

Executive summary

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative is successfully responding to low treatment rates for common mental disorders and improving outcomes for people with such disorders. Better Access consumers are not presenting with mild complaints. More than 90% have diagnoses of depression and/or anxiety (compared with 13% of the general population). More than 80% are experiencing high or very high levels of psychological distress (compared with 10% of the general population). The initiative is not just bolstering mental health care for those who were already using services. Around half of all Better Access consumers have no previous history of mental health care. Better Access consumers respond well to the care they receive through the initiative. Not only are they extremely satisfied with the skills of the providers they see and the quality of the treatment they are offered, but they also make statistically significant and clinically meaningful gains when assessed by standardised mental health outcome measures. Many report that their symptoms reduce, their psychological distress diminishes, and their overall wellbeing improves. Providers who are delivering services under Better Access are appreciative of the opportunities it affords for themselves and the consumers who seek care from them.

Background

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) was introduced in November 2006 in response to low treatment rates for common mental disorders. Its ultimate aim is to improve outcomes for people with such disorders by encouraging a multi-disciplinary approach to their care. Its key feature is a series of new item numbers which have been added to the Medicare Benefits Schedule (MBS) to provide a rebate for selected services provided by GPs, psychiatrists, psychologists, social workers and occupational therapists.

In 2009, the Commonwealth Department of Health and Ageing commissioned an evaluation of the Better Access initiative, and appointed a Project Steering Committee to provide advice to the evaluation. The Centre for Health Policy, Programs and Economics (CHPPE) at the University of Melbourne was contracted to undertake several components of the evaluation. The first of these, Component A, was designed to profile the consumers who had received Better Access services from clinical psychologists, registered psychologists, GPs and psychiatrists, and examine the outcomes of their care. A secondary aim of Component A was to examine the experiences of providers who delivered Better Access care, and the experiences of consumers who received it.

Method

We approached a stratified random sample of providers who had billed for at least 100 occasions of service under the Better Access item numbers in 2008 (509 clinical psychologists, 640 registered psychologists, 1,280 GPs and 203 psychiatrists) and invited them to participate. Those who agreed were asked to approach their next 20 consecutive English-speaking consumers with a view to recruiting 5-10.

Data collection began on 1 October 2009 and continued for 13 months. Seven types of data were collected from consumers and providers over this period. The first four were collected via a password-protected, secure, web-based minimum dataset, and the next three were collected via telephone interviews or surveys with consumers and providers.

Data collection via the minimum dataset

Four types of data were collected via the minimum dataset:

1. Provider-level data (demographic, professional): These data were collected from providers when they enrolled in the project at the beginning of the 13-month data collection period and included demographic details, professional qualification(s), year of most recent qualification, mental disorders treated etc.
2. Consumer-level data (socio-demographic, clinical): These data were collected from consumers by providers when they began treatment (i.e., at their first session) and included demographic details, socio-economic indicators (e.g., postcode, health care card status) and clinical information (e.g., diagnoses, previous psychiatric service use).
3. Consumer-level (outcomes): These data involved the use of two standardised outcome measures, namely the Depression Anxiety Stress Scales (DASS-21)¹ (used with consumers recruited by clinical and registered psychologists) and the Kessler-10 (K-10)² (used with consumers recruited by all providers). Data from these instruments were collected from consumers by providers when they began treatment (i.e., at their first session) and end treatment (i.e., at their final session, or in the final month of the data collection period, whichever came first).
4. Session-level data: These data were collected at each session and included detail on the duration of the session, the assessment(s) and intervention(s) that were provided during its course, the item number billed, and whether the session attracted a co-payment.

Logistically, data entry into the minimum dataset worked in the following way. The minimum dataset contained linked provider, consumer and session modules, each of which took the form of a screen that showed the relevant questions and provided check boxes which could be automatically ticked as appropriate. Once they were recruited into the study and had consented, providers were given access to the web-based minimum dataset, via a user name and password. They were then able to enter data into it from their own computers. They were asked to enter the above provider-level data into the minimum dataset, and then begin the process of recruiting their 5-10 new English-speaking consumers. Once the consumers were recruited, providers collected the relevant consumer-level data for them at the required points in time. In most cases, this involved asking consumers to complete a paper-based version of the particular instrument. Providers then took the completed paper-based forms from consumers, and entered the relevant data into the minimum dataset. For example, in the case of the consumer-level outcome data, consumers were given paper-based versions of the instruments and asked to complete them before they left. Once they returned these, providers entered the data into the web-based minimum dataset. Providers differed in how they chose to do this – some encouraged consumers to complete the instruments during the session, whereas others asked them to complete them in the waiting room once the session was over. The consumer-based clinical data was not elicited from consumers, but relied on judgements made by providers. Similarly, the session-based data did not require input from consumers, and was generated by providers. These data were entered by providers into the minimum dataset in the same way as data elicited directly from consumers.

Data collection via interviews/surveys with consumers and providers

In addition to the primary data that were collected via the minimum dataset, data were collected via brief (15 minute) telephone interviews or surveys with consumers and providers conducted at the end of their participation in the study. Both were initially asked to complete the interview

but those who were not able to do this were offered the survey option. Both methods elicited data via the same set of questions. The following three types of data were sought through the questions in the interviews/surveys:

1. Consumer-level data (experiences with receiving care through Better Access).
2. Consumer-level data (any change in health and wellbeing attributable to Better Access): This was ascertained by a question which required them to indicate whether their health and wellbeing had changed during the course of their care, and, if so, whether they attributed the change to the care they received.
3. Provider-level data (experiences with providing care under Better Access).

Members of the study team conducted the interviews and sent out the surveys. Consumer interviews/surveys were conducted in a staggered fashion, within one month of the last session being provided to a given consumer or in the last month of data collection, whichever came first; provider interviews/surveys were conducted in a block, towards the end of the 13-month data collection period. All consumers for whom data existed on the minimum dataset and all providers who had recruited consumers were invited to complete the interview/survey.

Key findings

In total, 41 clinical psychologists recruited 289 consumers, 49 registered psychologists recruited 317 consumers, 39 GPs recruited 277 consumers, and three psychiatrists recruited 23 consumers. Because of the low response rates for psychiatrists and the consumers recruited by them, these groups were excluded from the evaluation. Key findings as they relate to the remaining groups are presented below.

Characteristics of Better Access consumers

Medicare data show that two thirds of Better Access consumers are female, and that three quarters are aged below fifty. Location-wise, around three quarters reside in metropolitan areas, and about half live in areas that make up the two quintiles of least disadvantage. Our consumer samples were broadly representative of all Better Access consumers, although our sampling strategy resulted in some over-representation by consumers in rural areas and consumers in areas of relatively greater disadvantage.

Notwithstanding these relatively minor discrepancies, our study provides the first clinical profiles of Better Access consumers that are based on systematically-collected data. Data collected via our minimum dataset suggest that Better Access consumers are not “the worried well”. The vast majority (over 90%) of our participating consumers had diagnoses of depression and/or anxiety (with or without co-morbid conditions), and many (over 80%) had high or very high levels of psychological distress. Our data also refutes the suggestion that many Better Access consumers are people who were already “in the system” – around half of our consumers had no previous history of mental health care.

Outcomes of Better Access care for consumers

Participating consumers who received care from clinical psychologists, registered psychologists and GPs under Better Access shifted from having high or very high levels of psychological distress to having much more moderate levels of psychological distress (as assessed by the K-10). Consumers who received care from clinical psychologists and registered psychologists also showed shifts from moderate or severe levels of depression, anxiety and stress to having normal

or mild levels of these conditions (as assessed by the DASS-21). These consumers clearly achieved positive outcomes, as assessed by these standardised measures. These outcomes were not only statistically significant; they were clinically meaningful too.

In the main, socio-demographic factors did not appear to have a major influence on outcomes; equivalent outcomes were achieved irrespective of whether the consumer was male or female, young or old, or wealthy or struggling financially. Instead, clinical and treatment variables were generally the ones that made a difference. For consumers recruited by all three types of providers, those with worst baseline manifestations of psychological distress (i.e., higher pre-treatment K-10 scores) made the greatest gains. For consumers recruited by clinical psychologists, no other variables were predictive of outcomes. For consumers recruited by registered psychologists, those who had completed treatment or were still in treatment experienced greater gains than those for whom treatment was incomplete, and those in metropolitan areas showed lesser improvement than their rural counterparts. For consumers recruited by GPs, those who had six sessions of care experienced optimal outcomes, and 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.

Consumers' experiences with receiving care through Better Access

Participating consumers were extremely positive about Better Access, and their reports were consistent with the above findings with respect to their characteristics and outcomes. They provided corroboration for the suggestion that, as a group, Better Access consumers have significant mental health problems and are experiencing high levels of psychological distress; the most common triggers to their seeking care were a deterioration in their mental health and wellbeing observed by themselves or others, and specific traumatic events. Their subjective reports of improvement provided further evidence that Better Access is achieving positive consumer outcomes; the majority indicated that they had experienced significant changes for the better in terms of their mental health and their ability to cope with stressful situations, and that often this had gone hand-in-hand with rejuvenated outlook and/or improved life circumstances. They commonly spoke of improvements in their mental health, discussing reductions in symptoms and commenting on the strategies they had learnt to modify maladaptive thought patterns and change negative behaviours. The majority attributed these changes, at least in part, to the care they had received through Better Access.

Many consumers had experienced hurdles to accessing mental health care in the past – often related to cost – and they appreciated the fact that Better Access had made mental health care more readily available. They experienced extremely high levels of satisfaction with the care they received from the various providers. They appreciated the professional skills and competencies of these providers, often commenting on their ability to establish rapport, their communication skills, their listening abilities, their kindness, their empathy and their non-judgemental approach. Consumers also expressed satisfaction with the advice, strategies and guidance that they received from these providers. In addition to being positive about the clinical care offered by the Better Access providers, most consumers indicated that they found the process of dealing with Medicare very straightforward.

Relatively speaking, consumers had few complaints about Better Access. Those who did identify negative aspects tended to focus on the restricted number of sessions, or on residual difficulties with out-of-pocket payments. Some also found the process of “opening up” about their mental health issues quite confronting.

Providers' experiences with delivering care through Better Access

Participating clinical psychologists, registered psychologists and GPs were extremely positive about the Better Access initiative. Again, many of their views tallied with the evidence provided above with respect to the profiles of and outcomes for consumers. Many commented that they are now providing mental health care to a greater number of people, and that their caseloads include proportionally more people who have complex needs, are on low incomes, and would not have been able to access mental health care in the past. Many also mentioned that they are now in a better position to meet these consumers' needs because they can provide timely, comprehensive and integrated care. They perceived this to have direct benefits for consumers in terms of improved access and affordability of care, and, consequentially, improvements in their mental health status, understanding of mental health symptoms and how to manage them, and relapse prevention.

Participating providers were also positive about the processes associated with Better Access. In particular, they noted that the Better Access model of service delivery, which relies on psychologists and GPs collaborating with each other, has generally worked well. Each party has developed an increased appreciation of the role of the other in providing mental health care. The reporting requirements of Better Access have improved the two-way communication between these providers. In the main, these providers have had positive experiences with dealing with Medicare.

Participating providers reported few negative impacts of Better Access. Sometimes communication has been sub-optimal; psychologists have not always received adequate referral information from GPs, and GPs have sometimes felt that they do not get sufficient feedback from psychologists about consumers' progress. Some psychologists and GPs have experienced administrative issues, such as difficulties with the interface between their own local systems and the Medicare system. Some GPs sought greater clarity around the "rules" of Better Access, and some psychologists questioned some of its restrictions on the number of sessions and forms of therapy that they could provide. Some psychologists were critical of the fact that GPs acted as the "gatekeeper" to their care. Some psychologists also commented on the level of the rebate, calling for it to be brought in line with the Australian Psychological Society's recommended rate. Some registered psychologists questioned the level of reimbursement for their services, arguing that they should receive the same payments as clinical psychologists.

Conclusion

The findings suggest that Better Access is playing an important part in meeting the community's previously unmet need for mental health care. The initiative has improved access to services for consumers who have clinically-diagnosable disorders and are experiencing considerable psychological distress. These consumers' mental health status improves markedly during the course of their care; their symptoms reduce, their psychological distress diminishes, and their overall wellbeing improves. They are extremely positive about Better Access, appreciating the fact that it enables them to receive free or low-cost services from specialised providers. The providers are also positive, enjoying the role they are playing in facilitating access to quality care.