults a week whereas Level 1 GPs average 88 consults a week.

Of the estimated 77 consults per week conducted by Level 2 trained GPs, 39 involve mental health, resulting in 51% of all consults conducted by Level 2 trained GPs involving a mental health condition. In comparison, Level 1 trained GPs average 31 consults involving mental health in a typical week, equating to 35% of all consults.

The lower number of consults amongst Level 2 trained GPs may reflect that mental health consults take longer than others, and a greater proportion of their work is made up of patients with mental health conditions.

Figure 29. Average number of consults per week by level of training



51% of the weekly consults of FPS trained GPs involve a component of mental health.

Application of FPS by GPs with Skills Training

Nearly all Level 2 trained GPs (96%) who completed the survey are registered with Medicare as FPS providers, with 4% indicating that they had been registered previously but allowed their registration to lapse. The reasons cited (by 5 respondents) for not renewing their registration included:

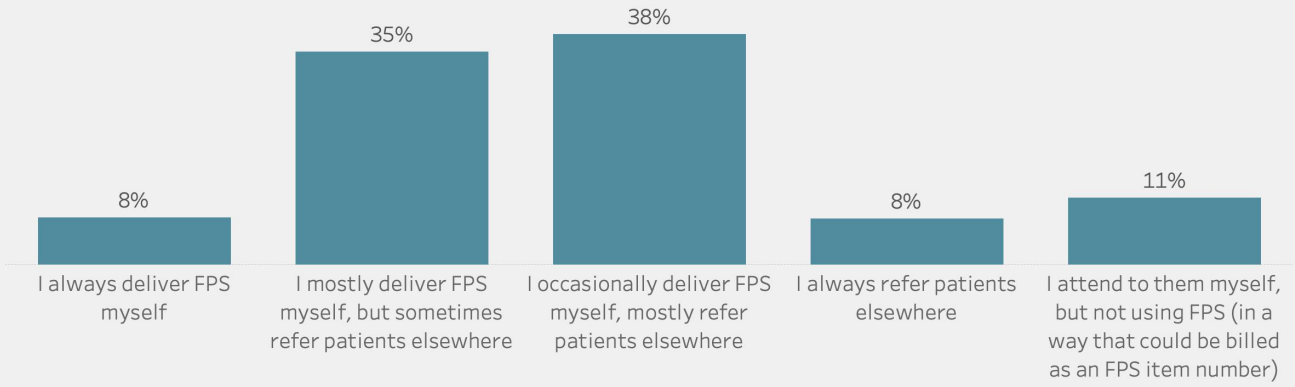
- Not using the item numbers so of no value to renew (for reasons such as taking away item numbers from the psychologist's allocation; difficult to fit in long consults because of the demands on their time as a GP; mental health is an intrinsic part of day-to-day practice and not separated out; not financially rewarding)
- Efforts to renew were difficult
- Cost and lack of readily available training

"Opportunities for CPD for those of us with FPS training are limited and repeated each triennium. I will be letting this qualification go this triennium if there is not a suitable training opportunity for me. It does not benefit me financially. I have done this training to improve the service that I can deliver to my patients especially as I am in a rural area where access to psychological services is limited."

In situations where FPS is considered appropriate, 43% of FPS registered GPs tend to deliver FPS themselves. Even among the 'Interested, Engaged & Resilient' GPs who are Level 2 trained, only 54% deliver FPS themselves.

Nearly half of Level 2 trained GPs (46%) tend to refer patients elsewhere. 11% attend to patients themselves, but not using FPS in a way that could be billed as an FPS consult.

Figure 30. Delivery of FPS in situations where FPS would be appropriate

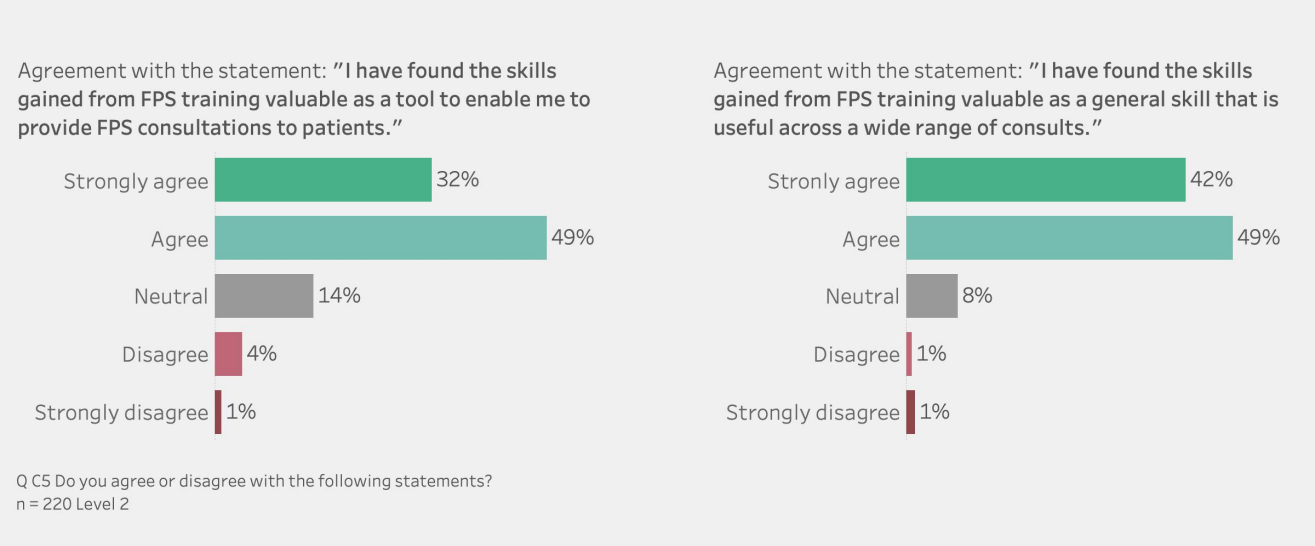


Q: C9 Which of the following best describes your approach in cases where Focussed Psychological Strategies is appropriate for a patient and could be billed as an MBS FPS item (2721 to 2731)?
n = 210 Level 2, registered FPS providers

The great majority of those who have completed FPS skills training agree they have found the skills gained from the training valuable, with very few (5%) disagreeing. Those who have undertaken the training say the skills gained are valued in allowing them to provide FPS consults, but even more positive about the benefit they have gained in being able to apply FPS skills across a wide range of consults.

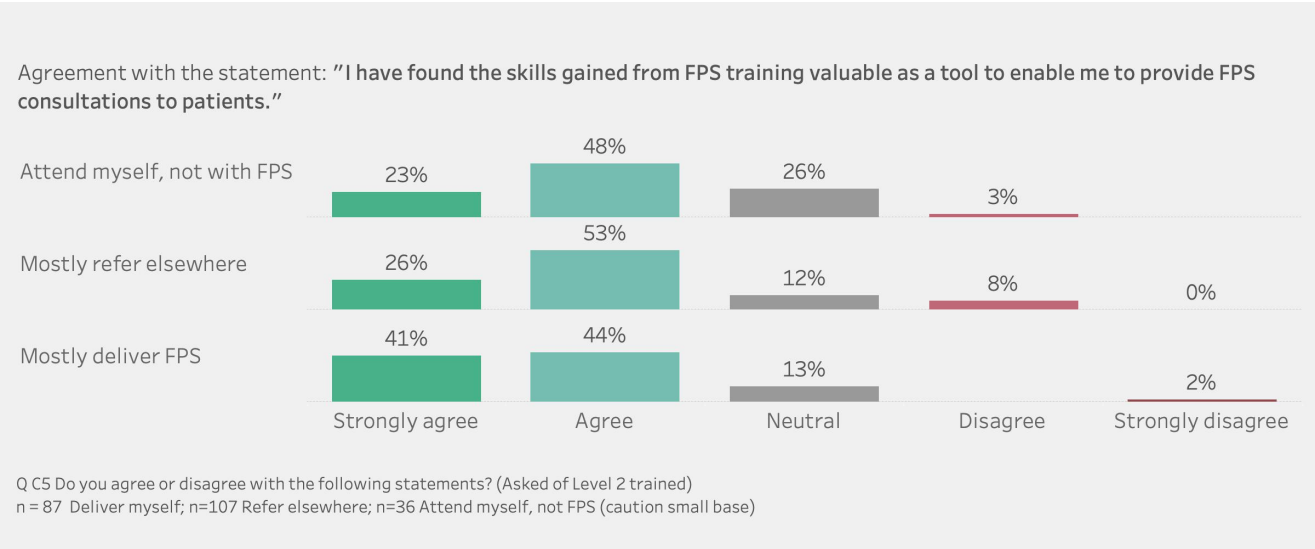
"So, I would use those skills every day. Informally. And I haven't ever used any of the billing numbers for the FPS consults but informally I use the skills from the FPS. And I try and help the registrar develop those skills too."

Figure 31. Perceived value of skills gained through FPS training



Regardless of whether GPs are delivering FPS themselves or referring patients elsewhere, the majority agree that the skills learnt in the training are valuable.

Figure 32. Perceived value of FPS training by GPs who deliver FPS vs refer patients



FPS registered GPs estimate, in a typical week, they attend to 16.4 consults where mental health is addressed as the only condition. When taking into account all consults that address a mental health condition, whether as the only condition or in combination with other conditions, the estimate is 41.7 per week.

Of the 16.4 stand-alone mental health consults, it is estimated that 6.4 would involve the use of FPS skills in a way that would qualify to be billed as an FPS MBS item number (irrespective of whether or not it was billed as one).

A higher number of mental health only consults (7.6) use the skills gained from FPS training, but not in a way that would qualify to be billed as an FPS item number.

Figure 33. Average number of mental health items in which FPS is applied (estimate) (FPS registered providers)

Average number of mental health consults in a typical week (estimated) among registered FPS providers in which FPS applied, **regardless of whether it was billed as an FPS item**

Consults that address mental health alone in the consult			All consults that address mental health, whether mental health only or in combination with other issue		
	Level 2	Level 2		Level 2	Level 2
MH Only - Consults using FPS to the extent that it would qualify to be billed as an FPS MBS item number	6.4	39%	Consults using FPS to the extent that it would qualify to be billed as an FPS MBS item number	11.8	28%
MH Only - Consults using skills gained from having done FPS training, but not in a way that would qualify to be billed as an FPS MBS item number	7.6	47%	Consults using skills gained from having done FPS training, but not in a way that would qualify to be billed as an FPS MBS item number	23.1	55%
MH Only - Consults not using FPS skills at all	2.3	14%	Consults not using FPS skills at all	6.8	16%
Total Mental Health ONLY consults per week	16.4	100%	All Mental Health consults per week	41.7	100%

Q: A5 In a typical week, what number of consults do you provide that...1) address only mental health in the consult 2) address a mix of mental health and other clinical issues in the consult?
Q: C7/8 You said that you do x consults in an average week. On average, what proportion of these consults do you... Note, please answer irrespective of whether you bill the consult as an FPS item number. The question refers specifically to whether you do work that would qualify for an FPS item number.
n=210 Level 2 trained and registerered as FPS provider

Use of MBS Item Numbers for FPS

For consults where mental health is the sole purpose of the consult, GPs who are registered as FPS providers estimate they conduct 6.4 consults in a typical week that would qualify to be billed as an FPS MBS item number. However, these same GPs estimate they only bill an average 2.5 consults per week as an MBS FPS item number (2721 to 2731). These estimates suggest only 39% of qualifying consults are billed as an FPS item number when mental health is the *only* matter addressed in the consult.

When considering all consults that address a mental health condition (whether as a stand-alone mental health consult or where other issues also addressed) FPS registered GPs estimate they conduct an average of 11.8 consults in a typical week that could qualify as an FPS MBS item number but only bill an average of 3.4 consults using an FPS item number (2721 to 2731).

Figure 34. Gap in estimated number of FPS consults and billing FPS item numbers (FPS registered providers)

	Consults that address mental health alone in the consult	All consults that address mental health, whether mental health only or in combination with other issue
Average number of mental health consults in a typical week (estimated) in which FPS applied, regardless of whether it was billed as an FPS item		
	MH Only - Consults using FPS to the extent that it would qualify to be billed as an FPS MBS item number: 6.4	Consults using FPS to the extent that it would qualify to be billed as an FPS MBS item number: 11.8
Average number of mental health consults in a typical week (estimated) allocated to each MBS item number		
	MH only - Item numbers for the provision of Focussed Psychological Strategies (2721 to 2731): 2.5	Item numbers for the provision of Focussed Psychological Strategies (2721 to 2731): 3.4

Q: A5 In a typical week, what number of consults do you provide that...1) address only mental health in the consult 2) address a mix of mental health and other clinical issues in the consult?
Q: C7/8 You said that you do x consults in an average week. On average, what proportion of these consults do you... Note, please answer irrespective of whether you bill the consult as an FPS item number. The question refers specifically to whether you do work that would qualify for an FPS item number.
Q: D2/3 Thinking abouit consults that address (INSERT), what proportion of these consults do you bill each of the following MBS items in a typical week?
n=210 Level 2 trained and registerered as FPS provider

As noted previously, 48% of FPS trained GPs agree they are reluctant to use a patient's allowance for a set number of mental health consults per year using the MBS mental health item numbers, so they use a different item number.

"I don't use FPS numbers at all because most of my patients are very complex and have others involved in their care e.g. psychologists or OTs and if I use the numbers it detracts from their sessions with psychologists. I use these numbers sometimes in the last quarter of the year when I think the patient is not going to engage with anyone else."

Providing FPS Treatment

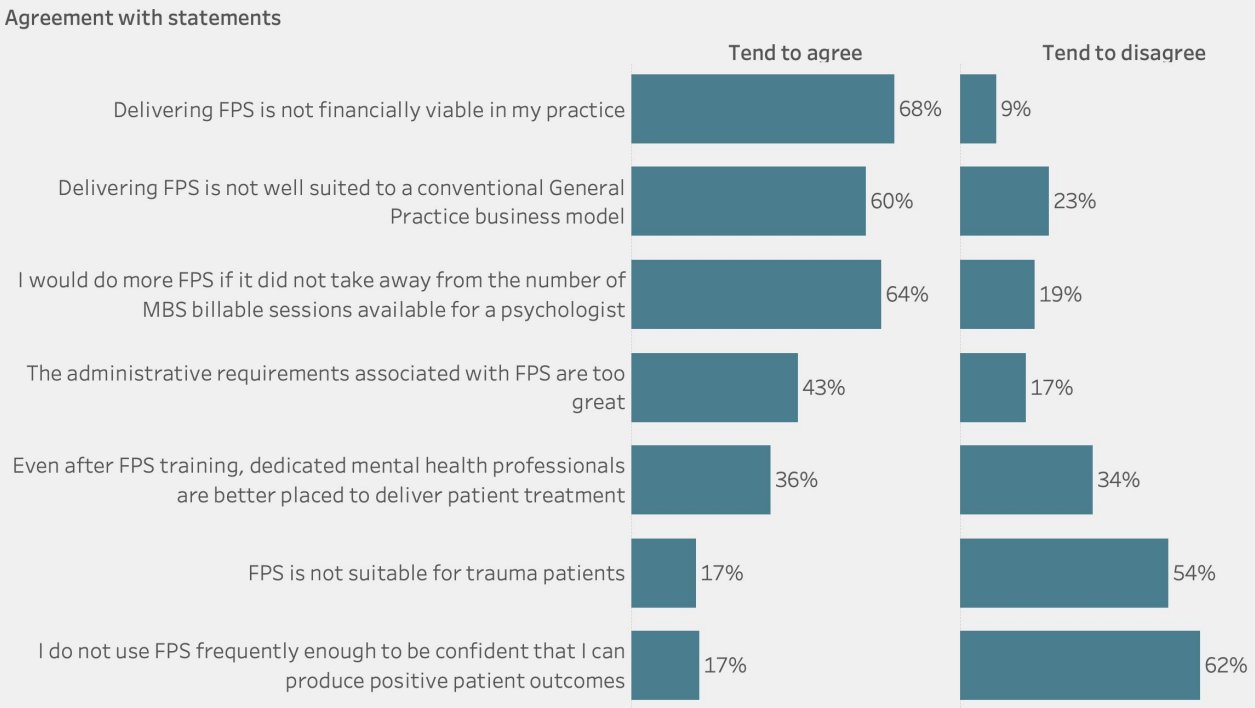
Delivering FPS treatment is perceived by FPS trained GPs to be subject to many of the same challenges associated with delivering mental health services broadly. 68% of FPS trained GPs believe delivering FPS is not financially viable in their practice, despite having access to additional MBS item numbers for the provision of FPS treatment. It was noted earlier that only 9% of GPs see a viable financial return on their time treating patients with mental health conditions and this is not unique to FPS.

60% say that providing FPS treatment is not well suited to a conventional General Practice business model.

The limit on the annual allocation of claims a patient can make is an additional deterrent to GPs doing FPS, with 64% tending to agree that they would do more if it did not take away from the number of billable sessions available for a psychologist.

More than one third (36%) of FPS trained GPs agree that dedicated mental health professionals are better placed to deliver patient treatment. Fewer than 20% say that they do not use it often enough to be confident that they can produce positive patient outcomes.

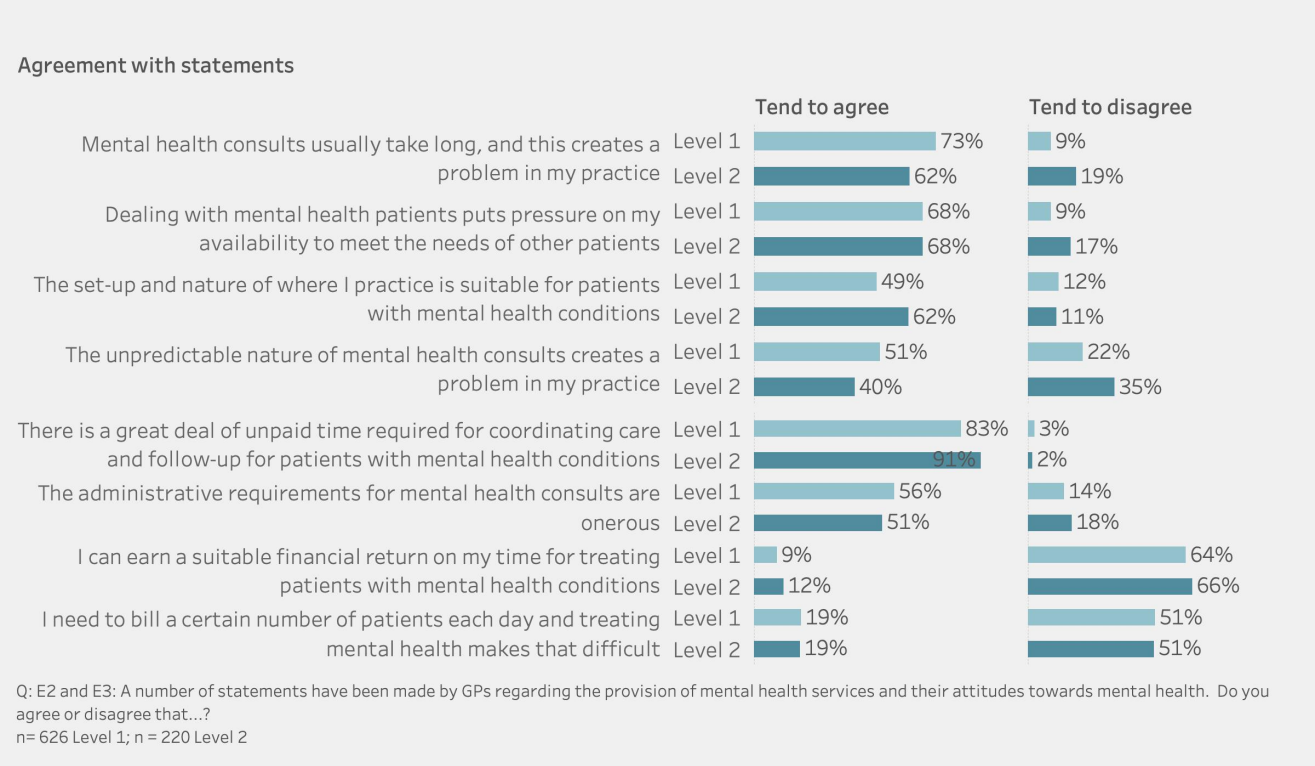
Figure 35. Perceptions of FPS amongst GPs with FPS skills training



Q: C10 To what extent do you agree or disagree with each of these statements?
n = 220 Level 2
Percentages have not been shown for those who were 'neutral'

Further training does not resolve the challenges experienced by GPs with delivering mental health support in their practice. Level 1 and Level 2 trained GPs both report challenges in delivering mental health, but the fact that some GPs who are Level 2 trained have developed their practice around mental health means that they have tailored their environment and are slightly less likely to be impacted by the unpredictable nature and long consults, and more likely to agree that the set up and nature of their practice is suitable for mental health.

Figure 36. Experience with mental health in practice by level of training

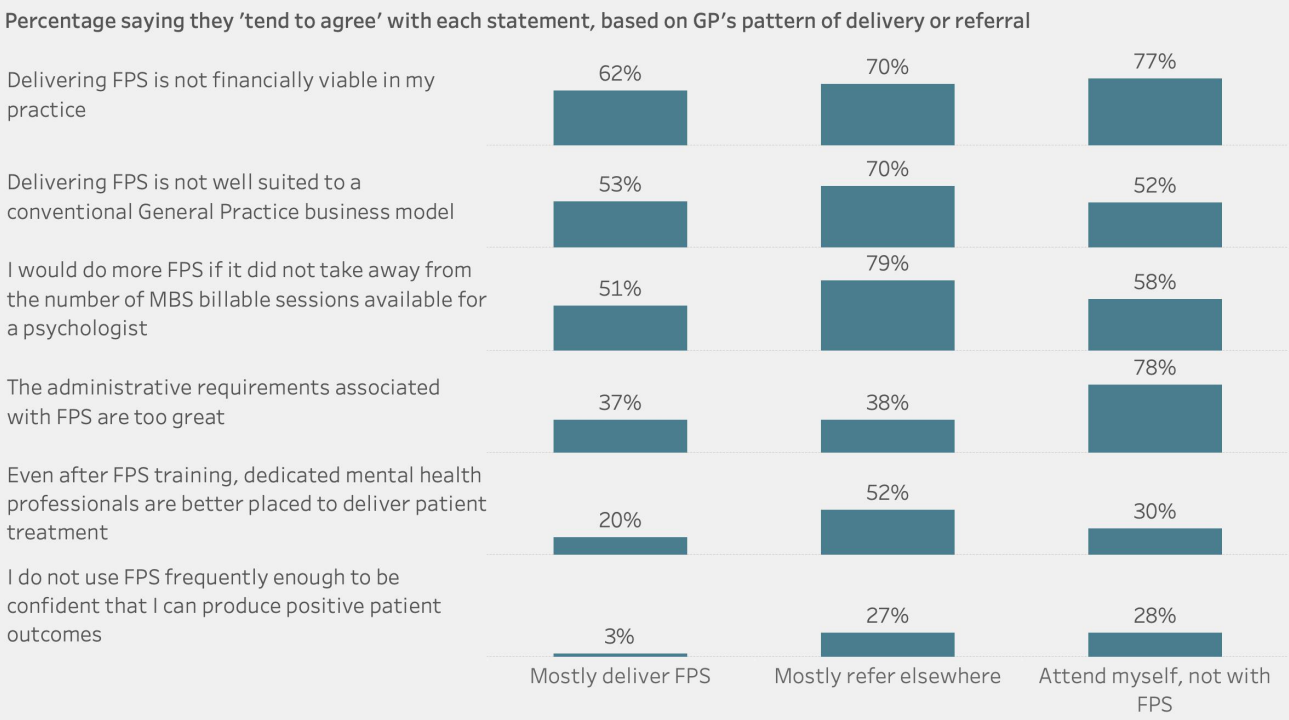


Q: E2 and E3: A number of statements have been made by GPs regarding the provision of mental health services and their attitudes towards mental health. Do you agree or disagree that...?
n= 626 Level 1; n = 220 Level 2

Figure 37 shows how attitudes to FPS differ by the role the GP tends to play in providing FPS treatment.

Financial viability is an issue raised by all FPS trained sub-groups. However, statistically significant differences exist between Level 2 trained GPs who mostly deliver FPS versus those who refer patients elsewhere on the attributes 'Delivering FPS is not well suited to a conventional GP business model'; 'I would do more if it did not take away from MBS billable sessions available for a psychologist'; 'Even after FPS training dedicated mental health professionals are better placed to deliver treatment'; and 'I do not use FPS frequently enough to be confident that I can produce positive patient outcomes'.

Figure 37. Attitudes to FPS by extent to which GPs deliver or refer patients for FPS



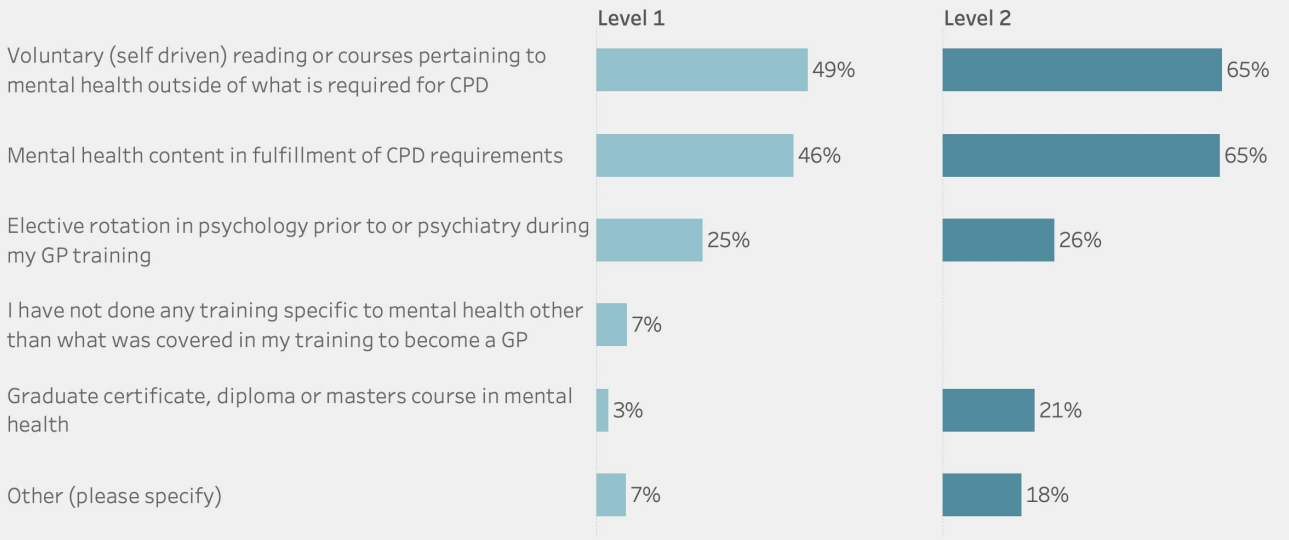
Q: C10 To what extent do you agree or disagree with each of these statements?
n = 87 Mostly deliver FPS; n=107 Mostly refer elsewhere; n=36 Attend myself, not with FPS (caution small base)
Percentages show the proportion who agree with each statement, based on whether they deliver or refer FPS

Disposition Toward Further Training in Mental Health

Disposition Toward Training in Mental Health

The chart below reflects the mental health skills development undertaken by GPs, in addition to the Level 1 and FPS (Level 2) skills training. It was noted previously that GPs who have undertaken FPS skills training are typically more interested in the subject matter. This may explain why more of these GPs have taken steps to upskill in mental health. More than 1 in 5 Level 2 trained GPs have a graduate certificate, diploma or masters degree in mental health.

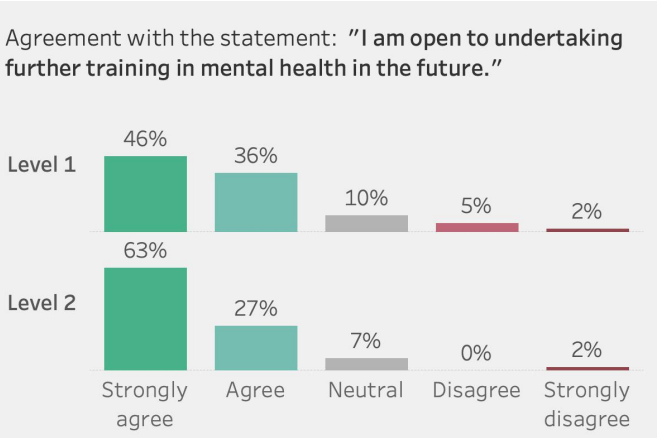
Figure 38. Training undertaken in addition to Level 1 skills training and FPS (Level 2) skills training



Q: A3 What, if any, training or professional development have you undertaken specifically relating to mental health?
n = 626 Level 1 n = 220 Level 2

The great majority of GPs indicate that they are open to undertaking further training in mental health, but list substantial barriers making this unlikely to translate into action.

Figure 39. Disposition to undertaking further training in mental health in the future



Q: A7 Do you agree or disagree with the following statement?
I am open to undertaking further training in mental health in the future
n = 626 Level 1 n = 220 Level 2

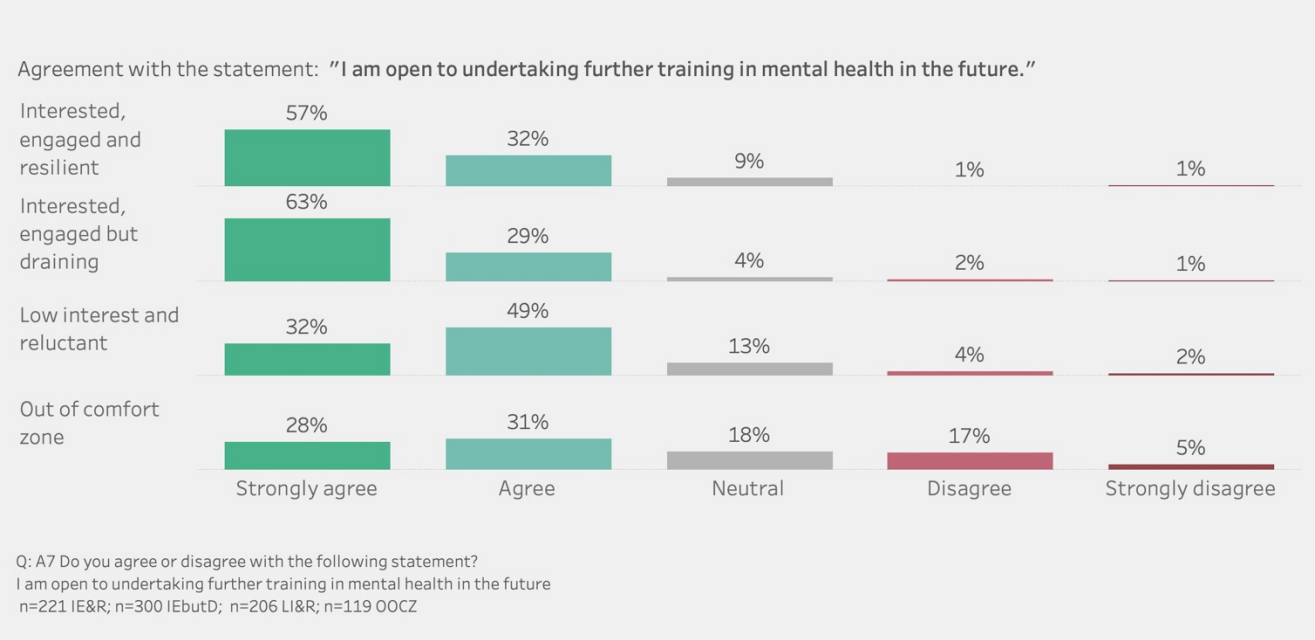
Many GPs indicate that they are open to undertaking further training in mental health in the future, but list substantial barriers making this unlikely to translate into action.

"There should be adequate facilities for regular mental health skills up-skilling for GPs. It is becoming very hard for patients to access psychologists and psychiatrists in a timely and affordable manner. GPs are bearing the brunt of this problem as most mental health providers have taken up private billing and we GPs, who do not have a high level of mental health skills, are the only ones left continuing to provide bulk billing services and hence patients rely on us to fix their mental health issues. Given this dire situation, GPs need up-skilling and there should be good improvement in the MBS rates so that it is financially viable and rewarding for us to deliver care to these unfortunate patients who are mostly from the lower socio-economic strata associated with other complex multiple health and social issues."

"The fundamental problem is that for every gap in healthcare, it seems that "educating GPs" is seen as the answer. It's not. We need a mental health care system that actually has capacity to see patients. It is so critical now, that unless someone is actively trying to kill themselves in front of the crisis team, they're told to "use the CALM app" and "follow up with your GP". It is so demoralising trying to help patients with mental health needs in our society."

Those GPs who are interested and engaged in mental health are most open to further training. It will be most difficult to convince those in the 'Out of Comfort Zone' segment of GPs to undertake further training.

Figure 40. Open to training by disposition to mental health (GP segmentation)



Predictably, interest in training is highest amongst GPs in their early career, with 54% of those who have been in practice for less than 5 years saying they strongly agree that they are open to further training. In comparison only 39% of those in their late careers strongly agree they are open to further training in mental health.

Where GPs are located is not a strong determinant of interest in training, interest levels are similar across MMM categories and the relative social disadvantage index for the area.

Barriers and Motivations for Further Training

As noted earlier, 63% of GPs disagree that they earn a suitable financial return on their time when treating mental health and this has a negative impact on their motivation to undertake further training in mental health. 65% of Level 1 trained GPs and 70% of Level 2 trained GPs claim they would be motivated to undertake further training if the mental health item numbers were more rewarding financially. Approximately 40% GPs say the fact that mental health is not financially beneficial reduces the likelihood of them undertaking further training.

In this time poor profession, the lack of time to undertake the training is cited most frequently as a factor undermining the likelihood of undertaking further training with 62% of Level 1 and 45% of Level 2 mentioning this. Similarly, over 55% of GPs mention that they would be motivated to undertake further training if an opportunity came up that was easy to access.

From the qualitative interviews it suggests that some GPs expect further training to lead to greater volumes of mental health work in their patient mix. Given the experiences and perceptions of GPs of mental health as particularly demanding, emotionally draining work, with a paucity of support services, long consults and concern about the economic viability, it is unsurprising some GPs are disinclined to take on more mental health work than they currently do.

"Mental health treatment is burdensome, there is a lot of transference, and it increases my emotional load and rate of burnout. I like the idea of being able to deliver basic mental health care but have little interest in developing further mental health skills unless the financial reward allowed me to take further time off work to deal with the increased practice burden."

"I have a very busy workload as it is. I'm booked out for over four weeks. To increase my skills in this area would increase my workload and patient bookings. I already address mental health in almost all consultations and don't have the time to go through more in a consult."

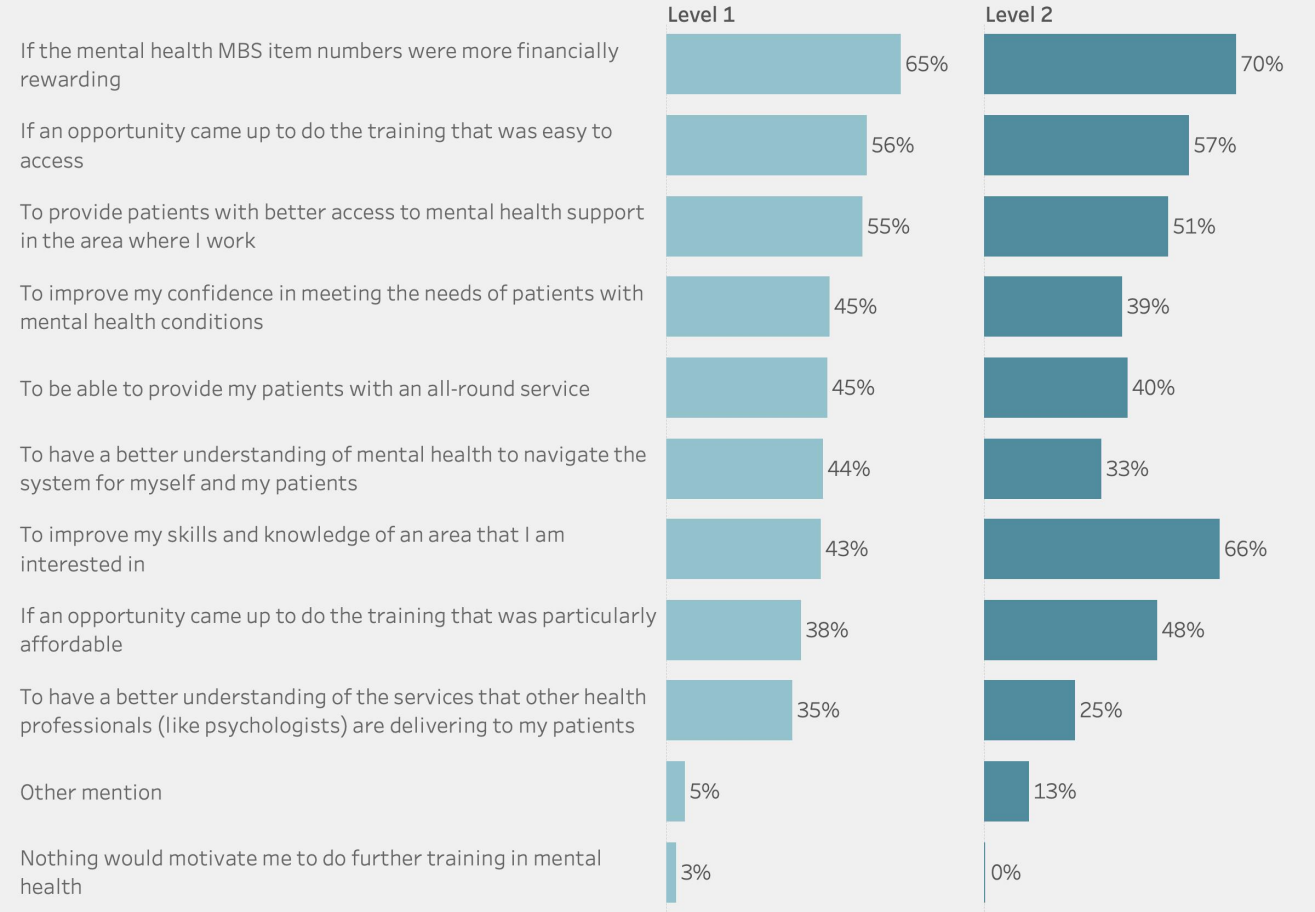
"I do not want to increase the amount of mental health work I am already doing in a week. The work is emotionally draining and I would likely burn out if I took on more."

"Time, or lack of it. Those item numbers require you to spend a long time with the patient, and we are overwhelmed. Also, I can see 3-4 patients in that time and bill more item numbers and bill more overall as those items don't pay that well for the time and emotional energy required."

"Until mental health consults attract at least double their current rate I will not be doing any further training with MH as it is not financially viable, time consuming and lack of availability to see other patients will lead me to lose patients."

"The current system does not reward the time required to properly deal with mental health issues. There is already a large burden of care on GPs without adding hour long CBT sessions into the mix. There is not enough time available in the day to deliver this kind of therapy for most clinicians. It is not realistic to expect that we all complete 20 hrs or more of extra training to be able to deliver further services if we do not have a special interest in the area. Putting the burden on GPs to make up for the shortage of psychological services may only lead to increased burn-out in the profession."

Figure 41. Factors that would motivate further training in mental health



Q: A9 What, if anything, would motivate you to undertake further mental health training?
n = 626 Level 1 n = 220 Level 2

GPs are motivated to undertake further training to improve outcomes for their patients, provide better access to mental health services (55% of Level 1 GPs mentioned this as a motivation), improve their own confidence in meeting patient needs, provide patients with an all-round service and help to navigate the system.

"Yes, I think that further training will be helpful. Sometimes, particularly patients who have had traumatic issues, they might not want to have to see you, and then get referred to see a psychologist, and then have to relive all that trauma and so I can perhaps have better skills that I might be able to provide a higher level of care than I do, but it's, it's a time thing." (Referring to lack of time to undertake training.)

"I wouldn't want to do CBT for an hour with my patient, but it would be useful to help me understand."

"I'm working in rural places, so my patients, whenever I'm trying to refer to a psychologist, they're facing difficulties because of the long waiting time. So, as their GP, if I can deliver this type of treatment to them, I think both will be very happy."

The cost of undertaking further mental health training is a disincentive for just under half of Level 1 and Level 2 trained GPs. Ease of access is also a barrier for some and over 50% said they would be motivated to do further training if an easily accessible option presented itself.

In the qualitative interviews some GPs mentioned access to online training would be advantageous, whilst others indicated they value hands-on and face-to-face training in mental health that creates the opportunity to practice the skills. It may be the case that the experience of GPs with telehealth during the COVID pandemic will help to bridge the perceived gap between online and in person training.

"I want it structured in a practical way. Don't want a lot of theory about how we do things, I want them to show me."

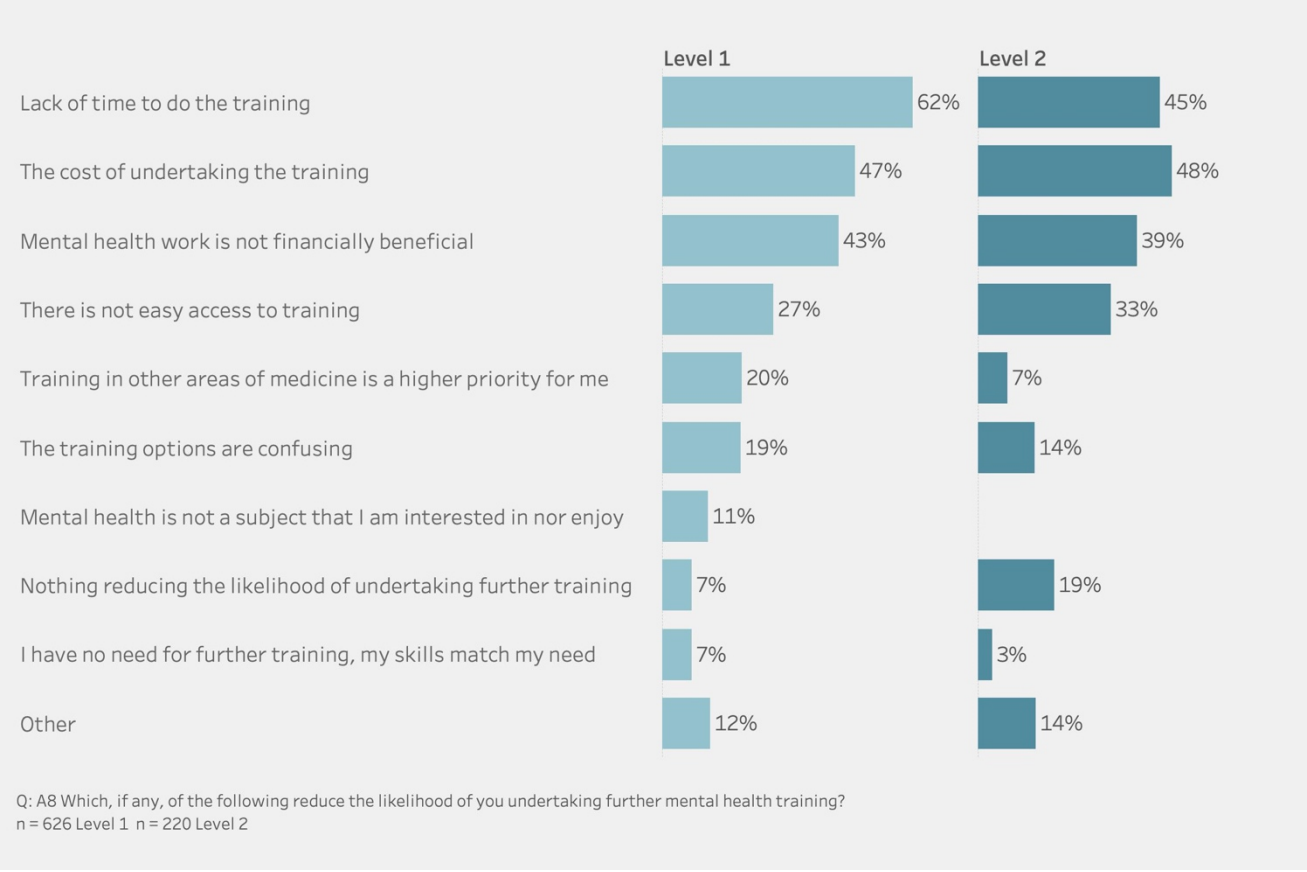
"And that safe space to practice it. So, you know, the nice thing with that was that it was small groups and so we did practice on each other, so it wasn't the first time, when you tried to talk a patient through relaxation exercise you'd already done that before. Actually having the logbook which said we had to go and try it on someone. "

In the qualitative interviews amongst GPs who had completed the FPS skills training, it was evident that for some GPs the decision pathway to doing the training was opportunistic, providing training that was readily accessible and affordable. This demonstrates the advantage of removing the access (including cost) barriers.

"... and also it was accessible at that time, it was through the PHN, and it was funded to do a course to sort of get some CBT skills etc. on board and that was a helpful weekend as I recall."

"I think, was just a random email that said we're doing a pilot program – do you want to do it."

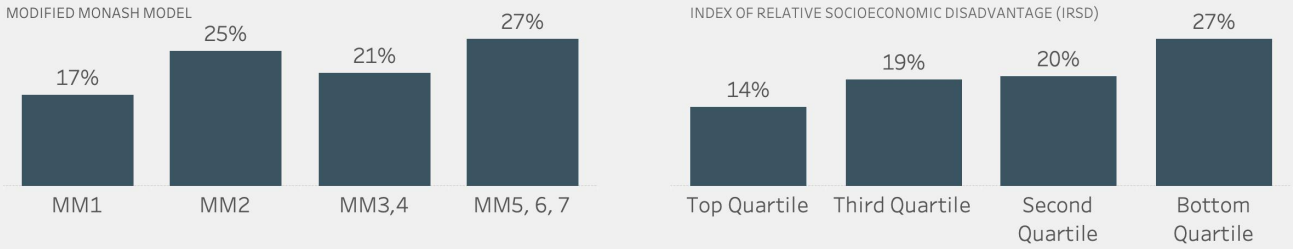
Figure 42. Factors undermining likelihood of undertaking further training in mental health



One in five Level 1 GPs indicate that training in other areas of medicine is a higher priority for them as a factor undermining the likelihood of undertaking further training in mental health. This is more of an issue for GPs working in postcodes that are most socioeconomically disadvantaged and in MM5, 6 & 7, the rural and remote areas.

Figure 43. GPs saying that training in other areas is a higher priority by MMM and IRSD

% who indicated that 'Training in other areas of medicine is a higher priority for me' as a factor reducing the likelihood of undertaking further mental health training.



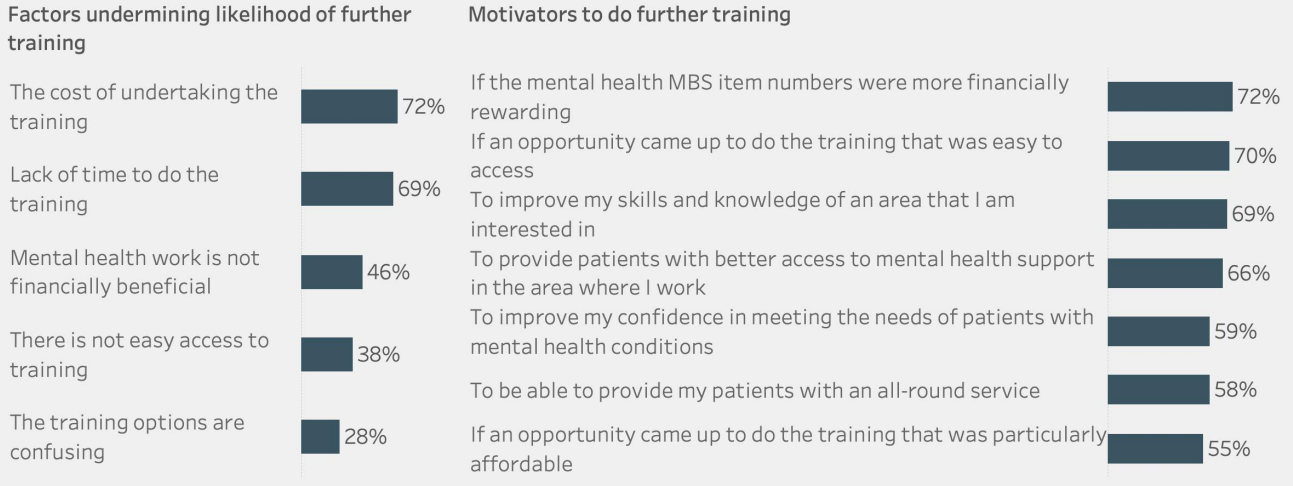
GPs in the top quartile on the Index of Relative Socioeconomic Disadvantage are practicing in the least disadvantaged postcodes, the bottom quartile is GPs practising in the most disadvantaged postcodes.

Q: A8 Which, if any, of the following reduce the likelihood of you undertaking further mental health training? Response to 'Training in other areas of medicine is a higher priority for me.'
n = 443 MM1; 144 MM2; 88 MM3, 4; 168 MM5, 6, 7; 218 bottom quartile; 225 2nd quartile; 203 3rd quartile; 200 top quartile

Offering cost effective, easily accessible, and easy to understand training is critical. This is highlighted by the finding that even amongst those most open to mental health training *and* positively disposed to mental health work, cost and time are the most frequently mentioned barriers to training. If these barriers can be addressed, along with improving the return on time for mental health consults, the positive disposition toward further training may lead to behaviour change.

Figure 44. Barriers and motivators amongst those most readily available to further training

Most frequently mentioned barriers and motivators of GPs who are most positively orientated to do further training: 'strongly agree' that they are open to further training and not in the 'Low Interest and Reluctant' or 'Out of Comfort Zone' segments.



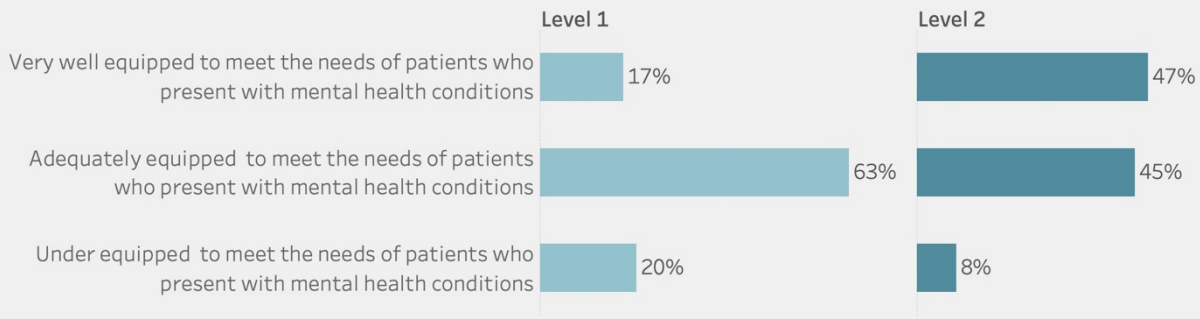
Q: A8 What, if anything, is reducing the likelihood of you undertaking further mental health training?
A9 What, if anything, would motivate you to undertake further mental health training?
n = 331 (strongly agree open to training & in one of the 'Interested and Engaged' segments)

Experience with and Proficiency in Mental Health

80% of Level 1 trained GPs and more than 90% of Level 2 trained GPs feel equipped to meet the needs of patients who present with mental health conditions. This finding suggests a lack of confidence or feelings of inadequacy will not be strong motivators for GPs to undertake further training in mental health.

Only 20% of Level 1 GPs feel under-equipped to meet the needs of patients who present with mental health conditions. This reduces to 8% among those with FPS skills training. The 'under-equipped' group are no more likely to be open to further training in mental health than the 'very well equipped' group.

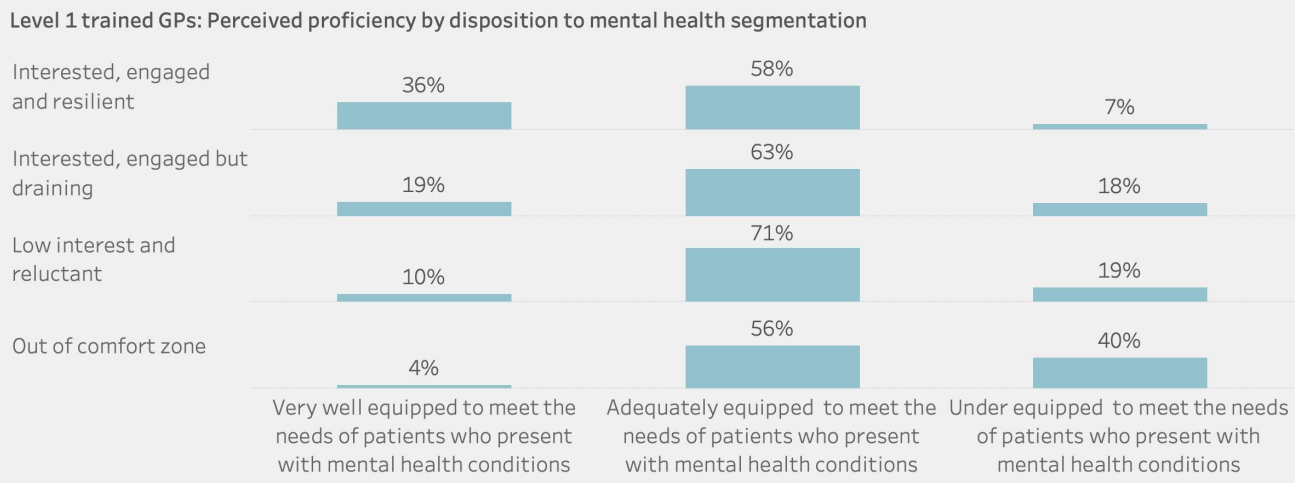
Figure 45. How well equipped GPs believe they are to meet the needs of patients who present with mental health conditions



Q: A6 How well equipped do you believe you are to meet the needs of patients who present with mental health conditions?
n = 626 Level 1 n = 220 Level 2

Feelings of being under-equipped to meet the needs of patients who present with mental health conditions is most prominent amongst those who are in the 'Out of Comfort Zone' category, with 40% of this group saying they are under equipped. Addressing this perceived gap in capability will be difficult to achieve through training as this cohort has the least interest in further training in mental health.

Figure 46. How well equipped GPs believe they are to meet needs of patients by disposition to mental health



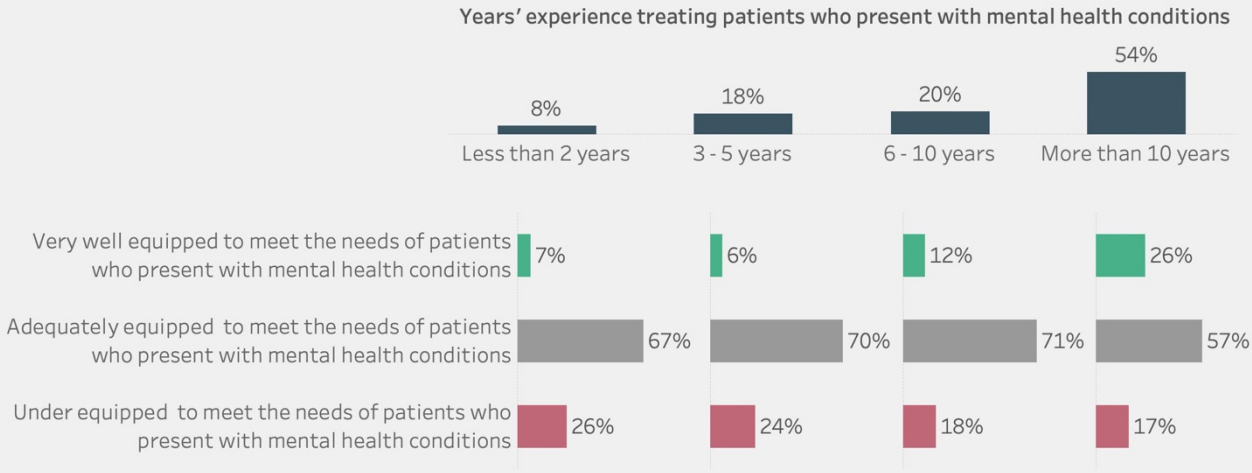
Q: A6 How well equipped do you believe you are to meet the needs of patients who present with mental health conditions?
Sample is Level 1 GPs. IE&R n=122; IE&D n=206; IE&R n=184; OOCZ n=112
How to read this chart: 36% of GPS who are in the Interested, Engaged & Resilient segment feel very well equipped to meet the needs of patients, 58% feel adequately equipped and 7% feel poorly equipped.

"I don't think we feel like we're unskilled in it. Mental health issues are really just one aspect of everything else GPs in primary care have to deal with. But it's very time consuming."

"To be honest I feel quite underprepared for this, I feel that I don't have enough skills or ways to help the patient, although I really want to help them. And I feel that it can be quite stressful, especially if half your days are mental health days. Every patient has a lot of problems with their mental health. Yeah, it can get quite difficult for the GP, I think."

More than half of all GPs have 10+ years' experience treating patients who present with mental health conditions. Amongst the least experienced GPs, a quarter believe they are under equipped to meet the needs of patients who present with mental health conditions.

Figure 47. Number of years' experience treating patients who present with mental health conditions

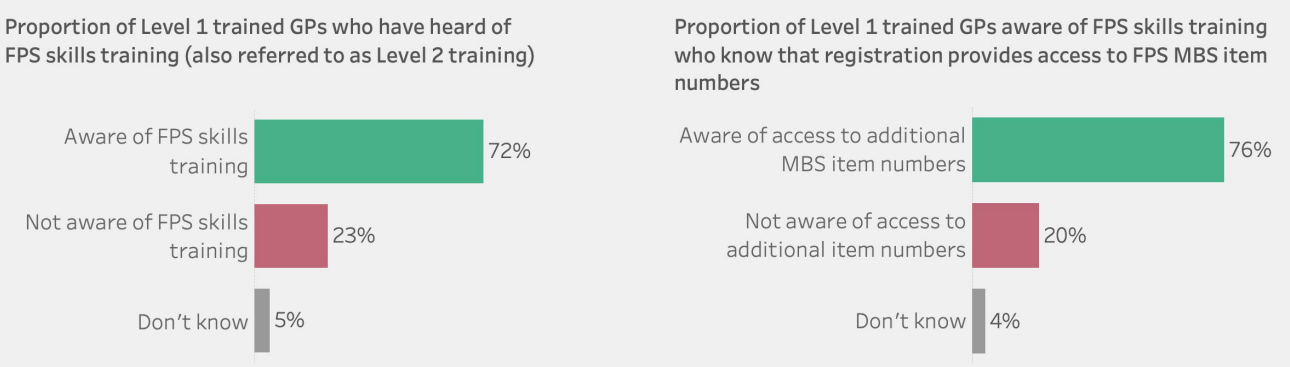


Q: A6 How well equipped do you believe you are to meet the needs of patients who present with mental health conditions?
n = 51 <2 years; 140 3-5 years; 170 6-10 years; 493 10+ years
How to read this chart: 26% of GPs who have treated mental health for less than 2 years feel under equipped to meet the needs of patients.

Awareness of and Disposition towards FPS Skills Training

GPs who had not completed the Level 2 skills training were asked if they were aware of FPS skills training (or Level 2 training). 72% are aware, and of those, 76% were aware that it provided access to additional MBS item numbers. While awareness levels are high when prompted, in the qualitative interviews it was found that FPS skills training is not highly salient, and GPs often needed to be reminded what it is.

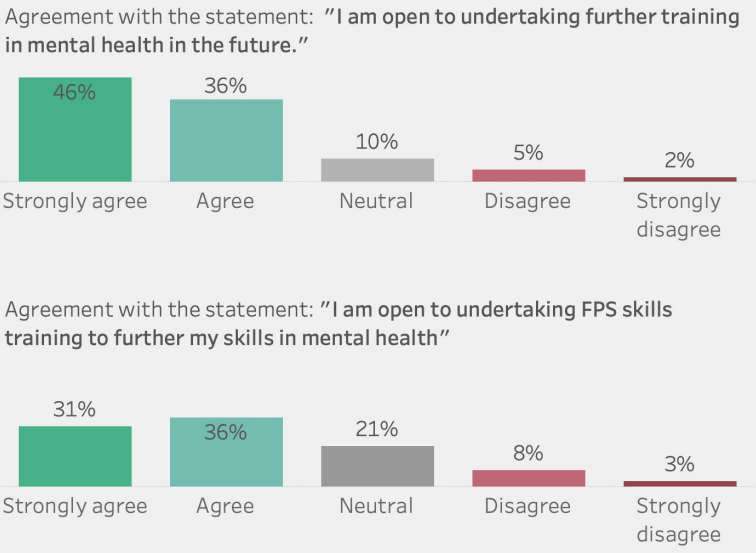
Figure 48. Awareness of FPS skills training and associated item numbers amongst Level 1 trained GPs



Q: B1 Have you ever heard of Focussed Psychological Strategies (FPS) skills training, sometimes referred to as Level 2 training? n=626 Level 1
Q: B2 (If they are aware of FPS skills training) Are you aware that completing Focussed Psychological Strategies (FPS) skills training and registering as an FPS provider enables GPs to bill additional MBS item numbers, specifically 2721 to 2731?
n=466 Level 1 aware of FPS

GPs were asked to read the description below and asked how open they were to undertaking FPS skills training. 66% of Level 1 GPs were open to it, but this is significantly lower than the 82% who claimed they were open to doing further mental health training in general.

Figure 49. Disposition to undertake FPS skill training (after reading description)



Q: A7 Do you agree or disagree with the following statement?
Q: B3 Now that you have read this description of FPS training, do you agree or disagree with the following statement?
n = 626 Level 1

DESCRIPTION OF FPS INCLUDED IN SURVEY

Focussed Psychological Strategies (FPS) refer to specific mental health treatment strategies derived from evidence-based therapies, such as cognitive behavioural therapy, interpersonal therapy, and relaxation strategies.

Accredited FPS skills training is a minimum of 20 hours of training.

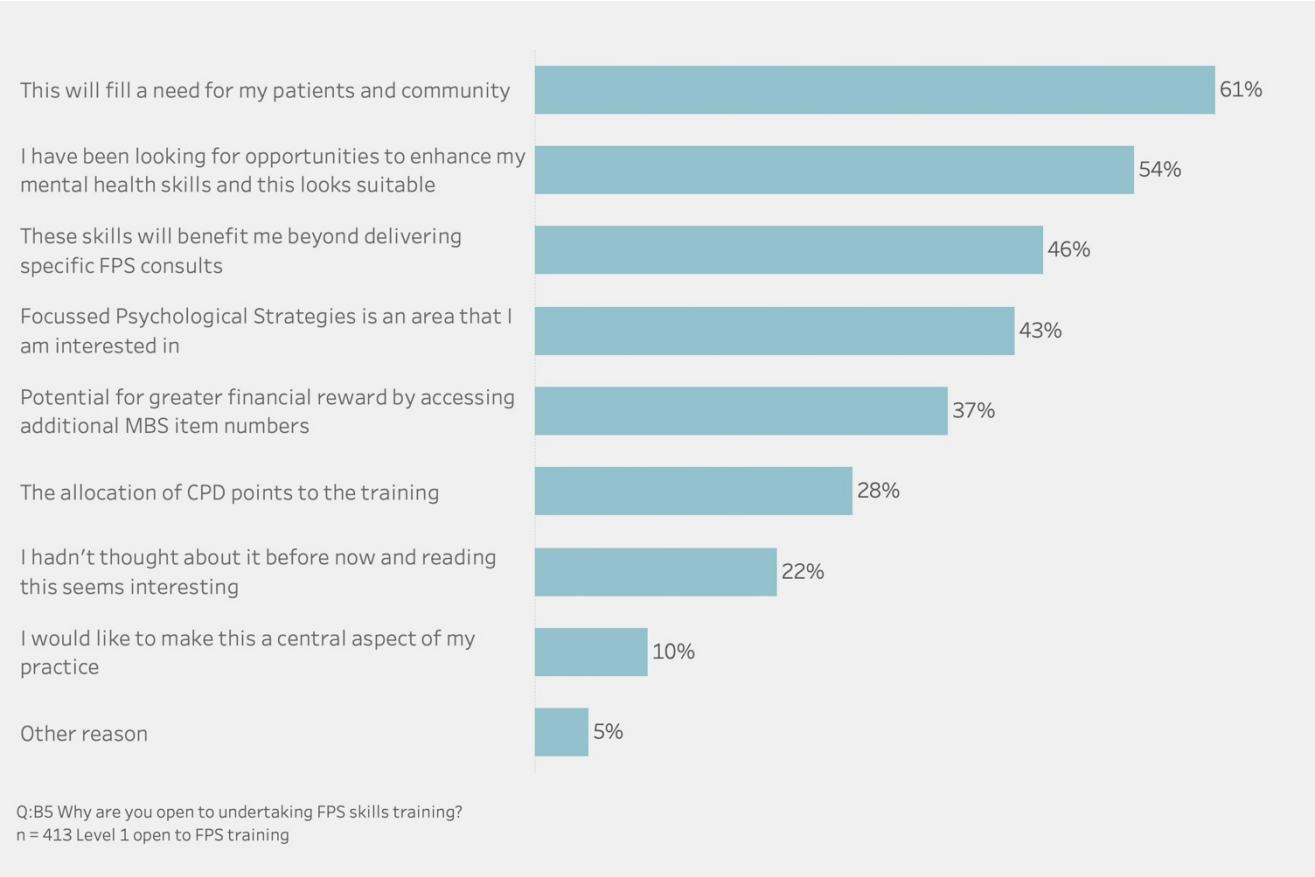
GPs who undertake the FPS training and who register as FPS providers have access to several benefits, including:

- GPs are eligible to claim item numbers for the provision of FPS (MBS item numbers 2721-2731)
- GPs who complete the requirements of FPS skills training are allocated CPD or PDP points
- GPs can provide psychological therapies if there is a shortage or lack of access to psychologists or psychiatrists.

Those who indicated that they were open to FPS skills training were asked their reasons. Fulfilling a need in their community was the most common response, followed by 54% saying they had been looking for an opportunity to enhance their mental health skills and this looks suitable. This accounts for 35% of all Level 1 trained GPs.

It was noted previously that GPs valued the skills beyond enabling them to deliver FPS and 46% mentioned this as a reason for being open to the training. While access to the additional FPS MBS item numbers were mentioned, this was only by 37% of GPs who were interested in this training.

Figure 50. Factors motivating interest in FPS skills training



"I am really keen to undertake Level 2 mental health skills training to deliver focussed psychological strategies for my rural community. The main constraints previously were cost, however the availability of subsidised training through Blackdog is excellent. Currently I'm a young dad with two small kids, and now it's about finding a weekend that lines up with the subsidised training. I do a disproportionately high amount of mental health in my practice, including to farming populations, adolescents and older males who may be less keen to see a psychologist, so the ability to deliver CBT in clinic is very attractive."

"I also note there is no financial incentive for me to be further trained in focussed psychological strategies or to bill for these items, when I can earn the same with other items I am currently able to bill. I am planning to complete FPS training in the next triennium because of interest in this area, to obtain CPD points, and to improve my service to my patients."

Appendices

Appendix 1: Research Methodology

Qualitative research

The qualitative research stage involved 33 semi-structured in-depth telephone interviews with GPs, undertaken by experienced interviewers. The interviews were approximately 15 minutes in duration.

Given the qualitative nature of this stage, a large representative sample was not required. Rather a diverse range of different types of GPs were recruited to ensure that a breadth of opinions and experiences were canvassed. The qualitative research participants included GPs who are active in clinical practice across the following dimensions:

Figure 51. Qualitative sample structure

		Level 1	Level 2	Total
Gender	Male	8	6	16
	Female	11	8	19
Practice Owner	Yes	5	1	6
Career Stage	Early career	6	5	13
	Mid-career	9	4	13
	Late career	4	5	9
MMM location	MM 1 Metropolitan	9	6	17
	MM 2 Regional centres	4	3	7
	MM3 - 4 Large or medium rural towns	3	3	6
	MM 5 - 7 Small rural towns and remote communities	3	2	5
State/Territory	NSW	4	4	8
	Vic	4	3	7
	Qld	4	3	7
	WA	2	1	4
	SA	2	1	4
	Tas	1	1	2
	NT	1	0	1
	ACT	1	1	2
Year Level 1 training completed	2002 - 2007	6	3	9
	2008 - 2014	7	5	12
	2015 - 2021	6	6	12

The qualitative research participants were recruited by the GPMHSC and provided a gift card to the value of $50 as an incentive.

A discussion guide was used by the qualitative researchers to ensure the conversations with GP participants consistently covered the key areas of investigation. Slightly different guides were used for Level 1 trained and Level 2 trained GPs. The topic areas included in the guides are summarised below:

Level 1 trained GPs

- Extent of and attitude toward providing mental health services
- Perceived need for and benefits associated with additional training
- Awareness of options for further training (including FPS ST)
- Perceived barriers to and challenges associated with further training (including reasons for not undertaking further training)
- Attitudes towards GPMHSC FPS skills training specifically

Level 2 trained GPs

- Extent of and attitude toward providing mental health services
- Perceived personal relevance of registering as FPS provider
- Challenges and benefits of FPS ST and subsequent registration (what has their experience been?)
- Whether they are they 'advocates' of FPS ST, with reasons (focus on what strengths can be amplified and weaknesses addressed)
- Use of MBS item numbers (understand underlying dynamics driving behaviour)

Quantitative research

The quantitative research was undertaken using and online survey methodology. A stratified random sample of Level 1 and Level 2 (FPS) trained GPs were invited by email to participate in the survey. Details about the sample design and response rates are provided in the following sections.

Questionnaire design

A summary of the topics covered by survey respondents is shown in the table below. A copy of the questionnaire is appended to this report.

All respondents

- Hours worked in clinical practice
- Types of practice settings worked in
- Types of patients seen
- Estimated number of consultations where patients presented with mental health conditions
- Use of MBS item numbers when patient present with mental health conditions
- Attitudes toward the use of MBS item numbers
- Extent to which mental health services are provided by the GP
- Extent of and attitude toward providing mental health services
- Additional mental health training undertaken
- Openness to undertaking further training in mental health
- Barriers and motivators to undertaking further training
- Practice characteristics and demographics

Level 1 trained GPs

- Awareness of FPS skills training
- Openness towards undertaking FPS skills training
- Barriers and motivators to undertaking FPS skills training

Level 2 trained GPs

- Registration status as an FPS provider
- Reasons for not maintaining registration
- Benefits of FPS skills training
- Use of FPS MBS item numbers
- Attitudes toward FPS skills training

Prior to the commencement of the survey fieldwork, the online questionnaire was tested in the following ways to ensure the questionnaire concepts were clear to respondents and language would be easily and reliably understood. The pilot testing also ensured the data structure was error free.

1. Draft questionnaire reviewed by GPMHSC executive
2. Online version of the questionnaire tested by a small number of GPs and GPMHSC executive
3. A “soft-launch” emailed to 350 respondents to allow the questionnaire to be tested on a larger scale before the “full-launch” to the remaining selected sample.

The online questionnaire was branded as 'The Navigators' to reinforce that the survey data was collected by an independent agency and individual responses would remain anonymous. This was particularly important given the survey asked GPs to disclose billing behaviour that did not comply with standard MBS requirements.

Respondents were offered the chance to win one of six gift vouchers of $100 on completion of the survey to encourage participation. The median length of time to complete the survey was 11.8 minutes.

Sample design

A sample of 626 Level 1 trained and 220 Level 2 trained GPs completed the survey, creating a total sample of 846.

A stratified random sample was designed to ensure sufficient representation of practicing GPs in rural and remote parts of Australia. The sampling frame was provided by the GPMHSC from their database of Level 1 and Level 2 trained GPs.

The following table shows the number of GPs selected by Level and each stratum, defined by Monash Modified Model (MMM) areas. Records without a postcode classification were excluded from the final sample frame. Stratifying the sample by MMM area was an important sample design feature so that statistically reliable and robust estimates could be generated for GPs practicing in rural and remote areas.

Figure 52. Quantitative sample structure

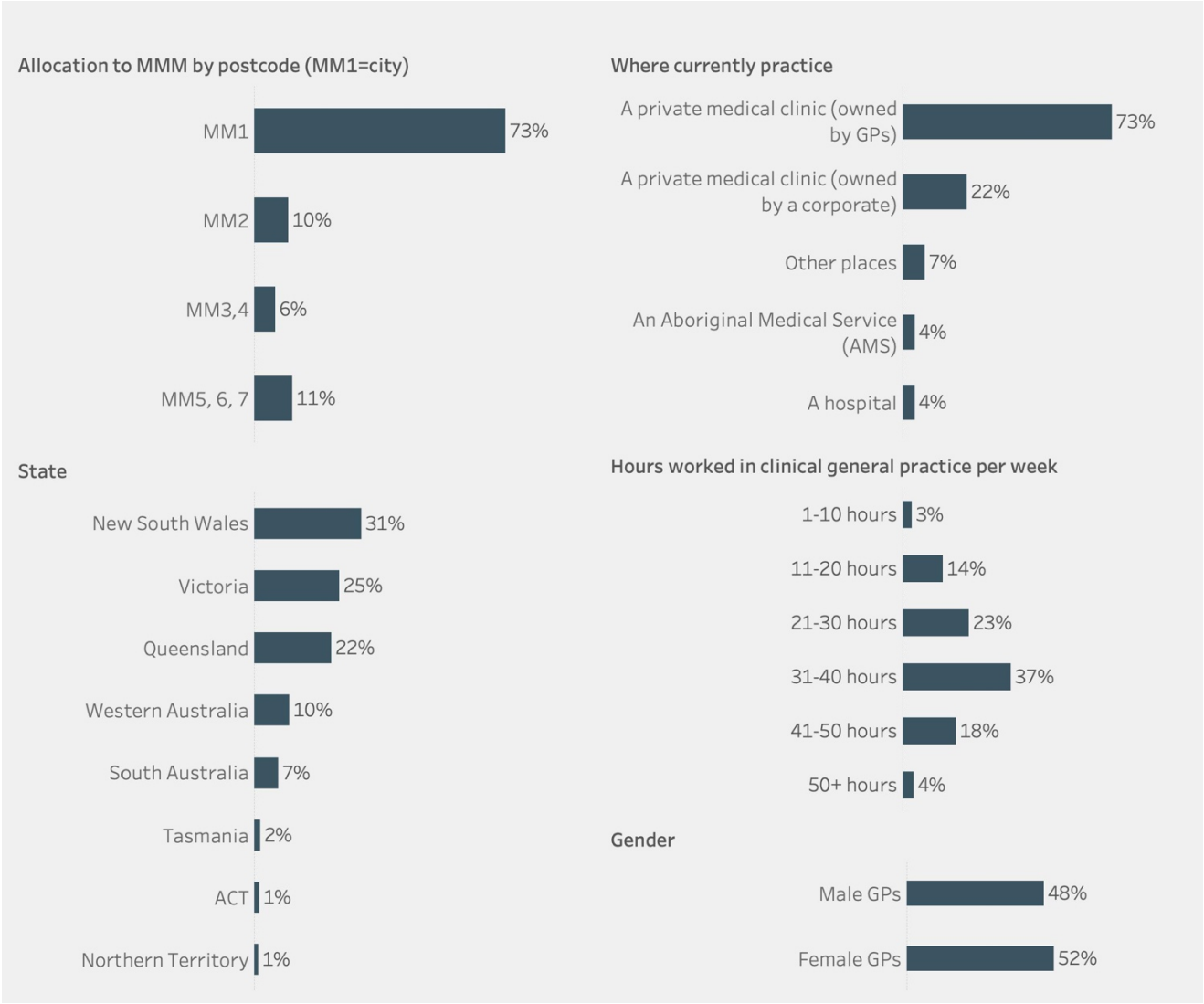
	Level 1			Level 2		
MMM	Population size	Selected sample	Sample achieved	Population size	Selected sample	Sample achieved
1	21745	7500	303	931	931*	140
2	2868	2500	111	145	145*	33
3 & 4	1709	1709*	76	110	110*	13
5, 6 & 7	3228	2500	136	217	217*	34
Total	29550	14209	626	1403	1403	220

* All Level 1 GPs in MMM areas 3 and 4 and all Level 2 GPs were included in the selected sample given the small population size in these strata.

The number of Level 1 records randomly selected was based on achieving a target of n=600 completed interviews on the assumption of a 4% response rate. The total selected sample comprised 15,612 GP records.

The final sample was created by de-duplicating email address records from the 15,612 records. The GPMHSC database contains a number of cases where GPs share the same email address with another GP or use a general email address for their practice. Any record that shared an email address with another selected record was removed. This data cleaning process resulted in a total cleaned sample of 15,173 GPs.

Figure 53. Sample profile, weighted total sample



Analysis

Weighting

The first stage of the analysis was the calculation and application of respondent weights. Weighting of respondents is an important step to ensure the estimates generated from the survey are representative of the population from which the sample has been drawn. Given the sample was stratified by MMM area, weighting is also necessary to ensure, when estimates are generated for the total population of GPs, that those in rural and remote areas are represented in proportion to their incidence in the total population.

A "rim" weighting procedure was used to calculate individual respondent weights for the following characteristics:

MMM Area	Population estimate	State/Territory	Population estimate	Level/Gender	Population estimate
1	73%	NSW	31%	Level 1 - Female	50%
2	10%	Victoria	25%	Level 1 - Male	46%
3 & 4	6%	Qld	22%	Level 2 - Female	2.5%
5, 6 & 7	11%	WA	10%	Level 2 - Male	1.5%
		SA	7%		
		Tas	2%		
		ACT	2%		
		NT	1%		

Population estimates for each of the characteristics were derived from the GPMHSC database.

Standard error of estimates

Standard errors apply to all survey estimates in this report. The standard error describes a range of values for a survey estimate, within which we can be 95% confident the *actual* population characteristic lies.

The standard error of estimates changes as a function of sample size. The maximum standard error is reached for sample survey estimates at 50%. Using that estimate as a baseline, the standard error that applies to key sample sub-groups in this study are shown in the table below:

Total Sample	Max Std Error	Training Level	Max Std Error	MMM Area	Max Std Error	Gender	Max Std Error
n=846	+/- 3.4%	Level 1 (n=626)	+/- 3.4%	1 (n=443)	+/- 4.6%	Females (n=530)	+/- 4.2%
		Level 2 (n=220)	+/- 6.6%	2 (n=144)	+/- 8.1%	Males (n=307)	+/- 5.6%
				3 & 4 (n=88)	+/- 10.0%	Other (n=9)	
				5, 6 & 7 (n=168)	+/- 8.0%		

Segmentation

A simple segmentation method called K-means cluster analysis was used to identify sub-groups within the respondent sample who shared similar characteristics based on their response to the following question:

E1: A number of statements have been made by GPs regarding the provision of mental health services and their attitudes towards mental health. Do you agree or disagree that ...?

- *Mental health is a subject I have an interest in*
- *I generally find mental health consults rewarding*
- *I find mental health work tiring or emotionally draining*
- *Mental health is something that I do somewhat reluctantly*
- *I feel I am naturally good at mental health and patients seem comfortable with me – the work is a good fit for me*

The K-means analysis identified that a total of 4 clusters was the optimal solution to describe GP segments that accounted for most of the variance (within-cluster sum of squares).

IRSD Quartiles

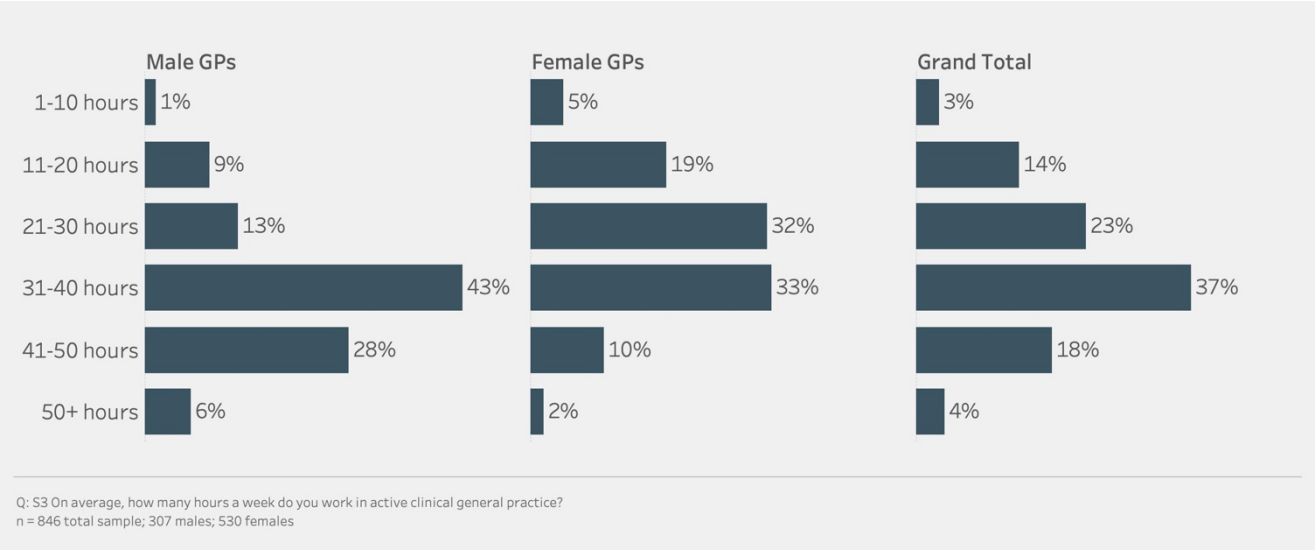
Analysis of the survey responses using the Index of Relative Social Disadvantage (IRSD) was facilitated by using the IRSD values for each postcode in Australia. These values were appended to the selected sample using the postcode values for each respondent to assign them the appropriate IRSD value.

To simplify the analysis of responses by IRSD, quartiles were calculated from the assigned IRSD values and applied to the final respondent sample. The quartiles are:

- Bottom quartile – 25% of respondents with the *lowest* IRSD values,
- Second and third quartiles – the next highest 25% groups of respondents by IRSD values, and
- Top quartile – 25% of respondents with the *highest* values

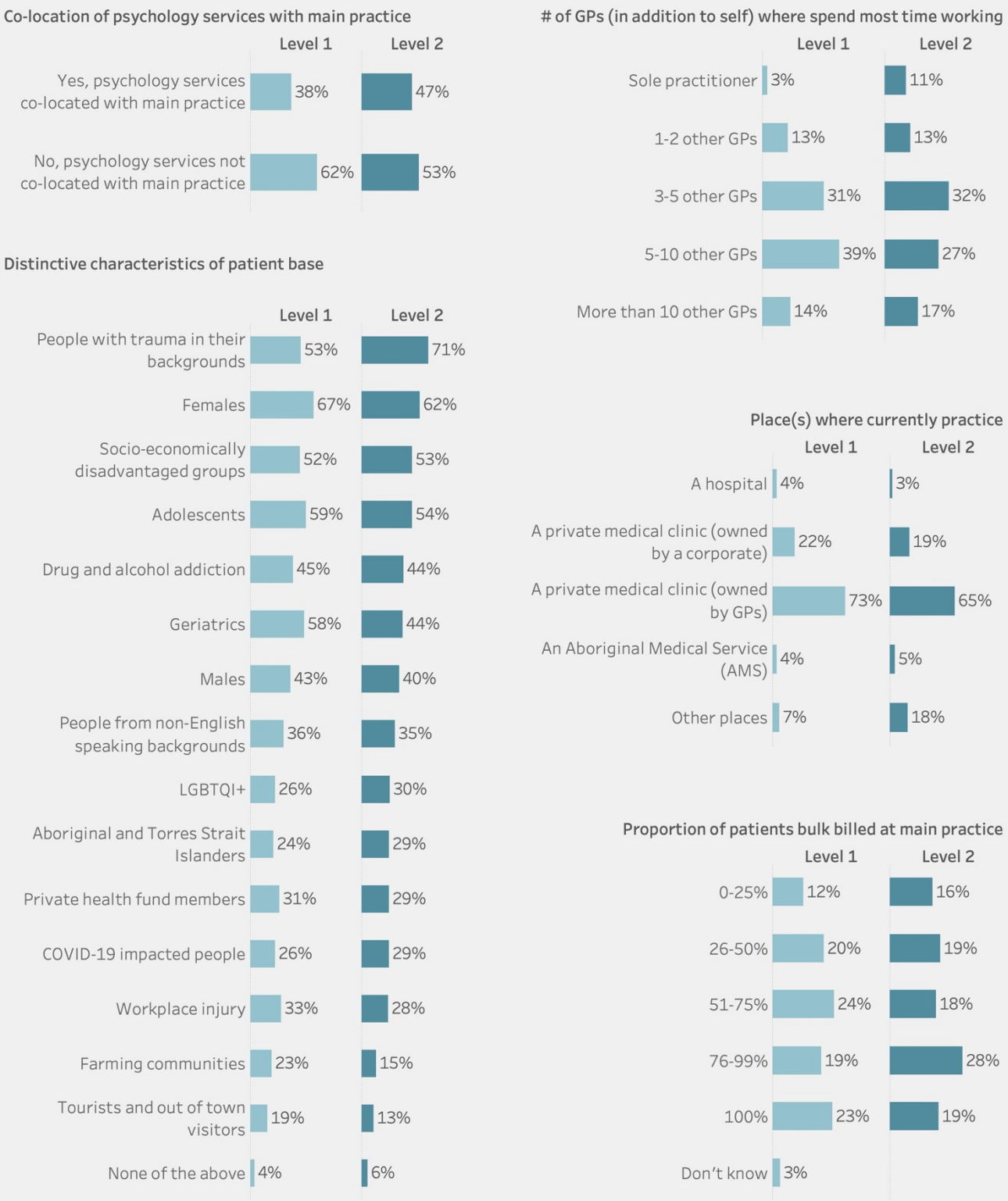
Appendix 2: Additional Data

Figure 54. Average hours worked per week in active clinical general practice



Q: S3 On average, how many hours a week do you work in active clinical general practice?
n = 846 total sample; 307 males; 530 females

Figure 55. Characteritics of practice worked in by level of training



Q: A3 What, if any, training or professional development have you undertaken specifically relating to mental health?
n = 626 Level 1 n = 220 Level 2

Appendix 3: Questionnaire

Introduction and screening

Thank you for clicking through to complete this survey, your input will help to provide an understanding of important issues that impact GPs in relation to providing services to patients with mental health conditions and training.

The Navigators, an independent research agency, is undertaking this survey to ensure that the data that is gathered remains anonymous and you should feel confident to give open and frank responses to the survey. As members of The Research Society in Australia (https://researchsociety.com.au/standards/code-of-professional-behaviour) The Navigators abides by its professional standards and ethics regarding the confidentiality of survey data and no individually identifiable responses will be made available.

If you have any questions regarding the survey, please contact mental_health_survey@thenavigators.com.au.

We strongly recommend that you complete the survey in one sitting (it will take approximately 12 minutes) but if you do need to close the survey and come back to it another time, you can use the same link to access the survey and continue where you left off.

Click the next button to move to the next page of the survey or the back button if you need to go back to a question.

S1. Hidden variable – sample source respondent list SR

Level 1 MHST	1
FPS ST	2

S2. Hidden variable – member organization SR

ACRRM	1
RACGP	2

S3. On average, how many hours a week do you work in active clinical general practice? SR

1–10 hours	1
11–20 hours	2
21–30 hours	3
31–40 hours	4
41–50 hours	5
50+ hours	6
I am not currently active in clinical general practice	7 Close

If not active in clinical general practice please close with these words "Thank you for your time, but this survey is only relevant to GPs who are currently active in clinical general practice. We appreciate your interest and hope that you can take part in future surveys. If you have any queries regarding this survey, please contact mental_health_survey@thenavigators.com.au."

S4. What is the postcode for the area in which you mainly practice? SR

_ _ _ _	

Use postcode to classify respondents by MMM (Modified Monash Model), RA (Remoteness Area), State, PHN (Public Health Network) and IRSD (Index of Relative Socio-economic Disadvantage).

Section A - Mental health training

A1. How many years of experience do you have, if any, treating patients who present with mental health conditions? Single response

	None, I have never delivered treatment	1
	Less than 2 years	2
	3 - 5 years	3
	6 - 10 years	4
	More than 10 years	5

Ask all

A3. What, if any, training or professional development have you undertaken specifically relating to mental health? Multiple response, randomise display order

	I have not done any training specific to mental health other than what was covered in my training to become a GP (retain at top)	1
	Elective rotation in psychology prior to or psychiatry during my GP training	2
	Level 1 Mental Health Skills Training	3
	Focussed Psychological Strategies (FPS) training (also referred to as Level 2)	4
	Graduate certificate, diploma or masters course in mental health	5
	Mental health content in fulfillment of CPD requirements	7
	Voluntary (self-driven) reading or courses pertaining to mental health outside of what is required for CPD	8
	Other (please specify)	10

Ask respondents who are sourced from the FPS ST sample, but who do not indicate that they have completed FPS training (code 3 in QA3).

A4. Have you completed Focussed Psychological Strategies (FPS) skills training (also referred to as Level 2)?

	Yes	1
	No	2

Flag respondents from FPS sample who do not mention FPS training in QA4 (NOT code 3) AND say no in QA5 (code 2).

Ask all

A5. In a typical week, what number of consults do you provide that …?

Please enter the number of consults in a typical week for each row. If you do not typically conduct consults of a particular type, enter '0' (zero) in the text box.

1	Address only mental health in the consult	insert number_
2	Address a mix of mental health and other clinical issues in the consult	insert number_
3	Address other clinical issues (with no mental health)	insert number_
	Total consults in a typical week (show running total)	

A6. How well equipped do you believe you are to meet the needs of patients who present with mental health conditions? Single response

	Very well equipped to meet the needs of patients who present with mental health conditions	1
	Adequately equipped to meet the needs of patients who present with mental health conditions	2
	Under equipped to meet the needs of patients who present with mental health conditions	3

A7. Do you agree or disagree with the following statement?

I am open to undertaking further training in mental health in the future. Rotate scale

	Strongly agree	1
	Agree	2
	Neutral	3
	Disagree	4
	Strongly disagree	5

A8. What, if anything, is reducing the likelihood of you undertaking further mental health training?

Please tick all those that apply to you. Multiple response, randomise display order

	I have no need for further training, my skills match my need	1
	Mental health is not a subject that I am interested in nor enjoy	2
	The cost of undertaking the training	3
	Lack of time to do the training	4
	Training in other areas of medicine is a higher priority for me	5
	The training options are confusing	6
	There is not easy access to training	7
	Mental health work is not financially beneficial	8
	Other (please specify)	9
	There is nothing reducing the likelihood, there are no barriers (retain bottom position)	10

A9. What, if anything, would motivate you to undertake further mental health training? Multiple response, randomise display order

	Nothing would motivate me to do further training in mental health (retain top position)	1
	To improve my skills and knowledge of an area that I am interested in	3
	To improve my confidence in meeting the needs of patients with mental health conditions	4
	To provide patients with better access to mental health support in the area	6

	where I work	
	To be able to provide my patients with an all-round service	9
	To have a better understanding of the services that other health professionals (like psychologists) are delivering to my patients	10
	To have a better understanding of mental health to navigate the system for myself and my patients	11
	If an opportunity came up to do the training that was easy to access	13
	If an opportunity came up to do the training that was particularly affordable	14
	If the mental health MBS item numbers were more financially rewarding	15
	Other (please specify)	16

Section B FPS training amongst Level 1 trained (not FPS trained)

All of Section B is only asked of those who have not undertaken FPS training (Level 1 sample)

B1. Have you ever heard of Focussed Psychological Strategies (FPS) skills training, sometimes referred to as Level 2 training?

	Yes	1
	No	2
	I don't know	3

Ask B2 if aware of FPS training (code 1 in QB1)

B2. Are you aware that completing Focussed Psychological Strategies (FPS) skills training and registering as an FPS provider enables GPs to bill additional MBS item numbers, specifically 2721 to 2731?

	Yes	1
	No	2
	Don't know	3

B3. Please read the description below.

Focussed Psychological Strategies (FPS) refer to specific mental health treatment strategies derived from evidence-based therapies, such as cognitive behavioral therapy, interpersonal therapy, and relaxation strategies. Accredited FPS skills training is a minimum of 20 hours of training.

GPs who undertake the FPS training and who register as FPS providers have access to several benefits, including:

- *GPs are eligible to claim item numbers for the provision of FPS (MBS item numbers 2721–2731)*
- *GPs who complete the requirements of FPS skills training are allocated CPD or PDP points*
- *GPs can provide psychological therapies if there is a shortage or lack of access to psychologists or psychiatrists.*

Earlier you indicated you [[A7:TEXT]] that you are open to undertaking further training in mental health. Now that you have read this description of FPS training, do you agree or disagree with the following statement?

I am open to undertaking FPS skills training to further my skills in mental health

	Strongly agree	1
	Agree	2
	Neutral	3
	Disagree	4
	Strongly disagree	5

Ask if open to undertaking FPS training (code 1 and 2 in QB3)

B5. Why are you open to undertaking FPS skills training?

Check all that apply. Multiple response, randomise display order

	I have been looking for opportunities to enhance my mental health skills and this looks suitable	1
	Focussed Psychological Strategies is an area that I am interested in	2
	I would like to make this a central aspect of my practice	3
	These skills will benefit me beyond delivering specific FPS consults	4
	Potential for greater financial reward by accessing additional MBS item numbers	6
	This will fill a need for my patients and community	7
	I hadn't thought about it before now and reading this seems interesting	9
	The allocation of CPD points to the training	11
	Other (specify)	12

Ask if ambivalent or not open to FPS training (code 3, 4 or 5 in QB3) and open to training in QA7 (code 1 or 2)

B6. You mentioned earlier that you **are open to undertaking further mental health training, yet you are not open to undertaking FPS skills training**. Why are you not interested in FPS skills training?

	Provide space for verbatim feedback.	

Skip to Section D

Section C: FPS training

Section C is only asked of those who have undertaken FPS training, sourced from the FPS sample - any people who are unaware they have done the training in QA3 and QA4

The following questions are being asked of people who have completed Focussed Psychological Strategies (FPS) skills training, sometimes referred to as Level 2.

Ask those who indicated that they have done FPS training in QA4, code 3 OR in QA5 (yes, code 1)

C1. Are you registered with Medicare as a FPS provider? Rotate response order

	No and have never been	1
	I was previously but have allowed my registration to lapse	2
	Yes, I am registered	3

Ask if registration has lapsed (code 2 in QC1)

C2. Why have you let your registration with Medicare as an FPS provider lapse?

Please be as detailed as possible in your response.

	Insert space for verbatim feedback	

C5. Do you agree or disagree with the following statement?

a) I have found the skills gained from Focussed Psychological Strategies (FPS) training valuable as a tool to enable me to provide Focussed Psychological Strategies (FPS) consultations to patients.
b) I have found the skills gained from Focussed Psychological Strategies (FPS) training valuable as a general skill that is useful across a wide range of consults.

Rotate scale - keep rotation the same as previous use of similar scale

		To provide FPS consultations	As a general skill
	Strongly agree	1	1
	Agree	2	2
	Neutral	3	3
	Disagree	4	4
	Strongly disagree	5	5

Ask if C5a is disagree or strongly disagree

C5c. Why have you not found FPS training valuable as a tool to enable you to provide Focussed Psychological Strategies (FPS) consultations to patients?

Please be as detailed as possible in your response.

	Insert space for verbatim feedback	

Ask if registered FPS provider (QC1 code 3) and do more than 1 mental health only consult per week (QA5 code 1 is not none)

C7. You said that you do [pipe response from QA5 code 1] consults in an average week where **mental health is the only condition you address**. This question refers to consults where you are **only attending to mental health conditions in the consult**.

On average, for what proportion of these consults do you ...

- Use FPS (Focussed Psychological Strategies) to the extent that it would qualify to be billed as an FPS MBS item number (Items 2721 to 2731) for that consultation, regardless of whether you billed it as an FPS item?
- Use the skills gained from having done FPS training, but not in a way that would qualify to be billed as an FPS MBS item number (Items 2721 to 2731), regardless of how you billed it?
- Not use FPS skills at all

Note: Please answer irrespective of whether you bill the consult as an FPS item number. The question refers specifically to whether you do work that would qualify for an FPS item number. (If you would like to check what would qualify for one of these item numbers, here is a link to the notes associated with the Medicare Benefits Schedule Link to MBS Online).

Move the sliders below so that the total shows 100% of consults.

Note when scripting, ensure that link opens in separate window to the survey

Consults using FPS to the extent that it would qualify to be billed as an FPS MBS item number	__%
Consults using skills gained from having done FPS training, but not in a way that would qualify to be billed as an FPS MBS item number	__%
Consults not using FPS skills at all	__%
Total must add to 100% (check total)	100%

Ask if registered FPS provider (QC1 code 3) and do more than 1 consult that addresses a mix of mental health and other clinical issues per week (not none) (QA5 code 2 is not none)

C8. You said that you do [pipe response from A5 code 2] consults in an average week where you address a mix of **mental health and other clinical issues in the consult**.

On average, for what proportion of these consults do you ...

- Use Focussed Psychological Strategies (FPS) to the extent that it would qualify to be billed as an FPS MBS item number (Items 2721 to 2731) for that consultation, regardless of whether you billed it as an FPS item?
- Use the skills gained from having done FPS training, but not in a way that would qualify to be billed as an FPS MBS item number (Items 2721 to 2731), regardless of how you billed it?
- Not use FPS skills at all

Note: Please answer irrespective of whether you do bill the consult as an FPS item number, the question refers specifically to whether you do work that would qualify for an FPS item number. (If you would like to check what would qualify for one of these item numbers, here is a link to the notes associated with the Medicare Benefits Schedule Link to MBS Online).

Note when scripting, ensure that link opens in separate window to the survey

Proportion of consults using FPS to the extent that it would qualify to be billed as an FPS MBS item number	__%
Proportion of consults using skills gained from having done FPS training, but not in a way that would qualify to be billed as an FPS MBS item number	__%
Not use FPS skills at all	__%
Total must add to 100% (check total)	100%

C9. Which of the following best describes your approach in cases where the use of Focussed Psychological Strategies is appropriate for a patient and could be billed as an MBS FPS item (2721 to 2731)? Please answer irrespective of whether you bill such consults using the FPS item numbers.

Rotate scale. Single response

	I always deliver FPS myself	1
	I mostly deliver FPS myself, but sometimes refer patients elsewhere	2
	I occasionally deliver FPS myself, mostly refer patients elsewhere	3
	I always refer patients elsewhere	5
	I attend to them myself, but not using FPS (in a way that it could be billed in an FPS item number)	6

C10. To what extent do you agree or disagree with each of these statements?

	Randomise order of statements	Tend to agree	Neutral	Tend to disagree
1	FPS is not suitable for trauma patients	1	2	3
2	Delivering FPS is not financially viable in my practice			
4	I would do more FPS if it did not take away from the number of MBS billable sessions available for a psychologist			
5	Delivering FPS is not well suited to a conventional General Practice business model			
6	The administrative requirements associated with FPS are too great			
7	I do not use FPS frequently enough to be confident that I can produce positive patient outcomes			
8	Even after FPS training, dedicated mental health professionals are better placed to deliver patient treatment			

Section D: MBS Item numbers

This section gets answered by people from both sample sources (Level 1 and FPS trained)

The following questions relate to the use of MBS item numbers for mental health consults. We understand that this may be sensitive and confidential information. For the integrity of this research, it is important that you provide responses to these questions as accurately as possible. We assure you that The Navigators is an independent research agency bound by the Professional Code of Behaviour for The Research Society of Australia (https://researchsociety.com.au/standards/code-of-professional-behaviour) and that the identity of individual respondents is removed from the survey data to ensure that your privacy is protected.

D1. Which of the following statements best applies to you? Single response

	My use of the MBS item numbers relating to mental health **understates** the volume of mental health I attend to in my consults (I do more mental health consults than reflected in my use of mental health item numbers)	1
	My use of the MBS item numbers relating to mental health is **an accurate reflection** of the volume of mental health I attend to in my consults	2
	My use of the MBS item numbers relating to mental health **overstates** the volume of mental health I attend to in my consults (I do less mental health consults than reflected in my use of mental health item numbers)	3
	I prefer not to answer	4

Ask if do 1 or more consults that are ONLY MENTAL HEALTH - (Question A5, code 1 is not NONE)

D2. You said that you do [pipe response from QA5 code 1] consults in the average week where mental health is the only condition addressed. Thinking about consults that address **mental health conditions only**, what proportion of these consults do you bill each of the following MBS items in a typical week?

Move the sliders below so that the total shows 100% of consults. Rotate responses, but keep mental health items together and 'other' beneath each section

	GP Mental Health item (2713)	__%
	GP Mental Health Treatment Plan items (272 to 282 for non-VR or 2700, 2712, 2715 and 2717 for VR GPs)	__%
	Item numbers for the provision of Focussed Psychological Strategies (2721 to 2731, available to FPS registered providers only)	__%
	23/36/44 (Level B, C or D). That is, a general item number, not specific to mental health	__%
	Other MBS item numbers	__%
	Total (must add to 100%) (insert running total)	100%

Ask if do 1 or more mixed mental health and other clinical issue consults - (Question A5, code 2 is not NONE)

D3. You said that you do [pipe response from QA5 code 2] consults in the average week where mental health **and** other clinical issues are addressed. Thinking about consults that address **a mix of mental health and other clinical issues**, what proportion of these consults do you bill the following MBS items in a typical week?

Move the sliders below so that the total shows 100% of consults. Rotate responses, but keep mental health items together and 'other' beneath each section

	GP Mental Health item (2713)	__%
	GP Mental Health Treatment Plan items (272 to 282 for non-VR or 2700, 2712, 2715 and 2717 for VR GPs)	__%
	Item numbers for the provision of Focussed Psychological Strategies (2721 to 2731, available to FPS registered providers only)	__%
	23/36/44 (Level B, C or D). That is, a general item number, not specific to mental health	__%
	Other MBS item numbers	__%
	Total (must add to 100%) (insert running total)	100%

D4. There are several different factors that influence how GPs use MBS item numbers for mental health consults. For each statement, please indicate whether you tend to agree or disagree.

	Randomise order in which statements appear	Tend to agree	Neutral	Tend to disagree
1	Concern about triggering an audit sometimes discourages me from using accurate MBS item numbers for mental health consults	1	2	3
2	I am reluctant to use a patient's allowance for a set number of mental health consults per year using the MBS mental health item numbers, so I use a different item number in its place (e.g., standard 23/36/44)			
3	Although I treat mental health and other clinical issues in one consult, I don't tend to bill the mental health component as the MBS system does not make provision for this			
4	Compliance with the requirements needed (e.g., recording history or documenting outcomes) when using some mental health item numbers discourages me from using those numbers			
5	I tend to use the standard 23/36/44 item numbers even if it is a mental health consult, because it is just simpler, more straightforward, and familiar to me			
6	I tend to use the standard 23/36/44 item number instead of mental health item numbers because they are financially beneficial			
7	I tend to use standard 23/36/44 item numbers for mental health consults because there is less risk of the claim being rejected by Medicare			
8	When doing mental health consults, I sometimes claim a shorter consult than was done to avoid billing too many long MBS item numbers			
10	I mainly use the mental health item numbers when referring a patient for other services			

Section E: Attitudes to mental health

Ask all

E1. A number of statements have been made by GPs regarding the provision of mental health services and their attitudes towards mental health. Do you agree or disagree that...?

	Randomise order of statements	Tend to agree	Neutral	Tend to disagree
1	Mental health is a subject I have an interest in	1	2	3
2	I generally find mental health consults rewarding			
3	I find mental health work tiring or emotionally draining			
4	Mental health is something that I do somewhat reluctantly			
6	I feel I am naturally good at mental health and patients seem comfortable with me - the work is a good fit for me			

E2. Here are some practice related issues that GPs have said encourage or discourage them to provide treatment for patients with mental health conditions. Do you agree or disagree that...?

		Tend to agree	Neutral	Tend to disagree
1	The unpredictable nature of mental health consults creates a problem in my practice			
2	Mental health consults usually take long, and this creates a problem in my practice			
3	The set-up and nature of where I practice is suitable for patients with mental health conditions			
4	Dealing with mental health patients puts pressure on my availability to meet the needs of other patients			

E3. Here are some other factors that GPs have said encourage or discourage them to provide treatment for patients with mental health conditions. Do you agree or disagree that...?

		Tend to agree	Neutral	Tend to disagree
1	I can earn a suitable financial return on my time for treating patients with mental health conditions	1	2	3
2	There is sufficient access to other mental health services in my area			
3	I treat the mental health conditions of patients who are unable or unwilling to see a mental health professional			
4	I need to bill a certain number of patients each day and treating mental health makes that difficult			
5	The administrative requirements for mental health consults are onerous			
6	The design and structure of the MBS item schedule is suitable for treating mental health as a GP			
7	There is a great deal of unpaid time required for coordinating care and follow-up for patients with mental health conditions			

Section F: Respondent classification

Ask all

These last few questions are about your practice and demographic details. We ask this so that we can understand how different cohorts respond to the questions asked in this survey, individual responses are not linked to your identity.

F1. For how many years have you been practicing as a GP?

Less than 5 years	1
6 to 15 years	2
16 to 30 years	3
31 or more years	4

F2. Which of the following best describes where you currently practise? MR

If you practise in multiple types of practices, please select all that apply.

If practise in more than one type of practice, ask:

F3. In which of these do you spend most of your time? SR. Only show options listed in the previous question.

	F2	F3
A private medical clinic (owned by GPs)	1	1
A private medical clinic (owned by a corporate)	2	2
A hospital	3	3
An Aboriginal Medical Service (AMS)	4	4
Other (specify)	5	5

F4. Approximately how many other GPs do you work with at the location you currently work or spend the most time working?

No others - I'm a sole practitioner	1
1–2 other GPs	2
3–5 other GPs	3
5–10 other GPs	4
More than 10 other GPs	5
Don't know	6

F6. Are there psychology services co-located with your main practice?

Yes	1
No	2

F7. Approximately what percentage of patients are bulk billed at your main practice?

0-25%	1
26-50%	2
51-75%	3
76-99%	4
100%	5
Don't know	6

F8. Which, if any, of the following are distinctive characteristics of your patient base?

Tick all those that apply. Multiple response, randomise display order

Aboriginal and Torres Strait Islanders	1
People from non-English speaking backgrounds	2
Females	3
Males	4
LGBTQI+	5
Adolescents	6
Geriatrics	7
Private health fund members	8
Socio-economically disadvantaged groups	9
People with trauma in their backgrounds	10
Drug and alcohol addiction	11
Tourists and out of town visitors	12
Workplace injury	13
Farming communities	14
Covid-19 impacted people	15
None of the above	16

F9. Do you identify as…?

Male	1
Female	2
Other/Gender diverse	3

Section G: Close

G1. Is there any other feedback that you would like to provide regarding the survey or any of the topics raised in the survey?

Note that because your responses are not linked to your identity, we are unable to get back to you with any specific feedback or follow up that you may request. If you would like specific follow up to be taken, please email mental_health_survey@thenavigators.com.au

Verbatim comments, optional response	

G2. To enter the competition to win one of six $50 gift vouchers, please answer the question below and provide your name and email address, so we can announce and contact the winners. The winners will be published on the GPMHSC website on the 19th of November.

Tell us your idea for a service the GPMHSC could provide for GPs and your reason why in 25 words or less.

COMPLETE THE SENTENCE IN THE BLOCK BELOW: The service I would like the GPMHSC to provide is...

In order that The Navigators can contact the winners, please enter your email below. Please note that both the name and email address fields must be entered to be eligible.

Enter first name and surname _____
Enter email address _____

OR
I do not wish to enter the competition or provide me details

Please click the link to see the terms and conditions.

Terms and Conditions

Thank you for participating in this survey, your time and contribution is appreciated. Please click next to submit your response.

End on GPMHSC website