Australian Government
Department of Health and Ageing

Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative

Questions and Answers

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1. GENERAL

1.1 What is the Better Access initiative?
The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative includes a range of Medicare rebateable services for people with a diagnosed mental disorder, including psychological services provided by appropriately qualified psychologists, social workers and occupational therapists.

Better Access was introduced in November 2006.

Eligible individuals may access up to 12 individual and up to 12 group allied mental health services in a calendar year. In exceptional circumstances, a GP may also recommend a further six individual services to a maximum of 18 services per calendar year.

The services covered under the Better Access initiative are psychological interventions that have demonstrated the best research evidence of clinical effectiveness for short term treatment of mental disorders, such as cognitive behavioural therapy.

1.2 When did the program evaluation of the Better Access begin and when was it completed?
The Department of Health and Ageing commissioned an independent evaluation of the program, which began in January 2009 and was completed at the end of 2010. The evaluation comprised of seven components plus a summative evaluation, and was overseen by experts in the research and mental health fields.

The summative evaluation which drew together the findings of the seven component reports was finalised in mid February 2011.

1.3 What was the purpose of the evaluation?
The program evaluation of the Better Access initiative aimed to assess the overall appropriateness, effectiveness and impact of the initiative.

1.4 What were the component parts of the evaluation?
An evaluation framework was developed at the start of the Better Access initiative, to guide the evaluation of the initiative.

The evaluation framework originally included six components (Components A-F), and a seventh was subsequently added (Component A.2).

The evaluation framework included a summative evaluation that was designed to bring together the findings from the evaluation components, as well as additional data sources to answer a series of evaluation questions.

In order to measure the effectiveness of the Better Access initiative, the evaluation included the following components:

- Component A: A consumer outcomes study to provide information on the outcomes of individual patient care.
• Component A.2: A consumer outcomes study to provide information on the outcomes of individual patient care focusing specifically on social workers, occupational therapists and their clients.

• Component B: A detailed analysis of routinely collected MBS and PBS data focusing on access, affordability, and the level and mix of service use and patterns of use of Better Access services. It also includes an examination of the extent to which there have been any changes in PBS medication use (in particular, use of anti-depressants).

• Component C: An analysis of the impact of the introduction of the Better Access initiative on the supply and distribution of the allied mental health workforce (psychologists, social workers and occupational therapists), including the extent to which there has been any change between the public and private sectors.

• Component D: A stakeholder consultation component focusing on stakeholders’ experiences, perceptions and opinions with regard to the effectiveness and appropriateness of the Better Access initiative.

• Component E: An evaluation of education and training activities to determine the extent to which these activities have changed the knowledge, skills, confidence and practices of professionals, and how they have supported interdisciplinary care.

• Component F: An analysis of the 2007 National Survey of Mental Health and Wellbeing to provide information on prevalence and service use for high prevalence mental disorders.

• An overall summative evaluation that draws on all the components above, and other relevant information (eg the Better Access post-implementation review), to determine the extent to which Better Access has achieved its objectives and has been an effective response to the need for primary mental health treatment for people with common mental disorders.

1.5 Who conducted the evaluation for the Australian Government?
In January 2009, following an open tender process, the Department appointed the following three consultants to undertake Components A to D of the evaluation.

Components A, A.2 and B were undertaken by the Centre for Health Policy, Programs and Evaluation, The University of Melbourne.

Component C was undertaken by the National Institute of Labour Studies, Flinders University.

Component D was undertaken by KPMG.

Component E draws on the evaluations of each of the individual education and training projects funded under the Better Access initiative, particularly the evaluation of the Mental Health Professionals Network project and was conducted by the Centre for Health Policy, Programs and Evaluation, The University of Melbourne.

Component F was conducted by the Department.
2. KEY FINDINGS

2.1 What is the overall level of uptake of Better Access services?
Use of Medicare rebatable mental health services under the Better Access initiative has been high and has increased over time.

In 2007, more than 700,000 Australians (one in every 30) received at least one Medicare rebatable mental health service under the initiative. In 2008, this figure was more than 950,000 (one in every 23), rising to more than 1.1 million people (one in every 19) in 2009.

Consumers received a total of 2.7 million Better Access services in 2007, 3.8 million in 2008 and more than 4.6 million in 2009.

After accounting for some people who received services in more than one year, this equates to more than two million individuals who received more than 11.1 million services over the three year period from 2007 to 2009.

2.2 Has Better Access increased the treatment rates for people with mental disorders?
The evaluation found that Better Access has increased the treatment rates for individuals with mental illness. In the 2007 National Survey of Mental Health and Wellbeing, it was estimated that 35% of people with a mental disorder in the previous 12 months accessed treatment, while in 2010 this has grown to an estimated 46%.

2.3 Has Better Access reached groups who are traditionally disadvantaged in terms of access to mental health care?
The evaluation found that people in hard to reach groups are accessing Better Access but that there are still some groups who are not accessing the services they need. This is particularly the case with young people aged less than 15 years, men, people living in rural and remote regions and people living in areas of high socio-economic disadvantage.

However all groups are using the services more each year, with the biggest increase for those who have traditionally been the most disadvantaged. For example, the relative growth in uptake between 2007 and 2009 was considerably greater for young people under 15 years than for all other age groups.

Two-thirds of people who used Better Access (65.5% in 2009) live in capital cities. Geographic disadvantage continues to be an issue – compared to capital cities, people living in rural areas used the services 12% less and people living in remote areas used the services 60% less.

Additionally, people in areas of socio-economic disadvantage are not using services at the same level as the broader population, with use of Better
Access around 10% lower for people living in the most socio-economic disadvantaged areas than in all other areas. People with the greatest levels of financial need were the biggest beneficiaries of bulk-billed services. The proportion of services that were bulk-billed increased from 68% in rural centres to just under 72% in remote areas. Bulk-billing levels also increased as the level of relative socio-economic disadvantage increased.

2.4 Has Better Access reached new consumers?
The evaluation indicates that around half of all Better Access consumers may be new, not only to Better Access but to mental health care more generally (see Component A report).

Of the more than 950,000 consumers who had received at least one Better Access service in 2008, more than two thirds were first-time Better Access users. In 2009, more than half of the 1.1 million consumers served by Better Access were first-time users (see Component B report).

2.5 Has Better Access reached consumers with moderate to severe disorders, or has it predominantly provided care to those with mild symptoms?
According to the evaluation, Better Access is providing treatment to people in need, i.e. people with severe symptoms and high levels of psychological distress.

The majority of consumers accessing mental health services under Better Access were experiencing depression and/or anxiety. This is consistent with the aim of the initiative, which is to improve access for people with common mental disorders who historically had low treatment rates.

Among consumers who received Better Access allied mental health services, 72.7% received between one and six services. The average number of services received was five.

2.6 Is Better Access achieving positive mental health outcomes for consumers?
The evaluation indicates that Better Access consumers experience clinically significant reductions in levels of psychological distress and symptom severity upon completing treatment. Consumers reported a decrease from high or very high levels of psychological distress at the start of treatment to more moderate levels of psychological distress at the end of treatment.

The same outcomes were achieved whether the consumer was male or female, young or old, or wealthy or financially disadvantaged.

2.7 Is Better Access a cost-effective way of delivering primary mental health care?
While it was difficult for the evaluation to assess cost-effectiveness directly, findings show the typical cost of a Better Access package of care delivered by a psychologist is estimated to be $753.31. Based on cost modelling for optimal treatments for a population with common disorders, it is estimated that optimal treatment for anxiety or depressive disorders costs about $1,100 in 2010 dollars.
3. METHODOLOGY

3.1 Was data on consumer outcomes collected as part of the evaluation?

Data on consumer outcomes was collected in Component A, using standardised and clinically sound measures of psychological distress, depression, anxiety and stress.

In addition, the summative evaluation drew on other research studies that have assessed consumers’ mental health outcomes in a similar way to that used in the evaluation.

3.2 How were mental health professionals and consumers recruited to participate in Components A and A.2 of the evaluation?

In Component A, randomly-selected groups of providers (GPs, clinical and registered psychologists and psychiatrists) were approached to participate by the researchers undertaking the evaluation.

Once they agreed to participate, providers approached consecutive new consumers (according to a specific protocol) and invited these consumers to take part in the evaluation.

Consumers were required to contribute information through outcome measures and to participate in interviews and surveys.

In Component A.2, the recruitment process was similar, except that all social workers and occupational therapists providing services under Better Access were invited to participate, and they were asked to approach consumers who had completed treatment to take part in an interview/survey.

This is a common way of recruiting consumers noting that consumer outcome data is not held by Medicare Australia and therefore a special study is required to examine consumer outcomes.

3.3 What mechanisms were put in place to ensure that the evaluation was balanced and independent?

To ensure that the Better Access initiative evaluation was robust and quality assured by experts, the Department convened and chaired a Project Steering Committee (PSC) to oversee the evaluation. The PSC comprised members with specific experience, expertise and knowledge in relation to program evaluation and the delivery of mental health services. Members were appointed as individuals not representatives of their profession or professional organisation(s).

Members were:

- Professor Gavin Andrews, School of Psychiatry, University of New South Wales (from January 2009 to March 2011)

- Ms Janne McMahon, Consumer, Chair, Private Mental Health Consumer Care Network (Australia) (from January 2009 to March 2011)
• Professor Alan Fels, Carer, Dean, Australian and New Zealand School of Government (from January 2009 to March 2011)

• Emeritus Professor Cliff Walsh, Research Fellow, Department of Economics, University of Adelaide (from January 2009 to March 2009)

• Dr Chris McAuliffe, GP and Mental Health GP Advisor to the Australian General Practice Network (from January 2009 to March 2011)

• Adjunct Professor John Mendoza, Former Chair, National Advisory Council on Mental Health (NACMH) (from January 2009 to June 2010)

• Mr Ron Hunt, CEO Occupational Therapy Australia (from July 2010 to March 2011)

• Ms Kandie Allan Kelly, CEO Australian Association of Social Workers (from July 2010 to March 2011)

• Professor Lyn Littlefield, Executive Director, The Australian Psychological Society Ltd (from July 2010 to March 2011)

In accordance with standard Departmental procedures, all PSC members were required to notify the Chair of any actual or potential conflicts of interest at each PSC meeting. All members completed annual conflict of interest and confidentiality agreements.

4. STAKEHOLDERS CONSULTED

4.1 Which stakeholders were consulted as part of the evaluation?
A broad range of more than 1200 stakeholders were consulted.

This included national as well as state and territory peak professional organisations, consumers and carers, individual experts, NGO mental health service providers, public mental health service providers, private inpatient mental health services, private health insurers, general practitioners, psychiatrists and individual private providers, including allied mental health professionals.

The evaluation used a number of methods to consult with stakeholders including individual and small group interviews, workshops and focus groups and online surveys.

4.2 How were social workers, occupational therapists and their clients involved in the evaluation?
Social workers and occupational therapists were consulted and included in each of the component parts of the evaluation.
A specific study was undertaken on consumer outcomes focusing specifically on social workers and occupational therapists and their clients under the Better Access initiative (Component A.2).

The component evaluations for client outcomes have slightly different methodologies to account for the different sample sizes for Component A (psychiatrists, psychologists and general practitioners) and Component A.2 (social workers and occupational therapists).

While there was initial concern regarding the small sample size that could be drawn from social workers and occupational therapists and the reliability of the data, the methodologies for Components A and A.2 are also slightly different due to the fact that the timing of the start of Component A.2 did not allow for pre and post outcomes data to be collected.

The consultant who completed both of these components designed the methodology for Component A.2 to enable comparison with Component A. Qualitative findings from Component A.2 are comparable with the findings from Component A.

5. AUSTRALIAN GOVERNMENT PRIMARY MENTAL HEALTH CARE PROGRAMS

5.1 In addition to Medicare rebatable mental health services available under Better Access, what other services are available to people with mental illness?

To complement Medicare mental health services, the Department of Health and Ageing also funds Divisions of General Practice under the Access to Allied Psychological Services (ATAPS) program. This allows GPs to refer patients who have been diagnosed as having a mental disorder to an allied health professional to provide short term focused psychological strategies services. ATAPS primarily treats people with common mental disorders such as anxiety and depression and targets hard to reach groups who are under-represented in the services provided through Better Access.

In the 2010-11 Budget it was announced that the Australian Government will fund a new Flexible Care Packages for people with severe mental illness measure as a new component of ATAPS. This will provide better clinical and non-clinical support for up to 25,000 people with severe mental illness in the community, built around their individual needs.

The Australian Government also provides targeted funding for mental health services in rural and remote areas under the Mental Health Services in Rural and Remote Areas (MHSRRA) Program. Non government organisations are funded to deliver mental health services by appropriately trained mental health care workers, including psychologists, social workers, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers.
6. FURTHER INFORMATION

6.1 What further information is available about the Better Access initiative evaluation?

The evaluation reports, these Q&As and a Factsheet are available from www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-eval

If you have any difficulty accessing the PDF printable versions of the Better Access evaluation reports, please email mentalhealth@health.gov.au

For all media enquiries, contact the office of the Minister for Mental Health and Ageing on (02) 6277 7280.