

## Executive summary

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This summative evaluation draws on data from 20 sources to examine whether Better Access has improved access to mental health care, has provided an effective (and cost-effective) model of service delivery, and has changed the profile and operation of Australia's mental health workforce. Each of these data sources has strengths and weaknesses but collectively they provide a picture of the achievements of Better Access.

There is good evidence that Better Access has improved access to mental health care 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 just 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 previously accessed mental health care; and it is providing treatment for people who have severe symptoms and debilitating levels of distress.

Consumers are generally positive about Better Access as a model of service delivery and they appreciate the clinical care they have received. They are also reporting positive outcomes as assessed by reductions 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.

These 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 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.

These achievements should not be under-estimated. 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 moderate to severe common mental disorders.

## Background and method

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative was introduced in November 2006 in response to low treatment rates for common mental disorders (e.g., anxiety, depression and substance use disorders). Its ultimate aim is to improve outcomes for people with these disorders by encouraging a multi-disciplinary approach to their care. Its key feature is the inclusion of a series of new item numbers on the Medicare Benefits Schedule to provide a rebate for selected services provided by particular providers, namely GPs (recognised as a core part of the general mental health workforce) and psychiatrists, psychologists, social workers and occupational therapists (recognised as specialist mental health service providers).<sup>1</sup>

A framework was developed at the commencement of the Better Access initiative to guide its evaluation.<sup>2</sup> Consistent with this framework, the Department of Health and Ageing

commissioned an evaluation of the Better Access initiative to assess its overall appropriateness, effectiveness and impact. The evaluation framework originally included six components (Components A-F), and a seventh was subsequently added (Component A.2). In addition, several independent pieces of work have been conducted that can inform the evaluation. The components and additional data sources are shown in Table i.

**Table i: Evaluation components and additional data sources**

<b>Part of original evaluation framework</b>	<b>Component A: A study of consumers and their outcomes<sup>3</sup></b> – In this study Better Access providers recruited 5-10 consumers to participate, according to a protocol. Forty one clinical psychologists recruited 289 consumers, 49 registered psychologists recruited 317 consumers, and 39 GPs recruited 277 consumers. Consumers were profiled on a range of socio-demographic, clinical and treatment variables, and their outcomes were monitored. Consumers and providers were also interviewed/surveyed about their respective experiences with receiving and delivering Better Access care.
	<b>Component A.2: A study of consumers and their outcomes (focusing on the occupational therapy and social work sectors)<sup>4</sup></b> – In this study Better Access providers invited 2-5 consumers to participate, according to a protocol. One hundred and ninety one social workers recruited 458 consumers, and 35 occupational therapists recruited 72 consumers. Consumers and providers were interviewed/surveyed about their respective experiences with receiving and delivering Better Access care.
	<b>Component B: Analysis of Medicare Benefits Schedule and Pharmaceutical Benefits Scheme administrative data<sup>5</sup></b> – This involved analysis of routinely-collected data from a range of sources (e.g., person- and service-level Medicare Benefits Schedule mental health item data and Pharmaceutical Benefits Scheme data, 2007 National Survey of Mental Health and Wellbeing, and the Access to Allied Psychological Services projects' minimum dataset). It addressed questions relating to the access, affordability, equity, and interdisciplinary nature of Better Access services, and the potential impact of Better Access on service use in other parts of mental health system.
	<b>Component C: An analysis of allied mental health workforce supply and distribution<sup>6</sup></b> – This involved the analysis of routinely-collected data from a range of sources (e.g., Medicare Benefits Schedule and Medicare provider data, Australian Bureau of Statistics 2006 Census of Population and Housing, Mental Health Establishments – National Minimum Data Set, Registration Board and other administrative data, and stakeholder consultations). It addressed issues related to identifying and characterising the actual and potential Better Access workforce, the impact of Better Access on the distribution of the allied mental health workforce, and future workforce needs.
	<b>Component D: Stakeholder consultations<sup>7</sup></b> – This involved consultations with 1,200 stakeholders (e.g., service providers from the private, public and non-government sectors, representatives of professional bodies, health insurers, consumers and carers) regarding their views about Better Access.
	<b>Component E: Evaluation of main education and training projects<sup>8,9</sup></b> – The most prominent education and training initiative was the Mental Health Professionals Network (MHPN), which undertook a large-scale project to promote interdisciplinary networking. The evaluation of this initiative drew on data from nearly 20 sources, some internal and some external, some routinely-collected (e.g., workshop and network attendance data) and some purpose-designed (e.g., surveys).
	<b>Component F: An analysis of the second National Survey of Mental Health and Wellbeing, completed in 2007<sup>10</sup></b> – The 2007 National Survey of Mental Health and Wellbeing was a nationally representative household survey of 8,841 individuals aged 16-85. The survey instrument was based on the World Mental Health Survey Initiative version of the Composite International Diagnostic Interview. It also collected information on the respondents' mental health status to assess whether or not they had experienced an affective disorder, an anxiety disorder and/or a substance use disorder during their lifetime, the past 12 months or the past 30 days. The survey also collected information on respondents' health service use and perceived needs for care, and a range of related variables (e.g., respondents' levels of functioning and disability, levels of psychological distress, quality of life) and socio-demographic variables.
<b>Additional data sources</b>	<b>Independent analyses of the 2007 National Survey of Mental Health and Wellbeing, including comparisons with the 1997 National Survey of Mental Health and Wellbeing<sup>11-16</sup></b> – Several members of our team and others have also conducted independent analyses of National Survey of Mental Health and Wellbeing data. Harris et al explored the use of Medicare-subsidised allied

	health services among people with a need for mental health treatment and Burgess et al considered service use for mental health problems more generally. The summative evaluation also makes reference to other more general publications on the 2007 National Survey of Mental Health and Wellbeing, and comparisons with the 1997 National Survey of Mental Health and Wellbeing, conducted before the introduction of Better Access.
	<b>Relevant Department of Health and Ageing documentation<sup>17</sup></b> – The Department of Health and Ageing has undertaken work to calculate current treatment rates for people with common mental disorders for each of the four financial years since Better Access was implemented.
	<b>Post-implementation review of Better Access<sup>18</sup></b> – This was conducted by the Department of Health and Ageing to assess the uptake, implementation and appropriate use of the Better Access item numbers. It involved analysis of service-level, patient-level and provider-level Medicare data, as well as consultations with stakeholders.
	<b>Australian Institute of Health and Welfare (AIHW) analyses of service-level and patient-level Medicare data<sup>19 20</sup></b> – As part of its routine reporting on mental health services in Australia, the AIHW has analysed the number of Medicare-funded services provided and patients served by GPs, psychiatrists, psychologist and other allied mental health professionals.
	<b>Independent analyses of service-level Medicare data<sup>21-26</sup></b> – Several independent analyses of service-level Medicare data have been conducted, including ones by Russell, Bassilios et al, Fletcher et al, Whiteford et al.
	<b>The Bettering the Evaluation and Care of Health (BEACH) program<sup>27 28</sup></b> – BEACH is a continuous national study of general practice activity. Each year, BEACH recruits 1,000 GPs who provide data on 100 consecutive encounters in their practices. Analyses have examined trends in GP encounters for psychological problems, and the use of Medicare Benefits Schedule items for these encounters.
	<b>A study of uptake of Better Access item numbers by women<sup>29</sup></b> – This study examined the uptake of Better Access item numbers among women with depression and anxiety, linking survey data from 14,911 participants in the Australian Longitudinal Study on Women's Health (ALSWH) to their Medicare records for the period November 2006-December 2007.
	<b>Australian Psychological Society surveys of members<sup>30 31</sup></b> – The Australian Psychological Society conducts ad hoc surveys of its members. The surveys examined participants' experiences with delivering care under Better Access
	<b>Independent surveys of occupational therapists<sup>32</sup></b> – This involved surveys of occupational therapists conducted six months (n=21) and 12 months (n=44) after the introduction of Better Access. The surveys examined participants' experiences with delivering care under Better Access.
	<b>Independent survey of psychologists<sup>33</sup></b> – This involved a survey of 73 psychologists conducted in the year after Better Access was introduced. The surveys examined participants' experiences with delivering care under Better Access.
	<b>Australian Psychological Society survey of consumers<sup>34</sup></b> – The Australian Psychological Society conducted a one-off survey of consumers receiving Medicare-funded psychological services under Better Access. Equal numbers of clinical and registered psychologists with a Medicare provider number recruited consumers. In total, 2,223 consumers were recruited. These consumers provided socio-demographic, clinical and treatment information, and offered their perceptions of treatment effectiveness.
	<b>A study of outcomes for consumers seen by psychologists through Better Access<sup>35 36</sup></b> – This study examined outcomes for 525 consumers seen by psychologists in a single private practice.
	<b>A study of outcomes for consumers seen by occupational therapists through Better Access<sup>37</sup></b> – This study examined outcomes for 31 consumers recruited by a single occupational therapist.

From the outset, the evaluation framework included a summative evaluation that was designed to synthesise the findings from the evaluation components and additional data sources to answer a series of evaluation questions. The relationship between the evaluation questions and data sources is outlined in Table ii, below.

**Table ii: Key questions and data sources**

PRIMARY QUESTIONS	SECONDARY QUESTIONS	RELEVANT SOURCES
<b>1. Has Better Access improved access to mental health care?</b>	1a. What is the overall level of uptake of Better Access services?	<ul style="list-style-type: none"> <li>• Component B<sup>5</sup></li> <li>• Post-implementation review of Better Access<sup>18</sup></li> <li>• Australian Institute of Health and Welfare (AIHW) analyses of service-level and patient-level Medicare data<sup>19 20</sup></li> <li>• Independent analyses of service-level Medicare data<sup>21-26</sup></li> </ul>
	1b. Has Better Access increased the treatment rates of people with mental disorders?	<ul style="list-style-type: none"> <li>• Independent analyses of 2007 and 1997 National Surveys of Mental Health and Wellbeing<sup>11 13 15</sup></li> <li>• Component F<sup>10</sup></li> <li>• Relevant Department of Health and Ageing documentation<sup>17</sup></li> </ul>
	1c. Has Better Access reached groups who are traditionally disadvantaged in terms of access to mental health care and, if so, has the rate of Better Access uptake improved over time for these groups?	<ul style="list-style-type: none"> <li>• Component B<sup>5</sup></li> <li>• Post-implementation review of Better Access<sup>18</sup></li> <li>• Australian Institute of Health and Welfare (AIHW) analyses of service-level and patient-level Medicare data<sup>19 20</sup></li> <li>• Independent analyses of service-level Medicare data<sup>21-23</sup></li> <li>• Independent analyses of 2007 National Survey of Mental Health and Wellbeing<sup>14</sup></li> <li>• Bettering the Evaluation and Care of Health (BEACH) program<sup>27 28</sup></li> <li>• A study of uptake of Better Access item numbers by women<sup>29</sup></li> </ul>
	1d. Has Better Access reached new consumers?	<ul style="list-style-type: none"> <li>• Component A<sup>3</sup></li> <li>• Component B<sup>5</sup></li> <li>• Independent analyses of 2007 National Survey of Mental Health and Wellbeing<sup>14</sup></li> <li>• Australian Psychological Society surveys of members<sup>30 31</sup></li> <li>• Bettering the Evaluation and Care of Health (BEACH) program<sup>27 28</sup></li> <li>• A study of uptake of Better Access item numbers by women<sup>29</sup></li> </ul>
	1e. Has Better Access reached consumers with moderate to severe disorders, or has it predominantly provided care to those with mild symptoms?	<ul style="list-style-type: none"> <li>• Component A<sup>3</sup></li> <li>• Component B<sup>5</sup></li> <li>• Independent analyses of 2007 National Survey of Mental Health and Wellbeing<sup>14</sup></li> <li>• A study of uptake of Better Access item numbers by women<sup>29</sup></li> </ul>
<b>2. Is Better Access an effective (and cost-effective) model of service delivery?</b>	2a. Is Better Access achieving positive outcomes for consumers?	<ul style="list-style-type: none"> <li>• Component A<sup>3</sup></li> <li>• Component A.2<sup>4</sup></li> <li>• Australian Psychological Society survey of consumers<sup>34</sup></li> <li>• A study of outcomes for consumers seen by psychologists through Better Access<sup>35 36</sup></li> <li>• A study of outcomes for consumers seen by occupational therapists</li> </ul>

		through Better Access <sup>37</sup> • Post-implementation review of Better Access <sup>18</sup> • Component D <sup>7</sup>
	2b. Do some consumers experience better outcomes than others?	• Component A <sup>3</sup>
	2c. Is Better Access a cost-effective way of delivering primary mental health care?	• Component A <sup>3</sup> • Component B <sup>5</sup>
<b>3. Has Better Access had an impact on the profile and operation of Australia's mental health workforce?</b>	3a. To what extent has Better Access had an impact on the distribution of allied health professionals in the public and private mental health sectors?	• Component C <sup>6</sup> • Component D <sup>7</sup> • Australian Psychological Society surveys of members <sup>30 31</sup> • Independent surveys of occupational therapists <sup>32</sup> • Independent survey of psychologists <sup>33</sup>
	3b. Has Better Access improved multi-disciplinary collaboration between mental health care providers?	• Component A <sup>3</sup> • Component A.2 <sup>4</sup> • Australian Psychological Society surveys of members <sup>30 31</sup> • Independent surveys of occupational therapists <sup>32</sup> • Independent survey of psychologists <sup>33</sup> • Component E <sup>8 9</sup>

Each of the data sources available to the summative evaluation had its own methodological strengths and weaknesses. In addition, the data sources provided more information about some components of Better Access than others. For example, Component A<sup>3</sup> successfully recruited large and reasonably representative samples of providers (n=129) and consumers (n=883), and collected data that were not available from any other source (e.g., consumer-level clinical, treatment and outcome data). However, the self-selection of providers and consumers may have introduced biases, and there was no capacity to include non-English speaking consumers. In addition, Component A primarily considered outcomes for consumers seen by clinical and registered psychologists. It 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, although Component A.2<sup>4</sup> gauged the experiences of these consumers via self-report.

Despite these limitations, the recourse to different data sources with different strengths and different emphases allowed for the triangulation of findings. It is fair to say that the findings provide a reasonably consistent picture of the achievements of Better Access, which engenders confidence in the conclusions that can be drawn from them. Caveats about data limitations are indicated in Table 1 in the body of the report, and highlighted in the text where appropriate.

## Key findings

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

#### **1a. What is the overall level of uptake of Better Access services?**

Data from Component B<sup>5</sup> showed that the overall uptake of the initiative has been high and has increased over time: 710,840 Australians (one in every 30) received at least one Better Access service in 2007, 951,454 (one in every 23) did so in 2008 and 1,130,384 (one in every 19) did so in 2009. After accounting for some people who received services in more than one year, this

equates to 2,016,495 unique individuals who received services over the three year period. These 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 – or a total of 11,144,130 services across the three year period. More than half of all Better Access services delivered were bulk-billed, and the average co-payment was around \$35.

#### **1b. Has Better Access increased the treatment rates of people with mental disorders?**

It is difficult to estimate the precise extent to which the uptake of Better Access has increased treatment rates for Australians. The most relevant data source – the 2007 National Survey of Mental Health and Wellbeing, used in Component F – was conducted in the first year of operation of Better Access, before it had become fully established, and could not provide data on treatment rates after 2007. A comparison of 2007 and 1997 National Surveys of Mental Health and Wellbeing data indicated that in 2007 persons with mental disorders were more likely to seek specialist mental health care than they were in 1997, but that the overall treatment rate had remained fairly stable at about 35%. Modelling by the Department of Health and Ageing used a variety of more recent data sources to estimate the percentage of people with mental disorders who had received mental health treatment since the introduction of Better Access. This modelling suggested that in 2009-10, 46% of individuals with a current mental disorder received some form of mental health treatment. Assessments of the effects of uncertainty on these estimates indicated that there has been a real increase in treatment rates for common mental disorders in the period 2006-07 to 2009-10.

#### **1c. Has Better Access reached groups who are traditionally disadvantaged in their access to mental health care and. If so, has the rate of Better Access uptake improved over time for these groups?**

The summative evaluation was not able to assess this question for all groups who are traditionally disadvantaged in their access to mental health care, because no data were available for some (e.g., people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people). It was, however, able to examine access for young people and older people, people in rural and remote areas, and people in areas of high socio-economic disadvantage. Component B<sup>5</sup> showed differentials in uptake rates on the basis of age, geographic region and socio-economic disadvantage. Separate analyses of service-level Medicare data conducted for the Post-Implementation Review of Better Access<sup>18</sup> and the Australian Institute of Health and Welfare's annual reports on mental health services<sup>19 20</sup> corroborate these findings, as do independent analyses conducted by Russell.<sup>21-23</sup>

Component B<sup>5</sup> demonstrated that although some groups have had greater levels of uptake of Better Access than others, Better Access has reached all groups. Rates of uptake have consistently increased over time for all groups, and increased most dramatically for those who have been the most disadvantaged in the past. To illustrate, those aged 0-14 years had the lowest rates of uptake (ranging from 10.1/100,000 in 2007 to 19.7/100,000 in 2009) but experienced the greatest percentage change in uptake from 2007 to 2009 (96.1%); those in most other age groups had initial rates of uptake of between 30.0/100,000 and 55.0/100,000 and later rates of uptake of between 50.0/100,000 and 80.0/100,000, and percentage changes of between 50 and 60%. Similarly, those in remote areas had lower rates of uptake than those in other areas but experienced greater percentage increases. The pattern was consistent for those in the most socio-economically disadvantaged areas.

These findings are corroborated by analyses of service-level Medicare data conducted for the Post-Implementation Review of Better Access<sup>18</sup> and the Australian Institute of Health and Welfare's annual reports on mental health services,<sup>19 20</sup> and by independent analyses conducted by Russell.<sup>21-23</sup>

The above rate estimates rely on the implicit assumption that the prevalence of mental disorders within each sub-group is the same, but this is clearly not always the case. For example, the rates of mental disorders for young people are lower than those for adults. Additional ecological analyses that were undertaken for Component B<sup>5</sup> and independent analyses of data from the 2007 National Survey of Mental Health and Wellbeing<sup>14</sup> overcame this problem, by modelling level of mental health need at an area level and examining its association with use of Better Access services. Both of these analyses found that level of mental health need was associated with uptake of Better Access. Data from the BEACH program also showed that when mental health need was taken into account differences on other variables diminished.<sup>27 28</sup>

A study of uptake of Better Access item numbers by women<sup>29</sup> showed somewhat different results with respect to socioeconomic factors. Byles et al compared the characteristics of four groups: women who used a Better Access MBS item; women who did not use a Better Access MBS item but had a recent mental health condition; women who did not use a Better Access MBS item but had a past mental health condition; and women who did not use a Better Access MBS item and did not have a mental health condition. They found that women who did not use a Better Access MBS item but had a recent mental health condition included more women who reported difficulty managing on their income and fewer women with post-school qualifications. However they did not find any differences between the groups in terms of area of residence.

As well as considering the relative level of access to Better Access by particular socio-demographic groups, Component B also profiled the costs of Better Access services according to consumers' socio-demographic characteristics. It showed that those with greatest levels of financial need were the biggest beneficiaries of bulk-billed services. The proportion of services that were bulk-billed increased as the level of remoteness and level of relative socio-economic disadvantage increased. The average co-payment decreased as level of relative socio-economic disadvantage increased (from \$38 to \$33). The average co-payment was higher among people in remote areas (\$37) and people in capital cities (\$37) than those in other regions (\$31-\$33).

#### **1d. Has Better Access reached new consumers?**

Evidence from a number of sources indicates that Better Access is reaching new consumers. Data from Component A<sup>3</sup> suggested that around half of all Better Access consumers may be new, not only to Better Access but to mental health care more generally. Data from Component B<sup>5</sup> showed that of the 953,161 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 1,130,348 consumers served by Better Access were first-time users. Psychologists who participated in the Australian Psychological Society's member surveys<sup>30 31</sup> indicated that, on average, about 70% of the consumers they see through Better Access have not previously consulted a psychologist. Independent analysis of the 2007 National Survey of Mental Health and Wellbeing<sup>14</sup> estimated that almost two thirds of people who used Better Access allied health services in 2007 had not previously used these services for mental health care.

Data from the study of uptake of Better Access item numbers by women also suggest that the initiative has reached "new" consumers.<sup>29</sup> Specifically, this study found that 93% of women who used relevant Better Access items had not previously seen a counsellor, psychologist or social worker.

The only contrary evidence comes from the BEACH program.<sup>27 28</sup> BEACH data showed that although the rate per 100 encounters at which depression was managed by GPs increased significantly from 1998-99 to 2008-09, the management rate of "new" cases of depression remained constant. There was also no change in the management rate of "new" cases of anxiety or substance use disorders.

**1e. Has Better Access reached consumers with moderate to severe disorders, or has it predominantly provided care to those with mild symptoms?**

More than 90% of Better Access consumers who participated in Component A<sup>3</sup> had a diagnosis of depression and/or anxiety. This compares with 13% of the general population. Around 80% of these consumers reported high or very high levels of psychological distress (as assessed by the Kessler 10, or K-10) when they presented for care, as compared with 10% of the general population.

Byles et al reported similar findings in their study of uptake of Better Access item numbers by participants in the Australian Longitudinal Study on Women's Health.<sup>29</sup> They observed that women who used Better Access item numbers tended to have poorer mental health, and that this had often declined prior to their use of the item numbers.

These findings are supported by independent analyses of the 2007 National Survey of Mental Health and Wellbeing.<sup>14</sup> These showed that the vast majority of respondents who had used Medicare-funded allied health services for mental health problems had either a 12-month affective, anxiety or substance use disorder (82%) or had some other indicator of treatment need (12%). It also showed that, among the Better Access allied health consumer group with a current mental disorder, almost half had a severe disorder (47.6%, as opposed to a mild or moderate disorder), 45.5% reported a high level of disability as measured by the World Health Organization Disability Assessment Schedule (WHO-DAS), 45.9% reported high or very high levels of distress as measured by the Kessler-10 (K-10), and 28.1% had experienced more than seven days out of role in the past 30 days.

**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. Levels of psychological distress (as assessed by the consumer-reported Kessler-10, or K-10) among consumers who were recruited to Component A<sup>3</sup> by clinical psychologists, registered psychologists and GPs decreased over the course of their treatment, from high or very high at the start to much more moderate at the end. Consumers who were recruited by the two groups of psychologists also shifted from having moderate or severe levels of depression, anxiety and stress to having normal or mild levels of these symptoms (as assessed by the consumer-reported Depression Anxiety Stress Scales, or DASS-21). The studies of outcomes for consumers seen by psychologists and occupational therapists, conducted by Mackey et al and Hitch et al, respectively, yielded similar results.<sup>35-37</sup>

These findings corresponded with the interview and survey data collected from the consumers recruited by clinical and registered psychologists and GPs in Component A,<sup>3</sup> those recruited by social workers and occupational therapists in Component A.2,<sup>4</sup> and the more general groups of Better Access consumers who contributed their views to Component D.<sup>7</sup> The majority of these consumers expressed satisfaction with the clinical care they had received through Better Access. They indicated that they had experienced significant changes for the better in terms of their mental health and their ability to cope with stressful situations. Similar findings were reported in the Australian Psychological Society's survey of consumers who received psychological care through Better Access,<sup>34</sup> 90% of whom felt that the treatment they had received had led to "significant" (45%) or "very significant" (45%) improvement.

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

Using a series of regression analyses, Component A<sup>3</sup> assessed whether particular variables predicted better outcomes as measured by the K-10. 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 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.

Clinical and treatment variables were generally the strongest predictors of outcome. Among consumers recruited by clinical psychologists, registered psychologists and GPs, the greatest gains occurred in those with the worst baseline manifestations of psychological distress (i.e., higher pre-treatment K-10 scores). Among consumers recruited by clinical psychologists, no other variables were predictive of outcomes. Among consumers recruited by registered psychologists, those who had completed treatment or were still in treatment experienced greater gains than those whose treatment was incomplete (e.g., those who had dropped out of treatment), and those living in metropolitan areas showed smaller 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, and those who had no previous history of mental health care showed greater improvement than those who had received mental health care in the past.

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

An analysis that combined data on outcomes from Component A<sup>3</sup> and data on costs from Component B<sup>5</sup> estimated the typical cost of a Better Access package of care delivered by a psychologist to be \$753.31. This equates to an average of \$73.46 per one-point improvement on the K-10. Previous work has estimated that optimal treatment for anxiety or depressive disorders would cost about \$1,100 in 2010 dollars. On the basis of these estimates, Better Access would appear to provide good value for money in terms of Medicare Benefits Schedule costs to government. It is recognised that this perspective does not take into account other costs to government, costs to consumers, and broader societal costs.

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

### **3a. To what extent has Better Access had an impact on the distribution of allied health professionals in the public and private mental health sectors?**

Better Access has made private practice a more viable option for allied health professionals. This prompted early concerns about an exodus of these providers from public sector mental health services. The stakeholder consultations conducted in Component D<sup>7</sup> suggested that the shift had not occurred to the extent anticipated. Component C<sup>6</sup> provided additional evidence by examining the numbers of full time equivalent (FTE) providers in the public mental health sector in each year from 1995-96 to 2007-08 (the Department of Health and Ageing provided supplementary figures for 2008-09 for the purposes of the summative evaluation). Component C<sup>6</sup> looked at whether there was any drop in these numbers following the introduction of Better Access in late 2006. They found no evidence that Better Access had reduced the size of the public sector mental health workforce. In fact, the numbers of FTE psychologists, social workers and occupational therapists providing care in public sector mental health services have risen steadily since 1995-96. The introduction of Better Access has had no apparent impact on this rate of increase.

### **3b. Has Better Access improved multi-disciplinary collaboration between mental health care providers?**

There is some suggestive evidence that Better Access has improved multi-disciplinary collaboration between mental health care providers. The clinical psychologist, registered psychologists, GPs, social workers and occupational therapists who completed interviews or surveys as part of Component A<sup>3</sup> and A.2<sup>4</sup> indicated that providers had developed an increased appreciation of the role of others in providing mental health care as a result of working together to provide Better Access services.. Having said this, a number of participants noted that communication has not always been optimal; allied health professionals have not always received adequate referral information from GPs, and GPs have sometimes felt that they do not get sufficient feedback from allied health professionals about consumers' progress. These diverse views were reinforced by participants in other relevant surveys of allied health professionals,<sup>30-33</sup> and by stakeholders who contributed to the post-implementation review of Better Access.<sup>18</sup>

As well as fostering multi-disciplinary care through the conditions of the Medicare item numbers, Better Access has made an explicit attempt to strengthen the links between different provider types through some of its education and training initiatives. In particular, the Mental Health Professionals Network has promoted communication and networking between allied health professionals, GPs and other mental health care providers by running almost 1,200 multi-disciplinary workshops, supported by a range of resources (e.g., education and training materials, a website and web portal, and a 1800 phone line). The evaluation of MHPN, which formed part of Component E, found that these workshops were attended by close to 12,000 individuals, and that four fifths of the workshops had led to ongoing, multi-disciplinary networks of local providers.<sup>8,9</sup> These networks are currently in their early stages, but there are signs that they are increasing collaboration between providers.

## **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 moderate to severe common mental disorders..