



***beyondblue* NewAccess
Demonstration
Independent Evaluation**

Summary of Findings
Reporting to August 2015



Building a better
working world

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Most of us have witnessed the devastating effects of depression and anxiety on our families or friends. Watching them try to navigate their way through our complicated system can be heartbreaking and, despite multiple reform efforts across many years, consumers often end up accessing services 'up-stream', because the lower end support system wasn't easily accessible for them.

Improving access to early intervention is a critical step towards improving the mental health and wellbeing of all Australians.

Jim Birch AM

EY Asia Pacific
Health Practice Chair

Glossary and abbreviations

Access Coach

The coach assigned to participants of the NewAccess program, who is responsible for helping to progress participants through the program and aid recovery. Also represents a potential new workforce within Australia

CALD

Cultural and linguistic diversity. For example, reference to CALD communities

Caseness

Refers to whether a person's symptoms are sufficiently severe to be considered above a clinical threshold on measurement tools (at case)

CBT

Refers to cognitive behavioural therapy, a therapy which is centred around individuals removing any unhelpful thoughts, feelings, or behaviours and aims at re-learning healthy thoughts, feelings, or behaviours

Commissioning

Refers to EY's role in bringing specific policies, governance, and other arrangements in to existence to enable NewAccess to function optimally

Deteriorated

Used when referring to recovery rate, and refers to when a patient reports their caseness to be proportionately worse than at initial assessment

Exited the program

Those who have left the program for a variety of reasons. See page 116 for definitions

Fidelity

Degree to which practice is replicated as intended. Staying within the therapeutic model

GAD7

Measure – Generalised Anxiety Disorder Assessment (7-item anxiety scale)

HiCBT

High intensity cognitive behavioural therapy

IAPT

Improving Access to Psychological Therapies

In-Scope

In reference to activity within the demonstration period

OR

Staying within given practicing framework (see fidelity)

K10

Measure – Australian developed test of psychological distress (10-item scale focused on the signs and symptoms of depression and/or anxiety)

LiCBT

Refers to low intensity cognitive behavioural therapy

ML

Medicare Local

NGO

Non-government organisation

NICE

National Institute for Health and Care Excellence

PC-MIS

Patient Case Management Information System

PHN

Primary Health Network

Glossary and abbreviations

Phobia scale

Measure – Brief social phobia scale

PHQ9

Measure – Patient Health Questionnaire (9-item Depression Diagnostic and Severity Measure)

Recovery

Used when referring to recovery rate. In terms of the measurement, it refers to a client who at initial assessment achieved caseness for either the PHQ9 and the GAD7; and who at the final session moved below caseness for both the PHQ9 and the GAD7

Recovery rate

The proportion of clients, of those who have exited the program during the reporting period and achieved caseness at initial assessment, who are demonstrating recovery

Referral

A process by which a patient is referred to the NewAccess program, for example by a GP, as opposed to inquiring directly about the service

Reliable improvement

This counts the number of people where pre and post treatment scores exceed the measurement error of the questionnaire, this being Clients who have moved 5.2 or more on the PHQ9, and 3.53 or more points on the GAD7 are classified as having 'reliable' change

Reliable recovery

This counts the number of people where pre and post treatment scores exceed the measurement error of the questionnaire and their score moves below the clinical cut-off

Supervisor

Refers to personnel who supervise Access Coaches and their development

Summary



Australian mental health landscape

In 2007 it was estimated that around 20% of Australians aged 16 to 85 had experienced a mental illness in the prior 12 months. The most common were anxiety disorders, affecting around 14% of Australians, followed by substance abuse (5%) and depression (4%)¹. Recent Commonwealth investments have reduced the level of untreated prevalence but large numbers are still not receiving evidence based care. Additional high volume clinically effective approaches are needed to increase reach and impact. Low intensity CBT (LiCBT) delivery systems are one option.

NewAccess

In this context *beyondblue*, with the support of Movember Foundation, researched, developed and commissioned NewAccess, funded by donations to *beyondblue* and Movember Foundation. NewAccess is an early intervention program using LiCBT and Access Coaches to guide problem solving and skills building for those with low to moderate depression and anxiety. It is an adaptation of UK's Improving Access to Psychological Therapies (IAPT), which demonstrated LiCBT is effective in treating mild to moderate depression or anxiety.² Economic evaluations of IAPT found it was cost-effective and within the usual National Institute for Health and Clinical Excellence threshold range of cost.³

Demonstration overview

Three demonstration sites were selected to deliver NewAccess over two years (now extended to October 2016). The three catchment areas had a varied client base that enabled assessment of the suitability of NewAccess across metropolitan and regional areas of Australia.

Evaluating NewAccess

The demonstration was not a clinical trial seeking to validate an existing evidence base; it was an implementation trial, to explore real-world outcomes in an Australian context. The evaluation of the demonstration was conducted over two years across four data collection points. Ethics approval was gained for the evaluation from LaTrobe University Human Research Ethics Committee.

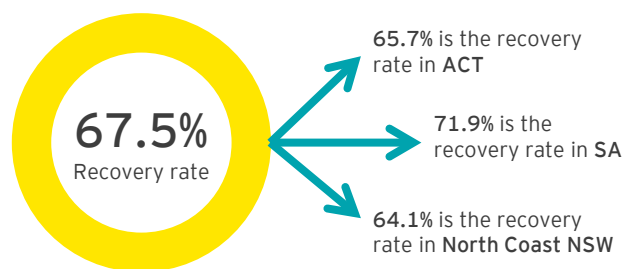
Summary



Overview of evaluation results

This independent evaluation of NewAccess found that the program was appropriate and effective in the Australian service delivery environment. Crucially, it showed that evidence-based guided self-help for anxiety and depression could be delivered by trained and supervised community members, who were not necessarily mental health professionals.

The program was safe and achieving better than UK recovery rates, and appeared to be meeting a previously unmet need in the Australian mental health service system.



"I was stronger than I realised."
NewAccess Client

"A lot of people accessing the service would not have accessed services at all or things would have gotten worse."
NewAccess Provider

"It was non threatening. Focused on positive thinking, setting goals, reducing stress rather than mental health."
NewAccess Client

The program was designed to fit within a system of stepped care, as recommended by the National Mental Health Commission Review Report. It targets people with low-moderate needs but can step-up those requiring more assistance.

Clients and referrers were positive about the program and its results. There was a high level of self-referral into the program. The design of NewAccess reportedly aligned with the preference level of support required by clients overcoming the hurdle of personal stigma. The program was safe and effective in health and social care environments and in fact widened the pool of potential clients by embedding the service in both these systems. It appeared to be meeting a previously unmet need.

While not all sites in the program were meeting the target proportion of male clients, the program demonstrated that the practical approach, ease of access and no cost were attractive to those men (35% to 47%) who did access the service. This was also attractive to women accessing the service.

An economic analysis concluded the program was economically viable and had the potential to deliver an economic benefit.

summary



Overview of evaluation results (cont.)

“Seeing it work is a really good feeling and being a part of that. They answer the phone and they sound a bit different and you can see the change which is really nice.”
Access Coach

“Get it out there more for men!”
NewAccess Client

The program was flexible while maintaining fidelity to core drivers of safety and effectiveness. Primary Health Networks (PHN), appeared to be suitable regional bodies to commission the program. A hub and spoke model was successfully implemented in a rural PHN.

Although Aboriginal and Torres Strait Islander people have successfully used the program, it was not specifically tested for these populations. There is evidence, noted in the report, that CBT is a viable option for Aboriginal and Torres Strait Islander people. It may be of value to undertake action research to determine culturally appropriate ways to market and deliver the program for these communities.

The workforce required to deliver the program was readily available - recruitment was not difficult. Retention rates for Access Coaches was high with only a small proportion leaving the program.

Critical success factors for the program included:

- ▶ Embedding the program within the health and social care systems and locating it in venues where men can easily access it
- ▶ The ability to self-refer to NewAccess and the low stigma associated with the program
- ▶ Recognising the place of the program in a stepped care mental health system
- ▶ Maintaining current processes to support fidelity and manage clinical risk, including the PC-MIS client information system and monitoring of outcomes and client risk
- ▶ Positioning the Access Coach in the Australian mental health workforce, accrediting training and developing career pathways
- ▶ Selecting a capable regional body to commission and monitor the program, if this is the chosen method of rolling the program out
- ▶ Commissioning arrangements to support clinical risk management, implementation fidelity and quality management
- ▶ Continuing to use a wide range of marketing modes to promote the program

Summary



Overview of recommendations

Key critical success factors for the program to retain its current effectiveness include:

- ▶ Embedding the program within the health and social care systems
- ▶ Recognising the place of the program in a stepped care mental health system
- ▶ Maintaining current mechanisms to support fidelity and manage clinical risk
- ▶ Continuing to use the PC-MIS client information system to support ongoing monitoring of outcomes and client risk management
- ▶ Recognising the Access Coach as a legitimate role in the Australian mental health workforce and accrediting training to reflect this
- ▶ Supporting workforce sustainability by developing career pathways for Access Coaches
- ▶ Selecting a capable regional body to commission and monitor the program, if this is the chosen method of rolling the program out
- ▶ Confirming effective commissioning arrangements that support clinical governance in service providers, defined performance expectations and ongoing monitoring and performance management of service providers
- ▶ Continuing to use a wide range of marketing modes to promote the program
- ▶ Socialising the public and existing service providers to this new model of care

Summary of findings



1

Question: Is NewAccess an effective and appropriate model for addressing mild to moderate depression and/or anxiety in the Australian context?

Finding: NewAccess was effective in achieving a recovery rate of 67.5%, demonstrating appropriateness in the Australian context and improving on UK reported rates of recovery for IAPT.

Recovery rate describes the percentage of people who entered above the clinical cut off score (caseness) and exited the program below the clinical cut-off (non-case).

The program was favorably viewed by the majority of clients and referrers who took part in the evaluation.

Client safety was addressed through a stringent risk management process that included a comprehensive supervision approach, oversight of coach activity via the PC-MIS system, and a clear process for “stepping up” those clients requiring more intensive services.

Recommendation: Future versions of the program should adhere to evidence and maintain and monitor current risk management approaches as a means of supporting client safety.



Summary of findings



2

Question: Is NewAccess improving access to support for men and other hard to reach population groups with mild to moderate depression and/or anxiety?

Finding: NewAccess appeared to improve access to mental health care for males and in rural communities on the North Coast of NSW. Across the three sites the proportion of male clients ranged from 35% to 47%, with the highest proportion in North Coast NSW. The overall proportion of male participants, although encouraging, did not reach the original target level for the program (40%). There was a decrease in the overall proportion of males over the life of the demonstration.

Rural communities remain disproportionately disadvantaged in access to mental health services. Stakeholders on North Coast NSW were unanimous in the view that access to mental health care had improved with the introduction of NewAccess. The program appeared to be reaching older people in residential aged care facilities in at least one site. The program was not tested in a remote rural environment or specifically with Aboriginal and Torres Strait Islander communities.

Recommendation: In order to maintain or increase attractiveness of the program to men, the key elements of the program - no cost, immediate access and convenient access (phone or face to face) should be continued. Marketing of the program should continue with a focus locally on those services with a high client load of males who are likely to be eligible for NewAccess.

Future rollouts should replicate successful strategies such as having the service hosted in employment services, as a means of attracting more males.

Future research on the program should consider the effectiveness of the program in specific populations, such as Aboriginal and Torres Strait Islander communities and/or CALD communities.

Summary of findings



3

Question: Does NewAccess provide the opportunity to develop a new workforce to support those experiencing mild to moderate depression and/or anxiety?

Finding: The Access Coach role represented a new workforce which, though small, appeared to be stable, with capacity to become a part of the continuum of mental health workforce in Australia. Results indicated that individuals from a range of backgrounds, with or without mental health training, had the capacity to be Access Coaches if trained and properly supervised. There was a recognised training program in place for coaches and supervisors. The role was attractive to those seeking a career pathway in mental health and those wanting to remain as coaches.

The maintenance of a strong recovery rate throughout the demonstration also supported this finding.

Recommendation: Consideration should be given to maintaining and expanding the existing infrastructure for training and supervision in any future rollout of the program. Coach selection should continue to be based on a mixture of personal characteristics, life experience and education. A mental health qualification should not be essential.

Summary of findings



4

Question: To what extent has the program retained fidelity with the UK IAPT program?

Finding: The Australian NewAccess program retained fidelity with the UK IAPT program. There were minor local adaptations made such as the development of a hub-and-spoke model for the more regional/rural site, however, these adaptations did not alter the core elements of the program. The most significant variation to the UK program was the non-inclusion of higher intensity CBT, within the same service (part of the UK IAPT model).

Treatment fidelity was essential in achieving outcomes and was monitored through supervision of coaches, fidelity audits of client sessions and monitoring of supervisors.

Recommendation: Future versions of the program should maintain fidelity with the current high level of risk management under which the program operates. Future adaptations should be reviewed to confirm they do not impact on fidelity.

Summary of findings



5

Question: What, as far as can be measured, are the cost and economic benefits of the NewAccess model?

Finding: The key benefit of NewAccess was the improvement in the quality of life for individuals who have recovered. There are also benefits in terms of reduced usage of (and expenditure on) existing mental health services and improved productivity.

Over the period examined (October 2013 to December 2014) NewAccess achieved a benefit-cost ratio of 1.5. This means that for every dollar invested in NewAccess, \$1.50 in benefits are estimated to arise. As a result, NewAccess yields a positive return on investment when the benefits are measured from the viewpoint of Australian society as a whole.

Recommendation: Should NewAccess be rolled out nationally, a follow-up economic cost benefit analysis, with expanded range for data, should be undertaken.

6

Question: Is the NewAccess model addressing an unmet need for those with mild to moderate depression and/or anxiety in the demonstration communities?

Finding: The initial scoping studies and consultation that were undertaken prior to the commencement of NewAccess indicated a gap in the mental health service system for LiCBT that included as an essential element, person to person coaching. The National Mental Health Commission Review Report highlighted the need for more early intervention services within a stepped system of care. Feedback from stakeholders interviewed for the evaluation indicated that prior to the introduction of NewAccess, there were no comparable options to which they could refer clients.

Recommendation: Consideration should be given to NewAccess as a service option in line with the recommendations of the National Mental Health Review for stepped care. It adds a new option for low acuity.

Summary of findings



7

Question: Is NewAccess appropriate for the Australian system?

Finding: NewAccess appeared to be appropriate in rural and metropolitan Australian environments and across the community care and health sectors. Adaptations to the mode of delivery (not content) were required to address local context.

NewAccess was able to be delivered using existing education (university), health (PHN), social services (NGO) infrastructure.

Self-referrals were high for the program. External referral sources appeared to be dependent on both the sector within which the hosting organisation had credibility and recognised links and where the hosting organisation chose to focus its marketing. The program complemented internet-based low intensity self-guided programs such as MindSpot.

The program relies on a regionally integrated stepped system of mental health care for full utilisation of its potential, and this system is not yet fully functioning in Australia. However, mental health reforms may increase the focus on stepped systems of mental health care in the near future.

Recommendation: Consideration should be given to testing the program (and alternative models of delivery) in a remote community. Future developments in NewAccess should continue to consider its place in the continuum of mental health care.

Summary of findings



8

Question:
Is NewAccess appropriate for national rollout?

Finding: Based on the client results, economic analysis, and consideration of the coach workforce, it appears NewAccess can be considered as an appropriate service model for wider rollout.

Recommendation: Consideration should be given to investigating options for a national rollout of NewAccess.

Any rollout should maintain the current level of risk management and monitoring/support of coaches and supervisors to maintain treatment fidelity.

A standardised approach to, and accreditation for, training providers, supervisors and service providers should be implemented.

To support consistent data collection and risk management practices, PC-MIS should be maintained as the client information system.

Consideration should be given to a mixed funding model based in part on throughput and in part on outcome measures (such as reliable recovery rate).

Well developed commissioning arrangements will be required to support:

- ▶ Effective, systematic approach, to clinical governance in service providers
- ▶ Well defined performance expectations
- ▶ Ongoing monitoring, performance management and quality management of service providers





Chapter footnotes:

1. ABS (2008). National Survey of Mental Health and Wellbeing 2007, Summary of Results (cat.no. 4326.0).
2. *beyondblue* (2013), New mental health workforce to improve mental health services in Australia, Media Release, Accessed at <http://www.beyondblue.org.au/about-us/news/news/2013/08/02/newaccess-a-new-way-to-get-help-for-depression-and-anxiety>
3. Mukuria, C et al (2013), Cost effectiveness of an improving access to psychological therapies service, *The British Journal of Psychiatry*, 202, p 220-227.

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