

Chapter 8: Discussion and conclusions

Summary of key findings

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 refute 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.

Our analyses of predictors of outcome should be treated with caution; the numbers in each of the three analyses were relatively low, which means that the results are conservative. Factors which did not appear to be significant predictors of outcome may in fact have emerged as significant had the numbers been greater. Nonetheless, the analyses allow us to make some early observations. Perhaps most importantly, our findings suggest that, 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.

Study limitations

Our response rates for participating clinical psychologists, registered psychologists and GPs were 8%, 8% and 3%, respectively. These sorts of response rates are common for studies of this kind.¹² Higher response rates would obviously have been desirable, but the samples were broadly representative of the groups from which they were selected, which engenders some confidence in the generalisability of the findings.

We could not calculate precise response rates for consumers because we were not privy to how many consumers each provider approached. We also have no way of ascertaining whether providers did approach their next 20 consecutive new consumers, or whether they were more selective. However, what we can say is that, ultimately, our samples of consumers were fairly representative of the groups from which they were drawn although participating consumers tended to be more disadvantaged than the overall pools of Better Access consumers, both in terms of being less likely to live in capital cities and more likely to live in areas of socio-economic disadvantage. They may therefore previously have had more limited access to mental health care. These characteristics may have meant they had particularly valuable insights about Better Access.

One further point to make about our samples of consumers is that those who did not speak English were "out of scope". This decision was made for resourcing reasons; we did not have the capacity to translate the interviews/surveys into other languages, or to make use of interpreters. We acknowledge, however, that this strategy introduced a systematic bias. The characteristics of Better Access consumers from culturally and linguistically diverse backgrounds may be different from those of their English-speaking peers, as may their clinical outcomes. They may also have different experiences of receiving care through Better Access.

Our evaluation relied heavily on outcome data collected from consumers via standardised measures and entered into the minimum dataset by providers. We acknowledge that this created some potential for data distortion, but the only way to have countered this would have been for us to recruit, follow and assess consumers ourselves, and this was not feasible from a practical or an ethical perspective. Our data collection was similar to other major real-world data collection exercises (e.g., the collection of routine outcome data in public sector mental health services across Australia). We also had the opportunity to "triangulate" our findings from the outcome data with our findings from the consumer interviews/surveys. Both pointed in a similar direction, giving us confidence in the data from our outcome measures.

Our interview/survey data collection relied on self-report. It examined the experiences of consumers and providers, so there were no right or wrong answers, but participants may have given responses that they felt were socially desirable in some way. There may also have been some biases in their likelihood of recalling particular experiences. Again, we would argue that the fact that there was a high level of correspondence between the different data sources strengthens the conclusions that can be drawn. For example, providers' perceptions of the benefits of Better Access for consumers aligned with consumers own reported experiences, and consumers' positive views of improvements in their mental health were consistent with the arguably more objective indicators of outcome taken from the standardised measures.

Interpreting the findings

The above findings are perhaps best interpreted in the light of the two key evaluation questions outlined in the Better Access evaluation framework and articulated in Chapter 1. To reiterate, these are:

- To what extent has the Better Access initiative achieved its objectives?
- To what extent has the Better Access initiative been an effective response to the need for primary mental health care for people with high prevalence mental disorders?

To what extent has the Better Access initiative achieved its objectives?

The current study provides evidence about the achievement of two of the stated objectives of Better Access:

- Encouraging more GPs to participate in early intervention, assessment and management of patients with mental disorders and streamlining access to appropriate psychological interventions in primary care; and
- Providing referral pathways for appropriate treatment of patients with mental disorders, including by psychiatrists, GPs, clinical psychologists, registered psychologists and other appropriately trained allied mental health professionals.

The current study certainly suggests that GPs are in a better position to play an important role in primary mental health care. According to those who participated in interviews/surveys, they are seeing proportionally more consumers with mental health problems, and are feeling better equipped to deal with them in an appropriate fashion. They can refer these consumers to specialised providers in the knowledge that the care they will receive will usually be low cost and high quality and will yield positive outcomes. They will not "lose" these consumers to the system; they will receive reports back from the psychologist (or other allied health professional), and will review consumers' progress at set points in their care.

The study also suggests that clinical and registered psychologists are an appropriate and effective point in the referral pathway. They have established two-way communication channels with referring GPs which are generally working well. They are providing evidence-based therapies (e.g., CBT) to consumers who have complex needs and may previously have had difficulty accessing psychological services for reasons of affordability. These consumers are experiencing gains in their mental health and wellbeing.

To what extent has the Better Access initiative been an effective response to the need for primary mental health care for people with high prevalence mental disorders?

The current study also suggests that Better Access has been effective in increasing treatment rates. Providers are offering psychological care to a greater number of consumers with disorders like depression and anxiety, many of whom are “new” to mental health care. These consumers value the care they are receiving. They recognise the specialised skills of the providers involved in delivering this care, and are satisfied with the nature of this care. Many report that they have learnt strategies that have led to improvements in their mental health and wellbeing. These reported positive outcomes correspond with significant gains on standardised outcome measures.

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.