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From GP Referral to Mental Health Care

Australian Access & Referral Report 2026

A national analysis of referral pathways, access barriers, affordability and continuity of mental health care in Australia

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Research integrity and disclosure

This publication is an independent secondary analysis of publicly available aggregate data. Therapy Near Me Pty Ltd provides mental health and allied health services in Australia; this commercial interest is disclosed because the report concerns referral pathways and access to mental health care. The analysis does not use Therapy Near Me patient records, and no individual-level patient data were accessed.

This edition has not been described as peer reviewed. Policy and Medicare rules can change. Readers should check current Department of Health, Disability and Ageing, MBS and Services Australia guidance before relying on referral or claiming requirements.

Clinical and emergency disclaimer

This report is for research, health-service and educational use. It does not replace clinical judgement, individual assessment, emergency triage or legal/Medicare billing advice. In an emergency in Australia, call 000 or attend the nearest emergency department.

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Key findings at a glance

38.8%
needed psychologist care; delayed or did not obtain it

24.2%
needed GP mental-health care; delayed or did not obtain it

2.64×
psychologist cost-barrier ratio vs GP

13.0m
Medicare mental-health services, 2024-25

In 2024-25, 18.9% of Australians aged 15 years and over reported needing to see a health professional for their mental health. Of those needing care, 34.4% delayed or did not obtain care on at least one occasion, and 8.8% did not obtain mental-health professional care at all when needed. [1]

The principal derived finding is a **14.6 percentage-point GP-to-Psychology Access Gap**: 38.8% for psychologist care versus 24.2% for GP mental-health care. The relative psychology access barrier was 1.60 times the GP rate. [1]

Cost produced an even larger relative difference. In 2024-25, 25.3% of people needing a psychologist reported cost-related delayed or forgone care, compared with 9.6% among people needing a GP for mental health. This produces a **Psychology Cost Barrier Ratio of 2.64**. [1]

The report also identifies a national measurement gap: the principal datasets measure need, utilisation, cost, workforce and self-reported access barriers, but this review did not identify a routinely published national indicator following Better Access psychology referrals from GP referral through provider acceptance to first treatment and course completion.

Executive summary

General practitioners occupy a central position in Australia's mental-health system. They assess mental-health presentations, provide treatment directly, prepare Mental Health Treatment Plans where appropriate, refer patients to psychologists and other professionals, coordinate ongoing care, and can direct patients to alternative community and digital services.

The effectiveness of this system cannot be assessed solely by counting Mental Health Treatment Plans, referrals or Medicare services. A distinct question is whether a person who needs mental-health care can progress from identification of that need to timely, affordable and sustained treatment.

This report examines that pathway using national patient-experience, Medicare utilisation, workforce and health-system data. The principal reference period is 2024-25, with historical trend data used where comparable.

Three central findings

1. A persistent access gap. In 2024-25, 24.2% of people who reported needing a GP for their mental health delayed or did not see one when needed. The corresponding rate among people needing a psychologist was 38.8%. Across the five ABS Patient Experiences releases from 2020-21 to 2024-25, the psychologist barrier remained approximately 1.5-1.6 times the GP mental-health barrier. [1-5]

2. Affordability creates a larger divergence. Cost-related delayed or forgone care affected 9.6% of people needing GP mental-health care and 25.3% of those needing psychologist care in 2024-25. The resulting ratio is approximately 2.64. [1]

3. Service activity is measured more comprehensively than referral conversion. Australia can describe need, service volumes, provider use, workforce and self-reported access barriers. The national data are substantially less complete for the sequence between referral issuance and treatment commencement.

In 2024-25 about 13.0 million Medicare mental-health services were delivered, with half provided by psychologists. Around 10% of the population received a Medicare mental-health service, and GPs saw 77% of those people. [7]

The central conclusion is therefore straightforward: **a referral is an important clinical action, but it is not itself an access outcome.**

1. Introduction

Mental-health care rarely consists of a single isolated clinical encounter. For many Australians, the pathway begins in general practice. A person may present directly with psychological distress or disclose mental-health symptoms during care for another condition. The GP may assess the presentation, manage risk, provide initial treatment, prescribe medication where indicated, prepare a Mental Health Treatment Plan, refer for psychological treatment or direct the person to another suitable service.

The referral itself is only one stage. After referral, the patient may need to identify an appropriate practitioner, establish whether the provider has capacity, understand the cost, arrange an appointment and attend. If treatment is required over multiple sessions, affordability and availability remain relevant. Clinical information may then need to return to the referring practitioner so care can be reviewed and coordinated.

1.1 Analytical distinction

This report separates four concepts that are often conflated: **need for care; referral or recommendation for care; service utilisation; and successful access to treatment.** These concepts overlap, but they are not equivalent.

The report also distinguishes direct source findings from calculations produced for this publication. Derived indicators are transparently defined and do not create longitudinal referral outcomes from cross-sectional survey data.

2. Australia's mental-health referral system

2.1 General practice as a major entry point

AIHW reports that approximately 10% of the Australian population received at least one Medicare mental-health service during 2024-25 and that GPs saw 77% of these people. [7] The Productivity Commission also describes GPs as often being the first service accessed by people seeking help for mental illness. [9]

Mental-health-specific MBS data do not capture every occasion on which a GP provides mental-health care, because some relevant consultations may be billed under general attendance items. AIHW therefore cautions that its Medicare mental-health patient counts do not represent all people receiving mental-health care from GPs. [7]

2.2 Better Access

Under Better Access, eligible patients can access Medicare benefits for mental-health treatment delivered by eligible clinical psychologists, registered psychologists, social workers and occupational therapists, in addition to relevant medical services. Current referral eligibility includes referral by a GP or prescribed medical practitioner managing the person under a Mental Health Treatment Plan, specified psychiatrist pathways, or direct referral by a psychiatrist or paediatrician. [10]

From 1 November 2025, Mental Health Treatment Plan preparation, Better Access referrals and reviews were linked to the patient's MyMedicare-registered practice or usual medical practitioner, subject to the applicable rules. [11,12]

2.3 A treatment plan is not the referral

Current Department of Health guidance explicitly distinguishes the Mental Health Treatment Plan from the referral. The plan is the structured management document; the referral is a separate formal document. [14,16] A written Better Access referral should include the patient's identifying details, symptoms or diagnosis, medications, the number of services requested, and a statement about the relevant Mental Health Treatment Plan or psychiatrist plan. [10,14]

2.4 Courses of treatment

The initial course of individual treatment may contain up to six services. Subsequent referrals may cover the remaining eligible services, up to a maximum of 10 individual services per calendar year. A new referral is required for each course. [10]

2.5 Referral-free and alternative pathways

Medicare Mental Health Centres provide free mental-health information, services and supports without requiring a referral or diagnosis. Medicare Mental Health Check In provides free low-intensity digital support for people aged 16 years and over experiencing mild mental-health challenges, also without requiring a referral or diagnosis. [13]

3. Methodology

This is a national observational secondary-data study combining cross-sectional, time-series and health-system analysis. It uses publicly available aggregate statistics and published policy guidance. No patient recruitment occurred and no Therapy Near Me clinical records were used.

3.1 Research questions

- How frequently do Australians report needing mental-health care?
- How often is needed care delayed or not obtained?
- How do reported access barriers differ between GP mental-health care and psychologist care?
- What role does cost play in delayed or forgone care?
- How do access and system capacity vary by age, sex, socioeconomic circumstances and geography where data permit?
- What role does telehealth play?
- What can national data show about the period between referral and treatment?
- Which stages of the referral pathway are not routinely measured at national level?

3.2 Primary data sources

The primary evidence base comprises ABS Patient Experiences 2020-21 to 2024-25, AIHW Medicare mental-health services and workforce reporting, the Productivity Commission Report on Government Services 2026, Services Australia and Department of Health Better Access guidance, and the ABS National Study of Mental Health and Wellbeing. A peer-reviewed Australian psychiatry waiting-time study is used as a methodological comparator. [1-15]

3.3 Denominator discipline

The report does not merge incompatible denominators. Survey respondents, Medicare patients, Medicare services and workforce FTE are different units. In particular, **services are not patients, patients are not referrals, and reported need is not proof that a GP referral occurred.**

3.4 Derived measures

GP-to-Psychology Access Gap = psychologist delayed-or-forgone-care rate minus GP mental-health delayed-or-forgone-care rate.

Relative Psychology Access Barrier = psychologist delayed-or-forgone-care rate divided by the corresponding GP rate.

Psychology Cost Barrier Ratio = psychologist cost-related delayed-or-forgone-care rate divided by the corresponding GP rate.

3.5 Interpretation

Derived measures are descriptive comparisons. They do not establish causation and they do not represent the percentage of GP referrals that fail. Detailed methods, inclusion rules and limitations appear in Appendix A.

4. Mental-health care need and service use

In 2024-25, 18.9% of Australians aged 15 years and over reported needing to see a health professional for their mental health. Of those needing care, 34.4% delayed or did not obtain it on at least one occasion; 8.8% did not see a mental-health professional at all when needed. [1]

During the same year, 17.3% of people reported seeing at least one health professional for their own mental health: 12.5% saw a GP, 8.5% a psychologist, 3.5% a psychiatrist and 2.3% another mental-health professional. These categories overlap because one person can see more than one provider. [1]

The earlier ABS National Study of Mental Health and Wellbeing provides a different denominator. In 2020-22, 21.5% of people aged 16-85 years met criteria for a 12-month mental disorder. Among those with a 12-month mental disorder, 45.1% saw a health professional for mental health, 35.5% saw a GP and 21.3% saw a psychologist. [6]

These datasets should not be directly combined to create a referral-conversion rate, but together they demonstrate the distinction between population mental-health need and observed professional service use.

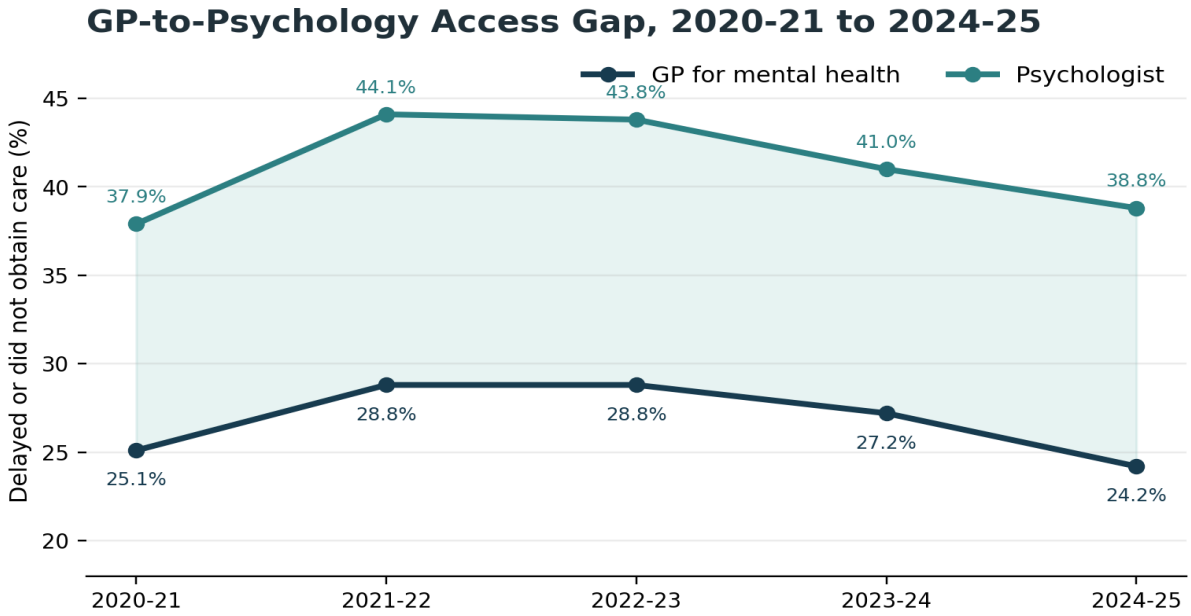
5. The GP-to-Psychology Access Gap

The strongest provider-specific finding in the 2024-25 ABS Patient Experiences data is the difference between reported access to GP mental-health care and psychologist care.

Provider needed	Delayed or did not obtain care
GP for mental health	24.2%
Psychologist	38.8%
Psychiatrist	36.6%
Other mental-health professional	31.3%

Source: ABS Patient Experiences 2024-25. [1]

The psychologist-GP difference is **14.6 percentage points** (38.8 - 24.2). The relative psychologist barrier is **1.60 times** the GP rate (38.8 / 24.2).



Source: ABS Patient Experiences 2020-21 to 2024-25. [1-5]. Calculations by Therapy Near Me Research.

5.1 Persistence across the series

The access difference is not confined to a single survey year. Across all five years of the current ABS mental-health patient-experience series, the psychologist rate remained approximately 1.5-1.6 times the GP mental-health rate.

Year	GP	Psychologist	Gap	Relative barrier
2020-21	25.1%	37.9%	12.8 pp	1.51×
2021-22	28.8%	44.1%	15.3 pp	1.53×
2022-23	28.8%	43.8%	15.0 pp	1.52×
2023-24	27.2%	41.0%	13.8 pp	1.51×
2024-25	24.2%	38.8%	14.6 pp	1.60×

Source: ABS Patient Experiences annual releases. [1-5]

5.2 Correct interpretation

This indicator must not be described as a “referral failure rate”. The ABS data measure whether respondents who needed a particular provider delayed or did not obtain care. They do not establish that every respondent needing a psychologist first received a GP referral or attempted to use Better Access.

6. Affordability

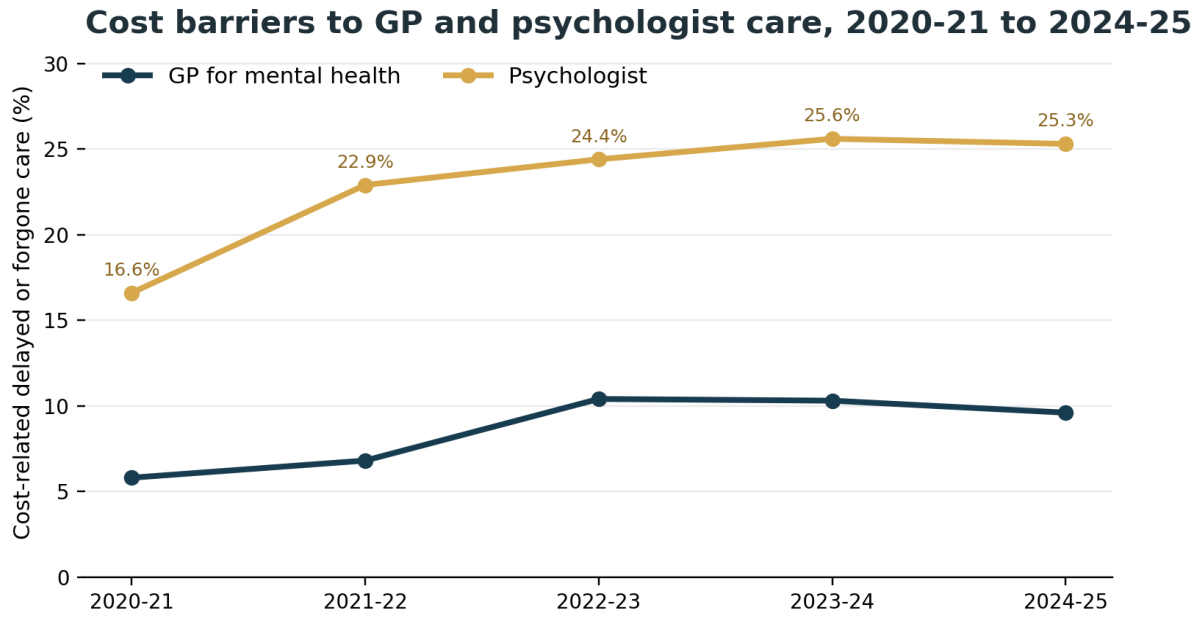
Affordability produces a larger relative provider difference than the overall access measure.

Provider needed	Delayed or did not obtain care due to cost
GP for mental health	9.6%
Psychologist	25.3%
Psychiatrist	25.4%
Other mental-health professional	17.0%

Source: ABS Patient Experiences 2024-25. [1]

The absolute psychologist-GP cost gap was **15.7 percentage points**. The relative Psychology Cost Barrier Ratio was **2.64**.

This ratio describes a difference in the frequency of reported cost-related access barriers. It does **not** mean that psychologist fees are 2.64 times GP fees.



Source: ABS Patient Experiences annual releases. [1-5]

6.1 Longer-run change

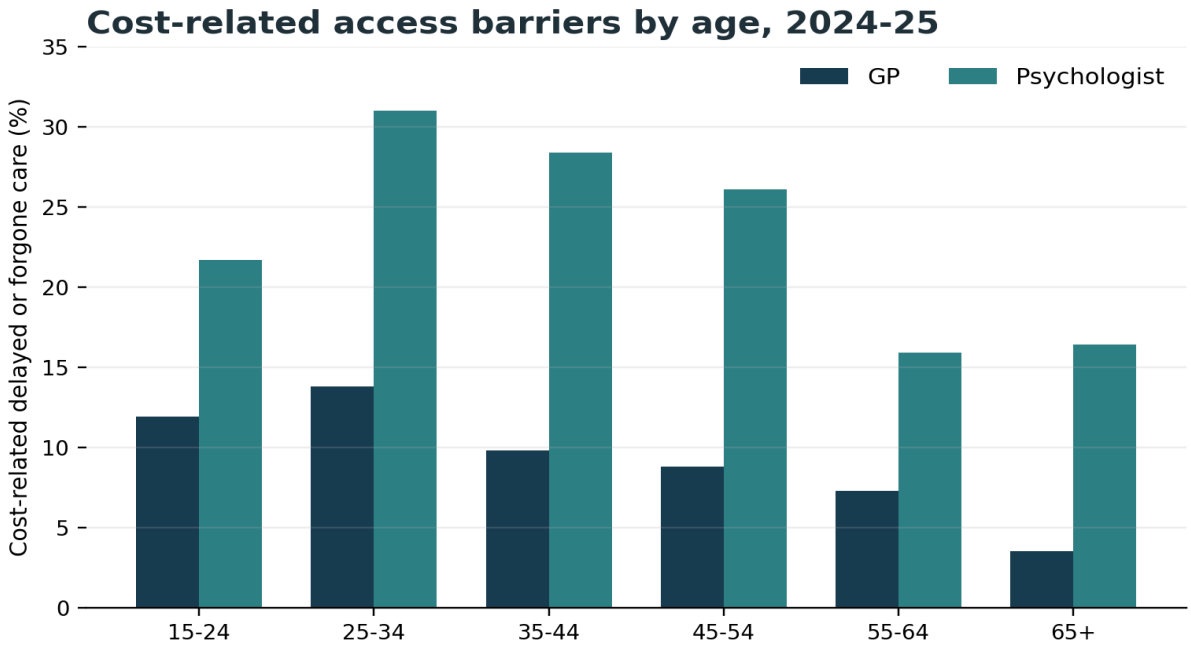
The psychologist cost-related barrier increased from 16.6% in 2020-21 to 25.3% in 2024-25. The GP mental-health cost barrier increased from 5.8% to 9.6% over the same endpoints. The latest year showed a small reduction from 25.6% to 25.3% for psychologists, but the level remained materially above 2020-21. [1-5]

The Productivity Commission independently reports that in 2024-25 respondents were almost two and a half times as likely to report cost-related delay for psychologists, psychiatrists and other mental-health professionals collectively (23.8%) as for GPs (9.6%). [9]

7. Age, sex and socioeconomic differences

7.1 Age

Cost-related barriers vary substantially by age. The highest 2024-25 psychologist cost-barrier rate was among people aged 25-34 years, at 31.0%. The largest absolute psychologist-GP difference occurred among people aged 35-44 years, at 18.6 percentage points. [1]



Source: ABS Patient Experiences 2024-25. [1]

Age	GP	Psychologist	Absolute gap
15-24	11.9%	21.7%	9.8 pp
25-34	13.8%	31.0%	17.2 pp
35-44	9.8%	28.4%	18.6 pp
45-54	8.8%	26.1%	17.3 pp
55-64	7.3%	15.9%	8.6 pp
65+	3.5%	16.4%	12.9 pp

7.2 Sex

Among people needing psychologist care in 2024-25, 28.4% of females and 20.2% of males reported cost-related delay or non-attendance. Females were also more likely overall to report use of mental-health professionals. The aggregate survey does not establish the causes of these differences. [1]

7.3 Socioeconomic disadvantage

Among people needing mental-health care, 22.6% of those living in the most socioeconomically disadvantaged areas reported delaying or not obtaining care due to cost, compared with 15.5% in the least disadvantaged areas. [1]

AIHW Medicare data show a separate utilisation gradient: by 2024-25, the service rate in the most disadvantaged SEIFA quintile was around 60% lower than in the least disadvantaged quintile, while the patient rate was around 40% lower. [7] These are area-level utilisation measures and should not be interpreted as individual-level causal effects.

8. Geography, workforce and capacity

Geographic access requires separate consideration of affordability, utilisation and workforce capacity. A lower reported cost barrier in one geographic group does not necessarily indicate greater service availability.

8.1 Patient experience by remoteness

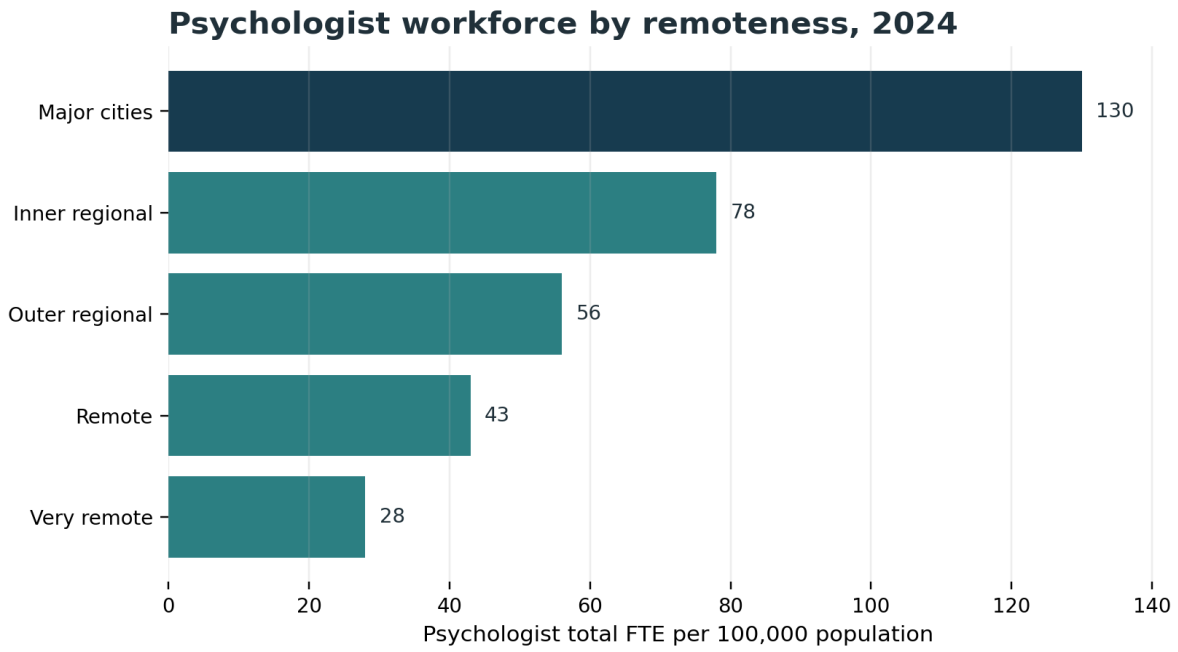
In 2024-25, people in major cities were more likely than those living in outer regional or remote areas to report delaying or not obtaining mental-health care due to cost (20.6% versus 13.0%). [1] This should not be interpreted as evidence that remote access is better overall.

8.2 Medicare utilisation

AIHW reports that Medicare mental-health service rates have been consistently highest in major cities. Across the decade to 2024-25, inner regional service rates were around 10% lower, outer regional rates around 40% lower, and remote/very remote rates moved from around 80% below major-city rates to around 70% below. Patient rates in outer regional and remote/very remote areas were around 20% and 60% lower, respectively, than the higher-access areas. [7]

8.3 Psychologist workforce

In 2024 there were about 36,900 psychologists employed in their registered profession in Australia. The national psychologist headcount rate was 136 per 100,000 population, total FTE rate 113, and clinical FTE rate 82. Total psychologist FTE increased from 88 per 100,000 in 2015 to 113 in 2024, an increase of about 28%. [8]



Source: AIHW National Health Workforce Dataset, 2024. [8]

The very remote psychologist FTE rate of 28 per 100,000 was about 78.5% below the major-city rate of 130. Workforce FTE is a capacity indicator, not a direct measure of appointment availability: practitioners may work outside private practice, may not accept new patients, or may not participate in Better Access.

9. Medicare service volume and utilisation

In 2024-25, about **13.0 million Medicare mental-health services** were provided at an average of five services per patient and an overall rate of 473 services per 1,000 population. Ninety-six per cent were delivered out of hospital. [7]

Combined clinical and other psychologist services produced the highest provider service rate at 226 per 1,000 population, followed by GP-specific mental-health services at 122 per 1,000. GPs were seen by 77% of people who received Medicare mental-health services. [7]

2024-25 Medicare measure	National result
Total mental-health services	~13.0 million
Overall service rate	473 per 1,000 population
Psychologist service rate	226 per 1,000 population
GP-specific mental-health service rate	122 per 1,000 population
Average services per patient	5 overall; 2 for GP-specific services
Setting	96% out of hospital
People receiving a GP mental-health service	77% of Medicare mental-health service users

Source: AIHW Medicare mental health services. [7]

9.1 Growth does not eliminate unmet access

Between 2015-16 and 2024-25, total Medicare mental-health services increased from about 10.6 million to 13.0 million. The service rate rose from 443 to 473 per 1,000 population, after peaking at 546 during 2020-21. [7]

The coexistence of high service activity and substantial patient-reported barriers is not contradictory. A system can deliver more services while still leaving part of demand unmet, delayed or unaffordable.

10. Telehealth and access

Telehealth is now an established mode of mental-health care. Among people who both needed and saw a health professional for their mental health in 2024-25, **26.0%** used telehealth at least once. [1]

Better Access permits individual mental-health treatment services to be delivered by telehealth where safe and clinically appropriate. Services Australia states that video is the preferred alternative to face-to-face care, although some services can be delivered by phone when video is not available. [10]

Telehealth can reduce travel requirements and broaden provider choice beyond a person's immediate locality. However, persistent geographic workforce and Medicare utilisation disparities indicate that telehealth should not be treated as a complete solution to access inequality. Affordability, digital access, clinical suitability, patient preference and provider capacity remain relevant.

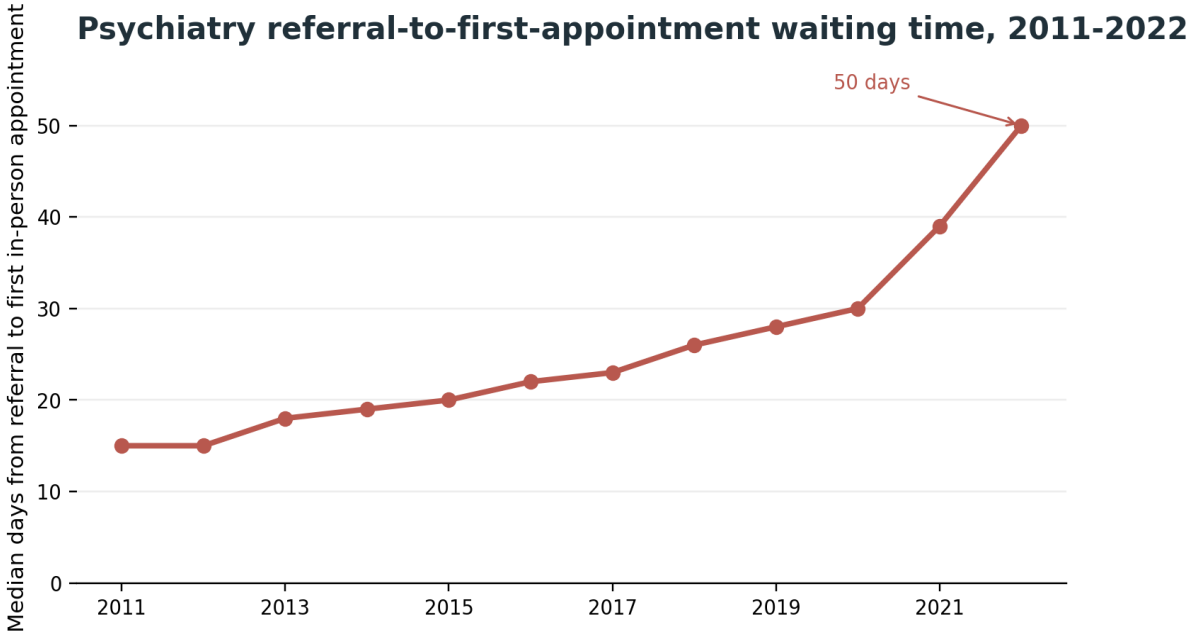
11. Waiting times and referral-to-treatment measurement

Waiting time is one of the most intuitive indicators of healthcare access, but it is not comprehensively measured for the national GP-to-psychology pathway.

The ABS can measure whether respondents delayed or did not obtain a needed service. That does not quantify the number of days between a particular GP referral and the first psychologist appointment.

11.1 Psychiatry as a methodological comparator

A 2025 JAMA Network Open study used whole-of-population Medicare-linked data to analyse 1,459,366 observations of GP referral to first psychiatric specialist appointment from 2011 to 2022. For in-person psychiatry, the median wait increased from 15 days in 2011 to 50 days in 2022. Regional and remote areas generally experienced longer waits than major cities. [15]



Source: Yang & Zhang, JAMA Network Open, 2025. [15]

Psychiatry waiting times should not be used as a proxy for psychology. The relevance of this study is methodological: it demonstrates that referral-to-first-appointment time can be measured when linked administrative data are available.

12. What happens after the referral?

A referral-access pathway can be divided into six stages. The framework below is not a claim that every patient follows the same clinical sequence; it is a measurement model for identifying where access may be lost.

Stage	Point in pathway	What it represents	National data visibility
1	Need identified	Mental-health concern is recognised by the patient or clinician	Strong national measurement
2	Entry to care	Person reaches a GP or another first-contact service	Strong national measurement
3	Referral decision	Clinician selects Better Access or another pathway	Rules measured; activity only partly visible
4	Referral conversion	Provider receives referral, has capacity and accepts patient	Limited national visibility
5	Treatment access	Appointment can be afforded, scheduled and attended	Strong self-reported barrier data
6	Continuity	Treatment continues and information returns to referrer	Partly measured; incomplete referral-specific data

The least visible stage in the principal national datasets is **referral conversion**: whether a referral reaches a suitable provider, is accepted, results in timely contact, and converts into a first attended appointment.

13. Communication and continuity of care

Referral success should not be defined only as attendance at a first appointment. Mental-health care can require communication between treating practitioners, ongoing review and further referral.

Services Australia requires allied mental-health professionals under Better Access to provide a written report to the referring medical practitioner after each course of treatment, including assessments undertaken, treatment provided and recommendations for future management. If treatment is not completed, a report is required after the last service. [10]

Broader ABS coordination data, while not mental-health-specific, show that among people who saw three or more health professionals for the same condition in 2024-25, 16.3% reported problems caused by lack of communication. Among those who received coordinated care, 60.1% said GPs helped most with coordination. [1]

These results reinforce the value of treating feedback to the referring practitioner as part of the access-and-continuity pathway rather than viewing the referral as complete once it has been sent.

14. National referral and access data gaps

Australia has extensive mental-health data, but coverage is uneven across the referral pathway. This review found strong national measures for need, provider use, Medicare service volume, cost barriers, self-reported delayed or forgone access, telehealth, workforce, geography and socioeconomic variation.

It found substantially less routinely published national information for the following stages:

- total number of GP psychology referrals issued
- percentage of referrals received by providers
- percentage accepted by the first provider
- percentage declined because of provider capacity
- referrals redirected to another provider
- time from referral to first provider contact
- time from referral to first psychologist appointment
- number of providers contacted before successful placement
- patients abandoning the process before treatment
- referrals not pursued after fees are disclosed
- first-appointment attendance after referral
- continuation beyond the first session where further treatment is indicated
- completion of the intended treatment course
- routine communication back to the referring GP.

The appropriate conclusion is not that none of these data exist anywhere. Individual services, PHNs, research projects or administrative systems may collect some of them. The narrower finding is that **no routinely published, nationally comparable measure was identified that follows Better Access psychology referrals through the complete sequence from GP referral to treatment commencement and completion.**

15. Proposed Australian Mental Health Referral Access Indicators

A future national referral-access framework could complement existing service-volume reporting with measures focused on conversion and continuity.

Indicator	Definition
Referral volume	Number of referrals issued for psychological or other mental-health treatment.
First-provider acceptance	Percentage accepted by the first provider approached.
Referral redirection	Percentage requiring another provider because of capacity, scope or other reasons.
First contact	Median time from referral to provider contact.
Treatment access	Median time from referral to first attended clinical appointment.
Affordability attrition	Percentage not proceeding after expected out-of-pocket cost is known.
Appointment conversion	Percentage of accepted referrals resulting in a first attended appointment.
Continuity	Percentage continuing beyond the first appointment where further care is recommended.
Completion/review	Percentage reaching planned completion or formal clinical review.
Communication	Percentage for which appropriate clinical feedback returns to the referring practitioner.

The purpose of this proposed indicator set is not to prescribe one model of care. It is to distinguish **referral activity** from **referral effectiveness** and make otherwise invisible points of attrition measurable.

16. Discussion

The evidence describes an Australian mental-health system with substantial service capacity and substantial access pressure at the same time. Australia has a sizeable and growing psychology workforce, millions of Medicare mental-health services each year, established telehealth, and alternative referral-free pathways. Yet more than one-third of people reporting a need for mental-health professional care in 2024-25 experienced delay or failed to obtain care on at least one occasion. [1,7,8]

16.1 The GP-to-Psychology transition deserves specific attention

The five-year ABS series shows a notable consistency: psychologist access barriers have remained materially above GP mental-health access barriers in every year examined. The absolute difference varies, but the relative psychologist barrier remains around 1.5-1.6 times the GP rate. [1-5]

This consistency supports continued measurement of provider-specific access, but the data cannot establish which mechanisms explain the gap. Availability, waiting time, affordability, geography, treatment preferences, suitability and other factors may all contribute.

16.2 Affordability is a major component

The 2024-25 cost-related psychology barrier was approximately 2.64 times the GP mental-health rate. The largest age-specific psychologist cost barrier was 31.0% among people aged 25-34 years. [1]

16.3 Workforce growth has not eliminated geographic inequality

National psychologist FTE increased by about 28% from 2015 to 2024, yet 2024 psychologist FTE in very remote areas remained only about 22% of the major-city rate. Medicare service utilisation is also markedly lower outside major cities. [7,8]

16.4 Activity and access must be measured separately

The report's main interpretive point is that a high volume of billed services does not, on its own, reveal whether everybody who needs care can obtain it. Nor does a written referral demonstrate that treatment has begun. The system needs both activity measures and conversion/access measures.

17. Implications for general practice

The findings support a practical principle: referral quality involves both **clinical appropriateness** and **access feasibility**.

- Confirm the current Better Access eligibility and referral requirements before relying on a Mental Health Treatment Plan alone.
- Where possible, consider whether the intended provider or service has capacity and whether expected out-of-pocket costs are workable for the patient.
- Discuss modality and location, including telehealth where clinically appropriate and acceptable to the patient.
- Provide the clinical information required for the referral and enough relevant context to support continuity.
- Consider alternative services where Better Access psychology is not clinically appropriate or is unlikely to be accessible.
- Plan for review and receipt of treatment feedback rather than treating the referral as the end of the episode.

These principles are not clinical directives for individual cases. They describe system-level considerations suggested by the access data and current referral architecture.

18. Implications for mental-health providers

Provider processes can influence whether a referral converts into treatment. Practical operational measures include maintaining clear referral criteria, current capacity information, transparent fees, prompt acknowledgement of referrals, timely notification when a referral cannot be accepted, and appropriate communication with referring practitioners.

Current Better Access requirements also create formal reporting obligations after each course of treatment. [10] Referral pathways work best when information moves in both directions.

19. Implications for health-system measurement

Australian reporting is strong on service activity. A complementary national focus on referral conversion could answer questions that service counts cannot:

- How many referrals result in an accepted placement?
- How long is the interval from referral to first treatment?
- At what point do patients leave the pathway?
- How often does cost prevent conversion after a service has been identified?
- How often must patients approach multiple providers?
- Does telehealth improve conversion where local workforce supply is low?
- How consistently does clinical information return to primary care?

Routine reporting of these measures would make it easier to distinguish provider supply, service utilisation, patient experience and referral effectiveness.

20. Conclusion

Australia has a large and active mental-health system. General practice remains central to that system, psychologists provide millions of Medicare-funded services each year, and telehealth and referral-free pathways have broadened available options.

However, substantial barriers remain between needing care and obtaining it. In 2024-25, 38.8% of people who reported needing a psychologist delayed or did not obtain that care, compared with 24.2% of those needing a GP for mental health. The resulting 14.6 percentage-point GP-to-Psychology Access Gap sits within a persistent five-year pattern. [1-5]

Cost represents an even larger relative divergence: 25.3% for psychologist care versus 9.6% for GP mental-health care, producing a Psychology Cost Barrier Ratio of approximately 2.64. [1]

At the same time, psychology workforce and Medicare service utilisation remain strongly geographically distributed, with substantially lower rates outside major cities. [7,8]

A referral is an important clinical action, but it is not itself an access outcome. A complete access framework should therefore measure not only whether needs are identified and services are delivered, but whether referrals are accepted and convert into timely, affordable, sustained treatment.

Appendix A. Detailed methodology

A1. Study design

National secondary analysis of publicly available Australian aggregate statistics, administrative reporting, health-policy documents and selected peer-reviewed research. The principal reference period is 2024-25. Historical series are used where definitions remain sufficiently comparable.

A2. Population and unit differences

Source	Population / unit	Principal use
ABS Patient Experiences	People aged 15+ who are usual residents of private dwellings	Need, utilisation, access barriers, cost, telehealth and selected demographic comparisons
ABS NSMHW 2020-22	People aged 16-85 in private dwellings	Mental-disorder prevalence and service use among people meeting diagnostic criteria
AIHW Medicare	MBS mental-health-specific patients and billed services	Service volume, patient reach, provider type, geography and socioeconomic distribution
AIHW workforce	Registered practitioners and FTE	Workforce capacity and geographic distribution
Productivity Commission	National performance reporting drawing on multiple datasets	Independent system-level corroboration
JAMA psychiatry study	Linked GP referral-to-first-psychiatrist appointment observations	Methodological comparator for waiting-time measurement

A3. Inclusion criteria

- Australian evidence with an identifiable source and reference period.
- Nationally representative or national administrative data preferred.
- Measures directly relevant to mental-health need, primary care, referral, access, affordability, utilisation, workforce or continuity.
- Peer-reviewed research used selectively where government datasets do not answer the relevant question.

A4. Exclusion rules

- Unidentified or unsourced national statistics.
- Provider-specific waiting times represented as national estimates.
- Overseas data used as Australian evidence.
- Commercial surveys without adequate methodology as principal quantitative evidence.
- Therapy Near Me internal operational data used to infer national performance.

A5. Missing data

Missing information is not treated as zero. “Not available”, “not collected”, “not reported”, “not comparable”, “estimate suppressed/unreliable” and “not applicable” are conceptually distinct.

A6. Derived indicator formulas

Indicator	Formula	2024-25 result
GP-to-Psychology Access Gap	Psychologist delayed/forgone rate - GP delayed/forgone rate	38.8% - 24.2% = 14.6 pp
Relative Psychology Access Barrier	Psychologist delayed/forgone rate ÷ GP rate	38.8 ÷ 24.2 = 1.60×
Psychology Cost Barrier Gap	Psychologist cost barrier - GP cost barrier	25.3% - 9.6% = 15.7 pp
Psychology Cost Barrier Ratio	Psychologist cost barrier ÷ GP cost barrier	25.3 ÷ 9.6 = 2.64×
Very remote workforce gap	1 - (very remote FTE ÷ major city FTE)	1 - (28 ÷ 130) = 78.5% lower

A7. Statistical approach

The analysis is primarily descriptive. It uses percentages, percentage-point differences, ratios, rates per population and time trends. A numerical difference is not described as statistically significant unless the underlying source provides evidence supporting that statement. Calculations in this report are generally based on the published rounded estimates, so derived ratios should be read as approximate.

A8. Research integrity rules

- No causal claim is made from descriptive associations.
- No attempt is made to convert survey-reported need into a referral count.
- Medicare services are not treated as unique patients or referrals.
- Workforce headcount/FTE is not treated as accepting-new-patient capacity.
- Psychiatry waiting time is not used as a proxy for psychology waiting time.
- Historical data are labelled by reference period and not presented as current prevalence.

A9. Data-gap audit method

For each conceptual referral stage, the review searched the principal national sources for a routinely published, nationally comparable measure. A “data-gap finding” means such a measure was not identified in the reviewed national sources; it does not assert that no local, administrative or research dataset exists anywhere in Australia.

Appendix B. DOI and bibliographic metadata

The DOI assigned to this report is shown below. The remaining metadata is formatted for repository, citation and bibliographic use.

B1. DOI / repository metadata

Metadata element	Registration-ready value
Title	From GP Referral to Mental Health Care: Australian Access & Referral Report 2026
Creator	Therapy Near Me Research
Publisher	Therapy Near Me Pty Ltd
Publication date	2026-10-01
Version	1.0
Resource type	Text / Research report
Language	en-AU
Canonical URL	https://therapynearme.com.au/gp-mental-health-referral-guide-australia/
Subjects	mental health; general practice; GP referral; psychology; Better Access; access to care; affordability; telehealth; workforce; Australia
Description	National secondary analysis of Australian referral pathways, patient-reported access barriers, affordability, Medicare utilisation, psychology workforce distribution and referral-data gaps.
Rights	Copyright © 2026 Therapy Near Me Pty Ltd. All rights reserved.
DOI	10.5281/zenodo.23129585

B2. Citation / bibliographic metadata

Field	Value
Title	From GP Referral to Mental Health Care
Subtitle	Australian Access & Referral Report 2026
Corporate author	Therapy Near Me Research
Publisher	Therapy Near Me Pty Ltd
Edition	1st edition / Version 1.0
Publication date	1 October 2026
Country of publication	Australia
Language	English
Format	Digital PDF
DOI	10.5281/zenodo.23129585

B3. Abstract for repository records

This report examines how Australians progress from a need for mental-health care through general practice and into psychological and other mental-health treatment. Using Australian Government patient-experience, Medicare and workforce data, it quantifies a persistent difference between reported access to GP mental-health care and psychologist care, analyses cost and demographic barriers, examines geographic workforce and utilisation inequalities, and identifies national gaps in measurement between referral issuance and treatment commencement. The report is a secondary analysis and does not use patient-level Therapy Near Me data.

Appendix C. Evidence-source register

ID	Source	Reference period / status	Used for
1	ABS Patient Experiences 2024-25	2024-25	Principal access, cost, demographics, telehealth, coordination
2	ABS Patient Experiences 2023-24	2023-24	Trend series
3	ABS Patient Experiences 2022-23	2022-23	Trend series
4	ABS Patient Experiences 2021-22	2021-22	Trend series
5	ABS Patient Experiences 2020-21	2020-21	Trend baseline
6	ABS NSMHW	2020-22	Prevalence and service use among people with a 12-month disorder
7	AIHW Medicare mental health services	2024-25; updated May 2026	Medicare service volume, patient reach, geography, SEIFA
8	AIHW mental health workforce	2024	Psychologist workforce and remoteness
9	Productivity Commission ROGS 2026	2024-25 where relevant	Independent performance corroboration
10	Services Australia Better Access referrals	Current page accessed 1 Oct 2026	Referral eligibility, course limits, content, reports, telehealth
11	Department Better Access redesign	From 1 Nov 2025	MyMedicare/usual-practitioner reform
12	Department Better Access FAQ	Published May 2026	Current policy clarification
13	Medicare Mental Health	Updated Jun 2026	Referral-free pathways
14	AskMBS Advisory - mental health treatment	Updated Mar 2026	Treatment plan vs referral distinction
15	Yang & Zhang, JAMA Network Open	2011-2022 data; published 2025	Psychiatry referral waiting-time comparator
16	MBS explanatory material	Current	Better Access referral requirements

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