

Chapter 6: Discussion and conclusions

Summary of key findings

1. Has Better Access improved access to mental health care?

The summative evaluation provides good evidence that Better Access has improved access to mental health care and increased treatment rates for people with common mental disorders. Uptake of Better Access services has been high in absolute terms, even among relatively disadvantaged groups in the community. Better Access is not simply catering to people who were already in receipt of care and/or who have relatively mild symptoms; it is reaching significant numbers of people who have not accessed mental health care in the past; and it is providing treatment for people who have severe symptoms and debilitating levels of distress.

2. Is Better Access an effective (and cost-effective) model of service delivery?

Consumers are generally positive about Better Access as a model of service delivery, and appreciate the clinical care they have received. They are also achieving positive outcomes as assessed by improvements on standardised measures of psychological distress, depression, anxiety and stress. In the main, these outcomes are related to clinical and treatment factors rather than socio-demographic characteristics. Preliminary analysis of outcome and cost data for consumers seen by psychologists through Better Access suggests that the initiative is providing good value for money; equivalent data were not available for consumers seen by other provider groups.

3. Has Better Access had an impact on the profile and operation of Australia's mental health workforce?

The above achievements do not seem to be occurring at the expense of other parts of the mental health system. The numbers of allied health professionals in public mental health services have continued to rise, despite the attraction for many of working as private practitioners in the primary mental health care sector. In fact, Better Access may have had a positive effect on the way in which the Australian mental health workforce operates, with some indications that providers are engaging in more collaborative care.

Strengths and weaknesses of the evaluation

There have been several calls for a rigorous evaluation of Better Access.^{45 46} The current evaluation drew on 20 data sources, seven of which were commissioned by the Department of Health and Ageing in the context of a pre-determined evaluation framework, and 13 of which constituted separate studies, mostly conducted by independent parties. Additional relevant work is being conducted around Australia but was not available to the summative evaluation at the time of publication (e.g., a study of the uptake and impact of Better Access services for women which draws on data from the Australian Longitudinal Study on Women's Health²⁹). Using multiple relevant data sources enabled us to triangulate the findings. Offering several perspectives on the same question in this way is consistent with internationally-recognised best practice in health program evaluation.⁴⁷ It is rare to see major national health reforms undergo such comprehensive evaluations.

Having said this, each of the data sources available to the summative evaluation had its limitations. These limitations should be borne in mind in interpreting the above findings. It is fair

to say that in quite a few cases the limitations of one data source were addressed by another, and the findings provide a reasonably coherent assessment of the achievements of Better Access that engenders confidence in the evaluation conclusions.

Collectively, the data sources provided more information about some components of Better Access than others. As a consequence, the summative evaluation was only able to offer partial answers to some evaluation questions. One example is Question 2 – Is Better Access an effective (and cost-effective) model of service delivery? Answering this question relied heavily on data from Component A,³ which primarily considered outcomes for consumers seen by clinical and registered psychologists. Component A also collected data on outcomes for consumers seen by GPs, but these data were difficult to interpret because these consumers may have been treated by the GP in isolation or may have been referred to an allied health professional for care. Component A attempted to collect data on outcomes for consumers seen by psychiatrists but participation by this group of providers was low. It was beyond the scope of Component A to collect standardised outcome data for consumers seen by social workers and occupational therapists. Component A.2^{3,4} gauged the experiences of these consumers via self-report. Component A's data coverage means that statements can only really be made about the effectiveness (and cost-effectiveness) of the clinical and registered psychologist components of Better Access.

In addition, there are a number of questions which have not been addressed by the summative evaluation. For, it was beyond the scope of the evaluation to consider whether Better Access is an appropriate policy initiative. Similarly, the evaluation could not shed light on whether all Better Access providers are providing evidence-based mental health care (although the positive outcomes demonstrated by Component A³ and other sources suggest that they are doing something right). In addition, the evaluation was not in a position to demonstrate whether there are particular points of efficiency or inefficiency in the current model of service delivery. The evaluation was also unable to examine issues of access for groups who are often disadvantaged in terms of their access to mental health care, including Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

Interpreting the findings

Better Access is the first time in Australia that specific primary mental health care services have attracted reimbursement through the MBS in any major way. It has been widely scrutinised by a range of observers. The concerns that have been expressed about Better Access have generally not been based on data. It is worth considering some of these criticisms, and examining the extent to which the summative evaluation's findings confirm or disconfirm them.

Firstly, some commentators have focused on the significant uptake of Better Access services and expressed concern about the resultant high costs to government.^{46 48} The summative evaluation suggests that the high level of uptake should be viewed positively rather than negatively, because it indicates that substantial numbers of consumers with previously unmet need for mental health care are now receiving it. In addition, the summative evaluation provides evidence that, when outcomes and costs are considered together, Better Access provides good value for money.

Secondly, there have been concerns that Better Access provides inequitable levels of service to particular at-risk groups – disadvantaging young people because they typically do not make contact with GPs, thereby limiting their referral to allied health professionals,^{46 48} and disadvantaging people in socio-economically disadvantaged and rural areas because providers prefer to practice in more affluent metropolitan areas.^{46 48 49} The summative evaluation shows that although young people and people in the most socio-economically disadvantaged and most

remote areas have made comparatively lower use of Better Access services, their uptake (in absolute terms) has still been significant. In addition, their uptake has been increasing at a greater rate than that of their peers.

Thirdly, the claim has been made that many of the recipients of care under the Better Access scheme were already receiving psychological care.^{46 48} The summative evaluation suggests that this is not the case. The majority of relevant data sources indicated that Better Access is providing services for significant numbers of “new” mental health consumers.

Fourthly, some commentators have argued that the fee-for-service foundation of Better Access has militated against collaborative care.^{50 51} The summative evaluation provides some evidence that Better Access has fostered collaborations between providers that did not exist in the past. The requirement that GPs must complete a mental health treatment plan in order for a consumer to be seen by an allied health professional has resulted in these professionals developing working relationships that are based on improved appreciation of each other’s role in mental health care. Communication between relevant parties appears to have improved, but is not yet optimal.

Finally, different groups of allied health professionals have expressed disparate views about the services that should be offered through Better Access and the providers who should be eligible to offer them.^{46 52-57} Registered psychologists have contended that they are essentially providing the same services as clinical psychologists and should be reimbursed commensurately; clinical psychologists have maintained that registered psychologists are providing the bulk of services and may not be achieving optimal outcomes for clients. Social workers and occupational therapists have stressed the importance of retaining their services. Various other groups of service providers have argued that their services should be eligible for a Medicare Benefits Schedule rebate. The summative evaluation can only inform these debates in a limited way. Component A provided evidence that registered psychologists are achieving positive outcomes for consumers, and Component A.2 showed that consumers were satisfied with the care they received from social workers and occupational therapists.

Conclusions

Better Access has increased access to mental health care for significant numbers of Australians. This includes many people who have been traditionally disadvantaged in the past. It has achieved good clinical outcomes for many of these consumers. These achievements should not be underestimated. Good mental health is important to the capacity of individuals to lead a fulfilling life (e.g., by studying, working, pursuing leisure interests, making housing choices, having meaningful relationships with family and friends, and participating in social and community activities). This major mental health reform seems to have improved access to and outcomes from primary mental health care for people with common mental disorders.