Chapter 4: Question 2 – Is Better Access an effective (and cost-effective) model of service delivery?

2a. Is Better Access achieving positive outcomes for consumers?

Better Access appears to be achieving positive outcomes for consumers. The strongest evidence for this comes from Component A of the evaluation.[3] As described earlier, Component A followed 883 consumers (289 recruited by clinical psychologists, 317 recruited by registered psychologists and 277 recruited by GPs) and examined the difference between mean pre- and post-treatment scores on standardised outcome measures for consumers with "matched pairs" of pre- and post-treatment scores. Table 13 summarises the findings. Consumers recruited by all three types of providers showed a decline from high or very high levels of psychological distress at the start of treatment to much more moderate levels of psychological distress at the end of treatment, as assessed by the Kessler-10 (K-10). Consumers who were recruited by clinical psychologists and registered psychologists shifted from moderate or severe levels of depression, anxiety and stress to normal or mild levels of these symptoms (as assessed by the Depression Anxiety Stress Scales, or DASS-21).

Table 13: Outcome data for consumers who participated in Component A and had "matched pairs" of pre- and post-treatment scores on standardised measures[1]

		Pre-treatment mean (s.d.)	Post-treatment mean (s.d.)	Mean difference (s.d.)	P-value
Consumers recruited by clinical psychologists	**K-10[4] (n=193)**	28.63 (7.57)	19.09 (6.96)	9.53 (7.84)	0.000
	DASS_Depression[5] (n=205)	21.02 (11.00)	9.66 (9.63)	11.37 (10.92)	0.000
	DASS_Anxiety[6] (n=205)	14.75 (9.44)	7.58 (7.32)	7.17 (8.73)	0.000
	DASS_Stress[7] (n=205)	22.85 (8.58)	12.93 (8.48)	9.93 (9.50)	0.000
Consumers recruited by registered psychologists	**K-10[4] (n=192)**	29.44 (7.33)	18.86 (7.13)	10.58 (8.83)	0.000
	DASS_Depression[5] (n=204)	20.41 (10.58)	8.96 (8.99)	11.46 (11.43)	0.000
	DASS_Anxiety[6] (n=204)	15.34 (9.59)	6.55 (7.01)	8.78 (10.09)	0.000
	DASS_Stress[7] (n=204)	23.91 (9.41)	12.22 (9.28)	11.69 (11.01)	0.000
Consumers recruited by GPs[2,3]	**K-10[4] (n=177)**	30.89 (7.94)	22.88 (8.54)	8.01 (8.72)	0.000

1. Received care through Better Access between 1 Oct 2009 and 31 Oct 2010.
2. Consumers recruited by GPs may have received treatment from the GP in isolation or may have been referred to an allied health professional for further care.
3. The DASS-21 was only collected for consumers recruited by clinical and registered psychologists, and not by consumers recruited by GPs.
4. Standard cut-off scores for levels of psychological distress are as follows: 10-15 (Low); 16-21 (Moderate); 22-29 (High); ≥30 (Very high)
5. Recommended cut-off scores for conventional severity labels are as follows: 0-9 (Normal); 10-13 (Mild); 14-20 (Moderate); 21-27 (Severe); ≥28 (Extremely severe)
6. Recommended cut-off scores for conventional severity levels are as follows: 0-7 (Normal); 8-9 (Mild); 10-14 (Moderate); 15-19 (Severe); ≥20 (Extremely severe)
7. Recommended cut-off scores for conventional severity levels are as follows: 0-14 (Normal); 15-18 (Mild); 19-25 (Moderate); 26-33 (Severe); ≥34 (Extremely severe)

Mackey et al used a similar approach to that of Component A in their own private practice.[35 36] They followed 525 consumers who were seen by psychologists in a single private practice, and assessed them before and after treatment on the Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI), Positive and Negative Affect Scale (PANAS), Satisfaction with Life Scale (SWLS), Outcome Rating Scale (ORS), Session Rating Scale (SRS) and Global Assessment of Functioning Scale (GAF). They observed significant changes in average scores on all measures.

Hitch et al.[37] conducted a similar, smaller-scale study with 31 consumers who received Better Access care from one occupational therapist. They assessed pre- and post-treatment outcomes using the K-10. These consumers experienced statistically significant improvements, from a mean pre-treatment score of 25.68 (a high level of psychological distress) to a mean post-treatment score of 21.00 (a moderate level of psychological distress). Some caution must be exercised in generalising these findings because of the small sample of consumers seen by a single provider.

The interview and survey data collected in Components A[3] and A.2[3 4] provide further evidence that Better Access is achieving positive outcomes for consumers. In total, 936 consumers offered their views to the evaluation (133 recruited by clinical psychologists, 152 recruited by registered psychologists and 121 recruited by GPs in Component A; and 458 recruited by social workers and 72 recruited by occupational therapists in Component A.2). Almost universally, these consumers were satisfied with the clinical care they had received through Better Access. The majority indicated that they had experienced significant improvements in their mental health and their ability to cope with stressful situations. Most attributed these changes, at least in part, to the care they had received through Better Access.

These findings are reinforced by those from the Australian Psychological Society's survey of consumers who received psychological care through Better Access.[34] This study sought the views of 2,223 consumers. Ninety per cent of these consumers felt that the treatment they had received had led to "significant" (45%) or "very significant" (45%) improvement.

The findings from Component D support the conclusion that Better Access consumers are experiencing positive outcomes.[7] Component D involved consultations with more than 1,200 stakeholders (including representatives from professional bodies and peak non-government organisations, individual providers, consumers and carers). Overall, these stakeholders agreed that Better Access has improved outcomes for consumers. Many made comments along these lines during the course of interviews and workshops. A number responded to questions in online surveys that were also informative. For example, 90% of the 529 allied health professionals, GPs, psychiatrists and paediatricians who were asked whether they thought Better Access had improved mental health outcomes for people with anxiety or depressive disorders indicated that they "agreed". Similarly, 41% of the 110 consumers who rated the helpfulness of services they had received from an allied health professional under Better Access reported that the services had made them feel "much better", and another 41% indicated that they had made them feel "somewhat better".

2b. Do some consumers experience better outcomes than others?

Using a series of regression analyses, Component A assessed whether particular variables predicted better outcomes as measured by the K-10.[3] The analytic approach assessed the predictive value of a given variable while controlling for all other variables in the particular model, including the initial K-10 score. In the main, socio-demographic factors did not appear to predict outcomes after treatment; equivalent outcomes were achieved whether the consumer was male or female, young or old, or wealthy or struggling financially.

Clinical and treatment variables were generally better predictors of outcome. For consumers recruited by clinical psychologists, registered psychologists and GPs, those with the worst baseline psychological distress (i.e., higher pre-treatment K-10 scores) made the greatest gains. For consumers recruited by clinical psychologists, no other variables predicted outcomes. For consumers recruited by registered psychologists, those who had completed treatment or were still in treatment showed greater gains than those for whom treatment was incomplete (e.g., those who had dropped out of treatment), and those in metropolitan areas showed less improvements than their rural counterparts. For consumers recruited by GPs, those who had six sessions of care experienced better outcomes than those who had more or fewer. Those who had no previous history of mental health care showed greater levels of improvement than those who had received mental health care in the past.

2c. Is Better Access a cost-effective way of delivering primary mental health care?

It was beyond the scope of the summative evaluation to conduct a comprehensive cost-effectiveness analysis of Better Access. However, some comments can be made about whether Better Access appears to provide good value for money. This can be done by comparing the outcomes and costs of care for consumers seen by psychologists in tandem, and making comparisons with recognised standards. Outcomes were taken from Component A, and costs were considered in terms of current Medicare Benefits Schedule costs to government. It is recognised that the perspective and time horizon are limited because they do not take into account broader or longer-term outcomes (e.g., improved social participation) or costs (e.g., other costs to government, costs to consumers or broader societal costs). It is also acknowledged that the focus on services provided by psychologists is limited because it does not allow statements to be made about the value for money of services offered by other providers. We were restricted to this provider group in the current analysis because of our reliance on Component A for outcome data.

Component A indicated that the care provided by both clinical and registered psychologists was associated with positive clinical outcomes.[3] As noted in Table 13, above, the mean improvement on the K-10 was 9.53 points for consumers who received care from clinical psychologists and 10.58 points for those who received care from general psychologists. Taking the average of these two estimates, consumers who received care from any psychologist improved by 10.26 points.

Data from Component B showed clinical psychologists most frequently used item number 80010 and registered psychologists item number 80110. Together, these item numbers accounted for more than 90% of sessions of care delivered by these providers.[5] This pattern of service delivery was also apparent for the samples of clinical and registered psychologists who participated in Component A.[3] Item numbers 80010 and 80110 both provide a rebate for 50+ minute consultations provided in psychologists' rooms. The rebates for these item numbers are $119.80 and $81.60, respectively. The weighted average rebate for the two item numbers is $94.33.[g]

Component B also showed that the median number of psychological services per consumer was five.[5] The full samples of consumers recruited by clinical and registered psychologists in Component A also had a median of five sessions, and those for whom "matched pairs" of outcome data were available had a median of six. Taking the higher figure of six on the grounds that this is the number of sessions for which Medicare coverage is available in the first instance,

[g] This average is weighted to take into account the fact that, according to Component B, registered psychologists provide approximately twice as many services under item number 80110 as clinical psychologists do under item number 80010.

and multiplying it by the unit costs of the above rebate, the typical cost to government of a package of care from a clinical or registered psychologist is $566.00.

Since a GP referral is necessary for a consumer to receive care from a psychologist through Better Access, the rebate for a mental health treatment plan (item number 2710, rebate $163.35) was added to the above costs. It was not appropriate to include the rebate for a mental health treatment review (item number 2712, rebate $108.90) in all cases; Component B showed that the ratio of people receiving mental health treatment plans relative to people receiving mental health treatment reviews was 4.6:1.[5] Accordingly, 22% of the rebate (i.e., $23.96) was added to the cost of the typical package of care from a clinical or registered psychologist. Adding these GP-related costs brings the cost to $753.31. Taking the above cost and outcome data together, the average cost per one-point improvement on the K-10 was $73.46 for consumers who were seen by a clinical or registered psychologist.

Andrews et al estimated that optimal treatment for anxiety or depressive disorders would cost about $1,000 per case in 1997 dollars.[44] This estimate was based on epidemiological data on the prevalence and burden of these disorders, and on the cost of providing evidence-based interventions. Their costs incorporated Medicare Benefits Schedule schedule fees rather than rebates. Rebates are typically lower (e.g., the rebates for item numbers 80010 and 80110 are 85% of the schedule fee), which brings the cost to government of optimal treatment to $850 per case in 1997 dollars. This translates to about $1,100 per case in 2010 after adjusting for changes in the Consumer Price Index. On the basis of these provisional estimates, Better Access care provided by psychologists would appear to represent good value for money for government.